Project Participation

The pilot project was started in February of 2010. Eight reports have been submitted and used to develop the evidence-based and practice-based reporting system. Thirty-seven pharmacists have signed up to use the system. They were able to log into the reporting system and review issues shared in practice. Learning about safety improvements that can be implemented in their practice.

Challenges to Participation

The challenges these pharmacists have identified to participation are time, high workload, and the fact that some pharmacists were already participating in corporate organizational error reporting systems and did not want to have to submit separate reports. However, once they used the website, pharmacists found it was simple and quick, taking only 2-5 minutes to submit a report.

Use of Other Error Reporting Systems

A few pharmacists noted using error reporting systems other internal to their organization or their pharmacy software. However, the majority of pharmacists either did not participate in an external reporting system or had not submitted a report to a system they reported participating in.

Results

Implications for Practice

Results from this project indicate that pharmacists find information about safety problems that others are experiencing, and strategies for addressing these problems highly useful. Though pharmacists still face time and workload issues in trying to submit safety reports, they take the time to read information disseminated to them, apply it to their practice as applicable, and use it as a future reference. There is a need for additional strategies to enable pharmacist communication across practices and geographic locations.

References


For More Information

http://chrp.creighton.edu
Email: JenniferFaber@creighton.edu
Developing a Rapid-Feedback Patient Safety Improvement System for Pharmacists
Jennifer Faber, Pharm.D., Kevin T. Fuji, Pharm.D., Kimberly A. Galt, Pharm.D., Ph.D.

Background

• More than 1.5 million Americans are injured every year by drug errors in hospitals, nursing homes, and doctor’s offices, a count that does not estimate patients’ own medication mix-ups, or other safety-related problems.1
• Hospital patients likely represent only a fraction of the total population at risk of experiencing a medication-related error, necessitating the need to also examine ambulatory patients.2
• A 2008 survey of Nebraska pharmacists revealed a wide range of safety problems present across all practice settings.3
• Nebraska pharmacists have expressed an interest in voluntarily sharing experiences about system problems, near misses, and risks in practice.4
• Key characteristics of a successful patient safety event reporting website include:5
  • Non-punitive
  • Confidential
  • Independent
  • Expert analysis
  • Systems oriented
  • Timely
  • Responsive

Methods

A HIPAA-compliant patient safety event reporting website was developed to facilitate a communication network reaching rural pharmacists across the state of Nebraska. This website was designed to be proactive, encouraging pharmacists to share not only errors, but also near misses, problems that they believe could arise in the future, and safety strategies they have successfully used in practice. Once a pharmacist submits a patient safety event report, the following steps are taken:
1. It is reviewed using both an evidence-based and practice-based approach.
2. A strategy to address the problem is generated and disseminated out to all pharmacists participating in the project.

Objectives

To describe the development of a web-based patient safety event reporting system for community pharmacists in rural Nebraska that provides rapid feedback of practice improvements to address reported safety problems.

Results

Project Participation

The pilot project was started in February of 2010. Eight reports have been submitted and used to develop the evidence-based and practice-based reporting system. Thirty-two pharmacists have signed up to use the patient safety event reporting system to share issues they are experiencing in practice, learn more about issues others are facing, and learn about safety improvements that can be implemented in their practice.

Challenges to Participation

The challenges these pharmacists have identified to participate are time, high workload, and the fact that some pharmacists were already participating in a corporate organizational error reporting system and did not want to have to submit two separate reports. However, once they used the website, pharmacists found it was simple and quick, taking only between 2-5 minutes to submit a report.

Use of Other Error Reporting Systems

A few pharmacists noted using error reporting systems either internal to their organization or their pharmacy software. However, the majority of pharmacists either did not participate in an external reporting system or had not submitted a report to a system they reported participating in.

Reported Errors

Analysis revealed that all members of the pharmacy staff are involved in errors, including the pharmacist, interns, and technicians. Errors stemmed from inaccurate information, including wrong medication, wrong directions, or wrong quantity.

