View online

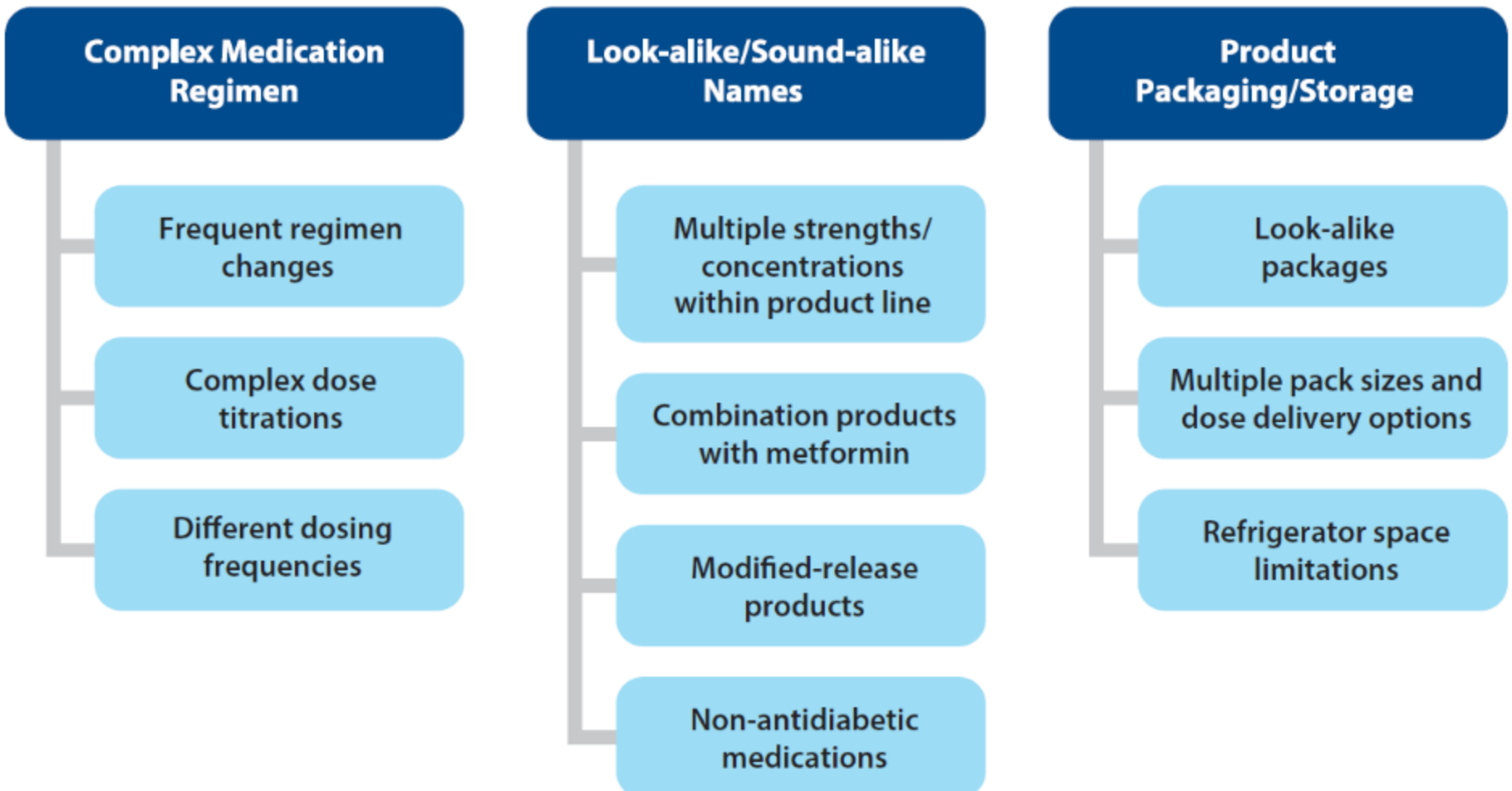
[directions]

COMPASS Program Newsletter Vol. 8 Issue 3 July 2023

Newer Classes of Medications for Diabetes Treatment: A Multi-Incident Analysis of Reports from the Community Pharmacy Setting

Diabetes management is complex, necessitating monitoring and frequent medication changes to achieve optimal glycemic targets. Safety efforts related to diabetes treatment have focused on insulin and older antihyperglycemic agents; errors related to the newer classes of oral and subcutaneous injectable agents are now being reported. This bulletin is focused on an analysis of community pharmacy incidents involving newer classes of medications for diabetes treatment and offers strategies to prevent errors.

