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COUNCIL BRIEFING NOTE
MEETING DATE: MARCH 2017

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Medication Safety Task Force

TOPIC: Continuous Quality Improvement (CQI) for Medication Safety

ISSUE: Circulation of a proposed model for a standardized continuous quality assurance program for pharmacies, including the collection of medication incident data.

BACKGROUND:

- Following an incident linked to a compounded medication error, the College reviewed the current processes for medication incident reporting in Ontario and completed a jurisdictional review to identify similar processes across Canada.
- The College's current approach is to rely on policies and Standards of Practice for designated managers and pharmacy professionals related to management of medication errors to improve patient safety. The College provides additional guidance to pharmacy professionals through multiple communication channels (e.g. articles, practice tools, practice advisors).
- In December 2016, Council directed the formation of a Task Force to develop a model for a standardized continuous quality improvement program.
- The composition of the Task Force included a public member, a patient representative, a pharmacy technician, a hospital pharmacist and two pharmacists from varying community practices.
- The jurisdictional review confirmed that Nova Scotia is the only province with a requirement for mandatory reporting to an external third party and that Saskatchewan recently approved full implementation of a mandatory reporting requirement for November 2017.
- Manitoba has recently approved a pilot program that began in January 2017 and PEI has committed to reviewing this topic in 2017.
- The College has consulted with the Nova Scotia College of Pharmacists and The Saskatchewan College of Pharmacy Professionals to gather information about SafetyNET-Rx and COMPASS, which are the standardized CQI programs that have been implemented in these jurisdictions.
- The Task Force also invited the Institute for Safe Medication Practice (ISMP) to present to the Task Force on Medication Safety and Continuous Quality Improvement (CQI) in Pharmacy Practice.

DISCUSSION:

- Media and public attention regarding the recent medication incident in Ontario has been focused on the issue of mandatory reporting of medication errors.

- Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care has expressed his support for mandatory reporting and has requested that the College follow-up with Nova Scotia to better understand their processes.

Model for Continuous Quality Improvement

- Based on information provided by ISMP, as well as the other jurisdictions, the Task Force determined that an effective Continuous Quality Assurance (CQA) Program would support a CQI model that focuses on systemic review of processes and root cause analysis of individual incidents to inform quality improvement initiatives.

- The objective of this CQA approach, which includes analysis of how the error came to be and reporting the error to an external body, is to ensure that all practitioners learn from these incidents and review and enhance their policies and procedures to reduce the chances of recurrence thereby improving patient safety.

- Medication error reporting provides the data required to support a systemic review of errors in individual pharmacies as well as an aggregate review of national trends.

- All jurisdictions consulted stated that mandatory standardized CQA programs have resulted in numerous benefits such as; reduction in blame and fear in discussing medication errors, more open discussions about near misses to prevent similar incidents from reaching a patient, increased practitioner accountability, clearer practice expectations with respect to CQI, increase in shared learnings and increased awareness of safety issues.

Medication Incident Reporting

- Based on feedback and recommendations from Saskatchewan and Nova Scotia, the Task Force determined that including a specified third party for incident reporting would maintain the quality of aggregate data and prevent data dilution in the event of multiple third party providers.

Sharing Learnings

- Feedback from Saskatchewan and Nova Scotia indicated that annual Medication Safety Self-Assessment (MSSA) completion was a barrier for many pharmacies due to time restrictions and that one year may not be sufficient to implement and monitor all quality improvement initiatives identified. ISMP recommends completion of an MSSA every one to three years.

- The Task Force proposed requirements for the completion of a MSSA every 2 to 3 years, or more frequently if needed, concluding that the recommended schedule would best support success and uptake of a CQA program.

- To support maximal uptake and reduce barriers presented by formal face-to-face meetings, the Task Force included a requirement that pharmacies implement regular communication between pharmacy staff regarding medication incidents and safety initiatives (i.e. would not always require face-to-face meetings) to encourage increased frequency of discussions.

Implementation

- The Task Force recommends that the College implement a mandatory standardized CQA program that outlines program requirements all pharmacy professionals must meet, including a requirement for medication incident reporting.

- Saskatchewan and Nova Scotia highlighted the need to implement in phases to allow for the development of peer champions that can support a more seamless full implementation by acting as mentors or coaches.

- Based on this feedback, the Task Force recommends that implementation occur over two phases, the initial phase to include volunteer pharmacies that are representative of pharmacy practice across Ontario (e.g. independent, chain, rural, urban) and the second phase to build upon the initial volunteers to further strengthen the peer champion network.

- As part of the enhanced practice assessments, practice advisors will review adherence to pharmacy CQA requirements and individual practice standards related to continuous quality improvement, as well as the requirements outlined in the mandatory standardized Continuous Quality Assurance Program (Appendix A).

NEXT STEPS:

- Should Council recommend that the College release the proposed model for public consultation, the proposed model (Appendix A) will be posted on the College website for 30 days following which the results will be presented to Council at its June meeting.

