

Background

As pharmacists take on greater responsibilities with expanding scope of practice, it is imperative that pharmacies employ a system to assess and manage risks on a regular basis. Risk management strategies should be in place in order to help reduce the risk of errors in the medication distribution system. This project aims to identify resources for risk management in community pharmacy practice.

Literature related to risk management in community pharmacy practice covers topics ranging from development of a culture of safety to actual measures that improve safety such as bar-coding and clinical support tool. Most of these topics have been incorporated into continuous quality improvement (CQI) tools.

Methods

The Institute for Safe Medication Practices Canada (ISMP Canada) performed an environmental scan in 2012 to identify selected CQI tools (Table 1 and Table 2) that are readily accessible to community pharmacy practitioners for the purpose of risk management.

Results

Establish a Culture of Safety

In order to implement changes in a pharmacy, a culture of safety must first be in place that encourages blame-free reporting and shared learning. The CQI tools *Manchester Patient Safety Assessment Framework (MaPSAF)* [1] and *Pharmacy Safety Climate Questionnaire (PSCQ)* [2] are a good starting point to evaluate the culture of safety in your pharmacy.

Facilitate the Culture – From Management to Frontline

Once a patient safety culture is established, the *Pathways for medication safety®: Looking collectively at risk* [3] document can facilitate a top-down approach (from management to frontline staff) to enhance the culture of safety and assist the investigation of a near-miss or a medication incident.

Encourage Shared Learning

Tools such as ISMP (US) *Improving medication safety in community pharmacy: Assessing risk and opportunities for change (AROC)* [4], and the ISMP Canada *Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy™ (MSSA-CAP)* [5] can be used to improve existing medication distribution systems and encourage shared learning from peers.

Table 1. Summary of Continuous Quality Improvement (CQI) Tools [1-5]

