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

[directions]

REPORT FROM THE FIELD ON OUR COMPASS PROGRAM

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Psychological Safety: An Essential Constituent of COMPASS

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Given the complexity of the dispensing of medications, medication incidents are an inevitable part of community pharmacy practice. In fact, it is estimated that as many as 7 million medication incidents occur in Canadian community pharmacies each year.[1] Quality improvement programs such as **COMPASS** encourage the reporting and analysis of these incidents in an effort to improve learning and prevent recurrence. Unfortunately, reporting and discussing errors among pharmacy staff is often avoided due to the fear of retribution from both fellow colleagues and management.[1]

Overcoming these barriers is necessary to create an environment of "psychological safety". Psychological safety refers to the phenomenon where members of a team are comfortable taking interpersonal risks, such as reporting and discussing medication errors, without fear of negative consequences to self-image, status, or career.[2]

In healthcare, where errors form the basis upon which improvements in processes are established, psychological safety sets the foundation in allowing organizations and individual practitioners to learn from errors.

The effects of psychological safety can be expressed across three different levels: individual, group, and organizational (Table 1).

Table 1. Effects of Psychological Safety at the Individual, Group, and Organizational Levels

Level	Description
Individual	A working environment where an individual feels psychologically safe elicits confidence, and therefore drives creativity, proactivity, and eagerness to share information with others. Employees are more likely to proactively engage in sharing information with their peers and create opportunity for generative discussion of improvement.[2]
Group	Psychological safety at a group level is encompassed by team learning and continuing innovation developed through task conflict and group collaboration. The resulting supportive networks allow members to learn from shortcomings and incidents and encourage innovative changes in existing processes to optimize outcomes in the future.[2]
Organizational	Psychological safety at the organizational level involves building relationships between employer and employee, and the development of support networks within the organization.[2] Management practices that promote a sense of psychological safety within the organization facilitate knowledge exchange between peers and create an environment where individuals feel safe taking interpersonal risks.[2]

Creating an Environment of Psychological Safety

Development of psychological safety within the workplace promotes sharing of errors via upwards communication. This encourages staff to express concerns and share incidents not only among their peers, but also with executive staff members, resulting in potential for implementation of organization-wide changes and improvements.[2]

To develop a work culture that embraces psychological safety, factors that influence employees' perception of the work environment must first be addressed. This includes improvement in key areas of interpersonal relationships, management behaviours, and organizational practices. Cumulatively, these factors enhance psychological safety and ensure that employees consistently feel comfortable with sharing any incidents that they encounter.

Interpersonal Relationships

Interpersonal relationships, and the social support and resources inherent within, promote psychological safety and contribute to team learning, performance, and innovation.[2] Characteristics such as shared team rewards, formal team structures, and engagement in cross disciplinary work improve the strength of social networks and enhance psychological safety.[2]

Management Behaviours

Supportive and clarifying management processes are the most effective management styles in promoting psychological safety in the workplace.[2] Management characteristics such as inclusiveness, support, trustworthiness, openness, and behavioural integrity strongly influence employee perceptions of psychological safety, which in turn, fosters beneficial outcomes such as team learning behavior, team performance, engagement in quality improvement work, and a reduction in errors.[2]

Organizational Practices

Supportive organizational practices are positively related to employee work outcomes such as organizational commitment and job performance as they heighten perceptions of psychological safety.[2] Providing a supportive environment through access to mentoring and implementation of diversity practices promotes open discussion and willingness of staff to express concerns.[2]

Psychological Safety and Continuous Quality Improvement (CQI)

Creating a psychologically safe environment in community pharmacies will be necessary for the success of **COMPASS**. **COMPASS** requires community pharmacies to report all medication incidents and near misses to the Institute for Medication Practices Canada (ISMP Canada) through the Community Pharmacy Incident Reporting (**CPhIR**) program.[3] The incident reports generated not only help individual pharmacies develop quality improvement initiatives, but also allow aggregate analysis for shared learning across Canada.[3] Without psychological safety, pharmacy staff will be less likely to report incidents, suggest new ideas, or seek assistance. Creating a positive team dynamic and ensuring management and regulatory support are essential to establishing a safe environment at the individual, group, and organizational levels. By working towards psychological safety in community pharmacies, organizations and individual practitioners can better learn from incidents and improve medication safety.

