There is a person behind every prescription

Melissa Sheldrick

PATIENTS FOR PATIENT SAFETY CANADA | PATIENTS POUR LA SÉCURITÉ DES PATIENTS DU CANADA

ISMP CANADA

HARVARD MEDICAL SCHOOL

Who is Andrew Sheldrick?


Hey Buddy Want To Play?

Sleep disorder: what is it?

- **Parasomnia:** All of the abnormal things that happen to a person when they sleep.
- **REM Sleep Behaviour Disorder:** A brain disorder. Kicking, punching, hitting during the night is often seen. Also, nightmares are common.

Local, provincial, and national media

GO PUBLIC | **Parents find son's lifeless body after pharmacy switches sleep medication for toxic dose of another drug**

Boy's mother wants legislation that would force pharmacies to make prescription errors public

By Rosa Marchitelli, CBC News Posted: Oct 20, 2016 5:00 AM ET | Last Updated: Oct 21, 2016 9:20 AM ET

News / Canada

Mother of boy who died from wrong medication calls for better reporting of pharmacy errors

NEWS ONTARIO

MANDEL

Pharmacy's error killed boy, lawsuit claims

Ontario doesn't track mistakes

My campaign for change in Ontario

On June 19th, 2017, Andrew's 10th birthday, the Ontario College of Pharmacists formally announced that the CQI program would be phased into all Ontario community pharmacies.

AIMS Assurance and Improvement in Medication Safety

A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

REPORT

DOCUMENT

ANALYZE

SHARE

2010-2017

2024

Future

Errors reported in community pharmacies in the province of Nova Scotia

SafetyNET Rx
reporting • learning • improving

Increasing Patient Safety in Community Pharmacies

NS pharmacy errors, 2010 - 2017

80,488	82%
Near Miss (Didn't reach patient)	
16,681	17%
No harm	
839	0.8%
Mild harm	
80	0.08%
Moderate harm	
7	0.007%
Severe harm	
2	0.002%
Death	

TOTAL: 98097 ERRORS

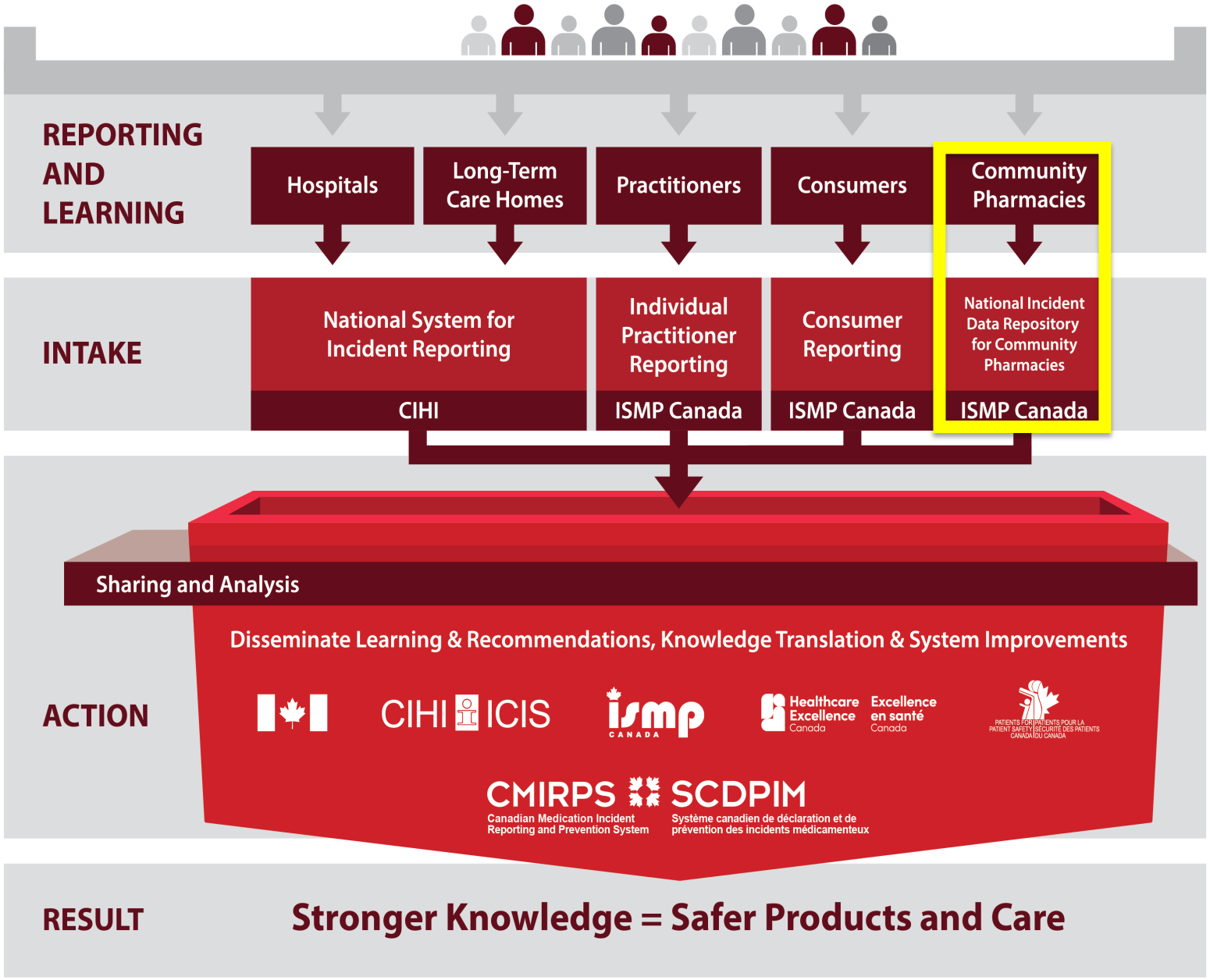
SafetyNET Rx reporting • learning • improving

