Using the Assess-ERR™ Tool in Community Pharmacy

The ISMP Assess-ERR™ found in Appendix 3 is a simple three step medication system worksheet designed to assist pharmacists and pharmacy operators with error report investigations. Use the Assess-ERR™ tool to record errors, near-errors, and/or hazardous conditions. Examples of errors to address with the Assess-ERR™ tool include dispensing the wrong drug, strength, or dose; look-alike/sound-alike errors; calculation or preparation errors; misuse of devices; and errors in prescribing, transcribing, dispensing, and/or monitoring of medications.

Using the Assess-ERR™ helps a pharmacy convert a negative error experience into a positive learning experience that enhances the overall future safety of that pharmacy’s practice. The tool aids in developing a standardized approach to documenting error incidents and helps to reveal the underlying system deficiencies that may have caused or contributed to the error. Additionally, the tool can help raise awareness of issues that have become so familiar to pharmacists in a particular practice setting that the issues are no longer even recognized as risks.

The suggested actions mentioned in each Key Element can be used to help identify the risk-reduction strategies called for in the Assess-ERR™ tool. Space is provided on the Assess-ERR™ form to document proposed interventions, staff responsibilities, the implementation process, and any immediate required actions (changes to policies, procedures, systems or processes).

Once the problems are identified using the Assess-ERR™ tool, use the strategies below to establish appropriate action.

- **Fail-safes and constraints** involve true system changes in the design of products or how individuals interact within the system. For instance, when the pharmacy computer system is integrated with the cash register, a fail-safe would prevent the clerk from "ringing up" the prescription unless final verification by a pharmacist had occurred.

- **Forcing functions** are procedures that create a "hard stop" during a process to help ensure that important information is provided before proceeding. For example, a pharmacy computer system that prevents overriding selected high-alert messages without a notation (e.g., patient-specific indication must be entered if high-alert medication selected)

- **Automation and computerization** of medication-use processes can reduce reliance on memory. Examples include true electronic systems that can receive electronic prescriptions from a prescriber, thus eliminating data entry misinterpretation at the pharmacy; and robotic dispensing devices.
- **Standardization** creates a uniform model to adhere to when performing various functions and to reduce the complexity and variation of a specific process. For example, create standardized processes to guide the pharmacist’s final verification of a medication or to enhance the safety of giving or receiving a telephoned medication order.

- **Redundancies** incorporate duplicate steps or add another individual to a process, to force additional checks in the system. Involving two individuals in a process reduces the likelihood that both will make the same error with the same medication for the same patient. However, the potential for error still exists since the redundant step may be omitted or ignored. Examples include use of both brand and generic names when communicating medication information. Patient counseling is often an underutilized redundancy that can detect many errors.

- **Reminders and checklists** help make important information readily available. For example, prescription blanks that include prompts for important information (e.g., medication indication, allergies, patient birth date).

- **Rules and policies** are useful and necessary in organizations. Effective rules and policies should guide staff toward an intended positive outcome. However, some may add unnecessary complexity and may be met with resistance, especially when implemented in haste in response to an error. Because their use relies on memory, they should be used as a foundation to support other strategies that target system issues.

- **Education and information** are important tactics when combined with other strategies that strengthen the medication-use system. The effectiveness of these tactics relies on an individual’s ability to remember what has been presented. Thus, on their own, they offer little leverage to prevent errors. An example of an education strategy would be having pharmacy personnel read and review policies and procedures on how to correctly perform a function such as prescription verification.

Use a variety of the above strategies to focus on system issues and human factors, to continually enhance safety procedures in your pharmacy. Share this information with colleagues at your site and within your greater organization.