Delivering pharmacy services is a complex, human process. Although technology is a helpful tool to assist in identifying red flag situations, mistakes can still occur. "Close-Up on Complaints" presents some of these errors so that practitioners can use them as learning opportunities.

Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

Medication Reconciliation Key in Transfer of Care

SUMMARY OF THE INCIDENT

This incident occurred when an elderly patient was discharged after a short stay in the hospital. Upon her release, the hospital pharmacy faxed a copy of her Best Possible Medication History (BPMH) form to the community pharmacy. Later that day the discharging physician phoned the community pharmacy to make changes to the patient's medication therapy. He requested to decrease the patient's doses of gabapentin and ferrous fumarate, to stop her furosemide, and to titrate off pantoprazole.

The patient's daughter visited the pharmacy to pick up her mother's prescriptions and returned home to care for her mother.

About four days later, the patient was re-admitted to the hospital with delirium. Hospital pharmacy staff contacted the patient's community pharmacy for a list of her current medications. It was then discovered that the community pharmacist had mistakenly given the patient four medications that had never been prescribed for her. These included three psychotropic/anticonvulsant medications and one calcium channel blocker — olanzapine, valproic acid, paroxetine, and nifedipine.

The four inaccurate medications were stopped when the patient was re-admitted to the hospital. After a week, she was discharged and sent home with her daughter.

WHY DID THIS HAPPEN?

When the patient was initially discharged, the hospital faxed a copy of her BPMH form to her community pharmacy. The second page of the form had no personal identifiers on it and it was discovered — after medications had been dispensed — that the second page of the BPMH belonged to a different person and was accidently included in the fax to the community pharmacy. The patient was dispensed, and took, all four of the medications that were listed on the second page of the BPMH.

Through the investigation process, it was determined that the pharmacist did not meet Standards of Practice for dispensing medications. For all prescriptions the pharmacist must reconcile the patient's drug therapy, perform a therapeutic check that considers patient specific factors, document the changes and rationale, and communicate the changes to the patient or the patient's agent. It was also determined that the pharmacy did not have appropri-

Have a Complaint?

Anyone who is not satisfied with the care of services provided by a pharmacy, pharmacist, pharmacy technician, student or intern can file a formal complaint with the College. Complaints must be received in writing and include as much detail as possible. The College investigates all written complaints.

ate safeguards in their workflow to ensure the accuracy of the patient's therapy. In particular, the Designated Manager (DM) had not implemented systematic procedures for receiving discharge orders.

COMPLAINT OUTCOME

The College's Inquiries, Complaints & Reports Committee (ICRC) oversees investigations of each complaint the College receives. The Committee considers a practitioner's conduct, competence and capacity by assessing the facts of each case, reviewing submissions from both the complainant and the practitioner, and evaluating the available records and documents related to the case.

The Committee found that this error was caused by a lack of due diligence and therapeutic insight when reviewing the medication history, and a lack of proper procedures in the pharmacy – especially when dealing with a vulnerable patient. The Committee noted that the pharmacist should have more closely followed the Standards of Practice, such as providing counselling, engaging in a therapeutic check of medications in relation to their appropriateness for the patient, and following up with the prescriber regarding any issues or discrepancies.

The Committee ordered that the pharmacist appear in person to receive an oral caution.

LEARNING FOR PRACTITIONERS

Pharmacists must use their medication expertise to ensure that the medications prescribed for patients are appropriate, and that they are dispensed accurately. This is especially true for patients who are transitioning between healthcare settings. Pharmacists must conduct an appropriate medication reconciliation using a patient's hospital discharge order, a BPMH (if available) and the patient's medication history at the pharmacy. Also, pharmacists must ensure that therapeutic checks are patient-centred and take into consideration patient-specific factors such as age, concomitant medical conditions, and the patient's ability to manage dosage forms and dosing schedules.

In this case, the pharmacist should have identified and reconciled the patient's new and existing medications. He should have asked himself questions like:

- Is this medication appropriate for my patient considering the patient's age, lifestyle, medical conditions, and current medications?
- Is the medication indicated for my patient?
- Is the dosage appropriate for my patient?
- Do any of these medications pose a risk to the patient?
- Is this medication going to help my patient get better?
- Are there any potential unintended dosage changes?
- Will there be any possible drug interactions?
- Are there any duplicate therapies?

In this case, the pharmacist should have noticed some red flags while conducting the medication reconciliation. Any time there is a transfer of care, there is an increased probability of medication errors. The pharmacist should have realized that two of the four unintended medications were not suitable for a geriatric patient and confirmed the indication for the other two medications. He should have had questions and followed up with the discharging physician, hospital pharmacy, the patient herself, the patient's daughter, or even the patient's primary care physician to ensure the medications prescribed were as he thought. The pharmacist missed an opportunity to discuss any discrepancies when the discharging physician called to make further changes to the patient's medications.

ORAL CAUTIONS

An oral caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. Oral cautions require the practitioner to meet with the ICRC in person for a face-to-face discussion about their practice and the changes they will make that will help avoid a similar incident from occurring in the future. It is not an opportunity for the practitioner to further argue their position, provide additional documentation, or attempt to change the ICRC's view with respect to their final decision. For all complaints filed after April 1, 2015, we post a summary of the oral caution and its date on the "Find a Pharmacy or Pharmacist" section of our website.

It's important to note that the pharmacist should have followed up his medication reconciliation process by documenting his interpretations, decisions, and actions in the patient record. The documentation should have been systematic and should have had enough information so that anyone on any healthcare team could determine what happened, why the change in therapy was made, and the rationale behind the pharmacist's decisions. The College has documentation guidelines that suggest a systematic documentation method to encourage completeness and consistency.

Red-flag patient populations require extra time and attention.

Finally, it's important to remember that pharmacists must counsel patients or their agents on all new therapies. This means that the pharmacist in this case should have taken the opportunity to communicate with the patient's daughter to discuss the new medications and ensure the medications were going to help the patient. If the pharmacist had investigated the indication for the new therapies and asked if the patient's daughter was aware of these changes to her mother's medication therapy, then the error may have been prevented.

All practitioners are responsible to practise to the Standards of Practice and the Code of Ethics, and for providing patient-centred care. Pharmacists must ensure that they do not lose sight of the patient when applying therapeutic knowledge and reviewing a patient's medication. Consideration of specific patient circumstances, including age, concomitant medical conditions and whether the patient can manage the prescribed dosage form and dosing schedule independently must be incorporated into the review process.

A contributing factor to this incident was the absence of appropriate policies and procedures intended to prevent medication errors. In all community pharmacies the DM is responsible for ensuring that the pharmacy has appropriate policies and procedures in place to support pharmacy professionals in practicing to the Standards. For example, to ensure that all staff engage in appropriate processes for reviewing and reconciling a patient's medication history.

The processes must be designed to minimize errors, protect the public, and enable staff to satisfy their professional and patient safety obligations. This includes all measures necessary to ensure that the medications dispensed are therapeutically appropriate — the right medication, for the right patient, in the right dose, in the right strength, with the correct instructions. Policies should clearly outline what pharmacists need to do in situations where there are outstanding questions about a patient's therapy, and how they should reconcile any discrepancies.

The pharmacist in this case may have identified the errors and prevented the incident if he had taken a moment to question the four medications listed on the second page of the BPMH.

PRACTICE TIP!

The patient record is comprised of the patient profile, a scanned copy of the original prescription, prescription information and more. You are responsible for maintaining a complete patient record. Learn all the documents that this comprises: http://www.ocpinfo.com/practice-education/practice-tools/fact-sheets/record-keeping/

Follow @OCPinfo on Twitter and get a helpful practice tip each week.
#OCPPracticeTip