


Making the Case for Quality

A Way to Improve Patient Safety



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Program Objectives

- Identify the importance of quality improvement in healthcare
 - Discuss the impact of medication errors on patient safety
 - Differentiate between types of errors – errors, incidents, near misses, etc.
 - Define elements of a Continuous Quality Improvement (CQI) program
 - Describe the importance of CQI in community pharmacy practice settings
 - Identify ways to implement quality improvement processes in your pharmacy practice
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What Was Your Mistake or Error?

- Did that prescription get filled correctly?
- How many of you have made a mistake?
- Introductions



What is its name?



- Error of execution
 - Failure of a planned action to be completed as intended
- Error of planning
 - Use of a wrong plan to achieve an aim
- **NCCMERP Definition/AHRQ/PSO**
 - Incident = reaches patient**
 - Near miss**
 - Unsafe Condition**
- Others

US Airline Industry

- Designs systems for safety
 - Human error is inevitable
- Fatal airline accidents
 - 1970
 - 1 in 2 million
 - 2004
 - 1 in 10.5 million



Complex Systems

- Reduce accidents
 - Simplify and standardize the process
- Build in redundancy
 - Aviation– Checklist requirements (1937)
- Develop backup systems



Aviation vs Healthcare

➤ Error reporting

➤ Aviation Safety Reporting System (ASRS)


- Accidents, 'near misses,' since 1976
- More than 30,000 reports annually

➤ MedMARx (hospital reporting) 1998


- Medication error reporting
- No 'near miss' reporting

➤ Public Perception

Institute of Medicine Report Series

- To Err is Human: Building a Safer Health System
 - 7,000 deaths from medication errors
 - Crossing the Quality Chasm: A New Health System for the 21st Century
 - Identified six aims for quality improvement: health care should be safe, effective, patient-centered, timely, efficient, and equitable
 - Patient Safety: Achieving a New Standard for Care
 - Need for an information infrastructure
 - Preventing Medication Errors: Quality Chasm Series
 - At least 1.5 million ADEs occur each year
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**What's
Your CQI
IQ?**



CQI IQ

1. What is an example of an error?

a. A patient receives medication with an easy open lid without signing a release

b. A prescription written for Zyrtec gets filled with Zyprexa and dispensed to the patient

c. A prescriber changes the directions on a prescription, but the patient isn't counseled and continues to take it as previously prescribed

d. All of the above



CQI IQ

2. How many deaths are caused each year due to medication errors?

- a. 1,000
- b. 7,000
- c. 44,000
- d. 98,000




CQI IQ


3. A pharmacist can be sued when a prescription is filled correctly.
 - a. True
 - b. False



CQI IQ

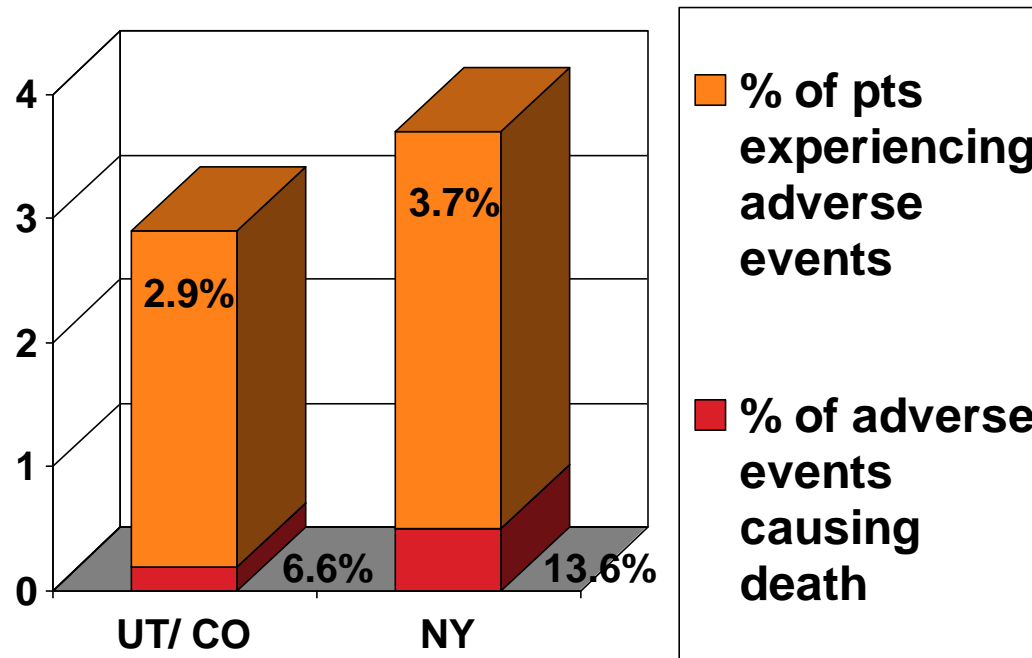
4. Who is at fault when an error occurs in your pharmacy?
 - a. Technician filling the prescription incorrectly
 - b. Pharmacist performing the final check
 - c. System breakdown
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CQI IQ

