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Patient safety and healthcare improvements –the hospital pharmacist's contribution

Student Symposium
Robert Gordon University, Aberdeen, UK
And EPSA

EAHP (Hamburg, 25 – 27 March 2015)

Who we are

Dr Scott Cunningham
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Disclosure of Relevant Financial Relationships

- Nothing to declare

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Where we are from …

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Aberdeen in the sunshine …




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Aberdeen in the winter …




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Our new campus …




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Learning Outcomes

- To gain an understanding of terminology associated with patient safety and medication errors
- To develop an awareness of facilitators and barriers to patient safety in a hospital environment including the role of ethics and inter-professional communication
- To acquire a basic knowledge of the 'PDSA' health improvement methodology and apply this to pharmaceutical care scenarios to consider how to change ways of working within an organisation

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PROGRAMME

2:00-2:15pm	Introductions, symposium structure and focus
2:15–2:45pm	Patient Safety: an overview (SC)
2:45-3:15pm	Group discussion: patients, staff and organisation in medication safety (AT & EPSA)
3:15-3:30pm	Quality Improvement methodology: PDSA (SC)
3:30-4:15pm	Coffee break
4:15-5:30pm	Case studies (All !!)
5:30-6:00pm	Conclusion and final thoughts

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Interactive questions Yes or No ?

- **'Transparency' in hospital patient safety relates to having better visibility of patients from the nurses stations**

- **In healthcare quality improvement PDSA stands for Plan, Do, Stop and Achieve**

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Patient Safety Video

The Francis Inquiry report (UK, Feb 2013)

Report into the failings at a UK Hospital

- **Issues relating to poor …**
  - **– patient safety**
  - **– quality of care**
  - **– culture of collective leadership**

- Francis: *'The extent of the failure … suggests that a fundamental culture change is needed.'*

http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

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Don Berwick

founder and former president, Institute for Healthcare Improvement

… asked by the UK Prime Minister to carry out a review following Francis report:

- embracing a **culture** of learning
- placing **quality** at the top of priorities
- making sure **patients** are present, powerful and involved

http://www.kingsfund.org.uk/audio-video/don-berwick-improving-safety-patients-england-highlights?gclid=CPDrupDAh8QCFebKtAodRjsAfQ

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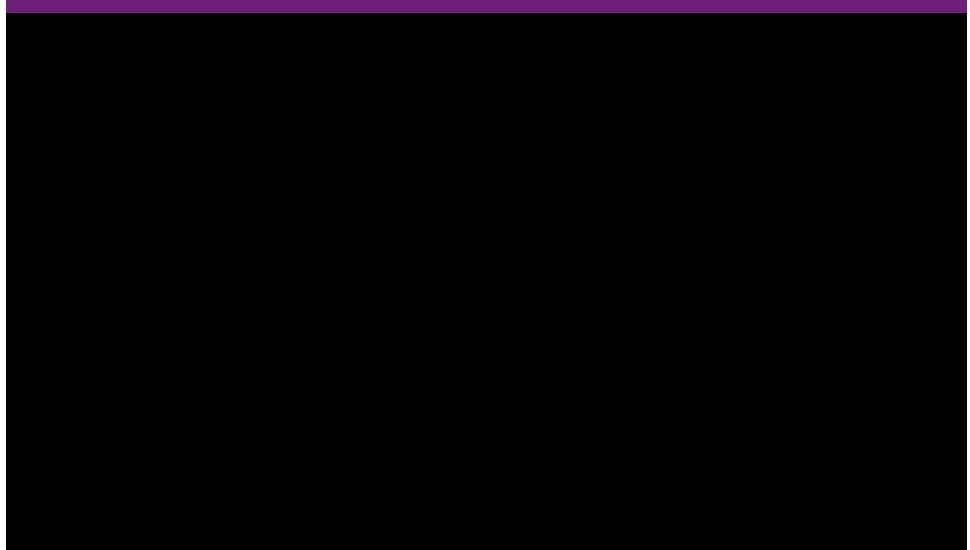
Don Berwick



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'Berwick's Elevator summary' – for patient safety …

1. Put **patient** experience first
2. Hear and empower **patients**
3. Invest in **staff** to grow and develop; own abilities and working together
4. **Organisational** transparency

Overall ….

