



# MedSTEP NL: Shared Learning for Medication Safety

---

Beth McGrath, Interim Director of Quality and Pharmacy Licensing

# MedSTEP NL Program Overview



Centred on principles of patient safety culture along with a just culture within pharmacy practice, encouraging learning through reporting without fear of punitive action.

- CPNL Standards for Continuous Quality Improvement and Medication Incident Reporting
- Implementation Date: July 1, 2024



656

Total reports of  
medication incidents  
and near misses

## Categories

Incidents by Medication System Stage

Incidents by discoverer

Incidents by type

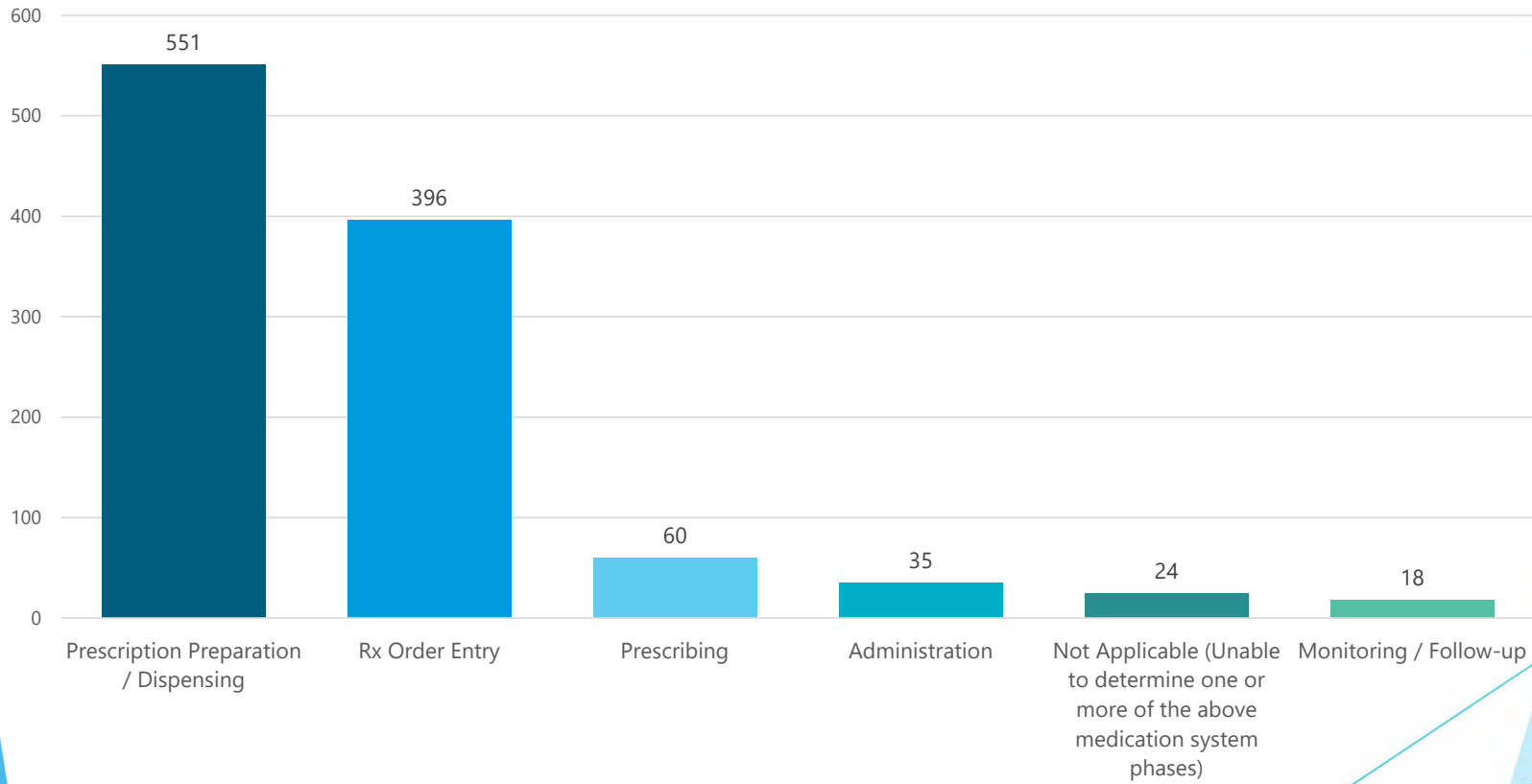
Incidents by outcome

Top 10 contributing factors

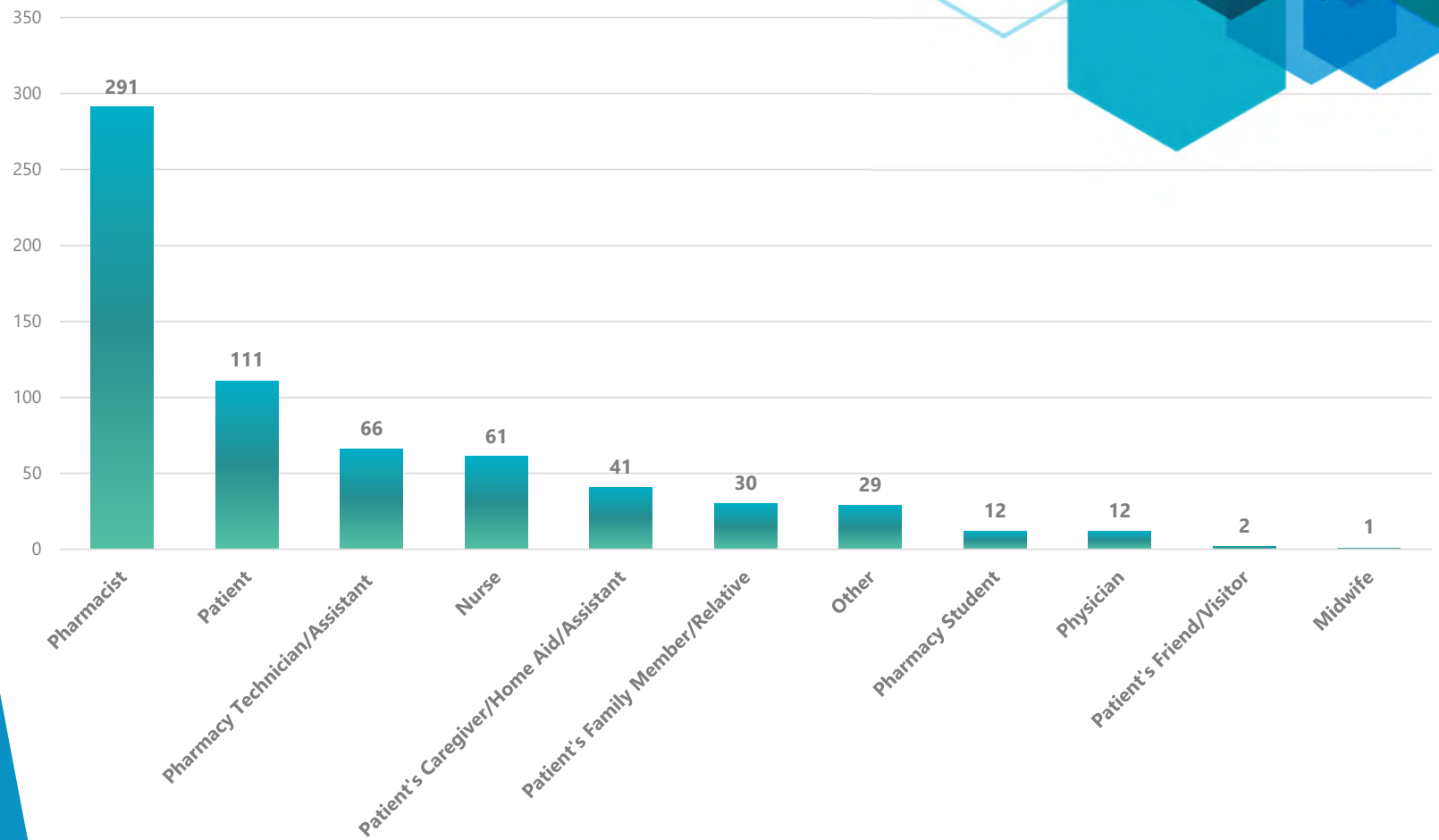
# NIDR Summary Report



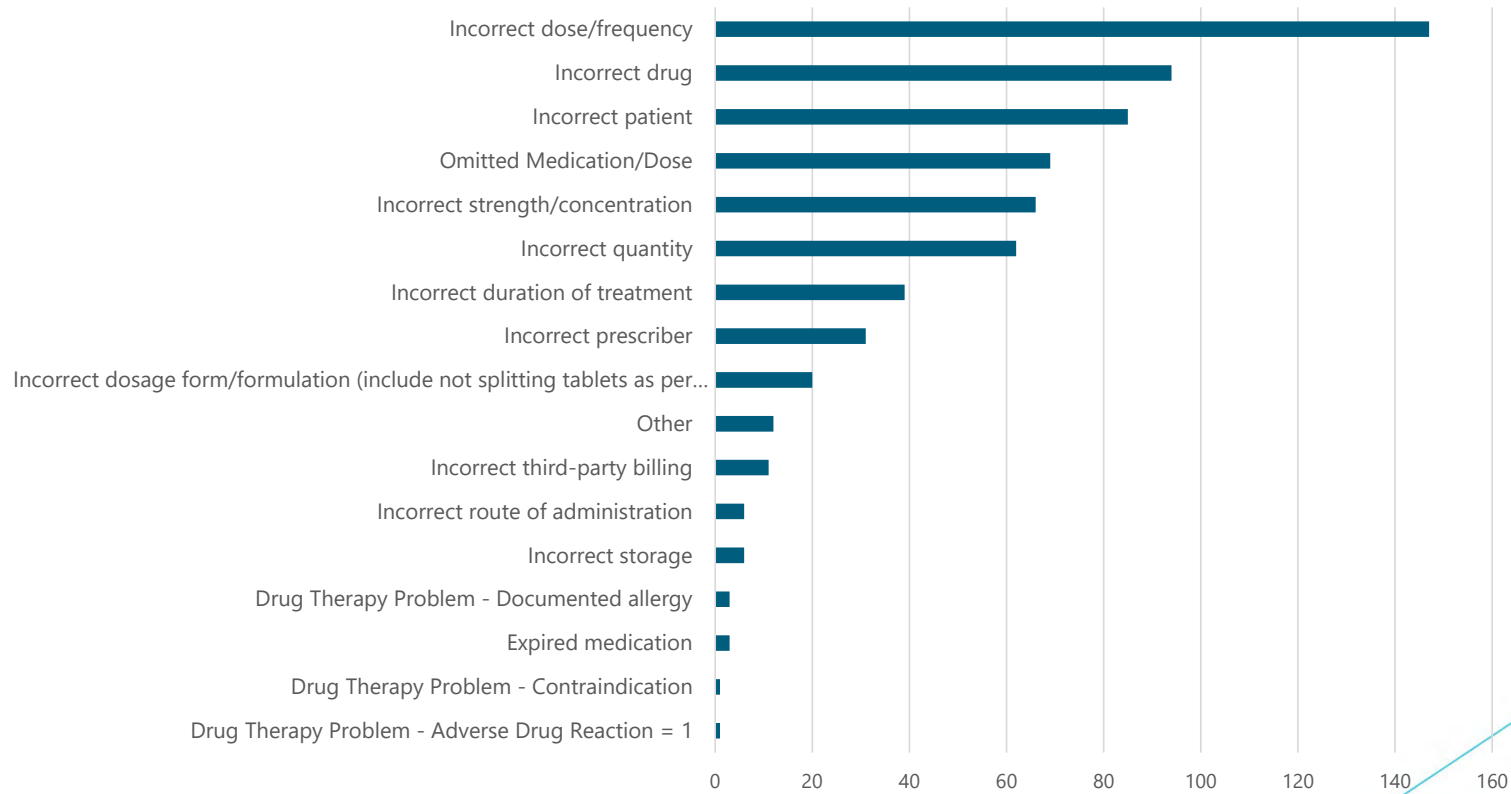
