SMART Medication Safety Agenda

Hospital Discharge

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** (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime-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

Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada

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

COMPASS Community Pharmacy Professionals Advancing Safety in Saskatchewan

Si Safety. Improvement. Quality.

Hospital Discharge

Incident Example: Error on Discharge Prescription

During counselling by the community pharmacist, the patient asked about INR paperwork because warfarin was expected. Although not on the discharge prescription, a call to the hospital confirmed that warfarin 5 mg was supposed to be started that night.

POTENTIAL CONTRIBUTING FACTOR:

- Medication reconciliation at discharge is not implemented in all hospitals, which impacts the completeness and accuracy of the discharge prescription (incorporating unchanged, stopped, adjusted, and new medications).

RECOMMENDATION:

- Implement medication reconciliation in the community post-hospital discharge. This will generate a complete and accurate list of current medications by reviewing and comparing all available sources of information about drug therapy.

Incident Example: Communication Issues

The discharge prescription included an order for Coversyl® (perindopril) 4 mg daily, and another order for Coversyl® 2 mg daily. Discussion with the patient revealed that the prescriber intended for the lower dose to be taken if the blood pressure was low.

POTENTIAL CONTRIBUTING FACTOR:

- Discharge prescriptions often comprise of multiple pages to reflect medication changes throughout the hospital stay. These may include complex regimens with patient-specific instructions that are not clearly communicated in writing on the order.

RECOMMENDATION:

- Implement medication reconciliation in the community post-hospital discharge. This will generate a complete and accurate list of current medications by reviewing and comparing all available sources of information about drug therapy.

Incident Example: Community Integration

Prior to discharge, the patient was taught how to inject the dose using the multidose vial of Fragmin® (dalteparin). The community pharmacy dispensed the pre-filled syringe, and not recognizing the difference, the patient opted out of counselling because training was done in hospital. The next day, the patient inadvertently damaged several doses before contacting the pharmacist for help.

POTENTIAL CONTRIBUTING FACTOR:

- Depending on the formulary, the product used in hospital may not be the same as what is available in community pharmacy. Patients may mistakenly assume that each medication is available in one formulation/product.

RECOMMENDATION:

- If a patient declines counselling, verify (and document) the reason. If the reason is previous experience with the product in hospital, inform the patient that the medication may be different than what was used during their hospital stay (e.g., different colour, brand, dosage form, device, etc.).

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: