



Community Pharmacists
Advancing **Safety**
in Saskatchewan

Continuous Quality Assurance (CQA)
Pilot Pharmacy Participants Manual



SASKATCHEWAN
COLLEGE OF
PHARMACISTS



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DISCLAIMER

The information contained in this guide was originally intended for the use by Nova Scotia pharmacists as a reference for their continuous quality assurance program as set forth by the Nova Scotia College of Pharmacists (NSCP). The authors of the original document were as follows;

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The information in this reference manual has been adapted for the use by pharmacists participating in COMPASS pilot project. The COMPASS (Community Pharmacists Advancing Safety in Saskatchewan) CQA pilot project is a joint effort between the Saskatchewan College of Pharmacists and ISMP Canada.

Introduction and Welcome!

Welcome to COMPASS (Community Pharmacists Advancing Safety in Saskatchewan).

Let me start by thanking you for agreeing to participate as one of the pharmacies involved in the pilot project. By participating you are showing you value the importance of a safe medication system and are willing to take steps towards a culture of safety in Saskatchewan. Your involvement is so important and is greatly appreciated.

The partners in the COMPASS pilot project will be the Saskatchewan College of Pharmacists (SCP), and the Institute of Safe Medication Practice (ISMP) Canada, with SafetyNET-Rx conducting some research for the project.

The pilot project is aiming to evaluate the implementation of a CQI program in Saskatchewan community pharmacies. Medication safety and safe medication practices are important issues throughout the health care spectrum. The Saskatchewan Ministry of Health has included patient safety and medication safety as part of their strategic plan for the next 5 years. SCP recognizes the importance of ensuring community pharmacies are not only recognizing, resolving and learning from medication errors but are also reviewing all their system processes to ensure patient safety.

Promising research has been done in Nova Scotia through the SafetyNET-Rx program that shows which components need to be in an effective community pharmacy CQI program. The SafetyNET-Rx project identified that the CQI program needs to be both proactive and reactive in order to be effective. COMPASS, the Saskatchewan CQA Pilot Project will be modeled after the SafetyNET-Rx project using the same tools and processes.

ISMP Canada will be providing three online tools that will be used during the pilot project. The online tools are the Community Pharmacy Incident Reporting (CPhIR) tool, the Medication Safety Self-Assessment (MSSA) tool and the Quality Improvement tool.

SafetyNET-Rx will be conducting research and collecting valuable information regarding the attitudes, barriers, supports, etc. of pharmacies reporting and participating in a CQI program.

SCP is very excited to be partnering with ISMP Canada and SafetyNET-Rx and would like to thank them as well, for their involvement in this very important project.

THANK-YOU FOR YOUR PARTICIPATION!

Timeline

Date		COMPASS Continuous Quality Assurance (CQA) Pilot Project
Sept 2013 – Aug 2014		<p>COMPASS pilot pharmacies are asked to utilize the CQA tools provided during the pilot – ISMP Canada Community Pharmacy Incident Reporting (CPhIR) Program, Medication Safety Self-Assessment (MSSA) and the Quality Improvement tool within the CPhIR Program – and conduct the following activities:</p> <ul style="list-style-type: none"> • Report medication incidents (including near misses) to CPhIR • Complete the MSSA • Utilize the quality improvement resources within the CPhIR Program to facilitate CQA quarterly meetings <p>Pilot pharmacies will be recruited throughout the pilot project and registration, orientation and training will be done as each new pharmacy joins on.</p>
2013		
<input type="checkbox"/>	Sep to Nov	SafetyNET-Rx - Pharmacist Mail Out Survey
<input type="checkbox"/>	Sep 8 th	ISMP Canada / SCP CE Session on Medication Safety in Regina
<input type="checkbox"/>		Recruitment of community pharmacies for the COMPASS pilot
<input type="checkbox"/>	Sep 15 th	ISMP Canada / SCP CE Session on Medication Safety in Saskatoon
<input type="checkbox"/>		Recruitment of community pharmacies for the COMPASS pilot
<input type="checkbox"/>	Sep to Dec	Registration, orientation and training of COMPASS pilot pharmacies to ISMP Canada CPhIR and MSSA Programs
2014		
<input type="checkbox"/>	Jan to Feb	SCP SPEP Survey of COMPASS pilot pharmacies to evaluate engagement
<input type="checkbox"/>	Mar to Apr	SCP Field Officers to visit COMPASS pilot sites
<input type="checkbox"/>		SafetyNET-Rx survey regarding the use of CQA tools provided during the pilot, incident reporting and learning by COMPASS pilot pharmacies
<input type="checkbox"/>		ISMP Canada / SCP Follow-up CE session with COMPASS pilot pharmacies
<input type="checkbox"/>	Oct	SafetyNET-Rx post-pilot survey and evaluation

Expectations

Throughout the pilot project ISMP Canada will be providing monthly follow-ups with each pilot site to ensure the pharmacy staff is comfortable with the tools and to identify any technical issues. ISMP Canada, via the CPhIR will be collecting the data on medication incidents from the pilot pharmacies and will be providing SCP with updates in an aggregate format. Reporting of medication incidents by the pilot pharmacies to ISMP will be anonymous and SCP will not be receiving any information regarding medication incidents reported in a format that will allow SCP to identify any particular pharmacy.

SafetyNET-Rx in order to collect the research information for the pilot project, will be contacting the pilot pharmacies periodically. SafetyNET-Rx will also be asking the pilot pharmacies to participate in surveys at various times during the pilot regarding barriers, supports, etc. in order to determine what enables or prevents pharmacy staff from reporting of QRE's or participating in a standardized CQI program.

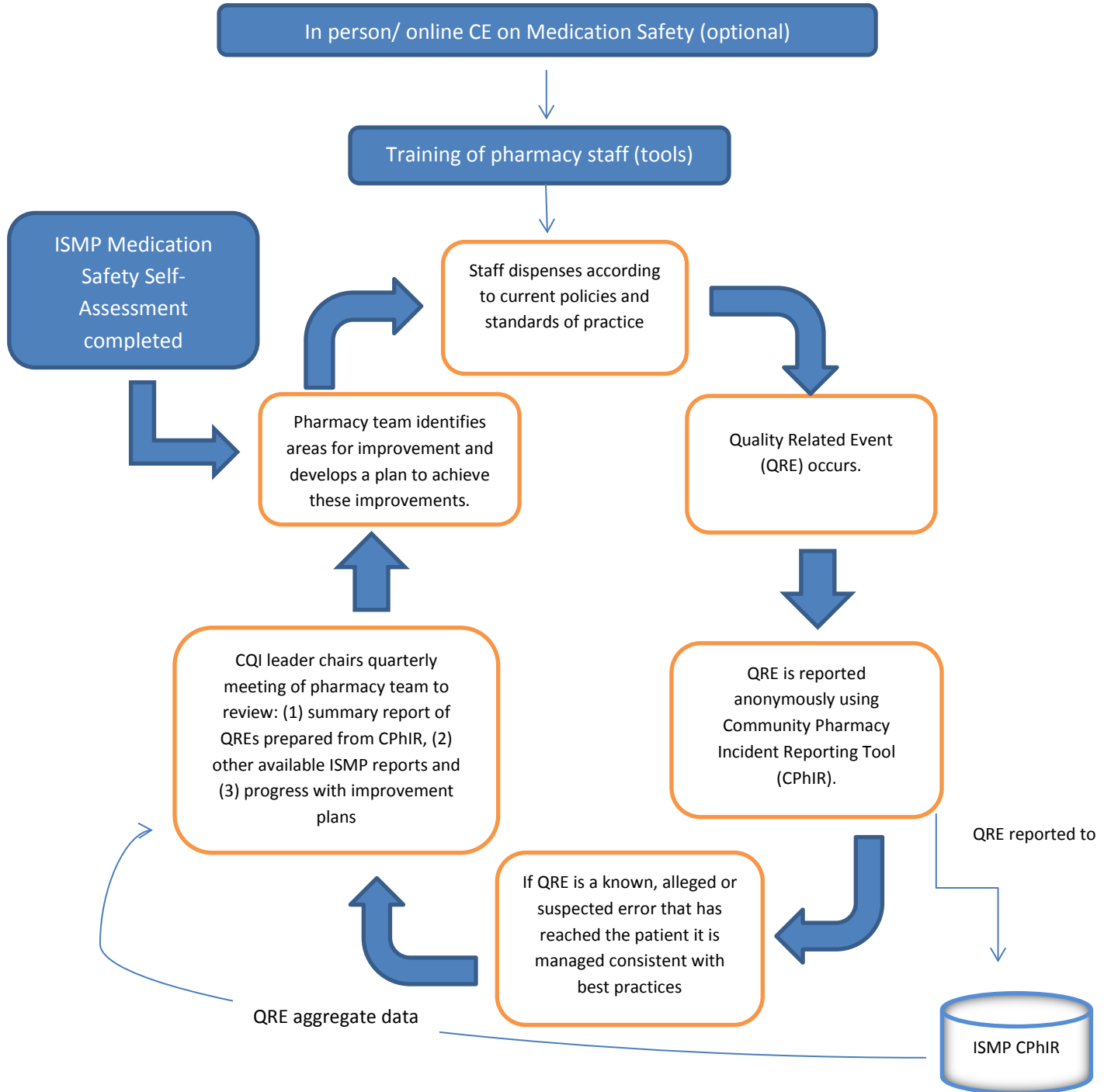
Each pilot pharmacy is expected to participate to the best of their ability in all elements of the pilot and to utilize **all** the online tools provided to the pilot sites, including completing the MSSA, recording all medication incidents (both those that reach the patient and near misses), holding quarterly meetings to discuss medication incidents and developing an improvement plan.

Where can I find contact information for those involved in the SK CQA Pilot Project?

Inquiry Type	Contact	Contact Information
Regulatory Issues	Jeannette Sandiford- Field Officer – Sask. College of Pharmacists	jeannette.sandiford@saskpharm.ca
Medication Safety Self-Assessment	Institute for Safe Medication Practices (ISMP) Canada	mssa@ismp-canada.org
Community Pharmacy Incident Reporting (CPhIR)	Institute for Safe Medication Practices (ISMP) Canada	cphir@ismp-canada.org

Saskatchewan CQA Pilot Project CQI Cycle

Below is the Continuous Quality Improvement (CQI) Cycle for Community Pharmacists. This provides a visual description of the process that will be used during the pilot project.