# Incidents by Medication System Stage



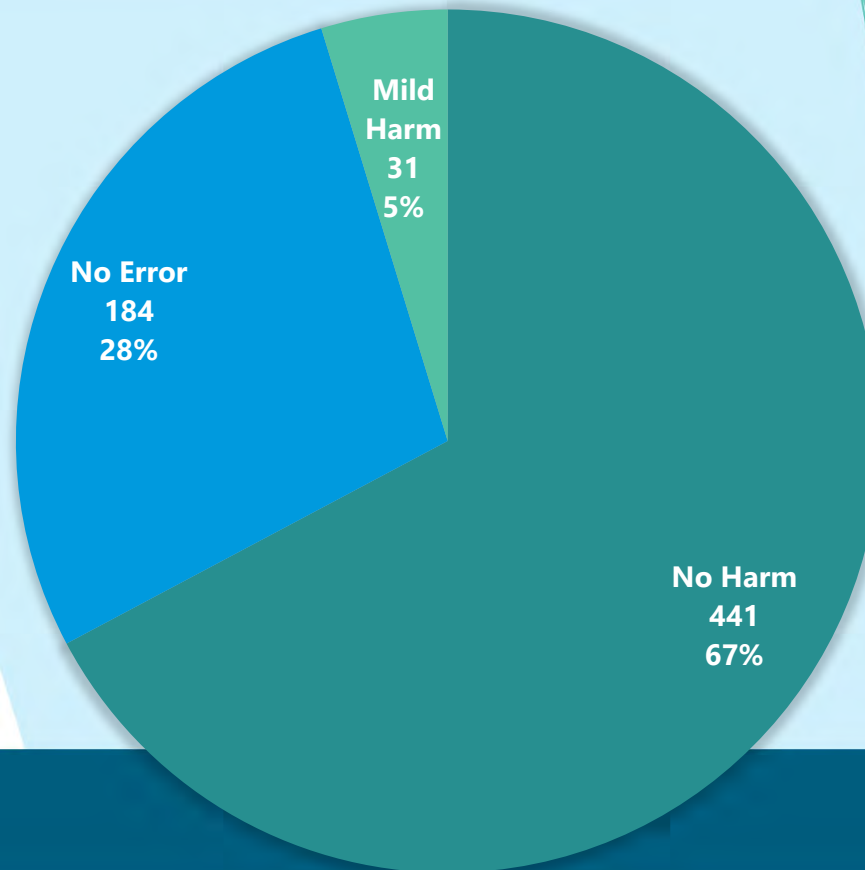
# Incidents by Discoverer



# Incidents by Type



## Incidents by Outcome



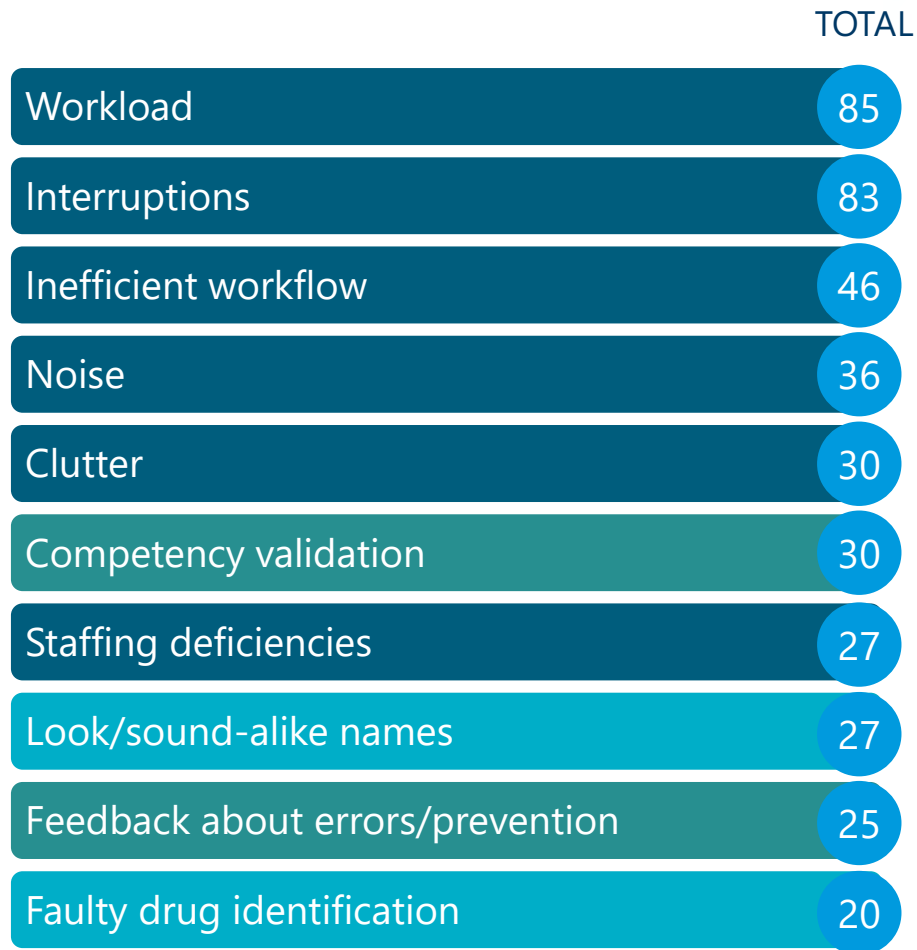
NO HARM – Medication dispensed; no symptoms detected or treatment required

