Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SPRING 2019 • VOLUME 26 NUMBER 2
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THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

QUALITY INDICATORS FOR PHARMACY

Selection of indicators involving patients, pharmacy and health system partners – the first of many steps in this quality improvement initiative **23**

IN THIS ISSUE:

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COUNCIL MEMBERS

Elected Council Members are listed below according to District. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. U of T indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. U of W indicates the Hallman Director, School of Pharmacy, University of Waterloo.

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H Nadia Facca
K Esmail Merani
K Tracey Phillips
L Billy Cheung
L James Morrison
L Sony Poulose
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M Kyro Maseh
M Laura Weyland (President)
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PM Sylvia Moustacalis
PM Joan A Pajunen
PM Joy Sommerfreund
PM Dan Stapleton
U of T Christine Allen
U of W David Edwards

Statutory Committees
- Accreditation
- Discipline
- Executive
- Fitness to Practise
- Inquiries Complaints & Reports
- Patient Relations
- Quality Assurance
- Registration

Standing Committees
- Drug Preparation Premises
- Elections
- Finance & Audit
- Professional Practice

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(2019-2021) OCP STRATEGIC FRAMEWORK

VISION
A trusted, collaborative leader that protects the public and drives quality and safe pharmacy care and improved patient outcomes.

MISSION
The Ontario College of Pharmacists regulates pharmacy practice to serve the interests, health and wellbeing of the public.

VALUES
ACCOUNTABILITY INTEGRITY TRANSPARENCY

STRATEGIC PRIORITIES
- Enhance system and patient outcomes through collaboration and optimization of current scope of practice
- Strengthen trust and confidence in the College's role and value as a patients-first regulator
- Enhance the College's capacity to address emerging opportunities and advance quality and safe pharmacy practice and regulatory excellence

The objectives of *Pharmacy Connection* are to communicate information about College activities and policies as well as provincial and federal initiatives affecting the profession; to encourage dialogue and discuss issues of interest to pharmacists, pharmacy technicians and applicants; to promote interprofessional collaboration of members with other allied health care professionals; and to communicate our role to members and stakeholders as regulator of the profession in the public interest.

We publish four times a year, in the Fall, Winter, Spring and Summer.

We also invite you to share your comments, suggestions or feedback by letter to the Editor. Letters considered for reprinting must include the author's name, address and telephone number. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.

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Laura Weyland,
R.Ph., B.Sc.Phm
President

Dear Colleagues,

The past few months have been a busy and productive time for the College. From holding regional meetings across Ontario, to continuing the province-wide rollout of our Medication Safety Program, to developing and releasing Quality Indicators For Pharmacy, the College remains focused on supporting pharmacy professionals in providing safe and quality care that will enhance public confidence in the profession.

Safety and quality were the focus of the discussion at the regional meetings, which were held this year in Thunder Bay, Peterborough, Ottawa, Markham, Sudbury, Mississauga, London and Windsor. The College heard from many pharmacy professionals practising in the community, hospitals, as well as students about to embark on their careers.

As pharmacists and pharmacy technicians take on a greater role in a patient's journey through the healthcare system, it's vital that we have the ability to assess the impact of their work on health outcomes. Currently, there is no systematic way to measure the quality of pharmacy care or its impact. That's why the College partnered with Health Quality Ontario and other health system stakeholders – including patients – to develop quality indicators for pharmacy that were launched on June 6 at the College's Symposium on Quality Indicators for Pharmacy. For the first time, Ontario will be able to measure the contribution pharmacy professionals make to health outcomes and determine what more can be done to improve the quality of care.

The College also heard from pharmacy professionals about the Assurance and Improvement in Medication Safety (AIMS) Program, which is being rolled out in all community pharmacies across the province. This input gave the College valuable insight on how it can support pharmacy professionals by working to eliminate any barriers to recording medication incidents and near misses through the Pharmapod platform in a timely and efficient way. The progress of the program's implementation remains very encouraging, and we expect all community pharmacies to be onboarded to the program by mid-summer.

> "Every day, pharmacy professionals work diligently to provide the best possible care to their patients. They use their knowledge to help people make informed choices about their health and provide a valuable service as healthcare providers who are easily accessible to patients."

Many regional meeting participants shared their experiences in encouraging pharmacy staff to feel comfortable and open in discussing medication incidents, why they happen and how they can be prevented. Participants provided excellent suggestions, such as senior pharmacists taking the lead and sharing what they learned from a medication error. It allows others to feel more comfortable opening up about their experiences.

Every day, pharmacy professionals work diligently to provide the best possible care to their patients. They use their knowledge to help people make informed choices about their health and provide a valuable service as healthcare providers who are easily accessible to patients.

As the provincial government moves forward to expand scope of practice, it will work with the College to ensure that pharmacy professionals have the knowledge, skills and judgment required to deliver safe care to patients across Ontario under expanded areas of care. More information will be available as this work proceeds during the coming months. It's important that all pharmacy professionals continue to build their knowledge as we get closer to those changes.

There are many opportunities ahead to keep raising the bar on the practice of pharmacy in Ontario. I look forward to working with all of you to reach these goals.

Yours in health,

Laura Weyland

MARCH 2019 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held on March 25th, 2019.

CHANGES TO COMMITTEE APPOINTMENTS

Ms. Laura Weyland informed Council of recent changes to Committee appointments. Effective immediately, the Chair of the Patient Relations Committee is Ms. Kathy Al-Zand and the Chair of the Registration Committee is Mr. Deep Patel. An updated list of Committee membership has been posted to the College website.

COUNCIL APPROVES AUDITED STATEMENTS OF COLLEGE OPERATIONS FOR 2018

Council approved the College's 2018 Audited Financial Statement as prepared by Tinkham LLP. Ms. Michelle Tkachenko, Audit Engagement Principal at Tinkham LLP, was on hand to present the audit report and answer any questions. Ms. Tkachenko indicated that it is the opinion of the auditors that the financial statements fairly and accurately reflect the financial position of the College as at December 31, 2018. The auditors also commended the College's financial stewardship practices including effective internal controls and made no recommendations for adjustments to its processes.

COUNCIL APPROVES NEW DISCIPLINE COST RECOVERY FRAMEWORK

Investigations and prosecutions of allegations of professional misconduct are often complex, time consuming, and expensive. It is a well-established principle within administrative law that the general membership of the profession should not bear the total costs related to a member's misconduct.

Pursuant to *Section 53.1 of the Health Professions Procedural Code (the Code)*, discipline panels may order costs against members who have been found guilty of misconduct or found incompetent. That provision reads: "In an appropriate case, a panel may make an order requiring a member who the panel finds has committed an act of professional misconduct or finds to be incompetent to pay all or part of the following costs and expenses: 1) the College's legal costs and expenses; 2) the College's costs and expenses incurred in investigating the matter; and 3) the College's costs and expenses in conducting the hearing."

At its March 2019 meeting, Council approved a discipline cost-recovery policy that directs College legal counsel to seek a higher proportion of costs in penalty orders related to expenses directly incurred by the College in prosecuting discipline cases. This may include the College's legal costs and expenses, costs and expenses incurred in investigating the matter, and costs and expenses incurred in conducting a hearing.

Council approved this policy, effective immediately. As well, Council adopted a schedule of hourly rates applicable to in-house staff engaged in prosecutions and investigations, for use by College counsel when seeking indemnification of College costs at hearings.

To learn more, please refer to the briefing note and appendices starting on page 37 of the March 25, 2019 Council meeting agenda.

ANNUAL REPORT

The 2018 annual report is now available online at www.ocpannualreport2018.ca and can be downloaded as a PDF. This year's report, entitled "*Measuring Performance, Improving Outcomes*", highlights several initiatives underway at the College aimed at using data and information to advance the College's public-protection mandate and influence quality and accountability. The report also includes updated statistics regarding the College's core regulatory programs and statutory activities.

COUNCIL MEETINGS

Watch for the September 2019 Council meeting report in the next few weeks.

Council meetings are open to the public and are held in the Council Chambers of the College at 483 Huron Street, Toronto, ON M5R 2R4. If you plan to attend, or for more information, please contact Ms. Sarah MacDougall, Council and Committee Liaison at council@ocpinfo.com. You can also follow along via Twitter during Council meetings.

COUNCIL ELECTIONS

Serving and protecting the public interest

Apply your knowledge, skills and experience as a pharmacy professional to help protect the public and contribute to quality and safe pharmacy practice in Ontario as a member of Council of the Ontario College of Pharmacists. This year, elections will be held in Districts K, L, T and TH.

JOIN COUNCIL IN 2019

There are a total of seven Council seats open in districts K, L, T and TH.

DISTRICT K

Two seats available for a three-year term* for pharmacists in electoral District K.

DISTRICT L

Three seats available for a three-year term* for pharmacists in electoral District L.

