COMPASS
Community Pharmacy Professionals
Advancing **Safety** in Saskatchewan

[directions]

REPORT FROM THE FIELD ON OUR COMPASS PROGRAM

VOLUME THREE / ISSUE TWO APRIL 2018

"A just culture allows for the imperfectness of humans and the recognition that there are other factors at play when an error occurs but also allows for individual accountability."

Just Culture – What is it?

The information in this article was based on an ISMP Medication Safety Alert published by ISMP on September 7, 2006, entitled *Our Long Journey Towards a Safety-Minded Just Culture, Part I: Where We've Been*.

The concept of a "Just Culture" is a relatively new one. It is not that long ago that health care environments had primarily a **punitive culture** when an error occurred. In a punitive culture, it is thought that errors occur due to faulty practitioners that are not vigilant enough and therefore by retraining, counseling and disciplining these workers, errors would not occur. As well, by removing these individuals from the work environment, healthcare would be much safer. The impact of this type of culture is that errors do not stop occurring, but when they do occur all attempts are made to hide them. Nothing is done to improve and prevent the error and no learning is occurring.

In **blame free** or **no blame** type of culture there is a belief that system, process, technical or environmental flaws allow for errors to occur. As well, because humans are a part of the system, there is a belief that errors occur due to mental

slips, lapses or honest human mistakes. Recognition of the fallibility of humans and the fact that they are not going to be perfect all the time allows for the ability to look at other factors for the root cause of an error. The advantage to this type of culture is that individuals are more willing to report and discuss errors if they are not going to be blamed or have to take responsibility for the error. However, this type of culture does not take into consideration errors that occurred due to unsafe, willful acts or other unsafe behaviors where the risks to patients or others are disregarded. Although, a blame free culture allows for the recognition that other factors are at play with respect to errors, and that it is not just a specific individual causing the error, there needs to be a belief that individuals will have to be accountable for errors that occur due to unsafe, willful acts. That is where a just culture comes into play.

A just culture is one that recognizes the imperfectness of humans and that system, process, technology and environmental flaws impact the occurrence of errors. However, there is also recognition that there needs to be individual accountability for errors that occur due to unsafe intentional acts. A leading authority on just culture, David Marx, describes it this way:

> On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake. It is a culture that rewards reporting and puts a high value on open communication—where risks are openly discussed between managers and staff. It is a culture hungry for knowledge.
>
> On the other side of the coin, it is about having a well-established system of accountability. A Just Culture must recognize that while we as humans are fallible, we do generally have control of our behavioral choices, whether we are an executive, a manager, or a staff member. Just Culture flourishes in an organization that understands the concept of shared accountability—that good system design and good behavioral choices of staff together produce good results. It has to be both.[1]

1 Marx D, Comden SC, Sexhus Z. Our inaugural issue—in recognition of a growing community. The Just Culture Community News and Views. Nov/Dec 2005;1:1.

Therefore, a just culture allows for the imperfectness of humans and the recognition that there are other factors at play when an error occurs, but also allows for individual accountability when an error occurs due to a willful disregard of safe practices.

Please watch for the next installment on Just Culture in the next edition of the [directions] newsletter due out in July. The topic will be "Just Culture - Why is it Important to Patient Safety."

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **3,055** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and March 30, 2018.

Incident Types

128 users have submitted at least one incident on CPhIR, with the top three types of incidents being:

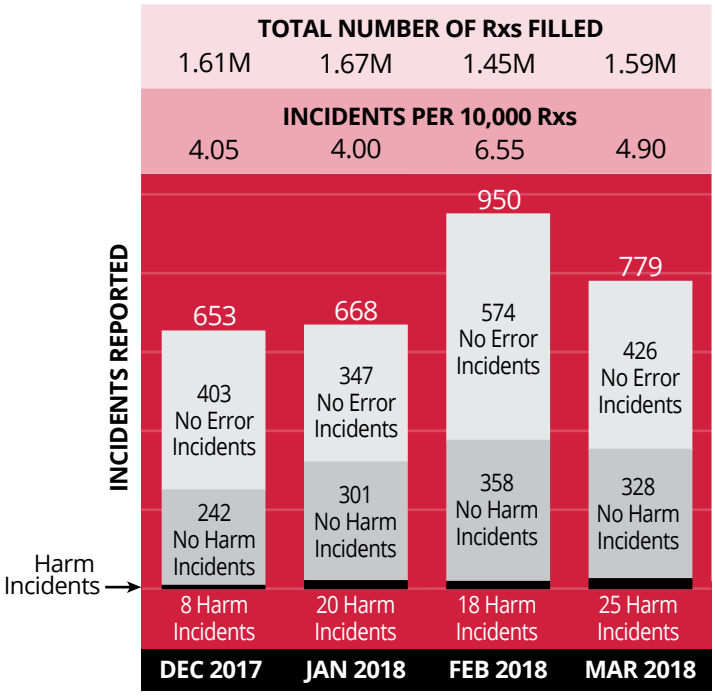
- incorrect dose/frequency **– 680**
- incorrect quantity **– 483**
- incorrect drug **– 545**

Outcomes

The majority or **1,750** of incidents reported had an outcome of NO ERROR, which means the incidents were intercepted BEFORE they reached the patient.

There were **1,229** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.

71 reported incidents did result in HARM, with most of these in the category of MILD HARM.



As well, **328** pharmacies have either completed or started their Medication Safety Self-Assessment (MSSA) online data entries and **32** Continuous Quality Improvement (CQI) meetings have been held.

Volunteers for the COMPASS Committee

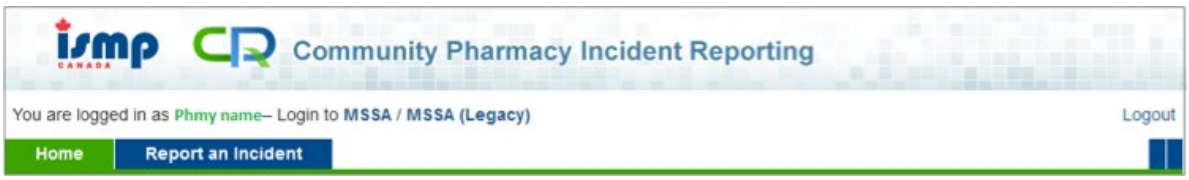
Now that COMPASS has been implemented in all Saskatchewan community pharmacies, volunteers are being requested to be a part of the COMPASS Committee. The COMPASS Committee is responsible for the continuous quality improvement of COMPASS and provides oversight and direction for the COMPASS CQI program to resolve program issues.

SCPP is specifically looking for COMPASS QI Coordinators to be a part of the committee. Interested members are asked to contact Jeannette Sandiford, COMPASS Lead, at **info@saskpharm.ca** or at 306-584-2292.

Messages from ISMP Canada

New MSSA Information

Have you noticed that at the top of the home page of your Community Pharmacy Incident Reporting (CPhIR) account, there are two links to the online Medication Safety Self-Assessment (MSSA) program?



What is the difference?

"MSSA" – ISMP Canada has launched a new version of the online MSSA platform. Going forward, please use this link to enter your pharmacy's MSSA data online.

"MSSA Legacy" – This is a link to the old MSSA platform. If you need to retrieve your pharmacy's MSSA data and results from previous years (i.e. prior to 2018), you can still access them through this link.

- A "Quick Start Guide" to the new MSSA platform is available on CPhIR under the **"Your Account"** tab and the **"CE & Resources"** tab.
- No additional password is needed to access either of the two links. The MSSA and MSSA Legacy are automatically linked to your CPhIR account.
- For additional information or clarification, please contact **mssa@ismp-canada.org**

MSSA Legacy Platform change

Effective **May 1, 2018** the MSSA Legacy platform will be in a read-only format. This means that no further changes will be able to be made to any MSSAs entered on this platform, including ratings for the indicators. Also, no new MSSAs will be able to be entered on this platform. Pharmacies that have entered their MSSAs on this platform will still be able to view their results, including any graphics. However, they will not be able to make any changes. Ensure that if you have started entering the results of your MSSA on this platform, that you complete it before May 1, 2018. Otherwise you will be required to re-enter the MSSA information on the new MSSA platform. For more information, please contact ISMP Canada at **mssa@ismp-canada.org**.