NO ERROR – Medication not dispensed / Near miss / Medication discrepancy

MILD HARM – Symptoms were mild, temporary, and short term; no treatment or minor treatment required.



# Top 10 Contributing Factors



- Environmental staffing, or workflow problem
- Staff education problem
- Drug name, label, packaging problem



# REDUCING RISKS: Reducing Distractions and Interruptions



Consider the physical design of the pharmacy – perform safety-critical work such as preparing methadone doses in a separate room if possible.

Provide situation awareness to patients – explain to the patient or customer that the pharmacist is completing safety-critical work that cannot be interrupted

Appropriately time necessary interruptions – avoid interruptions during the most complex part of a task (e.g. order entry or clinical verification)

Use checklists for safety-critical processes to ensure that each step gets completed

Implement a policy that outlines appropriate usage of personal cell phones in the pharmacy

Plan safety-critical tasks for when your mind is freshest

# REDUCING RISKS: Strategies for Understaffing



## Enhance Workflow

- Implement technology for refill requests
- Minimize staff interruptions

## Ensure Balance of Safety and Efficiency

- Identify problematic processes in workflow
- Rx order entry – copying previous Rx file
- Rx filling – repeat scanning of one item's barcode for multiple items
- Rx pick up – inadequate patient identification

## Manage Stress Levels

- Ensure staff plan for and take needed meal breaks
- Encourage staff to practice self-care outside of work

## Identify High-Risk Situations

- Overstressed employees may have increased vulnerability to medication incidents
- Example – Pediatric dose calculations may benefit from an independent double check

# REDUCING RISKS: Independent Double Checks



An independent double check is when two people complete the double check without knowledge of one another's results.

## Benefits

- Lessen confirmation Bias
- Can detect up to 95% of near-miss events

If necessary, can be limited to more risky processes such as

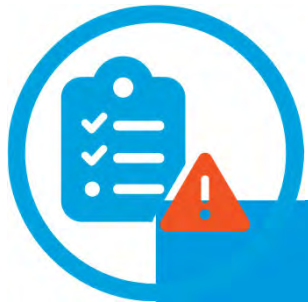
Checking high-alert medications such as direct oral anticoagulants

High risk processes such as compliance packaging, opioid agonist therapy or compounding

High risk patient populations such as pediatric patients

If a pharmacist is working alone, a delayed self-check can be performed.

A Safety Self-Assessment (SSA) proactively identifies patient safety concerns.



## Completing an SSA

- Must be completed regularly
  - during the first year of the MedSTEP NL program and every 2 years thereafter
  - Within 6 months following the change of the pharmacy's PIC
- Many MIR platforms offer an SSA as part of their service.
- Pharmacy staff members should complete SSA as a team
- Once results are submitted, they can be compared to the aggregate response to see how they are performing in a certain area in comparison to other SSA users across the country

# SAFETY SELF-ASSESSMENT: Overview



# SAFETY SELF-ASSESSMENT: Elements

Patient engagement and partnership

Medication storage and handling

Use of technology and devices

Quality assurance and continuous improvement

Addressing known areas of risk

Considerations for selected clinical situations

Considerations for selected high-alert medications



1 Complete the SSA with pharmacy team and compare to aggregate data

2 Identify areas for growth

3 Brainstorm safety strategies

4 Create an action plan – document implementation timeframe, team member responsibilities, potential challenges, how progress will be monitored

5 Prioritize action items

6 Implement strategies to improve medication safety

# SAFETY SELF-ASSESSMENT: Using for Quality Improvement





# QUESTIONS