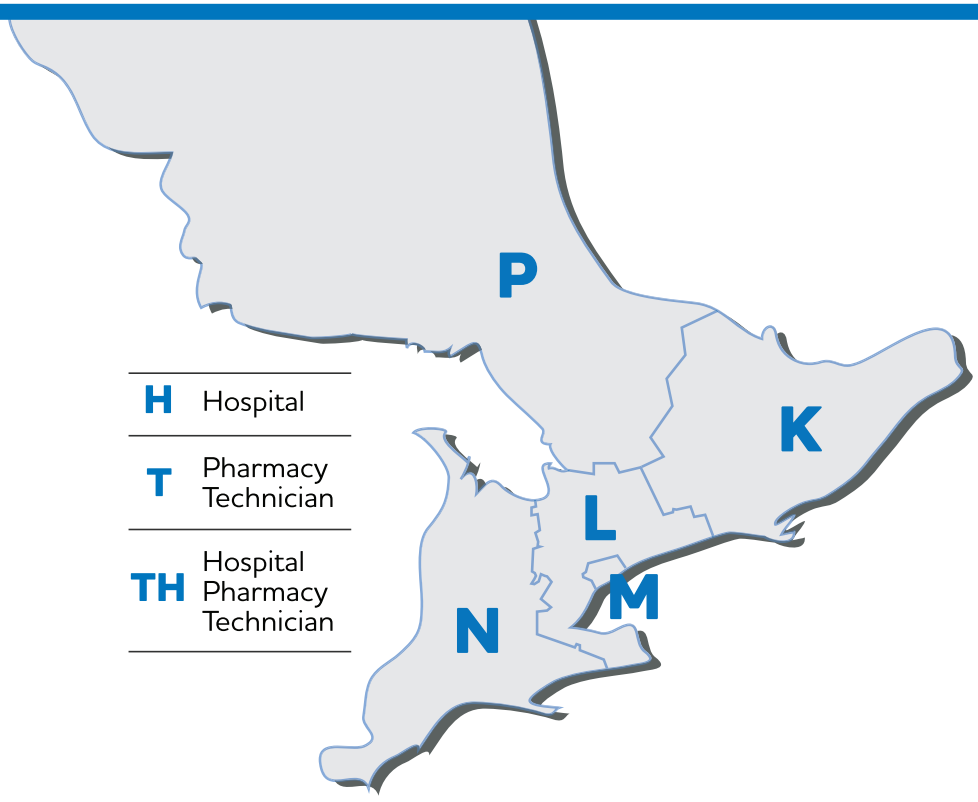
DISTRICT T

One seat available for a three-year term* for a community pharmacy technician in Ontario.

DISTRICT TH

One seat available for a three-year term* for a pharmacy technician practising in a hospital in Ontario.

*The College is undertaking changes to the Governance Framework for the Council and its Committees which may result in changes to the electoral districts and the terms of office. Any proposed changes will be implemented during the 2020/2021 Council year.



PROTECTING THE INTERESTS, HEALTH AND WELLBEING OF THE PUBLIC

Regulating pharmacy in the public interest is a privilege. The College exists to regulate pharmacy so that the public can be confident in the quality and safety of the pharmacy care and services they receive. They must also be able to trust in the College's ability to make decisions and act in accordance with its public protection mandate. Council members do not "represent" those who elected them and those who elected them are not "constituents." Rather, Council has a fiduciary duty to put their service to the public above all other interests.

COUNCIL COMPOSITION

Currently, members of Council include 15 elected pharmacists (two from hospital), two elected pharmacy technicians (one from hospital), two deans from the faculties of pharmacy at University of Toronto and University of Waterloo and between nine and 16 members of the public who are publicly appointed.

Council is the policy making group and acts as the board of directors for the College. The College's administrative staff are responsible for carrying out these policies and administering the *Regulated Health Professionals Act*, the *Pharmacy Act* and the *Drug and Pharmacies Regulation Act* and associated regulations.

Council meetings are held once per quarter and Council members may also be appointed to sit on one or more committees. The Discipline, ICRC (Inquiries, Complaints and Reports Committee), Quality Assurance and Registration Committees all operate using panels comprised by interchanging committee members. In consideration of running for a seat on Council, you should be aware that there will be a time commitment to serve on the panels of the committees. For example, a contested hearing for the Discipline Committee may require multiple-day attendance (i.e. between three to five days at a time). More information about Council can be found on the College's website.

THE ROLE OF A COUNCIL MEMBER

As a Council member, you are expected to observe the highest standards of impartiality, integrity and objectivity. Your major responsibilities include:

- Maintaining a working knowledge of the legislation under which the College operates and making decisions about regulating the profession in the public interest;
- Participating in establishing policy, strategic direction, and goals of the College to successfully meet its mission and purpose;
- Anticipating and responding to changing expectations and emerging trends and addressing emerging risks and opportunities;
- Anticipating and embracing opportunities for regulatory and governance innovation;
- Reviewing all preparation material in advance of Council and committee meetings and contributing and engaging constructively in discussions undertaken at these meetings.

NOMINATION PROCESS

To stand for election, you must be nominated by three members of the College who are eligible to vote in the electoral district for which you are nominated.

Your nomination paper must be accompanied by your signature which affirms your commitment to the Objects of the College and that you undertake to comply with the College's policies, the By-Laws, Code of Ethics and Code of Conduct and procedures for Council and committee members, all of which can be found on the College website.

If you are considering running for election in the future, please note that considerable weight will be given to candidates who have served on statutory committees as a Non-Council Committee Member prior to seeking election (see **The Role Of A Non-Council Committee Member** on page 8 of this issue).

Learn more about the election process on our website.

If you have questions, send an email to Sarah MacDougall, Council and Committee Liaison at: councilelections@ocpinfo.com.

KEY DATES FOR 2019 COUNCIL ELECTIONS

Last date for candidates to withdraw
Friday, June 28, 2019

Voting to commence on or by
Monday, July 8, 2019

Voting closes
Wednesday, August 7, 2019 at 5:00 p.m.

Calling for **VOLUNTEERS** *to Serve on College Committees*

You can make an invaluable contribution to helping the College regulate pharmacy in the public interest and advance the quality and safety of pharmacy practice in the province as a non-Council committee member!

The College's eight statutory committees play an important role in advancing the College's mandate to serve and protect the public interest. These committees require the appointment of pharmacists and pharmacy technicians who are not elected members of Council and whose competencies, skills and experience align with the College's needs and obligations. From time to time, these individuals are required to serve on various special committees, working groups or task forces. Their competencies reflect the criteria set out in the "*Eligibility and Competency-Based Committee Appointment Framework*" developed by the Advisory Group for Regulatory Excellence (AGRE), comprising the six largest health regulatory colleges. The framework is rooted in evidence and best practice in Ontario regulatory governance.

Non-Council committee members (NCCMs) are appointed at the beginning of each Council year (September Council). The Chairs of the Committees are elected on the first day of the Council meeting after which the remaining committee members are appointed.

Each NCCM is responsible for upholding the mandate of the College and acting in accordance with its values and policies. To further understand the role of an NCCM, please review the College Objects (Appendix 4 of the Governance Manual), By-laws, Code of Ethics and Code of Conduct for Council and Committee members.

THE ROLE OF A NON-COUNCIL COMMITTEE MEMBER

As a NCCM, you play an important role in the College's commitment to advance the interests, health and wellbeing of the public. As such, you also have a fiduciary duty to assert undivided loyalty and good faith in fulfilling the mandate of the College. This duty includes:

- Being **Diligent** – being prepared for meetings, reviewing materials, arriving on time and participating in discussion.
- Being **Civil** – respecting the process and fellow committee members, paying attention (e.g., no mobile devices during the meetings), genuine listening and consideration and adopting an objective approach to decision making.
- Being **Ethical** – using College resources appropriately, being aware of the facts (e.g., reading the materials on a particular matter).
- Being cognizant of and declaring **Conflicts of Interest** (e.g. financial, adjudicative, and organizational).
- Ensuring **Confidentiality** is maintained. This applies to all information obtained in the course of OCP duties, unless an exception applies. Discretion is critical especially in the area of complaints as, in some cases, allegations are unsubstantiated. Maintaining confidentiality prevents tainting of processes and facilitates the exploration of all options to avoid misinterpretation.

COMMITTEE OPPORTUNITIES

The table below provides a brief description of the duties of the Committees, the minimum number of NCCM positions required to be filled and the approximate number of days required for meetings.

Staff will solicit the availability of members well in advance of booking meetings and confirm dates and times with participants. In most cases, material will be made available online and prior to the meeting to allow time for review.

Committee	Frequency of Meetings and Minimum Number of NCCMs Required
Accreditation Committee	
The Accreditation Committee considers matters relating to the operation of community pharmacies in Ontario and also reviews issues relating to pharmacy assessments conducted by College practice advisors where the pharmacy has failed to comply with the requirements.	Approximately six times a year **TWO NCCMs**
Drug Preparation Premises Committee	
The Drug Preparation Premises Committee considers all matters relating to the operation of drug preparation premises (DPPs) in Ontario.	Two to three times a year (coordinated with Accreditation Committee meetings) **TWO NCCMs**
Discipline Committee	
Panels of the Discipline Committee hear allegations of professional or proprietary misconduct.	Approximately 25 hearings a year, heard by panels*, plus three meetings of the full committee **FIVE NCCMs**
Fitness to Practice Committee	
The Fitness to Practice Committee considers incapacity matters referred by the Inquiries, Complaints and Reports Committee.	One to two times a year **ONE NCCM**
Inquiries, Complaints and Reports Committee (ICRC)	
The Inquiries, Complaints and Reports Committee (ICRC) oversees all investigations into a practitioner's conduct, competence and capacity (this includes pharmacists, pharmacy technicians, students or interns), as well as all complaint investigations, registrar's investigations and health inquiries.	Three panel* meetings a month, plus two meetings of the full committee **SEVEN NCCMs**
Patient Relations Committee	
The Patient Relations Committee advises Council regarding the patient relations program, which enhances relations between practitioners and patients. It also deals with preventing and handling matters relating to sexual abuse of patients by practitioners.	One to three times per year **ONE NCCM**
Quality Assurance Committee	
The Quality Assurance Committee develops and maintains the Quality Assurance program. It supports continued competence and encourages continuing professional development of practitioners.	Panel* meetings four to six times a year, plus two to three meetings a year of the full committee. **THREE NCCMs**
Registration Committee	
The Registration Committee provides guidance to Council on matters concerning registration, examinations and in-service training required prior to registration.	Monthly panel* meetings, plus two to three meetings a year of full committee **ONE NCCM**

*The Discipline, ICRC, Quality Assurance and Registration Committees all operate using panels comprised by interchanging committee members. Note also that for the Discipline Committee, contested hearings may require multiple-day attendance i.e. between three and five days at a time

If you are interested in being considered for appointment to a committee, complete the application form and send by July 31, 2019 to Sarah MacDougall, Council and Committee Liaison in the Registrar's office at council@ocpinfo.com. You will be advised after Council's September meeting if you have been appointed to serve on a committee.

Compounding:
ARE YOU DOING IT?

This article originally appeared in the Winter 2018 issue and information has been updated.

College Council adopted NAPRA's *Model Standards for Pharmacy Compounding of Non-Sterile Preparations* at their meeting in December 2017. Since then, a three-phased implementation date has been determined.

These new standards require pharmacy professionals to place a renewed focus on the preparation of non-sterile products in pharmacies.

IS YOUR PHARMACY ENGAGED IN COMPOUNDING?

Health Canada considers compounding to be the following:

> "The combining or mixing together of two or more ingredients (of which at least one is a drug or pharmacologically active component) to create a final product in an appropriate form for dosing. It can involve raw materials or the alteration of the form and strength of commercially available products. It can include reformulation to allow for a novel drug delivery. Compounding does not include mixing, reconstituting, or any other manipulation that is performed in accordance with the directions for use on an approved drug's labelling material. [1]

Before compounding a non-sterile preparation, the need for the compounded product should be confirmed by checking for commercially available preparations in the Health Canada's Drug Product Database and contacting manufacturers. [2] To comply with the Health Canada policy on compounding, this confirmation is required in order to validate the lack of product availability and avoid duplicating an approved drug.

Non-sterile preparations can be categorized as simple, moderate or complex [3] (as outlined in *United States Pharmacopeia (USP) Chapter <795> Pharmaceutical Compounding – Nonsterile Preparations*). A number of factors go into determining the type of preparation and level of risk when compounding preparations. Pharmacists and pharmacy technicians who compound non-sterile preparations should evaluate their practice, develop service-related procedures and implement appropriate quality controls for both patients and compounding personnel, with a view to guaranteeing the overall quality and safety of non-sterile preparations.

HOW TO PREPARE FOR THE STANDARDS

Implementation priorities and timelines for completion of each phase are:

Phase 1: January 1, 2020 - Assessing Risks and Gaps

Phase 2: July 1, 2020 - Personnel Training and Quality Assurance

Phase 3: January 1, 2021 - Facilities and Equipment

The standards are accompanied by a guidance document which provides pharmacists and technicians who compound non-sterile preparations with the details necessary to evaluate their practice, develop service-related procedures, and implement appropriate quality controls for both the protection of patients and compounding personnel.

Pharmacy professionals are encouraged to review current policies and procedures, master formulations and Safety Data Sheets.

For more information, see How Are You Preparing for the New Standards on Non-Sterile Compounding? (Summer 2018).

1. Health Canada. Policy on Manufacturing and Compounding Drug Products in Canada (POL-0051). Retrieved at: https://www.canada.ca/en/health-canada/services/drugs-health-products/compliance-enforcement/good-manufacturing-practices/guidance-documents/policy-manufacturing-compounding-drug-products.html#a7

2. Ontario College of Pharmacists. Quality and Safety in Compounding Non-Sterile Preparations. Retrieved at: http://www.ocpinfo.com/library/practice-related/download/Quality%20and%20Safety%20in%20Compounding%20Non-Sterile%20Preparations.pdf

3. USP <795> Pharmaceutical Compounding—Nonsterile Preparations. Retrieved from: http://www.uspnf.com/sites/default/files/usp_pdf/EN/USPNF/revisions/gc795.pdf

CONSIDER THESE STEPS WHILE PREPARING FOR THE FIRST PHASE OF NON-STERILE COMPOUNDING COMPLIANCE:

The Hamilton Health Sciences Experience

By Meagan Quinlan RPh, BScPhm, BSc, PharmD,
Manager, Juravinski Hospital and Cancer Centre

The National Association of Pharmacy Regulatory Authorities (NAPRA) published the new Model Standards for Pharmacy Compounding of Non-Sterile Preparations with an accompanying Guidance Document for implementation. The Ontario College of Pharmacists requires all pharmacies engaging in Non-Sterile Compounding activities to comply with the NAPRA standards, using the following phased approach:

Phase 1: Assessing Risks and Gaps - January 1, 2020

Phase 2: Personnel Training and Quality Assurance - July 1, 2020

Phase 3: Facilities and Equipment - January 1, 2021

The following article provides a step-by-step description of the measures taken by Hamilton Health Sciences staff to prepare for the implementation of Phase 1.

RISK ASSESSMENT

The first step in preparing for Phase 1 of implementation is to evaluate your current practice with a risk assessment. A Risk Assessment, outlined on page five of the NAPRA standards, is designed to identify individual compounding requirements in order to minimize environmental contamination and protect personnel.

The following must be considered when completing a risk assessment for your pharmacy or organization:

OBTAIN ORGANIZATIONAL SUPPORT

Ensure senior management is engaged and aware of the new NAPRA Standards and OCP's mandate for pharmacy compliance with the Model Standards for Pharmacy Compounding of Non-Sterile Preparations by 2021. Some facilities may require capital investment or alternatives to continue providing these services to patients.

Leaders can assist by identifying key stakeholders to form a working group. While not all stakeholders will be engaged in the entire process, a working group should include representatives from pharmacists, pharmacy technicians, management, health information systems and housekeeping.

REVIEW YOUR SITE-SPECIFIC NON-STERILE PREPARATIONS

When completing the risk assessment, each compound should be reviewed to determine if the non-sterile preparation is still being utilized or is available commercially from a manufacturer, eliminating the need for compounding. (Processes no longer being used can be archived.) A risk assessment must then be performed to minimize contamination of each preparation and ensure protection of compounding personnel. The Decision Algorithm for Risk Assessment in the Guidance Document for Pharmacy Compounding of Non-Sterile preparations should be utilized to assess each preparation compounded at your centre.

STEP 1. DETERMINING HAZARDOUS RISK

Each compound should be reviewed to determine if the product is found on the NIOSH list or listed in the Hazardous Products Act. Pertinent information relating to the type of hazardous risk can also be located on a safety data sheet. If hazardous drugs are identified, it is important to determine the types of hazardous drug (anti-neoplastic, reproductive risk) or risk to the compounder (inhalation risk) and how this will apply to your pharmacy.

STEP 2. DEFINE SMALL QUANTITIES

When completing the Decision Algorithm and determining if small quantities are being compounded, it is important to ensure that you have appropriate documentation to support the 'small quantities' being compounded. A pharmacy must be able to monitor the quantities being compounded and appropriately assess and respond when quantities increase beyond definition. A key consideration when assessing small quantities being compounded is the effect of cumulative risk to personnel. How do we account for cumulative risk? How is that rationalized in your policies and procedures, if you have deemed small quantities part of your pharmacy practice?

STEP 3: DETERMINING LEVEL REQUIREMENTS

Your risk assessment may identify products needing alternative level requirements for compounding. If you have the appropriate facilities available, the Master Formulation Record for the specific preparations can be updated to indicate appropriate level requirements, rationale for risk assessment and evidence-based references for risk mitigation strategies. The Guidance Document provides a comprehensive list of approved references for appropriate handling of hazardous drugs and materials. Staff education should also be completed to reinforce awareness of procedural change and the need to plan for any possible disruption to work flow. It is important to ensure proposed changes are clearly understood by all personnel.

Some pharmacies may also identify products necessitating an alternative level requirement that the facility is unable to fulfill. If the pharmacy must continue compounding a specific preparation to ensure continuity of patient care without appropriate facilities, the master formulation must indicate the risk for compounding the preparation. Additional evidence-based risk mitigation strategies must be put into place to alleviate risk until the facility becomes compliant. This may include changes to workflow, using additional equipment, procedural changes, including steps such as wetting of powders preventing aerosolization, and containment strategies. The physical characteristics of each hazardous drug should also be considered. All water soluble drugs are suitable for dissolve and administer systems, limiting personnel exposure.

STEP 4: REVIEW THE RISK TO THE PREPARATION

All preparations must be compounded in a designated area free of interruption. The area must facilitate products in an environment free of contaminates including allergens, particulate and dust. Reviewing risks to the preparation is directly related to your gap analysis and cleaning procedures. Your gap analysis should include a review of your facility, identifying appropriateness of storage, lighting, ventilation, water supply, work surfaces and furniture. If the gap analysis identifies facility deficiencies, senior management should be notified regarding potential risk to personnel and preparation. The working group should also be engaged during this review to develop appropriate cleaning procedures for all work surfaces, equipment and furniture. Procedures and frequency of cleaning is an important component to mitigating preparation risks.

The standards play an important role in protecting patients. It is the responsibility of the designated manager, pharmacy manager and pharmacy professionals to ensure they are up-to-date on the standards and well on their way to achieving implementation.

To learn more, visit the Non-Sterile Compounding Key Initiative on the College's website.

PHARMACY5IN5

Developing New Topics to Self-Assess and Improve Your Knowledge

5/N/5
Never stop learning

Several new topics are in development for Pharmacy5in5, an interactive learning platform created by the University of Waterloo School of Pharmacy and supported and funded, in part, by the College.

The series is designed to help you, as a pharmacist or pharmacy technician, strengthen your knowledge in a variety of practice areas.

New modules will focus on Hypertension, Drug-induced Kidney Injury, and Inventory Management of Narcotic and Controlled Substances. Updates on the completion of each of these programs, as well as a new mobile app, will be announced in e-Connect and content will be featured in upcoming issues of *Pharmacy Connection*.

Recognizing the time pressures faced by many pharmacy professionals, the platform lets you test your knowledge on a given topic by taking a short quiz and answering just five questions in five minutes. With the platform, you can self-audit your knowledge and acquire a deeper understanding of a number of clinical and professional topics. You can also measure your learning outcomes against those of your peers.

HOW IT WORKS

- Simply log into the Pharmacy5in5 website, create your own account with an email and password of your choosing and take an interactive quiz on a topic you choose. Current topics include renewals, immunization, hypertension, injection administration, adaptations, pharmacy technician scope of practice, cannabis and naloxone, among others. While some quizzes review facts and considerations on a given topic, others introduce you to a fictitious scenario in a pharmacy where you must answer questions and make decisions.

- At the end of the quiz, you'll see your score and can view which questions you've answered incorrectly. You will also have the opportunity to improve your knowledge by reviewing a number of relevant educational resources including case studies, videos, infographics, helpful websites, and more.

- Pharmacy5in5 adds up your score based on all the quizzes you've completed and lets you see how you performed in comparison to other pharmacy professionals who have taken the quizzes.

- The platform was developed using educational psychology and health services research, including theories of behaviour change, multimedia learning, audit, feedback and game-based learning.

- In partnering with the University of Waterloo, OCP hopes to get a better idea of areas where the province's pharmacy professionals need more support. It will also allow the College to track progress in optimizing scope of practice and providing safe and quality pharmacy care. The College will be provided with anonymized aggregate data only.

WHY PHARMACY5IN5?

Pharmacy5in5 assists you in providing better patient care by helping you easily identify strengths and weaknesses in key practice areas and then giving you the tools and resources to improve where needed. No commercial funding is involved in the production of Pharmacy5in5.

Pharmacy professionals need to stay abreast of all current and emerging issues in practice and this platform helps you stay up-to-date with these issues. Over time, the platform will be updated with new content.

GET STARTED NOW

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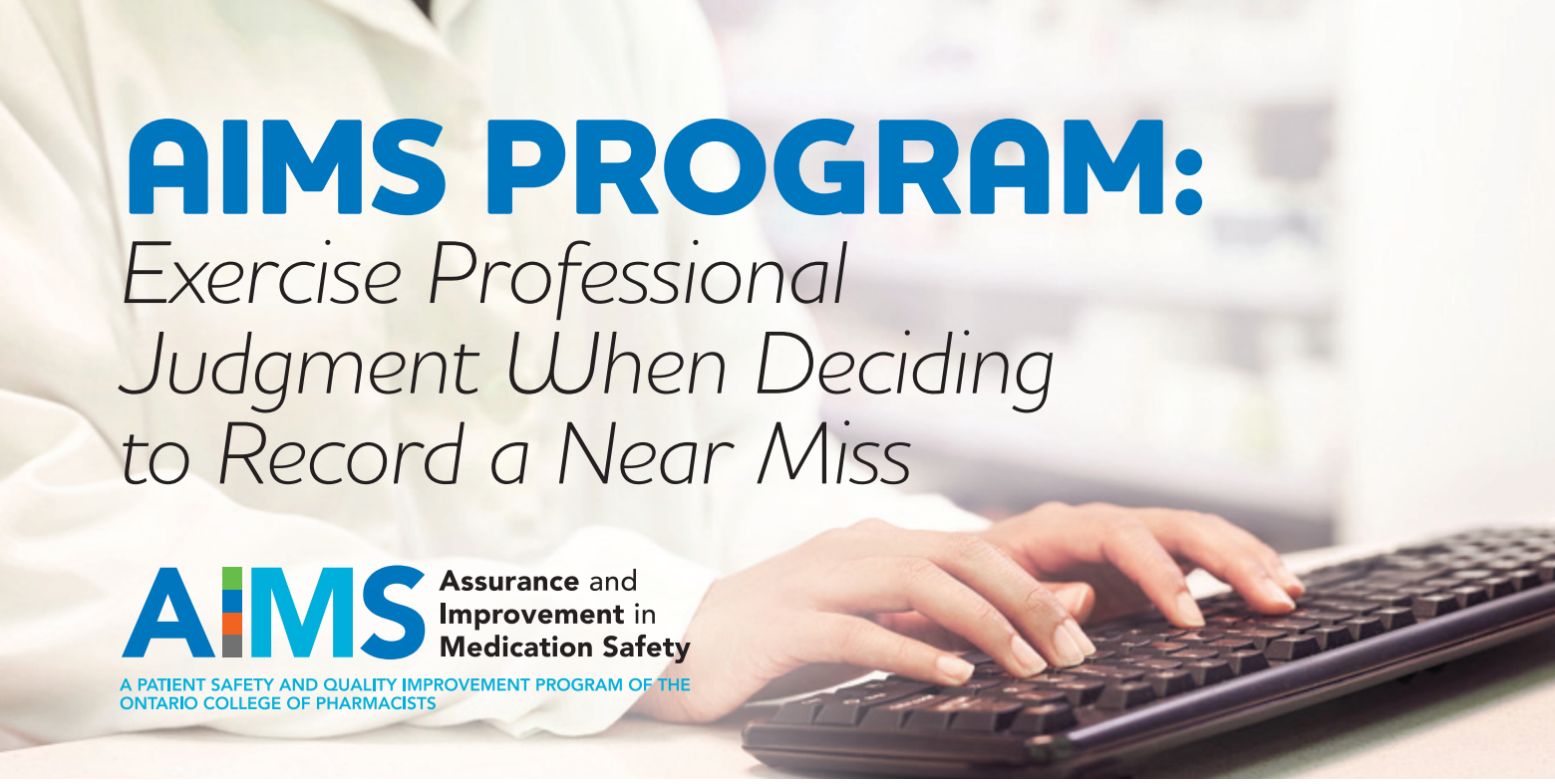
AIMS PROGRAM:
Exercise Professional Judgment When Deciding to Record a Near Miss



AIMS **Assurance** and **Improvement** in **Medication Safety**

A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

More than half of community pharmacies have onboarded to the Assurance and Improvement in Medication Safety (AIMS) Program and are using the incident-recording platform to anonymously record valuable data, including those related to near misses, which will help identify trends and support shared learning to improve patient safety.

Near misses – ***events that could have led to inappropriate medication use or patient harm but did not reach the patient*** – provide valuable insight into areas of risk and may indicate where systems can be improved to prevent patient harm. The recording of near misses through the incident-recording platform administered by program partner Pharmapod is a critical component of the AIMS Program.

Consider the recording of a medication incident as a retrospective analysis meant to minimize the risk of a recurring situation. A near miss provides an opportunity for a proactive review of workflow processes to identify areas of risk as well as procedures that can be enhanced to minimize the recurrence of future incidents. Essentially, the shared learnings from near misses recorded by one pharmacy may be used by another to prevent an error from reaching the patient.

Based on the experience of community pharmacies with the AIMS Program to date, the College recognizes that there is an opportunity to further educate pharmacy professionals and reinforce expectations regarding near misses. The following scenarios of near misses are intended to support the ongoing learning of pharmacy professionals who all play a vital role in building a safer pharmacy system in the province through continuous quality improvement.

SCENARIO 1

Background: A patient with moderate depression visits his healthcare provider and is prescribed Paxil 20mg®. He takes the prescription to his local pharmacy where a member of the pharmacy team misinterprets the drug name as Pariet® 20mg. This is not an isolated incident as the drug names have been confused before during previous intakes. Other members of the pharmacy team have caught the errors either during the technical check process or the therapeutic check.

Situation: When the patient picks up his prescription, the pharmacist discusses the medication with him and confirms that he was diagnosed with depression. Recognizing that Pariet is not the appropriate therapy, the pharmacist examines the original prescription, makes the necessary corrections and dispenses Paxil 20mg.

Decision to Record: This near miss is a recurring situation and requires a preventative process change. If this potential incident hadn't been detected, the patient would not have received the correct medication.

Outcome: The pharmacy team identified several areas of opportunity which led to process changes. Workflow was changed so that, when possible,

assistants, pharmacy technicians and pharmacists now collect the indication for therapy when the patient or caregiver presents the prescription and prior to computer entry. The indication is then recorded (on the prescription and in the appropriate place in the patient record.) so that it can be reviewed by the pharmacist when conducting the therapeutic check.

SCENARIO 2

Background: An opioid-dependent patient is admitted to a drug-treatment program where he is prescribed 5mg methadone. Several days into treatment, he takes a new prescription for 9mg methadone to his pharmacy. It is incorrectly entered as 90mg.

Situation: The dose is prepared, confirmed for technical accuracy by a pharmacy technician and therapeutic appropriateness by the pharmacist. At the time of the final patient assessment, the pharmacist confirms the expected dose prior to ingestion. The close call is discovered and a serious medication incident averted.

Decision to Record: Incomplete technical and therapeutic checks took place which would have resulted in the patient receiving 10 times the prescribed dose of methadone. It is important to determine how processes can be improved to avoid recurrence of similar scenarios.

Outcome: The pharmacy team identified several areas of opportunity which led to process changes. These included actions to be taken prior to dose preparation including:

- Assistants and pharmacy technicians are to alert the pharmacist of dose changes.
- Pharmacist to review previous dose/date/time/ missed doses/changes to dose as part of the therapeutic check.

SCENARIO 3

Background: Following dental surgery, a patient is prescribed Amoxicillin 500mg and takes the prescription to a community pharmacy. The pharmacy assistant gathers the usual information, including possible allergies to medications.

The patient indicates he is severely allergic to penicillin. The pharmacy assistant enters into the patient profile that he was allergic to "Pen". A few minutes later, after assisting another patient, the pharmacy assistant enters the prescription into the computer and fails to identify that Amoxicillin would be contraindicated for a patient who is severely allergic to penicillin; the contraindication is not detected because the computer alert system does not recognize "Pen" as penicillin.

Situation: Amoxicillin is prepared and the pharmacist checking the prescription fails to notice "Pen" listed as an allergy on the patient's profile. While counselling the patient, the pharmacist tells the patient: "This is amoxicillin, a penicillin type antibiotic." The patient expresses her frustration that, despite reaffirming her severe allergy to the dental office and the pharmacy, she was still given penicillin.

Decision to Record: The use of an abbreviated form for penicillin prevented the pharmacy's computer system from detecting the contraindication. Inputting short forms or incorrect spellings can hinder the software's ability to identify other drug-related problems such as the dispensing of an incorrect dose, inappropriate change to drug therapy and potential drug interactions.

Outcome: Following a discussion, pharmacy staff committed to selecting the specific drug allergen from the computer list rather than entering the information free form.

IN REVIEW

Although near misses are events that do not reach the patient, learnings from these experiences may be used to prevent medication incidents and their resultant patient harms. Within a safety culture, near misses are critical shared learning opportunities that benefit the entire pharmacy system. The work of the College's medication safety Response Team, which was referenced in the last issue of Pharmacy Connection, will include an analysis of reported near misses along with medication incidents and recommendations for the entire system on how they can be prevented.