5. When an error occurs in your pharmacy, what action do you take?
 - a. Tell the patient that you weren't working when the error happened and it's not your problem
 - b. Ask "Who?" made the mistake
 - c. Do nothing
 - d. Document error and evaluate possible causes and solutions to improve upon in the future
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Do We Have a Problem?

44,000 - 98,000 Deaths



Do We Have a Problem?

- **44,000-98,000 deaths annually as a result of medical errors**
- **More than motor vehicle accidents, breast cancer, or AIDS**
- **7,000 deaths from medication errors alone**

To Err is Human, Building a Safer Health System. IOM; 2000

Do We Have a Problem in Pharmacy?

- If a pharmacy is 99.9% accurate
 - Fills 1,000 prescriptions each week
 - How many mistakes each week? _____
- Other examples of 99.9% accuracy
 - Unsafe airplane landings 84/day
 - Lost mail 16,000/hr
 - Bank check errors 32,000/hr

Dean R. Medication errors: preventing the preventable. *Topics in Drug Therapy*. 1996.

Do We Have a Problem in Pharmacy?

- Claims against pharmacists
 - > 80% mechanical error
 - Wrong drug
 - Wrong strength
 - Wrong directions
 - Wrong dosage form
 - DUR claims increasing
 - Pharmacists can be sued even when a prescription is filled correctly
 - 1989 – 1.4%
 - 1998 – 12.1%
 - 2004 – 7.5%

**NOTHING WILL
CHANGE....**

UNTIL YOU CHANGE IT



Nothing Will Change...

- Improvements in quality
 - Challenging old habits
 - Thinking outside the box
 - “We’ve always done it that way”
- Everyone must commit to improving quality
- Leaders to Rally The Troops



Nothing Will Change...

- Are you willing to challenge old habits? Yes No
- Are you willing to think outside the box? No Yes
- Are you someone who is resistant to change? Yes No
- Is your staff resistant to change? Yes No
- How much risk are you willing to take to change?
None A little Average A lot
- How invested are you in whether others in this room will change?
None A little Average A lot
- What would it take to make a change?

...UNTIL YOU CHANGE IT



**What Can
We Do?**



Continuous Quality Improvement


➤ Goals

- Fix the SYSTEMS we rely on
 - Not to focus only on fix of *individuals*
- Help providers and patients get the job done right the *first* time