References

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2 Newman A, Donohue R, Eva N. Psychological safety: A systematic review of the literature. *Human Resource Management Review* 2017; 27(3): 521-535.

3 Saskatchewan College of Pharmacy Professionals (SCPP). Community Pharmacy Professionals Advancing Safety in Saskatchewan (COMPASS). Available from: https://saskpharm.ca/site/compass/compass?nav=sidebar.

Just Culture – Impact from Human Behavior

In the April edition of the [directions] newsletter, the concept of a "Just Culture" was introduced. 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 just culture is therefore both fair to workers who make errors and effective in reducing safety risks. To review this article, click **here**.

In the second part of the Just Culture series, we will explore the impact that human behavior has on just culture and the fact that because each behavior has a different cause, a different response is required.

There are three types of behavior that can be involved in an error: human error, at-risk behavior and reckless behavior.

Human Error

Human error involves unintentional and unpredictable behavior that causes or could have caused an outcome that is not desired. With this type of behavior, it is believed that human errors occur due to weaknesses in the system and therefore should be handled through changes to process, system or environment. Discipline is not justified or beneficial because the individual did not predict or intend to cause an error, nor the risk or harm that resulted. The best option is to console the individual and ensure that changes are made to the systems to prevent further errors.

At-Risk Behaviors

At-risk behaviors involve behaviors that occur when individuals start to lose sight of the risk of certain actions or believe that the risk is justified to achieve a certain outcome. For example, they take a shortcut to get more work done even though they know that there are safer ways to complete the work. Often, at risk behaviors can be reinforced by the work environment. For example, those that appear to be able to complete greater amounts of work, quicker, may be admired, whereas others may be criticized for taking too long to complete a task, even though it is being done in a safer manner. This is where the problem lies. The rewards of at-risk behaviors can become so common that perception of their risk fades and is believed to be justified.

It is important to determine the motivations for these unsafe behaviors, so that they can be removed, and stronger motivations implement toward safe behaviors. Punishing the individual that is exhibiting these at-risk behaviors is not the solution but instead identify the system-based reasons for their behavior and decrease staff tolerance for risk taking. Once the motivations for the at-risk behavior have been addressed, individuals should be coached to make better behavioral choices.

Reckless Behaviors

Reckless behaviors occur when the individual understands the risk, knows the risk is substantial and intentionally decides to engage in it anyway. A behavior can be considered reckless even if harm was not intended or was the result. An example of reckless behavior is when an employee shows up to work under the influence of alcohol or illegal drugs. The individual understands the risk, harm is likely not intended and may or may not occur, but they make the decision to do it anyway. Other examples could be subtler such as deciding, due to vanity, to not wear their prescription glasses while entering medication orders into the computer or not removing make-up prior to entering an IV room to prepare sterile products. Reckless behavior is considered blameworthy behavior and as such should be dealt with through remedial or disciplinary actions.

Operating within a just culture provides an accountability model that is fair to all stakeholders, as well as providing a model for addressing system and behavioral risks before and after incidents have occurred. Understanding which type of the behavior is involved in the error allows for the appropriate actions to be taken to prevent similar errors in the future. These actions can include uncovering and repairing system design flaws to prevent human errors, recognizing and eliminating incentives for at-risk behaviors or taking remedial or disciplinary action for reckless behavior. Other than when reckless behavior is engaged in, when an error occurs, within a just culture, the critical question to ask is not necessarily what actions need to be taken with the individual involved in the error but what can be done to prevent the next incident.

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

The information in this article was based on an ISMP Medication Safety Alert – published by ISMP September 21, 2006, entitled "Our Long Journey Towards a Safety-Minded Just Culture, Part I: Where We've Going."

De-fusing an Angry or Upset Patient in the Pharmacy

Written by Lindsay Yoo, BSc, BScPhm, RPh, CDE, CGP, PharmD formerly the Medication Safety Analyst at Institute for Safe Medication Practices Canada (ISMP Canada), May 18, 2018

As the most accessible healthcare providers, community pharmacists encounter many different scenarios during a typical shift; this often involves the challenge of navigating unexpected situations. Among these unexpected situations is having to de-fuse an angry or frustrated patient in the pharmacy.

