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

[directions]

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Communication: An Indispensable Component of COMPASS

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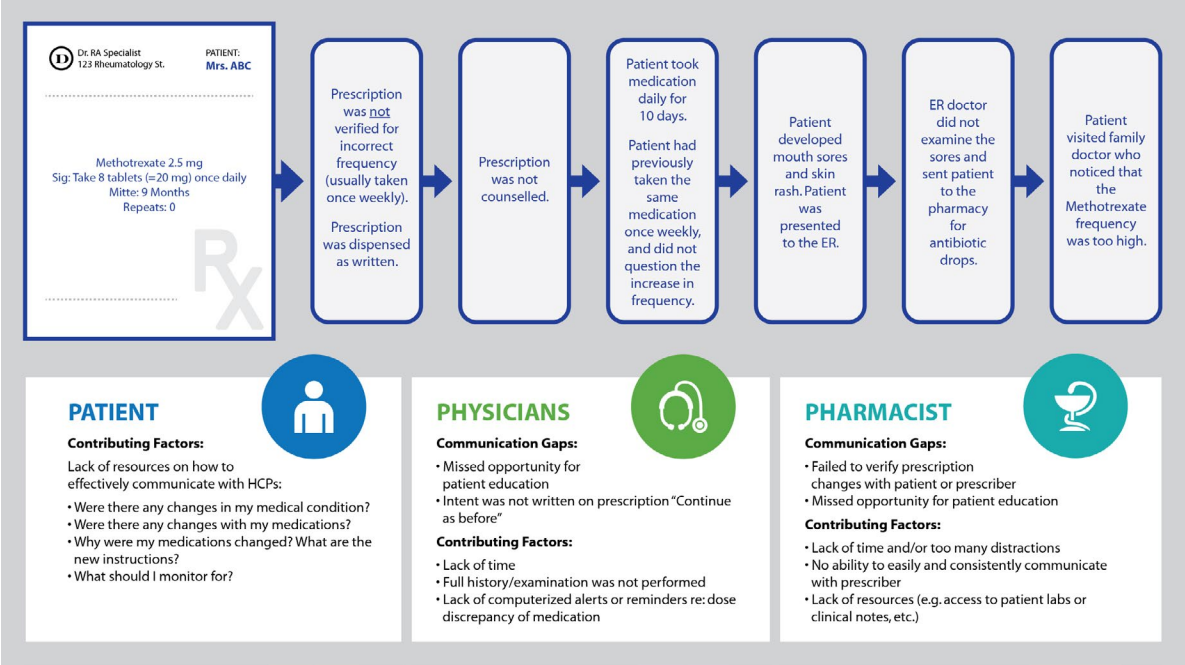
Communication gaps between patients and different health care providers (HCPs) are negatively impacting patient safety.[1] A total of 134 medication incidents associated with moderate to severe harm between 2009 to 2017 were extracted from the Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPhIR) program (**http://www.cphir.ca**), of which 58% involved communication gaps. Communication gaps occurred between patients and HCPs (for example, physicians, pharmacists, nurses, etc.) or among HCPs. These gaps included incomplete verbal or written communication, or lack of communication. In some of these incidents, communication gaps had led to severe harm, such as hospitalization or even death. **Figure 1** is an example of a medication incident that involves various degrees of communication gaps.

Figure 1 – A medication incident that involved communication gaps



Current Challenges

Ineffective communication skills

Advancement in technology has facilitated instantaneous communication globally (for example, text messages or instant messages via social media, etc.). However, as people communicate more frequently, the form of content becomes increasingly superficial and ineffective.[2, 3] This is apparent in the digital world but is also influencing in-person communication skills.[2, 3] Ineffective communication skills, amongst patients and HCPs, can compromise quality of care and patient safety.

Time is the largest barrier

Communication is a critical competency for HCPs.[4, 5] An open dialogue with patients will facilitate a stronger patient-HCP relationship and may also allow for better gathering of patient information.[4] However, HCPs are often challenged with limited face-time or contact time with patients. Decreasing time with patients may negatively affect the ability for patients and HCPs to build a relationship and also patient safety. How can patients and HCPs optimize the limited time that they spend together?

Recommendations

Preparing for the appointment

Patients are the common denominator among interactions of all members of the circle of care. Patients need to be educated on inquiring for the necessary information from their HCPs, such as, whether there are any changes in their medication(s), the nature of the changes in their therapy, and what actions are required on their part as patients.[6-8] HealthLinkBC has printable patient reference sheets (**https://www.healthlinkbc.ca/health-topics/hw226888**) that will guide patients with communication and asking important questions during different appointments (for example, new ailment, follow-up appointment, etc.).[7] HCPs should ensure that their patients fully understand what happen during the encounter. Techniques such as "show and tell" counselling and "teach back" patient education can help HCPs gauge the patient's understanding.[1] In addition, ISMP Canada, the Canadian Patient Safety Institute, Patients for Patient Safety Canada, the Canadian Pharmacists Association, and the Canadian Society for Hospital Pharmacists collaborated and developed a set of five questions (**https://www.ismp-canada.org/medrec/5questions.htm**) to help patients start a conversation about their medications to improve communications with their HCPs. When both parties come prepared for the interaction, it facilitates more effective and efficient communication.

