Introduction
- Continuous quality assurance (CQA) is necessary for advancing safe medication practices in community pharmacies.
- COMPASS (Community Pharmacists Advancing Safety in Saskatchewan) is a CQA pilot project for community pharmacies in Saskatchewan with support from Saskatchewan College of Pharmacists and ISMP Canada since September 2013.
- The Community Pharmacy Incident Reporting (CPhIR) program (available at: http://www.cphir.ca) is one of the key components in COMPASS designed specifically for community pharmacies to anonymously report medication incidents.
- A collaborative initiative between the Saskatchewan College of Pharmacists and ISMP Canada since September 2013.

Objectives
- Provides tools and support to help Saskatchewan community pharmacists recognize, resolve, and learn from medication incidents.
- Allows pharmacists to anonymously report incidents, proactively evaluate the safety of their systems, and develop action plans to continually improve their medication-use process.
- Advances medication safety and CQA in pharmacy practices.

Methodology
- From September 2013 to August 2014, 575 medication incidents were voluntarily reported to ISMP Canada by 10 community pharmacies in Phase I of COMPASS.
- Reported incidents underwent quantitative and qualitative analysis using the multi-incident analysis method as outlined in the Canadian Incident Analysis Framework.¹

Results
- Of 575 incidents reported, 84% (482 of 575) were near misses, 15% (88 of 575) caused no patient harm, and 1% (5 of 575) resulted in mild harm to the patient.
- Majority of incidents occurred at the order entry (n= 361; 68%) and dispensing stage (n=158; 30%).
- 26% (146 of 575) of reported incidents were related to incorrect quantity. Only 3 reported incidents had a drug therapy problem associated.
- 346 of these incidents that were reported with rich narrative information underwent qualitative analysis.
- The main themes identified from this multi-incident analysis were (1) Patient or caregiver initiated medication safety enhancements, (2) Miscommunication of drug orders, and (3) Incorrect drug product.

Discussion
- Incorporating the patient and/or caregiver in the circle of care can effectively prevent medication incidents, thus enhancing safe medication use.
- Medication incidents are often multifactorial in nature and often relates to the pharmacy workflow.
- It is important for pharmacies to proactively review their workflow and identify potential errors.
- The presence of these medication incidents does not seem to negatively affect the pharmacist-patient relationship.

Conclusion
- The pharmacist and pharmacy staff members should have a working relationship with the patient to prevent medication incidents.
- Pharmacy manager, as the team leader, should periodically review the workflow environment with the staff to identify error prone areas and implement safeguards.
- If everyone within the circle of care, including the patient, are proactively involved in safe medication use, then as a team we can reduce medication incidents and enhance patient safety.
- COMPASS is now expanded to Phase II in 2015 with 86 participating community pharmacies in Saskatchewan.

References

The authors would like to acknowledge the support from Ontario Ministry of Long-term Care for the development of the CPhIR program. CPhIR contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS). Available at: https://www.ismp-canada.org/cmirps/index.htm.

The authors would like to acknowledge the Saskatchewan College of Pharmacists for its support and facilitation of COMPASS. Available at: http://www.cphir.ca/Pages/compass.aspx. The incidents anonymously reported by community pharmacy practitioners in Saskatchewan to CPhIR were extremely helpful in the preparation of this poster.