



Community Pharmacy Safety in Practice (CP-SiP)

“Every patient, every time”

Orientation Manual

**Auckland DHB
Waitemata DHB**

2018 - 2019

Contents

Glossary	2
Purpose of this manual.....	4
Professional Development	4
Contact details.....	4
Why bother with patient safety?	5
The Safety in Practice Approach.....	6
Breakthrough Series	7
Community Pharmacy Requirements.....	8
High-risk areas targeted for improvement.....	8
Change Packages	9
Medicines Reconciliation.....	10
Anticoagulants.....	11
NSAIDs	12
Opioids.....	13
Data collection and submission.....	14
Team Reflection on Data	14
Example Data Collection Excel Spread sheet	15
Learning Sessions.....	16
Pharmacy Visits	16
Safety Climate Survey	16
Contracts	18
Invoicing	18
References.....	19

Glossary

Term	Meaning
ADHB	Auckland District Health Board
CMH	Counties Manukau Health
CP	Community Pharmacy
DHB	District Health Board
IHI	Institute for Healthcare Improvement
LS	Learning Session
NSAID	Non-steroidal anti-inflammatory drug
To offer written information	To actively ask if someone wants written information
PDSA Cycle	Plan Do Study Act Cycle of improvement
SiP	Safety in Practice
WDHB	Waitemata District Health Board

Welcome to Safety in Practice

Both Auckland and Waitemata DHBs consider patient safety a key priority. Safety in Practice (SiP) in primary care is an integral component of this. This is the first time DHBs have invested in supporting primary care teams to achieve greater capability in patient safety. So you are part of a programme that addresses issues at the very heart of healthcare.

SiP is recognised by the Royal NZ College of GPs, Pharmaceutical Society and the Health Quality Safety Commission. SiP is a key investment in primary care designed to provide tools and training in quality improvement methodologies to primary health care teams to enable them to reduce preventable harm to patients. .



We like to think that your involvement in the programme provides you with key skills, tools and know how that will help you provide quality care to the people that come and see you every day, as well as in the focus areas covered by the programme.

Our vision is for all these improvement activities to become embedded into your 'business as usual' and for the skills and capability developed to grow throughout your organisations.

We are looking at opportunities to link in with the hospital safety programme so we can have a focus on patient safety throughout the patient journey. We want to keep improving the programme so that it remains meaningful and valuable for you so your thoughts and feedback is always welcomed. We wish to expand this programme so that all primary care teams across Auckland can be involved. So please consider talking to your colleagues who are not participating about the benefits you have experienced and encourage them to engage.

Thank you for your participation, commitment and enthusiasm for this flagship programme. It is your individual efforts towards improving patient safety that makes a difference to the patient, their families and contributes to the overall success and expansion of this vital programme.

We hope you enjoy the programme.

A handwritten signature in blue ink, appearing to read 'Tim Wood'.

Tim Wood
Deputy Director Funding, Auckland and Waitemata DHBs
Safety in Practice Programme Sponsor

Purpose of this manual

The Safety in Practice (SiP) initiative is designed to reduce preventable harm within primary care by targeting an issue of clinical concern and gaining skills through practical experience and collaborative learning.

This manual is designed to support community pharmacy members enrolled in the Community Pharmacy Safety in Practice (CP-SiP) programme. It shall provide information regarding:

- Background to the programme
- How the programme works
- The Model for Improvement tool and Breakthrough Series collaborative method of learning
- The four change packages
- The safety climate survey
- Support provided by the Safety in Practice project team
- Contract and Invoicing

It is designed to be a dynamic document so please provide feedback to the project team about any areas that would benefit from alteration or expansion.

Professional Development

Pharmacists will be able to use the learning from the Safety in Practice Programme towards their ENHANCE continuing professional development. In addition, elements of this programme will also help pharmacists prepare for their pharmacy audits.

Group 1 points can be assigned to:

- time spent at each Learning Session
- meetings with your Quality Improvement Advisor and the Clinical Lead Pharmacist, and
- Peer Group discussions as a team in your pharmacy.

The Safety in Practice Programme also provides opportunities for pharmacists to work towards Group 3 Projects. Suggested examples of applying learnings towards a Group 3 Project could be in the form of:

- Group 1 points from reviewing additional journal articles, modules, presentations and meetings
- Group 2 points from assessed activities and learning from other organisations on your particular change package topic.

Contact details

General enquiries: info@safetyinpractice.co.nz

Submitting data: audit@safetyinpractice.co.nz

Website: www.safetyinpractice.co.nz

Meet our team: <http://aucklandnc.safetyinpractice.co.nz/our-programme/meet-the-team/>

Section 1: What is Safety in Practice?

The Safety in Practice (SiP) programme provides tools and training to primary health care teams to reduce preventable harm to patients. It is an adaptation of the Scottish Patient Safety Programme in Primary Care.

The programme was first introduced to the Auckland Metro region in 2014 with 23 general practices involved and has since expanded to include 64 general practices and urgent care clinics (UCCs) as well as 45 community pharmacies across Auckland and Waitemata DHB.

Why bother with patient safety?

In New Zealand and around the world, medication-related harm is common, occurs both in hospital and in the community, and is a substantial burden for patients and our healthcare system. A New Zealand study assessed medication-related harm to occur at a rate of 34.7 per 100 admissions; of these 29% originated in the community and precipitated an admission to hospital.¹

Research from Australia shows that of the 100,000 adverse drug events recorded as causing disability each year, 40-50% of these could have been prevented.² Similarly in the UK, 1 in 550 prescriptions have been associated with a severe error.³ Research from the Queens Medical Centre, Nottingham (UK) indicates that 6.5% of hospital admissions over a 6 month period are medicines-related, 67% of these were considered preventable.⁴ These admissions were mainly attributed to problems with prescribing, monitoring and patient adherence.⁴

Aims and Objectives

To work with Primary Health Care teams to reduce preventable patient harm from the care they receive			
Reduce preventable harm to patients	Create safer and more reliable systems	Promote a culture of safety	Develop quality improvement skills to improve patient care

The aim of SiP is to work with primary healthcare teams to reduce preventable patient harm from the care they receive. In order to achieve this goal, a range of tools and resources (adapted from the Scottish Patient Safety Programme in Primary Care), alongside support from improvement and clinical experts, are provided to general practice and community pharmacy teams to foster a positive and collaborative patient safety culture.

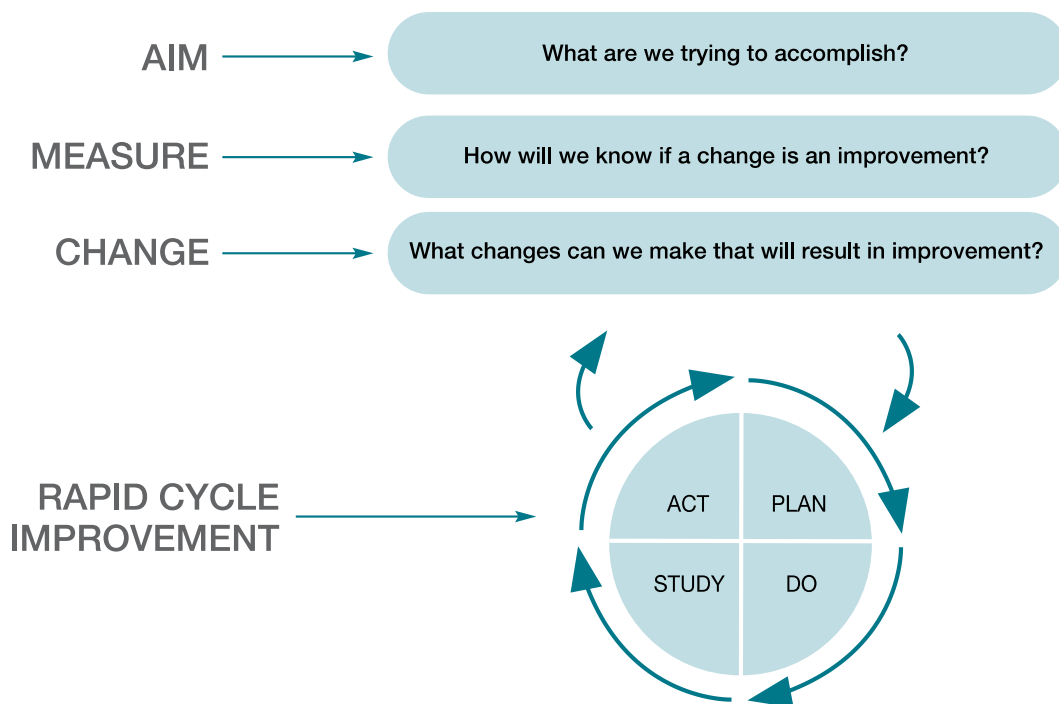
This is a 3 year programme. Year 2 of the Community Pharmacy Safety in Practice programme will run from July 2018 until June 2019, across 45 pharmacies from Auckland and Waitemata DHBs. Safety in Practice is supported by the Health Quality & Safety Commission (HQSC), The Pharmaceutical Society of New Zealand (PSNZ), The New Zealand Pharmacy Council, Green Cross Health, General Practice NZ and the Royal New Zealand College of General Practitioners.

The Safety in Practice Approach

Safety in Practice uses the Model for Improvement and the IHI Breakthrough Series methodology.

Model for Improvement

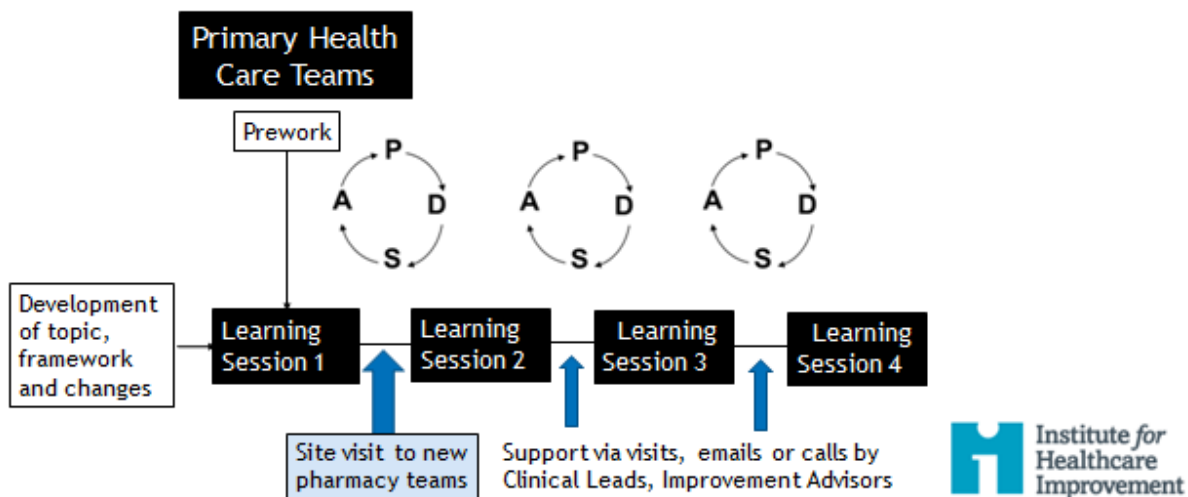
The Model for Improvement, (developed by Associates in Process Improvement), is a simple yet powerful tool for accelerating improvement.² It has three questions:



The final stage is the Plan-Do-Study-Act (PDSA) cycle which guides the test of a change to determine if the change is an improvement. For more information, see www.ihl.org/resources/Pages/HowtoImprove/default.aspx and www.healthnavigator.org.nz/clinicians/p/pdsa-cycle/

Breakthrough Series

The Breakthrough Series is a collaborative method of learning designed to help multiple teams close the gap between what we know and what we do, by creating a structure in which interested teams can easily learn from each other and from recognised experts in topic areas where they want to make improvements. A Breakthrough Series Collaborative is a short-term (six to 15 month) learning system that brings together a large number of teams from hospitals or practices to seek improvement in a focused topic area.



