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

[directions]

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Delivery of Opioid Agonist Treatment during a Pandemic

The provision of uninterrupted opioid agonist treatment (OAT) is an important patient care service that pharmacies offer to treat opioid use disorder. OAT, particularly when provided as directly observed therapy, is challenging during the COVID-19 pandemic because of the need for physical distancing and because patients may be quarantined or self-isolating.

To support continuity of care to patients during this time, Health Canada has issued temporary regulatory exemptions for providing OAT to allow prescribers to order OAT verbally and pharmacists to extend, renew, or transfer OAT prescriptions.

Regulatory exemptions also take into account the need for physical distancing when pharmacists observe and document doses ingested by a patient and permit additional options for delivering medications to the patient's home. Following Health Canada's temporary section 56 exemption, some provincial/territorial regulatory bodies have implemented additional guidance specific to the safe delivery and observed dosing of OAT, as needed.

ISMP Canada received a report of a medication incident whereby a patient missed a dose of OAT. The patient was receiving daily directly observed therapy with buprenorphine-naloxone and had to begin a period of self-isolation. At the request of the prescriber, the pharmacy scheduled daily deliveries of the OAT medication to the patient's home. The delivery was overlooked one day because of a particularly high volume of deliveries (attributable to the pandemic).

It is important to focus on developing robust OAT-related delivery processes to support patients during the pandemic, limiting the exposure of pharmacy staff to COVID-19 by implementing virtual communication, and managing the risks for medication errors. Key recommendations include:

- Work with prescribers to proactively identify patients who could receive carries and confirm the optimal frequency of deliveries and observed doses.
- When planning each day's medication delivery schedule, give priority to patients receiving OAT to reduce the risk of a missed dose, and maintain consistent delivery times, where possible.
- Use virtual communication (if permitted in the province/territory) to connect with the patient, to enable the pharmacist's assessment of the patient, and when necessary, allow for direct observation of dose ingestion.

For a more detailed description of the recommendations to support pharmacy workflow in providing safe delivery and observed dosing of OAT, the full ISMP Canada Safety Bulletin can be accessed here.

Article provided by Ambika Sharma, Medication Safety Specialist, ISMP Canada

Shared Learning Opportunity

Incidents that Occurred Due to Non-Traditional Dispensing Procedures

Community pharmacists and pharmacy technicians sometimes offer non-traditional dispensing services that may not involve the usual linear medication-use process. Some of these procedures involve dispensing medications to long-term care (LTC) homes and preparing compliance packs. These alternative dispensing procedures may have a greater potential of causing significant patient harm if errors occur.

Long term Care (LTC) and Compliance Packaging

Many community pharmacies prepare compliance packs to assist individual patients in managing their medications or dispense medications in "rolls" or packs to LTC homes. These forms of dispensing may have additional requirements and accountabilities compared to the traditional dispensing process.

Errors often occur when there are changes to a patient's medication therapy management, for example, failure to verify the most up-to-date prescription(s) to the compliance packs, omission of independent double checks, and missing corresponding changes to prescription labels and medication administration records (MARs), etc. In addition, as compliance packs are often prepared for patients with complex medication regimens, this element of complexity increases the likelihood of errors.

Long-Term Care (LTC) and Compliance Packaging Incidents that involve the unique aspects of dispensing to LTC homes or preparing compliance packs	The pharmacy received a new prescription for a Warfarin dose change. The change was reflected on the pharmacy dispensing system but not on the nursing home dispensing instructions. As a result, the Warfarin was packed with alternating 0.5 mg and 1 mg tablets instead of the correct 0.5 mg tablets daily. The incident was discovered several weeks later when a technician was checking and noticed a mismatch between the directions and the pack. Patient was scheduled for an INR that day by the physician.

There are several important considerations when preparing compliance packs or LTC medication "rolls". Any compliance pack guides, or templates, used to prepare the packs should be updated as soon as there are changes to a patient's medication therapy and a copy of the new prescription should be attached for checking purposes. In addition, the patient's profile should be compared to the medication administration records (MARs), the prescription, and compliance pack labels each time the packs or rolls are prepared. Lastly, independent double checks should be applied throughout the process to reduce the risk of errors. For more information on compliance pack preparation, please see the multi-incident analysis conducted by ISMP Canada here.

Parts of the above information was reprinted from ISMP's Canada Report – COMPASS Harm Incidents Qualitative Analysis – July 2019 (pages 5-6).

We want to hear from you

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.

