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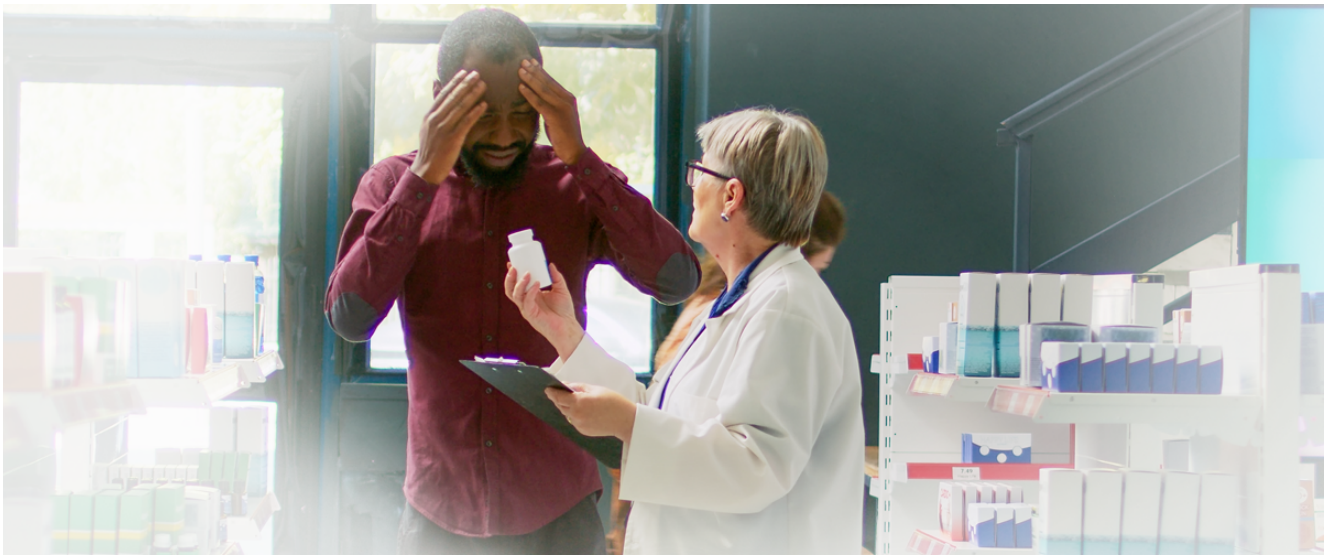
COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan

[directions]

COMPASS Program Newsletter Vol. 9 Issue 1 **January 2024**



Oral Opioid Agonist Therapy: A Multi-Incident Analysis of Reports from Community Pharmacies in Saskatchewan

Opioid agonist therapy (OAT) options such as buprenorphine/naloxone, methadone, and slow-release oral morphine (24-hour formulation) are considered to be high-alert products. In the Medications Most Frequently Reported in Harm Incidents over the Past 5 Years (2015–2020) Safety Bulletin, methadone has been identified as a leading cause of harm among medication incidents. A Multi-Incident Analysis of reports from community pharmacies in Canada describes an analysis of incidents involving oral OAT and presents strategies to prevent harm.

Of the 1169 medication incidents included in the national analysis, 271 medication incidents were further assessed for a Saskatchewan-specific subgroup analysis.

In this subgroup analysis, over 34% of medication errors reported were attributed to Incorrect Dose/Frequency, followed by 14.4% for Incorrect Quantity, and 13.3% for Incorrect Strength/Concentration (13.3%). The percentage of medication incidents per OAT medication indicates that methadone accounted for the largest component at 66%, followed by buprenorphine/naloxone at 31%, and slow-release oral morphine at 3%. The types of medication errors involved in the incidents reported by community pharmacies in Saskatchewan are presented in Table 1. The proportion of medication incidents per OAT medication is shown in Figure 1.

Type of Medication Error	Number of Incidents, n (%) (N=271)
Incorrect Dose/Frequency	**93 (34.32%)**
Incorrect Quantity	**39 (14.39%)**
Incorrect Strength/Concentration	**36 (13.28%)**
Incorrect Patient	32 (11.81%)
Incorrect Duration of Treatment	27 (9.96%)
Incorrect Prescriber	14 (5.17%)
Incorrect Drug	11 (4.06%)
Incorrect Dosage Form/Formulation	6 (2.21%)
Omitted Medication/Dose	6 (2.21%
Incorrect Storage	2 (0.74%)
Drug Therapy Problem (Contraindication)	2 (0.37%)
Expired Medication	1 (0.37%)
Incorrect Route of Administration	1 (0.37%)
Incorrect Third-Party Billing	1 (0.37%)

Table 1. Types of errors involving oral opioid agonist therapy (OAT) reported by community pharmacies in Saskatchewan (n is the number of incidents in that category; N is the total number of reported incidents; and % is the percentage of n/N).