Section 2: How does the programme work?

Community Pharmacy Requirements

The following are the requirements of the participating community pharmacies within Auckland DHB and Waitemata DHB for the 2018/2019 Safety in Practice programme.

Each participating pharmacy is required to establish a two to three (minimum) person Patient Safety Champion team which should preferably comprise a combination of a senior pharmacist, a junior pharmacist or a technician and another team member.

Pharmacies are required to:

1. **Attend** 4 evening learning sessions to ensure successful introduction to the Safety in Practice tools and quality improvements skills
2. **Collect** data in the assigned clinical focus area and **submit** to audit@safetyinpractice.co.nz by the 10th of each month (from September 2018 to June 2019)
3. **Review** the data and implement changes to make their care safer and more reliable
4. **Share** changes they have made at learning sessions
5. **Develop** their safety culture through the online safety climate survey tool. The results will be used to understand how best to establish and nurture an enhanced safety culture within the pharmacy team. Pharmacy teams will be taught how to use this tool in learning sessions.

High-risk areas targeted for improvement

The Community Pharmacy Safety in Practice programme focuses on the following modules:

1. Medication reconciliation
2. Anticoagulants (warfarin, dabigatran, rivaroxaban)
3. Non-steroidal anti-inflammatory drugs (NSAIDs)
4. Opioids

Each pharmacy team works on one of the four areas for improvement over the course of the programme. The following diagram shows the four modules as the rooms of the house.

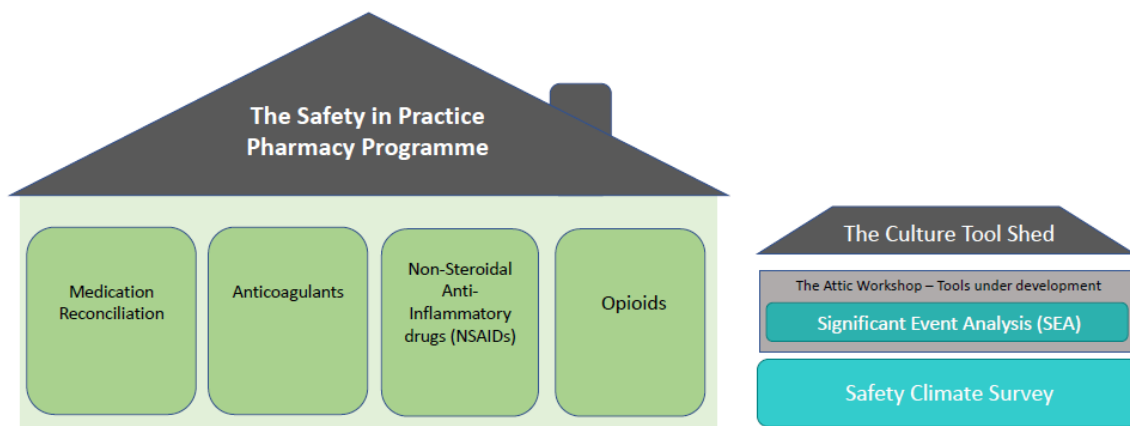


Figure 1: The home of Safety in Practice

Change Packages

A change package is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. It's a way of ensuring that patients receive all the evidence-based care to which they are entitled. This means ensuring that patients receive optimum care at every contact- **“Every patient, every time”**.

