INTRODUCTION

Standardized continuous quality improvement (CQI) programs are employed to assist pharmacies in recognizing medication incidents and developing solutions to prevent them. It is important to understand where practice culture surrounding medication safety stands to better support this endeavour.

OBJECTIVES

The objectives of this study were to explore the medication safety culture in Saskatchewan community pharmacies and identify whether pharmacies currently held a “blame-and-shame” (i.e. pathological) or “systems-oriented” (i.e. generative) attitude towards safety.

MEDICATION SAFETY CULTURE INDICATOR MATRIX (MedSCIM)

MedSCIM is an approach to qualifying safety culture using medication incidents. There are two key parameters:

Core Event Completeness evaluates whether key pieces of information relevant to a medication safety analyst were included in the incident report. This is graded discretely from not complete to fully complete (Figures 1 and 2).

Maturity of Culture to Medication Safety evaluates the attitudes of medication safety contained in the incident report. This is graded discretely from pathological to generative (Figures 1 and 2).

METHODS

The MedSCIM tool, developed by the Institute for Safe Medication Practices Canada (ISMP Canada), was used to analyze two sets of medication incidents reported by community pharmacies in Saskatchewan to the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) program from October 2013 to October 2017; one set was associated with patient harm, while another set contained randomly selected incidents from the top three types of medication incidents.

An independent analyst was assigned to analyze each set using MedSCIM. The analyses were recorded into a Microsoft Excel spreadsheet and subsequently summarized as quantitative data.

RESULTS

Core Event Completeness:

For randomly selected top three types of incidents (incorrect dose/frequency, incorrect quantity, incorrect drug) from October 2013 to October 2017:

Level 1: Report Fully Complete
Grade D: Pathological: 9.5%
Grade C: Reactive: 2.1%
Grade B: Calculative: 1.8%
Grade A: Generative: 1.0%
Total: 13

Level 2: Report Semi-Complete
Grade D: Pathological: 13.6%
Grade C: Reactive: 4.2%
Grade B: Calculative: 3.1%
Grade A: Generative: 2.2%
Total: 18

Level 3: Report Not Complete
Grade D: Pathological: 24.0%
Grade C: Reactive: 7.6%
Grade B: Calculative: 5.7%
Grade A: Generative: 2.2%
Total: 20

Total: 49

Maturity of Culture to Medication Safety:

For randomly selected top three types of incidents (incorrect dose/frequency, incorrect quantity, incorrect drug) from October 2013 to October 2017:

Grade A (Generative): 16.4%
Grade C (Reactive): 40.0%
Grade B (Calculative): 30.0%
Grade D (Pathological): 13.6%

Most incidents reported analyzed were found to indicate “calculative” and “reactive” attitudes towards medication safety, which represents a mix of identifying the error and also identifying the contributing factors of the error.

We continue to see “pathological” (blame-shame) medication safety attitudes still exist in community pharmacies. Fortunately, we identified that in the context of patient harm, the attitude shifts to a more “generative” (systems-oriented) one.

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REFERENCES


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CONCLUSIONS

By using medication safety incidents submitted by front-line pharmacy professionals, we were able to more objectively capture the medication safety culture in pharmacies. Such analyses provided an opportunity for pharmacy regulatory authorities to educate and reinforce proper attitudes towards medication incident reporting.

In Saskatchewan, our sample of incidents suggested that “pathological” (blame-shame) medication safety attitudes still exist in community pharmacies. Fortunately, we identified that in the context of patient harm, the attitude shifts to a more “generative” (systems-oriented) one.

Altogether, this work supported an alternative method of measuring medication safety culture, which can be insightful for pharmacy regulatory authorities and front-line pharmacy professionals.