Abbreviations: CQI – Continuous quality improvement; QRE – Quality related event

Fig. 1 - Modified from SafetyNET-Rx CQI Cycle (Keeping the "continuous" in CQI)

Quick Reference for Electronic Links for CPhIR and MSSA

The website link to CPhIR and MSSA is;

<https://secure.ismp-canada.org/CPhIR/Reporting/login.php>

Using the pharmacy username and password provided by ISMP Canada, log into the CPhIR program.

For future reference you may enter the pharmacy information below;

Username: _____

Password: _____

The MSSA electronic link can accessed once the above CPhIR log in information is entered.

For general questions and enquiries, use the email addresses below;

Community Pharmacy Incident Reporting System (CPhIR)

- cphir@ismp-canada.org

Medication Safety Self-Assessment

- mssa@ismp-canada.org



Community Pharmacy Incident Reporting (CPhIR) Program Instructional Guide

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Section 1 CPhIR Online Training Guide

Login the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) Program at <http://www.cphir.ca>. You can access the CPhIR Online Training Guide by clicking “CE & Resources” from the menu located at the top of the CPhIR homepage. Select Training Video # 2 and you can then view the narrated presentation of CPhIR Training Guide.

The screenshot shows the CPhIR website interface. At the top, there is a navigation menu with the following items: Home, Report an Incident, Search, Stats, Your Account, and CE & Resources. The 'CE & Resources' item is circled in red. Below the menu, the page title is 'Continuing Professional Development on Medication Safety'. The main content area is titled 'CPhIR Continuing Education (CE) & Training Videos' and lists several training modules. The second module, 'CPhIR Training Guide', is circled in red. To the right of the video list, there is a 'Training' sidebar with links for CPhIR Newsletter, FAQ, and Help.

A Key Partner in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)
 Un partenaire clé du Système canadien de déclaration et de prévention des incidents médicamenteux (SCDPIM)

Section 2 CPhIR Frequently Asked Questions

General Information

Who is ISMP Canada?

The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit agency committed to the advancement of medication safety in all healthcare settings. Our goal is the creation of safe and reliable systems for managing medications in all environments.

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.

Why should my pharmacy use CPhIR to report medication incidents?

The goal of ISMP Canada is to analyze medication incident reports and develop recommendations for enhancing patient safety in all healthcare settings. ISMP Canada created the CPhIR program with support from the Ontario Ministry of Health and Long-Term Care to specifically address incident reporting in community pharmacies. CPhIR contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (Further information on CMIRPS is available at <http://www.ismp-canada.org/cmirms.htm>).

Medication incidents are often under-reported. CPhIR will provide you with the ability to document and analyze contributing factors (e.g. miscommunication, staffing, and education) that can cause errors in the medication-use system. From the data reported and through understanding of the contributing factors, your pharmacy team can develop and implement system-based strategies for quality improvement and prevent potential errors from occurring again in the future.

How long will it take to report a medication incident?

The amount of time depends on how much information is included in the report, but it probably will not take more than 10 minutes to complete a report.

Is there a cost to using CPhIR?

There is an annual subscription rate to use CPhIR. Please refer to the ISMP Canada Product Price List at <http://www.ismp-canada.org/products/>.

Login

I forgot my username and/or password – how do I get a new one?

ISMP Canada will provide a username and password to login for the first time. If the username and/or password is lost or forgotten, please contact ISMP Canada by clicking “Contact ISMP Canada” on the login page. This will launch an e-mail window. Please include your pharmacy name and the contact person in charge of CPhIR. You can expect a response within two business days.

Is it possible to have more than one username per pharmacy?

No, each pharmacy location can only have access to one account. The key contact person will provide the username and password to pharmacy staff to report medication incidents. It is important to keep the password confidential.

Home

What is an Open Incident?

An Open Incident is an incident that has been entered into the system and is available for editing within 90 days of the initial entry date.

All open incidents will automatically be closed after 90 days. Closed incidents can no longer be edited. Once an incident is closed, it is available for search and analysis.

Can I access newsletters and publications about medication safety through CPhIR?

The following are provided by ISMP Canada complimentary to all CPhIR users and are accessible under the CPhIR home page:

- ISMP Canada Safety Bulletins
- SafeMedicationsUse.ca Consumer Newsletters and Alerts
- Medication Safety Alerts
- TransPhIR from CPhIR Newsletter

Report an Incident

Who can report a medication incident?

Any member of the pharmacy staff, including pharmacists, technicians, interns, and students, can use CPhIR to report medication incidents. All pharmacy staff members require the username and password to login to CPhIR.

What information is required to report an incident?

The following information is mandatory:

- Date Incident Occurred
- Type of Incident
- Incident Discovered By
- Medication System Stages Involved in this Incident
- Medication(s) Involved

- Degree of Harm to Patient due to Incident
- Incident Description/How the Incident was Discovered.

The following fields are optional: (i.e., not required to submit incident):

- Time Incident Occurred
- Patient's Gender
- Patient's Age
- Other Incident Information
- Contributing Factors to this Incident
- Actions at Store Level (Include action plan, person in charge, and target date for completion)
- Shared Learning for ISMP Canada to Disseminate (What has been done to prevent a similar occurrence in the future)

When you are ready to click "Submit Report to ISMP Canada", a reminder will pop up to make sure that you do not supply identifying information (e.g. patient name or date of birth, pharmacy name, or healthcare provider names). Once you hit submit, the incident information is then stored into the ISMP Canada secured CPhIR database.

Do I enter the date the medication incident occurred or the date it was discovered?

Please enter the date the incident occurred. For example, if an incorrect medication was dispensed Tuesday evening and the patient returns Wednesday morning, the incident happened Tuesday evening and this is the date entered.

If an incident or quality related event is identified and resolved prior to prescription order entry and dispensing, how can I capture this information in CPhIR?

In this case, if applicable, check the "Prescribing" option next to the "Medication System Stages Involved in this Incident" field. Alternatively, you can document this information in the "Incident Description" field.

Can I enter more than two medications?

Yes, as you complete each medication field, a new medication field will appear.

When a medication is entered, the black medication box disappears before I can choose a medication – can it stay open longer?

To view the options in the black auto-finish box, place the cursor anywhere within the box and it will remain open until a selection is chosen.

Can I enter the DIN instead of the medication name in the medication field?

Yes, the black auto-finish box will also appear if a partial DIN is entered. If the DIN is chosen from the list, the medication name will automatically be entered.

If an incident occurs in which an incorrect medication has been dispensed, which medication should be identified in the Medication field?

The incorrectly dispensed medication should be specified in the "Medication" field, as this was the medication that was involved in the medication incident. Mention the intended medication that was to be dispensed in the "Incident Description" field.

For example, in the instance that Prevacid® was inadvertently dispensed instead of Percocet®, enter Prevacid® in the “Medication” field and mention Percocet® in the “Incident Description” field.

The expiry date and lot number of the medication dispensed were not properly recorded. Where can I document this in CPhIR?

You can document this in the “Incident Description” field.

Where can I document incidents that involve dispensing in blister packs?

Click on the “Expand All” button next to the “Other Incident Info” field. Under the “Rx Order Entry / Dispensing Label Generation” category, check the “Nursing Home/Blister Pack” option. Alternatively, you can document this information in the “Incident Description” field.

With respect to drug shortages, often we have to dispense a generic brand or an alternative brand of a medication. If an incident involves the use of different brands of a medication, where can I document this in CPhIR?

Click on the “Expand All” button next to the “Other Incident Info” field. Under the “Rx Supply / Ordering” category, check the option(s) that apply to the incident. Alternatively, you can document this information in the “Incident Description” field.

How about improper storage of medications? Where can I document this in CPhIR?

Click on the “Expand All” button next to the “Other Incident Info” field. Under the “Rx Preparation – Storage” category, check the option(s) that apply to the incident. Alternatively, you can document this information in the “Incident Description” field.

If one of the contributing factors to the incident is due to an incorrect address being entered for the patient, where can I document this in CPhIR?

You can document this in the “Incident Description” field.

How long do I have to edit an incident?

An incident can be edited within 90 days of the initial entry date.

What will happen after the incident is open for 90 days?

All open incidents will automatically be closed after 90 days. Closed incidents can no longer be edited. Once an incident is closed, it is available for search and analysis.

How do I edit or close an incident?

Only Open Incidents can be edited. Click on the “Home” tab, and under “Your Open Incidents,” find the incident to be edited (listed numerically by incident number, or date incident was first entered) and click on the “incident number-Open” (in blue). The incident reporting form for the selected incident will appear. Edit information as needed. Once the report is complete, scroll to the bottom of the form and click the checkbox to “Close record from future edits”. Then click “Submit Report to ISMP Canada” to close and submit the incident.

When I submit an incident, an error window pops-up, what does this mean?

Upon submission, if one of the mandatory fields is not complete, a pop-up window will appear as a reminder to fill in all mandatory fields. Click OK to return to the form and fill in the missing information.

It is taking quite a while to submit an incident after I press the “Submit Report to ISMP Canada” button. Why?

Depending on your Internet browser or connection, sometimes it may take longer to submit an incident. A pop-up message will alert you when submitting an incident takes longer than expected. This message will assure you that the incident is being submitted.

I entered information into the form and it logged out, is the information saved?

No, after 24 minutes of inactivity, CPhIR will automatically time out for confidentiality reasons. All unsaved information will be lost. To prevent lost information, submit data as an open incident. Open incidents can be edited within 90 days.

Search**How do I search for an open incident?**

Open incidents cannot be searched. To find an open incident, click on the “Home” tab. All open incidents are sorted by incident number/date incident initially entered.

When I search for an incident, it does not display in the results, how do I find it?

Only closed incidents can be searched. All open incidents are displayed on the home page.

How do I export incident reports into PDF/Excel format?

Click the “Search” tab and enter the search criteria for the incidents to be exported. When the search results are displayed, scroll to the bottom of the page and click the “Export in PDF format” or “Export in Excel format.” All search results will be exported in the new file, which will appear in a new window.

Can I make customized graphs of my individual pharmacy data?

No, CPhIR does not graph individual pharmacy data. However the “Search” function allows you to find the selected data you wish to graph and export the incidents into Excel. Using Excel, you can then create customized charts and tables.

Stats**How do I view the graph with my pharmacy data and aggregate data?**

Click the “Stats” tab. Select the “Type of Search Result” you would like to view and enter any of the specific search criteria. Scroll to the bottom of the form and click “Submit Search.” The results will display as a graph and tables with your pharmacy data and aggregate data.

I am using Internet Explorer and I can view my pharmacy data and aggregate data in tables but not in graphs. Why?

There is a security setting called “Binary and script behaviors” that has to be enabled for the graphs to render. To access the “Binary and script behaviors” setting, click on “Tools” and select “Internet Options”. Under the “Security” tab, click on the “custom level ...” button. You will then see a “Settings” menu. Scroll down the menu and under “ActiveX controls and plug-ins”, ensure that the “Binary and script behaviors” option is enabled.

Your Account

How do I change my password?

Click on the "Your Account" tab. Enter the old password and type in the new password. Do not use the same password that you use for other online accounts. All passwords must be 8 characters in length with letters, numbers, and punctuation. Passwords are also case-sensitive. Remember to check your CAPS lock key. Re-enter the new password and click "Update Password."

CE & Resources

If there are members of my pharmacy staff who are new or not yet familiar with the CPhIR program, what is the best way to become familiarized with this tool?

Under the "CE & Resources" tab, there are multiple CE modules that are very useful for learning about fostering a reporting culture, how to navigate through CPhIR as well as some general information about medication safety and analysis. Each module is accompanied by a link to a set of presentation slides that the user can print or view in order to follow along during the module.

Quality Improvement

What is Continuous Quality Improvement (CQI) and why is it important?

CQI is an online environment for community pharmacies to document staff meetings and discussion in response to medication incidents (and incident analysis); as well as action plans to improve medication safety in the practice setting. Continuous quality improvement helps make the environment safer for practitioners and patients.

What is the difference between single and multi-incident analysis?

Single incident analysis allows you to analyze in detail of one reported incident (particularly those of high impact or resulting in severe patient harm) and identify potential contributing factors related to that incident.

Multi-incident analysis allows you to efficiently analyze a set of related incidents to identify potential system-based contributing factors. Either type of incident analysis will prompt you to develop system-based solutions to prevent similar incidents from recurring in your practice setting.

How do I import more than one incident into my Medication Incident Discussion?

Once you open the "Medication Incident Discussion" window, there are two methods to import medication incidents for discussion at the staff meeting and they are listed as follows:

- A. You may import each incident by clicking "Add CPhIR Incident" and inputting the CPhIR incident number.
- B. You may import a set of related incidents by clicking "Import CPhIR Incidents" and search the set of related incidents by the criteria desired. Then you can select all the desired incidents by marking the checkboxes listed under the

"Import" column. If you select the wrong incident, then you can simply unmark the checkbox or click the red-cross listed beside the CPhIR incident number. Once you complete your selection, click "Import Selected Incidents" to import all the desired incidents for your medication incident discussion with your staff members.

Why can't I search or add a new medication incident in my Medication Incident Discussion?

Open incidents cannot be searched or added into the "Medication Incident Discussion" section. To find an open incident, click on the "Home" tab, which shows a list of all your open incidents and you may check all the incidents that you wish to close. All open incidents are sorted by incident number/date incident initially entered. Only closed incidents can be searched and added into the "Medication Incident Discussion" section.

Can I still edit my discussion after I finalize it?

Yes, you can click "edit" and revise or update any previous medication incident discussion prior to finalizing it. Once you confirm that you would like to finalize the discussion, you will no longer be able to update the medication incident discussion.

I accidentally closed my webpage during the discussion, was my information saved?

No, unfortunately the information will not be saved. Therefore, it is recommended to periodically save your work to prevent any unnecessary loss.

Will content from my CQI meeting discussion be reported to ISMP Canada?

The CQI module is intended for your pharmacy's own documentation purposes. When you are ready to click "save and close", a reminder will pop up to make sure that you do not supply identifying information (e.g. patient name or date of birth, pharmacy name, or healthcare provider names). Once you click "OK" (to submit), the meeting discussion is then stored into the ISMP Canada secured CPhIR database.

Can I print CQI discussion for my records?

Yes. At the end of the documentation page, you can click "Save & Print" and a nicely laid out PDF of your staff meeting discussion will be available for you to save electronically or print as a hard copy.

Confidentiality/Privacy Policy

How will data from CPhIR be used?

The goal of ISMP Canada is to analyze medication incident reports and develop recommendations for enhancing patient safety in all healthcare settings. Medication incidents submitted through CPhIR will be used only for the purposes of analysis, shared learning, and formulation of incident prevention strategies.

Who has access to the data entered into CPhIR?

ISMP Canada has a privacy policy stating that data are used by ISMP Canada only for the purposes of analysis, shared learning, and incident prevention strategy formulation. Only selected employees at ISMP Canada have access to the data submitted through CPhIR.



Community Pharmacy Incident Reporting

*Institute for Safe Medication Practices Canada®
Institut pour l'utilisation sécuritaire des médicaments du Canada®*

If you have any further questions, please contact ISMP Canada:

cphir@ismp-canada.org
(416) 733-3131 or (866) 544-7672
4711 Yonge Street, Suite 501
Toronto, Ontario
Canada M2N 6K8
www.ismp-canada.org

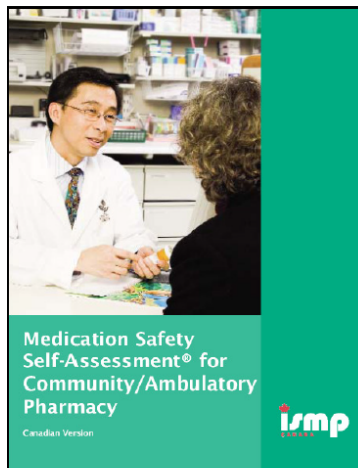
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Un partenaire clé du Système canadien de déclaration et de prévention des incidents médicamenteux (SCDPIM)*

9

Medication Safety Self-Assessment® (MSSA®) Instructional Guide

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ISMP Canada is not a standard-setting organization. The Self-Assessment is a checklist of items, encompassing all aspects of safe medication usage. The self-assessment characteristics in the MSSA are not purported to represent a minimum standard of practice, and should not be considered as such. MSSA findings are intended for internal use and become more useful as repeat assessments are performed to see where improvements have been achieved over time. No pharmacy should expect to score high in all areas.



Section 1 Completing the MSSA Handbook

Assemble a team from your pharmacy staff members to complete the 89 Medication Safety Self-Assessment (MSSA) items. At a minimum, MSSA team members should include a pharmacist, a pharmacy technician, and the pharmacy manager. Because medication use and dispensing are complex processes that involve more than one person, the value and accuracy of the self-assessment will be enhanced if it is completed by a number of members of the pharmacy team.

The estimated time to complete the MSSA Handbook is about three hours. ISMP Canada recommends three team meetings of one hour each. The team and group discussions often lead to talk about possible changes in practice and how to make them. Hopefully the staff did not make ranking decisions too quickly, or fall into line with a manager's viewpoint or any one pharmacist's, before a discussion was possible. Such results tend to reflect one person's practice, rather than the pharmacy's activities in general. An alternative would be to get everyone's rankings off-line and summarize them, and then plan a meeting to discuss only those items that have received a range of rankings (i.e., items that are inconsistently ranked).

When a decision is made about the level of implementation for each self-assessment item, mark one of the following choices next to each item:

A	There has been no activity to implement this item
B	This item has been discussed for possible implementation in the pharmacy but has not been implemented at this time
C	This item has been partially implemented for some or all patients, prescriptions, drugs or staff
D	This item is fully implemented for some patients, prescriptions, drugs, or staff
E	This item is fully implemented for all patients, prescriptions, drugs, and staff

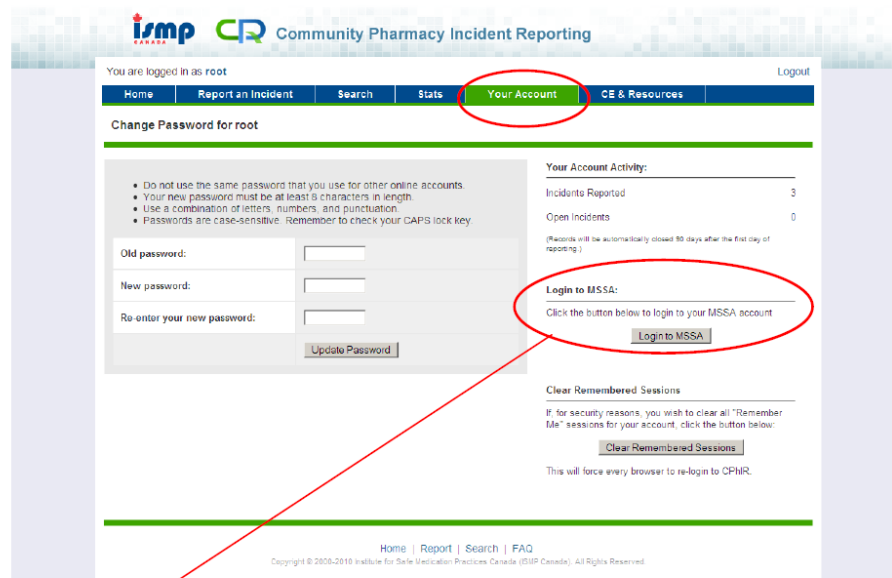
Please keep in mind that some of the MSSA items may refer to systems not currently in place at your store, yet these systems could be applicable to the scope of service provided and may reflect opportunities to enhance future medication safety. These items should be scored **A** or **B**, not E. That is, some of the self-assessment parameters may not yet be widely implemented, but they nonetheless reflect a level of practice to which all pharmacies should aspire. A rating of **A** indicates that the item is applicable to the store, but there has been no activity to implement it. An **A** rating identifies an opportunity for future quality and safety enhancements to the store systems.

Please refer to Page 5 to Page 9 of your MSSA Handbook for further details and instructions for conducting the self-assessment.

Section 2 Accessing your Online MSSA Account

Login to the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) Program at <http://www.cphir.ca>. You can access your MSSA account by clicking “Your Account” from the menu located at the top of the CPhIR homepage.

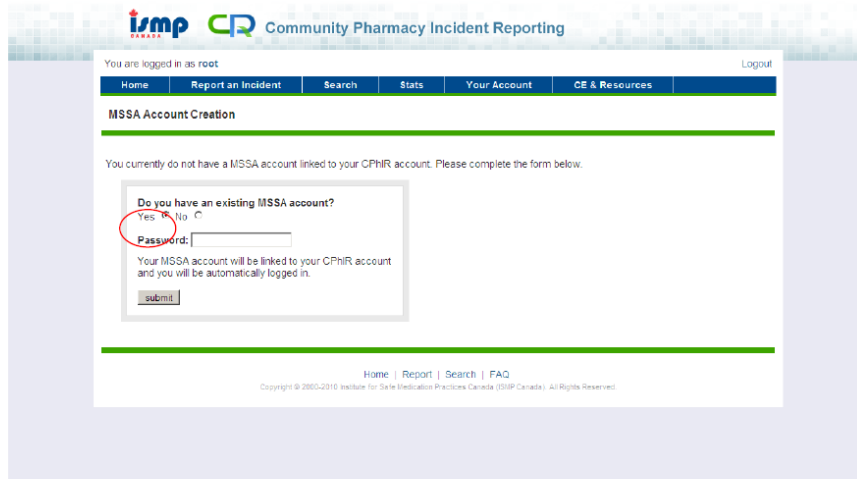
You will be taken to the following page:



The screenshot shows the 'Your Account' page in the CPhIR system. The 'Your Account' menu item is circled in red. Below it, the 'Login to MSSA' button is also circled in red. A red arrow points from the 'Login to MSSA' button to the text below.

Click on the “Login to MSSA” button and you will automatically be directed to your MSSA account. If it is your first time accessing MSSA through CPhIR, you will be prompted to complete one of the two following options:

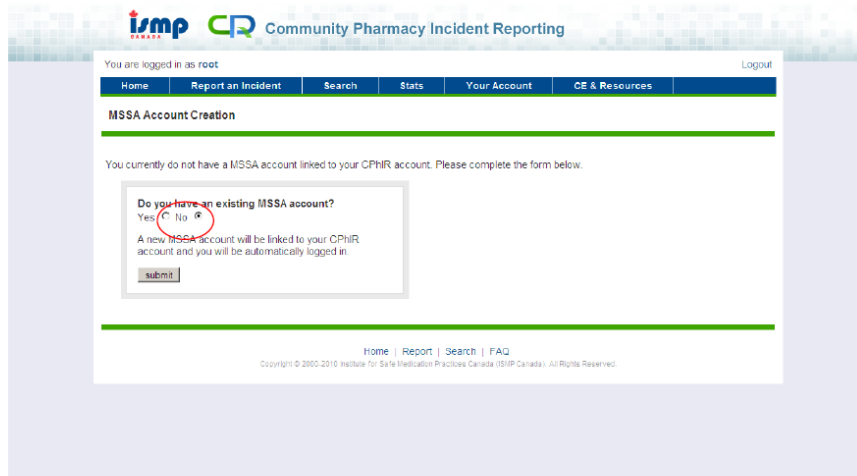
1. Link a current MSSA account, which has been used to enter online data, to your CPhIR account by entering your existing MSSA login details.



The screenshot shows the 'MSSA Account Creation' page. The form asks 'Do you have an existing MSSA account?' with 'Yes' selected. Below this is a 'Password:' field and a 'submit' button. The text below the form states: 'Your MSSA account will be linked to your CPhIR account and you will be automatically logged in.'

OR

2. Automatically create a new MSSA account for your CPhIR account if you have not previously entered online MSSA data.

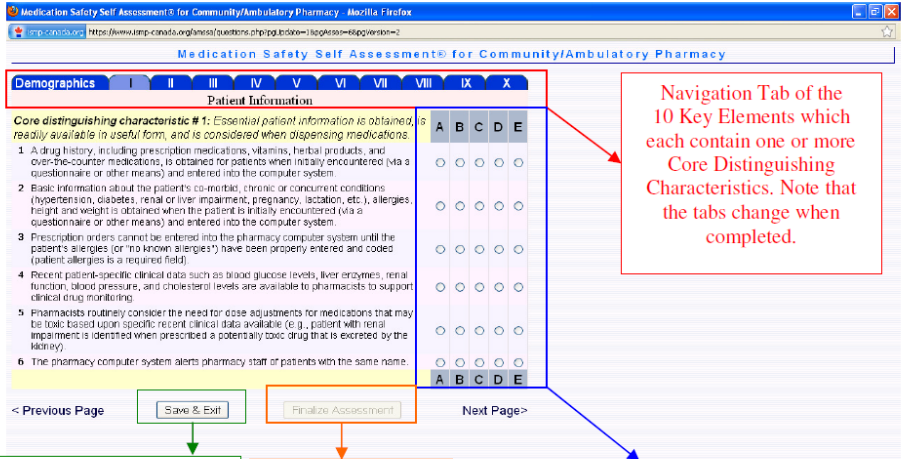


The screenshot shows the 'MSSA Account Creation' page. The form asks 'Do you have an existing MSSA account?' with 'No' selected. Below this is a 'submit' button. The text below the form states: 'A new MSSA account will be linked to your CPhIR account and you will be automatically logged in.'

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Section 3 Entering your MSSA Data Online

Before you start entering your MSSA question responses, you fill out your pharmacy's demographics. After this, you can complete the Self-Assessment Items for each of the 10 Key Elements. Each Key Element and Core Distinguishing Characteristic will be scored separately. The following screenshot displays the web browser as seen when completing an online MSSA:



The screenshot shows a web browser window titled "Medication Safety Self-Assessment for Community/Ambulatory Pharmacy". The page displays a table of assessment items under the heading "Patient Information". The table has columns labeled A, B, C, D, and E. Below the table are navigation buttons: "< Previous Page", "Save & Exit", "Finalize Assessment", and "Next Page >".

Navigation Tab of the 10 Key Elements which each contain one or more Core Distinguishing Characteristics. Note that the tabs change when completed.

Allows you to save your current choices so that you can finish and/or change the assessment at a later time

Click when complete, after which no more changes are allowed

**A = Applicable but no activity to implement
 B = Discussed but not implemented
 C = Partially implemented in some areas
 D = Fully implemented in some areas
 E = Fully implemented in all areas**

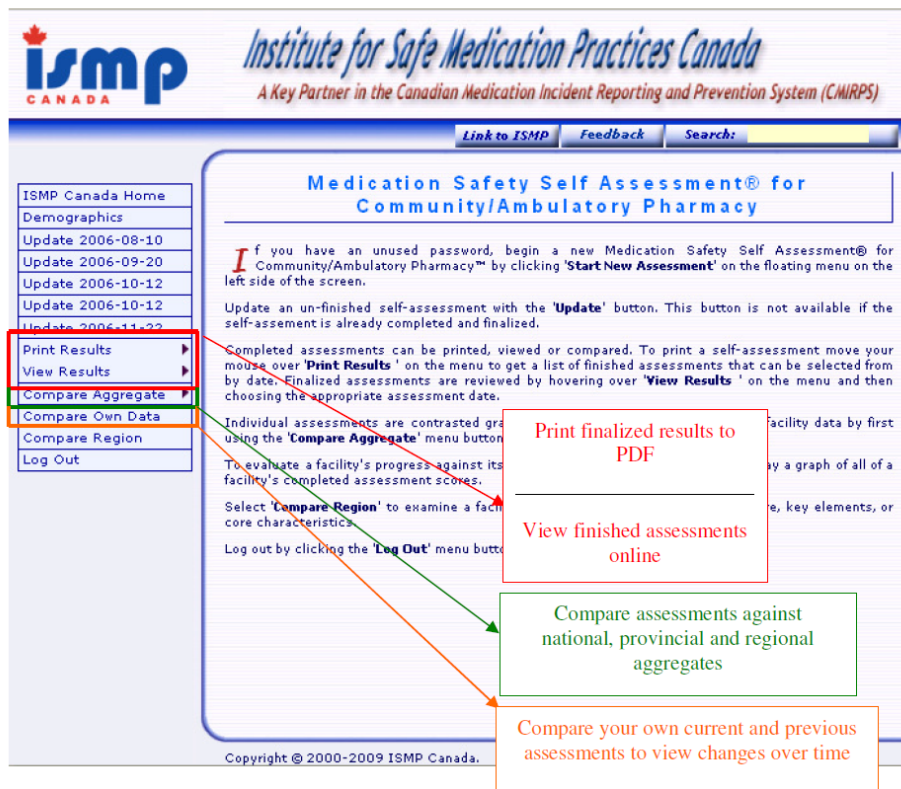
Although it is possible to enter and save your results by section during several online visits, all data should preferably be entered at one time, as this will reduce the opportunity for entry errors.

Once you have completed all 10 Key Elements, click on the "Finalize Assessment" button at the bottom right-hand corner to tabulate scores. You are now ready to analyze your MSSA data (See Section 4 and Section 5 of this Instructional Guide). Please note that you cannot go back to make any changes to your entries once you "Finalize" your assessment.

Section 4 Navigating your MSSA Account

After you have entered all your answers online, there are several reports that are available for you to interpret your results. The database will produce weighted scores from your responses. Scores are weighted based on an item's impact on patient safety and its ability to sustain improvement. You can view your results and print them in tabular or graphic form. This allows for a snapshot view of your current status, as well as comparison with aggregate data, from all pharmacies submitting data, when available. You can also compare against your own results to monitor your improvement over time. No other user of the MSSA is able to access or view your results. There is no link between the pharmacy identity and the aggregate self-assessment data.

