BUILDING ORGANIZATIONAL RESILIENCE THROUGH PROCESS IMPROVEMENT

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GOALS

1. Define what a High Reliability journey looks like in the pharmacy technician scope.

2. Differentiate between zero harm and zero error.

3. Apply the tools outlined in the presentation to real life patient safety scenarios.

HIGH RELIABILITY ORGANIZATIONS

"Operate under very trying conditions all the time and yet manage to have fewer than their fair share of accidents."

Source: Weick, Karl and Sutcliffe, Kathleen. Managing The Unexpected

HRO – PRINCIPLES

Preoccupation with Failure

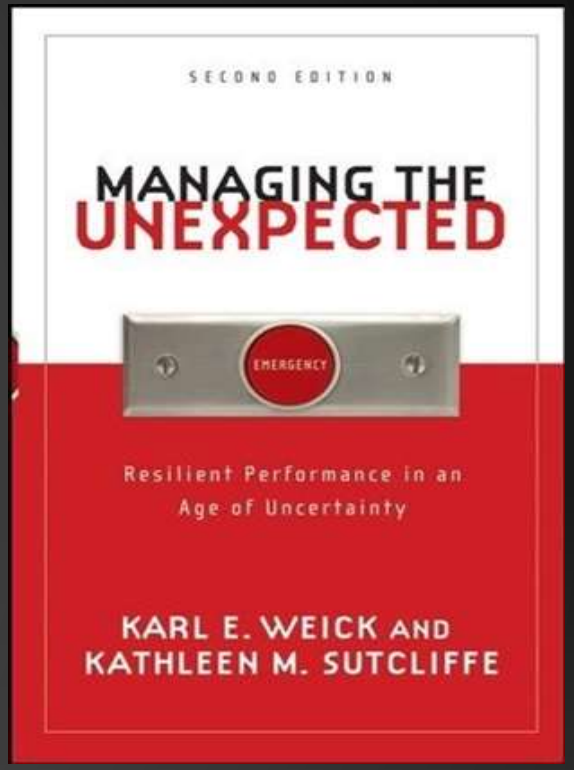
- **Anticipate challenges to prevent or mitigate effects**
- **Learn from experiences**

Sensitivity to Operations

- **Monitor and understand current work processes**

Reluctance to Simplify Interpretation

- **Try not to accept first answer whether outcome is good or bad.**



HRO – PRINCIPLES

Commitment to Resilience

- **The initial response and continued focus after a safety event**

Deference to Expertise

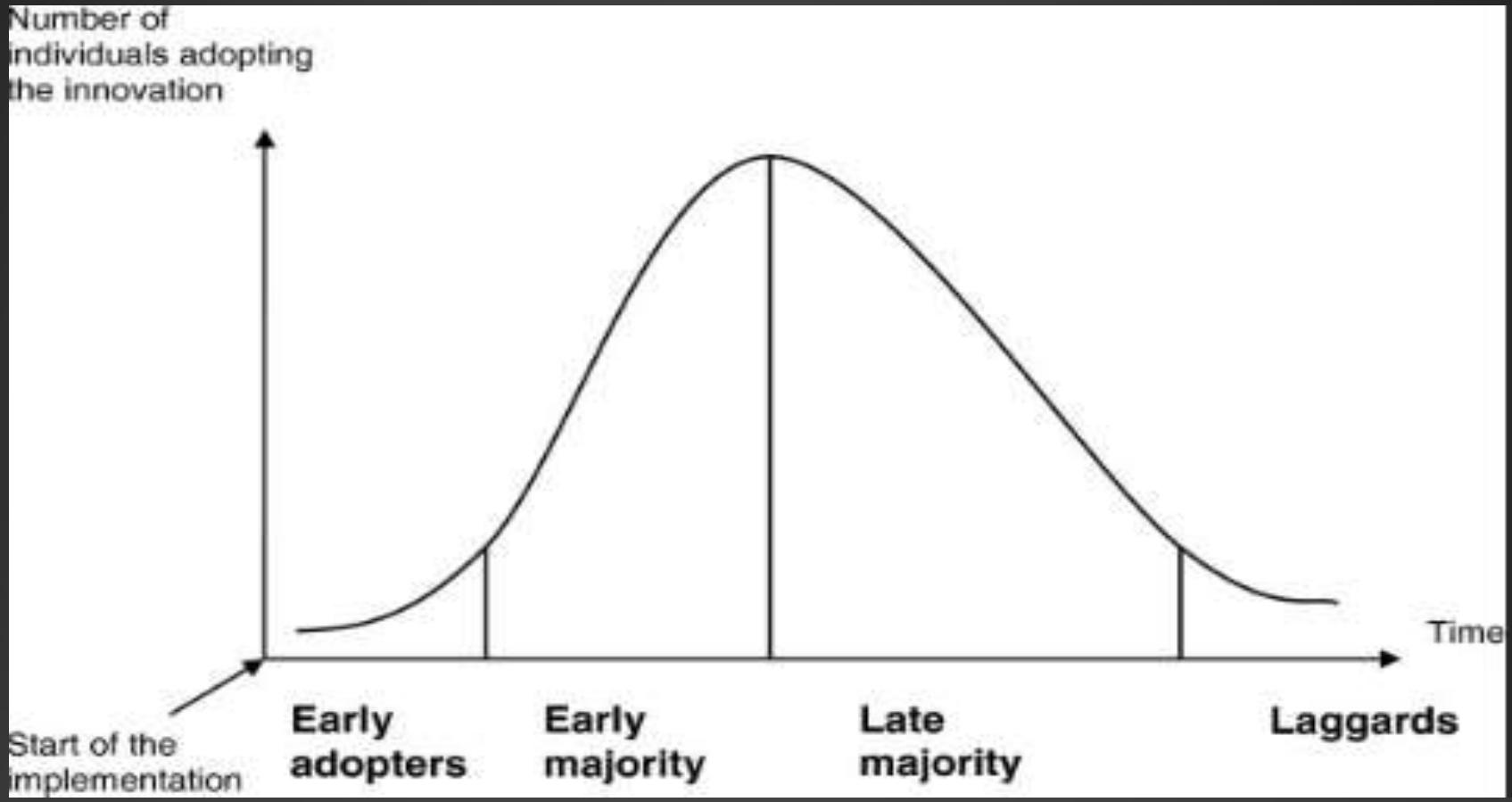
- **Allow decisions to be made by the subject matter experts, no matter position or authority level.**

Leadership Engagement

- **Create and maintain a culture where staff feel empowered to speak up.**


WHAT'S
YOUR WHY?

WHERE ARE YOU ON THE JOURNEY??



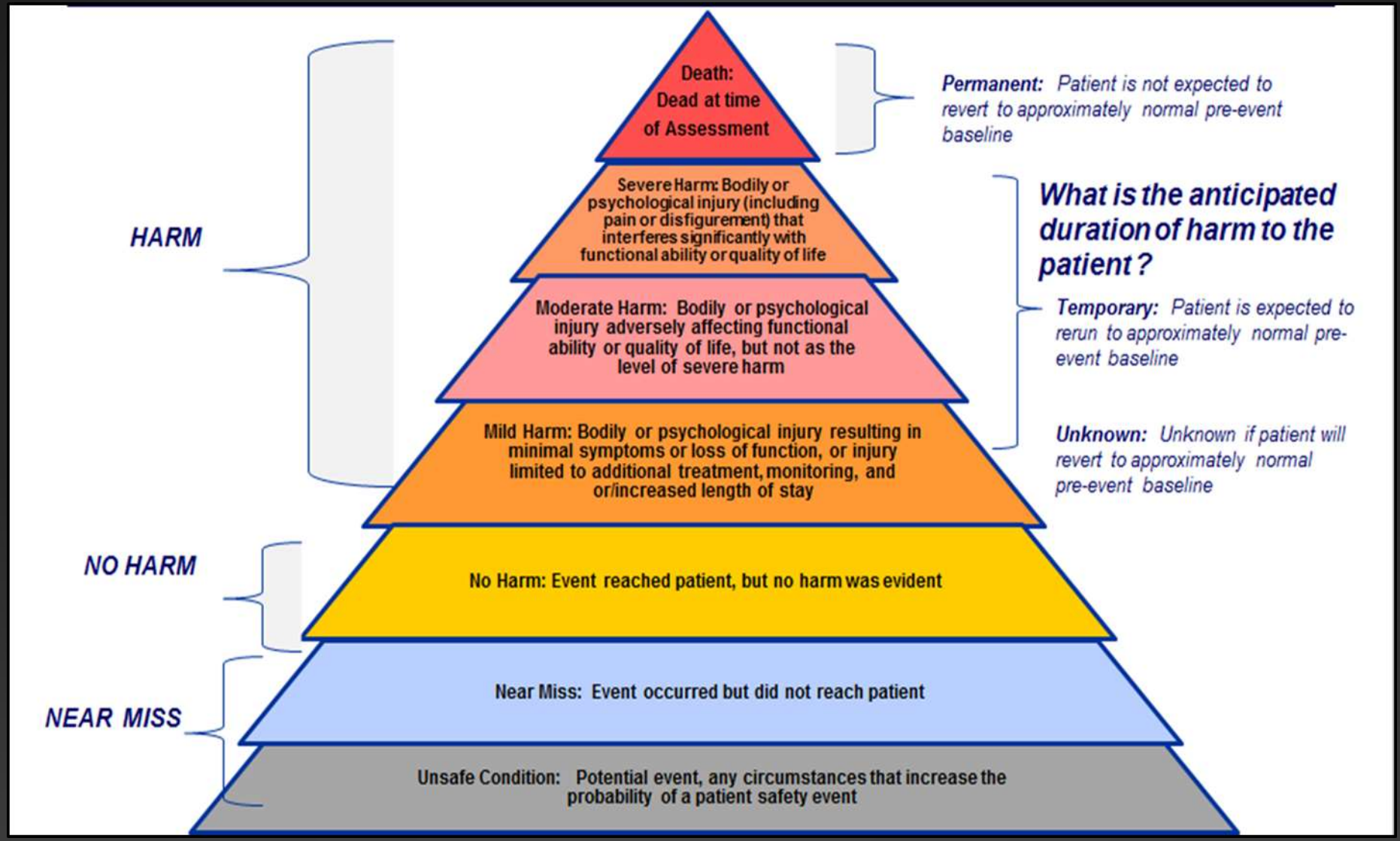
* Everett Rogers, *Diffusion of Innovation*

HRO – COMMUNICATION TOOLS

- Tools
  - Structured handoffs
  - Closed Loop Communication
  - Clarifying Questions

DIFFERENTIATE BETWEEN ZERO HARM AND ZERO ERROR.

Agency for Healthcare Research and Quality (AHRQ) Harm Scale



ICEBERG SAFETY THEORY

Accidents are only the tip of the iceberg!

For every accident there are 600 errors and/or unreported occurrences

Sentinel Event

Temporary Harm

Unsafe conditions or Near miss

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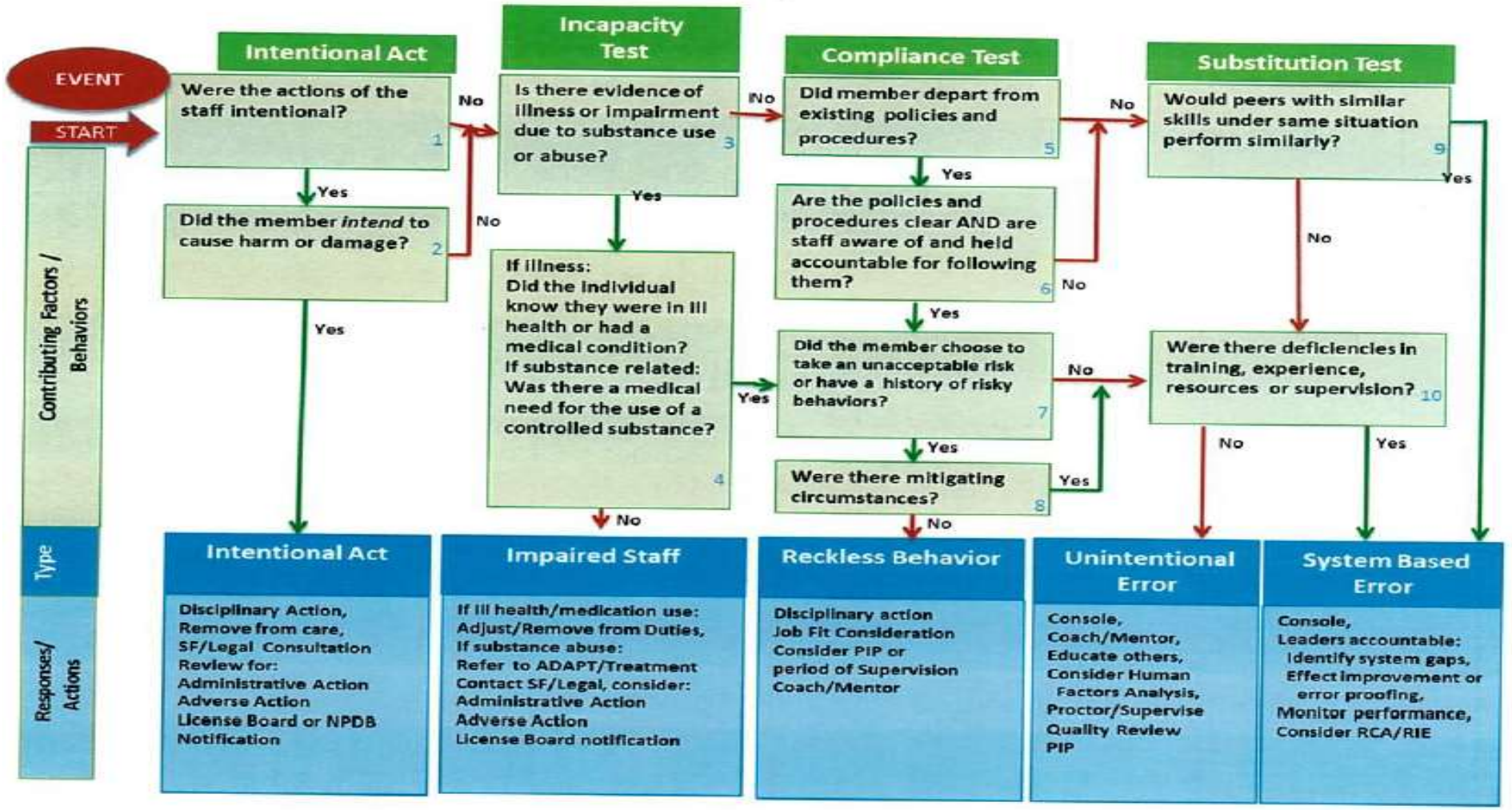
AFMS Just Culture Algorithm

