SMART Medication Safety Agenda

Look-Alike/Sound-Alike Drug Names

Table 1.

SMART Medication Safety Agenda

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).

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

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Table 2.

INCIDENT EXAMPLES:

- **Individual Factors**
  A prescription for hydrocortisone 1% in Mycostatin® (nystatin) was incorrectly filled as hydrocortisone 1% in Monistat® (miconazole).
- **Environmental Factors**
  Apo-Amilzide® (amiloride/hydrochlorothiazide) was to be refilled for a patient, but Apo-Amiloride® (amiloride) was mistakenly dispensed. The error was recognized when the patient noted that the tablet looked different.
- **Technological Factors**
  A patient with previous prescriptions for Tri-Cyclen® LO on her profile was prescribed Tri-Cyclen®. The Tri-Cyclen® LO prescription file was copied and filled instead of Tri-Cyclen®.
- **Unique Drug Factors**
  A pharmacist filled Advair® 250 Diskus instead of the prescribed Advair® 250 HFA. A second pharmacist corrected the error during the checking process.

POTENTIAL CONTRIBUTING FACTORS:

- Confirmation bias due to the similarity of generic and/or brand names and indications
- Close storage of look-alike/sound-alike drug products
- Confirmation bias due to the availability of the same medication in multiple strengths and formulations
- Copying an existing prescription file without a systematic review of all information fields

RECOMMENDATIONS:

- Encourage physicians to include generic and brand names of medications on prescriptions.
- Implement bar code scanning to minimize the risk of product mix-up in the dispensing process.[1]
- Apply warnings next to look-alike/sound-alike drug names that are at risk of selection error, both in the pharmacy software system and on the shelves.[2]
- Implement a policy to only allow copying a prescription file if the new prescription is unchanged from the previous prescription.

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. Pharmaceutical bar coding: national recommendations. ISMP Canada Safety Bulletin. 2012;12(8):1-4.
2. ISMP Canada. Direct oral anticoagulant medication incidents: a multi-incident analysis. Available from: https://www.ismp-canada.org/download/posters/Poster31-DirectOralAnticoagulant MedicationIncidents.pdf