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COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan

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COMPASS Program Newsletter Vol. 9 Issue 2 **May 2024**

Safer Labelling of Repackaged Active Pharmaceutical Ingredients for Pharmacy Compounding

A child's death resulting from a compounding error, described in an ISMP Canada Safety Bulletin, has reinforced the need for a focus on safety in pharmacy compounding. Recommendations set out in that bulletin included the use of unique chemical identifiers and automated identification (e.g., bar codes) for ingredients used in compounding.

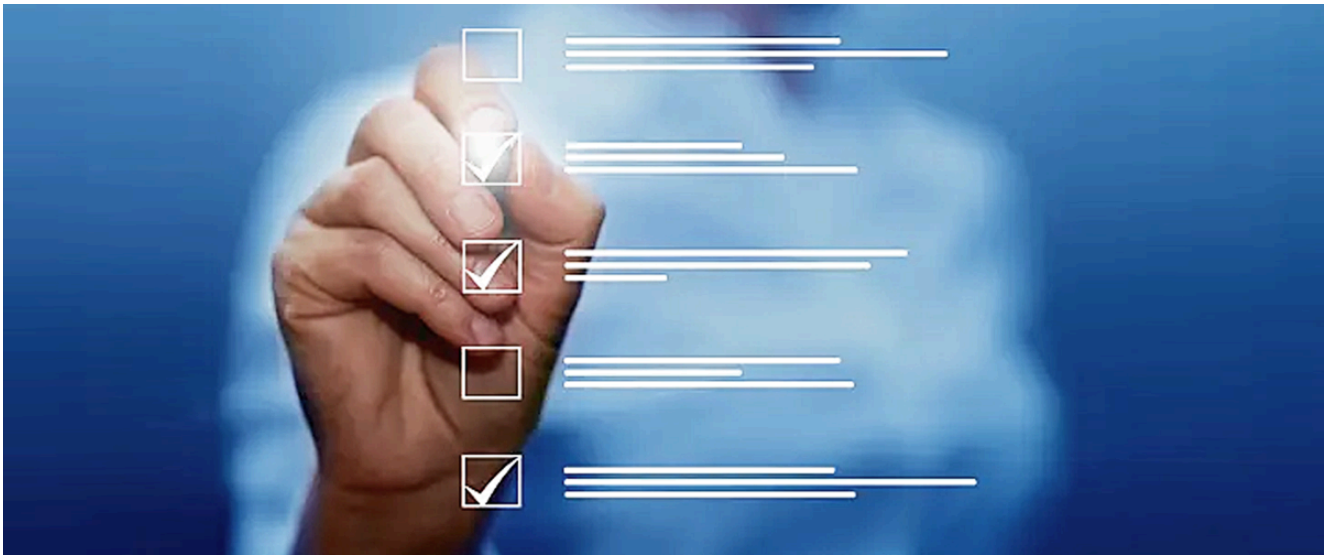
ISMP Canada and HealthPRO Procurement Services Inc. partnered to lead an initiative to improve the labelling of repackaged active pharmaceutical ingredients (APIs). They worked with an API Advisory Panel that included regulators, API repackagers, community and hospital pharmacists, and compounding associations from across Canada. This bulletin shares recommendations for safer API labels, as well as examples to illustrate improved label content and design.

The API Advisory Panel reached consensus on a set of safe labelling design considerations (listed below) for repackaged APIs, which are complementary to the requirements set out by Health Canada (GUI-0104) and the Workplace Hazardous Materials Information System (WHMIS).

1. Include automated identification (e.g., GS1-compliant barcoding).
2. Use i) the largest possible type size that can be read easily by a variety of users (minimum 6 points for key information), ii) sans serif type style, and iii) mixed-case lettering (i.e., lower-case letters with capitalization for proper nouns).
3. Display the chemical name of the API in larger type size than the name of the manufacturer/ repackager.
4. Stack a long, multiword name, so that the full name can be read without the need to rotate the package.
5. Include the Chemical Abstracts Service (CAS) Registry Number for the API as an additional product identifier. This is analogous to including the Drug Identification Number (DIN) or Natural Product Number (NPN) on drugs and natural health products, respectively.
6. Avoid dangerous abbreviations, symbols, and dose designations (see ISMP Canada's "Do Not Use" list).
7. Use one of the following formats for expiration dating: EXP 2020-JA-11 or EXP 11-JA-2020.
8. Present potency, if applicable (e.g., X mg erythromycin activity per Y grams erythromycin stearate) on the front panel in a manner that simplifies any needed calculations.
9. Consider the use of more than just colour to distinguish between products. Examples of other distinguishing features include the use of frames or keylines (boxes around text).
10. Use colour to draw attention to important label information, such as the API name, or to enhance or bring attention to warning statements.

Next steps include knowledge dissemination and knowledge translation to continue to advance safe labelling for repackaged APIs and integrate safety measures into compounding practices. ISMP Canada is supporting a multistakeholder approach to increasing safety for patients who need compounded medications.