As you consider these scenarios, you are encouraged to utilize professional judgment to determine whether a near miss provides a solid learning opportunity to improve existing pharmacy processes and procedures. A subsequent discussion among pharmacy staff can enhance best practices in workflow processes to increase patient safety.

EVERY PHARMACIST IS AN OPIOID STEWARD:

Putting the 2017 Canadian Opioid Guideline into Action

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BACKGROUND

Canada is currently experiencing an unprecedented opioid epidemic (1). Widespread use of increasing doses of prescription opioids to treat chronic pain in the past two decades has been a significant contributor to current opioid-related morbidity and mortality (2). Nearly half of all patients with chronic pain (approximately 20 per cent of Canada's population) still receive inadequate analgesia (3). So, we know that we have not yet struck the right balance between safety and efficacy in the management of chronic pain.

Pharmacists across all practice settings encounter people with chronic pain who also use opioids. These interactions are important opportunities for pharmacists to act as opioid stewards. Further, in the context of the current opioid crisis, people with chronic pain are often concerned about making decisions regarding opioid use. Their pharmacists are well positioned to support them in these decisions.

"The Canadian Guideline for Opioids for Chronic Non-Cancer Pain," hereafter referred to as "the Guideline," was published in May 2017 to address the use of opioids to manage chronic pain in adults (4). The full Guideline is available through MAGICApp online and through the National Pain Centre based at McMaster University.

To assist pharmacists in navigating this guideline and implementing it in practice, our paper, "A pharmacist framework for implementation of the Canadian Guideline for Opioids for Chronic Non-cancer Pain" was published in the Canadian Pharmacists Journal in January 2019 (5). Here, we provide a brief summary:

WHAT DID THE GUIDELINE RECOMMEND?

The Guideline includes 10 evidence-based recommendations related to initiation of opioid therapy, opioid dosing and opioid rotation and tapering. These are outlined in Box 1. The GRADE system was used to create the Guideline and applied a rating of the strength of each recommendation (strong or weak). If a recommendation is "strong," all or almost all individuals should receive the intervention. If a recommendation is "weak," pharmacists and other clinicians should recognize that different choices are appropriate for individual patients and acknowledge the need to support them in arriving at a decision that is in line with their own values and preferences. In other words, we need to understand what balance of risks and benefits is meaningful to our patients.

Best practice statements, informed by indirect evidence, were included as well as expert guidance statements to address areas where evidence was very limited or absent. As evidence emerges, these guidance statements may evolve into recommendations, or may no longer be applicable.

PHARMACIST FRAMEWORK TO IMPLEMENT THE GUIDELINE

Pharmacists must assess all patients initiating opioid therapy and provide ongoing monitoring of effectiveness (pain and function), safety (dose, adverse effects, long-term consequences of opioids, aberrant behaviours) and adherence as part of their care plan.

Recognizing the many challenges pharmacists could face implementing the Guidelines in daily practice, we proposed a Framework (sample of the Framework is shown in Table 1) to help pharmacists put all of this together.

The development of opioid-related policy changes, in response to the opioid epidemic, has led to patients perceiving increased stigma and a loss of autonomy related to their opioid use (6). For many patients, how the conversation about opioids is initiated is key to their engagement in a discussion about tapering. This is similar to other conversations about behavior change but complicated further by stigma and also fear relating to uncontrolled pain and opioid withdrawal. Thus, initiating this conversation can be daunting for pharmacists, requiring a motivational approach. Our framework and its suggested approach to engaging patients was reviewed by people with lived experience of chronic pain and opioid therapy.

Education should be tailored to the individual, ensuring they have information that is important to them. Patients using opioids are often surprised by the concept of opioid-related hyperalgesia, when opioids cause pro-nociceptive or sensitizing effects(7). Pain

may increase with opioid dose. Once understood, this may be motivating for people to want to decrease opioid doses. Listening to patients is an essential component of providing individualized education.

APPLYING THE FRAMEWORK

Arthur is a 68-year-old widower and grandfather of three with chronic low back pain and degenerative disc disease. He has used oxycodone extended release (ER) for the last 20 years and his current dose is 40mg twice daily (MED = 120mg). Arthur reports that his pain is getting worse over time and he doesn't get the same relief as he used to. His other medications for pain include acetaminophen and duloxetine. He asks you, his pharmacist, can his dose be increased for better relief of his pain?

For opioid doses >90mg MED, taper to the lowest effective dose, and potentially discontinue (weak recommendation) Arthur's dose is already above the recommended threshold of 90mg MED. However, the recommendation to taper when above this dose is classified as "weak," so Arthur's pharmacist should support him in reaching a decision that is right for him. Hearing that his pain is not as well controlled may mean that he has developed tolerance, and he may be experiencing some opioid-related hyperalgesia, which he perceives as worsening pain. Increasing the dose would exacerbate those circumstances. To support him in his decision, the pharmacist can help him set functional goals by asking, "what would living well with chronic pain look like?" They can also discuss adverse effects or complications he might be experiencing (e.g. sleep apnea, low testosterone, mood changes, constipation, falls) which could be important to him as he makes his decision about opioids. The pharmacist can recommend a referral for a sleep study, lab work or a mood assessment if needed to inform the discussion. His pain response and functional goals can be monitored over time using a tool such as the Brief Pain Inventory (8).

If he decides he would like to taper, his pharmacist can make recommendations on how to safely decrease his dose to the lowest effective dose. Working with Arthur to reassess his non-opioid and non-pharmacological therapy, his pharmacist can ensure other pain management and coping strategies are optimized.

Anita, a 45-year-old wife and mother of a teenage son, has chronic, widespread pain throughout her body. She has tried many medications since her diagnoses of fibromyalgia five years ago, but she hasn't been able to tolerate any of them after only a few days because of terrible side effects. She is currently using a transdermal fentanyl patch, 50mcg changed every three days (MED=200mg). She is confined to her home much of the time because of pain and spends most of her day in bed. She is interested in cutting back on her dose because of terrible constipation and sleepiness during the day, but she feels hopeless because the last time her prescriber decreased her dose, her pain had a severe flare.

Optimize non-opioid drugs and non pharmacological therapies (strong recommendation). Physical exercise reduces pain in fibromyalgia (4). Meditation and good sleep hygiene are also recommended (9). Anita's pharmacist can recommend these and refer her to other clinicians or programs if needed for further support. Unfortunately, Anita has not tolerated non-opioid medications in the past. Opioids have poor clinical response in fibromyalgia and may worsen pain because of increased risk of opioid-induced hyperalgesia (10).

For persistent problematic pain and/or problematic adverse effects, rotation to other opioids rather than keeping the opioid the same (weak recommendation). Anita is already using opioids at a high dose (MED >90mg), is experiencing intolerable side effects, and still her function is quite limited. Anita can be empowered to achieve her goal and taper her opioids gradually as the other strategies are put into place. Recommending an opioid rotation to a different drug may improve her pain management, and also facilitate the taper as the dose can be lowered when switching by up to 50 per cent to address incomplete cross tolerance. Further decreases may be possible in smaller increments. The pharmacist can support Anita to pause or slow down the taper as needed.

Michael is a 56-year-old single man with chronic neuropathic pain in his legs and feet where he has constant burning, tingling pain and also some numbness. He uses capsaicin topically and nortriptyline 100mg at bedtime which provides some relief but overnight pain still interrupts his sleep. His medical history is significant for diabetes, insomnia, and alcohol use disorder. His doctor has prescribed hydromorphone 2-4mg to take at bedtime (MED=10-20mg) to help with the pain overnight.

If there is history of substance use disorder, continue non-opioid therapy rather than adding an opioid (weak recommendation). Michael's pharmacist should engage him in a discussion to ensure he has the information he needs about his increased risk of opioid-related problems considering his history of alcohol use disorder. There are non-opioid therapeutic alternatives he can consider for neuropathic pain (e.g. duloxetine, pregabalin, topical lidocaine) before opioids.

WHERE TO BEGIN

Pharmacists are formally recognized in the Guideline for making important contributions to the inter-professional team, particularly with respect to their role in opioid tapering. An important first step is identifying patients with high opioid-related risk in their practice (e.g. opioid doses >90mg MED), with concurrent use of benzodiazepines and opioids, and with aberrant behaviours. The next step is partnering with them to discuss the Guideline. Working with patients and prescribers to recommend and monitor changes to therapy (e.g. opioid rotations, opioid tapers, optimizing non-opioid pain medications) are opportunities where pharmacists are highly-valued, ensuring safety and support to patients when they need it most.

BOX 1. EVIDENCE-BASED RECOMMENDATIONS

Recommendations for when to INITIATE opioid therapy:

- Optimize non-opioid and non-pharmacologic therapy first (strong).
- For patients who experience persistent, problematic pain despite optimized non-opioid therapy, consider a trial of opioids if no past or current substance use disorder or other active psychiatric disorders (weak).

Recommendations against initiating opioid therapy:

- Do not use opioids in patients with an active substance use disorder (strong).
- Suggest avoiding opioid therapy in patients with a history of substance use disorder, or other active psychiatric disorder (weak).

Recommendations for DOSING when starting opioid therapy:

- Restrict doses for patients beginning opioid therapy to <90mg MED (strong).
- Restriction to <50mg MED is suggested (weak).

Recommendations for opioid ROTATION and TAPERING:

- Rotate to a different opioid if patients using opioids have persistent problematic pain and/or adverse effects (weak).
- Taper to the lowest effective dose (and potentially discontinue) if patients are using ≥90mg MED daily (weak).
- Provide multidisciplinary support for patients struggling to reduce their opioid dose (strong).

Table 1. Sample of the Framework for Implementation of Guideline Recommendations

Ask	Assess	Canadian Opioid Guideline Recommendation	Recommend and Document
What benefits do you see related to your opioid therapy? What do they help you to do in your day? What are some of the downsides that you see from your opioids?	Track objective measures of pain and function (Brief Pain Inventory), adverse effects, long-term consequences (e.g. sleep apnea, hypo-gonadism, aberrant behaviours) Assess readiness for change.	**For >90mg MED: tapering to the lowest effective dose, potentially discontinuation (WEAK)** **For persistent pain and/or adverse effects: Rotate to other opioid rather than keeping the opioid the same (WEAK)**	Document calculations and endpoints from monitoring parameters. Engage patient and prescriber in discussion about tapering or rotation. Document patient goals and preferences, and readiness for change.
There are several strategies that we have to help lower your dose – which of these sound like they would be a good fit for you?			Create a plan for rotation, account for incomplete cross tolerance in calculations. Consider rotation as a strategy to decrease dose when appropriate. Educate patient about expectations for the taper, especially the temporary withdrawal pain and symptoms. Document patient progress over time. Follow up with patient frequently.
Note: MED=morphine equivalent daily			

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FIRST COLLEGE-APPROVED CANNABIS COURSE NOW AVAILABLE

The College has approved the first cannabis education program that meets the mandatory education requirements for Part A pharmacists.

The Essential Cannabis Knowledge for Pharmacists Certificate Program addresses the three required competencies identified by the College, with input from the Cannabis Education Advisory Group. They are:

- Ethical, legal and professional responsibilities;
- Patient care; and,
- Application of knowledge and research.

We expect other continuing education providers to develop and make available courses over the coming months, giving registrants time to meet the March 2020 timeline for course completion. Any new courses will be posted to the Continuing Education for Pharmacists page of the College website (under Cannabis).

Information about the College's Cannabis Strategy for Pharmacy, including frequently asked questions, is available on the website. Further details and information on the College's Cannabis Training Requirements and Courses are also available on the OCP website.

College and Health Quality Ontario Announce the First Set of Quality Indicators for Pharmacy

The College, in partnership with Health Quality Ontario, is pleased to establish the first set of quality indicators for community pharmacy in Canada. The indicators were announced at a recent event which brought together patients, pharmacy professionals, health system partners, regulators, government, academic and other pharmacy and health system stakeholders.

Quality indicators already exist in other areas of the health system, such as long-term care and primary care, and a great deal of work has already been done to establish indicators in hospital pharmacy. However, this work has not been undertaken for community pharmacy in Ontario – until now.

> "The Ontario College of Pharmacists has a mandate to serve and protect the public, and that includes encouraging continuous quality improvement. With better data to enhance our understanding of how community pharmacy care influences health outcomes, the College can also better support pharmacy professionals in their work to provide quality care to their patients."

– Nancy Lum-Wilson, CEO and Registrar, Ontario College of Pharmacists

A total of seven indicators (*see subsequent pages for a summary of the selected indicators)* represents a pivotal first step in providing pharmacy professionals, the public and health system stakeholders with a clearer picture of the overall quality of pharmacy care and its impact on health outcomes. With better data and information, both the College and pharmacy professionals can make evidence-informed decisions to support quality improvement.

The indicators focus on measuring four important areas: the patient/caregiver experience and outcomes, appropriateness of dispensed medications, medication-related hospital visits and transitions of care. Additional quality indicators aimed at measuring provider experience and engagement are also in development and will be publicly reported once that work is completed.

The selection of the first set of quality indicators is a major milestone; however, much more work remains to be done in collaboration with our partners and with pharmacy professionals throughout the province. In fact, continued collaboration will be key in gaining a better understanding of what tools and resources pharmacy professionals may need to support quality improvement. Those interested in being part of this discussion are welcome to take part in the College's Involvement in Quality Indicators Next Steps survey.

More information about this survey and about the quality indicators work will be communicated in eConnect and future issues of Pharmacy Connection. You can also access additional information, such as Frequently Asked Questions about the indicators for pharmacy professionals, on the College website at www.ocpinfo.com.

Ontario College of Pharmacists

Putting patients first since 1871

Quality Indicators for Pharmacy

The College has collaborated with Health Quality Ontario (HQO), the provincial advisor on healthcare quality, to establish quality indicators for pharmacy. The indicators, selected by an expert panel, will be used for public reporting and quality improvement.

OVERALL SCOPE AND PURPOSE OF THE QUALITY INDICATORS FOR PHARMACY

THE NEED FOR QUALITY INDICATORS IN COMMUNITY PHARMACY

There is a lack of understanding among providers, patients and the public about the profession of pharmacy and the impact it has on patient outcomes. Community pharmacists are the final checkpoint in the medication management system. Prior to dispensing a medication, a community pharmacist determines whether a medication is appropriate, including checking allergies, potential drug interactions and past medication history, among other factors.

A strong focus on indicators already exists in other areas of the health system (for example, in hospitals, primary care, long-term care and home care), however community pharmacy is an area that has not historically been measured. A great deal of work has already been done to establish indicators in hospital pharmacy, including the efforts of the Canadian Society of Hospital Pharmacists. Since the primary gap currently is in community pharmacy, this is the current focus of the indicators work.

Despite all current efforts, it is difficult to understand what part community pharmacy plays in a patient's health outcomes. Quality indicators are needed to provide the data and information required to understand the quality of pharmacy care and its influence on patient outcomes.

THE ROLE OF THE COLLEGE

The College has a mandate to serve and protect the public. To support its mandate, the College is responsible for encouraging continuous quality improvement within the profession of pharmacy. Establishing quality indicators will enable the College and pharmacy professionals to use data to make evidence-informed decisions and promote a better understanding of the quality of pharmacy care and the impact pharmacy has on patient outcomes.

THE GOALS OF THE QUALITY INDICATORS

The quality indicators for pharmacy are intended to provide the public and health system with information about the overall quality of pharmacy care and to support the sector in gaining a better understanding of pharmacy's impact on patient outcomes. Unlike other indicators that have recently been released by insurance companies, the quality indicators for pharmacy are not purposed for tracking the performance of individual pharmacy professionals or intended to be used for reimbursement.

QUALITY INDICATORS FOR PHARMACY

MEASUREMENT AREA: PATIENT/CAREGIVER EXPERIENCE AND OUTCOMES

Pharmacists, according to the NAPRA Model Standards of Practice for Pharmacists, are to give patients the information they need to make decisions about their care in a way they can understand. Pharmacy Technicians enable this by managing the technical aspects of pharmacy practice thus freeing up the pharmacists' time to provide clinical care. However, it is currently difficult to know whether a patient has understood what has been communicated to them by their community pharmacy team. This measurement area provides insight into the quality of care from the lens of a patient/caregiver.

There are four quality indicators that have been selected within this measurement area:

QUALITY INDICATOR: **My pharmacist helped me understand why I am taking each of my medications**

Importance/relevance to pharmacy: Explaining why each of their medications is necessary is vital to ensuring compliance and prevention of morbidity and mortality in patients. For instance, a patient prescribed two medications for controlling their Chronic Obstructive Pulmonary Disease, may need clarity on the need for both and the difference between the two.

QUALITY INDICATOR: **My pharmacist made sure I understood how to take my medication properly**

Importance/relevance to pharmacy: Explaining the details regarding proper medication administration is vital to ensuring optimal health outcomes, and the community pharmacist, as the final gatekeeper and education touchpoint for the patient, is in an ideal position to ensure the patient has a good understanding of this.

QUALITY INDICATOR: **My pharmacist made sure I understood what results I might expect from my medication, including any side effects or drug/food interactions that may occur**

Importance/relevance to pharmacy: Educating patients about the safety of their medications including potential common side effects and drug/food interactions is essential to ensure expectations are managed and medication-related adverse events are prevented. Pharmacists have extensive knowledge in pharmacodynamics and pharmacokinetics and have a duty to educate patients on the safety of their medication.

QUALITY INDICATOR: **My pharmacist helped me understand how to know if my medication is working**

Importance/relevance to pharmacy: Pharmacists are well placed within the health system to counsel patients on expectations of efficacy. For instance, medical conditions such as hypertension often present without any signs and symptoms, and hence patients lack clarity around whether or not their medication is working.

MEASUREMENT AREA: APPROPRIATENESS OF DISPENSED MEDICATIONS

Pharmacists are responsible, as per their Standards of Practice[1], for ensuring that when medications are dispensed, each prescription is reviewed to ensure that the medication is the most appropriate for the patient. Given that this measurement area is quite broad, the expert panel decided to focus on key quality challenges facing the health system today such as the opioid crisis.

QUALITY INDICATOR: Percentage of opioid-naïve patients who were dispensed an initial dose greater than 90 mg morphine equivalents per day.

Importance/relevance to pharmacy: This indicator was drawn from indicators outlined in the HQO Quality Standards for Opioid Prescribing for Acute Pain and Opioid Prescribing for Chronic Pain. As the HQO Quality standards describe, starting a patient on a high dose of opioids (greater than 90 mg morphine equivalents per day) can increase the risk of overdose and hence is rarely indicated, particularly in opioid naïve patients. Pharmacists, as the final gatekeeper before a medication is dispensed to a patient, should be vigilant in assessing new opioid starts in opioid-naïve patients and they are expected to collaborate with prescribers and patients to ensure appropriateness.

MEASUREMENT AREA: MEDICATION-RELATED HOSPITAL VISITS

Pharmacy professionals are responsible for ensuring optimal medication management and identifying and preventing medication-related incidents in their patients' medication regimens. By preventing these incidents, pharmacy professionals have an opportunity to, in collaboration with other health system providers, impact the number of medication-related emergency department visits and hospitalizations. Given the broad reach of this measurement area, the current focus is on opioid-related hospital visit data which is well coded and timely.

QUALITY INDICATOR: Hospital visits for opioid poisonings among patients that are actively treated with an opioid prescription.

Importance/relevance to pharmacy: Broader outcome indicators such as this are influenced by many different parts of the healthcare system. Pharmacists, in collaboration with their health system partners are responsible for ensuring opioid prescriptions dispensed are appropriate, and follow-up touchpoints are conducted with patients when appropriate to continuously discuss the patient's treatment regimen and to offer tapering in a timely manner. Technical specifications of this indicator including definitions of *hospital visits*, *opioid poisonings*, and *actively treated* will be developed in the next phase of the indicators work.

