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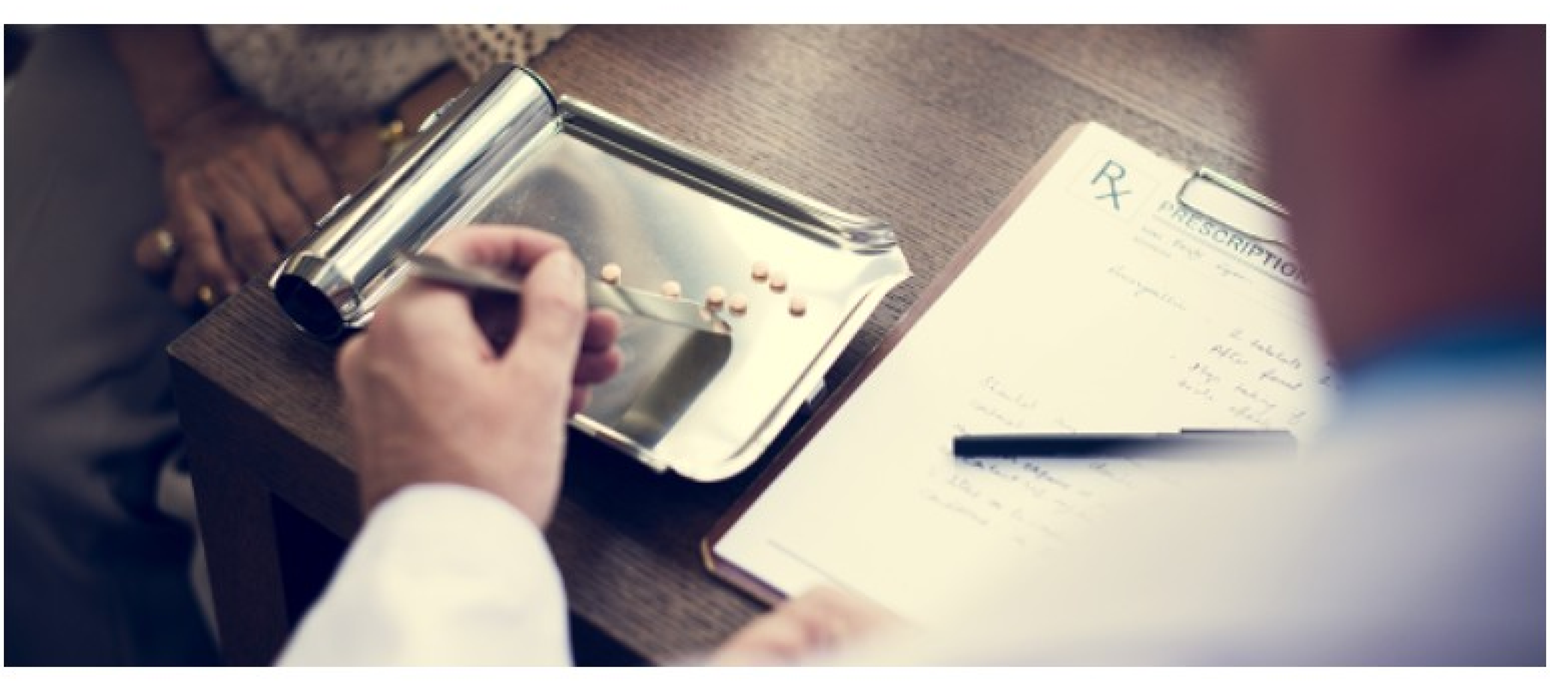
COMPASS — Community Pharmacy Professionals Advancing Safety in Saskatchewan

COMPASS Program Newsletter Volume 7 Issue 2 April 2022



Balancing Safety and Efficiency in Community Pharmacy

Efforts to address the high workload and multifaceted nature of patient care in community pharmacies may lead to prescription processing practices that can put patient safety at risk.

This bulletin highlights the findings from a multi-incident analysis of errors reported in the community pharmacy setting and identifies opportunities for process improvements.

The analysis identified six areas where measures intended to expedite prescription processing contributed to medication incidents. These measures can be grouped within three stages of prescription processing in community pharmacies: order entry, filling, and pickup (Figure 1).

