COMPASS
Community Pharmacy Professionals Advancing Safety in Saskatchewan

[directions]

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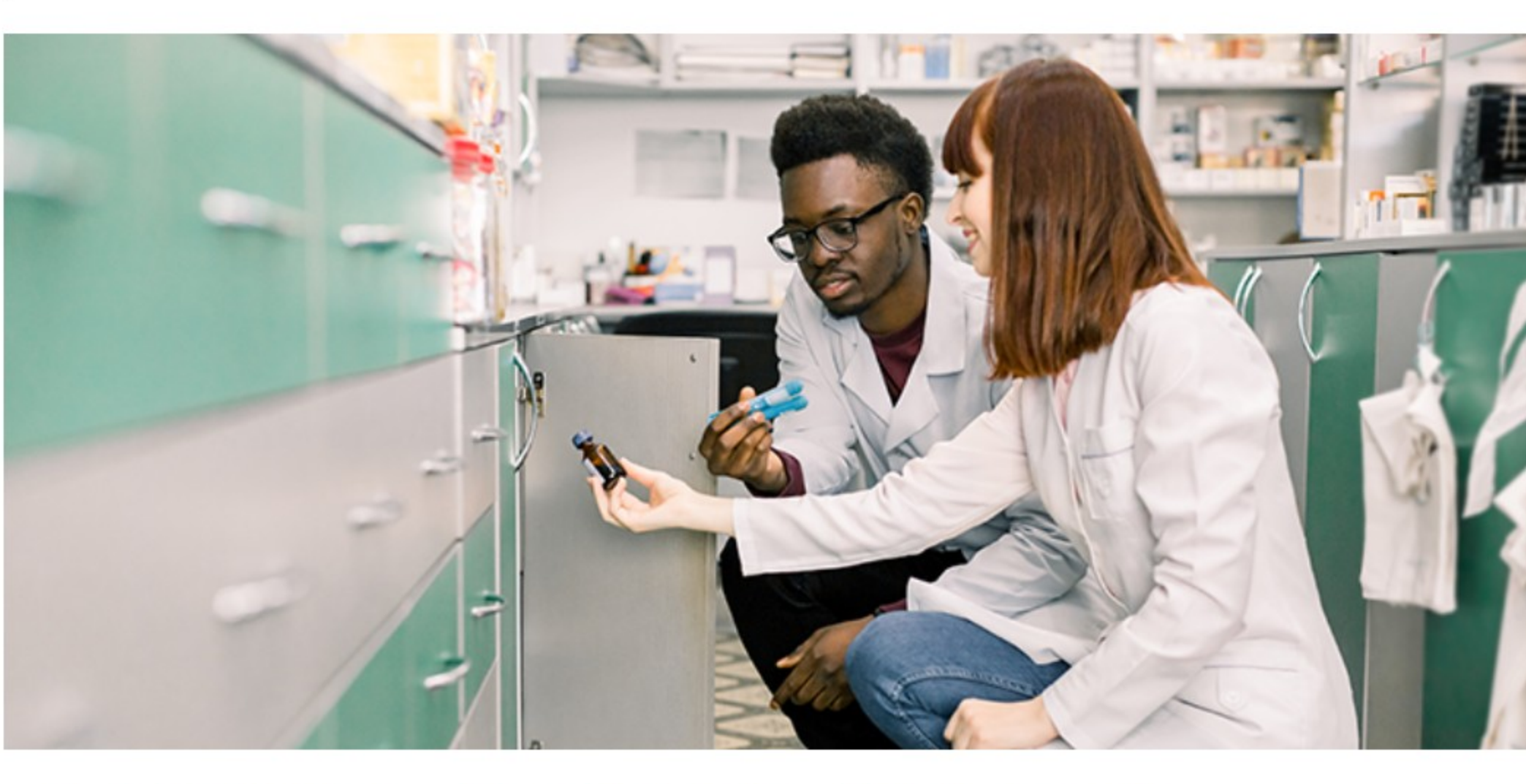

Safety Attitudes Questionnaire (SAQ) Results

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

Within a community pharmacy, a strong safety culture can help drive more robust medication safety initiatives to provide increased patient safety and high-quality patient care. Therefore, through assessing the safety attitudes of the pharmacy professionals within the pharmacy we can get a measure of the maturity of the safety culture.

There were 340 responses to the survey. 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 survey asked questions on six different domains: Teamwork, Safety Culture, Job Satisfaction, Stress Recognition, Perception of Management, and Working Conditions. The results for each domain were stratified into two areas of focus: years of experience and workplace type. Some of the highlights from the survey are as follows:

Teamwork and Safety Culture scored the highest amongst most respondents irrespective of the pharmacy type or years of service.

For Teamwork, independently owned pharmacy professionals scored higher on every question compared to their counterparts at banner and corporate pharmacies. However, corporate pharmacies had the biggest improvement. In terms of work experience, respondents with zero to five years of pharmacy work experience (e.g., new, or recent grads) scored relatively lower on average in Teamwork compared to those with more than five years of work experience. This is similar to the 2018 SAQ results.