The following screenshot displays the MSSA homepage and the navigation commands:





Institute for Safe Medication Practices Canada®
Institut pour l'utilisation sécuritaire des médicaments du Canada®
4711 Yonge St, Suite 501
Toronto, Ontario M2N 6K8
416-733-3131 or 1-866-54 ISMPC
www.ismp-canada.org

ISMP Canada protects the privacy, confidentiality and security of data submitted to the ISMP Canada server. (If more than one self-assessment has been completed, only the latest results are included in the aggregate, you can of course still view, print and compare against previous assessments.)

Print Results: Allows you to print the information you submitted in PDF form. Looking at the scores on the assessment item answers, you can identify which characteristics are most important and thus carry the highest values. Items are not equally weighted for scoring. Scores may range from 0 to 4, 0 to 8, 0 to 12, or 0 to 16. A question with a maximum weighted score of 16 obviously carries more importance with respect to medication safety than a question with a maximum score of 4.

View Results: Allows you to view your assessment results online. Information seen is the same as for “Print Results.”

Compare Aggregate: Allows you to compare your results against the aggregate scores of all users who have completed the MSSA online by region, province or Canada. You can compare Key Elements, Core Distinguishing Characteristics, and specific Self-Assessment Items. Separate graphs can be generated for each of the choices, as well as according to self-selected demographic criteria. The graph will indicate “n =” for the number of users in the aggregate grouping. The graph represents your score (column) as a percent of the maximum weighted scores. The graph shows the average aggregate result (red dot) and the standard deviation (red I-bar) for the data for all the users represented by “n”.

For more information on interpreting the aggregate data, please refer to Section 5 of this Instructional Guide.

Note: Print all graphs with Landscape Orientation in order to print all the contents of a graph on one page.

Compare Own Data: Allows you to compare previous and current assessment scores for the Key Elements or the Core Distinguishing Characteristics as a percent of the maximum weighted scores. The graphs provide an easy-to-understand visual picture of the data in the Print Results option. When additional assessments have been completed, the graph will show all of your results.

For more information on comparing your MSSA data and trends over time, please refer to Section 5 of this Instructional Guide.

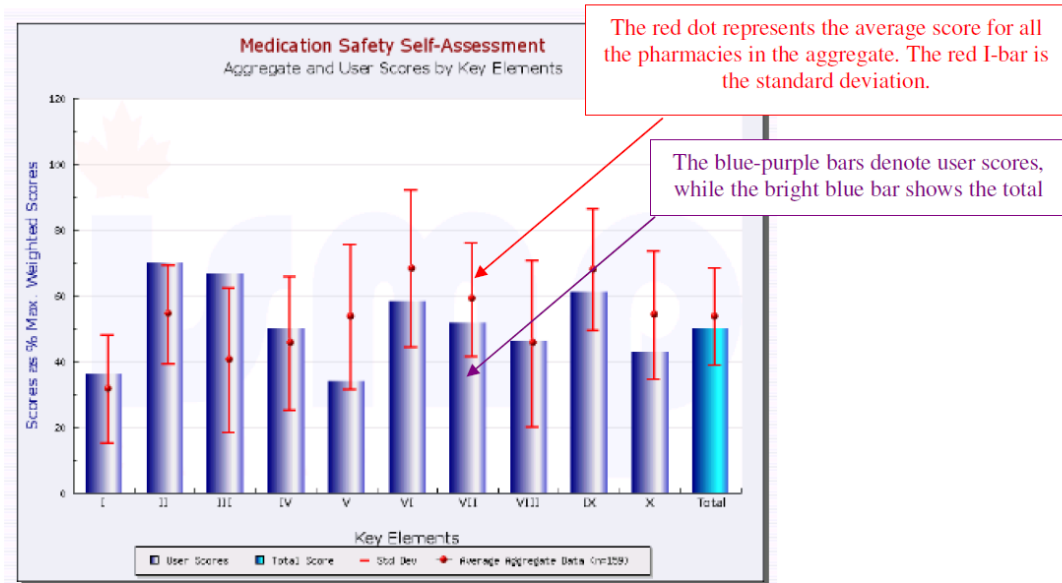
Note: Print all graphs with Landscape Orientation in order to print all the contents of a graph on one page.

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Section 5 Analyzing your MSSA Data

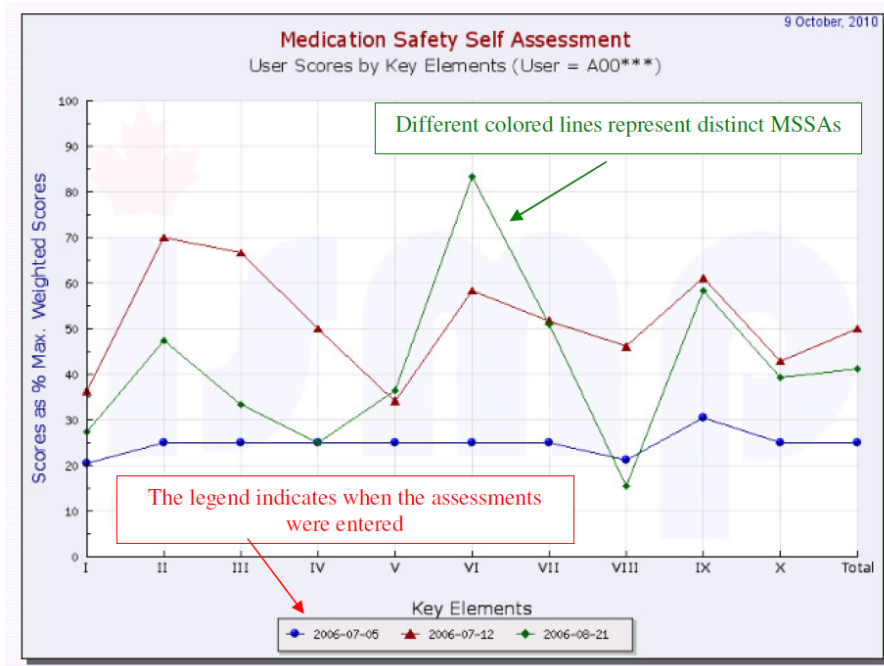
Compare Aggregate

You can compare your aggregate scores by clicking the “Compare Aggregate” tab on the left panel of the MSSA homepage. This function allows you to compare your MSSA scores with other users nationally, provincially or regionally. After you click on the “Compare Aggregate” tab, you will see a screen which allows you to adjust the parameters you want to compare, such as Key Elements, Core Distinguishing Characteristics, etc. Once you have selected your parameters, click “submit.” The screenshot below illustrates the layout of an aggregate analysis graph:



Compare Own Data

Alternatively, you can compare your MSSA data and trends over time by clicking on the “Compare Own Data” tab on the left panel of the MSSA homepage. After selecting your parameters, you will get a screenshot similar to the one below:



For assistance with interpretation or use of your MSSA results, or for information on how other facilities have made use of their MSSAs, please feel free to contact ISMP Canada at mssa@ismp-canada.org.

CQA FREQUENTLY ASKED QUESTIONS (FAQS)

What is a medication incident?

A medication incident includes errors that reach the patient as well as those that are intercepted prior to dispensing.

Do all medication incidents need to be reported?

The extent to which intercepted errors are reported will be a professional judgment decision of the pharmacy manager in consideration of the nature of the intercepted error, its implication for patient safety, and the extent to which it is reoccurring. All medication errors that reach a patient must be recorded anonymously online, as well as fully and identifiably within readily retrievable records in the pharmacy.

What is the Medication Safety Self-Assessment (MSSA) survey?

The MSSA survey assists pharmacies by allowing them to self-rate on a variety of safe practice characteristics across the spectrum of pharmacy activities. This assessment requires the pharmacy team to answer 89 questions on ten key elements. The tool will be completed by each participating pharmacy annually. For year two and onward, each pharmacy will receive a report identifying their improvement, including where they are in comparison to national aggregate results of participating pharmacies.

What is the Canadian Pharmacy Incident Reporting (CPhIR) tool?

Developed in collaboration with the ISMP Canada, the Ontario Ministry of Health and Long-term Care (OMHLTC), and the participating pharmacies of initial SafetyNET-Rx pilot. CPhIR is an online reporting program that allows pharmacies to anonymously and easily report a medication incident directly from their own computer terminals to an independent organization for population of a national aggregate database. Graphs can be generated instantaneously in order to assist pharmacy managers in presenting medication incident information to their staff for discussion at quarterly meetings and to identify trends over time. Having access to CPhIR has many advantages, including ISMP Canada's established policies and processes that enable anonymous reporting and that rigorously protect privacy, participants have comfort with using the program to submit sensitive information. By submitting to a national database, pharmacies enable the identification of safety-related trends and patterns that can be communicated across the profession, not just in their own pharmacy.

Is there a paper form that can be used in place of the online form?

Participants can choose to use paper forms to collect error reports if they prefer. These forms can be found on your CPhIR account under the "Report an Incident" tab. On the right hand side of the page, there is an option to "Print Blank Page." This can assist in having all members of 28 the pharmacy participate in the COMPASS program when computer terminals may not be readily

available to enter an online error report. Paper forms can be collected from staff and entered manually into the online reporting system at set time intervals to ensure that all information is captured for the production of medication incident reports.

Is the information that is submitted to ISMP Canada confidential?

Yes, the information submitted to ISMP Canada does not include identifiers for either the individual entering the data or the patient affected by the medication incident. This ensures anonymity of all individuals involved in the incident. The specific information submitted by individual pharmacies can only be viewed by that particular pharmacy by logging in using their username and password.

***Please remember to submit data as an open incident, to prevent lost information as CPhIR will automatically timeout after 24 minutes for confidentiality reasons.**

Is there a fee for the use of ISMP Canada’s MSSA and the CPhIR tool?

No, during the pilot all pharmacies will be provided these two tools free of charge for participating.

What is the purpose of quarterly meeting?

At least once every quarter, teams within each pharmacy including pharmacy managers, staff pharmacists and assistants should meet to discuss the previous quarter’s medication incidents, and to formulate strategies to reduce the likelihood of them occurring in the future. To provide a discussion framework for the meeting, using CPhIR, pharmacy managers can generate an Internal QRE Report detailing the reported medication incidents, as well as analysis and summary reports of the submitted medication incidents. Depending on the frequency and severity of the medication incidents occurring at the pharmacy, the pharmacy manager may decide that such meetings may take place more frequently. Also, any areas for improvements as identified in the MSSA, any staff education requirements, etc should be discussed. CPhIR also has an online tool under the “Quality Improvement” tab that allows the pharmacy to record and keep track of quarterly meeting medication incidents, MSSA issues and plans for improvement, etc.

