Safety culture:

What are the key features in pharmacy practice?

By Puja Modi and Certina Ho

Recently, there has been a growing interest in measuring safety culture, as it can impact patient outcomes and healthcare costs. Safety culture is not just a mere compilation of safety initiatives. It is the shared beliefs and values at a workplace that inspire all workers to give their attention to safety. In healthcare, we must evaluate the safety culture to help ensure that we have an adequate risk management system in place for delivering quality care and patient safety.

There are four main features, according to the Agency for Healthcare Research and Quality (AHRQ), to consider when optimizing a healthcare organization's safety culture. These features will be discussed below, with the support of a case example:

A patient normally takes two pills in the morning, but this time she was dispensed eight pills for the morning in her blister pack. The patient realized this difference and contacted her doctor to see if any changes in her medications were made. The doctor clarifies that no changes had been made. The pharmacy dispensed the wrong medications, as they were intended for another patient with the same first name. Personal and medical information for this other patient was also given with the blister pack. The patient identified the discrepancies before any dose was taken.

1. ACKNOWLEDGE THE HIGH-RISK NATURE OF HEALTHCARE AND ATTEMPT TO ACHIEVE CONSISTENTLY SAFE OPERATIONS

A healthcare organization should attempt to become a highly reliable organization (HRO). An HRO has a system, which has been developed to minimize risk and prevent errors, yet still anticipating unexpected errors and system failures. HROs proactively look for possible areas of risk, and quickly resolve the issues detected.

In the case scenario above, the pharmacy reflecting on the error would be considered retrospective. To be an HRO, the pharmacy should have previously identified the high-risk processes in blister pack preparation, and proactively addressed potential risks before the incident occurred.

Levels of Error	Human Error	At Risk Behaviour	Reckless Behaviour
Description	Slips	Shortcuts	Clear ignoring of the required steps for safety
Response to Error	Console	Coach	Punish

Figure 1. Three Levels of Error in Just Culture

2. CREATE A BLAME-FREE ENVIRONMENT WHERE INDIVIDUALS FEEL COMFORTABLE REPORTING ERRORS OR NEAR MISSES

For any error that occurs, most individuals would immediately want to blame someone. This blaming culture in healthcare may make people uncomfortable and prevent them from reporting, which can result in impairment of safety culture advancement. Though we may encourage organizations to have a blame-free culture, some accountability should be required. Therefore, a blame-free culture and the need for accountability have been integrated to what is called "just culture". The main goal of just culture is to identify and address issues at the system level that may lead individuals to engage in unsafe behaviour. In just culture, there are three levels of errors to consider (Figure 1). The response to the error or the corresponding method of management will depend on the type of behaviour, and not the severity of consequences due to the error (Figure 1).

In case example above, a possible human error would be unintentionally missing the fact that the last name of the patient was incorrect; an at-risk behaviour could be poorly completing the technical and therapeutic checks of a prescription; and reckless behaviour would be skipping the checking steps altogether. Even if the patient was not harmed in this case, it is important to take the required action and learn from this incident.

3. ENCOURAGE COLLABORATION TO SEEK SOLUTIONS TO PATIENT SAFETY ISSUES

When seeking solutions to patient safety issues, it is important to involve all individuals who are in the circle of care of the patient, as it can lead to better patient care, safety optimization, and work efficiency. This can help create a mutual support structure that can coordinate and resolve safety culture problems. Also, shared learning is imperative. Once problems have been identified and resolved, dissemination of information as well as potential risks or contributing factors of the incident is very important.

In the case example above, the pharmacy should be discussing the incident and potential contributing factors and subsequent solution as a team, allowing participation from all. This is a learning opportunity, which can help ensure a similar mistake will not happen again.

4. COMMIT RESOURCES TO ADDRESS SAFETY CONCERNS

This commitment can entail of pledging more resources or staff time towards patient safety, providing more safety related education, improving system-based processes, creating an anonymous or blame-free reporting culture, using advanced technology, and evaluating patient safety in the organization. System-based commitments are more impactful in mitigating risks than person-based strategies. This is due to a lack of requirement for individual attention and vigilance. Under the circumstances of limited budget and resources, system-based changes may not be always feasible. Hence, person-based strategies should not be ignored either.

For the above case scenario, the pharmacy may consider dedicating more resources to improve safety culture of the work environment. An example of a person-based strategy is to provide the pharmacy team with education and standard operating procedures in blister pack preparation. System-based changes may include the implementation of advanced technology in blister packing or outsourcing blister-pack preparation to an off-site automated dispensing system. H

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