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

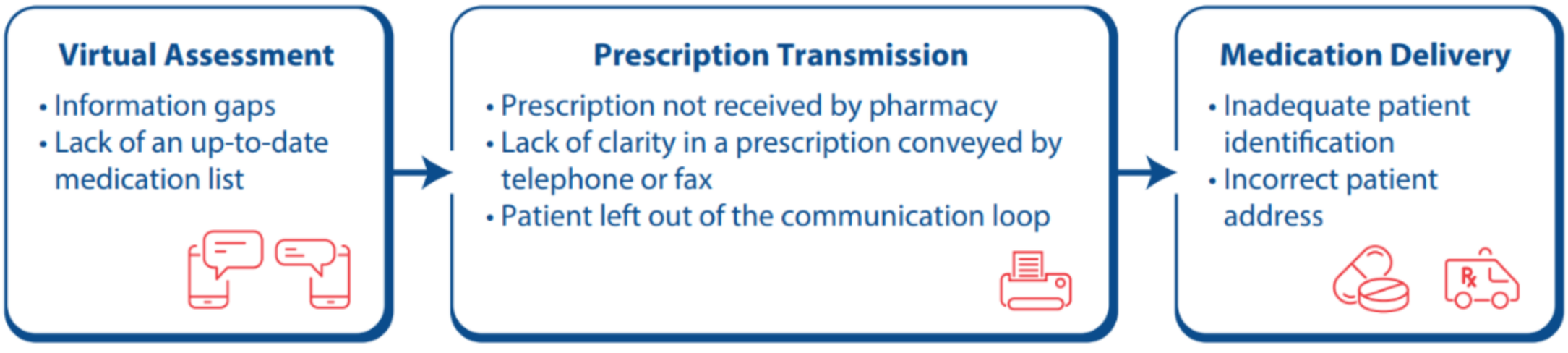
[directions]

COMPASS Program Newsletter Vol. 8 Issue 2 **May 2023**

Optimizing Medication Safety in Virtual Primary Care

During the COVID-19 pandemic, virtual care has allowed many Canadians to access health care remotely. The growth of virtual care has also highlighted the need to optimize the safety of this approach to care. This bulletin shares findings from an analysis of a cluster of medication incidents that occurred during the provision of virtual primary care. Areas of vulnerability identified in the analysis are described in Figure 1. Recommendations are made to inform continuous improvement.

Figure 1. Areas of vulnerability identified in an analysis of virtual primary care–related medication incidents.



Key Recommendations

- Confirm current medication use with the patient before prescribing or renewing medications.
  - The patient can contact their community pharmacist for a virtual medication review, before the appointment, to obtain an up-to-date medication list.
- Consider implementing a “virtual waiting room” where a nurse or pharmacist completes a best possible medication history with the patient and updates the medication list just before the appointment.
- Continue to use strategies to support safer transmission and receipt of telephone orders, such as allowing sufficient time to state the order clearly and for the person receiving it to read it back.
- Consider a communication mechanism for patients to be kept informed of the progress of the prescription filling process. For example, some pharmacies have an auto-text service to inform patients when their prescription is ready for pick-up.
- Confirm two patient identifiers (e.g., name and address) before delivery of medications, both at the pharmacy and again at the patient’s home.

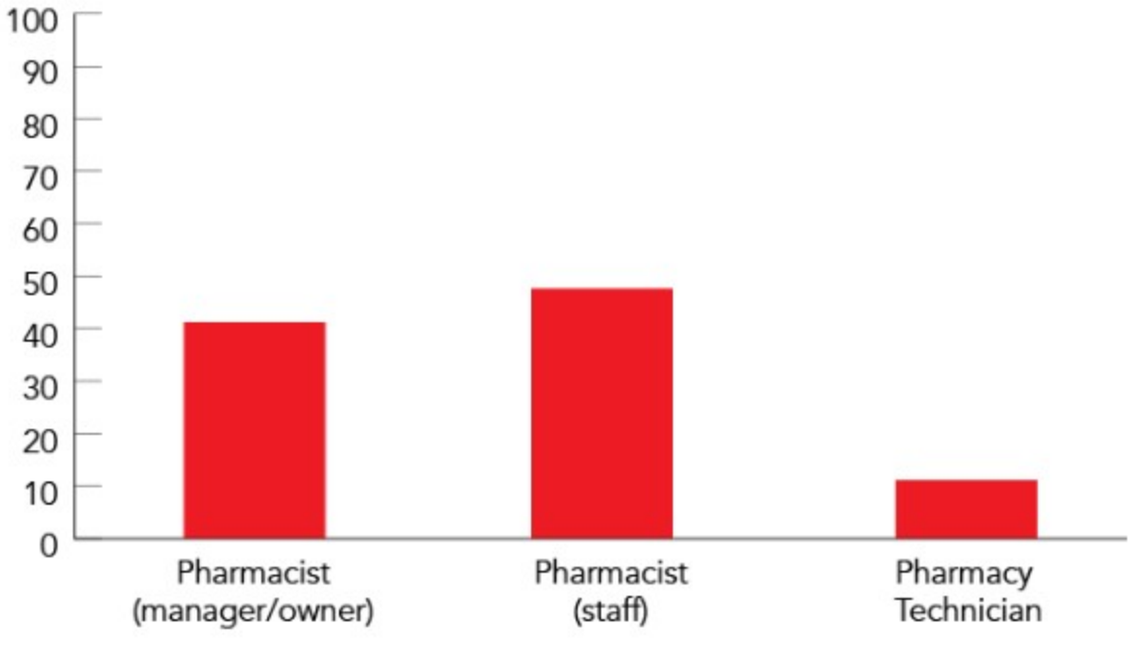
This analysis identified vulnerabilities and improvement strategies for medication safety in virtual care assessments, prescription transmission, and medication delivery. Although some of the findings may not be unique to virtual care, they reflect the experiences with new technologies and approaches, and demonstrate how shared learning can be used to inform continuous improvement.

