COMPASS
Community Pharmacy Professionals Advancing Safety in Saskatchewan

[directions]

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Strategies for Safer Telephone and Other Verbal Orders

Medication orders (prescriptions) conveyed verbally by telephone or in person are prone to errors. Problems can arise if a medication order is miscommunicated, misheard, or incorrectly transcribed.

The Institute for Safe Medication Practices (ISMP) Canada encourages the use of written orders, including electronic orders, to prevent medication errors. However, the COVID-19 pandemic has increased the need for and frequency of telephone and other verbal orders. Temporary changes in federal legislation now permit the use of telephone orders for controlled substances.

ISMP Canada received a report from a community pharmacy of a miscommunication in a telephone order for hydromorphone which led to dispensing of the oral liquid formulation instead of the intended injectable formulation. The oral product was injected by a home-care nurse, which resulted in harm to the patient.

Although telephone and other verbal orders are known to be susceptible to error, they may be necessary in some circumstances. Good communication practices, especially use of the read-back technique, can help to mitigate risk. Key recommendations of this technique include:

- Incorporate all the elements of a complete medication order, including drug name, dosage form, dose and strength (if applicable), route of administration, indication, directions for use, quantity to be dispensed and/or duration of therapy.
- Communicate drug names by first saying and then spelling them out. Consider using a phonetic alphabet to distinguish between sound-alike letters (e.g., "m" as in Mike or "n" as in November).
- Provide both the generic and brand names, especially for recognized look-alike, sound-alike medication pairs. Immediately transcribe or enter the medication order into its permanent record (e.g., patient chart, pharmacy hard copy and/or profile) to facilitate accurate documentation of the prescription.
- Read the complete order back to the prescriber as documented, for verification and to catch any errors (the "read-back" technique).

For a more detailed description of the incident, various contributing factors, and recommendations for communicating telephone and other verbal orders, the full ISMP Canada Safety Bulletin can be accessed here.

Article provided by Michael Hoffman, Medication Safety Specialist, ISMP Canada

Read more

1 Please note that Michael Hamilton was incorrectly written as Michael Hoffman. SCPP sincerely apologies for the error.

Safety Attitudes Questionnaire (SAQ) is Coming Soon

In October 2018, pharmacy staff were asked to complete the Safety Attitudes Questionnaire (SAQ). The link to the previous SAQ can be found here.

To evaluate the advancement in the culture of safety within community pharmacies since the first SAQ was administered, the SAQ will be repeated. The questionnaire will be provided to all community pharmacists and pharmacy technicians for completion in the next month.

The Safety Attitudes Questionnaire (SAQ) is the most commonly used and validated tool for assessing safety culture. It assesses six main factors (teamwork climate, job satisfaction, perceptions of management, safety climate, working conditions, and stress recognition) with approximately 40 questions.

The intent for administering the SAQ is to obtain updated data regarding the attitudes of pharmacists and pharmacy technicians. Watch for an email with the link to the questionnaire. We encourage all pharmacists and pharmacy technicians to participate.

Read more

Shared Learning Opportunity

Logged Prescription

A prescription for Clonidine 0.1mg, i tab BID was phoned into the pharmacy. The verbal prescription was transcribed with the correct strength of Clonidine 0.1mg.

The prescription was then logged onto the patient's profile. However, when the prescription was entered on the patient profile, it was entered as Clonidine 0.2mg i tab BID.

Once the patient requested the medication, and during the filling process, the pharmacist reviewed the patient profile, as well as the original prescription and discovered the error. The prescription strength was corrected, and the patient received the correct dose.

During the discussion of the incident, the staff determined that the main contributing factor was that the two drugs were look-alike/sound-alike drugs (similar strength).

Although the patient did not receive the incorrect medication, this incident was considered a near miss and was 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.

1. More checks would be implemented to ensure accuracy of the information entered, especially with look-alike/sound-alike drugs.
2. Reinforcement of the need to verify the prescription information by referring to the original prescription.

These interventions will be monitored for effectiveness.

The practice of logging prescriptions is common in community pharmacies and has been identified by ISMP Canada as a procedure that can increase the opportunity for medication errors if processes are not in place to confirm the correct information when the prescription is filled. One of these processes is to confirm all prescription information is correct by referring to the original prescription when the prescription is filled for the first time.

In fact, ISMP Canada has proposed adding the following questions to the Medication Safety Self-Assessment: High Risk Situations in Community Pharmacy, Pilot Version, 2020, in order for pharmacies to assess their procedures regarding logged prescriptions during the completion of the MSSA:

All staff involved in dispensing a new or logged prescription are trained to refer to the original paper prescription/scanned image or e-prescription at each step in the dispensing process to increase error detection opportunities during the first fill.

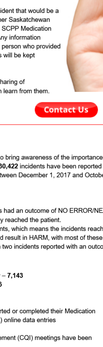
All logged prescriptions are verified against the original prescription (e.g., a filled copy, a scanned copy or an e-prescription) for accuracy, and against the medication profile to ensure continued appropriateness, before dispensing.

More information can be found on the ISMP Canada website regarding logged prescriptions. Please see the link below. There is also a short presentation under the CE and Resources section of the CPhR website – "Multi-incident Analysis: Medication Incidents associated with Logged Prescriptions."

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 an interesting 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. 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.

Contact Us

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **30,422** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and October 31, 2020. The statistics below relate to this time period.

Outcomes

- **18,243** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **11,329** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.
- **849** reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been two incidents reported with an outcome of DEATH.

Incident Types – Top Three

- Incorrect dose/frequency – **7,143**
- Incorrect quantity – **5,226**
- Incorrect drug – **5,084**

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

742 Continuous Quality Improvement (CQI) meetings have been held

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

Medication Incident Cheat Sheet

In the last edition of directions, the Medication Incident Cheat Sheet was introduced to assist pharmacy staff in ensuring incident reports were complete.

Due to the positive feedback from some pharmacy managers on its usefulness, but a lack of awareness from others, SCPP is including it in another edition for information and to increase awareness of this tool.

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

More

Contact

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