Multi-Incident Analysis of Incidents Associated with Harm Reported by Community Pharmacies in Manitoba
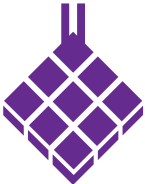# Summary of Recommendations

Theme 1: High-Risk Processes

Subtheme	Recommendations
Compliance Packaging	• Verify the printed compliance pack label (or medication administration record [MAR]) with the **most up-to-date prescription** for each medication. • Develop a **standardized procedure** to follow when a medication regimen is adjusted in the middle of the compliance pack cycle. This may include **making the change** in the compliance pack label as soon as the new prescription is received, **setting an alert** as a reminder at refill, **repackaging existing** packs, **delaying the change** with prescriber's approval, **clearly communicating** changes to the patient/caregiver using the repeat-back method, and **highlighting changes** directly on the label. • Conduct an **independent double check** of the medications in the compliance pack against the compliance pack label and the medication stock bottles.
Opioid Agonist Therapy	• Develop a **template for communication** with the prescriber regarding dose changes, including clarification of previous and current doses. • **Inactivate discontinued prescriptions** on a patient's profile before, or immediately after, entering the new prescription. Create a **copy of the new prescription** to keep with the log of witnessed and take-home doses to allow for review prior to dispensing and/or administration. • Using open-ended questions, ask the patient to **state the expected medication and dose**; repeat this back to the patient for confirmation.
Compounding	• Ensure **easy access to all resources** required during compounding, including the prescription and master formulation record. Highlight patient-specific details. • Perform an **independent calculation** to confirm the prescribed dose and quantity of ingredients. • **Require documentation of independent double checks** of calculations, active pharmaceutical ingredient (API) and excipient identities, lot numbers and expiry dates, weights and/or measurements, and the final product check.
Vaccination	• Arrange the **work environment** to facilitate safe dose preparation and verification (e.g., minimal distractions, clutter-free, with proper lighting). • Post **specific preparation instructions for each vaccine** in the preparation area. • Develop a checklist of **counselling points before** (e.g., indication, expected side effects) **and after** (e.g., monitoring and follow up) the vaccination.

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Theme 2: Patient Engagement

Subtheme	Recommendations
Patient Identification	• Request a minimum of **two patient identifiers** at pick-up, including the patient's name (e.g., address or date of birth). • **Open the bag** containing the prescriptions and review them with the patient. Confirm that each label bears the intended patient's name and the expected medication (i.e., medication name, dose, appearance).
Dialogue with Patient	• Identify and **document discussion points** (e.g., on the prescription hardcopy) during verification. Attach the documentation to the filled prescription as an alert for the pharmacist to engage in patient dialogue before the prescription is released. • Consider the use of **technology to support virtual communication** with patients when they are unable to pick up the prescriptions themselves.

Theme 3: Work Environment

Subtheme	Recommendations
External Pressure	• **Enhance the use of technology** (e.g., a medication synchronization program to align refill dates for a patient's medications) to improve workflow and reduce interruptions. • **Restart the task following an interruption** to facilitate a continuous thought process. • Schedule staff with an **appropriate shift overlap** during the busiest time(s) of the day and week. When this is not feasible, **communicate potential delays to staff and patients** to set reasonable expectations.
Storage of Look-Alike Medications	• **Fill one medication** (i.e., select the product, count as needed, and label the package) before working on another medication. • Develop a process to identify and communicate the potential for errors when **new drug products** with look-alike names, labels, or packages are added to stock. • Consider **separate storage and auxiliary labels** to distinguish look-alike products. • Consider incorporating TALLman lettering into dispensing software for differentiation.