Read the full bulletin for more details.

Safety Attitudes Questionnaire (SAQ) Response Results

During the month of March, pharmacists and pharmacy technicians were asked to complete a Safety Attitudes Questionnaire (SAQ). The SAQ is used to evaluate the advancement in the culture of safety within community pharmacies. There were **1357** emails sent out; 1218 to pharmacists and 139 to pharmacy technicians. There were **378** responses, for a response rate of **28 per cent**. The breakdown of the number and response rates for pharmacists and pharmacy technicians are below.

The information that is collected during the SAQ is invaluable in both identifying trends within pharmacies and providing useful information on ways that SCPP can assist pharmacies advance their culture of safety.



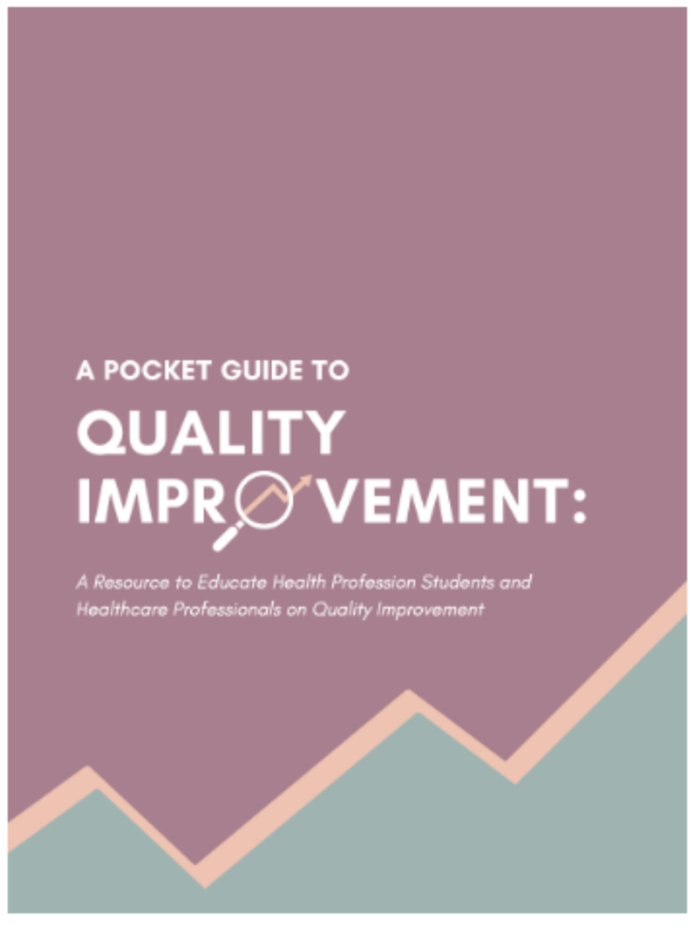
The Safety Attitudes Questionnaire (SAQ) is a validated tool for assessing safety culture. It has approximately 40 questions and consists of six main factors: teamwork climate, job satisfaction, perceptions of management, safety climate, working conditions, and stress recognition.

Thank you to all the pharmacists and pharmacy technicians that responded to the SAQ survey, the responses you provided are greatly appreciated. Please watch for the results of the SAQ in a subsequent [directions] newsletter.

