Quality Improvement and Today's Technician

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- October 6, 2018

Objectives:

- Why do we have Quality Improvement
- Steps of a Quality Improvement Program
- How does the role of the technician fit into this

I have no conflicts of interest with this presentation.

By show of hands:

1. How many of you know if where you work has a quality improvement program?
2. How many of you are involved with your peer review?
3. How many of you are actively involved with Quality Improvement?

Why do we have Quality Improvement?

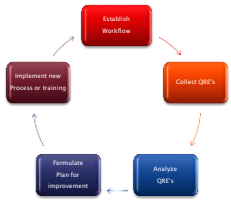
Why do we have Quality Improvement?

1. Patient Safety
No news is **not** good news.
We can not manage what we cannot measure.
"I am really careful and don't make mistakes.."
If a pharmacy fills 99.9% accurate
  -If they fill 1,000 prescriptions each week
  -How many errors each week?
  -52,000 rx's in a year – what is the error rate of a very careful pharmacy?

Why do we have Quality Improvement?

1. Patient Safety
2. State Board Regulations
3. Medicare Part D – FWA and Insurance Contracts
4. Freedom from Discovery
   1. Information must be uploaded to an approved Patient Safety Organization Website.
   2. All paperwork must be labeled as **P**atient **S**afety **W**ork **P**roduct. Mark your QI data as confidential and treat it as such.

5 Steps to a Quality Improvement Program



Step 1 – Establish Pharmacy Workflow

1. Divides the dispensing process into manageable parts, allowing us to concentrate on 1 process at a time.
2. Individuals within the workflow need to understand his/her role within the process.
3. Each process becomes a check on the other.
4. Increases efficiency.

Step 2 – Collect Quality Related Event Data

1. Responsibility of EVERY employee
2. Report QRE's to online website
3. Report dispensing errors using Process Improvement Report
   -Meets ND Board of Pharmacy requirements

Step 3 – Analyze QRE's

1. FHCP Peer Review Committee
   1. Meets monthly
   2. Consists of Pharmacy Director, Quality Supervisor, RPh, and Technician
   3. Review Process Improvement Forms

Step 3 – Analyze QRE's

2. Discussing Errors
   Negative:
   - -Dwells on the past
   - -Threatening, insulting, punitive
   - -Focuses on WHO made an error
   - -Concludes erring individual has character flaws they need to correct
   - -Individuals won't willingly participate

Step 3 – Analyze QRE's

2. Discussing Errors
   Positive:
   -Looks to the future
   -Open, Blame-free, non-punitive
   -Focuses on How or What in the system allowed the error to occur
   -Realizes error is a reality and recognizes the opportunity to improve for the future
   -Creates blame-free, shame-free environment

Step 4 – Formulate Improvement Plan

1. Propose workflow changes
2. Identify the need for training
3. Recommit to using existing workflow processes

Step 5 – Implementation

1. Communicate changes to pharmacy processes during staff meetings
2. Provide training when indicated
3. Allow staff to provide feedback, both positive and negative
4. Reassess changes and need for additional intervention

Annual Staff Training

1. Staff complete annual training on QI process
2. Provide monthly/quarterly newsletter from ISMP (Institute of Safe Medication Practices) as well as PQC (Pharmacy Quality Commitment)
3. PQC provides free QI related CE

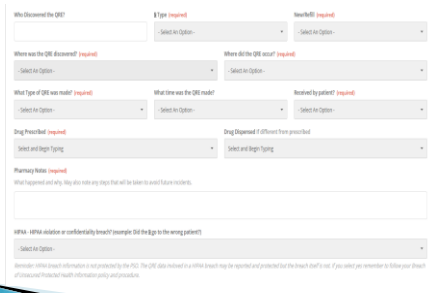
Reporting of Errors

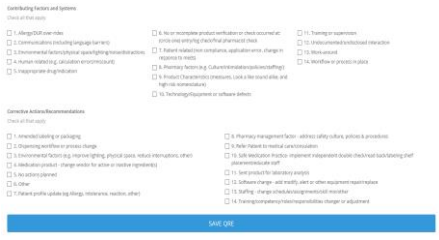
Two different ways to report

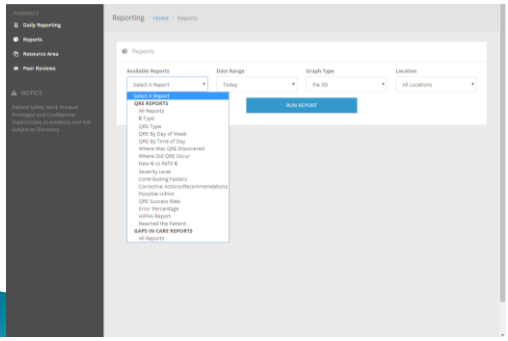
1. Errors that do not get past the pharmacist (near miss)
2. Errors that do get past the pharmacist (incident)

