Continuous Quality Assurance Pilot Project in Saskatchewan Community Pharmacies

Certina Ho, RPh, BScPhm, MISt, MEd; **Jim Hanwen Kong**, BSc, Pharm D Candidate; **Carol Lee**, C.H.I.M.

Institute for Safe Medication Practices Canada
L'Institut pour l'utilisation sécuritaire des médicaments du Canada

Community Pharmacy Incident Reporting

Objectives

- Continuous quality assurance (CQA) is necessary for advancing safe medication practices in community pharmacies.
- COMPASS™ (Community Pharmacists Advancing Safety in Saskatchewan) (http://saskpharm.ca/site/cqa_pp?nav=03) is a CQA pilot project for community pharmacies in Saskatchewan, Canada.
- A component of this pilot project is to determine the underlying system-based contributing factors to medication incidents in community pharmacies voluntarily reported to the ISMP Canada's Community Pharmacy Incident Reporting (CPhIR) Program (www.cphir.ca) and focus on the need for learning from incident reporting.

Methods

- From September 2013 to April 2014, 435 incidents were voluntarily reported by 9 community pharmacies participating in the COMPASS CQA pilot project.
- The medication incidents were analyzed, with a focus on the severity of outcome of the incidents and medication-use areas associated with these incidents in community pharmacy.

Results

- Of the 435 incidents, 89% (389 of 435) were near misses, 10% (42 of 435) resulted in no harm, i.e. medication was dispensed, but no symptoms were detected and no treatment was required in patients. 1% (4 of 435) resulted in mild harm to patients, i.e. symptoms were mild, temporary and short term; no treatment or minor treatment was required. (Figure 1)
- The majority of incidents occurred during the Prescription Order Entry and the Prescription Dispensing stages.
- The most common types of incidents reported were incorrect quantity (28%), incorrect dose/frequency (18%), and incorrect prescriber (15%). (Figure 2)
- Possible contributing factors of these near misses and medication incidents include illegible prescription orders, dangerous abbreviations, look-alike/sound-alike drug names, and interruptions in workflow. (Figure 3)

FIGURE 1.
MEDICATION INCIDENTS CLASSIFIED BY OUTCOME ($n = 435$)

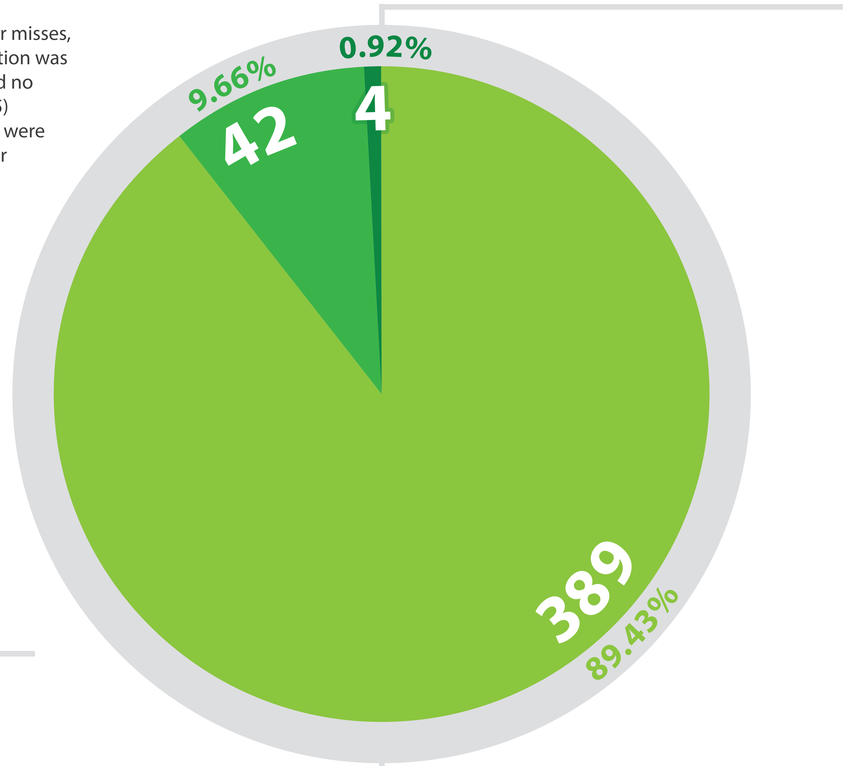
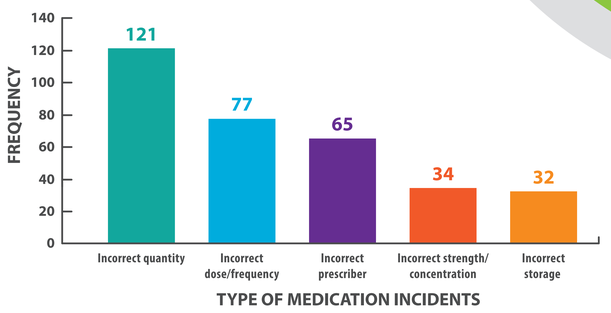


FIGURE 2.
TYPE OF MEDICATION INCIDENTS



Discussion

- Learning from medication incidents is a fundamental step to medication system improvement.
- Through the analysis of incidents and sharing of findings, practitioners can learn from reported incidents and implement safeguards.
- Creating a culture of patient safety with the support of a non-punitive reporting system needs to be encouraged within all areas of pharmacy practice.
- As the ISMP Canada CPhIR Program continues to accumulate data over time, trends and changes in medication incident patterns can be identified. CPhIR will continue contributing to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (www.ismp-canada.org/cmirps/), and help identify new areas of focus to enhance medication safety.

FIGURE 3.
POSSIBLE CONTRIBUTING FACTORS TO NEAR MISSES AND MEDICATION INCIDENTS

KEY ELEMENTS IN MEDICATION SAFETY	POSSIBLE CAUSES OF NEAR MISSES AND MEDICATION INCIDENTS
Miscommunication of drug order	Illegible prescription orders
	Dangerous abbreviations
Drug name, label, packaging problem	Look / sound-alike drug names
Environmental, staffing, or workflow problem	Interruptions in workflow

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