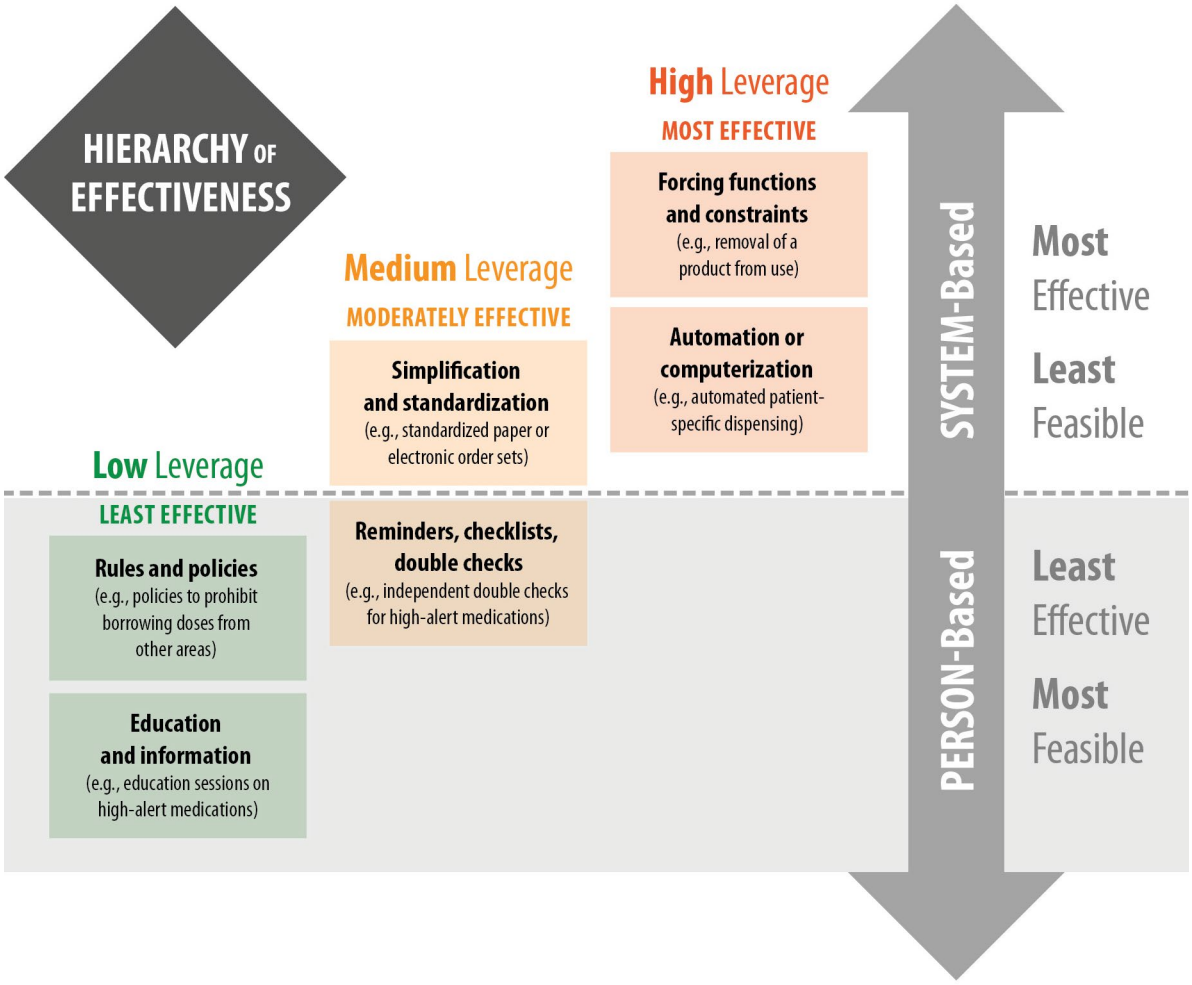
Technology

A patient's healthcare team should communicate with each other and with the patient. The hierarchy of effectiveness (**Figure 2**) demonstrates that merely expecting individuals to communicate, provide/receive education and information is, superficially, the most feasible, yet the least effective and sustainable solution.[1] So why not use a high-leverage solution, like technology, to approach the problem and facilitate lasting change?

The gold standard would be a fully functional e-health system. HCPs will then have ready access to the patient's health and medication records. This would give clinicians the "full picture" of a patient's history and would be especially useful if a patient is not aware of the health condition(s) and/or medication(s).

In the meantime, HCPs should demand their point-of-care or clinical decision support software vendors to arm them with better communication and clinical tools (for example, an app that will allow and support for urgent communication; or safety features, such as reminders for patient medication list updates and alerts for dose discrepancy, dose too high, or dose too low, etc.).

Figure 2 – Hierarchy of Effectiveness



Conclusion

The inherent nature of society's current way of communication largely hinges upon technology and networking. It is therefore prudent to leverage technology and evolve our current tools in order to be able to even begin delivering the highest possible standard of the future for patient care and safety.

The solutions are not by any means novel. In the end, all parties involved in the circle of care are responsible for ensuring that communication is clear and complete, as gaps in communication can have a detrimental effect on a patient's health and safety.

Final Remarks

The information in this article is adapted from an article published in the Fall 2018 issue of the Ontario College of Pharmacists (OCP) *Pharmacy Connection* and the Safe Medication column in May 2018 issue of *Hospital News*.

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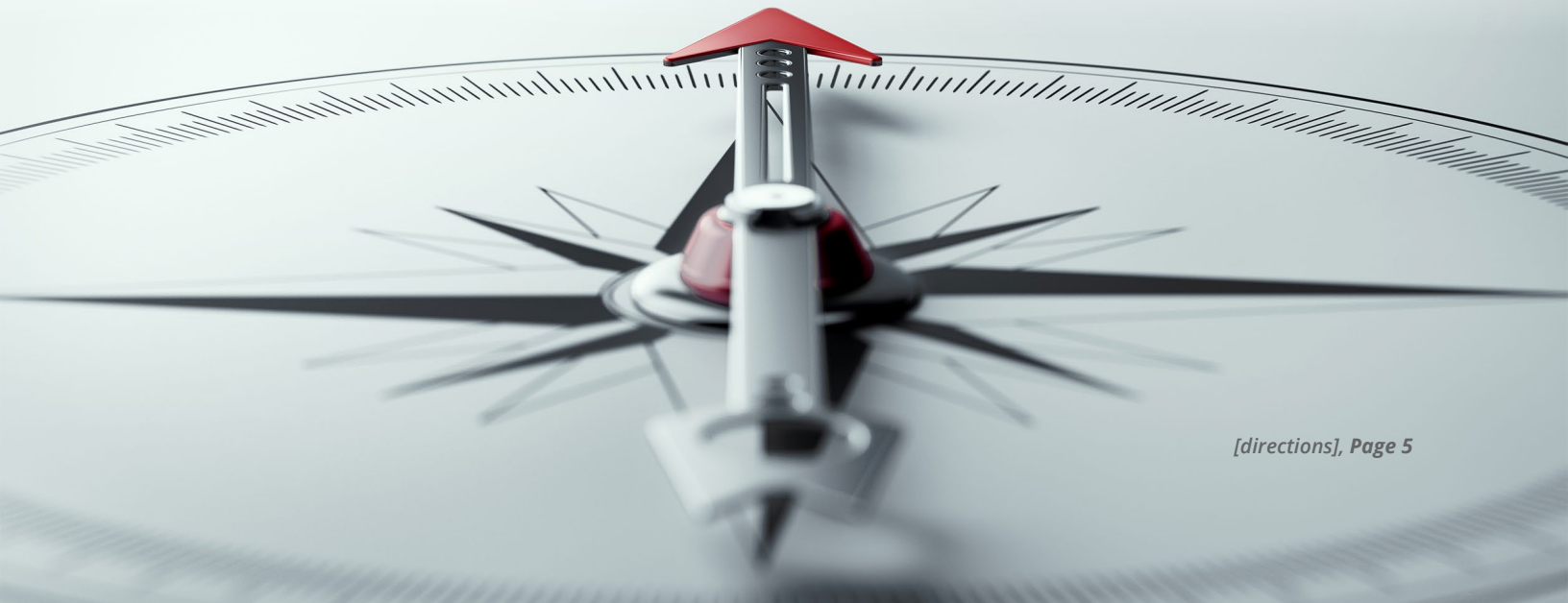
Quality Improvement Reviews are Coming!

In February 2019, the Saskatchewan College of Pharmacy Professionals (SCPP) is beginning Quality Improvement Reviews (QIRs). During the QIRs, the field officers will be reviewing the pharmacy's quality improvement activity, along with some other areas.

If pharmacies have not kept up to date on reporting incidents or haven't yet completed their Medication Safety Self-Assessment (MSSA), now is a good time to catch up or complete these activities.

If Quality Improvement (QI) Coordinators, pharmacy managers or pharmacy staff have any questions about QIRs, quality improvement activities or any of the tools used for COMPASS, they can contact Jeannette Sandiford at **info@saskpharm.ca** or 306-584-2292.



Just Culture – Why is it Important to Patient Safety?

The concept of "Just Culture" was introduced in the **April 2018 edition** of [directions]. A subsequent article in the **October 2018 edition** examined how human behaviours impact a Just Culture and reviewed appropriate actions that should be taken when these behaviours occur.

The next topics in this series look at how a pharmacy's or organization's values, justice and safety, and management of at-risk behaviors impacts how well the organization operates within a Just Culture and how this can in turn impact patient safety. In this article, the topic of the pharmacy's/organization's values will be explored. The other topics of justice and safety, and management of at-risk behaviors will be explored in future [directions] editions.

Pharmacy/Organizational Values

It is important that a pharmacy/organization operating within a Just Culture has defined its primary and secondary values to ensure that staff working in the pharmacy/organization know how to prioritize their work. Safety should always be the primary value. Values such as efficiency and productivity should be considered secondary values. Clearly communicated values ensures staff members understand that safety should never be sacrificed for efficiency or productivity. Even when time pressures start to build, working faster and taking unsafe shortcuts is not an acceptable solution.

It is of utmost importance that the practices and behaviors of the leaders/pharmacy managers within the pharmacy/organization demonstrate daily that safety is the primary value. When staff observe their leaders/pharmacy managers behaving in a manner that emphasizes safety always comes first, they are encouraged to also make safety a priority. If leaders/pharmacy managers give mixed messages when safety is to come first, this causes confusion among the staff and may promote unsafe behavioral choices, which can impact patient safety.

Lastly, it is important that pharmacies/organizations make patient safety a primary value as opposed to just a priority. Priorities can sometimes shift or take a back seat to other competing demands. By ensuring safety is a primary value, it is sustained and associated with every healthcare priority instead of subject to being reordered when another priority is identified.

Watch for the next article in this series in the April edition of the [directions] newsletter.

The information in this article is based on an ISMP Medication Safety Alert article published by ISMP on May 17, 2012, entitled, "Just Culture and Its Critical Link to Patient Safety (Part I)."

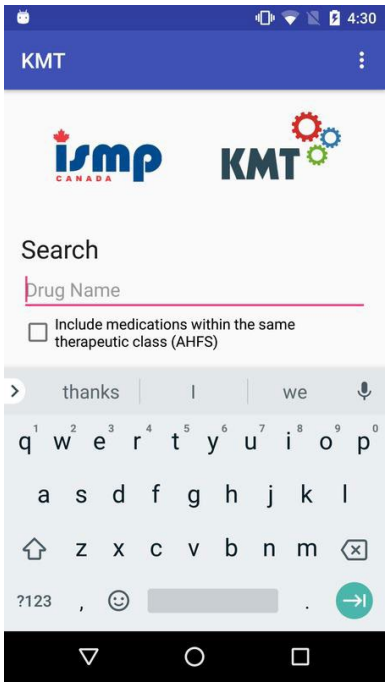
A resource that can help your team address specific medication issues

Pharmacy professionals can face a vast body of knowledge and recommendations when it comes to researching medication safety solutions. A general internet search can cause frustration and apprehension as it is sometimes difficult to assess the quality and accuracy of medication safety recommendations from multiple sources.

Knowledge Mobilization Tool

The Knowledge Mobilization Tool (KMT) developed by the Institute for Safe Medication Practices Canada (ISMP Canada) offers a novel solution to endless research and fact-checking.

The KMT is an educational tool that gathers and sorts relevant, context-specific information to help healthcare practitioners address medication safety issues. The KMT is a database powered by almost a decade's worth of medication incident and near miss reporting by healthcare professionals and patients to ISMP Canada. With the KMT, pharmacy professionals can quickly and easily search incident analysis and recommendations made by ISMP Canada over the last decade. By searching the KMT, reports can be found on previously published incidents, contributing factors and published recommendations.



Best of all, the KMT is now available as a mobile application for iPhone and IOS!

Please visit the KMT platform to begin searching for medication safety solutions:

- Desktop: **https://secure.ismp-canada.org/KMT/**
- Mobile Application for iPhone and iOS
- Review the following article for more details on the KMT platform: **https://www.ismp-canada.org/download/hnews/201712-HospitalNews-KMT.pdf**

This article has been adapted from the College of Pharmacists of Manitoba e-QUIPPED newsletter – Vol. 3.

COMPASS Statistics

Statistical reports bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **8,843** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and December 31, 2018. Statistics below are for this time period.

Incident Types

The top three types of incidents were:

- incorrect dose/frequency – **2,016**
- incorrect drug – **1,544**
- incorrect quantity – **1,471**

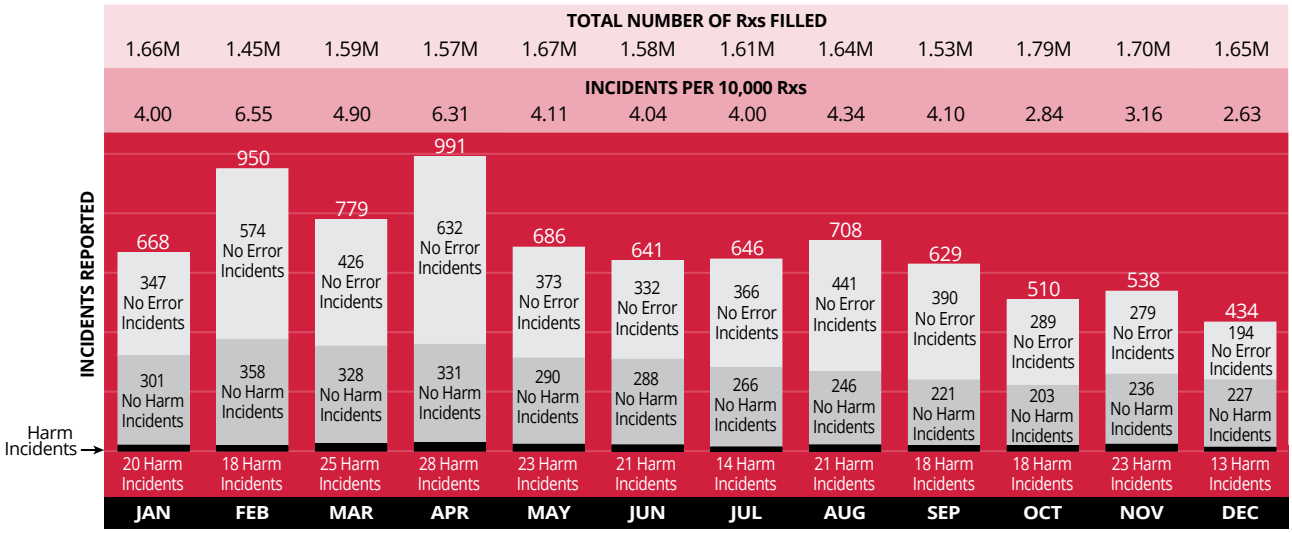
Outcomes

The majority or **5,046** of incidents reported had an outcome of NO ERROR, which means the incidents were intercepted BEFORE they reached the patient.

There were **3,537** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.

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

As well, **351** pharmacies have either completed or started their Medication Safety Self-Assessment (MSSA) online data entries and **221** Continuous Quality Improvement (CQI) meetings have been held.



Safety Attitudes Questionnaire

The Safety Attitudes Questionnaire (SAQ) was sent out to all community pharmacists and pharmacy technicians in November 2018. The 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. The response rate for the questionnaire was just above 18%. The Saskatchewan College of Pharmacy Professionals was very happy with this response rate and would like to thank all those that participated. Your participation was greatly appreciated.

Some of the preliminary results from the SAQ are:

230 responses received from 210 pharmacists and 20 pharmacy technicians

- 18.23% response rate (overall)
- 17.77% response rate (pharmacists)
- 25.00% response rate (pharmacy technicians)

Demographics:

Position:

- 33.17% Pharmacist (manager/owner)
- 59.13% Pharmacist (staff)
- 8.7% Pharmacy Technician

Pharmacy Type:

- 30.43% Independently owned
- 23.91% Banner
- 45.65% Corporate

Years of experience:

- 29.57% 0-5 years
- 18.26% 6-10 years
- 25.65% 11-20 years
- 26.52% 20+ years

Safety Culture:

79.72% of all respondents agree strongly that they would feel safe being treated as a patient at their respective pharmacy

74.19% of all respondents agree strongly that medication errors are handled appropriately in their respective pharmacy

47.47% of all respondents disagree strongly that it is difficult to discuss errors at their respective pharmacy

14.75% of respondents agree slightly or agree strongly that it is difficult to discuss errors at their respective pharmacy

The full report from ISMP Canada is currently being completed and will be available for review about the end of January 2019.

Contact Information

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