Community Pharmacy Professionals Advancing Safety in Saskatchewan direction

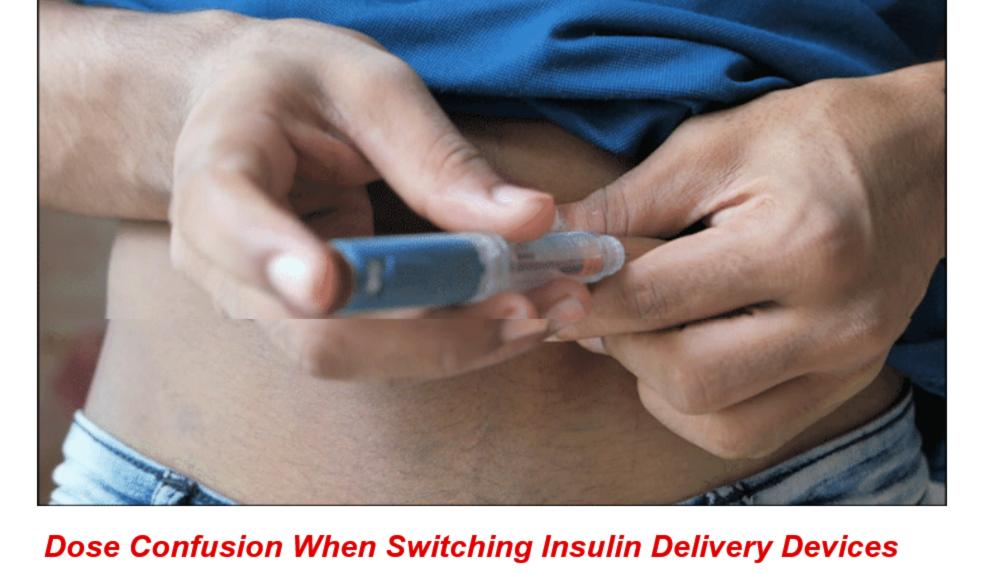
Compass Program Newsletter

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because of significant insulin resistance.

Insulin products are supplied predominantly as solutions with a standard concentration of 100 units/mL. However, several high-concentration products are available for patients who require relatively high doses

These high-concentration products are often provided in product-specific injection delivery devices. Failure to consider the differences among insulin products, including the insulin concentration and the delivery device, can lead to serious dosing errors.

ISMP Canada received a report of a dosing error with a high-concentration insulin product. A patient was

switched from Humulin R 500 units/mL (a multi-dose vial obtained through Health Canada's Special Access

Programme) to Entuzity KwikPen 500 units/mL (in a prefilled pen obtained through the community pharmacy). The patient reported that the Humulin R dose was measured as 30 units on the syringe. The physician then wrote the new prescription for Entuzity KwikPen 30 units twice daily. The patient declined pharmacist counselling at the time the prescription was dispensed, indicating familiarity with the use of high-concentration

regular insulin. However, after using the Entuzity KwikPen product for more than a week, the patient experienced hyperglycemia and had to be treated in hospital. Dosing errors with high-concentration insulin products and related insulin delivery devices are preventable. All

health care practitioners involved in prescribing, dispensing, monitoring, or providing education about insulin

units, and the delivery device when communicating with patients and others in the circle of care. Key

use should be aware of the need to determine the type and concentration of insulin, the insulin dose in terms of

in terms of units, and the delivery method or device used to administer each dose (i.e., syringe, insulin pen, or pump). Encourage patients to always describe their insulin dose in terms of units whenever they are asked for this information. Encourage patients who are switching insulin products to record and closely monitor their blood glucose

Determine a patient's insulin usage by confirming the type(s) of insulin, the concentration(s), the dose(s)

- When obtaining medication from Health Canada's Special Access Programme, prescribers should advocate for community pharmacies to be kept in the communication loop. For a more detailed description of the incident, the community pharmacist's identification of the dosing error,
- several contributing factors, and system-level recommendations to prevent recurrence, the full ISMP Canada Safety Bulletin can be accessed here.
 - Article provided by Ambika Sharma, Medication Safety Specialist, ISMP Canada

Shared Learning Opportunities Wrong Patient Incident

A 26-year-old female presented at the pharmacy to receive her daily witness of anti-retroviral medication,

stored in separate boxes, one for each patient. However, on this occasion the patient's medication was in another patient's box.

as well as a second medication of Sulfatrim 400/80mg.

As a routine practice, all daily witness medications are

recommendations include:

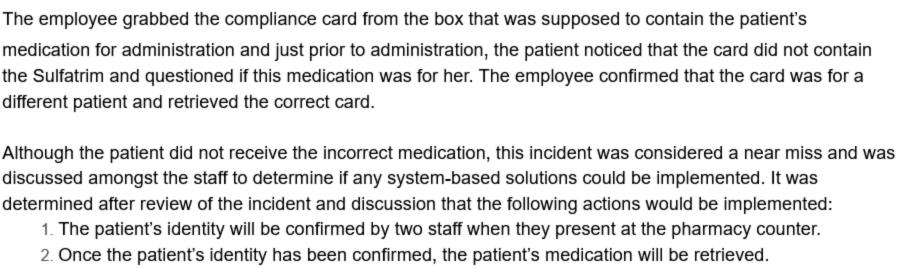
after the change.

The employee grabbed the compliance card from the box that was supposed to contain the patient's

different patient and retrieved the correct card.

discussed amongst the staff to determine if any system-based solutions could be implemented. It was determined after review of the incident and discussion that the following actions would be implemented:

These interventions will be monitored for effectiveness.



This incident was reported here with the involvement and permission of the Saskatchewan community pharmacy. Incidents that Occurred Due to Non-Traditional Dispensing Procedures

3. A double-check of the patient's name on the card by the individual witnessing all doses will be instituted.

Community pharmacists and pharmacy technicians sometimes offer non-traditional dispensing services that may not involve the usual linear medication-use process. Some of these procedures involve dispensing methadone, administering injections, and compounding mixtures, etc. These alternative dispensing procedures

Methadone and compounding incidents were often related to calculation errors, leading to over-dosing of

may have a greater potential of causing significant patient harm if errors occur.

methadone or preparation of an inappropriate mixture. Other incidents involving injections and methadone were associated with a lack of pharmacy staff training in these high-risk procedures. High-Risk Procedures Pharmacist was preparing the patient's daily Methadone dose. During the

dispensing process, the pharmacist went to assist another staff member

before returning to finish the Methadone preparation. Patient received 10

Parts of the above information was reprinted from ISMP's Canada Report –

times his regular dose. Patient felt unwell and had to be hospitalized.

High-risk procedures that were prevalent among reported harm incidents involved daily methadone dispensing,

injections, compounding) that have a greater risk of

Incidents that involve

community pharmacy

services (e.g. methadone,

High-Risk Procedures

administering injections, and compounding.

An intramuscular vaccine was administered subcutaneously, and the patient causing significant patient developed hives, welts, and redness at the injection site. harm when errors occur.

To reduce errors, pharmacy managers must ensure that all members of the pharmacy team are informed, educated, and trained on the standardized procedures. In addition, independent double-checks should be

included in all high-risk procedures (e.g. verifying calculations and methadone volume, etc.).

COMPASS Harm Incidents Qualitative Analysis – July 2019 (pages 6-7). We want to hear from you!

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. 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

One of the goals of COMPASS is to promote shared

learning between Saskatchewan pharmacies

Saskatchewan.

your pharmacy.

this time period.

Outcomes

Agenda

regarding incidents, unsafe practices and other important issues to improve pharmacy care in

One way to promote shared learning would be to

report an interesting incident/error that occurred within

Statistics

incidents/errors so everyone can learn from them.

HARM. There have been two incidents reported with an outcome of DEATH. Incident Types - Top Three Incorrect dose/frequency – 6,949 Incorrect quantity – 5,122 Incorrect drug – 4,922

intercepted BEFORE they reached the patient.

Safety Self-Assessment (MSSA) online data entries 681 Continuous Quality Improvement (CQI) meetings have been held

The SMART Medication Safety

The SMART (Specific, Measurable, Attainable, Relevant and Timebased) Medication Safety Agenda was introduced by the Institute of Safety Medication Practices Canada (ISMP Canada) to increase shared learning among 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

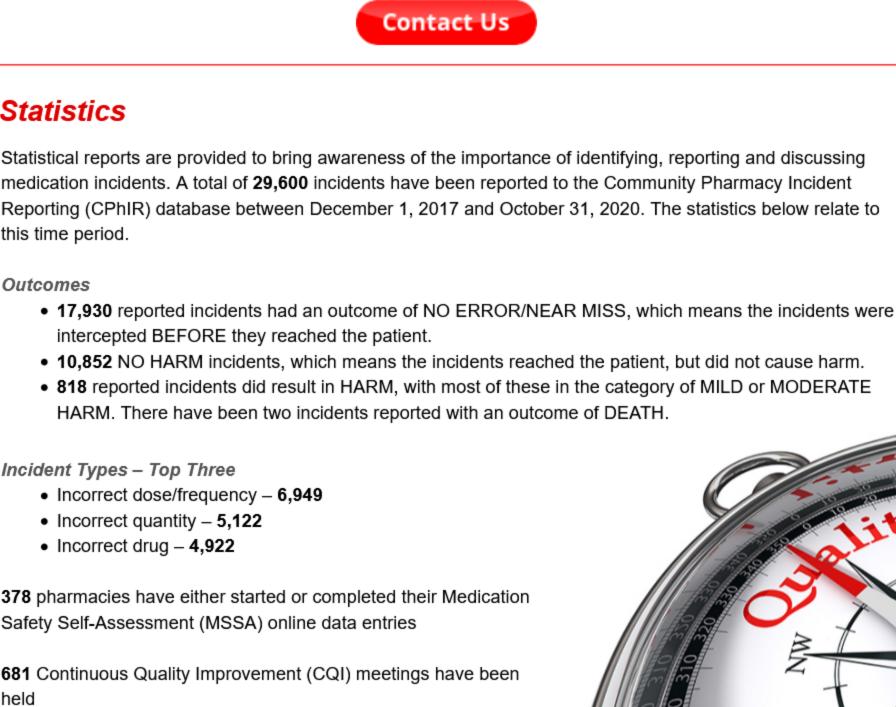
website under <u>COMPASS Newsletters</u>.

MedSCIM Assessments

the QIR (Quality Improvement Review) process.

offered to prevent future recurrence.

approach.



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Drug Tapering and Titration

CR CHIRPS IT SCOPE

SMART Medication Safety Agenda

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 **Drug Tapering and Titration**. All previous

editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP

More

There are **three** levels for assessing the reports' completeness: the medication incident and contributing factors. the medication incident. No information is provided about contributing factors.

- generative culture. For more information on MedSCIM see page 59-60 of the Quality Improvement Coordinator Manual. **Read more**
- MedSCIM ratings for the majority of medication Is the incident description clear and concise? incidents reported are between 2B – 3C, with a handful of reports obtaining a 1A rating. Have contributing factors been identified and are they included in the incident description?
- reports are complete. Therefore, to assist pharmacy staff in ensuring that the information that they are providing to CPhIR through their incident reporting is both complete and indicates a mature safety culture,

SCPP has created a Medication Incident Reporting Cheat Sheet. Pharmacies are encouraged to print off the cheat sheet and have it handy when medication incidents are reported. Please see below a copy of the cheat sheet. Click the image to access a copy for printing.

SCPP has received very positive feedback from

pharmacy managers on the usefulness of the

MedSCIM assessment in identifying areas for

recurring included in the incident

Is the action to be taken to prevent the incident from

Community Pharmacy Profesi Advancing **Safety** in Saskato

Contact COMPASS: Jeannette Sandiford, Assistant Registrar – Field Operations and

More

Quality Assurance – jeannette.sandiford@saskpharm.ca CPhIR: ISMP Canada: cphir@ismp-canada.org

SCPP emails and newsletters are official methods of notification to pharmacists and pharmacy technicians licensed by the

• Level 1 – Report fully complete – The medication incident provides sufficient information to describe Level 2 – Report semi-complete – The medication incident provides sufficient information to describe Level 3 – Report is not complete – The medication incident provides insufficient information to allow meaningful qualitative analysis.

Incident Reporting Cheat Sheet Medication Incident In your description, have you included: Cheat Sheet · What? · When? Where? Why? During the Quality Improvement Reviews (QIRs), the

How?

description?

- improvement with respect to incident narratives. Many have indicated a quick reference sheet when entering an incident would be very helpful to ensuring the

 - MSSA: ISMP Canada: mssa@ismp-canada.org
 - Technical Support (COMPASS): 1-866-544-7672

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The MedSCIM tool was developed by ISMP Canada as an assessment tool that is currently being used during The MedSCIM assessment involves looking at the narratives of selected medication incidents reported by the pharmacy to CPhIR and assessing these reports for completeness and the maturity of safety culture. There are four levels for assessing the maturity of safety culture: • Grade A – Generative – The medication incident uses a systems-based approach to describe the root causes and develop possible solutions to prevent future recurrence. • Grade B – Calculative – The medication incident uses a systems-based approach to describe the root causes. No solutions are offered to prevent future recurrence.

 Grade C – Reactive – The medication incident is treated as an isolated incident. No solutions are Grade D – Pathological – The incident focuses on human behaviours instead of a systems-based The desired level of assessment would be 1A, where the report is fully complete, and the narrative indicates a