Figure 1. Problems grouped by prescription processing stage – order entry, filling, and pickup

Prescription Order Entry

- Copying a previous prescription file
- Delay in profile updates

Prescription Filling

- Inadequate management of medication changes involving compliance packaging
- Repeat scanning of one item's bar code to represent multiple items

Prescription Pickup

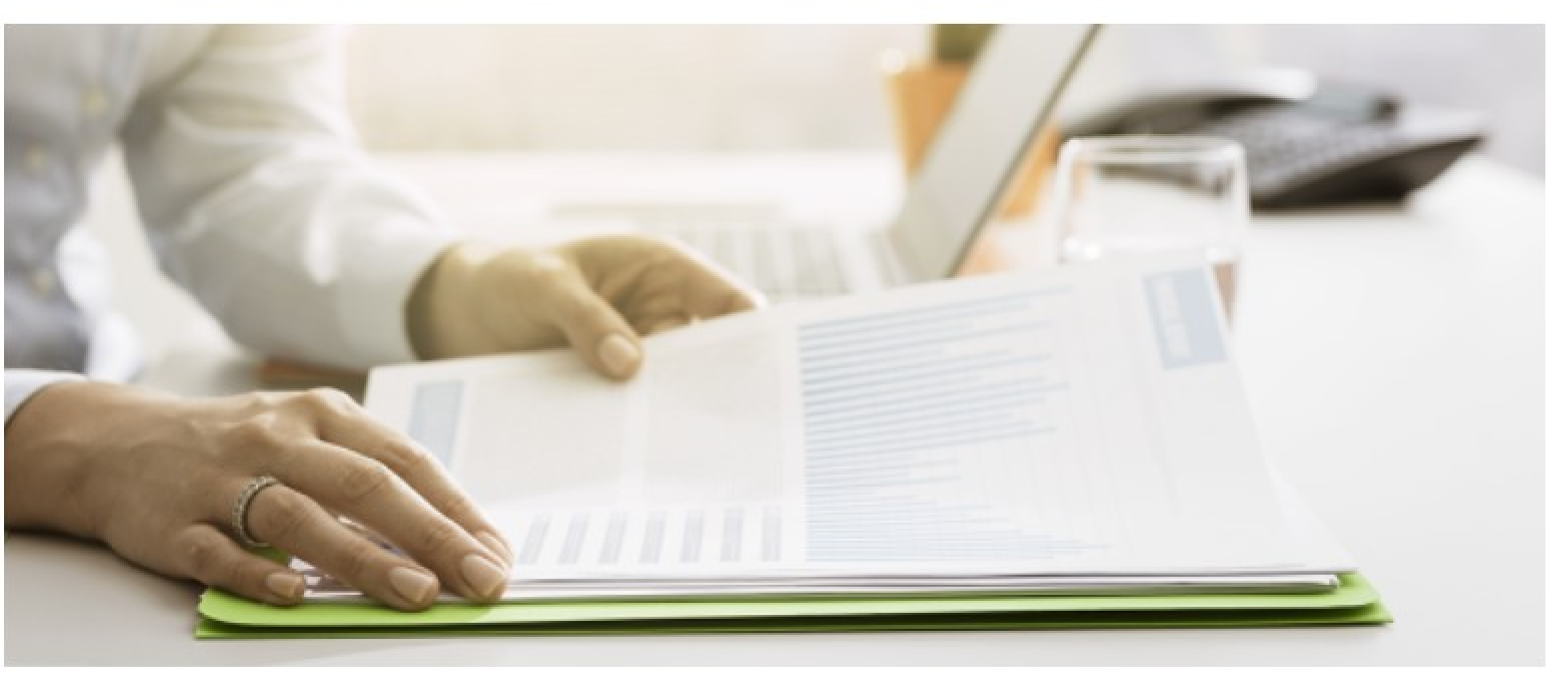
- Inadequate patient identification
- Lack of dialogue with patients

The complex demands of patient care and the often-high-pressure practice environment are key considerations when designing workflow in community pharmacies to ensure that processes and systems do not compromise patient safety.