MEASUREMENT AREA: TRANSITIONS OF CARE

Transitions of care are vulnerable points within the healthcare system involving multiple healthcare providers and an overwhelming amount of information provided to patients and caregivers. When a patient discharged from the hospital presents to a community pharmacy, the pharmacist has a responsibility to ensure the patient has a thorough understanding of their medication regimen, and is aware of which medications have been discontinued or added since their hospital visit.

QUALITY INDICATOR: Percentage of people who have had a medication review within 14 days of discharge home from hospital.

Importance/relevance to pharmacy: Community pharmacy professionals play an essential role in ensuring patients discharged from hospital to home understand their medication regimen and any changes that may have taken place during the transition. Hospital pharmacy professionals also have a duty to ensure continuity of care for patients by connecting and collaborating with their community pharmacy colleagues when a patient is discharged. A medication review helps provide an updated medication list as well as answer any questions the patient/caregiver may have.

MEASUREMENT AREA: PROVIDER EXPERIENCE AND ENGAGEMENT

There is a well-established link between provider experience and engagement and patient outcomes. Pharmacy professional experience and engagement is a critical area to measure, however currently, there are no pharmacy-specific measures available in the literature. This measurement area will be prioritized for future development and the College will be reaching out to various stakeholders, including frontline pharmacy professionals, to collaborate on further development and refinement of this area.

1 https://napra.ca/sites/default/files/2017-09/Model_Standards_of_Prac_for_Cdn_Pharm_March09_layout2017_Final.pdf

Measurement Area	Quality Indicators for Pharmacy
Patient / Caregiver Experience and Outcomes	My pharmacist helped me understand why I am taking each of my medications My pharmacist made sure I understood how to take my medication properly My pharmacist made sure I understood what results I might expect from my medication, including any side effects or drug/food interactions that may occur My pharmacist helped me understand how to know if my medication is working
Appropriateness of Dispensed Medications	Percentage of opioid-naïve patients who were dispensed an initial dose greater than 90 mg morphine equivalents per day
Medication-related Hospital Visits	Hospital visits for opioid poisonings among patients that are actively treated with an opioid prescription
Transitions of Care	Percentage of people who have had a medication review within 14 days of discharge home from hospital
Provider Experience and Engagement	Panel recommends this as an area for further review and refinement before reporting the provider experience and engagement indicators publicly

NEXT STEPS

Since quality indicators are relatively new territory for community pharmacy in Ontario, engagement of key stakeholders such as patients, frontline pharmacy professionals, corporate pharmacy sector leaders, academia and health system data experts will be vital for discussions around indicator implementation. Tools and resources to support pharmacy professionals in their quality improvement efforts will need to be determined to enable implementation.

Pharmacy sector engagement sessions during the selection process introduced a variety of implementation considerations including the importance of viewing the indicator data in context and recognizing how differing patient populations in pharmacies may affect indicator values. Additionally, the sector highlighted the importance of ensuring clarity behind the definitions and technical details of each indicator. Technical working groups will be convened to develop technical specifications for the indicators.

> “For many Ontarians like me, our local pharmacist constitutes our most recognizable and frequent contact point with the provincial healthcare system. Consequently, this timely introduction of Quality Indicators for Pharmacy by HQO and the OCP is a very appropriate and worthwhile development.”
>
> *- Harvey Naglie, Patient Partner*

RELEVANT RESOURCES

Final Report of Quality Indicators
Roundtable Synopsis Document
Frequently Asked Questions and Answers

DID YOU KNOW?

Pharmacy Professionals and Public Health Reporting

As of May 21, 2019, a total of 10 laboratory-confirmed cases of measles were reported in Ontario.[1]

Under Ontario's *Health Protection and Promotions Act, s25* (HPPA), in the course of providing professional services, pharmacists and pharmacy technicians are required to report if they believe a patient may have a disease of public health significance such as measles. Previously called "reportable diseases" (prior to May 1 2018), these include communicable and virulent diseases, and are listed in *Ontario Regulation 135/18*. The public health system depends upon this information as the basis for preventing the spread of disease and to promote/protect the health of Ontarians.

Pharmacy professionals who form the *opinion that a patient has or may have* a disease of public health significance must report this information to their region's public health unit as soon as possible. As health information custodians, disclosure of personal health information is permitted for these purposes per the HPPA and *Personal Health Information Protection Act, s39* (PHIPA).

Community pharmacists and technicians should know how to contact the Medical Officer of Health in their region and are advised to visit the website of the local public health unit. A list of all Public Health Units in Ontario can be found at: http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx.

Hospital pharmacists and technicians should be familiar with the hospital policy and procedure, including the expectation of pharmacists, if any, for reporting diseases of public health significance for inpatients and outpatients.

Pharmacy professionals are encouraged to collaborate with the patient's primary physician or nurse practitioner to ensure reporting requirements and timelines are met.

1. Public Health Ontario

ADDRESSING THE ILLEGAL MARKETING OF DRUGS AND DEVICES

Health Canada is enlisting the support of healthcare professionals in a program focused on ending the illegal advertising of drugs and medical devices.

The federal regulator launched the first of a multi-phased program with a web-based platform entitled Stop Illegal Marketing of Drugs and Devices. It aims to:

- create an understanding of legal and illegal practices;
- provide a quick and easy tool to file a complaint to Health Canada; and
- keep healthcare professionals from inadvertently perpetuating illegal advertising when discussing health products and/or services with patients.

Phase Two – expected to be launched this summer – will include online educational modules.

Health product advertising is the direct or indirect promotion surrounding the sale or use of any drug or device conducted by any means including print, Internet and broadcast. Only drugs and devices that have been authorized for sale by Health Canada may be advertised in Canada.

Areas under renewed marketing scrutiny include prescription drugs, biologics and biosimilars, opioids and other controlled substances, medical devices, veterinary health products and natural health products. In cases where the illegal marketing of drugs and medical devices is identified, Health Canada is taking action as required, including recommending criminal charges where appropriate. The complaint process is available on the website.

Be wary of marketing that omits/downplays risk or overstates effectiveness. Advertising of drugs and devices to health care providers is prohibited if the claims:

- are false, deceptive or misleading;
- do not provide a balanced representation of benefits and risks; and
- are not consistent with the terms of market authorization of the product.

As marketing materials provided by the pharmaceutical industry are among the information sources used by healthcare professionals to make decisions about patient care, Health Canada is striving to ensure they accurately convey the benefits and risks of products.

PHARMACY CONNECTION.ca

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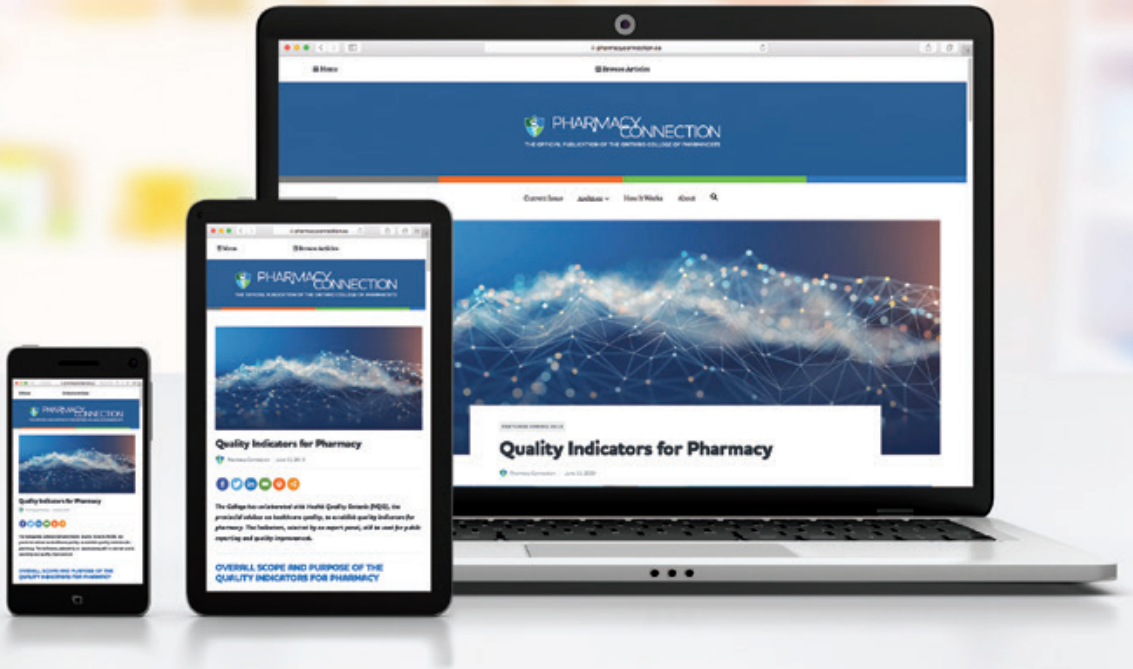

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CUT THE COUNT

A Campaign to Reduce Post-Surgery Opioid Use

Ontario Surgical Quality Improvement Network hospitals have embarked on a quality improvement campaign to Cut the Count, reducing the number of opioids prescribed to discharged surgical patients while providing alternative pain management options.

COMMUNITY PHARMACISTS

Surgeons at 47 hospital sites across the province are participating in the campaign which launched April 1 and runs until March 31, 2020. Although the campaign – supported by Health Quality Ontario – is aimed at the hospital-based surgical community, Cut the Count may impact community pharmacy professionals. Surgery patients discharged from local hospitals may request support related to their pain medications, including opioids.

A list of participating hospitals can be found in this Health Quality Ontario document.

To Cut the Count, surgeons will select at least one surgical procedure and make one or more of the following three changes:

- Adopt a common prescribing protocol
- Use multimodal pain management (both pharmacologic and non-pharmacologic)
- Talk to their patients about safe opioid use and other treatment options.

Materials, including a patient guide, are available to complement clinical judgment on pain management. Ongoing collaboration with patients' surgeons may also be required.

SUPPORTIVE EVIDENCE

Recent evidence, including the research paper "Standardization of Outpatient Procedure (STOP) Narcotics: A Prospective Non-Inferiority Study to Reduce Opioid Use in Outpatient General Surgical Procedures" from London Health Sciences Centre, supports the campaign's approach both in terms of effective pain management and patient experience.

