A Patient Safety Event Reporting Website for Pharmacists

Kevin T. Fuji, PharmD; Jennifer Faber, PharmD; Kimberly A. Galt, PharmD, PhD.

Creighton University
Center for Health Services Research and Patient Safety

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 pharmacist 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.[3]
- Key characteristics of a successful patient safety reporting website include:[4]
  - Non-punitive
  - Confidential
  - Independent
  - Expert analysis
  - Systems oriented
  - Timely
  - Responsive

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.

Methods

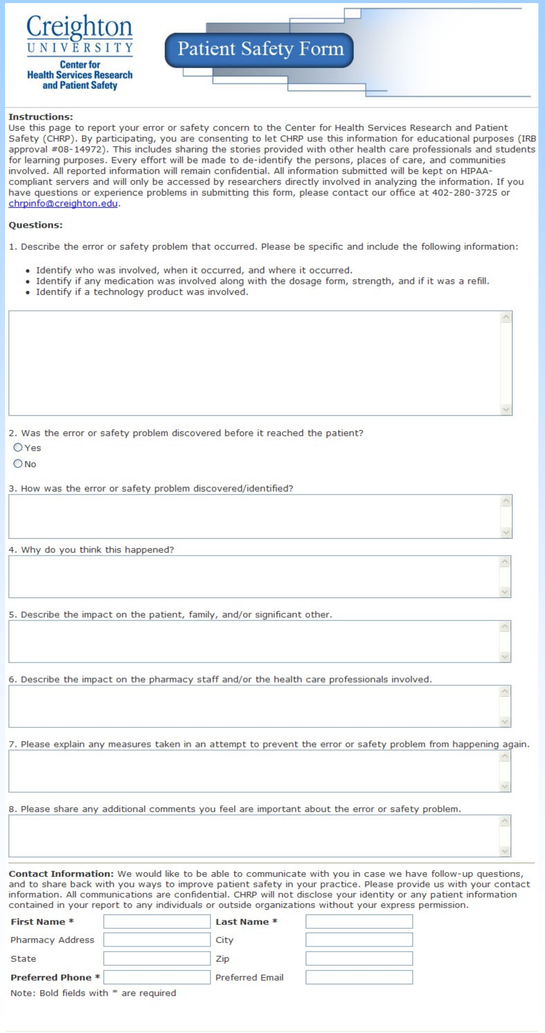
A HIPAA-compliant patient safety event reporting website was developed to facilitate a communication network reaching rural pharmacists across the state of Nebraska. This website was designed to be proactive; encouraging pharmacists to share not only errors, but also near misses, problems that they believe 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.

Funding Sources

This project is actively supported by grant number 84 from the Community Pharmacy Foundation and a contract from the Nebraska Department of Health and Human Services Office of Rural Health

Results



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6. Describe the impact on the pharmacy staff and/or the health care professionals involved.

7. Please explain any measures taken in an attempt to prevent the error or safety problem from happening again.

8. Please share any additional comments you feel are important about the error or safety problem.

Contact Information: We would like to be able to communicate with you in case we have follow-up questions, and to share back with you ways to improve patient safety in your practice. Please provide us with your contact information. All communications are confidential. CHRP will not disclose your identity or any patient information contained in your report to any individuals or outside organizations without your express permission.

First Name *		**Last Name ***	
Pharmacy Address		City	
State		Zip	
Preferred Phone *		Preferred Email	

Note: Bold fields with * are required

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-seven 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 participation 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.