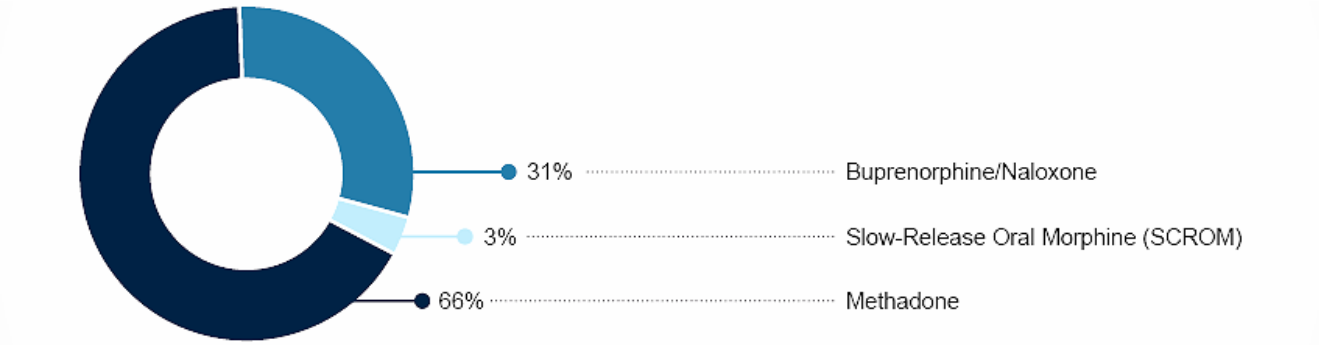
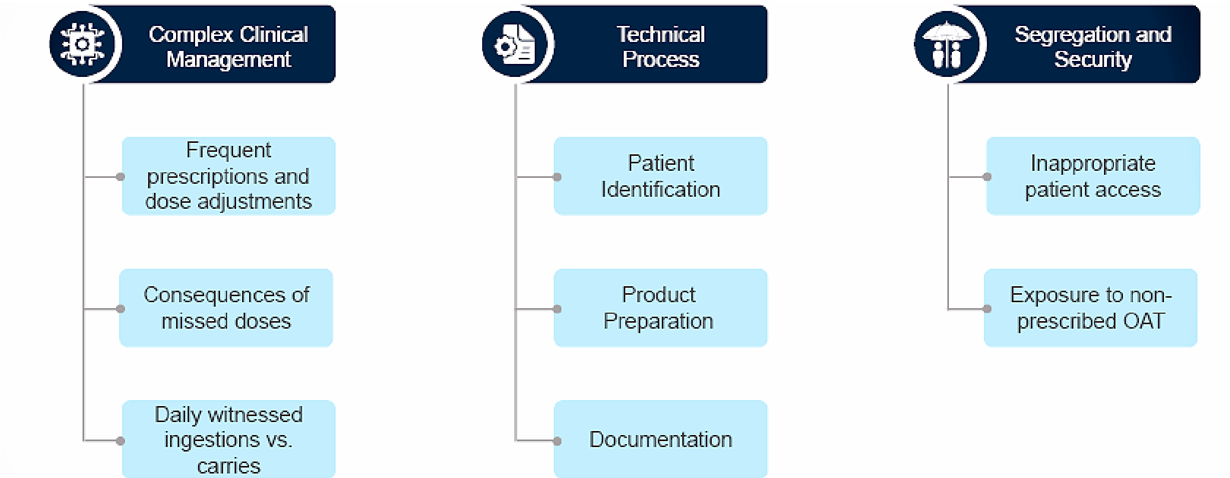


Figure 1. Proportion of medication incidents reported by community pharmacies in Saskatchewan per oral opioid agonist therapy (OAT) medication, which may reflect prescribing practices.

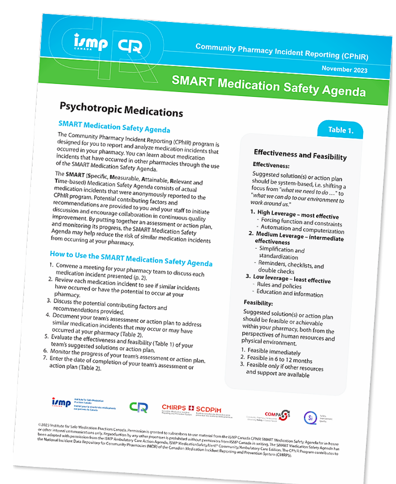
Three main themes and associated subthemes were identified in the multi-incident analysis.