news

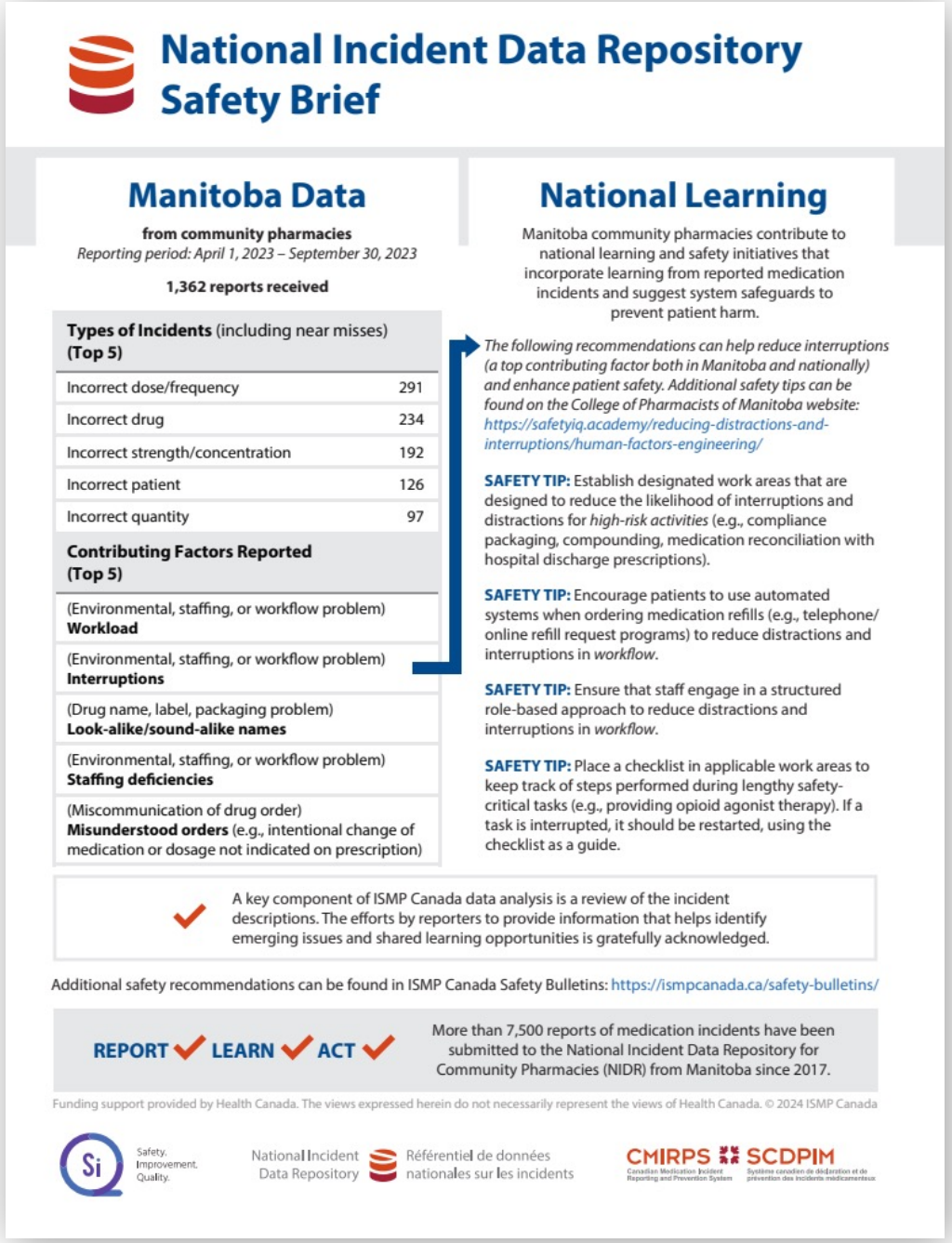
SOURCE: CMAJ Open

https://www.cmajopen.ca/content/6/4/E651

CMIRPS & NIDR


REPORTING AND LEARNING
Hospitals
Long-Term Care Homes
Practitioners
Consumers
Community Pharmacies
INTAKE
National System for Incident Reporting
CIHI
Individual Practitioner Reporting
ISMP Canada
Consumer Reporting
ISMP Canada
National Incident Data Repository for Community Pharmacies
ISMP Canada
Sharing and Analysis
Disseminate Learning & Recommendations, Knowledge Translation & System Improvements
ACTION
CIHI ICIS
ismp CANADA
Healthcare Excellence Canada
Excellence en santé Canada
PATIENTS FIRST PATIENTS POUR LA PATIENT SAFETY SÉCURITÉ DES PATIENTS CANADA DU CANADA
CMIRPS
Canadian Medication Incident Reporting and Prevention System
SCDPIM
Système canadien de déclaration et de prévention des incidents médicamenteux
RESULT
Stronger Knowledge = Safer Products and Care

NIDR
Safety Brief



National Incident Data Repository Safety Brief

Manitoba Data

from community pharmacies

Reporting period: April 1, 2023 – September 30, 2023

1,362 reports received

Types of Incidents (including near misses) **(Top 5)**	
Incorrect dose/frequency	291
Incorrect drug	234
Incorrect strength/concentration	192
Incorrect patient	126
Incorrect quantity	97

Contributing Factors Reported (Top 5)
(Environmental, staffing, or workflow problem) **Workload**
(Environmental, staffing, or workflow problem) **Interruptions**
(Drug name, label, packaging problem) **Look-alike/sound-alike names**
(Environmental, staffing, or workflow problem) **Staffing deficiencies**
(Miscommunication of drug order) **Misunderstood orders** (e.g., intentional change of medication or dosage not indicated on prescription)

National Learning

Manitoba community pharmacies contribute to national learning and safety initiatives that incorporate learning from reported medication incidents and suggest system safeguards to prevent patient harm.