Patient Safety Reports as a Reference

Many pharmacists reported keeping the error reports for future reference. Participants also used it for discussion both with other pharmacists and staff members. One pharmacist noted that, "*I sit down and read them, then I print it out and send them around to the rest of my staff.*"

Application of Patient Safety Strategies in Practice

Though many pharmacists could not point to a specific strategy or suggestion, the knowledge gained through the patient safety reports was emphasized. One pharmacist described, "*… if you are aware of potential errors, you are incorporating that into your practice.*" For others, the patient safety strategies were, "*more of a reinforcement of what we do already.*"

Results

Impact of the Project on Patient Safety

Participants discussed the value of learning about what patient safety problems their peers were experiencing. As one pharmacist shared, "*I think it is important for pharmacists to have a vehicle to share barriers and instances...If you are 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...the more information you get the better.*"

This was described as particularly beneficial for rural providers who have limited communication with other pharmacists. One pharmacy shared the benefit of participating in this project and learning about others' perspectives, "*...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.*"

Overall, there was a sense that, "*Anytime you learn about errors, it makes you safer.*"

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

1. Aspden P, Wolcott J, Bootman JL, Cronenwett LR, (Eds), Institute of Medicine (U.S.). Committee on Identifying and Preventing Medication Errors. *Preventing medication errors.* Washington, DC: National Academies Press; 2007.
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For More Information

CHRP website: 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.

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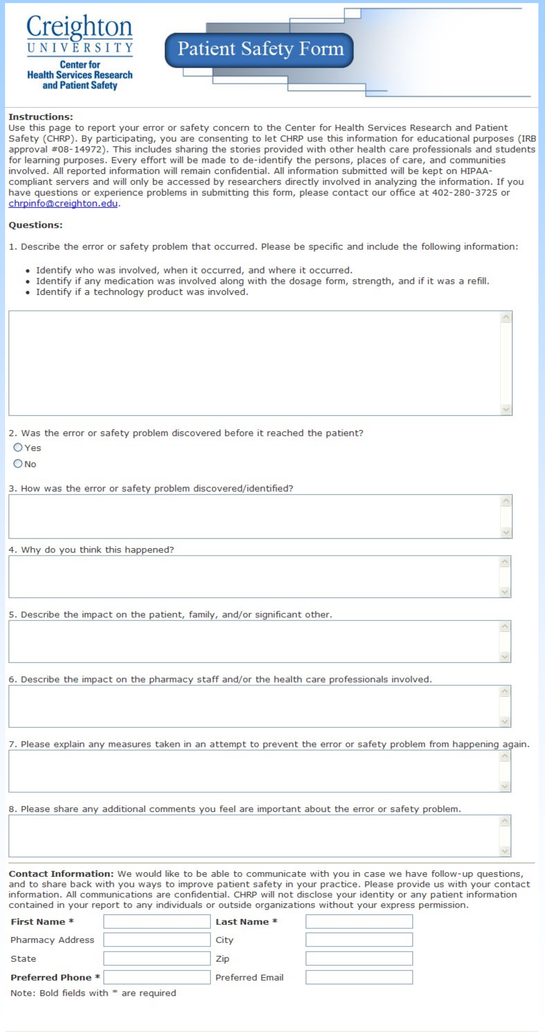

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Results

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 participation 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 that they could look up in the future, and maintained 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."*

Impact of the Project on Safety

All participating pharmacists reported that the information provided to them through this project made them more aware of safety problems, and reinforced the importance of patient safety.

Results

Importance of Sharing Strategies

A number of pharmacists noted the importance of being able to see what other pharmacists are experiencing in practice, and applying it to their pharmacy. 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 all use it, we can all benefit from it".*
- *"I think it is important for pharmacists to have a vehicle to share barriers and instances...If you are 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."*

Conclusion

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.

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All Things Ignatian

Pharmacists for Patient Safety

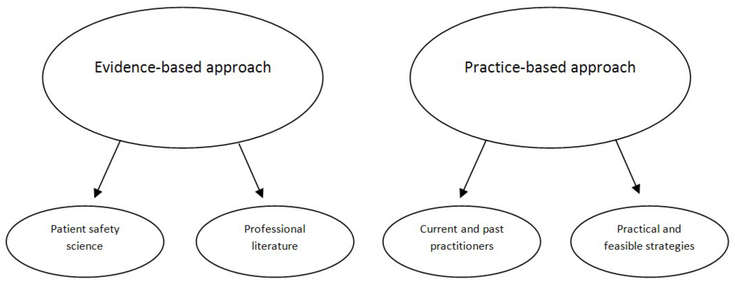
Jennifer Faber, Pharm.D., Kevin Fuji, Pharm.D. and Kimberly Galt, Pharm.D., Ph.D.

Patient Safety Event Reporting System

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

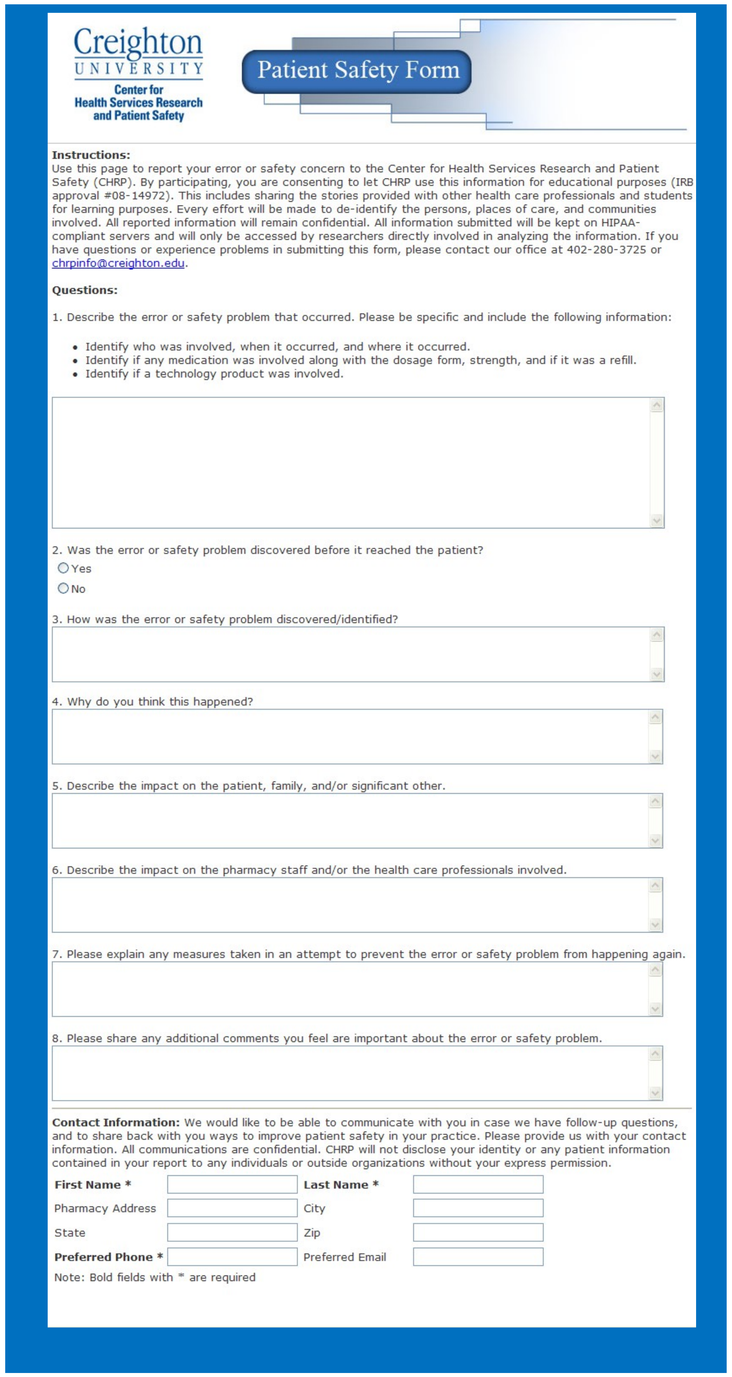
- Report patient safety problems (errors and near misses)
- Receive feedback about ways to address problems and prevent future occurrences
- Share strategies for improving patient safety
- Engage in a communication network with their peers

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.



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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.

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