COMPASS
Community Pharmacy Professionals
Advancing **Safety** in Saskatchewan

[directions]

COMPASS Program Newsletter Volume Four / Issue Four October 2019

Quality Improvement Reviews (QIRs) Are Coming!

Within the next month, the Saskatchewan College of Pharmacy Professionals (SCPP) will be starting Quality Improvement Reviews (QIRs). During the QIRs, the field officers will be reviewing the pharmacy's quality improvement activity, along with other areas. If pharmacies have not kept up to date on reporting incidents or haven't yet completed their Medication Safety Self-Assessment (MSSA), now is a good time to catch up or complete these activities. If Quality Improvement (QI) Coordinators, pharmacy managers or pharmacy staff have any questions about QIRs, quality improvement activities or any of the tools used for COMPASS, they can contact Jeannette Sandiford at **info@saskpharm.ca** or 306-584-2292.

Medication Safety Culture Indicator Matrix (MedSCIM)

One of the assessment tools used during the QIR process is MedSCIM. It was developed by ISMP Canada to be able to assess the completeness and maturity of reported medication incidents. During the QIR process, field officers will be assessing the narratives of medication incidents of the pharmacy to determine the pharmacy's safety culture towards medication incident reporting.

Prior to the QIR, the field officers will be requesting approximately 5-10 incidents to review and provide feedback to the pharmacy team during the QIR. An additional 5-10 incidents will be assessed during the QIR. More information regarding the MedSCIM tool can be found in the **October 2018 edition of [directions]**. If there are any questions regarding this assessment tool, please contact Jeannette Sandiford at the SCPP office.

Shared Learning Opportunity

Incidents that Occurred Due to Communication Gaps

Patient Communication Example

Pharmacy staff members are one of the last points of contact between the healthcare system and the patient. When verifying prescriptions, pharmacists are expected to provide the necessary counselling so patients can use their medications safely. The following incidents were identified, which might have resulted from inadequate confirmation of patient understanding despite counselling. In addition, patient requests for refills and other patient encounters might have resulted in harm incidents when information gathering was incomplete and/or assumptions were made.

Miscommunication During Patient Encounters or Patient Counselling

Incident Example One

A patient was taking Gabapentin 100 mg three capsules twice daily. A new prescription was filled with 300 mg capsules instead. The pharmacist documented the change and left a note for the cashier to inform the patient. The patient did not recall being informed. The patient took three 300 mg capsules twice daily and noticed adverse effects. The error was discovered when an early refill was requested.

Incident Example Two

Patient dropped off a new prescription of an anti-depressant with a dose increase. When requesting for a refill, the patient asked the staff to refill "the two medications." The staff saw the two strengths of the anti-depressant and refilled both. The patient received both strengths of the anti-depressant while the anti-hypertensive medication was omitted.

As the one constant throughout their journey in the healthcare system, patients themselves can act as the last layer of protection against preventable harm from medications. The IDEA framework (which stands for **I**ndication, **D**uration, **E**ffect and **A**dverse Effects) or the "show and tell" technique can both be implemented during counselling to enhance patient understanding and medication safety. To improve completeness of information gathering, standardizing the process, such as the use of the Best Possible Medication History (BPMH) approach, can be used. Similarly, information gathering during any patient encounters at community pharmacies can also be standardized to include key questions, such as confirming the indication and name of the medication to be dispensed, etc.

One of the goals of COMPASS is to promote shared learning between Saskatchewan pharmacies regarding incidents, unsafe practices and other important issues to improve pharmacy care in Saskatchewan. One way to promote shared learning would be to report an interesting incident/error that occurred within your pharmacy. If your pharmacy has had an incident that would be a good learning opportunity for other Saskatchewan pharmacies, please forward it to SCPP Medication Safety at info@saskpharm.ca. Any information regarding the pharmacy and the person who provided the details of the incidents/errors will be kept anonymous. The College encourages open sharing of incidents/errors so everyone can learn from them.

Parts of the above information was reprinted from ISMP's Canada Report – COMPASS Harm Incidents Qualitative Analysis – July 2019 (page 4).

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **13,670** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and August 31, 2019.