The principle of SiP is that the pharmacies can complete a simple set of measures that capture the key moments for a particular clinical module. Each month, the pharmacy must then review a minimum of 10 patient records from the previous month to determine which measures were achieved. Based on these results, change ideas can be formulated, tested, and monitored for improvement over time.

Each package has a section with the rationale/evidence for the measures used. These are process measures and outcome measures. The measures have been developed by a Pharmacy Expert group from the Metro-Auckland area, based on the Scottish Patient Programme in Primary Care.

Below are the change package measures for the four clinical modules in the 2018/2019 Community Pharmacy Safety in Practice programme.

For more information on these measures see the relevant modules here: www.safetyinpractice.co.nz

Medicines Reconciliation

Aim: All patients with non-GP* generated prescriptions will have their medicines reconciled and follow-up actions completed at time of dispensing.

*Non-GP includes prescriptions that have the potential to change regular medicines such as hospital discharge and outpatient prescriptions. This excludes A&E and dental prescriptions and one-off or new specialist prescriptions
Please note: these questions relate to the patient or carer as appropriate.

Process Measures

Collect:

- 1a. Is there evidence the prescription was reconciled with a minimum of 2 valid sources?
- 1b. Is there evidence that the adverse drug reaction (ADR) status was checked?
- 1c. Is there evidence that the allergy status was checked?

Compare

- 2. If there were any unexplained discrepancies, is there evidence that they have been clarified with the prescriber?

Communicate

- 3a. Is there evidence the patient has been educated about any changes, or that there have been no changes?
- 3b. Is there evidence the patient been given the opportunity to ask questions?
- 3c. Is there evidence the patient been offered an up-to-date list of their current medicines?

Outcome measures

- 4a. Is there evidence that the next GP script was reconciled?
- 4b. If Yes, (the next GP script was reconciled), does this GP script match the up-to-date medicines list in the pharmacy?
- 4c. If No, (the next GP script does not match the updated pharmacy medicines list), is there evidence that the GP script changes were intentional? (eg the GP practice was contacted to confirm their script is correct)

Anticoagulants

Aim: All patients prescribed warfarin, dabigatran or rivaroxaban will be offered education at time of medicine collection.

Please note: these questions relate to the patient or carer as appropriate.

Process Measures

1. Is there evidence the patient has been informed how to use their medicine?
2. Is there evidence the patient has been informed what to do if they miss a dose?
3. a. Is there evidence the patient has been informed about possible side effects?
b. If yes, is there evidence they have been informed what to do?
4. Is there evidence the patient been informed about interactions with other medicines supplements, and/or food and alcohol?
5. Is there evidence the patient been offered written information about their medicine?

Outcome Measures

6. Was the patient able to correctly describe (dose/frequency) how to use their medicine?
7. Was the patient able to describe what to do if they missed a dose?
8. Was the patient able to identify a possible side effect of their medicine?
9. Was the patient able to identify who to ask for help with their medicines?

NSAIDs

Aim: All patients receiving a prescribed NSAID (including Cox-2 inhibitors) will have clinical checks performed and offered education at time of medicine collection.

Please note: these questions relate to the patient or carer as appropriate.

Process Measures

1. If the patient is prescribed a Triple Whammy, is there evidence the prescriber was notified?
2. If the patient is considered to be in a high-risk group and not on gastroprotection, is there evidence the prescriber was notified?
3. Is there evidence the patient was informed how to use their medicine?
4. a) Is there evidence the patient was informed about possible side effects?
b) If Yes (they have been informed about possible side effects), is there evidence the patient has been informed what to do?
5. Is there evidence the patient been informed of the risks of a dehydrating illness and to keep hydrated?
6. Is there evidence the patient was offered written information about the medicine?

Outcome Measures

7. Was the patient able to correctly describe (dose/frequency) how to use their medicine?
8. Was the patient able to identify a possible side effect of their medicine?
9. Was the patient able to identify who to ask for help with their medicine?

