Community Pharmacy

“Every patient, every time”

Orientation Manual

Auckland DHB
Waitematā DHB

2020-21

Contents

Abbreviations

Term	Meaning
DHB	District Health Board
GP	General Practice
HQSC	Health, Quality & Safety Commission
IHI	Institute for Healthcare Improvement
LS	Learning Session
NSAID	Non-steroidal anti-inflammatory drug
PDSA Cycle	Plan Do Study Act Cycle of improvement
PSNZ	Pharmaceutical Society of New Zealand
SiP	Safety in Practice
SSRI	Selective Serotonin Reuptake Inhibitor
UCC	Urgent Care Clinic

Welcome to Safety in Practice

Both Auckland and Waitematā 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.

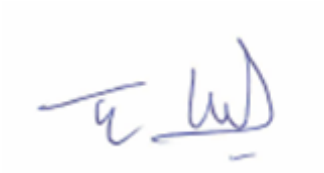
We like to think that your involvement in the programme provides you with key skills, tools and know how that will help you provide quality care to the people that come and see you every day, as well as in the focus areas covered by the programme.

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.



Tim Wood
Deputy Director Funding, Auckland and Waitematā 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 Safety in Practice programme. It provides 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 culture tools
- 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

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 with capacity for 110 teams comprising of general practices, and urgent care clinics (UCCs) and community pharmacies across Auckland and Waitemata DHB.

1.1 Why bother with patient safety?

In New Zealand and around the world, medicine-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 medicine-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]

1.2 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.

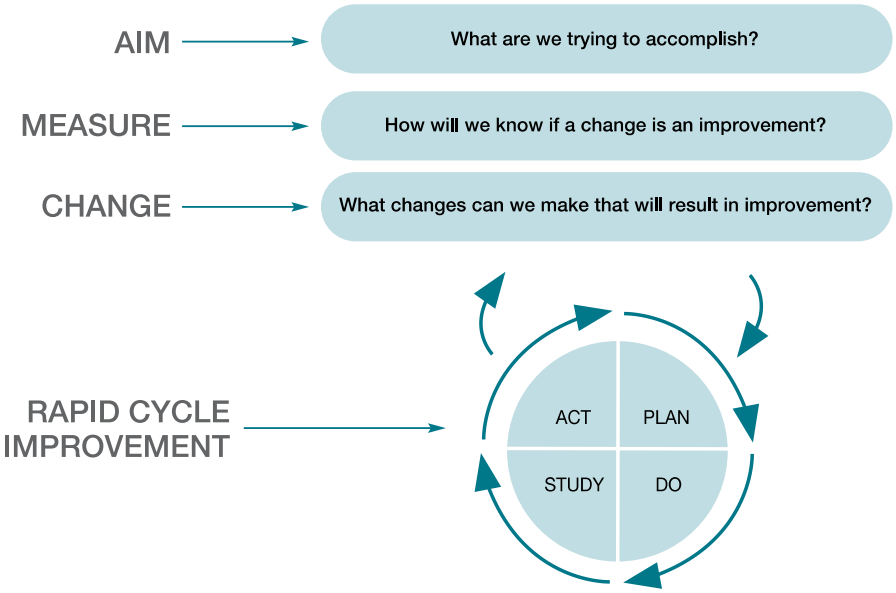
This is a 3 year programme. Safety in Practice is supported by the Health Quality & Safety Commission (HQSC), The Pharmaceutical Society of New Zealand (PSNZ), The New Zealand Pharmacy Council, Green Cross Health, General Practice NZ and the Royal New Zealand College of General Practitioners.

