COMPASS
Community Pharmacy Professionals Advancing **Safety** in Saskatchewan

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Mix-up between Methadone and Buprenorphine-Naloxone

Opioid use disorder is one of the most challenging forms of addiction facing the Canadian health care system. Almost 4000 Canadians lost their lives to an opioid-related overdose in 2017. The ability to treat opioid use disorder using opioid agonist treatment with methadone or, more recently, buprenorphine-naloxone (brand name Suboxone™), has played an integral role in addressing Canada's Opioid Crisis. This bulletin shares a report of a medication incident in which non-standardized documentation of opioid agonist treatment led to preventable harm.

ISMP Canada received a report of a medication incident whereby a patient inadvertently received 8 mL (80 mg) of liquid methadone instead of buprenorphine 8 mg / naloxone 2 mg. The relief pharmacist, on duty alone at the time, was unfamiliar with the pharmacy's dispensing procedures for opioid agonist treatment and did not access the most detailed documentation record. The record for last observed dose simply read "8" without specifying either the unit of measure or the dosage form.

The pharmacist received verbal confirmation from the patient that the expected medication was methadone; immediately after ingestion, however, the patient realized it was the incorrect medication.

Standardized protocols for prescription intake, processing, dispensing, administration, and documentation for opioid agonist treatment can help to reduce the risk of errors. Key recommendations include:

- Standardize documentation templates for opioid agonist treatment to include the medication name, dose, and unit of measure.
- Implement independent double-check processes for dispensing methadone and buprenorphine-naloxone. Use more than one record to verify the medication name and dose to be dispensed.
- Ensure that doses of opioid agonists are recorded in milligrams (mg) and that entries for buprenorphine-naloxone include the amount of each component, to help clearly differentiate doses of the combination product from doses of methadone.

For a more detailed review of the potential contributing factors and recommendations, the full ISMP Canada Safety Bulletin can be accessed here.

Prepared by Ambika Sharma – ISMP Canada

Shared Learning Opportunity

Incidents that Occurred Due to Communication Gaps

Pharmacy Staff Communication

Any member of the pharmacy team may be involved in the initial patient encounter. To fulfil patients' needs regarding their medication therapy management, pertinent information obtained initially will need to be documented and communicated among pharmacy team members, especially during shift changes. Lacking documentation after patient encounters or neglecting pre-existing documentation within patient profiles has led to harm incidents.

Pharmacy Staff Communication Miscommunication between pharmacy team members, including pharmacy technicians and students	Patient requested a refill for one prescription. A relief pharmacist on duty at the time was not aware that the patient preferred brand name. The generic was dispensed. The patient returned the next day after experiencing adverse effects.

Pharmacy practice management system (PPMS) or pharmacy dispensing software provides a platform where documentation can be stored in a patient's profile for future reference and an opportunity to improve communication among team members. PPMS functions should be properly utilized in order to flag or alert pharmacy team members regarding pre-existing documentation in patient profiles, such as drug allergies, medical conditions, etc. A common issue is that documentation may not be completed consistently due to various reasons, for instance, a lack of time. As such, a cultural change to recognize the importance of documentation is warranted.

Interprofessional Communication

Optimal medication use requires effective collaboration among different health care providers. Communication within the health care system is often challenging, in particular, in situations where patients have multiple care providers. Harm incidents occurred when ambiguous prescriptions were not clarified with prescribers; this occurred most frequently when medication formulation was unspecified or handwriting was unclear. In long-term care (LTC) settings where there are multiple health care professionals practising, confusion over interprofessional roles has resulted in medication-related harm as well.

Interprofessional Communication Miscommunication between pharmacies and other health care providers, such as physicians or nurses, and misinterpretation of physician orders	The patient was seen by several physicians. A new prescription was received by the pharmacy for an increased dose of the patient's medication. At the patient's telehealth meeting, a home care nurse noted a discrepancy where an order was received from a different physician indicating that the dose should not be increased. The nurse was giving the lower dose to the patient during this period.

To help reduce communication gaps between health care providers, patients can be encouraged to keep an up-to-date medication and vaccination history and be empowered to become an active participant in managing their own health. To health care practitioners, e-prescribing should be encouraged. If a prescription is ambiguous or illegible, it should always be clarified with the prescriber.

One of the goals of COMPASS is to promote shared learning between Saskatchewan pharmacies regarding incidents, unsafe practices and other important issues to improve pharmacy care in Saskatchewan. One way to promote shared learning would be to report an interesting incident/error that occurred within your pharmacy. If your pharmacy has had an incident that would be a good learning opportunity for other Saskatchewan pharmacies, please forward it to SCPP Medication Safety at **info@saskpharm.ca**. Any information regarding the pharmacy and the person who provided the details of the incidents/errors will be kept anonymous. The College encourages open sharing of incidents/errors so everyone can learn from them.

Parts of the above information were reprinted from ISMP's Canada Report – COMPASS Harm Incidents Qualitative Analysis – July 2019 (page 4)

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **26,753** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and March 30, 2020. The statistics below relate to this time period.

Outcomes

- **16,748** reported incidents had an outcome of NO ERROR, which means the incidents were intercepted BEFORE they reached the patient.
- **9,326** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.
- **679** reported incidents did result in HARM, with most of these in the category of MILD HARM.

Incident Types – Top Three

- Incorrect dose/frequency – **6,323**
- Incorrect quantity – **4,713**
- Incorrect drug – **4,415**

368 pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries.

581 Continuous Quality Improvement (CQI) meetings have been held.

The SMART Medication Safety Agenda

The SMART (Specific, Measurable, Attainable, Relevant and Time-based) Medication Safety Agenda was introduced by the Institute of Safety Medication Practices Canada (ISMP Canada) to increase shared learning amongst pharmacies. Each edition of the newsletter deals with a specific drug or process within a community pharmacy and the related incidents that have occurred.

The cases described are actual medication incidents anonymously reported into the Community Pharmacy Incident Reporting (CPhIR) program. Potential contributing factors and recommendations are provided for users to initiate discussion and encourage collaboration towards continuous quality improvement in the pharmacy.

By putting together an assessment or action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar medication incidents in the pharmacy.

The topic of the latest edition of the SMART Medication Agenda is **Methadone**. All previous editions of the SMART Medication Safety Agenda can be found under the **COMPASS link** on the SCPP website.

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CE and Resources

The Institute of Safe Medication Practices (ISMP) Canada provides several resources through its website, including Continuing Education and Training videos. Videos vary in length from under 10 minutes to over an hour and feature a variety of topics and learning opportunities. They can be used for review and discussion at a Continuous Quality Improvement meeting, as continuing education opportunities, or for training new staff on the Medication Incident Reporting process. Access the videos by logging into the **CPhIR website** and clicking on the CE & Resources tab on the home page.

Pharmacy staff members are encouraged to review this resource, as well as the other resources available through the **CPhIR website**.

Contact Information

COMPASS ..... Jeannette Sandiford, Assistant Registrar - Field Operations and Quality Assurance – jeannette.sandiford@saskpharm.ca

CPhIR – ISMP Canada ..... cphir@ismp-canada.org

MSSA – ISMP Canada ..... mssa@ismp-canada.org

Technical Support (COMPASS) ... 1-866-544-7672