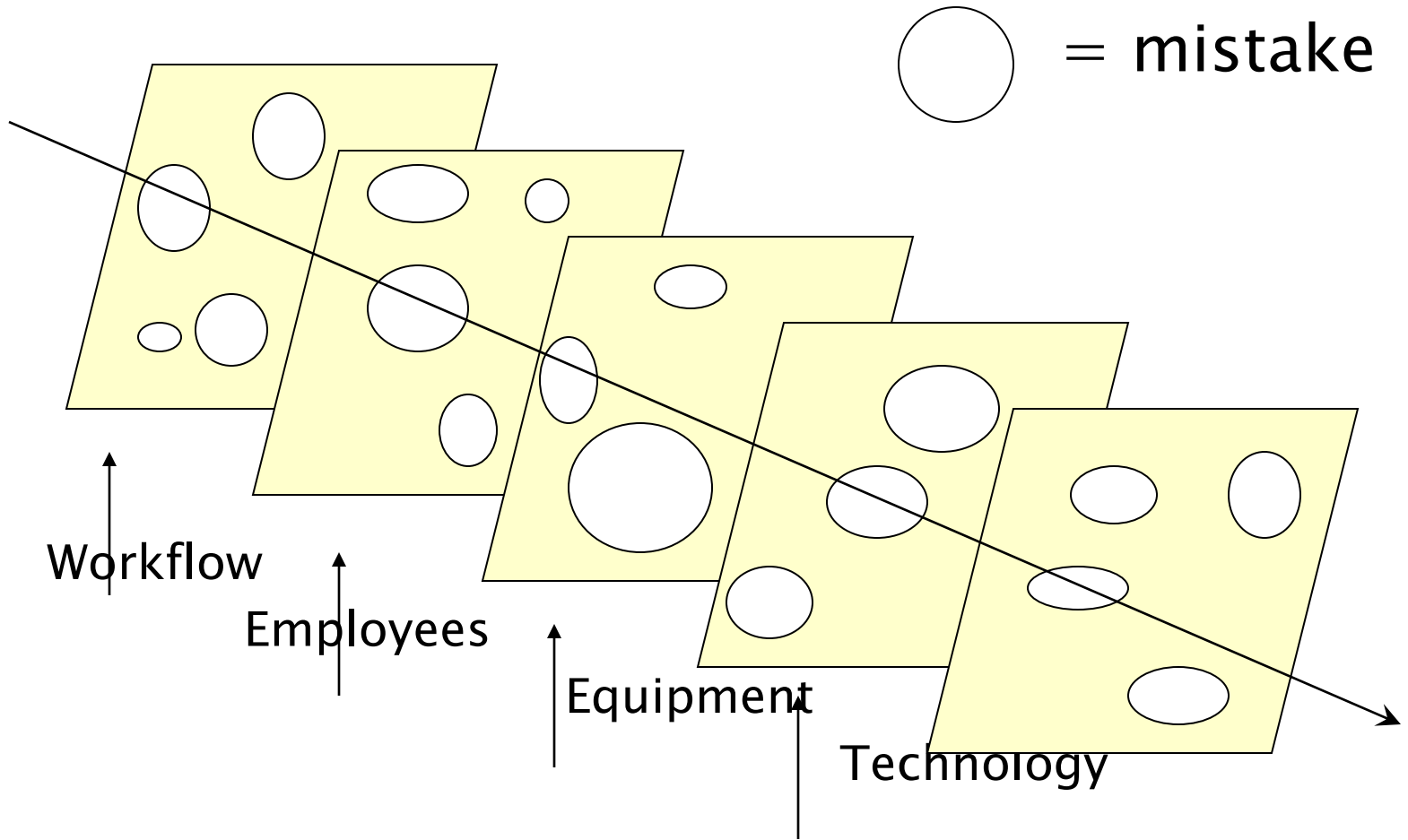


- Complex health systems
 - How many steps exist for a patient to receive a prescription?

Systems Approach

- Primary objectives of systems design for safety is to make it difficult for individuals to err
 - Systems designed so that incidents and near misses can be detected ASAP so corrective action can be taken
 - Build in safety nets (features that automatically correct for human error) and create redundancies to guard against duplication of critical mechanisms
 - Prevention focused on correction of system failures
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Swiss Cheese Effect



You Can Fix the System

➤ Organized workflow

- A systematic approach will reduce the likelihood that a quality related event will be made
 - Less likely to ask, “Now where was I?”
 - Less likely to miss a step that could lead to an incident that reaches the patient
- Quality does not happen by chance, it is a result of quality habits
 - Redundancy is positive
 - Process will become ingrained

Quality is a Habit!

- Teach quality habits
 - New hires
 - Full and part-time staff
- Look at your system
 - Workflow, personnel, technology, environment
- Document all failures of quality
 - Incidents that reach the patient and ‘near misses’
- Blame-free, shame-free environment
 - Encourage reporting of errors and ‘near misses’


What Do You Document?