The following recommendations can help reduce interruptions (a top contributing factor both in Manitoba and nationally) and enhance patient safety. Additional safety tips can be found on the College of Pharmacists of Manitoba website: https://safetyiq.academy/reducing-distractions-and-interruptions/human-factors-engineering/

SAFETY TIP: Establish designated work areas that are designed to reduce the likelihood of interruptions and distractions for *high-risk activities* (e.g., compliance packaging, compounding, medication reconciliation with hospital discharge prescriptions).

SAFETY TIP: Encourage patients to use automated systems when ordering medication refills (e.g., telephone/online refill request programs) to reduce distractions and interruptions in *workflow*.

SAFETY TIP: Ensure that staff engage in a structured role-based approach to reduce distractions and interruptions in *workflow*.

SAFETY TIP: Place a checklist in applicable work areas to keep track of steps performed during lengthy safety-critical tasks (e.g., providing opioid agonist therapy). If a task is interrupted, it should be restarted, using the checklist as a guide.

A key component of ISMP Canada data analysis is a review of the incident descriptions. The efforts by reporters to provide information that helps identify emerging issues and shared learning opportunities is gratefully acknowledged.

Additional safety recommendations can be found in ISMP Canada Safety Bulletins: https://ismpcanada.ca/safety-bulletins/

REPORT ✓ LEARN ✓ ACT ✓

More than 7,500 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Manitoba since 2017.

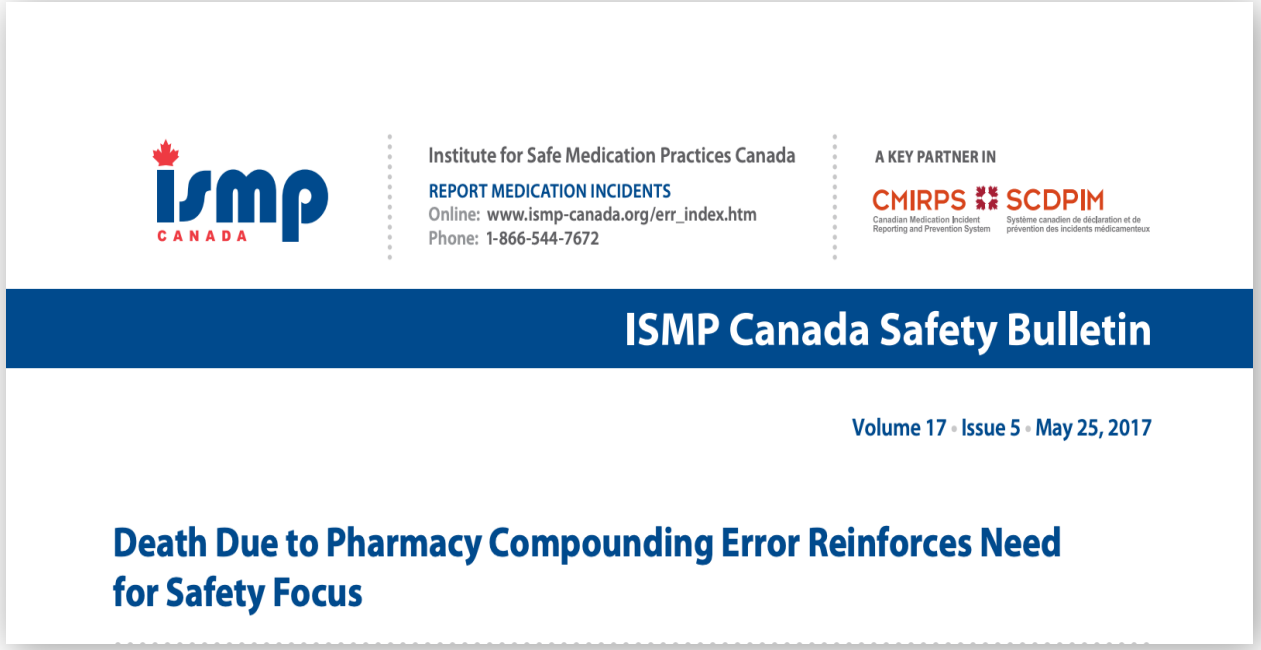
Funding support provided by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Safety. Improvement. Quality.

National Incident Data Repository | Référentiel de données nationales sur les incidents

CMIRPS SCDPIM

Analysis and recommendations



- Includes actionable recommendations for
  - regulatory agencies,
  - manufacturers of compounding chemicals, and
  - pharmacy teams.

https://ismpcanada.ca/wp-content/uploads/ISMPCSB2017-05-Tryptophan.pdf

Shared learning

https://ismpcanada.ca/wp-content/uploads/ISMPCSB2022-i9-API-Labelling.pdf
https://safemedicationuse.ca/newsletter/downloads/202202NewsletterV13N02-compounding.pdf

Why is a robust medication safety program important?