Incident Types

Of the 13,670 incidents, the top three types were:

- incorrect dose/frequency – **3,197**
- incorrect quantity – **2,439**
- incorrect drug – **2,332**

Outcomes

The majority or **7,768** of incidents reported had an outcome of NO ERROR, which means the incidents were intercepted BEFORE they reached the patient.

There were **5,519** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.

382 reported incidents did result in HARM, with most of these in the category of MILD HARM.

As well, **360** pharmacies have either completed or started their Medication Safety Self-Assessment (MSSA) online data entries and **240** Continuous Quality Improvement (CQI) meetings have been held.

Be a Part of Canadian Patient Safety Week

Canadian Patient Safety Week occurs from **October 28 – November 1, 2019**.

During Canadian Patient Safety Week, the Canadian Patient Safety Institute (CPSI) focuses on medication safety, with the goal of reducing medication errors across Canada. The theme this year is **Conquer Silence**.

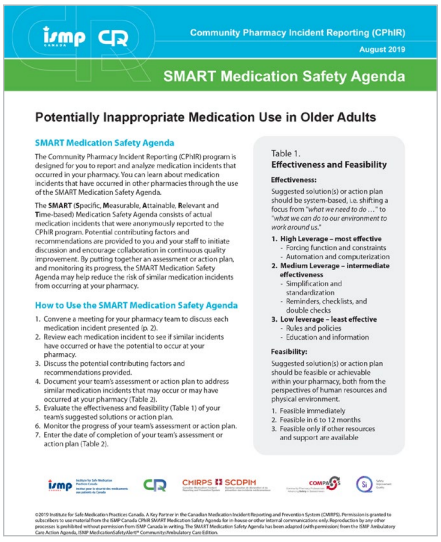
The Canadian Patient Safety Institute states that in our collective efforts to reduce patient harm, what we must battle systemic silence – silence between patients and providers, between colleagues in healthcare facilities, between administrators in different regions, and between the public and policymakers. If something looks wrong, feels wrong, or is wrong – we need people to speak up, in the moment. It is only by bringing these issues to light that we can begin to work together to solve them.

Saskatchewan community pharmacies are encouraged to participate in Canadian Patient Safety Week to show that patient medication safety is a priority within community pharmacies.

By registering for Canadian Patient Safety Week, the pharmacy has access to a free communications toolkit, promotional products and the ability to download free digital resources. There are also other activities during the week including webinars and podcasts. For registration, click **here**.

The SMART Medication Safety Agenda

The SMART Medication Safety Agenda was introduced by the Institute of Safety Medication Practices Canada (ISMP Canada) to increased shared learning amongst pharmacies. The SMART Medication Safety Agenda deals with a specific drug or process within a community pharmacy and the incidents that have occurred with that drug or process. The SMART (Specific, Measurable, Attainable, Relevant and Time-based) Medication Safety Agenda consists of actual medication incidents that have been anonymously reported into the Community Pharmacy Incident Reporting (CPhIR) program. Potential contributing factors and recommendations are provided for users to initiate discussion and encourage collaboration towards continuous quality improvement in the pharmacy. By putting together an assessment or action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar medication incidents in the pharmacy.


Community Pharmacy Incident Reporting (CPhIR)
August 2019
SMART Medication Safety Agenda
Potentially Inappropriate Medication Use in Older Adults
SMART Medication Safety Agenda
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 (Specific, Measurable, Attainable, Relevant and Time-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

The topic of the latest edition of the SMART Medication Agenda is **Potentially Inappropriate Medication Use in Older Adults**. All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under **COMPASS Newsletters**.

CPhIR Newsletter

One of the services ISMP Canada provides on its website are bulletins that highlight safety issues relating to community or hospital pharmacy practices. These bulletins are valuable tools in bringing different safety issues to light to help prevent the occurrence in other pharmacy practices. One of these ISMP Canada safety bulletins is the CPhIR newsletter. The topic of the most recent edition is **Aftermath of a Medication Incident: Caring for the Patient, the Family, but also the Healthcare Professional**. The newsletter can be accessed by logging into the CPhIR program and clicking on the link on the home page.

Pharmacy staff members are encouraged to review this newsletter, as well as the other newsletters available through the CPhIR site.

Contact Information

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