ISMP Incident Form

<p><u>Date Incident Occurred (Mandatory)</u></p>	<p><input type="text"/> (YYYY-MM-DD)</p>	<p>Time Incident Occurred</p>	<ul style="list-style-type: none"> • <input type="checkbox"/> <u>Unknown</u> • <input type="checkbox"/> <u>Morning (06:00-12:00)</u> • <input type="checkbox"/> <u>Afternoon (12:00-18:00)</u> • <input type="checkbox"/> <u>Evening (18:00-00:00)</u> • <input type="checkbox"/> <u>Overnight (00:00-06:00)</u>
<p>Type of Incident (Mandatory)</p>	<ul style="list-style-type: none"> • <input type="checkbox"/> <u>Incorrect patient</u> • <input type="checkbox"/> <u>Incorrect prescriber</u> • <input type="checkbox"/> <u>Incorrect drug</u> • <input type="checkbox"/> <u>Incorrect dose/frequency</u> • <input type="checkbox"/> <u>Incorrect strength/concentration</u> • <input type="checkbox"/> <u>Incorrect dosage form/formulation (include not splitting tablets as per patient's request)</u> • <input type="checkbox"/> <u>Incorrect route of administration</u> • <input type="checkbox"/> <u>Incorrect duration of treatment</u> • <input type="checkbox"/> <u>Incorrect quantity</u> • <input type="checkbox"/> <u>Incorrect storage</u> • <input type="checkbox"/> <u>Omitted Medication/Dose</u> • <input type="checkbox"/> <u>Expired medication</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Contraindication</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Adverse Drug Reaction</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Documented allergy</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Drug-drug/OTC/Natural Health Product interaction</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Drug-food interaction</u> • <input type="checkbox"/> <u>Drug Therapy Problem - Drug-disease interaction</u> • <input type="checkbox"/> <u>Incorrect third-party billing</u> 	<p>Incident Discovered By</p>	<ul style="list-style-type: none"> • <input type="checkbox"/> <u>Pharmacist</u> • <input type="checkbox"/> <u>Pharmacy Technician</u> • <input type="checkbox"/> <u>Pharmacy Student</u> • <input type="checkbox"/> <u>Patient</u> • <input type="checkbox"/> <u>Patient's Family Member/Relative</u> • <input type="checkbox"/> <u>Patient's Caregiver/Home Aid/Assistant</u> • <input type="checkbox"/> <u>Patient's Friend/Visitor</u> • <input type="checkbox"/> <u>CCAC Home Care Coordinator</u> • <input type="checkbox"/> <u>Physician</u> • <input type="checkbox"/> <u>Medical Student</u> • <input type="checkbox"/> <u>Paramedic</u> • <input type="checkbox"/> <u>Nurse</u> • <input type="checkbox"/> <u>Nursing Student</u> • <input type="checkbox"/> <u>Social Worker</u> • <input type="checkbox"/> <u>Dentist</u> • <input type="checkbox"/> <u>Midwife</u> • <input type="checkbox"/> <u>Chiroprapist/Podiatrist</u> • <input type="checkbox"/> <u>Respiratory Therapist</u> • <input type="checkbox"/> <u>Dietician</u> • <input type="checkbox"/> <u>Physiotherapist</u> • <input type="checkbox"/> <u>Occupational Therapist</u> • <input type="checkbox"/> <u>Veterinarian</u> • <input type="checkbox"/> <u>Other</u>

Medication System Stages Involved in this Incident (Mandatory)	<ul style="list-style-type: none"> • <input type="checkbox"/> Prescribing • <input type="checkbox"/> Rx Order Entry • <input type="checkbox"/> Prescription Preparation / Dispensing • <input type="checkbox"/> Administration • <input type="checkbox"/> Monitoring / Follow-up • <input type="checkbox"/> Not Applicable (Unable to determine one or more of the above medication system phases)
-----------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Medications (Mandatory)	Medication 1 Medication 2 Medication Name: <input type="text"/> <input type="text"/> DIN: <input type="text"/> <input type="text"/>
--------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------

Gender <ul style="list-style-type: none"> • <input type="checkbox"/> Unknown • <input type="checkbox"/> Male • <input type="checkbox"/> Female 	Age <ul style="list-style-type: none"> • <input type="checkbox"/> Unknown • <input type="checkbox"/> 0-28 days inclusive • <input type="checkbox"/> > 28 days to 18 years inclusive • <input type="checkbox"/> > 18 years to 65 years inclusive • <input type="checkbox"/> > 65 years
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Degree of Harm to Patient due to Incident (Mandatory)	<ul style="list-style-type: none"> • NO ERROR <ul style="list-style-type: none"> ○ <input type="checkbox"/> No Error (Medication Not Dispensed / Near Miss / Medication Discrepancy) - Circumstances or events that have the capacity to cause harm • NO HARM <ul style="list-style-type: none"> ○ <input type="checkbox"/> No Harm (Medication Dispensed) - No symptoms detected; no treatment required • HARM <ul style="list-style-type: none"> ○ <input type="checkbox"/> Mild Harm - Symptoms were mild, temporary and short term; no treatment or minor treatment was required ○ <input type="checkbox"/> Moderate Harm - Symptoms required additional treatment or an operation; the incident kept the patient in hospital longer than expected; or caused permanent harm or loss of function ○ <input type="checkbox"/> Severe Harm - Symptoms required major treatment to save the patient's life; the incident shortened life expectancy; or caused major permanent or long term harm • DEATH <ul style="list-style-type: none"> ○ <input type="checkbox"/> Death - There is reason to believe that the incident caused the patient's death or hastened the patient's death
--------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Incident Description / How Incident was Discovered

Other Incident Info (Check all that apply)

- **Rx is from:**
 - Hospital
 - Medical Clinic / Prescriber's Office
- **Rx is presented as a:**
 - Hand-written Prescription
 - Computer-generated / Pre-printed Prescription
 - Verbal Prescription
 - Fax Prescription
 - e-Prescription
- **Type of Rx**
 - Regular
 - Narcotic / Controlled Drugs
 - Log
- **Rx Order Entry / Dispensing Label Generation**
 - New Rx
 - Repeat Rx
 - Balance Owing
 - Nursing Home/Blister Pack
- **Rx Supply / Ordering**
 - Interchangeable Brand Dispensed
 - On-order / Back-order Item
- **Rx Preparation - Dispensing**
 - Patient/Patient Representative Waiting
 - Patient/Patient Representative Coming Back to Pick Up
 - Rx Delivery

Contributing Factors of this Incident

- **Critical patient information missing**
 - Age
 - Weight
 - Height
 - Allergies
 - Body Surface Area
 - Vital signs
 - Lab values
 - Pregnancy
 - Renal/liver impairment
 - Diagnosis / Medical Condition / Indication of Prescribed Medication
 - Third Party Info
- **Critical drug information missing**
 - No medication history
 - Inadequate medication reconciliation
 - Outdated/absent references
 - Inadequate computer screening
- **Miscommunication of drug order**
 - Illegible
 - Ambiguous
 - Incomplete
 - Misheard orders
 - Misunderstood orders (e.g. Intentional change of medication or dosage not indicated on Rx)
 - Intimidation/faulty interaction

	<ul style="list-style-type: none"> • Rx Preparation - Checking <ul style="list-style-type: none"> <input type="checkbox"/> DUR Info Generated by Dispensing System • Rx Preparation - Storage <ul style="list-style-type: none"> <input type="checkbox"/> Rx stored in pick-up drawers <input type="checkbox"/> Rx stored in delivery basket or drawer <input type="checkbox"/> Rx stored in on-order / balance-owing / back-order basket on dispensary counter <input type="checkbox"/> Rx stored in fridge • Administration <ul style="list-style-type: none"> <input type="checkbox"/> Medication was administered <input type="checkbox"/> Medication was not administered • Monitoring <ul style="list-style-type: none"> <input type="checkbox"/> Call-back / Follow-up Performed by Pharmacist 		<ul style="list-style-type: none"> • Drug name, label, packaging problem <ul style="list-style-type: none"> <input type="checkbox"/> Look/sound-alike names <input type="checkbox"/> Look-alike packaging <input type="checkbox"/> Unclear/absent labelling <input type="checkbox"/> Faulty drug identification • Drug storage or delivery problem <ul style="list-style-type: none"> <input type="checkbox"/> Rx stored in wrong bag/pick-up drawer <input type="checkbox"/> Rx given/delivered to incorrect patient • Drug delivery device problem <ul style="list-style-type: none"> <input type="checkbox"/> Poor device design <input type="checkbox"/> Misprogramming • Environmental, staffing, or workflow problem <ul style="list-style-type: none"> <input type="checkbox"/> Noise <input type="checkbox"/> Clutter <input type="checkbox"/> Interruptions <input type="checkbox"/> Change of shift <input type="checkbox"/> Staffing deficiencies <input type="checkbox"/> Workload <input type="checkbox"/> Inefficient workflow • Staff education problem <ul style="list-style-type: none"> <input type="checkbox"/> Competency validation <input type="checkbox"/> New or unfamiliar drugs/devices <input type="checkbox"/> Orientation process <input type="checkbox"/> Feedback about errors/prevention • Patient education problem <ul style="list-style-type: none"> <input type="checkbox"/> Lack of information <input type="checkbox"/> Information provided to patient delegate <input type="checkbox"/> Non-adherence <input type="checkbox"/> Not encouraged to ask questions <input type="checkbox"/> Lack of investigating patient inquiries
--	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

			<ul style="list-style-type: none"> • Lack of quality control or independent check systems <ul style="list-style-type: none"> <input type="checkbox"/> Independent checks for high alert drugs/high risk patient population drugs <input type="checkbox"/> Equipment quality control checks
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**Recommended Actions at Store Level
(Include action plan, person in charge, and target date for completion)**

Shared Learning for ISMP Canada to Disseminate

Documents

Documents included in this manual are for your reference and use; however most of the documents included are also available in an electronic format on the CPhIR website under the *Quality Improvement* tab.