- Costs $42B/1% global health expenditure
- 1 person dies/day and 1.3M injured/year

https://www.who.int/news-room/facts-in-pictures/detail/patient-safety

World Health Organization – Medication Without Harm Global Challenge

In 2017, the W.H.O announced the Medication Without Harm Global Challenge, which aims to reduce medication errors, globally, by 50% in the following 5 years.

https://www.who.int/initiatives/medication-without-harm

Elevate the voice of Patients for patient safety

World Health Organization

75 HEALTH FOR ALL

World Patient Safety Day 17 September 2023

World Patient Safety Day 17 September 2023

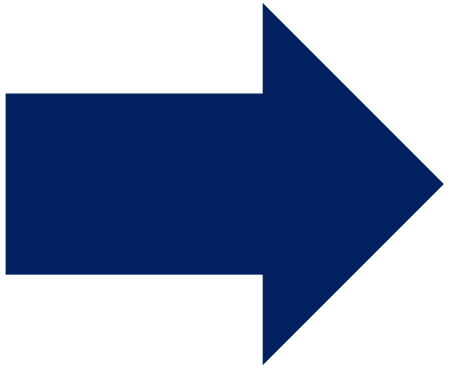
What is patient engagement?

PATIENTS FOR PATIENT SAFETY CANADA | PATIENTS POUR LA SÉCURITÉ DES PATIENTS DU CANADA

Patients for Patient Safety Canada is a patient-led program. We are the voice of the patient and bring our experiences to help improve patient safety at all levels in the healthcare system.

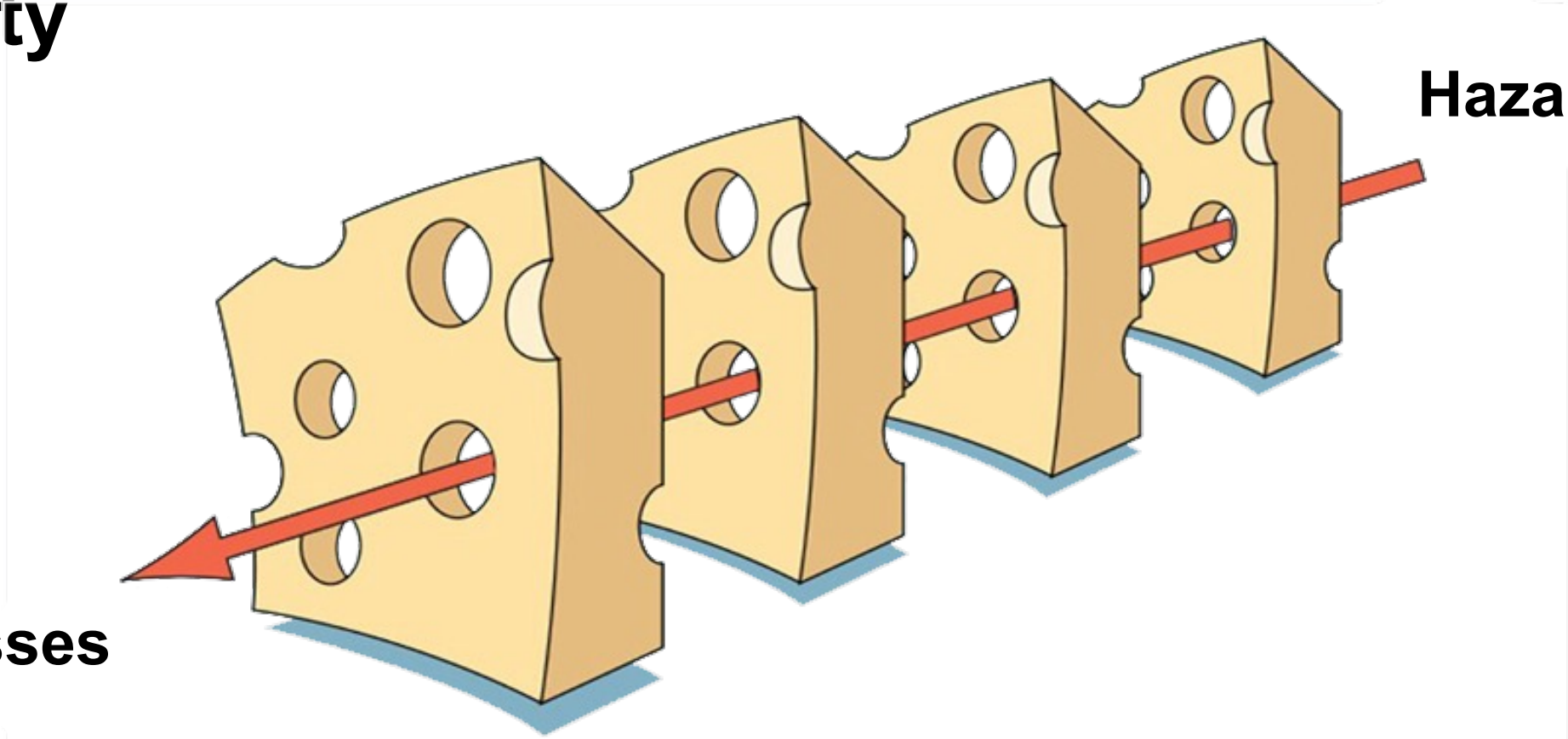
Quality improvement shift

Person Approach



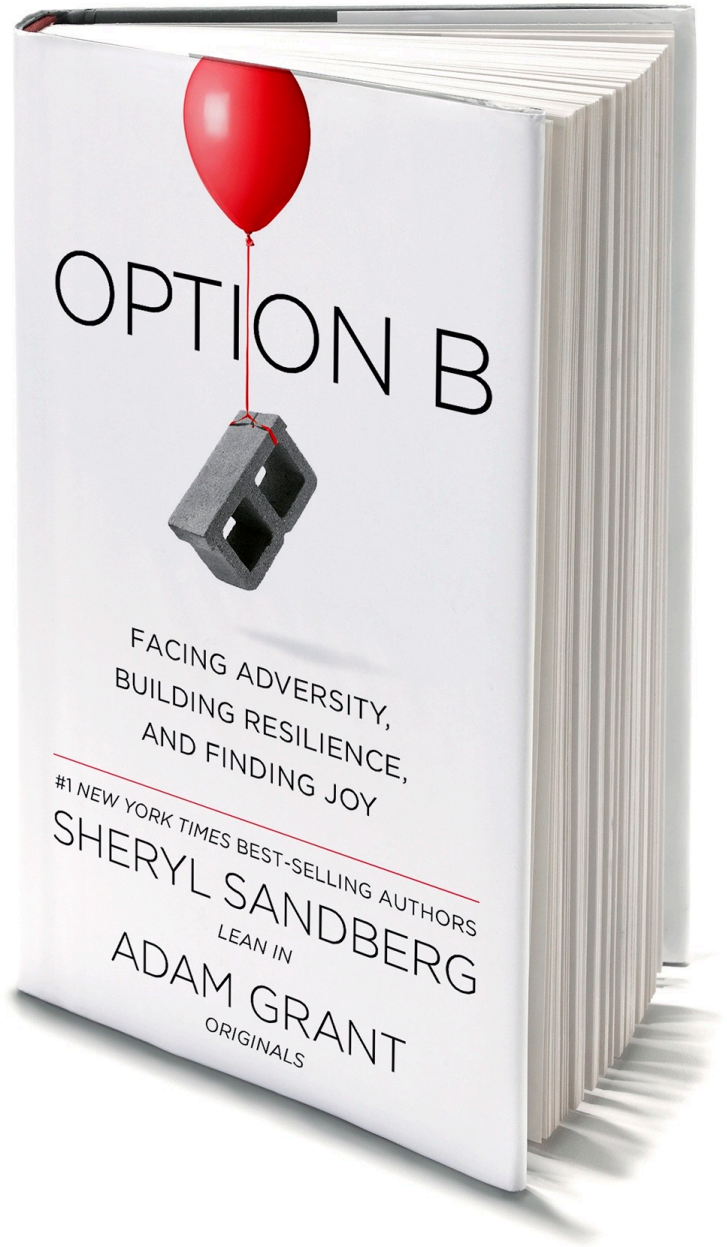
Systems Approach

James Reason's Swiss Cheese Model of Patient Safety



Evaluation Clinical Practice, Volume: 24, Issue: 1, Pages: 187-197, First published: 23 November 2017, DOI: (10.1111/jep.12847)

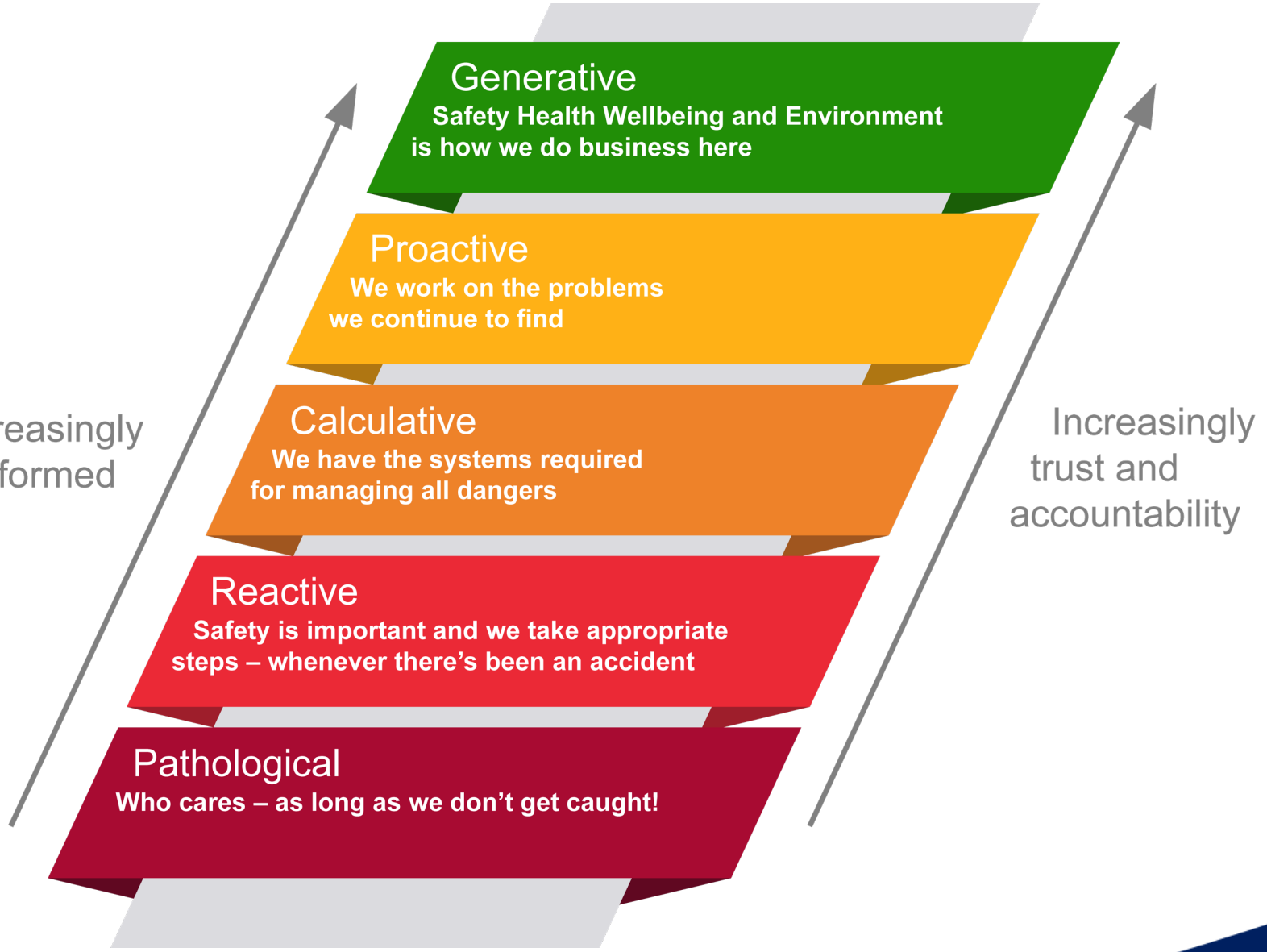
“…when it's safe to talk about mistakes, people are more likely to report errors and less likely to make them. Yet typical work cultures showcase success and hide failures. Teams that focus on learning from failures outperform those who don’t, but not everyone works in an organization that takes the long view.”



Culture shift

http://www.westeve.com/safety/our-safety-culture

The safety culture ladder



Accessed from The Patient Safety Company

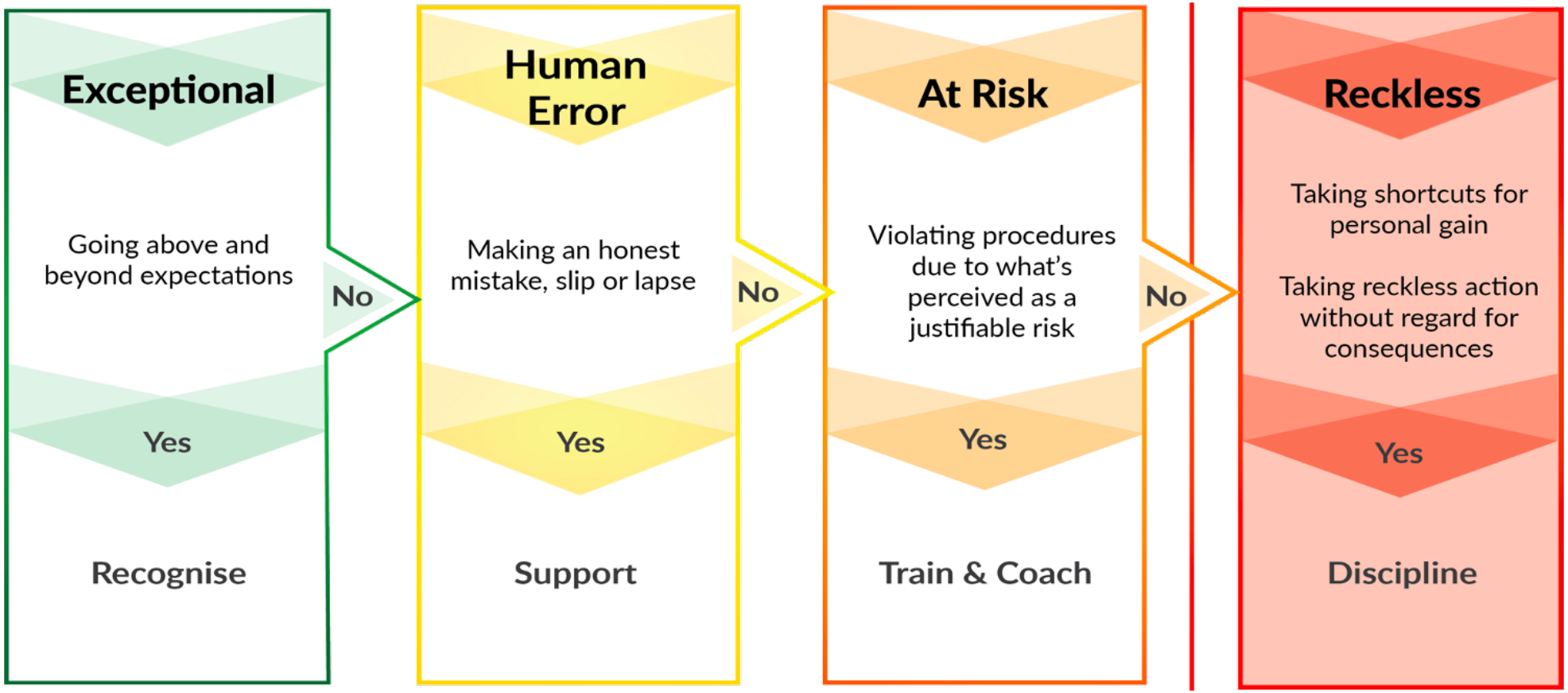
Psychological Safety & Medication Errors

Professor Amy Edmondson discusses the findings of medication errors in different types of teams.

Watch: 4:05 – 7:12

Watch on YouTube

Just culture



https://www.cortexia.com.au/fair-just-culture-implementation/fair-and-just-culture-model-simple-2/

Bringing it all together

Key messages

- There is a human life directly affected with every decision you make as a pharmacy professional.
- Collaboration and communication are key to increasing safety. You are not alone! Ask questions and innovate.
- Establish a safety culture within your mindset and embed it into your practice every day. Work together to minimize and eradicate preventable errors.
- Find ways to engage with patients and families.

acp CONNECT

Patient Safety & Continuous Quality Improvement

Brett Baumback, BSc. Pharm.
ACP Quality Improvement Project Lead

Reflection

Have you ever been involved in a medication error or practice incident?

ACP Council – Strategic plan – Goal #4

- Data intelligence is used by registrants and the college to make more informed decisions.

Key objective

- Information collected through centralized reporting of pharmacy errors will enable pharmacy teams to improve their practices.

ACP initiative

- Develop a program for documenting, collecting, and analyzing medication incidents.

Where are we today?

Pharmacy teams are already embodying Quality Assurance (QA) processes within their practice environments

- documenting practice incidents when they occur,
- investigating contributing factors,
- developing action plans to prevent future occurrences, and
- conducting ongoing monitoring of QA activities through quarterly reviews.