Modeled after *Reason, A Decision Tree for Determining the Culpability of Unsafe Acts* (1997)



Unintentional Error: During mid-morning rush pharmacy technician miss-counts maintenance refill for one patient.

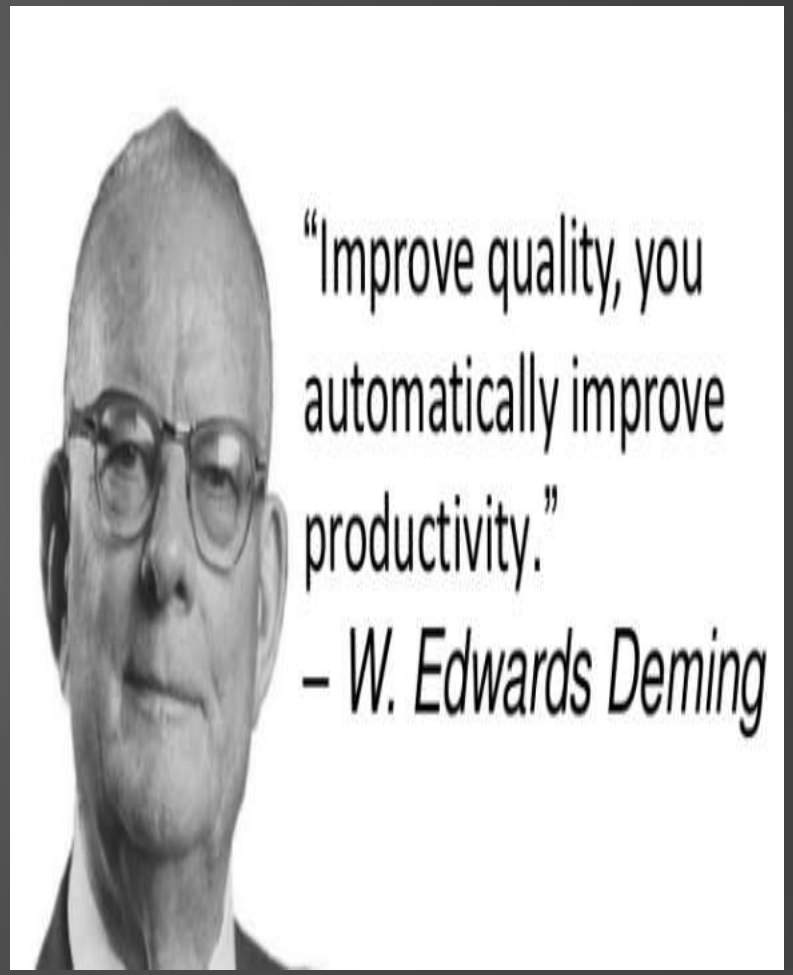
At-Risk Behavior: Pharmacy Technician dispenses wrong medication to patient because they didn't verify full name and DOB

Reckless Behavior: Pharmacy technician has been caught multiple times on their phone while at work. The potential risk to the patient and their career has been explained. It leads to a dispensing error and significant patient harm.


„Failure is the limit of my abilities“
FIXED MINDSET
„I‘m either good at it or I‘m not“
„My abilities are unchanging“
„I don‘t like to be challenged“
„I can either do it, or I can‘t“
„My potential is predetermined“
„When I‘m frustrated, I give up“
„Feedback and criticism are personal“
„I stick to what I know“
„Failure is an opportunity to grow“
GROWTH MINDSET
„I can learn to do anything I want“
„Challenges help me to grow“
„My effort and attitude determine my abilities“
„Feedback is constructive“
„I am inspired by the success of others“
„I like to try new things“

Apply the tools outlined in the presentation to real life patient safety scenarios.

Deferring to the Quality Improvement Experts



What is Lean Six Sigma?

Lean

- Removes Waste
- Increases Speed
- Removes non-value added process steps
- Fixes connections between process steps
- Focuses on the customer

Six Sigma

- Reduces Variation
- Improves Quality
- Reduces variation at each remaining step
- Optimizes remaining process steps
- Focuses on the customer

Speed + Accuracy =

Better Delivery | Better Quality | Satisfied Employees | Satisfied Customers

https://ucsandiegoextensionbiz.files.wordpress.com/2013/02/uc-san-diego-extension-lean-six-sigma-black-belt-information-session1.jpg

“Keeping It Simple” Four Step Process Improvement

1. The Pharmacy team needs to identify the problem or what are we trying to improve?

2. Team will determine the reasons (Root Causes) why the problem exists or performance targets are being missed?

Goal	ACTIONS	OWNER

Based on data collection and review, place causes in order of importance, impact and feasibility?

Pharmacy Scenario

1. **The Pharmacy team needs to identify the problem or what are we trying to improve?**

The Pharmacy Team at Always Safe Pharmacy has noticed an increase in patient wait times and dispensing errors on weekdays from 3:00pm to 5:00pm.

The increase in wait times has led to numerous customer complaints and the dispensing errors have led to potential patient harm.

Always Safe Pharmacy Staffing Levels

1. **One full time Pharmacist**

2. **Two full time technicians**

Always Safe fills and dispenses 100 prescriptions per day and 35% of the volume is dispensed between 3:00pm and 5:00pm.

Pharmacy Scenario

2. Team will determine the reasons (Root Causes) why the problem exists, or performance targets are being missed?

- **The Pharmacy Team tracked prescription edits and provider "Cross Check" for one month and discovered the following.**

  Clinic A accounts for 25% of their daily volume BUT also is contributing to 50% of the edits and "Cross Checks" completed by Always Safe.

  Clinic B accounts for 15% of their daily volume BUT also is contributing to 20% of the edits and "Cross Checks" completed by Always Safe.

- **The Pharmacy Team looked at staffing ratios during that time and realized Tech B left at 3:30pm daily for evening college classes.**

The Always Safe determined time spend doing prescription edits and inadequate staffing at peak times were contributing to their wait times and dispensing errors.

Pharmacy Scenario

3. Based on data collection and review, place causes in order of importance, impact and feasibility?

The Always Safe Pharmacy determined that both prescription edits and staffing levels were equally as important.

- **The team contacted both clinics and discovered that providers weren't receiving the feedback regarding prescription edit volume and how it negatively affected the pharmacy.**
- **Always Safe Pharmacy Management armed with the data collected by the Pharmacy Team understood how inadequate staffing affected the Quality and Safety of their service.**

Pharmacy Scenario

4. The Team develops Goals, Corrective Actions and Owners to ensure follow through on new processes.

The Always Safe Pharmacy will continue to track all prescription edits and "Cross Checks". This information will be submitted to all clinic mangers in the community to ensure proper review and dissemination. ***(Owners: Pharmacist and Pharmacy Technician Staff)***

- **The Always Safe Pharmacy is busy and will track their data in their daily/weekly huddle.**
- **The goal is to reduce edits by 50% over 90 days and free up time for staff during peak times.**

Always Safe Pharmacy Management will start interviewing new hire candidates and specifically ensuring their schedule permits working during peak pharmacy hours.

The team to plan for the unexpected.

Allow team members' needs and expectations to be met.

Creates a safe place for new employees

Thank you for your time today and for keeping our patients safe.

- **We Want Your Thoughts…**
- **What did you like about the session today?**
- **What could have made this session better?**
- **What will you do differently tomorrow based on what you learned today?**
- **Please complete and submit your evaluation form prior to leaving.**