The multi-incident analysis identified three themes and several subthemes.



This thematic analysis highlights errors related to DPP-4 inhibitors, SGLT2 inhibitors, and GLP-1 receptor agonists occurring in the community pharmacy setting and shares selected safety tips. Key considerations include modifying pharmacy software display for look-alike product names, implementing barcode scanning technology in pharmacy processes, organizing refrigerator space to ensure separation and visibility of products and individual prescriptions, and reviewing label instructions with patients at prescription pick-up to ensure the information matches what the patient expects to receive.

Pharmacy teams are encouraged to review their own incidents, in addition to the learning from this analysis, to guide improvements to their medication-use process. Read the bulletin to learn more about the analysis' findings and safety tips to minimize errors.

Pharmacy Manager QIR Surveys

Evaluating the effectiveness of the Quality Improvement Review (QIR) is an important part of the COMPASS program.

In order to ensure that QIRs are useful for the pharmacy manager, a QIR Pharmacy Manager survey was implemented at the same time that COMPASS became a requirement in SK community pharmacies. After each QIR a survey link is sent to the pharmacy manager to complete. The survey is voluntary and we have had a good response from pharmacy managers so far, but we would encourage all pharmacy managers to complete the survey.

Through pharmacy managers providing their continuing feedback regarding the QIR, SCPP is better able to refine the QIR process to ensure it is useful for both pharmacies in continuing safe practice and SCPP in maintaining the quality of the review.

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 was the Online Pocket Guide to Quality Improvement which was presented in the May edition of [directions]. The next resource is the QI Microlessons Playlist.

The QI Microlessons Playlist is a group of six short YouTube videos that highlight a playlist with microlessons on QI concepts. The topics of the videos are:

1. Defining Quality Defining a QI Project: QI vs QA
2. Planning a QI Project: Identifying a Quality Gap
3. Planning a QI Project: QI Tools
4. Conducting a QI Project: The Model of Improvement
5. Conducting a QI Project: The PDSA Cycle

The videos are very useful for providing general information and as an introduction to Quality Improvement concepts.

Watch for more of these great resources in upcoming [directions].

Shared Learning Opportunity

Incorrect Drug Due to Confirmation Bias

Upon review of a prescription filling, it was determined that a patient received NovoRapid instead of Novolin NPH insulin. The patient identified the error and contacted the pharmacy because the insulin that had been filled and picked up did not look like the insulin they usually take. The pharmacist that filled the prescription remembered hearing the patient indicate they wanted their Novo insulin and immediately thought of NovoRapid.

Upon review of the incident by the pharmacy staff, it was determined that the error occurred due to confirmation bias at the order entry step and, due to missing the DIN check during the filling step, the error was not caught. The main contributing factors that led to the incident occurring were identified as (1) miscommunication of drug order (misheard order), (2) look/sound-alike names, and (3) faulty drug identification.

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 separate the Novolin NPH from the NovoRapid in the fridge to prevent choosing the incorrect insulin.
3. To reinforce the need to follow the policy to check the DIN on every prescription fill.
4. To ensure that the DIN is written on the hardcopy to reinforce that the DIN has been checked.

For more information on errors due to look-alike packaging see the following link on the CPhIR website titled A Multi-Incident Analysis of Medication Incidents Related to Look-Alike Packaging.

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.