A sample *Quarterly Meeting Agenda* has been included to help pharmacy managers conduct quarterly staff meetings. By following a standard agenda, quarterly meetings should address the same content and provide staff members with a predictable, structured flow. Time is allocated for review of old business, review of new medication incidents, and announcements to staff. At the end of each meeting, a tentative date for the next meeting should be set by all in attendance. It is important that the improvement plan is reviewed and amended as needed at each meeting.

The *Quarterly Meeting Report Form* should be filled out for each quarterly meeting. The form encourages discussion and analysis of medication incidents based on a number of dimensions, including workflow, staffing and environment issues. The creation of action plans in each of these areas assist in the effort to reduce the likelihood of the medication incident reoccurring. These forms also aide in the discussion of “old business” during quarterly meetings to ensure follow through on the action plans.

The *CQA Summarization Document* will likely eventually be used by the inspectors to help assure the pharmacy has achieved the standards of practice. The document is also useful to provide a “self-audit” for pharmacies nearing their inspection date. Please ensure that this document is filled out completely and accurately. It can be useful to fill this document out monthly to help keep track of the number of medication incidents reported and when quarterly meetings take place.

Additional documents included in this guide are intended as resources to aide pharmacies in topics related to the CQI.

Root Cause Analysis Instructions provide pharmacies with directions on how to employ root cause analysis techniques when analyzing medication incidents during quarterly and staff meetings. A *Fishbone Diagram* is also included to help staff visually discuss root causes and identify solutions.

The *Suggested Protocol for Handling Medication Errors* provides an easy-to- follow policy when a medication incident that has reached the patient has occurred or is suspected to have occurred in the dispensary. The protocol is generic enough to use in all instances where a medication incident has reached a patient and provides direct advice on how to proceed. This protocol

should be placed on a shared notice space for all pharmacists, pharmacy techs and locum staff to view and reference.

The *Canadian Disclosure Guidelines*, compiled by the Canadian Patient Safety Institute (CPSI), provide guidance on how best to disclose medication incidents to patients who have been impacted. This document is meant as a guideline only, and pharmacies are encouraged to discuss the procedures in place in their pharmacy for disclosure to patients.

QUARTERLY MEETING AGENDA

Date: _____

1. Attendance
2. Old Business
 - a. Quick review of medication incident statistics from last meeting
 - b. Review of action plans made
 - c. Discuss Progress (continue/change action plans as needed)
3. New Business
 - a. Presentation of medication incidents for consideration
 - b. Discussion and analysis of medication incidents
 - i. Summarization of issues
 - ii. Identify solutions
 - iii. Create action plan (use fishbone diagram if appropriate)
4. Announcements
5. Schedule date for next meeting in 3 months
6. Adjourn

Adapted from Florida Pharmacy Continuous Quality Improvement (CQI) Manual, 2002.



Quarterly Meeting Report Form

	Quarterly Meeting #1	Quarterly Meeting #2	Quarterly Meeting #3	Quarterly Meeting #4
Date				
Number of pharmacists present				
Number of technicians present				
Pharmacy manager present (Y/N)				
Pharmacy Owner present (Y/N)				
Number of medication incidents reviewed				

QUARTERLY MEETING REPORT FORM

Meeting #1 Comments: _____

Meeting #2 Comments: _____

Meeting #3 Comments: _____

Meeting #4 Comments: _____

QUARTERLY MEETING ACTION PLAN FORM

Planned Action	Meeting #1 (Date & Discussion)	Follow-Up		
		Meeting #2 (Date & Discussion)	Meeting #3 (Date & Discussion)	Meeting #4 (Date & Discussion)
Ex. Place Rx's to be picked up in red basket	May 19, 2011 Confusion surrounding which Rx's to be picked up vs. waited for. Will use colour-coded baskets.	August 19, 2011 Not adopted by all staff. Discussed again to ensure everyone is on same page.	November 19, 2011 Working well. Less confusion and reduced near misses.	February 19, 2012 Trained new staff on procedure. Still working well.

ANNUAL MSSA IMPROVEMENT PLAN FORM

MSSA Element					
	I	II	III	IV	V
Deficiency	Ex. Complete OTC drug information is not always taken upon new patient intake				
Improvement Plan	Ex. Put a reminder sticky on computer terminal to ask patients to name complete list of OTC drugs at intake and upon refills				

ANNUAL MSSA IMPROVEMENT PLAN

MSSA Element					
	VI	VII	VIII	IX	X
Deficiency					
Improvement Plan					

CQA SUMMARIZATION DOCUMENT

General Information

Pharmacy Trade Name:	License No.:
Address:	Phone/Fax No.:
Email:	
Time period of report (mm/yyyy – mm/yyyy):	

Medication Safety Self-Assessment

Date of last completed self-assessment: (dd/mm/yyyy) _____

How many individuals participated in the completion of the self-assessment? _____

Dates of follow-up discussions with staff:

Was an analysis of the self-assessment results completed? (Y/N) ____ If Yes, when? _____

Medication Incident Reporting

Number of medication incidents reported each month:

Jan _____ Feb _____ Mar _____ Apr _____ May _____ Jun _____ Jul _____
 Aug _____ Sep _____ Oct _____ Nov _____ Dec _____

Who primarily enters medication incident data?

Person who discovers medication incidents Pharmacist Technician Student

Quarterly Meetings

	Q1	Q2	Q3	Q4
Date of meeting (dd/mm/yyyy)				

Number of participants				
	Q1	Q2	Q3	Q4
Length of meeting				
Number of medication incidents reviewed (individually or as part of a summary review of the total)				
Number of improvement plans made				
Number of previous improvement plans reviewed				

Staff Education

Have staff CQI education activities taken place? (Y/N) ____ (these can include independent study lessons, etc.) _____

If yes, when? (dd/mm/yyyy) _____

Please provide a short description of what was covered:

Pharmacist's signature: _____ Date: _____

Inspector's signature: _____ Date: _____

Adapted from National Association of Boards of Pharmacy (NABP) Model Act, 2010. (16 July, 2010)

ROOT CAUSE ANALYSIS STEPS AND INSTRUCTIONS

Root Cause Analysis is a method of problem solving techniques with a purpose of determining the “root cause” of a medication incident in order to prevent the medication incident from occurring again in the future. Root Cause Analysis views every medication incident as an opportunity to learn and improve a process by determining the “root cause” of a medication incident so that the issue can be addressed in order to take appropriate action in your community pharmacy to improve the overall process. When determining the “root cause” of a medication incident it can be helpful to use a fishbone diagram with your pharmacy staff for brainstorming purposes. The fishbone diagram will list various possibilities to where the “root cause” of the medication incident lies.

The steps to Root Cause Analysis can be described as follows¹:

Step 1: Define and describe the medication incident that occurred in your community pharmacy.

When defining the medication incident that occurred in your pharmacy it is important to be specific about the incident that occurred (e.g. what drugs were involved). You may also want to categorize the medication incident that occurred in your pharmacy as well during this step (e.g. wrong dose; wrong drug).

Step 2: Detail as much information about the medication incident as possible.

Gather as much detail about the situation as possible on your own and from pharmacy staff who were working at the time of the medication incident. Asking questions such as “when did the medication incident happen?” and “what else was going on in the community pharmacy at the time?” are some examples. You may want experienced staff, who may be knowledgeable of why exactly the medication incident happened, to speak at your brainstorming session for determining the root cause of the problem.

Step 3: Determine all possible causes of the medication incident using the Fishbone Diagram and sort based on the categories of causes in the diagram.

During your brainstorming session with your pharmacy staff, start out by using the Fishbone Diagram on a white board or where everyone can see it and contribute. Fill in the medication incident defined in Step 1 in the head of the fishbone where it says medication incident. The back of the fishbone diagram contains categories where causes of the medication incident may lie. Brainstorm with your staff all the possible causes of the medication incident and fill them into the lines under the appropriate categories. The categories listed in the

diagram are only a suggestion so feel free to add any categories that you feel are appropriate for your pharmacy. Also, it is not important to fill all of the categories, it is only important for you and your staff to do a thorough brainstorming session here and to consider all of the categories on the Fishbone Diagram so that no potential causes of the medication incident are missed.

Step 4: Define relationships between the potential causes of the medication incident identified in Step 3 by asking why repeatedly.

Now that your Fishbone Diagram is filled out, look at each of the causes of the medication incident that you've listed under the categories individually. For each cause ask the team to brainstorm why it happened. For example, if you've determined that the medication incident was that the wrong medication was given out and one potential cause was that the staff member was not trained correctly, ask why. When you've determined the potential cause of the staff member not being trained correctly ask why again and keep going with this process until the question why cannot be answered. Continue this process for each of the potential causes that you have listed in your Fishbone Diagram.

Step 5: Brainstorm which potential cause would eliminate the medication incident in the community pharmacy if it was fixed and identify potential solutions to eliminate the potential cause.

When brainstorming possible solutions to eliminate the cause of the medication incident the solution must meet three important criteria. First, the solution to eliminate the cause of the medication incident must eliminate the medication incident if it is implemented. Second, if eliminated, the root solution cannot result in more medication incidents within the pharmacy. Third, the solution must also be possible within the pharmacy. When conducting the brainstorming session there should be discussion among the pharmacy staff why a potential strategy for the removal of the cause of the medication incident does or does not meet the specified criteria. This process could leave you with only one possible solution or several.

Step 6: Rank solutions that will best eliminate the medication incident in the pharmacy

If Step 5 leaves you with only one possible solution than there is no need to determine the best solution as there is only one choice. If instead there are several possible solutions from Step 5 then the team should be asked to rank each solution based on effectiveness of eliminating the medication incident and feasibility of the solution. The averages of the two scores should be calculated and the solution with the best score should be chosen for implementation.

Step 7: Implement the solutions determined in Step 6 into your pharmacy's process and monitor to ensure the solutions have been effective.

Upon implementation of the chosen solution it is important to monitor to ensure the solution has had the desired effectiveness. If the solution has not resulted in the desired effectiveness it could be because the "root cause" of the medication incident was incorrect or because the best possible solution to remove the "root cause" was not chosen.

