COMPASS

Community Pharmacists Advancing Safety in Saskatchewan Continuous Quality Assurance Pilot Project: Phase I

Certina Ho, RPh, BScPhm, MISt, MEd; **Marvin Ng**, BSc, PharmD Student; **Kelly Ng**, BSc, PharmD Student; **Carol Lee**, C.H.I.M.; **Jeannette Sandiford**, BSP

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 work 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.

FIGURE 1.
Medication incidents classified by severity of outcome

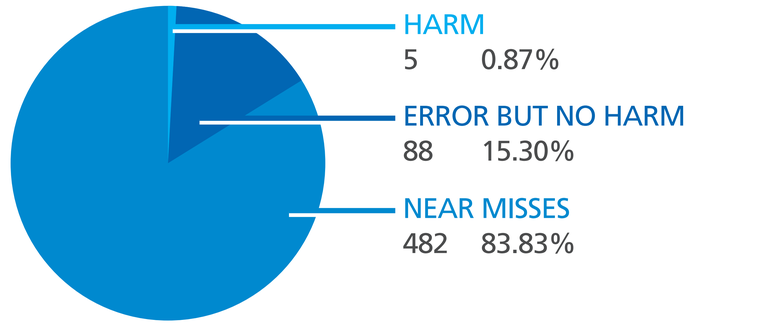


FIGURE 2.
Medication incidents in pharmacy workflow

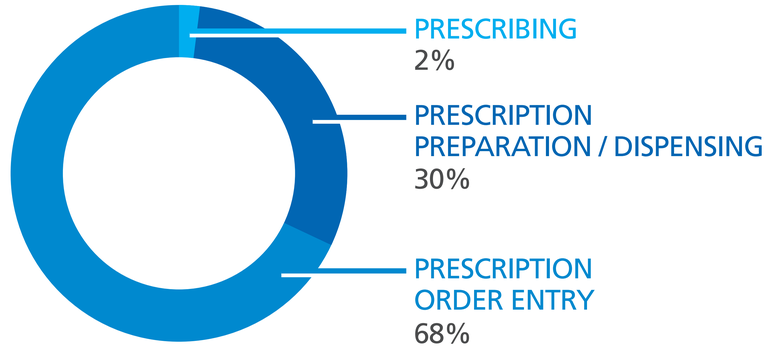
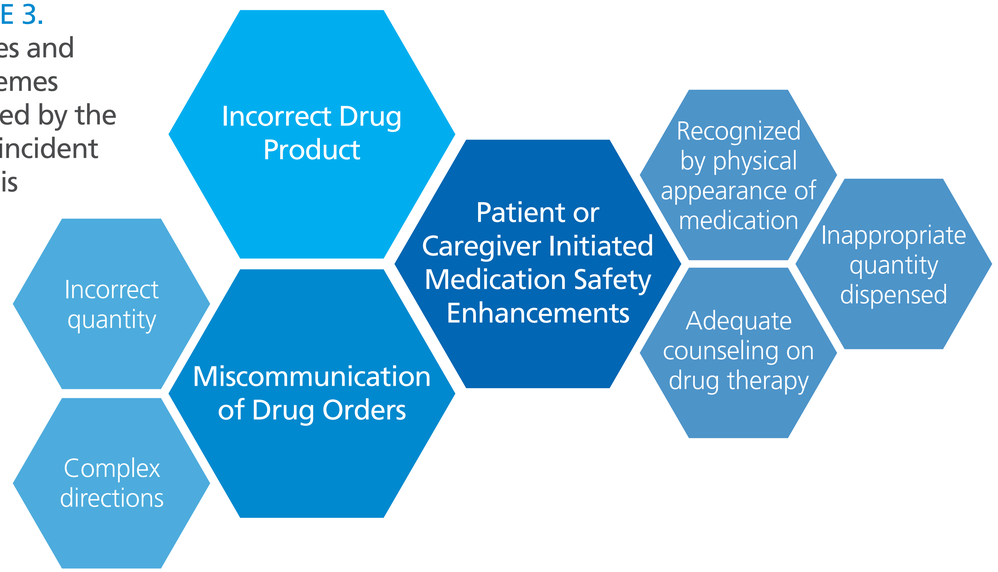


FIGURE 3.
Themes and subthemes revealed by the multi-incident analysis



References.
1. Incident analysis collaborating parties. Canadian analysis framework. Edmonton, AB: Canadian Patient Safety Institute; 2012 [Cited 2013 June 24]. Available from: http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Pages/default.aspx

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