Read the full bulletin for additional details, including label examples.



Safety Attitudes Questionnaire (SAQ) Results

During the month of March 2023, pharmacists and pharmacy technicians were asked to complete a Safety Attitudes Questionnaire (SAQ). The SAQ is designed to assess the current state of safety attitudes of community pharmacy staff and is used to evaluate the advancement in the culture of safety within community pharmacies. There were 378 responses, for a response rate of 28 per cent.

The SAQ is a validated tool for assessing safety culture, with approximately 40 questions covering six main factors: teamwork climate, job satisfaction, perceptions of management, safety climate, working conditions, and stress recognition.

This was the third administration of the SAQ. The first SAQ was in 2019, the second in 2021, and the third in 2023.

When comparing the results of the 2018 SAQ to the 2023 SAQ, there was a positive change in all domains except Stress Recognition. The biggest positive change was seen in working conditions.

However, when comparing the results of the 2021 SAQ to the 2023 SAQ, there was minimal change in all domains. The two domains where there was a positive change were stress recognition and working conditions. The three domains where there was a negative change were teamwork, job satisfaction, and perception of management.

The full report can be found on the SCPP website under Research in the COMPASS tab (click to view report).

Thank you to all the pharmacists and pharmacy technicians that responded to the SAQ survey. The information that is collected during the SAQ is invaluable in both identifying

trends within pharmacies and providing useful information on ways that SCPP can assist pharmacies advance their culture of safety. Your participation is greatly appreciated.

Safety Resources

SMART Medication Safety Agenda


Community Pharmacy Incident Reporting (CPhIR)
February 2024
SMART Medication Safety Agenda
Safe Medication Use in Older Persons
SMART Medication Safety Agenda
How to Use the SMART Medication Safety Agenda
Table 1.
Effectiveness and Feasibility

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.

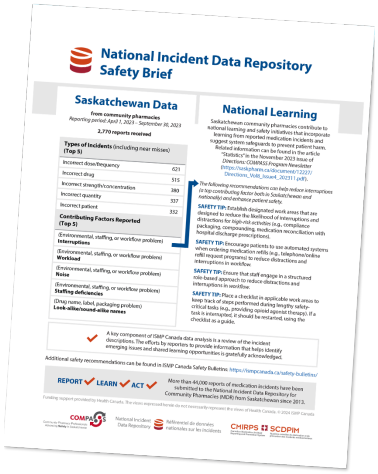
Potential contributing factors and recommendations are provided for users to initiate discussion and encourage collaboration towards continuous quality improvement in the pharmacy. By putting together an assessment or action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar medication incidents in the pharmacy.

The topic of the latest edition of the SMART Medication Agenda is Safe Medication Use in Older Persons**.** All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.

COMPASS Resources

National Incident Data Repository Safety Brief – SK Data

The next edition of the National Incident Data Repository Safety Brief is now available. The brief contains Saskatchewan specific information regarding the number and types of incidents reported into CPhIR, as well as tips to help prevent errors. ISMP Canada has developed this brief to optimize safe medication practices.


National Incident Data Repository
Safety Brief

Saskatchewan Data

National Learning

This is a biannual publication (with six-month reporting periods).

CQI Coordinator Supplemental Training Reminder

The CQI Coordinator Supplemental Training for all current CQI Coordinators was to have been completed by **April 30, 2024**. The training is approximately one hour in length and has been assessed for **1 CEU**. Any CQI Coordinators that have not yet completed the training will have until **May 7th, 2024**, to complete the training without penalty.

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

Incorrect Dose – Contributed to, by Faulty Equipment Control Checks

A prescription for a nursing home resident was filled with quetiapine 25mg instead of donepezil 25mg. The pharmacy preparing the prescriptions utilized technology to provide the medication in medication pouches. When the pouches were checked by the electronic scanner, the error was not picked up by the machine. However, when a manual check was done of the pouches the error was discovered. Therefore, the medication did not reach the patient. The main contributing factors that led to the incident occurring were identified as (1) faulty drug identification - packaging problem, and (2) lack of quality control - equipment quality control checks.

The system-based solutions recommended were:

1. To share the details of the incident with all pharmacy staff, so they are all aware.
2. To contact the software provider to ensure any issues with the scanner program is resolved and ensure staff are aware of any quality control checks that need to be performed regularly.
3. To ensure that when medication cartridges are refilled in the machine that two individuals are completing independent DIN checks and confirming the correct medication is being placed in the cartridge.

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.