- All Quality Related Events (QREs)
 - Incidents that reach the patient whether they caused harm or not
 - Near Misses
 - Unsafe Conditions
- Both are important to track and analyze



When an Incident Reaches the Patient

➤ Corrective action


- Give patient your full attention
 - Show concern to patient
 - Admit there was a mistake
 - Document what happened
 - Notify the prescriber
 - Inform patient or caregiver you will take steps to prevent this type of occurrence from happening again
 - Fix mistake for patient in timely manner
 - Ask if there's anything else you can do for the patient
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When a Near Miss Occurs

➤ Preventative Action

- Type of event
- Who discovered the mistake
- What medications were involved
- Where in the workflow it occurred
- How it was detected
- When it happened
- Whether patient/prescriber consulted
 - Communication/discussion with staff
 - Possible causes and possible solutions to improve for the future
 - Description of possible solutions, and implementation and assessment of change
 - Easily retrievable and accessible

Documentation & Analysis

- Document all failures of quality
 - For the purpose of future improvement
 - Not for purpose of punishment
 - Discuss with staff involved
 - Every QRE is different
 - Analyze collected data
 - Peer review by entire staff
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Discussing Errors

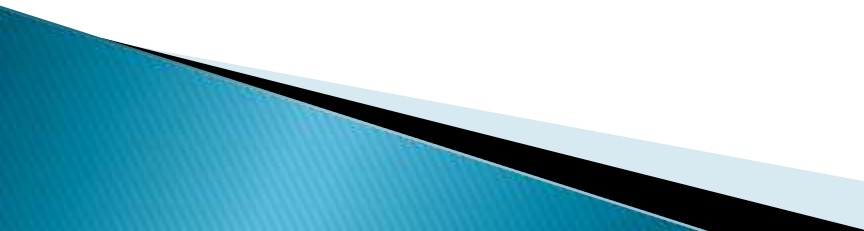
Negative

- Dwells on the past
- Threatening, insulting, punitive
- Focuses on WHO made an error
- Concludes erring individual has character flaws they need to correct
- Individuals won't willingly participate


Positive

- Looks to the future
- Open, blame-free, non-punitive
- Focuses on HOW or WHAT in the system allowed error to occur
- Realizes error is a reality and recognizes the opportunities to improve for the future
- Creates blame-free, shame-free environment

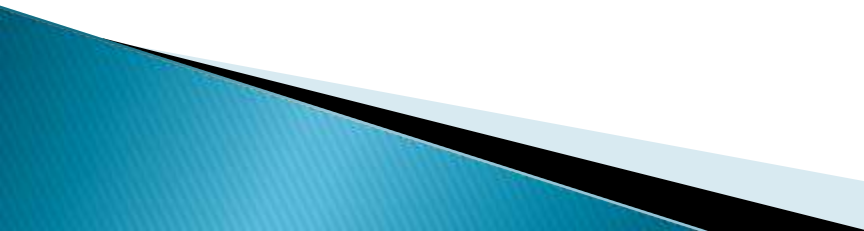
Analyze (root cause analysis)

- What happened?
 - What happened on that particular day?
 - Why did it happen?
 - What made that particular day different?
 - What usually happens?
 - What are the norms?
 - What should have happened according to policy and procedure?
 - What will prevent it from happening again?
 - What actions need to be taken?
 - How will the outcomes be measured?
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How to analyze

- Use a team approach
 - Chart how events unfolded chronologically leading up to the adverse event or close call
 - Examine the process to identify where vulnerabilities exist
 - Be sure to capture what actually happened, not what was supposed to have happened
 - Ask “why” at each step
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How to analyze – questions to consider

- Was communication between RPh and techs adequate?
 - Was training provided, and monitored over time?
 - Had procedures been reviewed to ensure a good match between people and tasks?
 - Was there sufficient staff on hand for the workload at that time?
 - Was the work area designed to support the function it was being used for?
 - If Policy & Procedure were not used, what were the barriers to their usefulness to staff?
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Actions and Changes


- Ideally will prevent the same event or minimize its occurrence
 - Physical rather than procedural
 - Install speed bumps instead of relying on speed limit sign
 - Permanent rather than temporary
 - Replace equipment known to malfunction in the hands of “float” staff, instead of taping warnings or additional instructions on machine
- Proposed actions should not burden people’s memory (i.e., “pay more attention next time”)

Continue Improvement Every Day

- Continuous Quality Improvement
 - Taking a systems view
 - Committing to change
 - Documenting all failures of quality
 - Analyzing data to identify opportunities to improve for the future
 - Implementing changes

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CHANGE....
UNTIL YOU CHANGE IT

LET'S CHANGE IT!**



Questions?

