Patient Counselling:
A current practice tool utilized by pharmacists to mitigate medication errors

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Background

Medication errors can occur at any stage of the medication-use process:

- Prescription counselling, a key transitional stage can play a large role in mitigating errors.
- According to National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards of Practice for Pharmacists, patient counselling was emphasized as “providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications[1]

Objectives

To identify the solutions and practices that community pharmacists are currently undertaking to mitigate errors

To encourage pharmacists and patients to be more involved in the mitigation of medication errors

Approach

- A multi-incident analysis was performed on incidents reported to the Community Pharmacy Incident Reporting Program (CPhIR) (http://www.cphir.ca), developed by the Institute for Safe Medication Practices Canada (ISMP Canada)
- The search included counselling-related terms, such as “counsel”, “question”, “discover”, “explain”, “teach”, and “pick up”
- Between September 2014 and August 2015, 115 incidents met the inclusion criteria
- All of the incidents were “near misses”, meaning that no harm was done, but potentially could have resulted in harm if the error was not intercepted.

Results

Two main themes were identified: pharmacist-led identification of error and patient-led identification of error. The two main themes are stratified into subthemes below.

Pharmacist-led Identification of Error

Prescription Reconciliation

“When the pharmacist gave the name of the medication and **then read directions from the prescription to tell patient how to take it**, she realized the discrepancy – [she had] filled regular clarithromycin which should be "one BID" and the directions were for "two once daily.”

- Reference back to the original prescription while counselling
- Reconcile the original prescription and medication

Product Demonstration

“When counselling the patient and **showing the medication**, [the pharmacist] realized that the capsule looked different. The correct medication was changed and the patient did not receive any wrong doses.”

- Display the actual medication acts as a **double check** by two stakeholders (pharmacist and patient)

Follow Up of Therapy

“[The pharmacist] saw that Micronor® was written, but the instructions were 2 tabs HS… **[the pharmacist] asked her if she experienced nausea since she was taking 2 tablets instead of the usual one**. She then pointed out that she takes 60mg and this is 0.70mg…the prescription was actually written for Remeron®.”

- Use a **checklist** when trying to identify drug therapy problems (i.e. prime questions)

Patient-led Identification of Error

Use of Patient Identifiers

“The patient brought in 5 [prescriptions] on 4 papers. Three were for her and two for her husband. When counselling patient, **she questioned the two [medications] that were for her husband and then it was noticed that all were processed [under] her name.**”

- **Standardize** the packaging and storing of medications, by patient name, as opposed to by family
- State the number of prescriptions per patient

Therapy Confirmation

“At pick-up, the pharmacist discovered that she had filled the [prescription] for azithromycin with the usual supply of 5 [days] instead of 7 as [prescribed]. The **mother had mentioned that the [doctor] wanted her to be on it longer** and that prompted the [pharmacist] to double check the [prescription].”

- Use descriptive words to **identify therapy changes** (e.g., decreased, the same, increased)
- Optimize auxiliary labels for **reminders** and education

Storage Confirmation

“The patient was picking up her prescription and it was taken from the regular storage drawer. **She remarked that she expected it to be in the fridge**. [The pharmacist] checked the product and it should be refrigerated after preparation.”

- Use colour-coded **reminders** to identify patients receiving medications that require special storage

Future Practice

- Pharmacists should utilize patient counselling not only as an opportunity for education but also for double check and error mitigation.
- Behavioural changes are highly effective at catching errors during transitions of care.
- Asking open-ended questions allow the pharmacists to assess the prescription’s accuracy, both therapeutically and technically.
- Use “Prime Questions”, a series of open-ended questions which pharmacists ask patients regarding the medications they are receiving.[2,3]
- When asking the prime questions, some pharmacists may encounter friction, as patients are embarrassed or uncomfortable in responding to an unfamiliar individual.
- When pharmacists initiate encounters with a knowledge-based statement, patients are more likely to answer the open-ended prime questions.[4]
- Amalgamation of relationship-building and patient interviewing can allow pharmacists to effectively identify errors and equip the patient with knowledge.
- Patients are additional gatekeepers for advancing safe medication use; engage patients in the medication-use process as an independent double check.

References

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