# SMART Medication Safety Agenda

## Order Entry

***One Click Away from a Medication Incident***

### 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** (**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.

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Table 2.

### Selection of Incorrect Medication

**INCIDENT EXAMPLE:**
A hospital discharge prescription for Prevacid (lansoprazole) was misinterpreted as Percocet (oxycodone/acetaminophen). After ingesting the incorrect medication, the patient required immediate medical attention in the emergency department.

**POTENTIAL CONTRIBUTING FACTORS:**
- Unclear or illegible prescription
- Confirmation bias due to look-alike/sound-alike medication names

**RECOMMENDATION:**
- Encourage prescribers to include on a prescription the medication's generic and brand names,[1] as well as the indication.[2]

### Missed Dose Change

**INCIDENT EXAMPLE:**
A new prescription for levothyroxine 125 mcg was entered by copying the patient's previous prescription record for levothyroxine 100 mcg. The necessary dose change, however, from 100 mcg to 125 mcg, was overlooked.

**POTENTIAL CONTRIBUTING FACTOR:**
- Inattentional blindness due to external factors (i.e., heavy workload, understaffing, distractions)

**RECOMMENDATIONS:**
- Limit the copy function to new prescriptions that are unchanged from the previous prescription in the patient's profile.[3]
- At pickup, open the bag containing the prescriptions and confirm the medications with the patient.[3]

### Miscalculated / Misinterpreted Dose

**INCIDENT EXAMPLE:**
A child was prescribed codeine 10-15 **mg**. The prescription was entered as 10-15 **mL** of a 5 mg/mL syrup. Before the error was recognized, the patient had ingested 75 mg (15 mL) of codeine – five times the prescribed dose of 15 mg.

**POTENTIAL CONTRIBUTING FACTOR:**
- Failure to verify weight-based dosing of high-alert medication for a child,[4] which is a never event in community pharmacy

**RECOMMENDATION:**
- Incorporate an independent double check to confirm dose calculations,[1] particularly unit conversions, to verify appropriate and safe dosing according to age, weight, and other patient factors.

### 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:

**References**
1. ISMP Canada Safety Bulletin. 2023;23(4):1-7.
2. ISMP Canada Safety Bulletin. 2004;4(2):1-2.
3. ISMP Canada Safety Bulletin. 2021;21(7):1-4.
4. ISMP Canada Safety Bulletin. 2021;21(3):1.