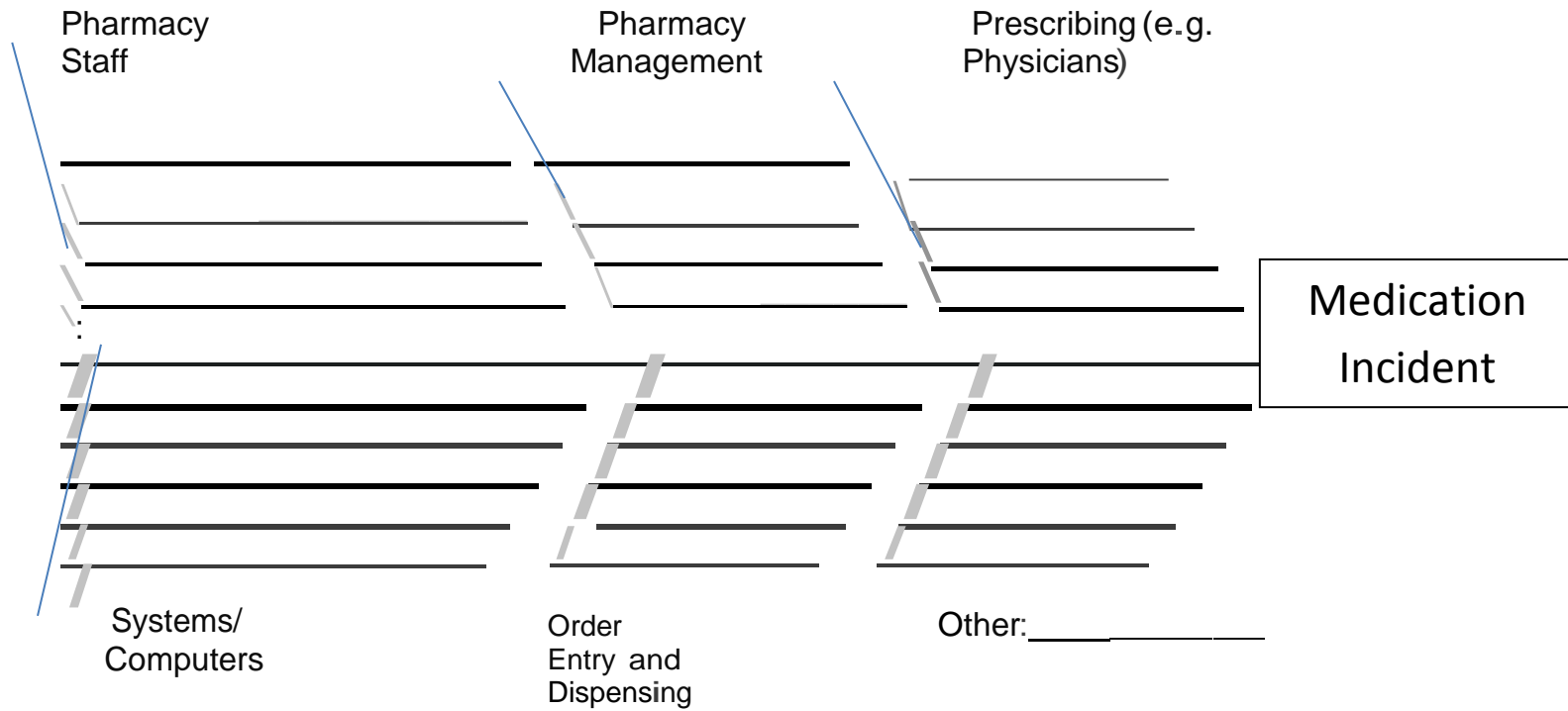
Step 8: If the medication incident continues to occur repeat the Root Cause Analysis process

If you determine that the solution implemented has not had the desired effectiveness it may be necessary to complete the Root Cause Analysis again to determine a different "root cause" to the medication incident that may have been incorrectly defined previously, or to brainstorm a better solution to remove the "root cause" from the process. Because it may be necessary to repeat the Root Cause Analysis in your pharmacy for the same medication incident if the solution is not effective it is important to keep all notes and information gathered about the medication incident until the solution has been deemed to be a success.

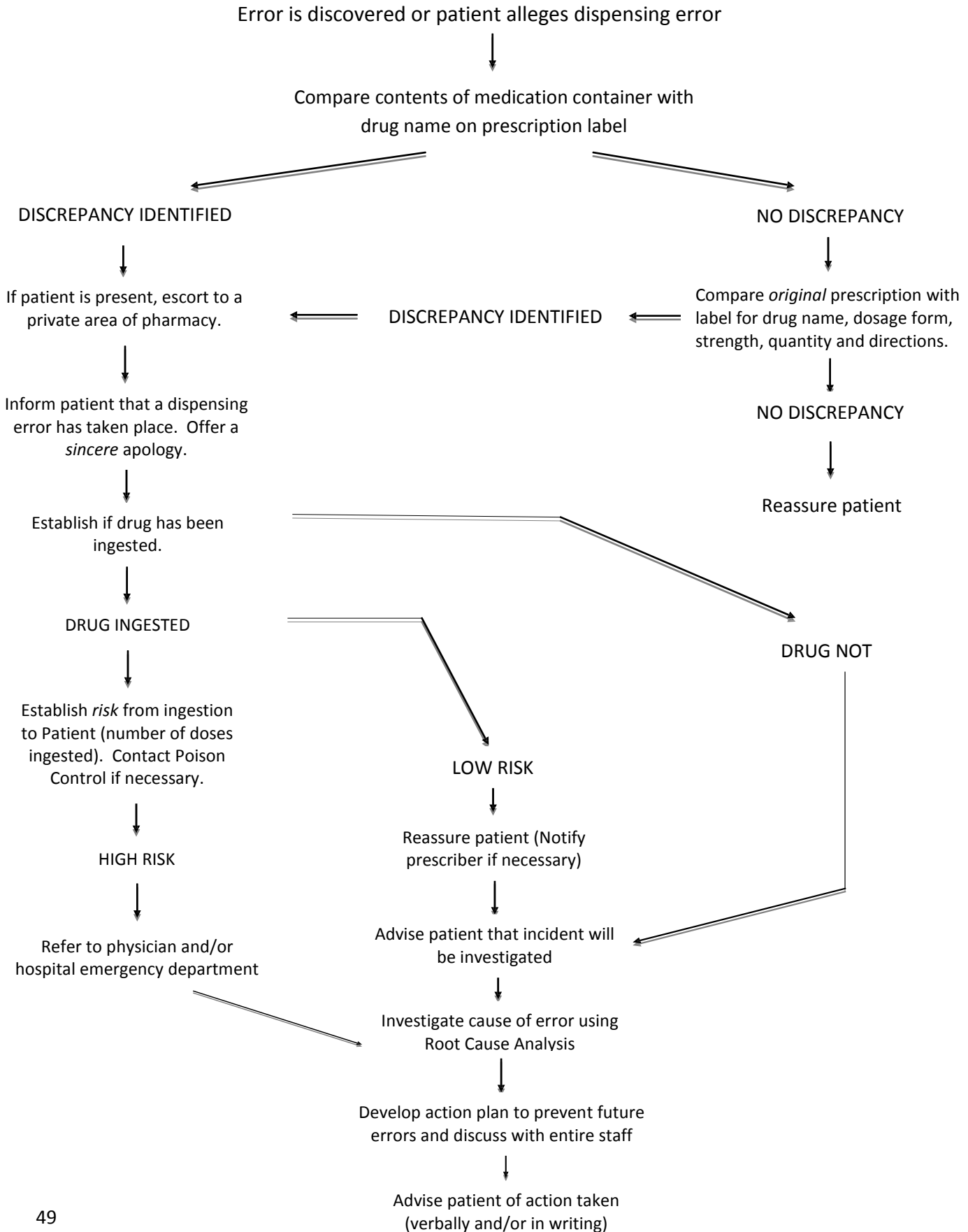
Meeting Date: _____

Version: _____

Fishbone Diagram



SUGGESTED PROTOCOL FOR HANDLING MEDICATION ERRORS



CANADIAN DISCLOSURE GUIDELINES

CHECKLIST FOR DISCLOSURE PROCESS

- The immediate patient care needs are met
- Ensure patient, staff and other patients are protected from immediate harm.

Disclosure Process Plan

- Gather existing facts.
- Establish who will present and who will lead the discussion.
- Set when the initial disclosure will occur.
- Formulate what will be said and how effective disclosure will be accomplished.
- Locate a private area to hold disclosure meeting, free of interruptions.
- Be aware of your emotions and seek support if necessary.
- Anticipate patient's emotions and ensure support is available including who the patient chooses to be part of the discussion such as family, friends, etc.
- Contact your organization's support services for disclosure if uncertain how to proceed.

Initial Disclosure

- Introduce the participants to the patient, functions and reasons for attending the meeting.
- Use language and terminology that is appropriate for the patient.
- Describe the facts of the adverse event and its outcome known at the time.
- Describe the steps that were and will be taken in the care of the patient (changes to care plan as applicable).
- Avoid speculation or blame.
- Express regret.
- Inform the patient of the process for analysis of the event and what the patient can expect to learn from the analysis, with appropriate timelines.
- Provide time for questions and clarify whether the information is understood.
- Be sensitive to cultural and language needs.
- Offer to arrange subsequent meeting along with sharing key contact information.
- Offer practical and emotional support such as spiritual care services, counselling and social work, as needed.
- Facilitate further investigation and treatment if required.

Subsequent and Post-Analysis Disclosure

- Continued practical and emotional support as required.
- Reinforcement or correction of information provided in previous meetings.
- Further factual information as it becomes available.
- A further expression of regret that may include an apology with acknowledgement of responsibility for what has happened as appropriate.
- Describe any actions that are taken as a result of internal analyses such as system improvements.

Document the disclosure discussions as per organizational practices and include:

- The time, place and date of disclosure.
- The names and relationships of all attendees.
- The facts presented.
- Offers of assistance and the response.
- Questions raised and the answers given.
- Plans for follow-up with key contact information for the organization.

Source: Canadian Patient Safety Institute (CPSI). *Canadian Disclosure Guidelines*. 2008. Available: www.patientsafetyinstitute.ca