Opioids

Aim: All patients receiving prescribed opioids* will be offered education about the medicine at time of medicine collection *(codeine, dihydrocodeine, morphine, oxycodone, tramadol, fentanyl).

Please note: these questions relate to the patient or carer as appropriate.

Process Measures

1. Is there evidence the patient been informed how (dose/frequency) to use the medicine?
(eg long acting and/or short acting opioids, regular and/or PRN, frequency to take each medicine)
2. a) Is there evidence the patient been informed about possible side effects?
(eg nausea and vomiting, constipation, drowsiness)
b) If Yes, is there evidence the patient has been informed what to do?
3. Is there evidence the patient been informed about interactions with other substances that can increase the risk of sedation?
(alcohol, sedative medicines)
4. Is there evidence the patient has been informed when to seek advice relating to alarm symptoms?
(eg decreased alertness, drowsiness, shortness of breath, uncontrolled pain)
5. Is there evidence the patient been offered written information about their medicine?
(eg SafeRx information or Self Care card)

Outcome Measures

6. Was the patient able to correctly describe (dose/frequency) how to use their medicine?
7. Was the patient able to identify a possible side effect of their medicine?
8. Was the patient able to identify who to ask for help with their medicine?

Data collection and submission

The modules all follow a similar process for data collection:

- Identify the target patient population
- Randomly select 10 patients from list
- Review patient records for the 10 patients (retrospective audit)
- Add data to the spreadsheet
- Submit data to project team.

Note: Examples of options for randomisation are to use a random number generator to pick patients from the list, or to perhaps select every 5th patient on the list. For smaller pharmacies with a limited number of in the target group, this might need to be every second patient. Please discuss with the clinical lead or quality improvement advisor for more support regarding this.

Each measure question has defined responses, generally yes or no. A decision must be made on whether the patient record being reviewed meets these criteria. If it is unclear, select No.

The measures are collected monthly and then a run chart will be produced so teams can identify areas of their systems that need to be improved. See below for an example of a run chart.

Team Reflection on Data

Regular pharmacy-based team meetings are recommended to allow reflection on data collected and to identify areas of change to be tested within the pharmacy. The pharmacy team will:

- Review the findings from the data collection
- Consider other quality improvement activities (eg process mapping, data analysis, cause and effect analysis)
- Consider opportunities to improve care associated with the focus area
- Carry out PDSA testing of small scale change
- Review and note progress to share at learning sessions

Example Data Collection Excel Spread sheet

Pharmacy Name		Date	
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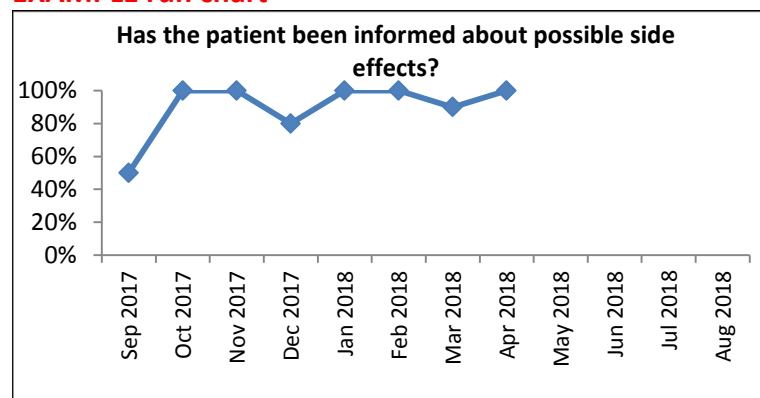
Method: Each month, select 10 patient records, and check to see if there is documented evidence for the following:

	1		2		3		4		5		6	
Patient	Has the patient been informed how to use the medicine?		Has the patient been informed about possible side effects?		Has the patient been informed how to manage possible side effects?		Has the patient been informed what to do if they miss a dose?		Has the patient been offered written information about the medicine?		Have all the measures been met?	
1	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
2	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
3	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
4	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
5	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
6	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
7	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
8	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
9	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
10	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

The measures are circled

Enter Y = Yes, or N = No

EXAMPLE run chart



If you are using Microsoft office excel, after the spreadsheet has been filled in, a run chart will automatically be generated.

Learning Sessions

These sessions are designed to be collaborative, bringing together safety champions from each enrolled primary care team and pharmacy to learn about best practice and facilitate sharing of knowledge and experiences. This method of collaborative learning has been widely demonstrated as an effective method of accelerating change within primary care. These sessions are most effective if the same 2 or 3 members of your team attend each time.

Learning sessions are held in August, November, March/April and June. Each learning session is held at a central and North Shore location.

The purpose of the learning sessions is to:

- Develop skills and capabilities in quality and patient safety improvement methodologies and processes – see diagram below.
- Share experiences and learn from other programme participants.
- Promote the value of the programme and emphasise the importance of safety in patient care.
- Share successes to encourage continued engagement and participation in the programme.

Prior to Learning Sessions 2, 3 and 4, each pharmacy will be required to complete a **Progress Update template**. On the evening of the learning session, the templates are used to discuss shared learning across the groups. Pharmacies will have the opportunity to discuss their improvement work with other primary care teams e.g. how the pharmacy has achieved buy-in from the rest of the team, their initial change ideas and an example of a PDSA – can be a great success or failure, but ideally achieved learning.

Pharmacy Visits

To support teams in the programme we offer pharmacies a visit from a Safety in Practice clinical lead and may include a SIP improvement advisor. They will be able to assist pharmacy teams with:

- Up-skilling teams in improvement methodology
- Identification of current systems, processes and behaviours
- Data analysis
- Review of systems and processes
- PDSA testing of small-scale change and familiarity with the Safety in Practice change package tools
- Introduction of a primary care safety culture survey.

Safety Climate Survey

A strong safety culture within healthcare organisations is recognised as an important component of providing safe reliable care. Continuous assessment, reflection and improvement are key to ensuring a culture of safety. Assessments of historical organisational failures within the health sector have often cited poor safety culture as a contributing factor. Examples include reviews conducted in hospitals in Bristol¹¹ and Stafford¹² in the United Kingdom.

The safety climate survey is a standardised and validated tool to assess and improve the safety culture of your pharmacy. This is an anonymous online survey and comprises of five subject areas (communication, workload, leadership, teamwork and safety systems & learning) with between four to eight questions for each area. The exercise generally takes less than 10 minutes per staff member to complete.

It is designed to give the pharmacy a picture of staff perceptions in each domain and then facilitate discussion to identify opportunities to improve. It provides comparisons between clinical and non-clinical staff, and management and non-management depending on the size of the pharmacy.

The results are then collated and returned to the pharmacy. Below is an example of results from one domain:

Safety Climate Survey Report

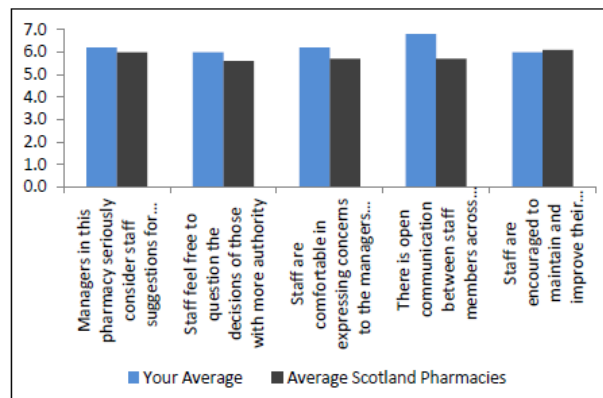
Communication

Summary	
Your Average	Scotland Pharmacies Average
6.2	5.8

This factor covers: honest discussion between team members at all levels and freedom to challenge, understanding of pharmacy developments and management decisions, whether staff feel comfortable questioning decision of managers, expressing their concerns, openness of communication at all levels, whether staff are kept up to date with current developments, and overall vision of leaders