For Safety Culture, respondents collectively felt strongly that medication errors are handled appropriately when they occur and they themselves would feel safe as a patient at their respective pharmacy. This implies that pharmacy staff generally continue to feel confident in the standards and processes that are in place to maintain patient safety.

Job Satisfaction and Perception of Management were the third and fourth highest scoring domains amongst respondents.

For Job Satisfaction, this domain saw the second highest percentage improvement regardless of pharmacy type or work experience. Although respondents generally agree that they like their job and that their respective pharmacy is a good place to work, pharmacy morale was again a dividing issue amongst respondents. Independently owned pharmacy respondents scored higher in job satisfaction and pharmacy morale, compared to their banner and corporate pharmacy counterparts. Corporate pharmacy had the lowest score for this domain, but also had the largest improvement from 2018.
For Perception of Management, the results of this SAQ demonstrate that all respondents, regardless of pharmacy type or years of work experience, agree that pharmacy management supports their daily efforts and do not knowingly compromise patient safety. However, the lack of sufficient staffing was still a concern for 25 per cent of all respondents.

Working Conditions and Stress Recognition were the lowest scoring domains amongst respondents.

While the Working Conditions domain was one of the lowest scoring domains, it had the highest percentage of improvement. The main area of concern was regarding inadequately trained new personnel, especially pharmacy assistants. Pharmacy professionals with increased years of experience correlated with an increased score for working conditions. Independent pharmacies scored higher on every item, compared to banner and corporate pharmacies. This is the same as 2018.
Interestingly, in the 2018 SAQ, there was a relatively large gap in the average scores between banner and corporate pharmacies, with banner pharmacies scoring higher. However, with this SAQ, the average scores were identical, potentially indicating that changes might have been undertaken in corporate pharmacies to improve working conditions.

For Stress Recognition, this was the only domain with a decrease in the overall weighted average score. There was also a decrease in score regardless of pharmacy type, with corporate pharmacies showing the greatest decrease. The decrease in the weighted score may indicate a reduction in pharmacy professionals' ability to acknowledge how and when their performance is impacted by stressors and, therefore, they may not be taking steps to resolve the situation.
Respondents with fewer than five years of work experience recorded a lower average score compared to respondents with six or more years of work experience. They also had the greatest reduction in scores compared to the 2018 results.

When stratified by pharmacy type, respondents from independent pharmacies reported lower levels of stress recognition compared to banner and corporate pharmacies.

Conclusion

Based on the responses gathered from the second administration of the SAQ, pharmacy professionals generally have an increasingly positive view of the current safety culture.
Domains such as Teamwork and Safety Culture have again had higher overall scores and there is a general consensus that medication errors, when they occur, are handled appropriately by a well-coordinated pharmacy team.

Some challenges re-identified by this SAQ are perceptions of pharmacy morale, which tend to differ amongst respondents from different types of pharmacies.

As well, although respondents trust management and believe that patient safety is never knowingly or purposely compromised, there is a need for management to address staffing levels in order to be better aligned with the workload and to ensure training and supervision of new pharmacy personnel.

Finally, new or recent pharmacy graduates feel that their input could be better received, especially in terms of patient care, and may benefit from a comprehensive pharmacy orientation/team-building program. As well, COVID may have accelerated the optimization of staff scheduling, resulting in successful teamwork outcomes, but potentially dampened the ability of pharmacy professionals to recognize stressors that could compromise staff wellness and patient safety.
For more information or a copy of the full report access Sask. Safety Attitudes Questionnaire_SAQ_Final Report_2021.

The information in the above article is adapted from the SAQ research results prepared by ISMP Canada

Unauthorized Access to Methadone in a Community Pharmacy Contributes to Death

Methadone has a narrow therapeutic index, and an inappropriate dose can lead to serious harm. As part of an ongoing collaboration with a provincial death investigation service, ISMP Canada received a report describing the death of an individual who ingested a large amount of methadone that had been inappropriately accessed in a community pharmacy.

A patient was receiving buprenorphine-naloxone (available as Suboxone or a generic) from his regular community pharmacy for opioid use disorder treatment. On the day of the incident, the patient jumped over the dispensary counter into the unattended staff-only area, took a bottle containing methadone, and began drinking the methadone liquid directly from the container. Once at the hospital, the patient's condition began to deteriorate rapidly. Despite intubation, administration of naloxone, and other interventions, the patient died the next day because of multi-organ failure due to acute methadone toxicity.

This bulletin highlights several strategies that pharmacies can implement to improve the safe storage and security of their methadone inventory and suggests a proactive approach to prepare pharmacy staff who may be faced with an emergency situation, such as a patient experiencing an opioid overdose. Select recommendations are shared here:

- Ensure that methadone preparation and storage areas are always supervised by pharmacy staff, with no opportunity for unauthorized patient access.
- Store methadone in a secure manner, out of public view.
- Reconcile narcotic inventory more often than every six months (SCPP recommends four times per year), and conduct daily inventory counts and reconciliation for frequently dispensed controlled substances, such as methadone.
- Educate staff to recognize an individual experiencing a mental health crisis and empower them to follow up their concerns with the patient and relevant health care providers.
- Ensure accessibility to an emergency preparedness protocol to guide staff in circumstances such as an opioid overdose and/or a patient presenting with suicidal ideation.