AUTHORS / ORGANIZATION	PURPOSE OF CQI TOOL	FOCUS OF CQI TOOL	RECOMMENDED USE OF CQI TOOL
UK: Manchester Patient Safety Assessment Framework (MaPSAF) [1]			
University of Manchester, Manchester, UK	<ul style="list-style-type: none"> To facilitate reflection and raise awareness on patient safety. To stimulate discussion about strengths and weaknesses of patient safety culture. To reveal any differences in perception on patient safety among staff members. To identify areas for improvement. To evaluate safety interventions and monitor progress over time. To develop a mature safety culture. 	Illustrate dimensions of patient safety and risk management culture that are applicable to community pharmacy practice: <ol style="list-style-type: none"> Commitment to patient safety Incident reporting Investigating causes of incidents Learning from incidents Communication Staff management Staff education and risk management training Teamwork 	Encourage individual staff member to honestly assess the pharmacy practice setting on the various aspects of risk management culture. This exercise will take approximately 1 hour to complete. Discuss individual ratings with the rest of the pharmacy team. Identify areas for improvement; discuss strategies, evaluate interventions, and track changes or progress over time. Available at: http://www.pharmacy.manchester.ac.uk/cip/resources/MaPSAF
UK: Pharmacy Safety Climate Questionnaire (PSCQ) [2]			
University of Manchester, Manchester, UK	To seek pharmacy staff members' viewpoints on patient safety issues and incident reporting in their community pharmacy practice setting.	This 34-item questionnaire correlates to dimensions of patient safety and risk management culture in the MaPSAF (see above). This tool was developed by the University of Manchester and validated in several European countries [6]. See Table 2 for relationship between MaPSAF and PSCQ.	Encourage individual staff member to complete the questionnaire honestly, to indicate his/her agreement or disagreement with the statements or items about the community pharmacy in which he/she works. This exercise will take approximately 10 to 15 minutes to complete. Then, as a team, discuss and identify areas for improvement, implement interventions, evaluate, and track changes over time. Available at: http://www.pharmacy.manchester.ac.uk/cip/resources/pscq/
US: Pathways for medication safety®: Looking collectively at risk [3]			
American Hospital Association, Health Research and Educational Trust, and ISMP (US)	Help hospital personnel assess and act on medication risks. Selected components can be applied to community pharmacy practice.	Describe processes to enable implementation of medication safety initiatives. Offer assessment tools to evaluate and monitor progress of risk reduction strategies.	Pharmacy managers can use this manual as a guide for fostering a culture of safety in the practice setting. Section 2.1 – Building Blocks for Assessing Risk and Section 2.2 – Failure Mode and Effects Analysis can serve as a universal educational tool for all pharmacy practitioners. Available at: http://www.medpathways.info/medpathways/tools.html
US: Improving medication safety in community pharmacy: Assessing risk and opportunities for change (AROC) [4]			
ISMP (US)	To educate pharmacists on error prone processes and strategies to reduce risks and enable self-assessment.	Recommend strategies that can reduce errors from occurring in 10 Key Elements of medication use processes: <ol style="list-style-type: none"> Patient information Drug information Communication of drug orders and other drug information Drug labelling, packaging, nomenclature Drug standardization, storage, distribution Medication device acquisition, use, monitoring Environmental factors, workflow, staffing patterns Staff competency and education Patient education Quality processes and risk management AROC also includes useful information in appendices such as dangerous abbreviations and look-alike drug names with recommended tall man lettering.	Pharmacy staff members can consult this document and reflect on current practices and identify areas for improvement. Available at: http://www.ismp.org/community/ro/arc/
Canada: Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy™ (MSSA-CAP) [5]			
ISMP Canada	Identify and assess safe medication practices in community/ambulatory pharmacy; and monitor improvements in safe medication practices via the online interface.	Categorize known medication safety strategies into 10 Key Elements (see below) and 20 Core Distinguishing Characteristics. <ol style="list-style-type: none"> Patient information Drug information Communication of drug orders and other drug information Drug labelling, packaging and nomenclature Drug standardization, storage and distribution Use of devices Environmental factors Staff competence and education Patient education Quality processes and risk management The MSSA-CAP was updated in 2012 in order to accommodate the expanding scope of pharmacy practice in Canada and a new online interface is currently under development.	Pharmacy members can complete the MSSA-CAP items as a team during 2 to 3 one-hour meetings. Use the MSSA-CAP online interface to track trends and monitor progress or improvements in safe medication practices. Available at: https://www.ismp-canada.org/amssa/index.htm

Discussion

As pharmacists and pharmacy technicians take on additional responsibilities, we must first ensure that we have an adequate risk management system in place to strive for patient safety and medication safety. Pharmacies can first use the MaPSAF and PSCQ to assess their safety culture. Pharmacy managers can subsequently use *Pathways for medication safety®: Looking collectively at risk* to devise a plan for embracing change and enhancing the cultural competency of the practice setting. Finally, medication safety self-assessments such as the AROC from ISMP US and the MSSA-CAP from ISMP Canada can help pharmacy practitioners learn from each other and improve the medication distribution system as a whole.

Risk management is a collaborative and iterative process. We recommend using the CQI tools with all staff in the pharmacy at least annually in order to ensure continuous quality improvement.

Table 2. Relationship between MaPSAF and PSCQ [2]

	Dimensions of Patient Safety and Risk Management Culture in MaPSAF	Items in PSCQ
1	Commitment to patient safety (Correspond to 3 items in PSCQ)	7, 17, 22
2	Incident reporting (Correspond to 6 items in PSCQ)	4, 10, 14, 20, 25, 30
3, 4	Investigating causes of incidents; and Learning from incidents (Correspond to 8 items in PSCQ)	3, 11, 13, 19, 23, 28, 32, 34
5	Communication (Correspond to 6 items in PSCQ)	1, 6, 9, 16, 21, 27
6	Staff management (Correspond to 5 items in PSCQ)	2, 12, 24, 29, 31
7	Staff education and risk management training (Correspond to 3 items in PSCQ)	8, 18, 33
8	Teamwork (Correspond to 3 items in PSCQ)	5, 15, 26

References

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