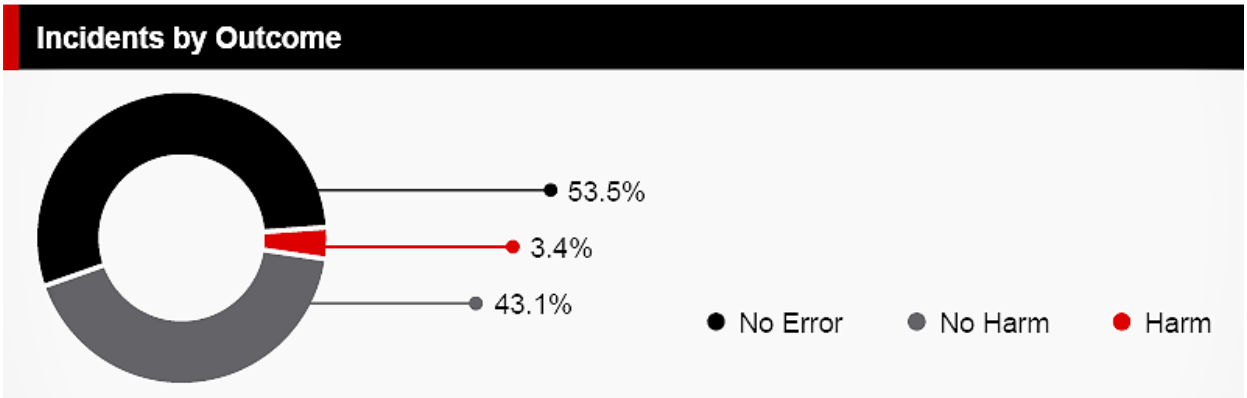
Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **47,515** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between **September 1, 2013,** and **March 31, 2024.**

The statistics below relate to this time period.

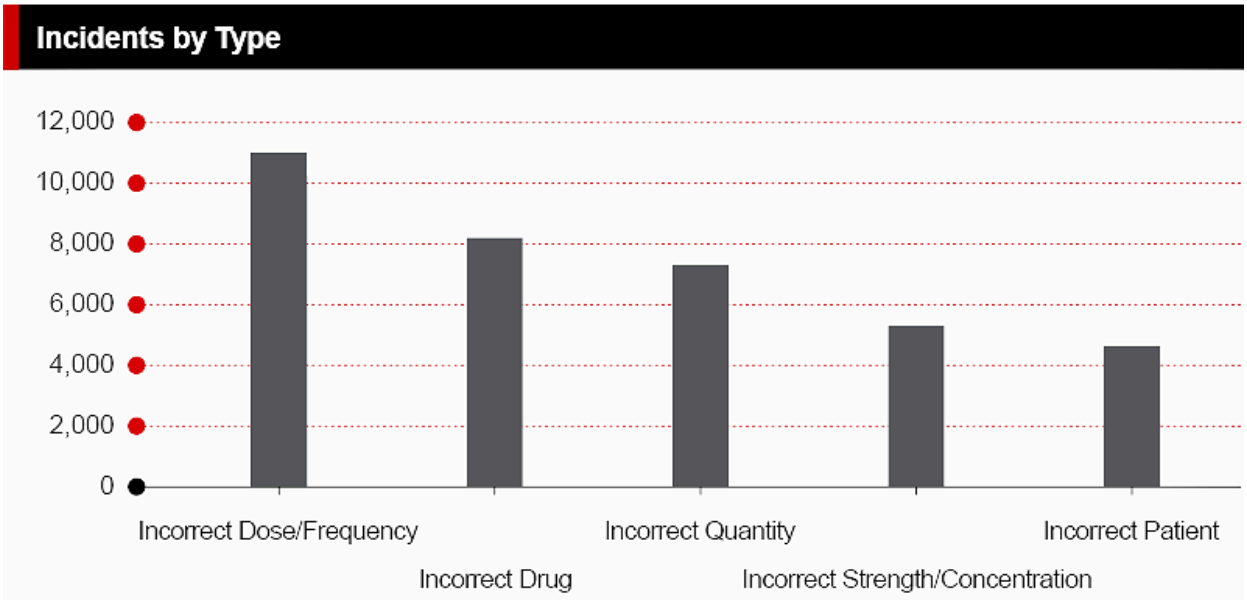
Outcomes

- **25,391** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **20,469** reported NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,623** reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been **4** incidents reported with an outcome of DEATH.



Incident Types – Top Five

- Incorrect Dose/Frequency – **10,938**
- Incorrect Drug – **8,282**
- Incorrect Quantity – **7,458**
- Incorrect Strength/Concentration **– 5,230**
- Incorrect Patient **– 4,807**

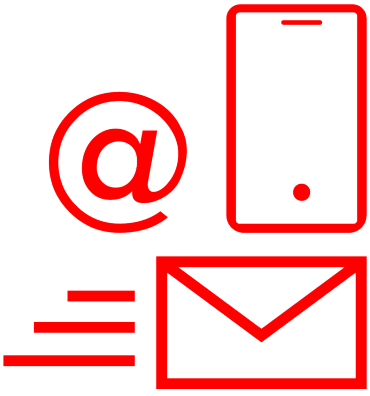


424 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

2,014 Continuous Quality Improvement (CQI) meetings have been held.

Contributing Factors – Top Five

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



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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