



Pharmacists for Patient Safety

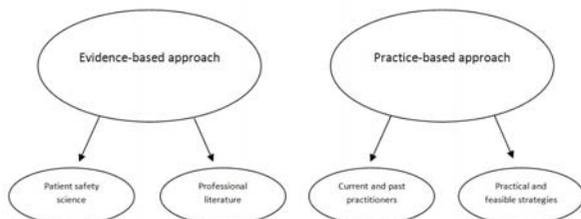
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Patient Safety Event Reporting System

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.

Creighton UNIVERSITY
Center for Health Services Research and Patient Safety

Patient Safety Form

Instructions:
Use this page to report your error or safety concern to the Center for Health Services Research and Patient Safety (CHSRP). By participating, you are consenting to let CHSRP use this information for educational purposes (2016 approval with IAHG). This includes sharing the stories provided with other health care professionals and students for learning purposes. Every effort will be made to de-identify the persons, places of care, and communities involved. All reported information will remain confidential. All information submitted will be kept on intranet-compliant servers and will only be accessed by researchers directly involved in analyzing the information. If you have questions or experience problems in submitting this form, please contact our office at 402-280-3725 or chsrp@creighton.edu.

Questions:

- Describe the error or safety problem that occurred. Please be specific and include the following information:
 - Identify who was involved, when it occurred, and where it occurred.
 - Identify if any medication was involved along with the dosage form, strength, and if it was a refill.
 - Identify if a technology product was involved.
- Was the error or safety problem discovered before it reached the patient?
 Yes No
- How was the error or safety problem discovered/identified?
- Why do you think this happened?
- Describe the impact on the patient, family, and/or significant other.
- Describe the impact on the pharmacy staff and/or the health care professionals involved.
- Please explain any measures taken in an attempt to prevent the error or safety problem from happening again.
- 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. CHSRP 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 *
 Primary Address City
 State Zip
 Preferred Phone * Preferred Email

Note: Bold fields with * are required.

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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.