Learning from the analysis of these errors is shared to help pharmacy teams better understand the potential risks associated with problematic processes and to encourage consideration of how various technologies and available resources can be better utilized to optimize efficiency without compromising safety.

Read the full bulletin for incident examples and improvement tips for each identified subtheme.

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

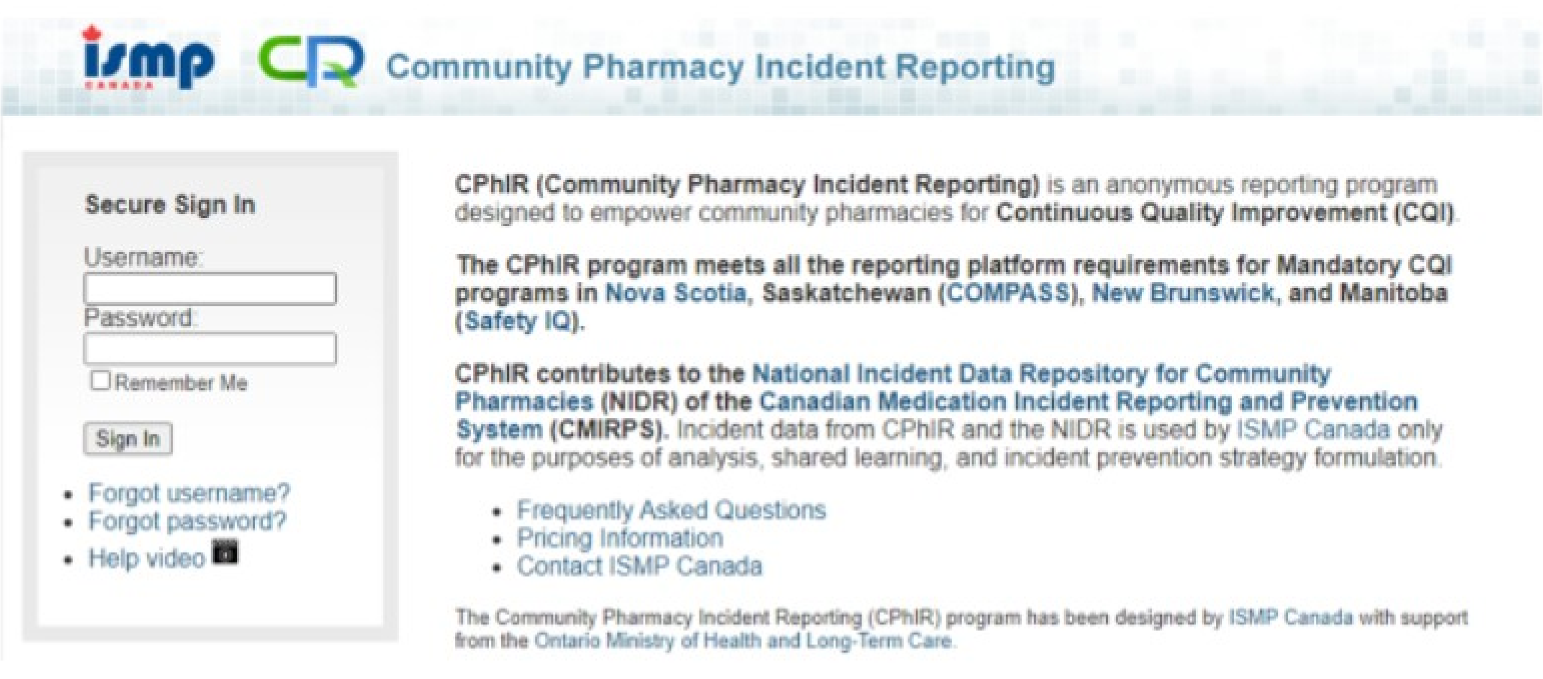


Reporting Incidents in Duplicate Programs

During Quality Improvement Reviews (QIRs) the Field Officers have been made aware of situations in which community pharmacies have more than one program in which they are required to report medication incidents.

Generally, there are two programs: the CPhIR program and the company or corporate program.