Communication	Your Average	Average Scotland pharmacies
Managers in this pharmacy seriously consider staff suggestions for improving safety	6.2	6.0
Staff feel free to question the decisions of those with more authority	6.0	5.6
Staff are comfortable in expressing concerns to the managers about the way things are done in this pharmacy	6.2	5.7
There is open communication between staff members across all levels in this pharmacy	6.8	5.7
Staff are encouraged to maintain and improve their knowledge and skills	6.0	6.1

A high score is always desirable
Scale: 1 (Strongly Disagree) to 7 (Strongly Agree)



With the results in hand, a team discussion is held and the reflection tool completed.

Section 3: Contracts and Invoicing

Contracts

When joining the safety in Practice programme you will need to sign a contract outlining the key deliverables of the programme for which you will be remunerated. This service schedule will be included in your Integrated Community Pharmacy Services Agreement (ICPSA).

Invoicing

Invoices must be submitted on the SiP invoice template. This can be found in your welcome pack and also on the SiP website. Invoices should be submitted and paid according to the schedule below:

Payment period	Invoice Amount	Submission Date	Payment date	Payment condition 1	Payment condition 2
July-Dec 2018	\$2,550 excl GST	1 st Jan 2019	20 th January 2019	Attendance to Learning session 1 & 2 (Usually in August and November)	Audit data received for: August – submitted in Sept September – submitted in Oct October – submitted in Nov November – submitted in Dec
Jan – March 2019	\$1,425 excl GST	1 st April 2019	20 th April 2019	Attendance to Learning session 3 (Usually in March)	Audit data received for: December - submitted in Jan January - submitted in Feb February - submitted in March AND Culture tool report submitted in March
April – June 2019	\$1,425 excl GST	1 st July 2019	20 th July 2019	Attendance to Learning session 4 (Usually in June)	Audit data received for: March - submitted in April April - submitted in May May - submitted in June

Please Note: The DHBs will conduct annual audits and final payments may be withheld if these deliverables are found to not be met.

Where to send your invoice:

Email: providerinvoices@moh.govt.nz

Cc: info@safetyinpractice.co.nz

Post: Provider Payments
Ministry of Health
Private Bag 1942
Dunedin 9054

Any queries please contact info@safetyinpractice.co.nz

References

1. Robb G, Loe E, Maharaj A, Hamblin R, Seddon ME. Medication-related patient harm in New Zealand hospitals: New Zealand Medical Journal 2017;130(1460):21-32. www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1460-11-august-2017/7328 (Accessed 10-07-18)
2. 'A Window on the Quality of New Zealand's Health Care' 2017 Health Quality & Safety Commission www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/A Window on the Quality of NZ Health Care 2017.pdf (Accessed 10-07-18)
3. Avery T, Barber N, Ghaleb M et al. Investigating the prevalence and cause of prescribing errors in general practice: the PRACTiCe study. A report for the General Medical Council. 2012, 227p. [http://researchprofiles.herts.ac.uk/portal/en/publications/investigating-the-prevalence-and-causes-of-prescribing-errors-in-general-practice\(42e0e1ed-fe43-4041-80ba-7b0ef4e57003\).html](http://researchprofiles.herts.ac.uk/portal/en/publications/investigating-the-prevalence-and-causes-of-prescribing-errors-in-general-practice(42e0e1ed-fe43-4041-80ba-7b0ef4e57003).html) (Accessed 10-07-18)
4. Howard RL, Avery AJ, Howard PD, Partridge M. Investigation into the reasons for preventable drug related admissions to a medical admissions unit: observational study. Quality and Safety in Health Care. 2003;12(4):280–5. <http://qualitysafety.bmj.com/content/qhc/12/4/280.full.pdf> (Accessed 10-07-18)