

SMART Medication Safety Agenda

Methadone [28:08:08 OPIATES]

SMART Medication Safety Agenda

The Community Pharmacy Incident Reporting (CPhIR) program is designed for you to report and analyze medication incidents that occurred in your pharmacy. You can learn about medication incidents that have occurred in other pharmacies through the use of the SMART Medication Safety Agenda.

The **SMART** (Specific, Measurable, Attainable, Relevant and Time-based) Medication Safety Agenda consists of actual medication incidents that were anonymously reported to the CPhIR program. Potential contributing factors and recommendations are provided to you and your staff to initiate discussion and encourage collaboration in continuous quality improvement. By putting together an assessment or action plan, and monitoring its progress, the SMART Medication Safety Agenda may help reduce the risk of similar medication incidents from occurring at your pharmacy.

How to Use the SMART Medication Safety Agenda

1. Convene a meeting for your pharmacy team to discuss each medication incident presented (p. 2).
2. Review each medication incident to see if similar incidents have occurred or have the potential to occur at your pharmacy.
3. Discuss the potential contributing factors and recommendations provided.
4. Document your team's assessment or action plan to address similar medication incidents that may occur or may have occurred at your pharmacy (Table 2).
5. Evaluate the effectiveness and feasibility (Table 1) of your team's suggested solutions or action plan.
6. Monitor the progress of your team's assessment or action plan.
7. Enter the date of completion of your team's assessment or action plan (Table 2).

Table 1.

Effectiveness and Feasibility

Effectiveness:

Suggested solution(s) or action plan should be system-based, i.e. shifting a focus from "what we need to do ..." to "what we can do to our environment to work around us."

1. High Leverage – most effective

- Forcing function and constraints
- Automation and computerization

2. Medium Leverage – intermediate effectiveness

- Simplification and standardization
- Reminders, checklists, and double checks

3. Low leverage – least effective

- Rules and policies
- Education and information

Feasibility:

Suggested solution(s) or action plan should be feasible or achievable within your pharmacy, both from the perspectives of human resources and physical environment.

1. Feasible immediately
2. Feasible in 6 to 12 months
3. Feasible only if other resources and support are available

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Unique Characteristics

Not knowing that the patient was on a tapering dose of methadone, the pharmacist made an assumption and dispensed the previous dose. This led to the patient receiving a higher-than-anticipated methadone dose. Both the patient and prescriber were okay with decreasing the dose at the next scheduled administration instead.

POTENTIAL CONTRIBUTING FACTORS:

- Methadone treatment is associated with highly individualized dosing.
- Copying a previous prescription can lead to confirmation bias and an inability to recognize a change in the current prescription.

RECOMMENDATIONS:

- Methadone doses can vary significantly within and between patients, therefore doses must be regularly reassessed and communicated to all those within the circle of care, including patients.
- Develop a methadone administration process that includes a discussion with the patient regarding identity verification, expected medication and dose, and time of last dose.

Medication-Use Process

The pharmacist inadvertently poured orange juice into a cup without methadone and witnessed the dose ingestion. Within 5 minutes of the patient leaving, the pharmacist realized the error. The pharmacist immediately called the methadone clinic and the nurse attempted to contact the patient, but to no avail. The patient returned the following day and was told no methadone had been in the cup the day before. The patient was asked about withdrawal symptoms, but thankfully, none were experienced.

POTENTIAL CONTRIBUTING FACTORS:

- The presence of methadone, much less its dose, cannot be estimated based on the physical appearance of the dispensed final product.
- An independent double check was not completed during methadone dispensing, despite its high-alert status.

RECOMMENDATIONS:

- Separate the complex process of methadone preparation from regular workflow to ensure a safe dose preparation and dispensing environment.
- Adopt a workflow that allows for independent double checks to verify order entry, dispensing, and administration of methadone.

Table 2.

Assessment / Action Plan

Effectiveness:

- Forcing function and constraints
- Automation and computerization
- Simplification and standardization
- Reminders, checklists and double checks
- Rules and policies
- Education and information

Feasibility:

- Feasible immediately
- Feasible in 6 to 12 months
- Feasible only if other resources and support are available

Progress Notes

Date of Completion:
