We were able to provide practical insights. We extracted medication incidents involving compliance-pack related medication incidents. We searched the Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPhIR) Program. CPhIR provides users with secure online interface to document medication incidents, export data for analysis, and view comparisons of individual pharmacy and aggregate data. CPhIR depends on voluntary reporting of medication incidents.

We extracted medication incidents involving “blister pack”, “compliance pack”, “pill pack”, and/or “bubble” from the period of June 2012 to May 2013. A total of 170 incident reports met inclusion criteria and were included in this qualitative, multi-incident analysis. Medication-use system unpredictability and variations of the multi-compartmental design, which increases the vulnerability in the pharmacy workflow due to its packaging introduces further complexity and unpredictability. Although multi-medication compliance aids may facilitate patient’s adherence and improve treatment outcomes, the complexity of the design and procedures for preparation may potentially lead to an increased risk of errors. Recognizing the vulnerabilities of compliance pack preparation creates opportunities for pharmacists to implement additional safeguards to enhance medication safety.

A total of 170 incident reports met inclusion criteria and were included in this qualitative, multi-incident analysis. Two prescriptions from the hospital discharge order were put under the blister pack. Several errors were made. (Yet, these errors were not discovered until the pharmacist was trying to fax the patient’s family doctor for subsequent refills at a later time).

The SIG on allopurinol was read “TO the once daily.” Clopidogrel was supposed to be continued for 39 days after discharge as per the hospital discharge order, but it was only filled for 28 days without putting the refill for the remaining 11 days. (Note: 28-day supply was typical for blister packs for a four-week supply). The pharmacy was rushing to get new orders from the patient’s family doctor and calling the hospital to clarify for warfarin since it was not on the hospital discharge order, and it was supposed to be restarted after clopidogrel was finished.

**Results:**

Two main themes were identified: (1) Order Entry and (2) Packaging Process.

**Theme 1: ORDER ENTRY**

Major concerns with order entry were associated with:

- Hospital discharge order
- Discontinuation of medication from new order
- New and prospective update of prescriptions
- Miscalculation

**Theme 2: PACKAGING PROCESS**

Other concerns in regards to packaging process included:

- Labeling
- Incorrect time of administration
- Half-label medications
- Improper return-to-stock procedures
- Dose and medication omission
- Incorrect medication and strength

**INCIDENT EXAMPLE**

Patient showed up at 4:30 pm and pharmacy’s closing time was at 5:00 pm. The patient was discharged from a hospital with numerous changes to his blister pack. Several errors were made. (Yet, these errors were not discovered until the pharmacist was trying to fax the patient’s family doctor for subsequent refills at a later time).

- Two prescriptions from the hospital discharge order were put under the patient’s family doctor’s name and not the hospital discharge doctor’s.
- The SIG on allopurinol was read “TO the once daily.”
- Clopidogrel was supposed to be continued for 39 days after discharge as per the hospital discharge order, but it was only filled for 28 days without putting the refill for the remaining 11 days. (Note: 28-day supply was typical for blister packs for a four-week supply).
- The pharmacy was rushing to get new orders from the patient’s family doctor and calling the hospital to clarify for warfarin since it was not on the hospital discharge order, and it was supposed to be restarted after clopidogrel was finished.

**RECOMMENDATIONS**

- Verify the printed prescription labels with the most current prescription order(s), especially when there is a new update or change to the patient’s profile, including hospital discharge order, new prescription, and/or discontinuation of medications, etc.
- Incorporate reminders on the computer system that will automatically flag any prospective changes needed to be made during the next compliance pack cycle.
- Conduct independent double-checks whenever possible in the pharmacy workflow.
- Implement barcode scanning (if possible) which serves as an automated independent double check to verify that the drug product and strength selected from the inventory matches with what has been entered into the patient’s profile.

**Conclusion:**

- Although multi-medication compliance aids may facilitate patient’s adherence and improve treatment outcomes, the complexity of the design and procedures for preparation may potentially lead to an increased risk of errors.
- Recognizing the vulnerabilities of compliance pack preparation creates opportunities for pharmacists to implement additional safeguards to enhance medication safety.
- 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.

**References**


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- Authors of this poster have the following to disclose concerning possible personal or financial relationships with commercial entities that may have a direct or indirect interest in the subject matter of this presentation:
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**Honorarium**

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