Safety Resources

Keeping up with QI for Health Care Professionals: Bite-sized Resources and Communities for Collaboration

Continuous quality improvement empowers health care professionals to achieve higher quality health systems. There have been a number of resources developed by PharmD students from the Leslie Dan Faculty of Pharmacy at the University of Toronto and led by Dr. Certina Ho in order for health care professionals to understand the continuous quality improvement initiative by breaking them down into bite-sized resources. The first of the resources is the **Online Pocket Guide to Quality Improvement**.



The Online Pocket Guide to QI is a series of infographics that take you through how to define, plan, and conduct a QI project. In less than 15 minutes, you can find the answers to common questions such as “What is the difference between quality improvement and quality assurance?” or “How do we measure quality improvement?”

Over the next few [directions] newsletters, other resources will be introduced. Watch for more of these great resources.

SMART Medication Safety Agenda

The topic of the latest edition of the SMART Medication Agenda is **Preventable Drug-Drug Interactions**. All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.

Shared Learning Opportunity

Incorrect Dose / Frequency Due to Lack of Staff Education

During the course of preparing methadone doses, the pharmacist noticed that a patient who had missed three consecutive doses of methadone, had been provided two subsequent doses without review or assessment by the prescriber.
When the patient was contacted, they indicated that they were feeling fine, but had slept heavier than normal. When the staff were discussing the incident, the lack of knowledge of the differences between methadone and suboxone thresholds for missed doses that required review by the prescriber was indicated as one of the reasons for the error.

Upon review of the incident by the pharmacy staff, it was determined that the error occurred at the administration stage due to a lack of pharmacist education and outdated/absent resources. The main contributing factors that led to the incident occurring were identified as (1) environmental factors, specifically workload and (2) staff education issue, specifically the lack of knowledge of the difference between methadone and suboxone thresholds for missed doses that require the review and assessment by the prescriber.

The system-based solutions that were recommended were:

1. To share the details of the incident with all pharmacy staff, so they are all aware.
2. To review the missed dose protocol for both methadone and suboxone at a staff meeting.
3. To post the algorithm for missed doses in the methadone logbook for easy reference.
4. To ensure that all pharmacists review the OAT standards, specifically around missed doses and the protocol when this occurs.

For more information on methadone errors see the following link to a short presentation on the CPhIR website titled Incidents Involving Methadone- A Multi-Incident Analysis and ISMP Canada article – Methadone – Not Your Typical Narcotic.

This incident was reported here with the involvement and permission of the Saskatchewan community pharmacy.

We want to hear from you!

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.

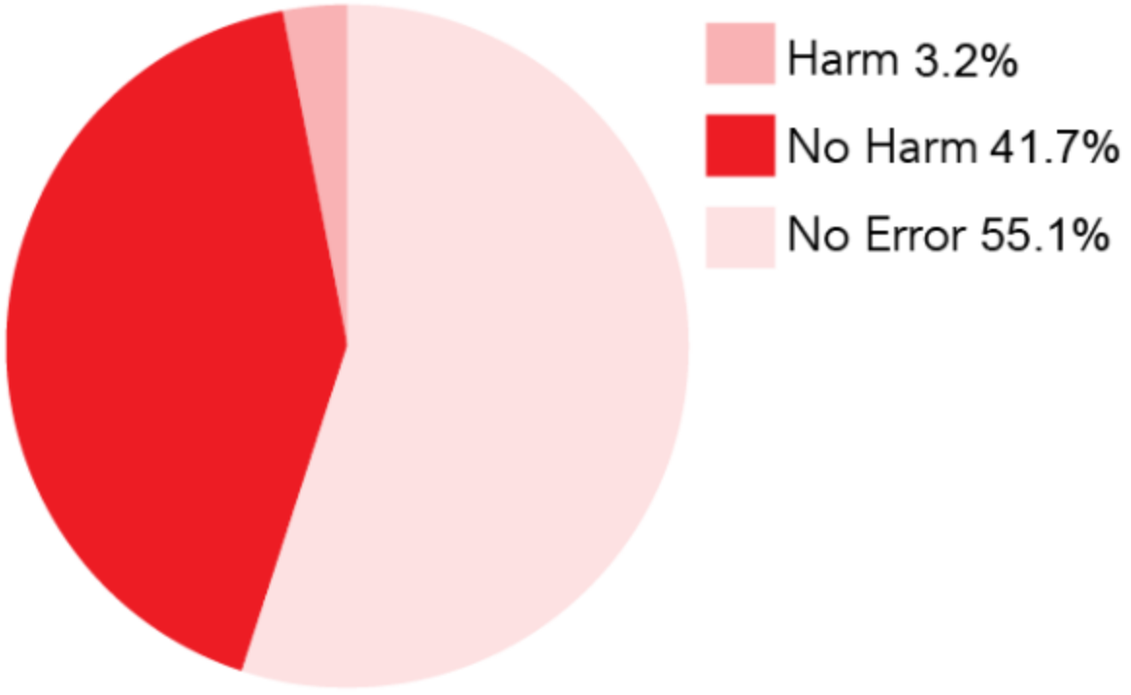
One way to promote shared learning would be to report a noteworthy incident/error that occurred within your pharmacy. If your pharmacy has had an incident that would be a good learning opportunity for other Saskatchewan pharmacies, please forward it to SCPP Medication Safety at info@saskpharm.ca.