Handling a difficult situation that involves an angry or upset patient is a reality that most, if not all, pharmacists will face or have faced at least once in their career. How individuals respond and resolve the issue is just as important as the issue itself, if not more so; the approach taken by the pharmacist, and the way in which the situation is dealt with can make the difference between a satisfactory and resolved outcome, or the abrupt end of the patient-provider relationship.

Despite attempts to de-escalate a hostile situation, emotions sometimes threaten to take over; after all, anger and its associated emotions occur in the right side of the brain, whereas listening and rationalization are experienced in the left side of the brain. Being prepared with an approach in mind, or at least being aware of how to deal with such scenarios, can be helpful to mitigate tensions that are inherent in these types of situations.

The objective of this article is to bring awareness of some key considerations to de-fuse an angry patient, which the following describes.

Considerations	DO	DO NOT
Stop, focus, and use your best listening skills	Stop whatever you are in the middle of doing	Multi-task (e.g. listen and do something else at the same time)
	Give the patient your full attention, and listen to him/her	Assume that you know all the facts about the situation without letting the patient finish his/her explanation, clarifying facts, and/or inquiring about certain points
	Summarize or paraphrase what you've heard/ understood and ask questions to clarify	Interrupt the patient while he/she is speaking
	Express through your facial expression (e.g. keeping eye contact) and body posture (e.g. stand or sit up straight) that you are paying attention, receptive, and in control	Use any hostile or dismissive facial expressions or body language (e.g. clenching the jaw, frowning, smirking, rolling of the eyes)

Considerations	DO	DO NOT
Remain calm and commit to keeping your cool	Resist being drawn into the anger; detach from the situation and try to observe as a third-party person or bystander	Take the patient's remarks personally
Sympathize and acknowledge the anger	Resist the temptation to rationalize with the patient at the very beginning. This should be attempted after the issue is resolved and the patient has calmed down	Respond to the patient's anger with your anger
	Sympathize with what the patient has told you, and how he/she feels	Fault the patient for the situation or be overly defensive
	Address the patient by his/her name; use a soft, firm, and slow voice when speaking to the patient	Shout over the patient
Apologize	Offer a sincere and straightforward apology for the problem they are having (or perceive to be having) and/or the emotions that they are experiencing	Infer that you accept blame for something for which you are not responsible or have no control over
	Show empathy for the patient – acknowledge the emotions	
Look for a solution	Ask the patient what he/she believes should be done, or offer your own feasible resolution to the problem	Try to win or argue with an angry patient

Take proactive steps to prevent a recurrence

Although not directly related to defusing an angry patient, taking steps to prevent a similar occurrence in the future is an important consideration. If possible or if applicable, steps should be taken to address any underlying issues that contributed to the patient's anger.

The above considerations can be included in staff training and orientation. A proactive approach can include taking measures such as meeting and discussing with staff to tackle the issue, making improvements to a process, or seeking clarification and documentation to prevent the same situation from happening again. As difficult and frustrating as this encounter may be to the pharmacy and to staff members, this is also a valuable learning opportunity to re-evaluate the system and make improvements to ensure that the service being provided to your patients is the best it can be.

Where to speak with the angry patient?

If a patient is noticeably irate and is causing a disruption to the pharmacy and the provision of services to other patients, try asking the patient to see if they would accompany you to a more private setting such as the counselling room or an office. Doing so may help to further calm the patient down, as this shows a sincere interest in speaking with the patient and that he or she will receive your full attention.

At the same time, however, be vigilant and judge the situation appropriately; never attempt to de-fuse an angry patient who could be dangerous (e.g. verbally or physically abusive) by yourself or place yourself in a situation where you would be alone with him/her. Instead, ask a colleague to join the discussion. If you find that the patient is becoming progressively hostile or threatening as the discussion goes on, do not hesitate to contact security or the police when necessary. In anticipation of such potential cases that may arise, it may be helpful for you and your staff to come up with a secret code or phrase that signals to other members of the team to call for help.

Concluding remarks

De-escalating an intense situation with a patient is not an easy task; however, with a careful, calm, and considered approach, it can be less daunting. Consulting with fellow colleagues and coworkers on what they would do in such a situation, or what they have done in the past, can be helpful to glean different perspectives and ideas to better handle these challenging encounters.

References

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Implementation of a Standardized Continuous Quality Improvement (CQI) Program in Community Pharmacies

Written by Larry Sheng, BSc, PharmD Candidate [1,2] and Lindsay Yoo, BSc, BScPhm, RPh, CDE, CGP, PharmD [1,2] ([1] Institute for Safe Medication Practices Canada; [2] School of Pharmacy, University of Waterloo)

Documenting discussions and ideas pertinent to quality improvement and medication safety is critical for the advancement of medication safety culture (Figure 1). The "Quality Improvement" tab within the Community Pharmacy Incident Reporting (**CPhIR**) program was created with this philosophy in mind – to encourage and enable open dialogue regarding medication incidents amongst staff, and to provide a standardized and structured format to document these meetings.

The benefits of CQI are apparent not only from the perspective of front-line pharmacy professionals, but from a management perspective as well. CQI enables transparency and communication between management and staff; it also provides a systematic approach from which management can build upon towards improving pharmacy workflow processes and monitoring of patient outcomes.

Ultimately, the CQI program provides pharmacy professionals with tools to identify areas of inefficiency and vulnerabilities within the pharmacy, and the steps that can be taken to address these potential risks in a proactive manner.

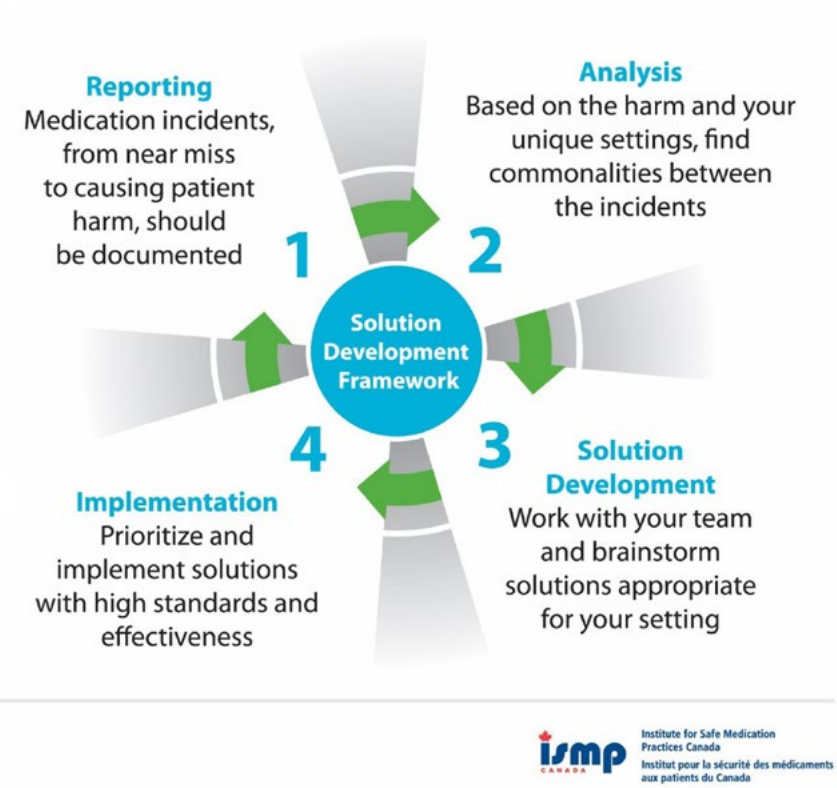


Figure 1 – The four pillars in CQI: Reporting, Analysis, Solution Development, and Implementation of an Effective and Feasible Action Plan

COMPASS Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **6732** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and August 31, 2018. All statistics below are for the time period of December 1, 2017 to August 31, 2018.

Incident Types

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

- incorrect dose/frequency **– 1,523**
- incorrect drug **– 1,169**
- incorrect quantity **– 1,098**