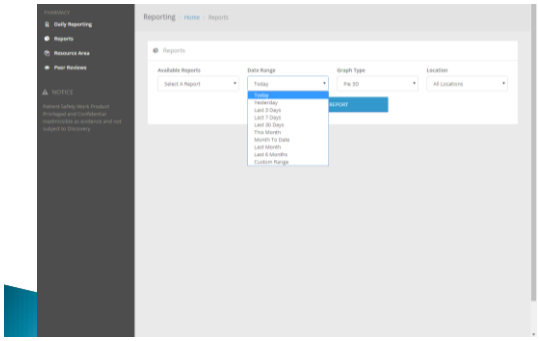
Errors that do not get past the pharmacist (near miss):

1. Errors still need to get entered into your PQC program
2. Allows us to generate reports to see where/when different types of errors occur
3. Allows us to proactively look at our system to find flaws before errors occur


Who Discovered the QRE?
IL Type (required)
New/Refill (required)
- Select An Option -
Where was the QRE discovered? (required)
Where did the QRE occur? (required)
What Type of QRE was made? (required)
What time was the QRE made?
Received by patient? (required)
Drug Prescribed (required)
Drug Dispensed If different from prescribed
Select and Begin Typing
Pharmacy Notes (required)
What happened and why. May also note any steps that will be taken to avoid future incidents.
HIPAA - HIPAA violation or confidentiality breach? (example: Did the Rx go to the wrong patient?)


Contributing Factors and Systems
Check all that apply
Corrective Actions/Recommendations
Check all that apply
SAVE QRE


Reporting
Home
Reports
Daily Reporting
Reports
Resource Area
Peer Reviews
NOTICE
Available Reports
Date Range
Graph Type
Location
Select A Report
Today
Pie 3D
All Locations
RUN REPORT
QRE REPORTS
All Reports
Rx Type
QRE Type
QRE By Day of Week
QRE By Time of Day
Where Was QRE Discovered
Where Did QRE Occur
New Rx vs Refill Rx
Severity Level
Contributing Factors
Corrective Actions/Recommendations
Possible HIPAA
QRE Success Rate
Error Percentage
HIPAA Report
Reached the Patient
GAPS IN CARE REPORTS
All Reports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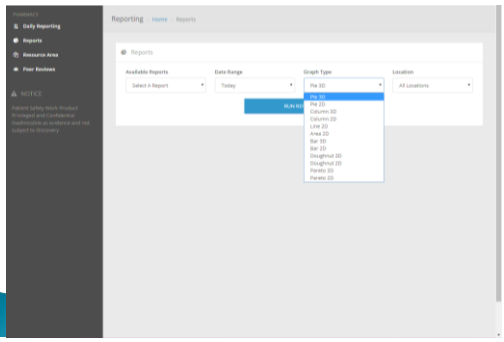
This Month
Month To Date
Last Month
Last 6 Months
Custom Range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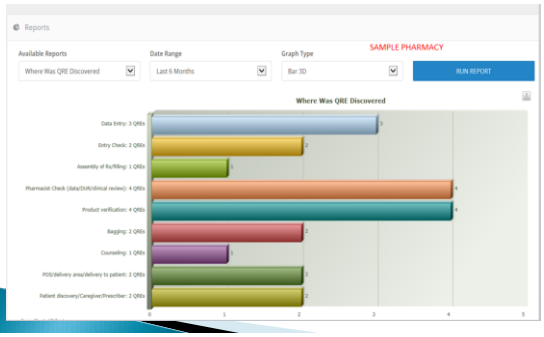
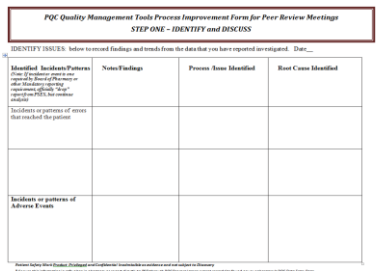
Line 2D
Area 2D
Bar 2D
Bar 3D
Doughnut 2D
Doughnut 3D
Pareto 2D
Pareto 3D


Reporting
Home
Reports
SAMPLE PHARMACY DATA
Available Reports
Date Range
Graph Type
Where Was QRE Discovered
Last 6 Months
Pie 3D
RUN REPORT
Where Was QRE Discovered
Patient Safety Work Product
Privileged and Confidential
Inadmissible as evidence and not subject to Discovery



Errors that get past the pharmacist (incident):

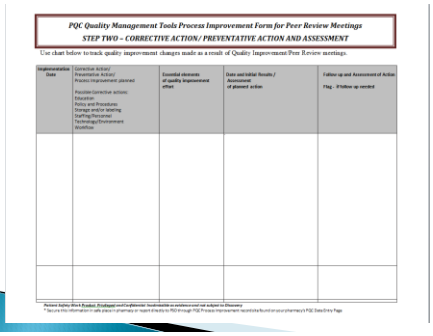
1. Need to be entered into your PQC website
2. Need additional report filled out (incident report)
3. All parties involved need to do both of the above steps
4. These reports are to be analyzed at the Peer Review Meeting



PQC Quality Management Tools Process Improvement Form for Peer Review Meetings
STEP ONE – IDENTIFY and DISCUSS