1.3 The Safety in Practice Approach

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

1.3.1 Model for Improvement

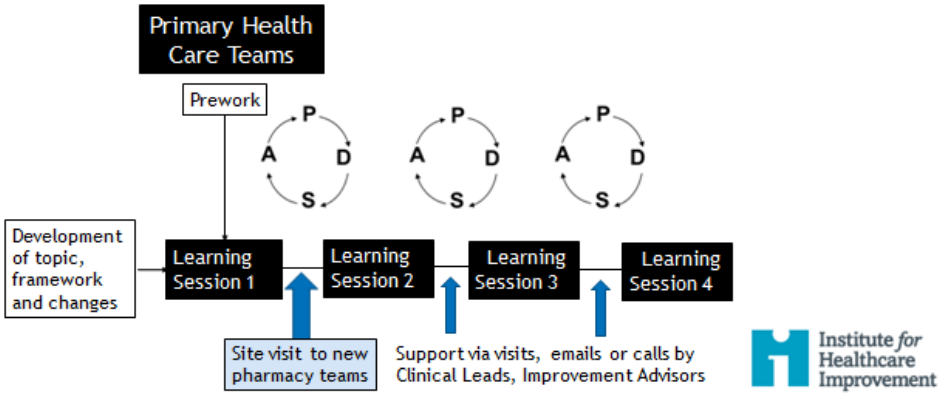
The Model for Improvement, (developed by Associates in Process Improvement), is a simple yet powerful tool for accelerating improvement.[2] It has three questions:



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.ihi.org/resources/Pages/HowtoImprove/default.aspx and www.healthnavigator.org.nz/clinicians/p/pdsa-cycle/

1.3.2 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?

2.1 Community pharmacy requirements

The following are the requirements of the participating community pharmacies within Auckland DHB and Waitemata DHB for the 202021 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. The Patient Safety Champions represent your team at learning sessions, drive the programme within your pharmacy and communicate Safety in Practice to your wider team. The teams that perform the best in this programme are the teams that have fully engaged all members of staff with everyone aware of the programme and their responsibilities so your team can work together to improve patient safety.

Pharmacies are required to:

1. **Attend** 4 evening learning sessions during the year to ensure successful introduction to the Safety in Practice tools and quality improvements skills
2. **Collect** data in your clinical focus area and **submit** to audit@safetyinpractice.co.nz by the 10th of each month (from September 2020 to June 2021)
3. **Review** the data, discuss with your team and implement changes to enable safer and more reliable care
4. **Share** changes they have made at learning sessions with other teams
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. Year 2 and 3 teams can choose to either repeat the safety climate survey or complete the significant event analysis tool.

2.2 High-risk areas targeted for improvement

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

1. Medicine reconciliation
2. Anticoagulants (warfarin, dabigatran, rivaroxaban)
3. Non-steroidal anti-inflammatory drugs (NSAIDs)
4. Opioids
5. Selective serotonin re-update inhibitors (SSRIs) – offered to year 2 and 3 teams only

Each pharmacy team works on one of the areas for improvement per year. The following diagram shows these as the rooms of the house.