Community pharmacies are reminded that reporting medication incidents and near misses into the Community Pharmacy Incident Reporting (CPhIR) program is a bylaw requirement, and therefore all near misses and medication incidents that reach the patient must be entered into the CPhIR program, regardless of whether they are also entered into the company or corporate program.



CPhIR Website – Focus on New MSSA

The Community Pharmacy Incident Reporting (CPhIR) website has many resources in addition to just the incident reporting program, including the MSSA program.

In this edition, the focus will be on the updated Medication Safety Self-Assessment (MSSA) that has been developed and validated by an expert advisory panel, which included patient and family advisors, practising pharmacists and pharmacy technicians, pharmacy regulatory authorities, academic institutions, a national pharmacy association, and a prescriber.

Saskatchewan pharmacies needing to complete an MSSA will now use this updated version.

COMPASS pharmacies have been using ISMP Canada's MSSA-CAP (2006 Version) to assess practices and monitor improvements in their pharmacy. This previous version of the MSSA-CAP will be closed to new assessments, but the MSSA data will remain available to pharmacies for review, and is accessible via the menu.

ISMP Canada will provide a cross reference table between the versions to facilitate comparison.

The new Medication Safety Self-Assessment for Community Pharmacy has been available since the week of March 28, 2022. For CPhIR subscribers, access to the MSSA is included in the annual fee. For more information on or questions regarding the updated MSSA, email mssa@ismpcanada.ca.

To access the updated MSSA, log into CPhIR using your designated username and password (same as when entering an incident) at Community Pharmacy Incident Reporting Site (ismp-canada.org) and navigate to the MSSA portal located at the top of the home page.

Shared Learning Opportunity

Incorrect Drug/Look-Alike/Sound-Alike Drugs

A patient presented at the pharmacy to pick up a prescription for the antibiotic eye drop, Ciprofloxacin 0.3% drops. However, Ciprodex 0.3/0.1% eye drops were dispensed.

The patient used the eye drop for two days and suffered mild harm. The error was discovered when the patient came in to get a different eye drop because the previous one was not resolving her condition.

Upon review of the incident by the pharmacy staff, it was determined that the error occurred at the order entry stage due to a misunderstanding of the prescription, caused by a confirmation bias. Ciprofloxacin eye drops were rarely dispensed at the pharmacy; however, Ciprodex was dispensed very commonly.

The main contributing factors that led to the incident occurring were identified as (1) miscommunication of the drug order, specifically a misunderstood order (2) look-alike/sound-alike drug names, and (3) an environmental, staffing, and workload problem, specifically interruptions and staffing deficiencies.

The system-based solutions that were recommended were:

1. To remind staff of common look-alike/sound-alike drug names.
2. To ensure that independent double checks are completed at order entry and at each dispensing stage where possible.
3. To encourage staff to take the time required to accurately fill a prescription, especially during busy times of the day when or if they get interrupted, or if the patient is waiting for the prescription.

(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 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.

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting, and discussing medication incidents. A total of **37,404** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between Sept. 1, 2013, and March 31, 2022. The statistics below relate to this period.

Outcomes

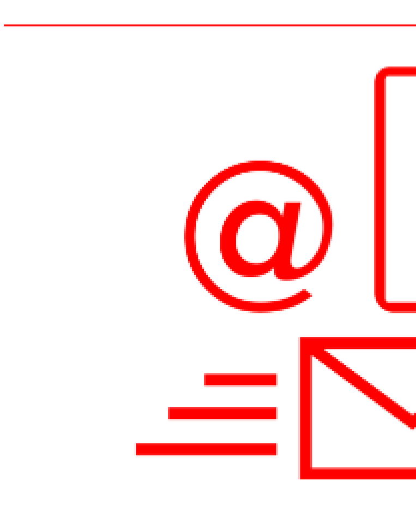
- **21,373** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **14,1870** NO HARM incidents, which means the incidents reached the patient but did not cause harm.
- **1,139** reported incidents did result in HARM, with 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 – **8,711**
- Incorrect drug – **6,318**
- Incorrect quantity – **6,202**

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

1,228 Continuous Quality Improvement (CQI) meetings have been held.



The SMART Medication Safety Agenda

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

Contact

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