IDENTIFY ISSUES: below to record findings and trends from the data that you have reported investigated. Date:__

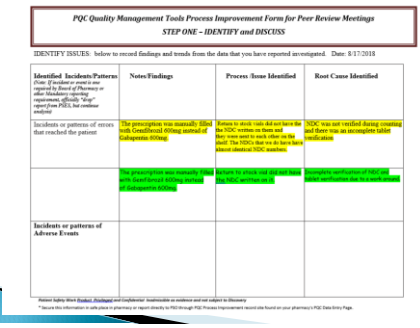
Identified Incidents/Patterns *(Note: If incidence- event is one required by Board of Pharmacy or other Mandatory reporting requirement, officially "drop" report from PSES, but continue analysis)*	Notes/Findings	Process /Issue Identified	Root Cause Identified
Incidents or patterns of errors that reached the patient			
Incidents or patterns of Adverse Events			



PQC Quality Management Tools Process Improvement Form for Peer Review Meetings
STEP TWO – CORRECTIVE ACTION/ PREVENTATIVE ACTION AND ASSESSMENT

Use chart below to track quality improvement changes made as a result of Quality Improvement/Peer Review meetings.

Implementation Date	Corrective Actions/ Preventative Action/ Process improvement planned Possible Corrective actions: Education Policy and Procedures Storage and/or labeling Staffing/Personnel Technology/Environment Workflow	Essential elements of quality improvement effort	Date and Initial Results / Assessment of planned action	Follow-up and Assessment of Action Flag – If follow up needed



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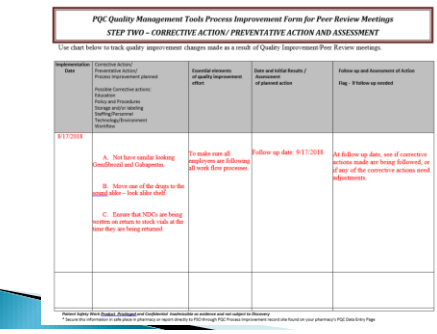
STEP ONE – IDENTIFY and DISCUSS

IDENTIFY ISSUES: below to record findings and trends from the data that you have reported investigated. Date: 8/17/2018

Identified Incidents/Patterns *(Note: If incidence- event is one required by Board of Pharmacy or other Mandatory reporting requirement, officially "drop" report from PSES, but continue analysis)*	Notes/Findings	Process /Issue Identified	Root Cause Identified
Incidents or patterns of errors that reached the patient	The prescription was manually filled with Gemifloxacil 600mg instead of Gabapentin 600mg.	Return to stock vials did not have the NDC written on them and they were sent to stock vials on the shelf. The NDCs that we do have have almost identical NDC numbers.	NDC was not verified during counting and there was an incomplete tablet identification.
	The prescription was manually filled with Gemifloxacil 600mg instead of Gabapentin 600mg.	Return to stock vial did not have the NDC verified on it.	Incomplete verification of NDC on ticket verification that this is worth noting.
Incidents or patterns of Adverse Events			



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8/17/2018	A. Not have similar looking Gemifloxacil and Gabapentin. B. Move one of the drugs to the second aisle – look alike shelf. C. Ensure that NDCs are being written on return to stock vials at the time they are being returned	To make sure all employees are following all work flow processes.	Follow up date: 9/17/2018	At follow up date, see if corrective actions made are being followed, or if any of the corrective actions need adjustments.

REVIEW:

1. Is this a positive or negative entry into PQC for an incident?

I went to fill the posted prescription and the posting tech had entered the day supply in wrong.

Review:

2.What should happen in this situation?

a. Posting tech should enter into PQC what lead them to post the rx with the wrong day supply
b. Filling tech should enter into PQC why they did not catch the incorrect day supply
c. Person counting the rx should enter into PQC why they did not catch the incorrect day supply
d. If it got past the pharmacist, the pharmacist should enter into PQC why they did not catch the incorrect day supply and an incident report should be filled out.

REVIEW:

3.Why do we have Quality Improvement?

A.Patient Safety
B.State Regulations
C.Medicare Part D – FWA and Insurance Contracts
D.Freedom from Discovery
E.All of the above

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Review:

4.What are the steps of a Quality Improvement Program?

A.Establish Pharmacy Workflow
B.Collect QRE's
C.Analyze QRE's
D.Formulate plan for improvement
E.Implement New Process or Training
F.All of the Above

Review:

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Review:

5.How does the Technician fit into Quality Improvement?

A. Always keep in mind patient safety
B. It is the responsibility of every employee, including the technician
C. Technician input, both prospectively and retrospectively allows us to analyze our system for flaws
D. Employee feedback, including technicians, helps us to determine if our trainings or implementations were successful or need to be re-evaluated.
E. All of the above

Review:

5.How does the Technician fit into Quality Improvement?

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E. All of the above

References

ND Board of Pharmacy Administrative Code 61-02-09
Alliance for Patient Medication Safety (APMS) Pharmacy Quality Commitment (PQC+) Program (powerpoint)