Quality Improvement Review (QIR) – Need for a Quality Improvement (QI) Plan

While performing QIRs, SCPP field officers have noticed that one of the most common issues requiring follow-up is the lack of a clear quality improvement (QI) plan. The requirements of the COMPASS Continuous Quality Improvement (CQI) program as per the SCPP Regulatory Bylaws, Part I, Section(12)(2) are that;

> *(2) Every pharmacy must have a Continuous Quality Improvement program that meets the following requirements:*
>
> *(a) anonymous reporting of Quality Related Events to an independent, objective third party organization for the population of a national aggregate database approved by Council, in which learnings can be communicated across the profession;*
>
> *(b) completion of a Medication Safety Self-Assessment every two years by all pharmacy staff;*
>
> *(c) development and monitoring of a Continuous Quality Improvement plan;*
>
> *(d) documentation of all Continuous Quality Improvements; and*
>
> *(e) participation in Continuous Quality Improvement meetings as follows:*
>
> *(i) the number of Continuous Quality Improvement meetings held per year will be determined by the Quality Improvement Coordinator and pharmacy manager in order to meet the requirements of clauses 12(2)(a), (b), (c), and (d) of Part I; and*
>
> *(ii) there shall be no less than one Continuous Quality Improvement meeting held annually.*

Aside from it being a regulatory requirement, there are benefits that come from developing and monitoring a QI plan. Having a thorough QI plan provides concrete directions or plans for medication-related system improvements. Without clear plans on what system changes need to be made, most incidents are treated as one-time incidents and have the potential to occur again.

QI Plans also allow the pharmacy team members to see if proposed changes made because of a medication incident or MSSA deficiency have made a difference in reducing incidents.

There is no way of knowing if a change has been successful unless it is monitored. Often the root cause of an incident is not initially clear; therefore, it may be necessary to make a few changes before an impact on incidents is seen. So, by developing, monitoring, and documenting the actions taken it will allow pharmacy staff to see which actions were successful.

The CPhIR tool has a "Quality Improvement" tool that can be very useful in developing a QI Plan during CQI meetings. This tool allows for the entering of incidents and any MSSA deficiencies for discussion at the meeting, as well as other issues the team may want to address.

By completing the information in this tool during or after a meeting it allows the pharmacy team to have a record of proposed actions and a documentation of any monitoring for the next meeting. The proper use of this tool is considered by SCPP as meeting the bylaw requirement for a QI Plan.

If pharmacy teams have other tools they want to use that meet the requirements or would prefer a paper version of their QI Plan, that is also acceptable. Again, the important part of the QI Plan is that it is documented, monitored, and updated as required to ultimately reduce medication incidents and make pharmacy care that much safer.

Reminder – It is Time to Complete Your Next MSSA

Most pharmacies completed their first Medication Safety Self Assessments (MSSA) in 2017. As per the SCPP Regulatory Bylaws, Part I, Section (12,) an MSSA must be completed every two years, therefore most pharmacy MSSA reports are now due to be repeated. The main benefit of repeat assessments is that they act as a comparison, in order to identify the areas where improvements have been made since the last MSSA was completed and which areas still need improvements. If you have not already done so, start preparing your pharmacy team for the completion of the next MSSA. More information regarding the completion of the MSSA can be found in the SCPP COMPASS Manual.

Statistics

Statistical reports are provided to bring awareness of the importance of identifying, reporting and discussing medication incidents. A total of **27,962** incidents have been reported to the Community Pharmacy Incident Reporting (CPhIR) database between December 1, 2017 and June 30, 2020. The statistics below relate to this time period.

Outcomes

- **17,210** reported incidents had an outcome of NO ERROR/NEAR MISS, which means the incidents were intercepted BEFORE they reached the patient.
- **10,023** NO HARM incidents, which means the incidents reached the patient, but did not cause harm.
- **729** reported incidents did result in HARM, with most of these in the category of MILD HARM.
- **368** pharmacies have either started or completed their Medication Safety Self-Assessment (MSSA) online data entries
- **618** Continuous Quality Improvement (CQI) meetings have been held

Incident Types – Top Three

- Incorrect dose/frequency – 6,608
- Incorrect quantity – 4,900
- Incorrect drug – 4,639

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 Direct Oral Anticoagulants. All previous editions of the SMART Medication Safety Agenda can be found under the COMPASS link on the SCPP website under COMPASS Newsletters.

I'm Pharmacy Podcasts and Evaluation

"What does it mean to be a pharmacist? Or a pharmaceutical scientist? From drug discovery to deprescribing, we are exploring and pushing the limits of the profession and the science resulting in better medications, a better health system and better health. This podcast project dives deep into both emerging professional trends in pharmacy and breakthrough science led by our world-leading faculty and research teams. It shines a light on student experiences, interests and growth and taps into the widespread success of our alumni community." (I'm Pharmacy Podcast home page)

The I'm Pharmacy Podcast is available at https://im-pharmacy-podcast.simplecast.com/. The podcast series was created as an additional resource for pharmacy students and pharmacy professionals by the University of Toronto Leslie Dan Faculty of Pharmacy to learn more about current topics and issues in pharmacy practice.

Topics of the first series include: interprofessional collaboration, medical cannabis education, common ailments, personal branding, using social media as a tool, and continuous professional development.

Each episode is approximately 20-30 minutes in length. The creators of the podcasts would like to invite you to listen to any or all of the episodes and complete a 5-minute evaluation survey. The survey can be accessed here until the end of July 2020. Your feedback on the relevance and quality of the materials discussed in these episodes will be very helpful for future improvements.

Contact Information

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