The full ISMP Canada Safety Bulletin can be accessed here.

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

Read more

CPhIR Website - Focus on the Home Page

The Community Pharmacy Incident Reporting (CPhIR) website has many resources in addition to the incident reporting program and the MSSA program. In this edition, the focus will be on the Community Pharmacy Incident Reporting (CPhIR) Home Page. There are many useful tools that can be found on the home page. Aside from all the tabs at the top of the page that takes the user to the different tools e.g., Search, Stats, Your Account, etc. there are also the following tools:

1. **Tip of the Week**

   The tip of the week includes useful tips for three areas.

   i) Have you Ever…. – this tip gives a scenario of a possible situation where a medication incident might occur for the user to consider.
   ii) Look Alike/Sound Alike – this tip provides a list of different drugs names that could be confused due to look alike/sound alike characteristics.
   iii) Dangerous Abbreviations – this tip provides an example of a dangerous abbreviation, an explanation of the abbreviation, and a recommendation of what to use instead.

2. **Poll**

   This part of the home page asks a poll question that the user can participate in. By clicking on the "Poll Results" button, the user can see the results of the poll.

3. **Newsletters**

   This section has available to the user a quick way to access all the ISMP Canada newsletters.

   This section includes the following newsletters:

   i) CPhIR Newsletter
   ii) SMART Medication Safety Agenda
   iii) ISMP Canada Safety Bulletins
   iv) SafeMedicinesUse.ca Newsletter

4. **Your Open Incidents**

   This section includes all the pharmacy's open incidents. Once an incident entry is complete and there is nothing further that will be entered into the incident information, the incident can be closed. A pharmacy doesn't have to wait for the default 90 days to close an incident.

To access the Home Page, log into CPhIR using your designated username and password (same as when entering an incident) at the Community Pharmacy Incident Reporting Site.

New MSSA Coming!

The Medication Safety Self-Assessment (MSSA) is getting a refresh. The new MSSA will be launched by ISMP Canada in March 2022. Watch for more information and details in an upcoming SCOPe/MicroSCOPe.

Shared Learning Opportunity

Incorrect Quantity / Copying Over a Prescription

A patient came into the pharmacy to pick up a prescription for an antibiotic with the directions of one capsule three times daily for 10 days.

The patient had been on the antibiotic previously, as one capsule three times daily for seven days. The pharmacy staff that entered the prescription copied over the previous prescription and modified the sig directions for the medication to be taken for 10 days. However, they did not modify the quantity which stated 21 capsules.

The patient noticed once they got home that there were not enough capsules in the vial for the full 10-day course, and so returned to the pharmacy to obtain the additional capsules. The pharmacy staff confirmed the patient should have gotten 30 capsules instead of 21 capsules and provided the patient with the additional doses.

Upon review of the incident by the pharmacy staff, it was determined that due to the pharmacy staff copying over an old order that was not the same as the new order, the error occurred. The main contributing factors that led to the incident occurring were (1) an inappropriate workflow process, 2) an environmental, staffing, and workload problem, and (3) a staff education problem.

The system-based solutions that were recommended were:

1. To confirm that all the prescription information is exactly the same before copying over a prescription. If any part of the prescription is different then the prescription is not to be copied over.
2. To educate pharmacy staff to discontinue the process of copying over antibiotics or other short-term medication orders, as the dose, quantity, etc. are likely to be different.
3. To ensure that independent double checks are completed prior to the prescription being provided to the patient, especially if the pharmacy is busy or the person filling the prescription has been interrupted during the process.

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 **35,974** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between Dec. 1, 2013, and Dec. 31, 2021. The statistics below relate to this period.

Outcomes

- **20,753** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **14,125** NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,078** reported incidents did result in HARM, with most of these in the category of MILD or MODERATE HARM. There have been four incidents reported with an outcome of DEATH.

Incident Types – Top Three

- Incorrect dose/frequency – **8,403**
- Incorrect drug – **6,044**
- Incorrect quantity – **6,012**

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

1,114 Continuous Quality Improvement (CQI) meetings have been held.

The SMART Medication Safety Agenda

In August 2021 the topic for the SMART Medication Agenda was **Look-Alike/Sound-Alike Drug Names**. However, due to the timing of the directions newsletter, this topic has not been featured in a [directions] newsletter. During QIRs, it has been noted that one of the common contributing factors to errors has been look-alike/sound-alike drug names, therefore this SMART Safety Agenda is being highlighted in this edition of directions. All previous editions of the SMART Medication Safety Agenda can be found under 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 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

COMPASS: Jeannette Sandiford, Assistant Registrar – Field Operations and Quality Assurance – jeannette.sandiford@saskpharm.ca

CPhIR: ISMP Canada: cphir@ismp-canada.org

MSSA: ISMP Canada
mssa@ismp-canada.org

Technical Support (COMPASS): 1-866-544-7672