- Consultation would be framed by presenting specific questions to guide feedback on the concept the College is proposing to best ensure successful adoption by pharmacists.

- The College will develop a comprehensive implementation and monitoring plan including an expected date of full achievement.

- The College will develop a comprehensive communication plan to support successful implementation. Stakeholders, including educators, are being identified.

DECISION FOR COUNCIL:

- Recommend that Council support public consultation on the proposed model for a Continuous Quality Assurance Program in Pharmacies in order to determine potential barriers to full implementation as well as factors to support successful rollout.

- Does Council have any feedback on the proposed model prior to posting for consultation?

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Continuous Quality Assurance Programs in Pharmacies

Recent studies on the prevalence of medication errors have brought increased attention to continuous quality improvement (CQI) in healthcare in North America. These reports have identified the need for increased efforts to create a safer healthcare delivery system.[1]

In 2015, as part of its commitment to CQI, the College introduced enhancements to the long-standing pharmacy inspection process. Now referred to as practice assessments, the new process is designed to increase adherence to both pharmacy operational and individual practice standards. In an ongoing effort to improve patient safety, community pharmacies are required to implement a mandatory standardized continuous quality assurance program that enables enhancement of the safety culture of pharmacies.

Continuous quality improvement (CQI) involves an ongoing and systematic examination of an organization's work processes to identify and address the root causes of quality issues and implement corresponding changes.[2] Effective CQI programs involve implementation of quality improvements as a result of both proactive review of work processes to identify areas of risk and retrospective review of specific medication incidents. The objective of CQI is to ensure that all practitioners learn from medication incidents and review and enhance their policies and procedures to reduce the chances of recurrence, thereby improving patient safety.

According to the Standards of Practice, all pharmacists and pharmacy technicians have the responsibility and obligation to manage medication incidents and address unsafe practices. This includes documenting and communicating all medication incidents and near misses with the rest of the staff in the pharmacy, and as appropriate to the patient and other health care providers if the incident reaches the patient. It is the responsibility of the Designated Manager (DM) to ensure that there is an appropriate mechanism in place for this to occur, and that learnings are continuously being documented, identified and applied to improve processes within the pharmacy.

To achieve safer care for patients, CQI must focus on both systemic improvements and the tasks that individual practitioners perform. The CQI model supports shared accountability; it holds pharmacies accountable for the systems they design and for how they respond to staff behaviours fairly and justly. It holds pharmacy professionals accountable for the quality of their choices and for reporting both their errors and system vulnerabilities. To enable a culture that supports learning and accountability over blame and punishment, individuals must be comfortable to discuss medication incidents without fear of punitive outcomes.

A critical element in safe medication practices is the sharing of lessons learned from medication incidents through medication error and near miss reporting, to support sustainable changes in practise. Using the lessons learned from both medication incidents and near misses enables continuous process improvements to minimize errors and maximize health outcomes to improve the quality of care provided in pharmacies.

[1] A Systemic Review of Medication Errors. International Journal of Drug Development and Research (2015). Retrieved on January 31, 2016 from http://www.ijddr.in/drug-development/a-systematic-review-on-medication-errors.php?aid=7947

[2] Boyle TA, Bishop AC, Duggan K, Reid C, Mahaffey T, MacKinnon NJ, et al. Keeping the "continuous" in continuous quality improvement: Exploring perceived outcomes of CQI program use in community pharmacy. *Res Social Adm Pharm* 2014 Jan-Feb; 10(1): 45-57.

The required components of an effective standardized quality assurance program for pharmacies addresses both medication errors that reach the patient as well as near misses that are intercepted prior to dispensing, and must achieve all of the following four elements:

Report

- Enable and require *anonymous* reporting of all medication incidents by pharmacy professionals to a specified independent, objective third-party organization for population of an aggregate incident database to identify issues and trends to support patient safety improvement.

Document

- Require pharmacy professionals to document appropriate details of medication incidents and near misses in a timely manner to support the accurateness of information reported.
- Document CQI plans and outcomes of staff communications and quality improvements implemented.

Analyze

- Necessitate that when a medication incident occurs pharmacy professionals analyze the error in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident.
- Require completion of a medication safety self-assessment (MSSA) within the first year of implementation of the Standard, then at least every 2-3 years. The Designated Manager may determine an MSSA is required more frequently if a significant change occurs in the pharmacy.
- Analyze individual and aggregate data to inform the development of quality improvement initiatives.

Share Learning

- Require prompt communication of appropriate details of a medication incident to all pharmacy staff, including causal factors of the error and actions taken to reduce the likelihood of recurrence.
- Ensure the scheduling of regular CQI communication with pharmacy staff to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete an MSSA, and develop and monitor quality improvement plans.
- Support the development and monitoring of CQI plans, outcomes of CQI communications and quality improvements implemented.