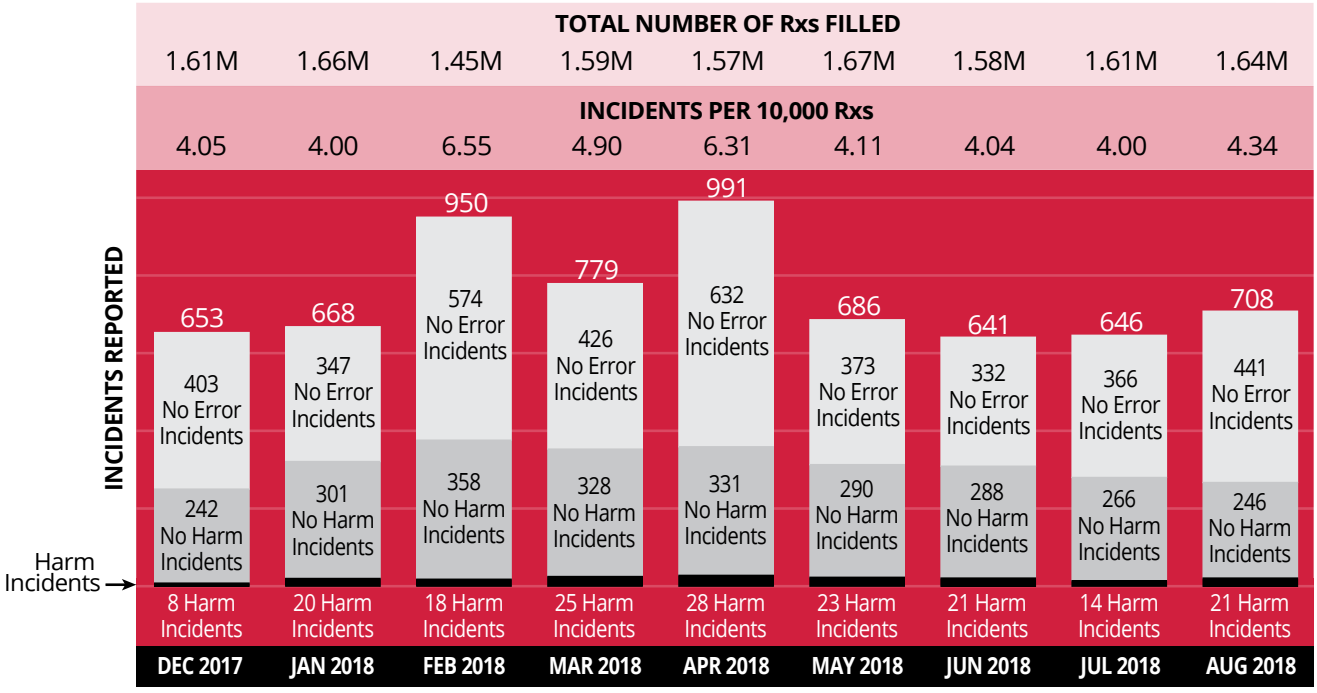
Outcomes

The majority or **3,894** of incidents reported had an outcome of NO ERROR, which means the incidents were intercepted BEFORE they reached the patient.

There were **2,650** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.

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

As well, **357** pharmacies have either completed or started their Medication Safety Self-Assessment (MSSA) online data entries and **186** Continuous Quality Improvement (CQI) meetings have been held.



*[directions], **Page 11***

MedSCIM – Medication Safety Culture Indicator Matrix

The MedSCIM tool was developed by ISMP Canada and is an assessment tool that was initially utilized during Professional Practice Reviews (PPRs) beginning in January 2018, and which will continue during the new Quality Improvement Review (QIR) process.

During the QIR process, field officers will be assessing the narratives of medication incidents of the pharmacy to determine the pharmacy's safety culture towards medication incident reporting.

The MedSCIM assessments involves looking at the narratives of medication incidents reported and assessing the report for completeness and maturity of culture.

There are three levels for assessing the reports' completeness:

Level 1 – Report fully complete – The medication incident provides sufficient information to describe the medication incident and contributing factors.

Level 2 – Report semi-complete – The medication incident provides sufficient information to describe the medication incident. No information is provided about contributing factors.

Level 3 – Report is not complete – The medication incident provides insufficient information to allow meaningful qualitative analysis.

There are four levels for assessing the maturity of culture:

Grade A – Generative – the medication incident uses a systems-based approach to describe the root causes and develop possible solutions to prevent future recurrence.

Grade B – Calculative – The medication incident uses a systems-based approach to describe the root causes. No solutions are offered to prevent future recurrence.

Grade C – Reactive – The medication incident is treated as an isolated incident. No solutions are offered to prevent future recurrence.

Grade D – Pathological – The incident focuses on human behaviours instead of a systems-based approach.

