SMART Medication Safety Agenda

Drug Shortage

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The Community Pharmacy Incident Reporting (CPhIR) program is designed for you to report and analyze medication incidents that occurred in your pharmacy. You can learn about medication incidents that have occurred in other pharmacies through the use of the SMART Medication Safety Agenda.

The **SMART** (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-based) Medication Safety Agenda consists of actual medication incidents that were anonymously reported to the CPhIR program. Potential contributing factors and recommendations are provided to you and your staff to initiate discussion and encourage collaboration in continuous quality improvement. By putting together an assessment or action plan, and monitoring its progress, the SMART Medication Safety Agenda may help reduce the risk of similar medication incidents from occurring at your pharmacy.

How to Use the SMART Medication Safety Agenda

1. Convene a meeting for your pharmacy team to discuss each medication incident presented (p. 2).
2. Review each medication incident to see if similar incidents have occurred or have the potential to occur at your pharmacy.
3. Discuss the potential contributing factors and recommendations provided.
4. Document your team's assessment or action plan to address similar medication incidents that may occur or may have occurred at your pharmacy (Table 2).
5. Evaluate the effectiveness and feasibility (Table 1) of your team's suggested solutions or action plan.
6. Monitor the progress of your team's assessment or action plan.
7. Enter the date of completion of your team's assessment or action plan (Table 2).

Table 1.
Effectiveness and Feasibility

Effectiveness:

Suggested solution(s) or action plan should be system-based, i.e. shifting a focus from "*what we need to do …*" to "*what we can do to our environment to work around us.*"

1. **High Leverage – most effective**
   - Forcing function and constraints
   - Automation and computerization
2. **Medium Leverage – intermediate effectiveness**
   - Simplification and standardization
   - Reminders, checklists, and double checks
3. **Low leverage – least effective**
   - Rules and policies
   - Education and information

Feasibility:

Suggested solution(s) or action plan should be feasible or achievable within your pharmacy, both from the perspectives of human resources and physical environment.

1. Feasible immediately
2. Feasible in 6 to 12 months
3. Feasible only if other resources and support are available

Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada

CMIRPS Canadian Medication Incident Reporting and Prevention System
SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan

Si Safety. Improvement. Quality.

Drug Shortage

Incident Examples:

- **Incorrect Directions on Medication Bottles**
  Since Avalide® (irbesartan and hydrochlorothiazide) 150/12.5 mg was back-ordered; the patient was given the 300/25 mg strength and was told to take half of a tablet. The Avalide® 150/12.5 mg tablets became available again, and so the prescription was reversed to the previous Avalide® 150/12.5 mg prescription. However, the directions were not changed, despite the fact that the pharmacist counselled properly on the directions for use. When the patient went home, she discovered that the directions on the bottle did not match with what the pharmacist had said.
- **Un-notified Brand Change**
  A pharmacy normally had Ventolin® in stock, but since it was back-ordered, Apo-Salvent® was ordered instead. The inhalers look different between the two brands, and the patient was not informed of the brand change. The patient went home and was worried that he/she received the wrong medication.

Potential Contributing Factors:

Drug shortages can lead to changes to a patient's prescription (e.g. generic-brand change, strength change). The extra steps added into the workflow introduce new opportunities for errors to occur and require extra caution. Also, the changes made to the prescription can lead to patient confusion in the absence of sufficient pharmacist-patient communication.

Recommendations:

- Independent double checks are effective preventative strategies for the latent errors that may arise as a result of drug shortages.[1]
- Counselling patients on the changes made to their prescription due to drug shortages will prevent misunderstanding, inappropriate use of the medication, and establish strong rapport.[2]
- A change in the patient's regular medication may cause confusion, hence follow-up and monitoring is crucial to ensure patients are adhering to their medications and not suffering from adverse effects as a result of these changes.[2]

[1] ISMP Canada. Concerned Reporting: Lowering the Risk of Medication Errors: Independent Double Checks. *ISMP Canada Safety Bulletin* 2005 Jan;5(1):1-2. Available from: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2005-01.pdf

[2] ISMP Canada. Concerned Reporting: Mix-ups Between Bisoprolol and Bisacodyl. *ISMP Canada Safety Bulletin* 2012 Aug 30;12(9):1-6. Available from: http://www.ismp-canada.org/download/safetyBulletins/2012/ISMPCSB2012-09-ConcernedReporting-BisoprololandBisacodylMixups.pdf

Table 2.
Assessment / Action Plan

Effectiveness:

- ☐ Forcing function and constraints
- ☐ Automation and computerization
- ☐ Simplification and standardization
- ☐ Reminders, checklists and Double checks
- ☐ Rules and policies
- ☐ Education and information

Feasibility:

- ☐ Feasible immediately
- ☐ Feasible in 6 to 12 months
- ☐ Feasible only if other resources and support are available

Progress Notes

Date of Completion: