SMART Medication Safety Agenda

Logged Prescriptions

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).

Table 1.

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

Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada
CMIRPS Canadian Medication Incident Reporting and Prevention System
SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux
COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan
Si Safety. Improvement. Quality.

SMART Medication Safety Agenda

Logged Prescriptions

To Log or Not to Log

INCIDENT EXAMPLE:
A patient brought in a prescription for multiple medications to be filled, but one was inadvertently logged. At pickup, the patient's daughter noted that a medication was missing. Pharmacy staff checked the original prescription and filled the missing medication.

POTENTIAL CONTRIBUTING FACTOR:
- Miscommunication between pharmacy staff and patient

RECOMMENDATION:
- At prescription intake, ask which medications are to be filled and which are to be logged. Utilize the repeat-back method to ensure mutual understanding. Document "log" and "fill" directly on the prescription for clarity.

Unfilled but Not Unchecked

INCIDENT EXAMPLE:
A prescription written for Flovent® (fluticasone) 150 mcg was logged as Flovent® 250 mcg. Flovent® is available in strengths of 50 mcg, 125 mcg, and 250 mcg. The discrepancy was noted at the time of filling, and the need to contact the prescriber delayed the patient receiving the medication.

POTENTIAL CONTRIBUTING FACTOR:
- Lack of independent double check of prescription details prior to logging the prescription

RECOMMENDATIONS:
- Confirm illegible prescriptions with the prescriber at the time of logging to prevent misinterpretation and to avoid an unnecessary delay in filling.
- Develop a policy to require verification with the original prescription before filling a logged prescription.

Reconcile the Profile

INCIDENT EXAMPLE:
A patient requested a refill for Lyrica® (pregabalin); an outdated, logged Lyrica® 75 mg prescription was incorrectly filled, despite an available updated prescription for Lyrica® 150 mg. The error was corrected.

POTENTIAL CONTRIBUTING FACTOR:
- Lack of process to inactivate old prescriptions when therapeutic regimens are updated[1]

RECOMMENDATION:
- Configure the software to prompt inactivation of therapeutic duplicates in the patient's profile when logging prescriptions with therapeutic changes. This prompt can then be bypassed with a documented reason.

Table 2.

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:

Reference
1. ISMP Canada. Balancing Safety and Efficiency in Community Pharmacy. ISMP Canada Safety Bulletin. 2021;21(7):1-4.