COMPASS Community Pharmacy Innovations Advancing Safety in Collaboration

[directions]

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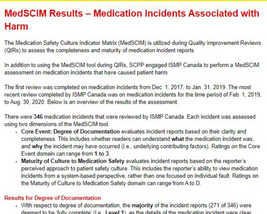

MedSCIM Results – Medication Incidents Associated with Harm

The Medication Safety Culture Indicator Matrix (MedSCIM) is utilized during Quality Improvement Reviews (QIRs) to assess the completeness and maturity of medication incident reports.

In addition to using the MedSCIM tool during QIRs, SCPP engaged ISMP Canada to perform a MedSCIM assessment on medication incidents that have caused patient harm.

The first review was completed on medication incidents from Dec. 1, 2017, to Jan. 31, 2019. The most recent review completed by ISMP Canada was on medication incidents for the time period of Feb. 1, 2019, to Aug. 30, 2020. Below is an overview of the results of the assessment.

There were 346 medication incidents that were reviewed by ISMP Canada. Each incident was assessed using two dimensions of the MedSCIM tool.

- **Core Event: Degree of Documentation** evaluates incident reports based on their clarity and completeness. This includes whether readers can understand **what** the medication incident was, and **why** the incident may have occurred (i.e., underlying contributing factors). Ratings on the Core Event domain can range from **1** to **3**.
- **Maturity of Culture to Medication Safety** evaluates incident reports based on the reporter's perceived approach to patient safety culture. This includes the reporter's ability to view medication incidents from a system-based perspective, rather than one focused on individual fault. Ratings on the Maturity of Culture to Medication Safety domain can range from A to D.

Results for Degree of Documentation

- With respect to degree of documentation, the **majority** of the incident reports (271 of 346) were deemed to be fully complete (i.e., **Level 1**), as the details of the medication incident were clear, and potential contributing factors were suggested.
- Approximately one-**fifth** of the incidents (71 of 346) were deemed to be 'semi-complete' (i.e., **Level 2**), as their level of documentation allowed for an understanding of what medication incident had occurred.
- **Very few** of the incidents (4 of 346) were deemed to be 'not complete' (i.e., **Level 3**). In these cases, details of the medication incident remained unclear.

Results for Maturity of Culture

- Nearly **two-thirds** (n = 222) of the analyzed incidents were characterized as having a 'generative' (i.e., **Grade A**) culture. Which means reporters went beyond simply resolving medication incidents as they occur and offered solutions to identified system flaws with the aim of preventing error recurrence.
- **Fifty two** of the 346 reports fit within the 'reactive' (i.e., **Grade C**) culture. These reports treated incidents as isolated events and did not approach the incidents from a system-based perspective or offer a solution.
- **49** of the reported incidents had a 'calculative' (i.e., **Grade B**) culture. Reporters considered how the medication system may have allowed the incident to occur but did not advance remedial strategies.
- **23** of the reports displayed a 'blame-and-shame' or 'pathological' (i.e., **Grade D**) culture, which emphasized human behaviours and individual fault in their description of events.

When a comparison was undertaken between the previous assessment and this more recent one the following results were observed:

Degree of Documentation

It was evident that COMPASS pharmacies displayed a more positive culture with more complete reporting in 2020. In the previous review, there was less than half (41 per cent) of medication incident reports classified as 'fully complete,' while the majority of incident reports (70 per cent) received in 2020 were deemed to be 'fully complete.'

Maturity of Culture

A significant improvement was also seen in the maturity of culture to medication safety, where the number of Level A incidents increased from 18 per cent in the previous review to 64 per cent in 2020.

Conclusions

The overall conclusion from the second review of medication incidents causing patient harm was that COMPASS pharmacies continue to demonstrate many areas of strength with respect to their patient safety culture.

Most incidents associated with patient harm were reported with a sufficient level of detail to describe what medication incident occurred as well as to specify potential contributing factors to the incidents. Furthermore, the majority of COMPASS pharmacies demonstrate a 'generative' approach, considering what system-factors may have allowed the incidents to occur and offering solutions to the identified problems.

Ultimately, in comparison to the previous report, COMPASS pharmacies have transitioned towards a 'generative' culture with more 'fully complete' reporting of medication incidents.

Never Events for Community Pharmacy

'Never events' are patient safety incidents that result in serious patient harm or death, and that can be prevented by using organizational checks and balances.

A new Medication Safety Self-Assessment: Focus on Never Events in Community Pharmacy reflects learning from incident analyses and on-site community pharmacy assessments, as well as expectations from standards of practice.

Never events of greatest concern in community pharmacy are listed below: Never events are death or serious patient harm as a result of the following:

- Providing a medication to which a patient has a documented allergy
- Preparing a compounded product for internal use with:
  a. an incorrect medication or active pharmaceutical ingredient; or
  b. an incorrect quantity of medication or active pharmaceutical ingredient
- Dispensing methotrexate with instructions for daily administration when prescribed for a non-oncologic indication
- Dispensing an incorrect formulation of an immunosuppressant prescribed to prevent organ transplant rejection
- Dispensing a long-acting opioid without assessment for opioid tolerance
- Failing to verify weight-based dosing of a high-alert medication for a child

More information about the complimentary self-assessment focused on never events is available from: MSSA Focus on "Never Events" in Community Pharmacy.

The full ISMP Canada Safety Bulletin can be accessed here.

Article provided by Ambika Sharma, Medication Safety Specialist, ISMP Canada

Read more

Safety Attitudes Questionnaire (SAQ) Results are Coming

In March 2021, pharmacists and pharmacy technicians were asked to complete the Safety Attitudes Questionnaire (SAQ), with the goal being to evaluate the advancement in the culture of safety within Saskatchewan community pharmacies since the first SAQ was administered in November 2018.

There were 340 responses; of these, there were 306 pharmacists and 34 pharmacy technicians that completed the questionnaire for a response rate of 25.3 per cent. This is an increase from the previous questionnaire where the response rate was 18.2 per cent.

The results of the survey are almost ready and will be provided in the next edition of the [directions] newsletter.

Please watch for these exciting results!

Continuous Quality Improvement (CQI) Plan Cheat Sheet

Note: The Quality Improvement lab in CPHR is the recommended place to document your CQI Plan

Have you included in your plan:

- New Incidents discussed during the CQI meeting?
- The action plans created for each incident?
- Updates to previously discussed incidents and their action plans?
- New MSSA Focuses (non-medication) identified from the most recent MSSA?
- The action plans created for the MSSA improvement initiative?
- Updates to previous MSSA improvement initiatives?
- Upcoming staff safety education?

Contact your Pharmacy Quality Improvement Coordinator if you need assistance.

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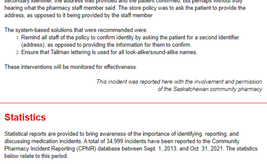
Another Helpful Reference – CQI Cheat Sheet

To assist pharmacy staff in ensuring they have a complete CQI plan, SCPP has created a CQI Plan Cheat Sheet. Pharmacies are encouraged to print off the cheat sheet and have it handy when developing, monitoring and updating their CQI plan. Please see below a copy of the cheat sheet. To access a copy for printing, click here.



Shared Learning Opportunity

Wrong Patient/Similar Names

A patient came into the pharmacy to pick up their new prescription. The patient stated their name to the pharmacy staff member who then pulled the prescription from the drawer.

It was noted at that time that the prescription was new and so the pharmacy staff member alerted the pharmacist in order for the pharmacist to provide. The pharmacist provided the education and the patient left with the prescription.

The next day, the patient returned with the prescription indicating that the name on the prescription was not theirs and that they thought they had received someone else's prescription. The error was confirmed that the patient had received another patient's medication with a similar name.

Upon review of the incident by the pharmacy staff, it was determined that the main contributing factors that led to the incident occurring were (1) Look-alike, sound-alike patient names, (2) Confirmation bias, and (3) Deviation from set store policy.

During the review of the incident, it was discovered that instead of asking the patient for their address as a secondary identifier, the address was provided and the patient confirmed; but perhaps without truly hearing what the pharmacy staff member said. The store policy was to ask the patient to provide the address, as opposed to it being provided by the staff member

The system-based solutions that were recommended were:

1. Remind all staff of the policy to confirm identity by asking the patient for a second identifier (address), as opposed to providing the information for them to confirm
2. Ensure that Tallman lettering is used for all look-alike/sound-alike names

These interventions will be monitored for effectiveness.

This incident was reported here with the involvement and permission of the Saskatchewan community pharmacy

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of 34,999 incidents have been reported to the Community Pharmacy Incident Reporting (CPInR) database between Sept. 1, 2013, and Oct. 31, 2021. The statistics below relate to this period:

Outcomes

- **20,520** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **13,633** NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1029** reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been 3 incidents reported with an outcome of DEATH.

Incident Types – Top Three

- Incorrect dose/frequency – **8,106**
- Incorrect quantity – **5,892**
- Incorrect drug – **5,887**

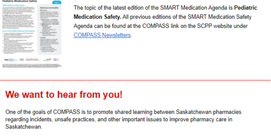
416 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

1051 Continuous Quality Improvement (CQI) meetings have been held.

Medication Safety Self-Assessment (MSSA) – Community and Ambulatory Care Is Being Revised

ISMP Canada has formed a committee of community pharmacy practitioners, pharmacy regulatory bodies (PRBs), patients and public members, etc., to review and revise the comprehensive Medication Safety Self-Assessment (MSSA) for Community/Ambulatory care. This is the MSSA that Saskatchewan pharmacies currently complete every two years.

As the committee finalizes the content, pharmacy teams across Canada are being asked to test the new MSSA as a part of the validation process. Please see the invitation (left) for more information regarding how to volunteer to be a test site, or contact Jeannette Sandford at info@saskpharm.ca



The SMART Medication Safety Agenda

The topic of the latest edition of the SMART Medication Agenda is **Pediatric Medication Safety.** All previous editions of the SMART Medication Safety Agenda can be found at the COMPASS link on the SCPP website under COMPASS Newsletters.

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

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

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