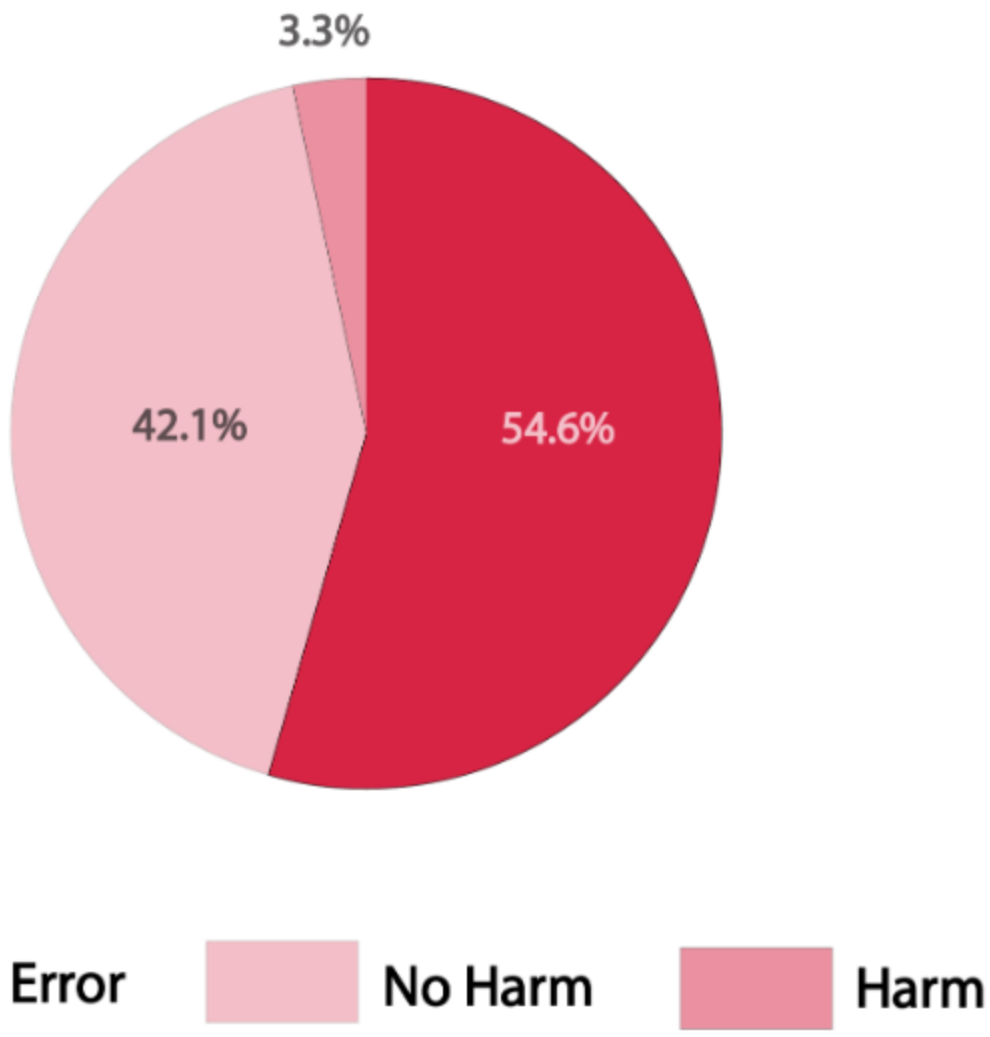
Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents.

A total of **43,811** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **Sept. 1, 2013**, and **June 30, 2023**. The statistics below relate to this time period.

