Creating a Safe Culture

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Disclosure
- No financial relationship to disclose

Objectives
- Review the role of pharmacists, pharmacy technicians, leaders, patients, and providers in creating a culture of safety
- Describe activities and processes that can improve, create, and promote a safety culture in your pharmacy
- Explain the importance of identifying and reporting medication errors or events including reporting, transparency, proactive versus retrospective, and harm huddles in order to improve safe practice
- Outline opportunities and challenges of technology and equipment and their impact on safety
Outline

- Culture of Safety
- How You Can Contribute
- Practical Applications

MultiCare Health System

- Multi-hospital, non-profit organization
  - Allenmore
  - Auburn
  - Good Samaritan
  - Mary Bridge
  - Tacoma General

- Medication Safety Committees
  - Hospital specific
  - Integrated

MultiCare Good Samaritan Hospital

- 295 beds, average 220 ED visits daily
- 20 Pharmacist FTE, decentralized model
  - ICU
  - ED
  - Medical
  - Surgical
  - Oncology
  - Cardiac
  - AMS
  - Residency program
What is a Safety Culture

- A set of core values and behaviors that emphasize safety as an overriding priority
- Safety cultures consist of shared beliefs, practices, and attitudes that exist in an organization
- Culture is the atmosphere created by those beliefs and attitudes that shape our behavior
- A culture is an environment whose philosophy permeates the daily activities of the organization

Why is a Culture of Safety Important

- Prevent errors
  - Medication errors
    - Inpatient 1 death per 854 patients
    - Outpatient 1 death per 131 patients
  - Pharmacists believe workplace environment contributes heavily to occurrence of events

Creating a Safe Culture

- Starts with YOU
Start with Self

- Work environment
  - Calm, quiet, orderly
  - Chaotic, interrupt others

Start with Self

- Respond to questions
  - Defensive vs Open
  - Proactive

Culture

- Create open culture
- Positively reinforce
Develop Trust Among Coworkers
- Essential component for effective safety culture
- Encourage open discussion
  - What is working
  - What is not
  - What still needs to change

Accountability – Evaluation Process
- Behaviors
  - Maintains environment that fosters concentration and quiet
  - Seeks ways to decrease chaos
  - Takes ownership to identify, problem solve and report
- Results
  - Identifies and resolves errors
    - Includes reporting, providing peer feedback
  - Identifies safety risks and initiates change
  - Communicates risks and ideas for improvement

Ownership
- Idea Board
Error Identification

- Idea Card - Chemo storage area

Chemotherapy Storage Area

- Solutions
  - Add more shelves
  - Remove doors
  - Order more red bins
  - Alphabetize
  - Label shelves and bins
Chemotherapy Storage Area

- Post Idea Card

### Breakout Exercise # 1

- Share 2 examples of what you have done to create/support a culture of safety
- Pick a spokesperson to share 3 ideas at the end of 5 min

### Practical Application

- Create a blame-free environment
- Encourage reporting
- Develop process
  - Pharmacy
  - Hospital
- Optimize technology and equipment
- Celebrate success
Blame-free Environment

- Implement Just Culture
  - Discipline for at-risk behaviors, not cultural norms
  - Lack of fear encourages reporting
- Pursue system causes
  - Uncover systems/practices that encourage at-risk practices
- Emphasize process
  - 80% process, 20% people

Unsafe Acts Algorithm

Reporting

- Events
- Near misses
- Internal checks
Doses Dispensed vs. Harm Events vs. Reports

Error Prevention

- Proactive review - external literature
  - ISMP
  - IOM
  - AHRQ
  - ASHP
  - Hospital Pharmacy
  - TJC – Sentinel Event Reports

- Develop standard processes
- Clearly define roles
- Make it easy to identify when something isn’t being followed
- Train to the standard process
- Use Lean tools/concepts
### Standard Pharmacy Processes

- Job Instruction Sheet
- Standard to Use/Train to

<table>
<thead>
<tr>
<th>Important Steps (short/concise, verb/subject)</th>
<th>Key Points (How) Anything in a step that might</th>
<th>Reasons (Why) Reasons for the key points</th>
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<tbody>
<tr>
<td></td>
<td>1. Make or break the job</td>
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<td>2. Injure the worker</td>
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<td>3. Make the work easier</td>
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### Patient’s Own Medications

- Pre-standard work
  - Patient own medication policy
  - Inconsistent policy application
  - Medications frequently “lost”

### Patient’s Own Medications

- Scope
  - Receiving
  - Storage
  - Repackaging
  - Asked for volunteers
Standard Work

- Cart for intake
- Check-in/out books
- Cards
- Bags
- Stickers
- Gloves
- New storage area/bags
- Epic process

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Standard Work

- Storage Area

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Breakout Exercise # 2

- Discuss
  - What workaround do you routinely use?
    - How can process be changed so don’t have to use workarounds?
  - What medication safety successes have you seen in your pharmacy, work environment?

- Pick spokesperson to share 2 successes or ideas for process changes at the end of 5 min
System Ideas
- USP 2008 Chapter – Physical Environments that Promote Safe Medication Use
- Sound/Noise
- Illumination
- Interruptions and distractions
- Physical design and organization of work space
- Medication Safety Zones

Medication Safety Zones
- Pilot on Medical Unit
- Worked with staff and leaders to identify areas to focus
- Stop sign with “Staff Only Beyond this Point”
- Anti-fatigue mats with orange lines around designating quiet medication zone
- Task lighting under all upper cabinets
- Scripting for medication passes

Medication Safety Zones
- New Tower Construction
  - Memo to design team regarding med rooms
  - Acoustic tiles
  - Increase counter height to 42”
  - Task lighting
  - Use flooring to define med safety zones
Safety Integrated into Daily Work

- Time outs for critical tasks
- Chemotherapy
- Share stories
  - Anatomy of a Medication Error
    - "Swiss Cheese" Model

Technology

- Can help system issues
  - Problem - wrong medications given consistently
  - Solution – implement bedside bar-coding

- Must compliment workflows
  - Problem – bedside bar-coding implemented
  - Nurse process - administer meds, then chart and scan
    - Technology can’t fix system/workflow issue
  - Solution – ensure workflow changed so medications are scanned (which opens chart), checked and administered

Technology - EHR

- Allergy alerts
Celebrate and Share Successes

- Leader rounding
- Patient safety leadership walk arounds
- Patient safety stories: good catches
- Sharing Our Goal at Medication Safety Committee
  - Recognition of safe medication moment
  - Verbal, handwritten thank you note and e-card
- Huddles (standup meetings)
  - Recognition of individuals for safe practices, being a team member

Celebrate Success

Resources

- Institute for Safe Medication Practices (ISMP)
- ASHP - Medication Use Safety Resources
  - Patient Safety Organizations
  - Guidelines
  - Tools
  - Recommended Readings
- USP chapter
- Just Culture
Take Home

- Get involved
- Be proactive
- Seek feedback

Questions

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