Use of the Error Reports

Pharmacists reported primarily using the error reports as a reference for future practices, and mentioned it in both e-mail and printed format. A few pharmacists reported using the disseminated strategies in their practice. The pharmacists who had not used any of the strategies noted that it was, “more a reinforcement of what we do already.”

Importance of Sharing Strategies

A number of pharmacists noted the importance of being able to see what other pharmacists are experimenting in practice, and applying it to their own practice. Representative quotes of the value pharmacists placed on this information is presented:

• “Really for us, it is an awareness issue - it gives us examples of what may be going on in other places and helps us avoid the same things.”
• “If we see all use it, we can all benefit from it.”
• “I think it is important for pharmacists to have a vehicle to share best practices and standards. If we part of a company, we only hear about 10 or 11 stores, it is better to see things other businesses are running into, especially if it is something we are not doing yet, or we haven’t seen yet, or hasn’t been a problem yet.”
• “…we are kind of out here in the middle of nowhere and we are an independent and so to have a resource to see how others have handled it is nice...It is always nice to have another perspective or place to find information...When it is just the two of us here, you kind of feel like you are floating on your own.”

Conclusions

Results from this project indicate that pharmacists find information about safety problems that others are experiencing, and strategies for addressing these problems highly useful. Though pharmacists still face time and workload issues in trying to submit safety reports, they take the time to read information disseminated to them, apply it to their practice as applicable, and use it as a future reference. There is a need for additional strategies to enable pharmacist communication across practices and geographic location.

References


For More Information

CRHP website: http://crhp.creighton.edu
Email: Jennifer.faber@creighton.edu
Pharmacists for Patient Safety

Jennifer Faber, Pharm.D., Kevin Fuji, Pharm.D. and Kimberly Galt, Pharm.D., Ph.D.

Patient Safety Event Reporting System

A communication network and supporting website was developed for Nebraska pharmacists who are geographically isolated to:

- Report patient safety problems (errors and near misses)
- Receive feedback about ways to address problems and prevent future occurrences
- Share strategies for improving patient safety
- Engage in a communication network with their peers

Reports are analyzed using an evidence- and practice-based approach, and provides pharmacists with feedback within a two-week timeframe.

Progress

Thirty-seven pharmacists are participating and have submitted nine patient safety event reports. Analysis of the reports revealed that all members of the pharmacy staff are involved in errors. Errors stemmed from inaccurate information, including wrong medication, directions, or quantity. Pharmacists indicate submitting a report takes two-five minutes. Challenges to participation that pharmacists have identified are time, high workload, and current use of a corporate organizational error reporting system, which requires pharmacists to submit the same report to two separate systems.

Current Findings

Pharmacists are willing to participate in a system to improve patient safety practices within their pharmacy and share their experiences with other pharmacists. They require rapid feedback with proven or practical implementable strategies. Time and workload continue to be barriers to use.

Ignatian Values

The formation of a communication network allows for sharing of patient safety problems in pharmacy practice and potential solutions for those problems. Gaining a greater understanding of the difficulties that each of us faces as practitioners and communicating with one another to share our thoughts, feelings, and ways of handling these difficulties embodies men and women for and with others.

Providing pharmacists with feedback about patient safety problems they are experiencing, and monthly patient safety education enables all participants to gain a greater understanding of how to provide rural patients with safer care. Rural patients and providers face unique difficulties in accessing and providing care. Providing pharmacists with a communication network facilitates them becoming true change agents who encompass the faith that does justice.

This project provides pharmacists with an understanding of how safety issues impact both the patient and their provider in a physical, emotional, and spiritual way. Through openness, honesty, respect, and fairness, pharmacists are guided in making the best decision possible for all involved. This foundation of magis and cura personalis establishes that we are all human and make mistakes, but that we must work to care for the whole person and the greater good in our treatment of both our patients and peers.