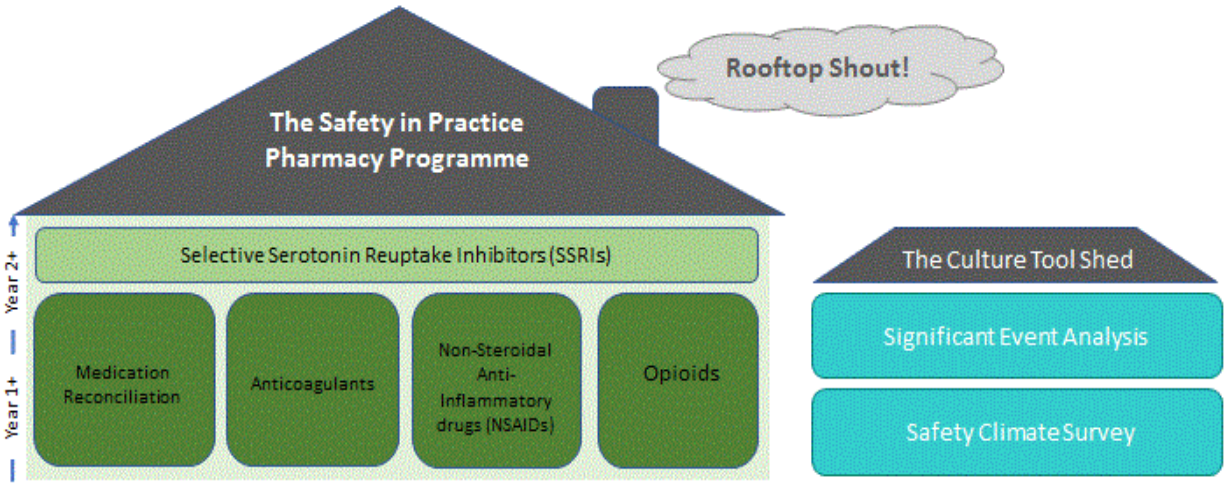


Figure 1: The SiP Community Pharmacy programme

2.3 Clinical modules

A change package is a structured way of improving processes to deliver reliable outcomes. In this programme it is a way of ensuring that patients receive evidence-based care to which they are entitled at every contact.

"Every patient, every time"

Pharmacies complete a simple set of measures that capture the key safety points. Each month, 10 random patient records from the previous month are reviewed to determine which measures were achieved. Based on these results, change ideas can be formulated, tested, and monitored for improvement over time.

Each package includes rationale and evidence for the measures used. The measures have been developed by a Pharmacy Expert group from the Metro-Auckland area, based on the Scottish Patient Programme in Primary Care.

2.3.1 Process and outcome measures

There are process measures for each module and patient outcome measures for anticoagulants, NSAIDs, opioids and SSRI modules. The **process measures** assess whether there is documented evidence of the activity taking place. This information needs to be recorded in the patient file (Toniq or RxOne). An example of a process measure is:

Is there documented evidence there was a discussion about how to use the medicine?

The **patient outcome measures** assess whether the patient has understood and can recall correctly the information provided. An example of an outcome measure is:

Was the patient able to correctly describe (dose and frequency) how to take their medicine?

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

2.3.2 Module aims

Anticoagulants: All patients receiving anticoagulants will receive education about the medicine at time of medicine collection.

NSAIDs: All patients receiving a prescribed NSAID will have clinical checks performed and receive education about the medicine at time of medicine collection.

Opioids: All patients receiving prescribed opioids will receive education about the medicine at time of medicine collection.

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

SSRIs: All patients receiving SSRIs will receive education about the medicine at the time of medicine collection by June 2021.

2.3.3 Data collection and submission

The 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.

We recommend a random number generator to pick patients from the list. Each measure question generally has a yes or no response. Decide whether the patient record meets these criteria. If there is no evidence, select 'No'.

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

2.3.4 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 is expected to:

- Review the findings from the data collection
- 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

2.3.5 Example data collection Excel spreadsheet

Pharmacy Name		Date	

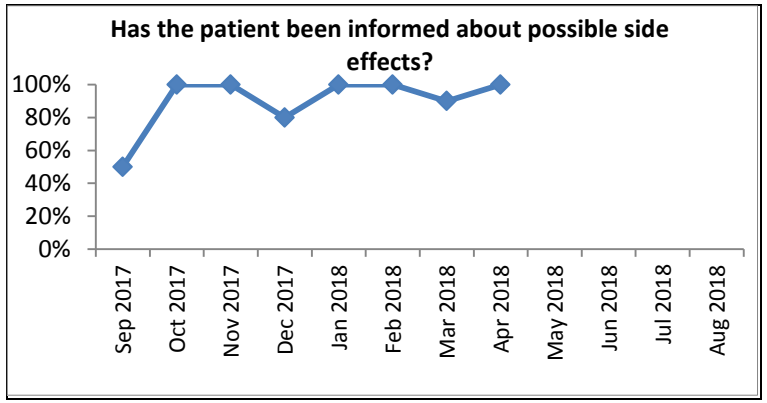
Method: Each month randomly select 10 patient records, and check to see if there is documented evidence for the following:

	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 on a separate tab on your spreadsheet.

2.3.6 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 usually held in August/September, November, March and June. Each learning session is usually held at a central and North Shore location; some may be offered via Zoom instead.

The purpose of the learning sessions is to:

- Develop skills and capabilities in quality improvement methodologies and processes – see diagram below.
- Share experiences and learn from other participants.
- 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 **Reflection sheet**. On the evening of the learning session, the reflections 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 their PDSAs.

2.3.7 Pharmacy visits

To support teams in the programme we offer year 1 pharmacies that are new to the programme a visit from a Safety in Practice clinical lead and in some cases, 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

2.3.8 Culture tools

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 Bristol[11] and Stafford[12] in the United Kingdom.

All year 1 teams will complete the Safety Climate Survey; year 2 and 3 teams can choose either the Safety Climate Survey or the Significant Event Analysis each year, but must have completed both over the 3 year period.

2.3.8.1 The Safety Climate Survey (SCS)

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:

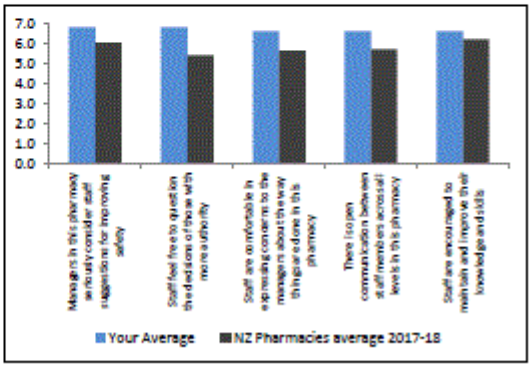
Safety Climate Survey Report

Communication

Summary	
Your Average	Other pharmacy Teams
6.7	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 Other Pharmacy Teams
Managers in this pharmacy seriously consider staff suggestions for improving safety	6.8	6.0
Staff feel free to question the decisions of those with more authority	6.8	5.4
Staff are comfortable in expressing concerns to the managers about the way things are done in this pharmacy	6.6	5.6
There is open communication between staff members across all levels in this pharmacy	6.6	5.7
Staff are encouraged to maintain and improve their knowledge and skills	6.6	6.2



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.

2.3.8.2 Significant Event Analysis (SEA)

The SEA is a technique to reflect on, and learn from, individual incidents to improve quality of care. This offers an important opportunity and reduces the likelihood of the same thing happening again.

Examples could range from a serious incident such as medicine error leading to disability or death, to one of a seemingly trivial nature which has consequences to patient experience such as failing to change a recorded message on a long weekend.

For individuals closely involved guilt, blame and self-isolation are common responses. Effective, well timed debriefing, in a supportive environment that focuses on error rather than blame, and a comprehensive learning process can help minimize this 'second-victim' response.

Whether the event is clinical, administrative or organisational, the significant event analysis process enables your team to answer the following questions:

- What happened?
- Why did it happen?
- What have you learned?
- What have you changed or plan to change?

After working through these questions, your team can embark on a process of determining the root cause by asking 'Why' 5 times in a row. This will assist with solutions to reduce the chance of the event happening again.
The Cause and Effect diagram is another tool that can help to explore many causes that contribute to an effect or outcome.

These tools will be further explained during learning session 2 and discussed in learning session 3.

Section 3: Contracts and Invoicing

3.1 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).

3.2 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 condition 1	Payment condition 2
July 2020 – June 2021	$5,400 excl. GST	30th June 2021	**FIRST YEAR TEAMS:** Attendance to Learning session 1 – Quality Improvement Skills Workshop (Usually in August/September). **ALL TEAMS:** Attendance to Learning session 2 (Usually in November) Attendance to Learning session 3 (Usually in March) Attendance to Learning session 4 (Usually in June)	Audit data received for: August – submitted in September September – submitted in October October – submitted in November November – submitted in December December - submitted in January January - submitted in February February - submitted in March 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@health.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

Section 4: 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)
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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 (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)