This multi-incident analysis of reported errors with oral OAT identified several vulnerable processes in the care of patients receiving this treatment in the community pharmacy setting in Saskatchewan. Pharmacy teams are encouraged to review their own processes and associated incidents and consider how learning from this analysis can help to identify opportunities to support the safe delivery of OAT to patients, as well as continuous quality improvement.

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 Psychotropic Medications**.** All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.

Health Quality Council

The Health Quality Council (HQC) is an independent organization committed to improvement in health and health care in Saskatchewan so residents can live healthy lives and have access to high-quality health care.

By using their skills in quality improvement, measurement (research and analytics), collaboration, and skill-building, and partnering with and supporting health organizations, government, and community organizations across the province they drive progress toward better health and better care for all. They place their energy where they believe they can use their skills to make the most impact, and their work is informed by citizens, communities, and shared system priorities impacting health.

Some of the resources that the HQC provides to Saskatchewan citizens include blogs, e-newsletters, tools and resources, training programs and QI Power Hour webinars.

For more information on the HQC or to sign up for their blog or e-newsletter contact Saskatchewan Health Quality Council.

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 Leading with Quality Podcast series was presented in the October edition. The last resource is the QID: A QI Community of Practice.

QID is an online platform for pharmacists, pharmacy technicians, and pharmacy students who are registered with a provincial regulatory authority or college in Canada. It allows pharmacy professionals to collaborate and discuss pharmacy QI related issues. The platform has many communities of practice, including the QI Community, where you will find content from the resources previously discussed packaged in bite-sized posts meant to provide a practical introduction to important topics in QI. You can find the link to join the platform here.

CQI Coordinator Supplemental Training

The CQI Coordinator Supplemental Training is now available for all current CQI Coordinators to take. This training must be completed by **April 30, 2024**. The training is approximately one hour in length and has been assessed for **1 CEU**.

The training provides information regarding developing an MSSA Improvement Initiative, as well as monitoring and updating the pharmacy QI plan. There is also information regarding additional CQI tools that can be used when assessing the effectiveness of a change in process, e.g. PDSA cycles, and identifying the main issues with respect to an incident e.g. Root Cause Analysis.

To register for the training, contact USask-CPE. COMPASS CQI Coordinator Supplemental Training.

Shared Learning Opportunity

Drug Interaction Due to Staff Education and Workflow Problem

A patient presented at the pharmacy with a prescription for carbamazepine 200mg. Carbamazepine was on back order at the time, so the prescription was filled by a pharmacy staff member, but the patient only received the quantity the pharmacy had on hand and then the pharmacist was to discuss an alternative with the prescriber the next day. However, before contacting the prescriber the next day, the pharmacist noticed an alert on the file that there was a drug interaction between carbamazepine and another medication the patient was already on, atorvastatin. The patient was contacted to

inform them of the interaction. The patient agreed to discontinue the prescription and pick up an alternative medication. The main contributing factors that led to the incident occurring were identified as (1) environmental issues, specifically interruptions and workload, and (2) staff education issues, specifically competency validation, orientation process, and feedback on errors/prevention.

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 ensure that the pharmacist is made aware of any interactions that come up on the screen when the prescriptions are being filled and to not continue until the pharmacist has reviewed the interaction.
3. To ensure that the pharmacist reviews the patient's profile when checking prescriptions and confirming that there are no drug interactions.
4. To make any additional assessments and provide training to staff regarding proper procedure when filling new prescriptions and when an interaction warning comes up on the screen.

For more information on other drug interaction, see the following link on the CPhIR website for a webinar on Drug Interaction Pairs Associated with an Increased Likelihood of Hospitalization: A New Look at the Evidence.

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.

