

COMPASS

Community Pharmacists Advancing Safety in Saskatchewan Continuous Quality Assurance (CQA) Pilot Project

About COMPASS

In September 2013, the Saskatchewan College of Pharmacists and ISMP Canada started COMPASS as a continuous quality assurance initiative by providing tools and support for community pharmacies as means to enhance patient safety. One of the key component of this initiative is the Community Pharmacy Incident Reporting (CPhIR) program (available at: <http://www.cphir.ca>) which allows members to anonymously report medication incidents. All reported incidents are analyzed by ISMP Canada analysts.

Results in Brief

- From September 2013 to August 2014, 575 medication incidents were voluntarily reported to ISMP Canada by 10 community pharmacies in Phase I of COMPASS.
- 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.
- These incidents were commonly found at the order entry and dispensing stage, with a majority of them related to incorrect quantity of medication.

Results from the Multi-Incident Analysis

| Main Themes | Subthemes | Incident Example |
|---------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient or Caregiver Initiated Medication Safety Enhancements | Recognized by physical appearance of medication | Dose was increased and [the pharmacist] didn't notice when filling prescription, even missed it after checking. [The patient] was taking 2 tablets paroxetine 20mg and it was increased to 2 tablets of 30mg paroxetine. [Paroxetine 20mg tablets were dispensed]. The patient noticed and said she would take 3 tablets of paroxetine 20mg. She was not mad about it at all. |
| | Inappropriate quantity dispensed | |
| | Adequate counseling on drug therapy | |
| Miscommunication of Drug Orders | Complex directions | [The prescriber] wrote "as directed", however "Take 1 tablet daily for 21 days, stop for 7 days then repeat" was also written on the [prescription]. |
| | Incorrect quantity | |
| Incorrect Drug Product | n/a | Processed the tamsulosin prescription but grabbed dutasteride instead, counted it and put the tamsulosin prescription label on it. |

Concluding Remarks

- 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.
- COMPASS is now expanded to Phase II in 2015 with 86 participating community pharmacies in Saskatchewan.

