Medication Safety Culture

Not a numbers game: Indicator Matrix (MedSCIM)

By Anastasiya Shyshlova, Jim Kong, Calvin Poon, and Ceritna Ho

Medication incident reporting is becoming a standardized and mandated practice across many Canadian provinces. Health Canada, the Institute for Safe Medication Practices Canada (ISMP Canada), the Canadian Institute for Health Information (CIHI), and the Canadian Patient Safety Institute (CPSI) collaborate under the Canadian Medication Incident Reporting and Prevention System (CMIRPS) program to capture, analyze, and disseminate shared learning from medication incidents. To determine the understanding of an organization or institution in medication safety, we often look at its safety culture. This involves examining the patient safety culture of a healthcare institution. Medication Safety Culture Indicator Matrix (MedSCIM) is a novel tool designed by ISMP Canada to assess the quality of qualitative data gathered from medication incidents for a more robust evaluation of the overall medication safety culture in various healthcare settings.

MedSCIM tool allows healthcare organizations to assess the maturity of medication safety culture in an organization.

**TABLE 1:** MedSCIM dimensions

<table>
<thead>
<tr>
<th>Core Event</th>
<th>Maturity of Culture to Medication Safety (MedSCIM)</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: Report fully complete</td>
<td>MedSCIM provides sufficient information to describe the medication incident and contributing factors.</td>
<td></td>
</tr>
<tr>
<td>Level 2: Report semi-complete</td>
<td>MedSCIM provides sufficient information to describe the medication incident. No information is provided about contributing factors.</td>
<td></td>
</tr>
<tr>
<td>Level 3: Report not complete</td>
<td>MedSCIM provides insufficient information to allow meaningful qualitative analysis.</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 2:** Maturity of medication safety culture

<table>
<thead>
<tr>
<th>Grade D: Blame and Shame</th>
<th>Grade C: Reactive</th>
<th>Grade B: Calculative</th>
<th>Grade A: Generative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1D</td>
<td>1C</td>
<td>1B</td>
<td>1A</td>
</tr>
<tr>
<td>2D</td>
<td>2C</td>
<td>2B</td>
<td>2A</td>
</tr>
<tr>
<td>3D</td>
<td>3C</td>
<td>3B</td>
<td>3A</td>
</tr>
</tbody>
</table>

**TABLE 3:** Incident: Case Examples

**Core Event:** Medication incident

**Maturity of Culture to Medication Safety (MedSCIM):**

**Grade D:** Blame and Shame

**Grade C:** Reactive

**Grade B:** Calculative

**Grade A:** Generative

**Outcome:**

- Level 1: Report fully complete
- Level 2: Report semi-complete
- Level 3: Report not complete

**Definition:**

- The medication incident provides sufficient information to describe the medication incident and contributing factors.
- The medication incident provides sufficient information to describe the medication incident. No information is provided about contributing factors.
- The medication incident provides insufficient information to allow meaningful qualitative analysis.

**Discussion:**

The documentation states the error clearly: the incorrect dose of Coversyl® (perindopril) was filled. As well, contributing factors such as constant interruptions were provided in the narrative description. Measures were taken to make sure the error does not happen again, such as documenting a specific note on the patients file, as well, a system change to inform staff to provide more accurate wait times to patients.

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