Continuous quality improvement and 'Zero harm'

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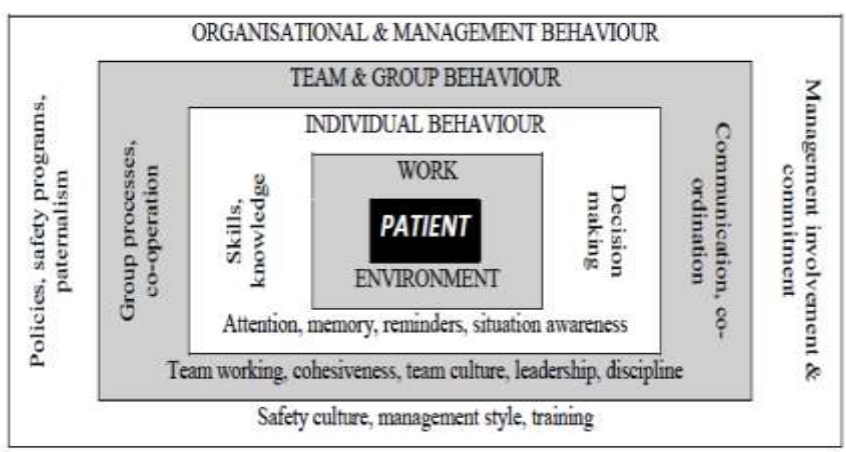
Human Factors in Patient Safety



http://blogs.cmdn.dundee.ac.uk/humanfactors/files/2013/09/WHO-Human-Factors-in-Patient-Safety-Review-of-Topics-and-Tools.pdf

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Group Discussion

Student perceptions of …

- **Patients**; listening to and empowering them
- **Staff**; development and inter-professional communication
- **Organisation;** transparency, ethical dilemmas

…. in PATIENT SAFETY

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Patients

Listening to and Empowering

Scenario: Mrs Q is 65 years old and has been admitted to hospital for an elective hip replacement operation. She has a longstanding history of rheumatoid arthritis and takes several medicines including a biologic agent. She is knowledgeable of her drugs and condition and very independent. She is surprised and annoyed that she is not allowed to keep and take her own medicines when in hospital

- **How can not listening /empowering Mrs Q compromise medication safety in hospital?**
- **What can pharmacists (or pharmacy interns) do to help Mrs Q and improve medication in the hospital setting?**

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Staff

Development and interprofessional

Scenario: The acute medication admissions unit (AMAU) of a large teaching hospital has recently had a number of new staff members in all groups; nurses, doctors and pharmacists. As a result some patients have not received all their medicines at all and others have not received them on time.

- **How can staff development help improve medication safety in this scenario?**
- **How can communication (or lack of it) play a role in medication errors in this scenario?**
- **How can communication (or lack of it) between AMAU and the patients next destination play a role in increased (or decreased) patient safety in this scenario?**

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Organisation

Transparency; ethical dilemmas

Scenario: You have recently started as the clinical pharmacist on a psychiatric ward. You have noticed that the nurses routinely crush and mix several medicines together with food for patients. The patients are unaware of this. Recently one patient who was allergic to penicillin, was administered amoxicillin. She suffered a severe anaphylactic reaction but recovered well.

- **How does the term 'transparency' apply in the context of this scenario?**
- **What are your views on the ethics of such 'covert' medicine administration? Are there any situations where it could be justified?**
- **What actions would / should be taken in such a situation?**

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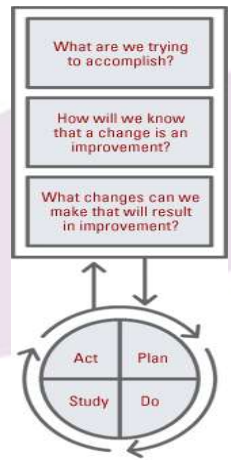
Quality Improvement Methodology: PDSA



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PDSA: Initial Questions

What are we trying to accomplish?

- Forming the team
- Setting aims

How will we know that a change is an improvement?

- Establishing measures

What changes can we make that will result in improvement?

- Selecting Changes

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PDSA Cycle

PLAN

- **I plan to:** Here you will write a concise statement of what you plan to do in this testing.
- **I hope this produces:** Here you can put a measurement or an outcome that you hope to achieve.
- **Steps to execute:** Here is where you will write the steps that you are going to take in this cycle.
- **Time:** Indicate the time limit that you are going to do this study

DO

- After you have your plan, you will execute it or set it in motion.
- **What did you observe?** Here you will write down observations you have during your implementation.

STUDY

- After implementation you will study the results.
- **What did you learn? Did you meet your measurement goal?** Here you will record how well it worked, if you meet your goal.

ACT

- **What did you conclude from this cycle?** Consider what you came away with for this implementation, if it worked or not

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PDSA – plan-do-study-act worksheet II

TOOL:	STEP:	CYCLE:
PLAN		
We plan to:		
We hope this produces:		
Steps to execute:		
DO		
What did we observe?		
STUDY		
What did we learn? Did we meet our measurement goal?		
ACT		
What did we conclude from this cycle?		

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The last word … from Don Berwick

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Interactive questions Yes or No ?

- **'Transparency' in hospital patient safety relates to having better visibility of patients from the nurses stations**

no

- **In healthcare quality improvement PDSA stands for Plan, Do, Stop and Achieve**

no

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The very, very last word ….. The Safety Dance ….

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