CANADIAN PHARMACISTS CONFERENCE | CONGRÈS DES PHARMACIENS DU CANADA

June 24-27, 2016
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Calgary, AB

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Patient Counselling: An Overarching Method to Mitigate Medication Errors and Ensure Continuity of Care

T. HE[3] and C. HO[1,2]

1. Institute for Safe Medication Practices Canada
2. Leslie Dan Faculty of Pharmacy, University of Toronto
3. University of Waterloo School of Pharmacy

UNIVERSITY OF WATERLOO FACULTY OF SCIENCE School of Pharmacy

ISMP CANADA

UNIVERSITY OF TORONTO LESLIE DAN FACULTY OF PHARMACY

CMIRPS Canadian Medication Incident Reporting and Prevention System | SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

INTRODUCTION

Patient counselling is emphasized as "providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications."[1]

- As healthcare orients towards patient-centered care, **treat patients as the active decision-makers and become more mindful of patient education** so that patient themselves can make informed decisions with respect to their own health.
- When errors occur, tracing back to the original causes of error is *reactive.* Ideally, we should be ***proactive* by reinforcing the barriers to errors through interventions** such as patient counselling.

OBJECTIVE(S)

- To identify methods and behavioural strategies in which community pharmacists can utilize during patient counselling in order to intercept potential medication incidents.
- To recommend further development on error-identifying solutions and patient education for enhancing health literacy and continuity of care.

METHOD(S)

Searched ISMP Canada Community Pharmacy Incident Reporting (CPhIR)[2] Database for medication incidents occurring at patient counselling and medication pick up from September 2014 to August 2015

Search criteria included counselling-related terms such as "counsel", "question", "discover", "explain", "teach", and "pick up".

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Selected Incidents for final analysis

115 incidents met inclusion criteria and were included in this multi-incident analysis

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Analyzed and categorized incidences into two mains themes and further divided into subthemes

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Identified potential contributing factors

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Provided recommendations to fill in patient-safety gaps

RESULT(S)

PHARMACIST-LED

Identification of medication errors at patient counselling & pick up

Prescription Reconciliation

Example: *During counselling, the pharmacist realized that she had filled regular clarithromycin, which should be "one tablet twice daily" but the directions entered was "two tablets once daily".*

Comment: Counselling while referencing back to the original prescription instead of the prescription hard copy acts as a **double check** before the patient leaves the pharmacy with the medication. This facilitates as a reconciliation between the original prescription and the prescription vial label, thereby confirming the accuracy of the medication.

Demonstration of Product

Example: *The pharmacist had mistaken a clonazepam prescription as a renewal for risperidone. The error was caught when showing the product to the patient's mom.*

Comment: Displaying the medication or boxes of medication in front of the patient acts as an independent **double check** by two stakeholders – the pharmacist and the patient**.** This verifies that the right medication is dispensed, not only by a medication expert (the pharmacist), but also the person who will be consuming the medication (the patient).

Questionable Therapy

Example: *The pharmacist read the prescription as Micronor® 2 tabs qhs which she found odd. She asked the patient if she is experiencing nausea since she was taking 2 tablets instead of the usual one. She said no. The pharmacist then pointed out that she takes 60 mg and this is 0.70 mg because the prescription was actually written for Remeron®.*

Comment: Using a **checklist** (e.g. prime questions) facilitates as a quick and effective method to identify drug therapy problems as well as potential medication errors. Asking the patient about what they know with respect to the medication's indication, duration, expectations, and adverse effects, can be considered as potential opportunities to mitigate errors. The prime questions can be tailored for new or refill prescriptions and for building patient-pharmacist relationships.

PATIENT-LED

Identification of medication errors at patient counselling & pick up

Incorrect Patient

Example: *The patient brought in five prescriptions on four 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 incorrectly processed under her name.*

Comment: **Simplify and standardize** the packaging and storing of medications by sorting the medications for different patients into different bags or baskets, *especially* if they are in the same family (common source of error).

State the number of prescriptions per patient at the time of pick up to facilitate as an **alert** to the patient for possible discrepancies and a **double check** for confirmation of accuracy.

Unfamiliar Therapy

Example: *A prescription for azithromycin was filled as its usual days' supply of 5 instead of 7 as written on the prescription. The pharmacist was prompted to double check with the mother who said that the doctor wanted her to be on it longer. Azithromycin was corrected to 7 days instead.*

Comment: Using descriptive words (e.g. decreased, the same, increased, changed, etc.) can act as behavioural **alerts** to the patient in catching potential medication errors for unintentional therapy changes.

Auxiliary labels can serve as **reminders** for patients about the indication of the medication(s) they are taking. These can also be considered as **education and information** to patients beyond the pharmacy.

Improper Storage

Example: *Evra® Patch was erroneously stored in the refrigerator while waiting for pick up. The patient asked about storage on pick up and the error was realized. The medication was replaced and dispensed.*

Comment: Using **reminders** (e.g. auxiliary labels, different coloured baskets) can help identify prescriptions with special storage requirements.

CONCLUSION(S)

- Errors identified at counselling and pick up are often "near misses", and **solutions for identifying such errors are typically behavioural in nature**.
- **Pharmacists can provide patients with the knowledge** to identify and intercept medication incidents through counselling and education.
- **Incorporating and tailoring a list of prime questions, as well as a visual demonstration of the dispensed products** to patients can mitigate errors in the final stage before the medication leaves the pharmacy.

ACKNOWLEDGEMENTS

ISMP Canada would like to acknowledge support from the Ontario Ministry of Health and Long-Term Care for the development of the Community Pharmacy Incident Reporting (CPhIR) Program (http://www.cphir.ca). The CPhIR Program also contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (http://www.ismp-canada.org/cmirps/). A goal of CMIRPS is to analyze medication incident reports and develop recommendations for enhancing medication safety in all healthcare settings. The incidents anonymously reported by community pharmacy practitioners to CPhIR were extremely helpful in the preparation of this multi-incident analysis.

REFERENCES

1. National Association of Pharmacy Regulatory Authorities (NAPRA). Model Standards of Practice for Canadian Pharmacists. March 2009. http://napra.ca/Content_Files/Files/Model_Standards_of_Prac_for_Cdn_Pharm_March09_Final_b.pdf
2. ISMP Canada. Community Pharmacy Incident Reporting (CPhIR) Database. http://www.cphir.ca

Images:
Checkmark by Nathanael Siering from thenounproject.com

CONTACT INFORMATION

For more information contact us below:

Website: www.ismp-canada.org
Telephone: 416-733-3131 (Toronto)
1-866-54-ISMPC (1-866-544-7672) (Toll Free)
Fax: 416-733-1146
Address: 4711 Yonge Street, Suite 501
Email: info@ismp-canada.org