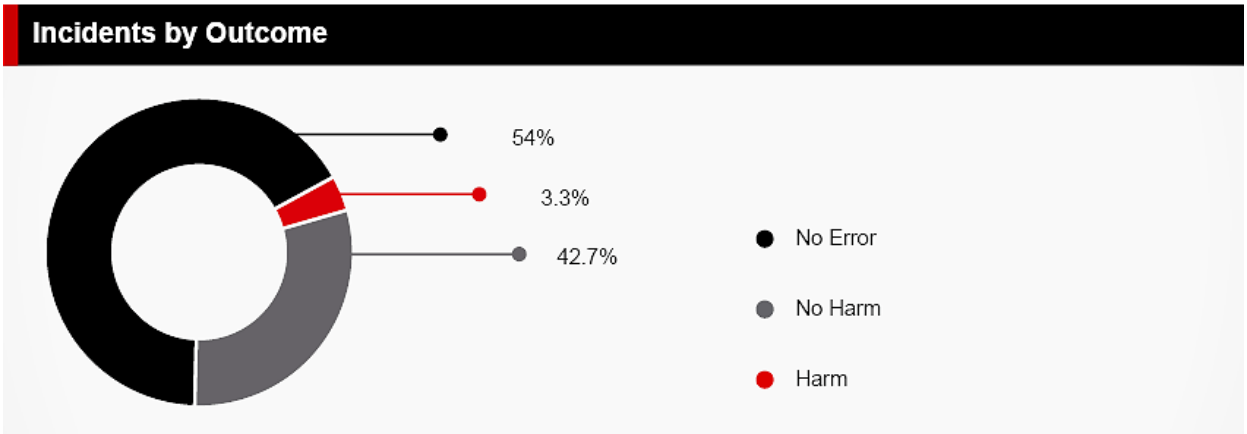
Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **46,078** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **September 1, 2013,** and **December 31, 2023.**

The statistics below relate to this time period.

Outcomes

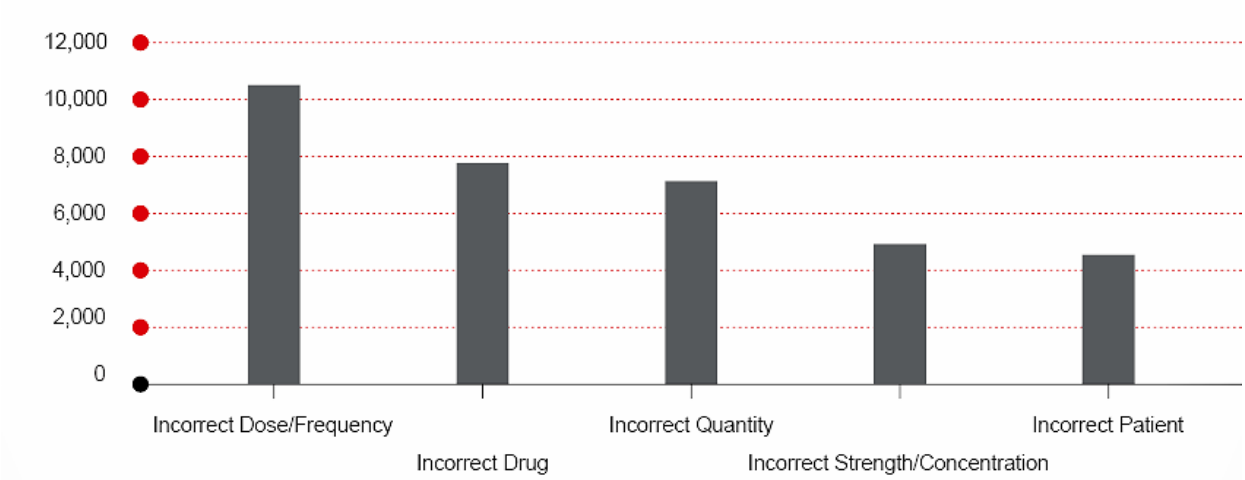
- **24,841** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **19,665** reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,536** reported incidents did result in 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 – 10,626
- Incorrect Drug – 7,997
- Incorrect Quantity – 7,312
- Incorrect Strength/Concentration – 5,055
- Incorrect Patient – 4,604

Incidents by Type

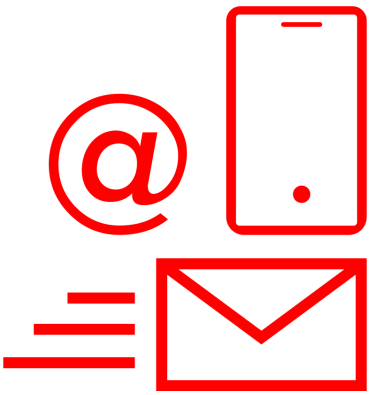


422 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

1,911 Continuous Quality Improvement (CQI) meetings have been held.

Contributing Factors – Top Five

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



Contact

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

MSSA: ISMP Canada mssa@ismp-canada.org

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

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