

SMART Medication Safety Agenda

Psychotropic Medications

Table 1.

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).

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

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Table 2.

Additive CNS Effects

INCIDENT EXAMPLE:

A long-term care resident was started on clonazepam soon after receiving a dose of lorazepam. After a short while, the patient fell, was disoriented, and required transfer to the emergency department.

POTENTIAL CONTRIBUTING FACTOR:

- Lack of review of an up-to-date medication administration record prior to prescribing, dispensing and administering a high-alert medication

RECOMMENDATION:

- Incorporate alerts into all medication-use systems to notify users of duplicate therapies (i.e., drug interactions/additive effects).

Personalized Doses

INCIDENT EXAMPLE:

A patient experienced extreme drowsiness after receiving bromazepam 3 mg in hospital. The dose was obtained from the patient’s prescription vial label; however, the patient was only taking 1.5 mg (half of the prescribed dose) at home.

POTENTIAL CONTRIBUTING FACTOR:

- Lack of a best possible medication history with the patient to discern actual medication use

RECOMMENDATION:

- Implement timely and accurate processes for medication histories and reconciliation at all transitions of care.¹

Formulation Errors

INCIDENT EXAMPLE:

In response to a nursing inquiry, the pharmacist suggested using haloperidol lactate (short-acting) instead of haloperidol decanoate (long-acting) due to a medication shortage. A prescription was then sent to the pharmacy for haloperidol LA, but the short-acting formulation was inadvertently dispensed and administered. The patient experienced symptoms of sedation and decreased alertness for 3 days.

POTENTIAL CONTRIBUTING FACTORS:

- Unfamiliarity with the different formulations of the medication
- Use of an abbreviation at risk of misinterpretation (i.e., abbreviated formulation, LA, was misinterpreted as lactate due to prior conversation).

RECOMMENDATION:

- Encourage prescribers to use the entire medication name when writing prescriptions for products available in multiple formulations, including the salt or other complex (e.g., haloperidol decanoate, long-acting injection).²

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. 2012;12(2):1-5.
2. ISMP Canada Safety Bulletin. 2014;14(11):1-6.