Alberta College of Pharmacy

Drug incident report form

Drug incident - patient safety report

1. As per Standard 1.10 of the Standards of Practice for Pharmacists and Pharmacy Technicians, each pharmacist and pharmacy technician must participate in the quality assurance processes required by the Standards for the Operation of Licensed Pharmacies.
2. Use this form for all related drug incidents.
3. As per Standard 6.4(b), the regulated member involved in the drug error must document an account of the error as soon as possible after the discovery. If the regulated member involved is not on duty at the time of discovery, the regulated member or employee who discovers the drug error must initiate the documentation.
4. Notify all regulated health professionals and caregivers whose care for the patient may be affected by the drug error.
5. Attach Rx & transaction record – photocopies or originals are acceptable.
6. Retain this report for 10 years from discovery date.
7. This form is for drug incidents, drug errors and adverse drug events only; not adverse drug reaction reporting (ADRs).
8. All reports must be reviewed at least quarterly to evaluate success of changes implemented (Standard 6.6).

What is a drug incident? (Standard 6)

a. Drug incident means any preventable event that may cause or lead to inappropriate drug use or patient harm. Drug incidents may be related to the practice of pharmacists or the practice of pharmacy technicians, drugs, health care products, aids and devices, procedures or systems, and include
   - prescribing;
   - order communications;
   - product labeling, packaging, nomenclature;
   - compounding;
   - dispensing;
   - distribution;
   - administration;
   - education;
   - monitoring; and
   - use.

b. Adverse drug event means an unexpected and undesired incident related to drug therapy that results in patient injury or death or an adverse outcome for a patient, including injury or complication.

c. Drug error means an adverse drug event or a drug incident where the drug has been released to the patient.

