SMART Medication Safety Agenda

Safe Medication Use in Older Persons

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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 ❋ SCDPIM
Canadian Medication Incident Reporting and Prevention System
Système canadien de déclaration et de prévention des incidents médicamenteux

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Advancing **Safety** in Saskatchewan

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Safety.
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Table 2.

Compliance Packaging

INCIDENT EXAMPLE:
During the sealing process of a compliance pack, a digoxin tablet inadvertently moved from one slot to another. Among other medications, one slot had double the dose of digoxin and the other slot was missing the dose.

POTENTIAL CONTRIBUTING FACTOR:
- Multiple medications in the same bubble/slot, which is common for older patients, reduces the ability to visually detect errors (i.e., added or missed doses)

RECOMMENDATIONS:
- Incorporate an independent double check at key points in the preparation process for compliance packs, including after the pack is sealed.[1]
- Segregate the preparation process for compliance packs from usual pharmacy workflow (i.e., provide a distraction-free environment).

Complex Medication Management

INCIDENT EXAMPLE:
A patient was switched from insulin NPH to insulin glargine; however, they were unaware of the order to discontinue insulin NPH. After continued use of both insulin products, the patient presented with blood glucose levels below target.

POTENTIAL CONTRIBUTING FACTOR:
- Lack of appropriate patient counselling following a change in therapy; this is particularly important for older patients with many medications

RECOMMENDATIONS:
- Perform comprehensive patient counselling (and a medication review, if appropriate) when a patient starts or has a dose change with a high-alert medication.[2]
- Use the teach-back method during patient counselling to confirm understanding of medication and dose changes.[3]
- Encourage patients to update and carry a list of their medications, doses, and directions for use, as well as any allergies.[3]

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. Complexity and Vulnerability of Compliance Pack Preparation: A Multi-Incident Analysis. Pharmacy Connection. 2014;Winter:32-37. Available from: https://www.ismp-canada.org/download/PharmacyConnection/PC2014Winter_PackPreparation.pdf
2. ISMP Canada. Insulin: A high-alert medication. Hospital News. 2015;28(12):17. Available from: https://www.ismp-canada.org/download/hnews/2015Dec-HospitalNews-Insulin.pdf
3. ISMP Canada. Medication Incidents Associated with Patient Harm in Community Pharmacy: A Multi-Incident Analysis. Pharmacy Connection. 2018;Winter. Available from: https://pharmacyconnection.ca/ismp-multi-incident-analysis-winter-2018/