The desired level of assessment would be **1A**, where the report is fully complete, and the narrative indicates a generative culture. As is illustrated below 1B, 1A and 2A fall into the green area, whereas 1C, 2C and 2B fall into the yellow and 1D, 2D, 3D, 3C, 3B and 3A fall into the red. The MedSCIM tool will be used is to assess a pharmacy's individual culture of safety, but also the overall culture of safety of pharmacies in Saskatchewan.

Overtime, it is expected that with increased experience with reporting that the culture of safety will be strong and therefore the majority of incidents report will fall into the green area.

		Maturity of Medication Safety Culture			
		Grade D Pathological	Grade C Reactive	Grade B Calculative	Grade A Generative
Core Event Description	Level 1 Report fully complete	0	0	0	0
	Level 2 Report semi-complete	0	0	0	0
	Level 3 Report not complete	0	0	0	0

The information presented below in the chart is from PPRs completed from January to June 2018 and indicates that the majority of reports assessed fell into the yellow area which means that for the most part reports were semi-complete and that the maturity was either reactive or calculative.

		Maturity of Medication Safety Culture			
		Grade D Pathological	Grade C Reactive	Grade B Calculative	Grade A Generative
Core Event Description	Level 1 Report fully complete	0	2	3	1
	Level 2 Report semi-complete	1	23	11	0
	Level 3 Report not complete	0	3	1	0

In the information presented above, most of the reports assessed included a good description of what the error was but were considered semi-complete (usually missing the “why” or “how” the incident occurred). With respect to the maturity, most pharmacies were either treating the incident as a single or isolated event and thus no attempt was made to review the “why” the error occurred (root cause) or system issue or they didn’t determine a strategy to prevent it from occurring again. It is important for pharmacy staff to understand that by first identifying and documenting the “why” or “how” an incident occurred, it will help them to them determine what needs to be implemented to prevent the error from occurring again. Thus, strategies can then be implemented to prevent the error from occurring again.

Be a Part of Canadian Patient Safety Week

The Canadian Patient Safety Institute (CPSI) invites YOU to become involved in making **Patient Safety** a priority during Canadian Patient Safety Week – October 29 to November 2, 2018.

Canadian Patient Safety Week 2018

Canadian Patient Safety Week is a national annual campaign started in 2005 to inspire extraordinary improvement in patient safety and quality. It's for everyone involved in the delivery of healthcare in Canada, as well as those receiving care.

During Canadian Patient Safety Week 2018, the CPSI will focus on Medication Safety, with the goal of reducing medication errors across Canada. The theme this year is **Not All Meds Get Along**. The message is to encourage patients and healthcare professionals to use medication reviews for patients especially those in at-risk populations.

Canadian Patient Safety Week Events

- New series of award-winning patient podcasts
- Medication Safety Webinar
- Medication Safety Contest with terrific prizes
- Medication Safety Quiz – one for the public, one for healthcare providers!

Get Involved!

Saskatchewan community pharmacies are encouraged to participate in Canadian Patient Safety Week to show that patient medication safety is a priority within community pharmacies. **Register now** for Canadian Patient Safety Week to receive updates and information on activities, contest, webinars and podcasts.

You can also go to the CPSI website now to download **free** resources:

- **Communications Toolkit** provides prepared messages about the campaign
- **Digital Resources:** posters, social media images and handouts
- **Other Resources:** list of potential ideas to do with staff or for patients, FAQs, patient and family stories, healthcare provider stories, podcasts and more

For more information about the Canadian Patient Safety Institute and Canadian Patient Safety Week, access their website at **www.patientsafetyinstitute.ca**.

Safety Attitudes Questionnaire

SCPP and ISMP Canada are preparing to administer The Safety Attitudes Questionnaire (SAQ) in October.

The SAQ will be provided to all community pharmacists and pharmacy technicians for completion. The Safety Attitudes Questionnaire (SAQ) is the most commonly used and validated tool for assessing safety culture. The SAQ assesses six main factors (teamwork climate, job satisfaction, perceptions of management, safety climate, working conditions, and stress recognition) with approximately 40 questions.

The intent for administering the SAQ is to obtain baseline data regarding the current attitudes of pharmacists and pharmacy technicians and then administer the SAQ again at specific times in the future to see the advancement in the culture of safety within community pharmacies. ISMP Canada has already modified the SAQ to be applicable to Saskatchewan pharmacies.

Watch for the email with the link to the questionnaire. The College encourages all pharmacists and pharmacy technicians to participate.

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