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COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan

[directions]

COMPASS Program Newsletter Vol. 8 Issue 4 **November 2023**

Confusion between Vaccine Expiry and Beyond-Use Dates Leads to Multi-Patient Incident

The COVID-19 vaccine product involved in this incident had 3 pertinent dates:

A manufacturer-assigned expiry date that was applicable so long as the product remained in the frozen state

A BUD of 30 days once the product was placed in the refrigerator for thawing and storage

A BUD of 6 hours once the vial was first punctured (i.e., when the diluent was added)

The introduction of vaccines to protect against COVID-19 was a turning point in the management of the pandemic. Knowledge about these products continued to evolve rapidly after they were made available, which resulted in frequent updates to stability and storage requirements and associated product labelling. These changing requirements created a challenging work environment for health care providers who were administering the vaccines. This bulletin shares learning from an analysis of a multi-patient incident involving administration of COVID-19 vaccines that were past their beyond-use date (BUD).

Incident Example

A health care organization in a small community was collaborating with the local public health unit to offer COVID-19 vaccination clinics. A nurse who was new to the organization was reviewing the vaccine supply and discovered that the available doses of vaccine were past their BUD. A subsequent review of vaccine administration records showed that more than 50 people had received the vaccine between 4 and 31 days past the BUD. Consultation by the incident management team with the vaccine manufacturer resulted in a recommendation for revaccination of about 40% of the individuals involved.

Key Contributing Factors

- Vaccine labelling and packaging
- Vaccine inventory management
- Availability of vaccine information

Select Recommendations

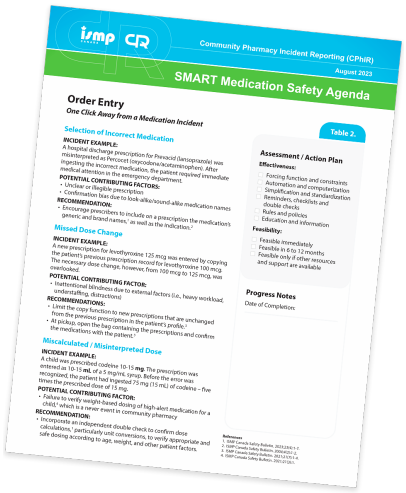
- Reduce the cognitive workload for staff involved in managing COVID-19 vaccines.
  - Develop concise practice aids/work instructions to support vaccine administration.
  - Develop a checklist for vaccine inventory management that includes BUD(s) check.

- Ensure training and supporting materials differentiate between expiry dates and BUDs.
- Implement a record system for tracking vaccine inventory.
- Implement an independent double-check process that includes a check of the BUDs during the vaccine selection, preparation, and administration steps.

All stakeholders involved in the production, distribution, preparation, and administration of new vaccines are encouraged to read the full bulletin to learn about the analysis findings and recommendations, available here.

Safety Resources

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.

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 Order Entry – One Click Away from a Medication Incident. All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.

Keeping up with QI for Healthcare Professionals: Bite-Sized Resources and Communities for Collaboration

Continuous quality improvement empowers healthcare 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 healthcare 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 presented in the April edition of directions. The next resource was the QI Microlessons Playlist, presented in the July edition of directions. The latest resource is the Leading with Quality Podcast series.

The podcasts are designed for early career healthcare professionals to learn about QI, medication safety, leadership, and business management. The guest speakers include U of T faculty members and clinical directors, discussing their QI and leadership experiences.

There are seven podcasts of varying lengths that discuss a variety of topics. All podcasts are available on Spotify.

Episodes	Duration (Minutes)
Falsified and Substandard Medications with Oksana Pyzik and Zubin Austin	18:30
Competency Framework with Oksana Pyzik and Zubin Austin	16:55
Developing and Implementing Clinical Pharmacy KPIs with Olavo Fernandes	35:45
Regulation of Pharmacy Technicians, A Project with Susan James	39:39
Choosing and Developing the Right People for Healthcare with Andrea Sweezy	22:50
Advancing Pharmacy Practice through Leadership with David Edwards	31:43
Straddling the Line between Academia and Industry with David Dubins	47:36

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

Canadian Patient Safety Week

– October 23 -27

The theme of the Canadian Patient Safety Week this year was:

Small Changes
Big Impact
Safer Care

“Change is possible. Join in exploring how even small changes can have a big impact when it comes to safer care. Small things like asking questions, engaging in safety discussions, and acting proactively.”

To access the resources in order to explore a new approach to safer care and how we can all make an even bigger difference every day, click here.

Shared Learning Opportunity

Incorrect Strength Due to Staff Education and Workflow Problem

A patient attended the pharmacy and requested a refill of their gliclazide MR 60mg twice daily prescription. The patient did not have any refills on their prescription. An older logged prescription for gliclazide MR 30mg, 3 tablets once daily was noted on the patient profile and filled by the pharmacy staff member. The prescription was checked and set aside for the patient to pick up. When the patient came in, a second pharmacist asked the patient if they were expecting a change in their dose, and it was then determined that the incorrect strength had been filled. The main contributing factors that led to the incident occurring were identified as (1) staff education issues, specifically competency validation and feedback on error, and (2) inefficient workflow, specifically not inactivating discontinued medications.

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 have more regular staff meetings so errors can be discussed, and feedback can be obtained from staff regarding the errors.
3. To ensure that, when a new prescription is brought in that indicates any changes, the old prescription the patient is no longer taking is discontinued.
4. To make any additional assessments and provide training to staff regarding proper procedure when refilling prescriptions.

For more information on using patient counselling & pick up to prevent medication incidents, see the following link on the CPhIR website titled Using Patient Counselling & Pick Up to Prevent Medication Incidents.

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. In particular, we encourage the submission of any incidents that may have occurred during the course of a pharmacist prescribing and the solutions that were implemented.

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.

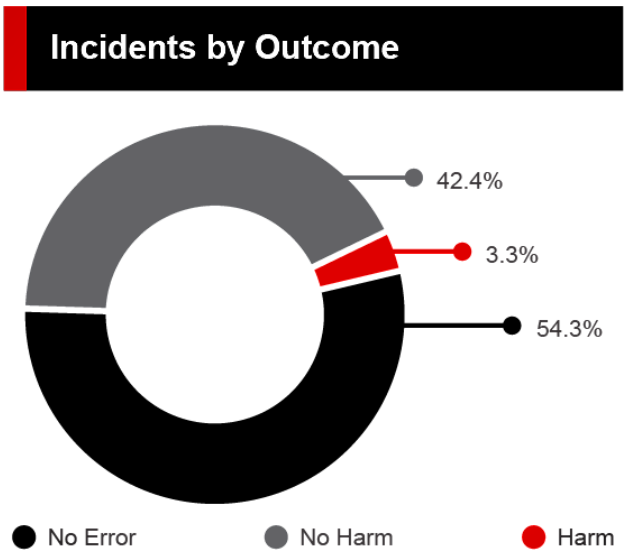
Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **45,029** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **September 1, 2013**, and **September 30, 2023.**

The statistics below relate to this time period.

Outcomes

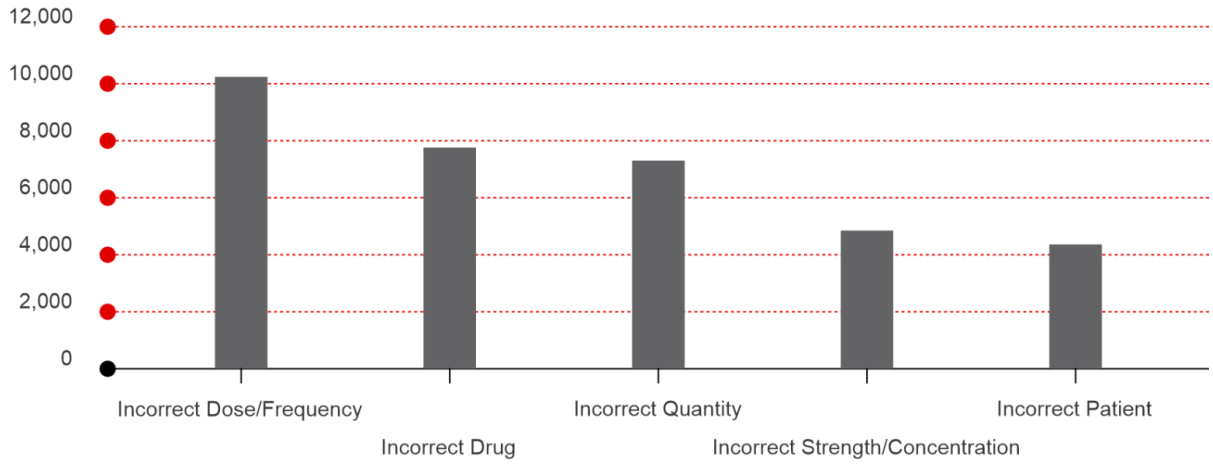
- **24,447** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **19,065** reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,485** reported incidents did result in 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 – 10,387
- Incorrect Drug – 7,781
- Incorrect Quantity – 7,191
- Incorrect Strength/Concentration – 4,925
- Incorrect Patient – 4,485

Incidents by Type

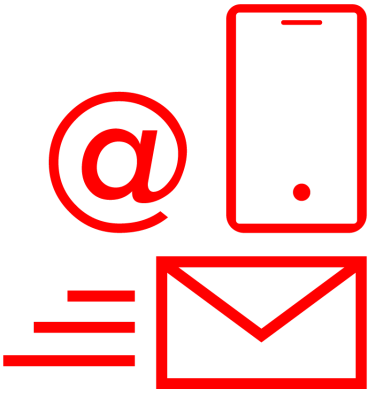


421 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

1,831 Continuous Quality Improvement (CQI) meetings have been held.

Contributing Factors – Top Five

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



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