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.

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **42,424** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **Sept. 1, 2013**, and **March 31, 2023**.

The statistics below relate to this time period.



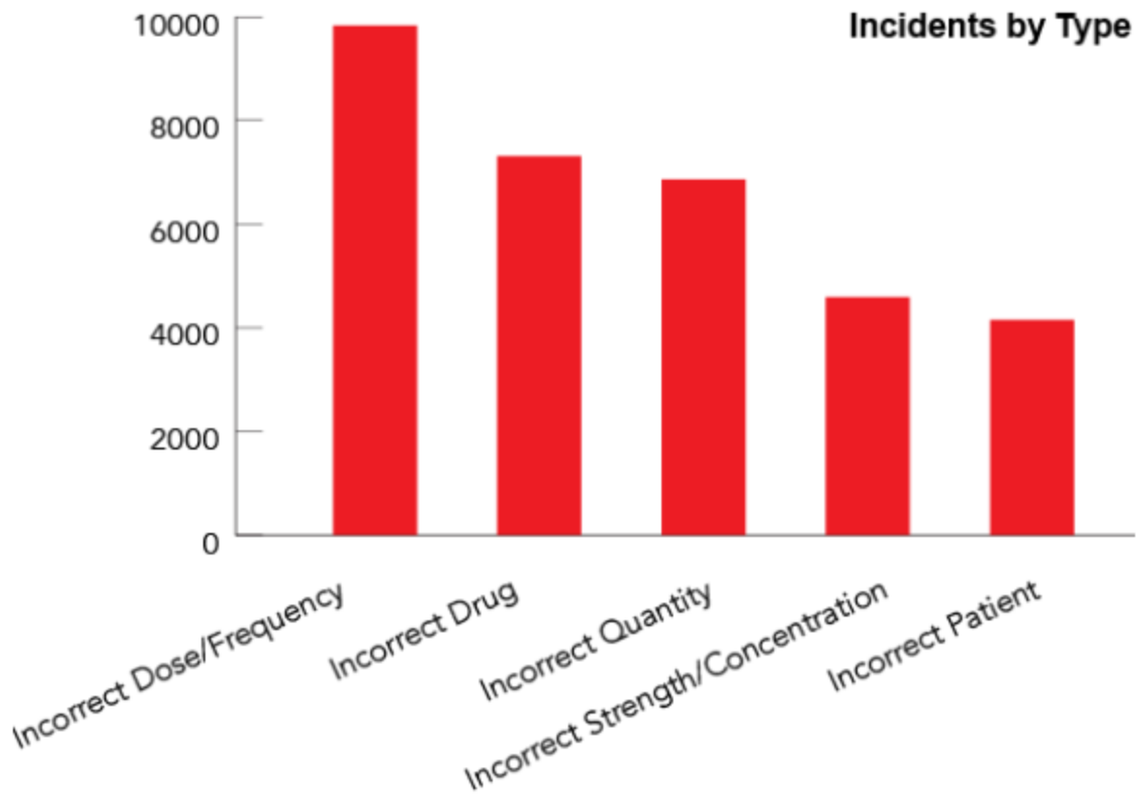
Outcomes

- 23,368 reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- 17,672 reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.

- 1,359 reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been four incidents reported with an outcome of DEATH.

Incident Types – Top Five

- Incorrect Dose/Frequency – 9,829
- Incorrect Drug – 7,308
- Incorrect Quantity – 6,859
- Incorrect Strength/Concentration – 4,592
- Incorrect Patient – 4,151



Contributing Factors – Top Five

- Interruptions – 5,512
- Workload – 4,262
- Look / Sound Alike Names – 2,276
- Noise – 2,179
- Staffing Deficiencies – 2,177

Additional Notes:

- 417 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.
- 1,614 Continuous Quality Improvement (CQI) meetings have been held.

Contact

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MSSA: ISMP Canada mssa@ismp-canada.org

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