Incident Reporting

ISMP Canada would like to thank everyone for their ongoing support and engagement in the COMPASS program. The following are a few key messages regarding the Community Pharmacy Incident Reporting (CPhIR) program:

- Whenever possible, please consider providing as much detail in the **"Incident Description"** field, as this provides the most rich and informative information, especially for analysis
- While entering a medication incident, please consider checking off relevant contributing factors within the **"Contributing Factors"** section of the incident reporting form. This information provides additional insight for analysis, which is helpful for pharmacy staff members to analyze and discuss during continuous quality improvement (CQI) meetings
- Upon completion of an incident report, please remember to **"Close and Submit"** the incident. **ISMP Canada only receives "Closed Incidents."** "Open Incidents" are only saved locally within the pharmacy's CPhIR account, and are not sent to ISMP Canada

Implementation Dates Reminder

Pharmacy staff are reminded that the COMPASS tools are to be implemented into their workflow by the dates listed below. The dates have been chosen to allow staff to implement each of the safety tools without getting overwhelmed.

February 1, 2018 – Community Pharmacy Incident Reporting (CPhIR) tool

- reporting actual incidents and near misses (good catches)

April 1, 2018 – Medication Safety Self-Assessment (MSSA)

- survey completed and entered online

June 1, 2018 – Quality Improvement (QI) Tool

- improvement plan developed and documented

The next tool to implement is the Quality Improvement Tool. Pharmacy staff members can use the tool to develop and document their quality improvement plan. Any pharmacies that have not yet started entering incidents or have not yet completed an MSSA are strongly encouraged to do so as soon as possible. Any questions or needed clarification can be directed to Jeannette Sandiford at **info@saskpharm.ca** or at 306-584-2292.

Ask Me Anything Sessions

ISMP Canada has developed a process to allow community pharmacy staff members, specifically Pharmacy Managers and/or QI Coordinators, to request a designated time to ask questions, troubleshoot problems or get instruction on the COMPASS tools (CPhIR and MSSA). These "Ask Me Anything" sessions are intended for questions that may need a little more time (15-30 minutes). Pharmacy staff can continue to phone ISMP Canada to talk to an ISMP Canada staff member anytime for shorter, less in-depth questions.

ISMP Canada wants to ensure that individuals who have questions or require other information (refresher training) are able to speak directly to an ISMP Canada staff member. SCPP members are welcome to register for a date and time to speak with ISMP Canada via scheduled teleconference. ISMP Canada will then call you accordingly. Scheduled calls are in 15-minute or 30-minute allotments. RSVP can be done via the following link: **https://secure.ismp-canada.org/CPHIR/Reporting/ama.php**

Focus on Patient Safety

The Institute for Safe Medication Practices Canada is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada works collaboratively with the healthcare community, regulatory agencies and policy makers, provincial, national and international patient safety organizations, the pharmaceutical industry and the public to promote safe medication practices. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

ISMP Newsletter Subscriptions

ISMP Canada Safety Bulletins are designed to disseminate timely, targeted information to reduce the risk of medication incidents. The purpose of the bulletins is to confidentially share the information received about medication incidents which have occurred and to suggest medication system improvement strategies for enhancing patient safety. The bulletins will also share alerts and warnings specific to the Canadian market place.

The following ISMP Canada Safety Bulletins have been issued since the last issue of the Newsletter: ISMP Canada Safety Bulletins for Practitioners, 2018 – Volume 18:

- **Deprescribing: Managing Medications to Reduce Polypharmacy**
- **Students Have a Key Role in a Culture of Safety: A Multi-Incident Analysis of Student-Associated Medication Incidents**
- **Death Associated with an IV Compounding Error and Management of Care in a Naturopathic Centre**

SafeMedicationUse.ca Newsletters and Alerts for Consumers, 2017 - Volume 8:

- **Using Your Own Medications While in Hospital**

All issues of the ISMP Canada Safety Bulletins, including those issued in previous years, are freely downloadable from the ISMP Canada website at **www.ismp-canada.org**. ISMP Canada is pleased to distribute The Medication Safety Alert! (US) newsletters along with ISMP Canada Safety Bulletins to Canadian practitioners and corporations.

To subscribe and for more information on all ISMP Canada's publications, events and services visit the ISMP Canada website at **www.ismp-canada.org**.

ismp CANADA eLearning

New!! Online Learning Program: Medication Safety Considerations for Compliance Packaging

Have you experienced an error or a near miss when preparing a compliance package?

Have you wondered if there is a safer way to do compliance packaging?

The complexity of filling compliance packages is often underestimated and errors have occurred, some causing serious patient harm.

This 5 module course is designed to help pharmacists, pharmacy technicians, and pharmacy assistants safely prepare compliance packages. It introduces medication safety principles and concepts specifically applicable to compliance packaging, examines the potential for medication errors associated with compliance packaging, and provides system-based strategies for prevention.

CEP® ACCREDITED

The Canadian Council on Continuing Education in Pharmacy (CCCEP) has accredited this program for 3 CEUs for both pharmacists and pharmacy technicians; CCCEP # 1231-2017-2195-I-P and 1231-2017-2196-I-T.

After completing this course you will be able to:

1. Differentiate between patients who would and would not benefit from compliance packaging;
2. Describe the steps involved in initiating compliance packaging for a patient;
3. Compare and contrast the different types of packaging available;
4. Understand the types of errors that can occur with the different steps in compliance packaging preparation;
5. Identify critical intervention points to prevent errors;
6. Understand the roles of pharmacists, pharmacy technicians and pharmacy assistants in dispensing compliance packages; and
7. Examine your current workplace, and implement process changes to minimize the likelihood of medication errors when dispensing compliance packs.

Who should take this program?

Pharmacists, pharmacy technicians, and pharmacy assistants who want to learn more about how to safely prepare compliance packages.

What modules are included?

1. Introduction to Medication Safety
2. Patient Selection and Initiation of Compliance Packaging
3. Overview of Regulatory Requirements for Compliance Packaging
4. Preparing Compliance Packages Safely
5. Environmental Factors

Each module is 10-20 minutes in length - modules can be completed all at once or one at a time. To obtain a statement of completion and continuing education units, completion of the course test and evaluation is required. The program includes links to guidance from pharmacy regulatory authorities across Canada, where available.

Program cost: $225 + applicable taxes.

For more information or to register, visit the **ISMP website**.

Disclosure and Reporting of Medication Incidents Document

ISMP Canada has developed a document as a quick reference for front-line pharmacy staff about disclosing and reporting incidents. The reference provides a five-step approach to prepare for and deliver the disclosure of a medication incident to a patient and/or family. Error prevention principles are also included in the reference, including the hierarchy of effectiveness. The hierarchy of effectiveness is very useful in determining appropriate actions after a medication incident has occurred including which solutions are the most effective and the most feasible. A link to the reference document is available on the SCPP website under the COMPASS tab. The direct link is: **https://scp.in1touch.org/document/4164/Disclosure_Reporting_Med_Incidents_20170426.pdf**. If you have questions or for more information, please contact Jeannette Sandiford at **info@saskpharm.ca**.

The Second Victim: Supporting the Healthcare Providers involved in Medication Errors

Clinically complex and busy healthcare settings with multiple practitioners providing care for multiple patients intrinsically involves a risk of errors. Unfortunately, adverse events, medical errors and medication errors can occur despite the best intentions of healthcare workers.

Upon the discovery of a medical or medication error, there are usually two victims who are affected by the aftermath: The "first victim," which refers to the patient and their loved ones, and the "second victim,"[2] the healthcare professional involved in the error. The profound effects and impact of errors to the first victim and their family are of utmost importance, consideration, and priority; focusing on their needs, well-being and recovery takes precedence.