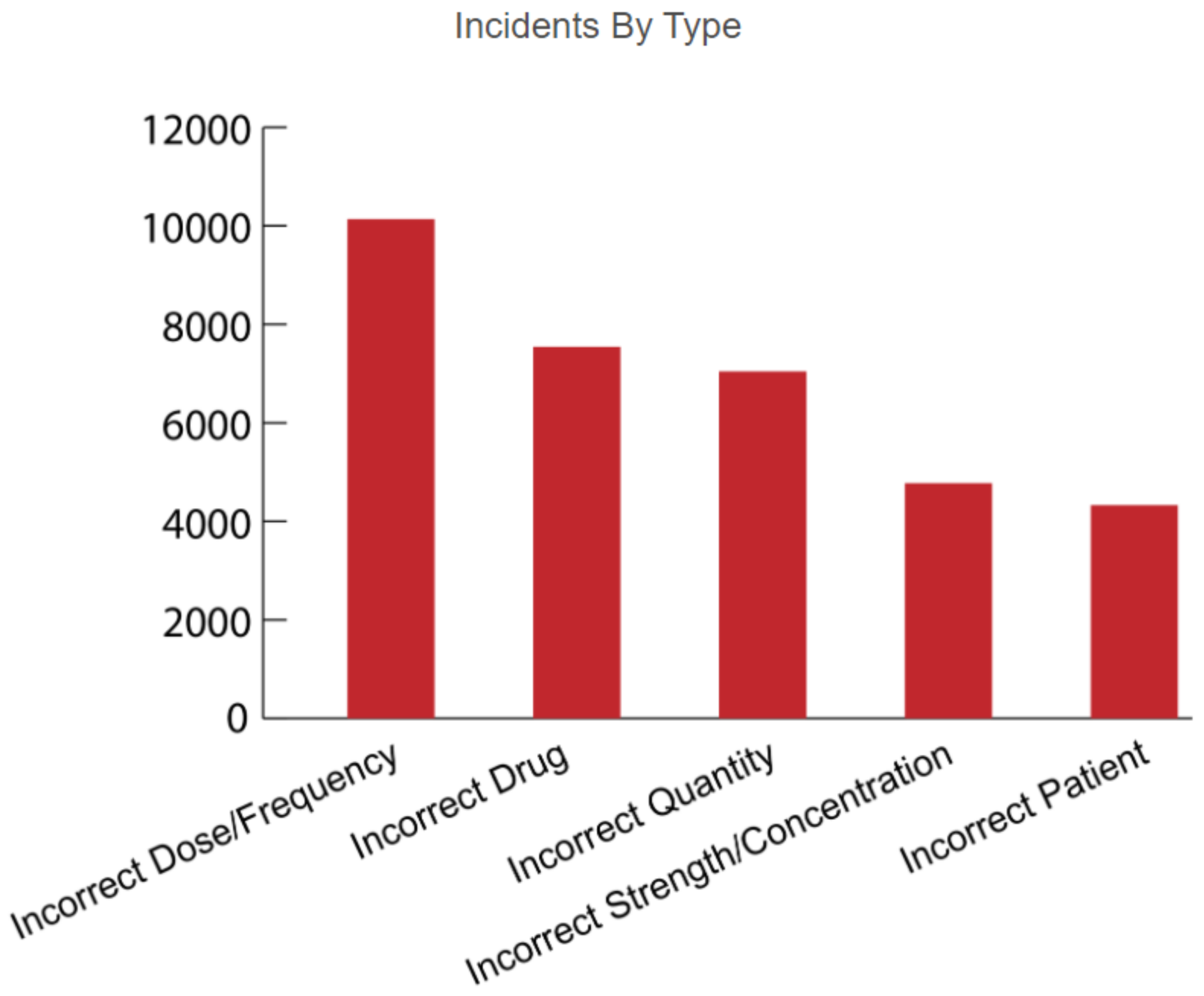
Outcomes

- **23,904** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **18,438** reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,441** 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 – **10,133**
- Incorrect Drug – **7,543**
- Incorrect Quantity – **7,042**
- Incorrect Strength/Concentration – **4,775**
- Incorrect Patient – **4,327**



417 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

1,721 Continuous Quality Improvement (CQI) meetings have been held.

Contributing Factors - Top Five

- Interruptions
- Workload
- Look / Sound Alike Names
- Noise
- Staffing Deficiencies

The SMART Medication Safety Agenda

The SMART (Specific, Measurable, Attainable, Relevant, and Time-based) Medication Safety Agenda was introduced by the Institute of Safety Medication Practices Canada (ISMP Canada) to increase shared learning amongst pharmacies.

Each edition of the newsletter deals with a specific drug or process within a community pharmacy and the related incidents that have occurred. The cases described are actual medication incidents anonymously reported into the Community Pharmacy Incident Reporting (CPhIR) program.


ismp CR
Community Pharmacy Incident Reporting (CPhIR)
May 2023
SMART Medication Safety Agenda
Immunosuppressive Agents
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
CHIRPS SCDPM

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.

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

Contact

COMPASS: Jeannette Sandiford, Assistant Registrar – Field Operations and Quality Assurance – jeannette.sandiford@saskpharm.ca

CPhIR: ISMP Canada: cphir@ismp-canada.org

MSSA: ISMP Canada mssa@ismp-canada.org

Technical Support (COMPASS): 1-866-544-7672

The profession of pharmacy is continually evolving. Information in past publications may likely be outdated, and it is vital and incumbent on pharmacy professionals to seek out the most updated version of SCPP policies, guidelines and bylaws in more recent publications, the news section, and the Reference Manual. SCPP emails and newsletters are official methods of notification to pharmacists and pharmacy technicians licensed by the College, providing you with timely information that could affect your practice. If you (Regulated members of a regulatory college) unsubscribe you will not receive important news and updates from the College, including mandatory requirements. Make sure you get the information you need to practise legally and safely by reading College newsletters and ensuring SCPP emails are not blocked by your system.