Patient information

Name Sam Anyone

Address 123 Anystreet Rd. Anytown, AB T0T 0T0

Phone 780-123-4567

Email sam.anyone@yahoo.ca

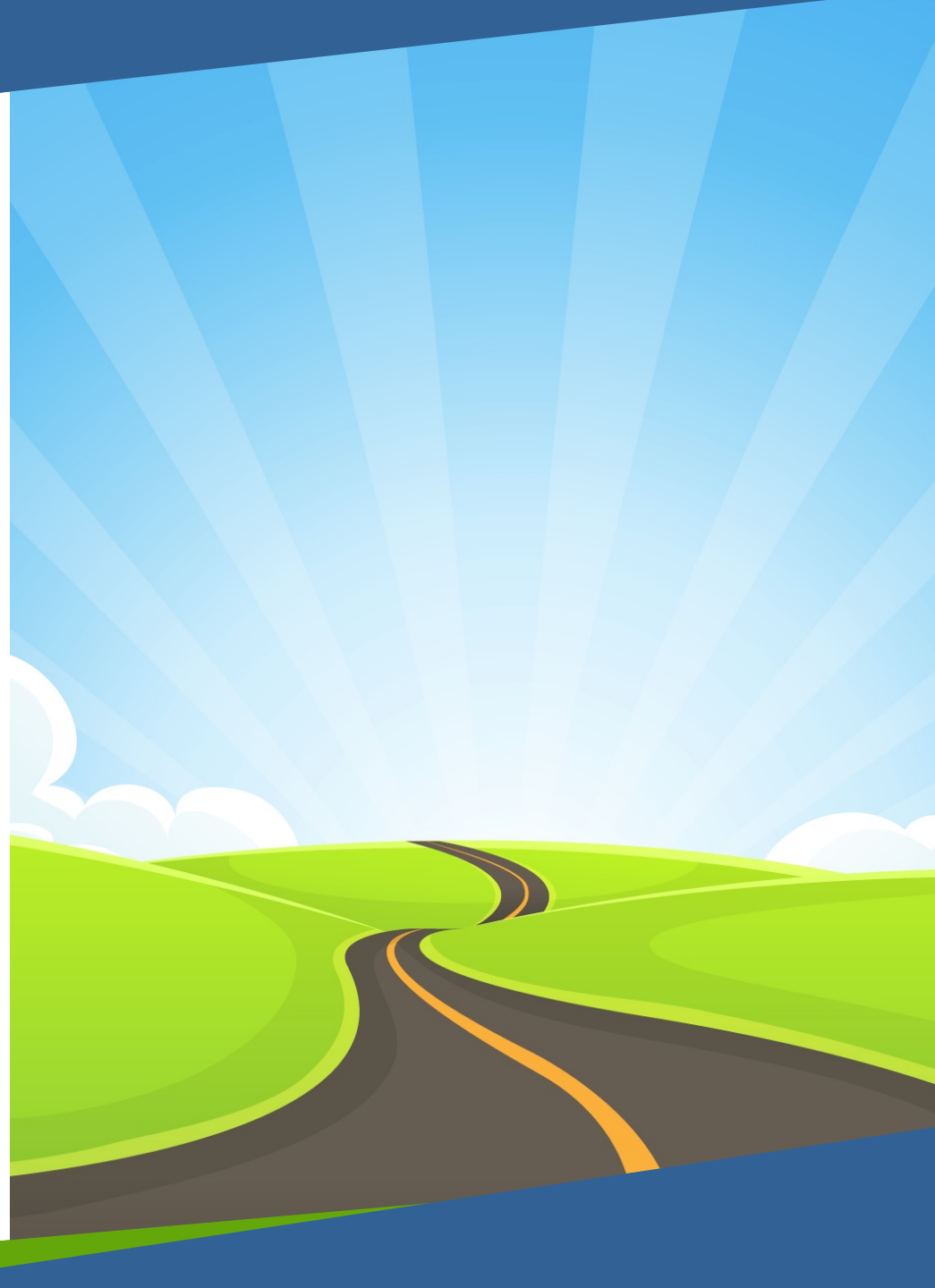
Sex (M) F

D.O.B 01 / 02 / 42 Day / Month / Year

Other relevent demographic data weight = 75 kg

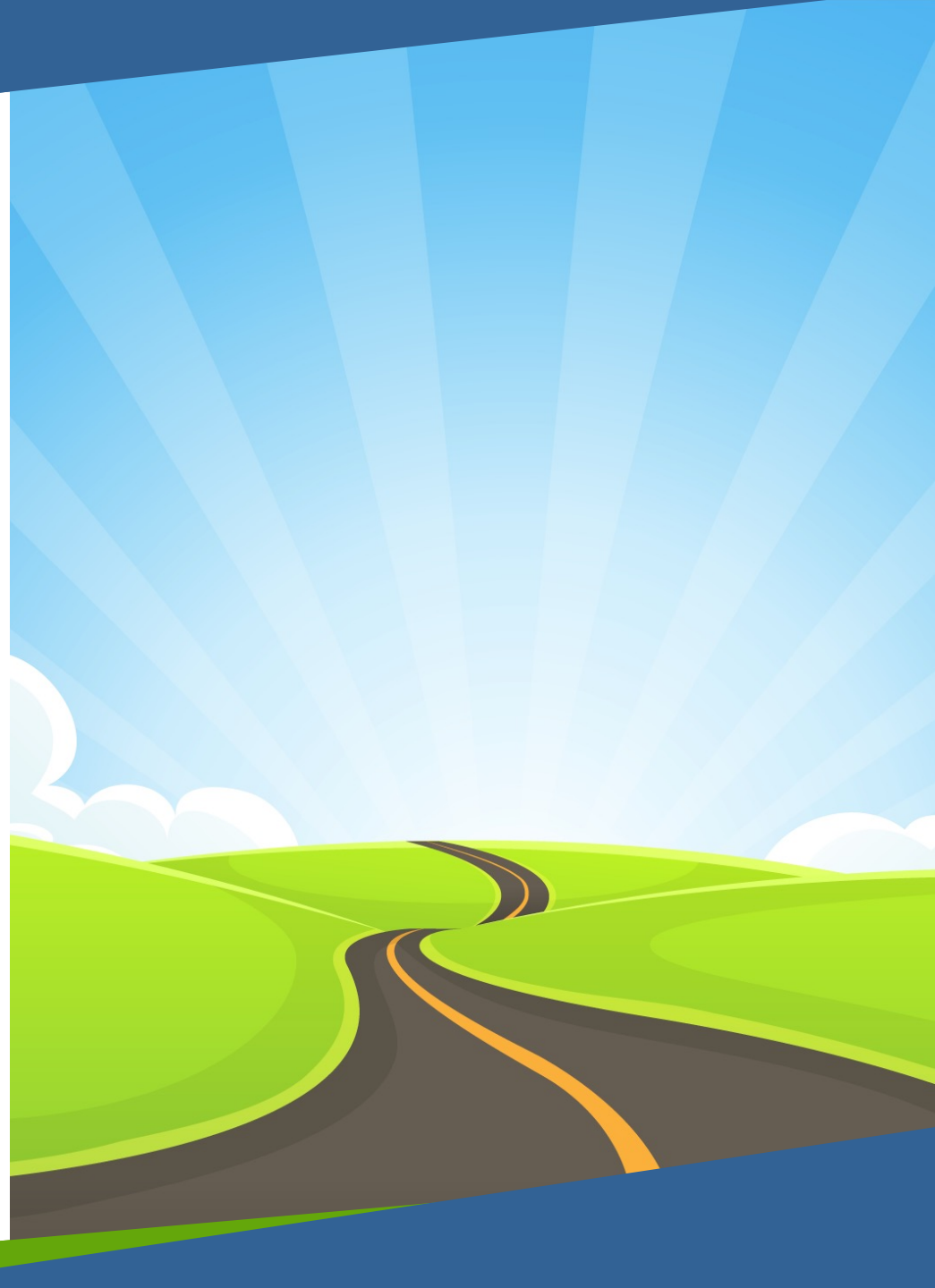
Where are we headed?

- Key to our success is sharing our learnings
- This requires pharmacy professionals to embody **safety culture**
- The culture must also be **just**
  - Feeling safe and supported to talk about quality, and to raise concerns



Where are we headed?

- Consider how we can engage our patients as partners in this journey
- What opportunities are there to share our learnings beyond the pharmacy environment?



CQI+

CQI+ will empower the safety culture in Alberta community pharmacies through continuous quality improvement processes and sharing of information about practice incidents.

Key features

- Documentation and analysis of practice incidents and close calls using supporting technology
- Anonymous reporting to a central database
- A CQI process to address and monitor quality in the pharmacy

Key features

- Self-assessments to proactively identify risk
- Resources to support safety culture and just culture in the pharmacy
- Training and support for pharmacy team members
- Trends and insights from incident data collected

What CQI+ is

- Anonymous
- Just
- Proactive
- Provincial in scope
- Patient-centred

What CQI+ isn't

- Blaming
- Punitive
- Reactive
- Narrow in scope
- Pharmacy-centred

What's next?

Reflect

Pharmacy teams begin reflecting on the safety culture in their practices

Communicate

ACP will communicate program details and requirements to pharmacy teams

Document & report

Pharmacy teams will begin documenting and reporting practice incidents and close calls

Implement

Full implementation of CQI+ by the end of 2025

Get involved!

- Over the coming months, ACP will engage with registrants, licensees, proprietors, and other stakeholders
- Are you a patient safety champion? Please get in touch with me!

brett.baumback@abpharmacy.ca