In addition to the "first victim," there is inevitably a "second victim," which refers to healthcare professionals who experience emotional distress following an adverse event, medical incident or medication incident that results in patient harm. Second victims feel as though they have failed the patient and start to second guess and doubt their clinical skills, knowledge, and career choice[3],[4]. ISMP Canada has published a bulletin titled, *"The Second Victim: Sharing the Journey toward Healing,"* which provides a first-hand account from a pharmacist who was involved in the death of a patient, and how the pharmacist coped with the medication error.

It is estimated that almost 50% of all healthcare providers are a second victim at least once in their professional career[5]. Frequently, these individuals feel isolated and personally responsible for the patient outcome, and experience emotions such as guilt, anxiety, grief, depression, distress and inadequacy. The

2 Marmon LM, Heiss K. Improving surgeon wellness: The second victim syndrome and quality of care. Semin Pediatr Surg. 2015; 24(6):315-318. doi: 10.1053/j.sempedsurg.2015.08.011

3 Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009; 18: 325 0 300

4 Scott, S.D., et al. (2010) Caring for our own: deploying a systemwide second victim rapid response team. Joint Commission Journal on Quality and Patient Safety, 36, 233–240.

5 Edrees, HH., Paine, LA., Feroli, ER., Wu, AW., 2011. Health care workers as second victims of medical errors. Polskie Archiwum Medycyny Wewnętrznej 121, 101-108

emotional burden to the second victim can last for a long time, ranging from several days to several weeks; a few go on to suffer long-term consequences, similar to post-traumatic stress disorder[6].

Second Victims need our compassion and support

To support second victims, it is important that they are met with the "5 Rights of Second Victims," particularly when reviewing events and addressing staff[7]:

T reatment that is just
R espect
U nderstanding and compassion
S upportive care
T ransparency and opportunity to contribute

Organizations and staff are encouraged to create "safe spaces" in which healthcare professionals can openly share and discuss matters relating to medication incidents in a non-judgmental and confidential manner. A "safe space" can be any forum, formal or informal, for second victims and healthcare practitioners to:

1. share their experiences with medication incidents and recommendations to prevent recurrences of such errors;
2. discuss coping strategies; and
3. promote shared learning and knowledge transfer with respect to medication incidents.

The goal of most second victims is reconciliation and closure, which is best achieved through disclosure[8]. As such, the healing properties of sharing can enable second victims to release their emotions in a cathartic manner, while gaining insight and deriving meaning from the incident[9].

Don Berwick, one of the authors of the Institute of Medicine's landmark report on medical errors titled, *"To err is human: Building a safer health system"*[10]

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6 Wu A, Steckelberg R. Medical error, incident investigation and the second victim: doing better but feeling worse? BMJ Qual Saf. 2012; 21(4): 267 – 270

7 Prowse D, Long S. Healing after harm: Creating awareness of second harm and providing support to second victims. Pharmacy Practice. 2014;1(4): 23 – 25

8 Cabilan CJ, Kynoch K. Experiences of and support for nurses as second victims of adverse nursing errors: a qualitative systematic review. JBI Database of Systematic Reviews and Implementation Reports. Sept 2017; 15(9): 2333 – 2364

9 Gladding S, Drake Wallace M. The Potency and Power of Counseling Stories. Journal of Creativity in Mental Health 2010;5(1):15-24.

10 Kohn KT, Corrigan JM, Donaldson MS. To Err Is Human: Building a Safer Health System. Washington, DC: National Academy Press; 1999.

explained that: *"Technically the biggest 'safety system' in healthcare is the minds and hearts of the workers who keep intercepting the flaws in the system and prevent patients from being hurt. They are the safety net, not the cause of the injury."*

In keeping with this philosophy, second victims should be part of the discussion, and provided with emotional first aid, counselling and education to help them recover from the aftermath of the error.

To learn more about how to support second victims, the following presentation from ISMP Canada includes information on identifying second victims, stages of recovery, barriers to support, and the structures that can promote healing: **https://youtu.be/bz1MKJ0Z0dQ**.

Contact

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