For additional information, contact Health Quality Ontario at PainQI@hqontario.ca.

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AFTERMATH OF A MEDICATION INCIDENT:

Caring for the Patient, the Family, but also the Healthcare Professional

In clinically complex healthcare settings, adverse events and medication errors can occur despite the best intentions of healthcare professionals. Healthcare organizations typically take a structured approach to providing care and supporting patients and their families when an unintended event results in patient harm. However, healthcare practitioners involved in a critical incident can also experience emotional trauma, from sadness and concern to suffering and anguish, which often go unrecognized and overlooked.[1]

A PHARMACIST'S STORY

The following pharmacist's story is extracted from the October 31st, 2017 issue of the Institute for Safe Medication Practices Canada ISMP Canada Safety Bulletin "The Second Victim: Sharing the Journey toward Healing":[2]

"About two years ago, while transcribing an order, I made a single incorrect keystroke on my keyboard, and a patient's anticoagulant was held instead of being restarted. The patient went on to develop an extensive arterial thrombus that eventually led to her death.

The first few days after the patient died, honestly, were terrible. I was flooded with thoughts and emotions that I could hardly even identify at the time. I felt incredibly sad. I was anxious. I was scared of being sued. I felt alone. I couldn't understand why I wasn't able to use my thinking to take control of my emotions. I wasn't sure what to say or do. Others tried to say helpful things, but no words helped, especially words that tried to convince me I shouldn't feel so bad."

It is estimated that almost 50 per cent of healthcare providers will experience a medical error or unintentional adverse event that results in significant mental distress at least once in their career.[3] Frequently, these practitioners feel personally responsible for the unexpected patient outcomes, leading them to second-guess their clinical skills and knowledge base.[4]

Following an incident, practitioners will often experience symptoms that include extreme sadness, difficulty concentrating, depression, repetitive and intrusive memories, and sleep disturbances, which can result in absenteeism and a reduced ability to perform at work (**Figure 1**).[5] For most, these symptoms pass with time, but for a few, the effects can be long lasting.[6]

Aftermath of a Medical/Medication Incident Common Symptoms Experienced by Healthcare Practitioners

- Extreme sadness
- Difficulty concentrating
- Depression
- Repetitive and intrusive memories
- Sleep disturbances
- Avoidance of similar types of patient care

Figure 1. Symptoms Reported by Healthcare Practitioners Involved in Patient Safety Investigations[5]

Not everyone involved in a patient safety incident will experience emotional trauma, but there are a number of factors that may influence the impact of an incident on a practitioner. Incidents associated with harm or death, patients who "connected" the clinician to his/her own family (such as a patient with the same name, age, or physical characteristics as a loved one), the length of relationship between the patient and the practitioner, and the involvement of pediatric patients, can all contribute to the overall impact of an event.[6] In addition, certain aspects of the healthcare organization's environment, such as its safety culture, may protect against or intensify incident-related trauma.[4]

THE RECOVERY PROCESS

"Some days I could breathe through the emotion, some days I completely fell apart and had to go home. I wasn't sure I should be working, but I worried that if I went home for too long, I might never come back to work again. I got offered the hospital's employee assistance program. I declined. In the first few days, everything felt scary in ways that made no sense. I knew I should probably be talking to someone, but I was scared to, and I didn't know why. And so, I sought out my own help. I connected with a trusted colleague who had experienced something similar, and that helped me feel less alone. I connected with a friend in pastoral care, and we just sat together. I did some art in the hopes of processing parts of the experience."[2]

The personal recovery process following an incident typically involves six steps: (1) chaos and accident response; (2) intrusive reflections; (3) restore integrity; (4) endure inquisition; (5) obtain emotional first aid; and (6) moving on (**Figure 2**).[6] Practitioners who have successfully navigated this process highlight specific interventions that can aid recovery.[6] One is simply discussing the incident with peers and colleagues, especially those who have previously been involved in an incident.[7]

Sharing stories with a supportive colleague who is not judgmental can give the practitioner insight and reassurance and help reduce feelings of isolation. This can be a powerful support mechanism and appears to be preferred to external services (e.g. mental health professionals) following an event.

Another coping strategy is for practitioners to participate in the case review (e.g. root cause analysis or comprehensive analysis) to help address identified system issues and build action plans to prevent future incidents. Inclusion in these blame-free discussions helps promote clinician healing and recovery. Finally,

practitioners can participate in disclosure. Patients and families can be surprisingly forgiving when the error is disclosed by a caring practitioner with a sincere apology.[1]

Figure 2. Trajectory of the Recovery Process[6]

Organizations can also support the recovery process, for example, through employee assistance programs. A number of institutions have demonstrated success and cost-effectiveness of peer-to-peer support hotlines for those who experienced trauma.[8,9]

Like any program that involves disclosing sensitive information, there are a number of barriers to access, including stigma associated with reaching out for help, fear of losing professional respect, fear of losing income, perception that using a program indicates weakness, not feeling like one's problems are important, difficulty taking time off work, and doubts about confidentiality of services offered.[9] As such, it is important that organizations aim to create a culture of safety, where employees are supported and encouraged to discuss errors openly, and contribute to organizational change.

A perceived low level of organizational support has been linked to negative outcomes, such as ongoing emotional distress, intention to leave employment, and absenteeism. A supportive and fair culture that facilitates discussion and sharing, promotes reporting of incidents and near misses, and creates opportunities for learning has been associated with the avoidance of these negative outcomes.[5]

SUMMARY

Despite our best efforts, healthcare practitioners are not perfect, and mistakes do happen. The above pharmacist's story highlights the challenges practitioners may experience following a critical incident and the lessons learned through the recovery process. The healthcare organization, colleagues, and those involved can all play a role in facilitating the recovery process of the affected individuals (**Figure 3**). Organizations can nurture a workplace culture in which practitioners are not afraid to seek help and establish or strengthen practitioner support programs. Colleagues, especially those who have gone through similar experiences, can play the vital role of peer support. Practitioners can take part in the disclosure process, work with the patient, the family, and the organization to identify solutions to prevent future incidents.

Healthcare Practitioners
Be part of the disclosure
Reach out to your colleagues for support
Inquire about programs or processes in place to support staff involved in errors
Participate in the incident review process
Organizations
Support the practitioner through access to employee assistance programs
Strive to create a culture of safety through open discussion about incidents

Figure 3. Facilitating the Recovery Process

Caring for the patient and the family is always the priority following a medication incident. It is important for healthcare organizations to ensure that pharmacy professionals are acknowledged and able to receive appropriate support in order to strive for a patient safety culture and a safe and effective healthcare system.

FINAL REMARKS

The term "second victim" was first introduced in the literature in 2000 to remind us that healthcare professionals involved in a patient safety event should not be forgotten, as they also need emotional and organizational support throughout the recovery process (**Figure 2**). However, recently there has been controversial discussion in the literature regarding the term "second victim".[10] Nevertheless, it is more important for us, as healthcare professionals, to:

- Acknowledge the fact that preventable medication harm is often due to both system factors and human factors;
- Openly discuss and learn from our errors; and
- Engage with patients, families, our peers, and healthcare organizations to work towards a safer healthcare system.[10]

ACKNOWLEDGEMENTS

The authors would like to acknowledge Dr. Lindsay Yoo, Dr. Mengdi Fei, and Ms. Jemima Selorio for their previous research and written work on this topic during their tenure at ISMP Canada. Dr. Yoo was a Medication Safety Analyst at ISMP Canada. Dr. Fei and Ms. Selorio completed a PharmD rotation at ISMP Canada in 2017 and 2018, respectively.

Promoting a safety culture a fundamental component of the AIMS Program: The College

The promotion of a safety culture is an increasingly important aspect of quality improvement and patient safety in every part of our health system, including pharmacy. In a safety culture, which some organizations call a just culture, the focus is not on assigning blame, but on openly reviewing and discussing incidents and near misses within the team to understand why they happened, develop processes and take steps to prevent them from recurring and sharing those learnings with others.

Consistency in this approach is extremely important as it helps organizations and the people who are ultimately the heart of our health system – healthcare professionals – monitor and make improvements so that they know they're having an impact on quality and patient safety. These are the principles of a safety culture, which is a fundamental component of the Assurance and Improvement in Medication Safety (AIMS) Program currently rolling out to community pharmacies across the province.

The Standards of Operations and supplemental Standard of Practice provide information for pharmacy staff and Designated Managers regarding their roles in promoting a safety culture in pharmacy along with the four core components of the AIMS Program. For more information, please visit the AIMS Program section on our website.

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Coroner's Inquest into the

DEATH OF AN ELDERLY PATIENT ATTRIBUTED TO MEDICATION ERROR DURING CARE TRANSITION

CASE SUMMARY

An 83-year old woman died three months after admission to a Long Term Care Home (LTCH). **While the reported cause of death was severe hypothyroidism, it was attributed to complications from hypothyroidism (myxedema coma) due to a medication error. Dementia, hypertension and diabetes were contributing factors.**

The case was referred to the Geriatric and Long Term Care Review Committee which assisted the Office of the Chief Coroner in the investigation.

The Committee's recommendations are highlighted following a review of the case.

CASE HISTORY

Prior to her placement in a LTCH on March 10, 2017, the woman had received overnight respite care through a community Alzheimer's program.

Upon her arrival at the LTCH, a registered nurse (RN) erroneously transcribed "hyperthyroidism" on the admitting order sheet and a medication list was compiled. L-thyroxine was omitted from the admitting

medication list. However, it did appear on other documents, including the medical administration record from the community Alzheimer's program, the application for the LTHC admission health report and the resident assessment instrument. It is unclear if a formal "Best Possible Medication History" process was followed.

The patient had several co-morbid conditions which are listed in Appendix A. Her medications on admission to the LTCH , as indicated in the Coroner's Report, are listed in Appendix B.

The patient was admitted to hospital with generalized weakness, bilateral pleural effusions with mild hypoxemia (Sa02 88 per cent), hypothermia (temperature 32.7°C) and bradycardia (HR 48 bpm). Her admission bloodwork showed a TSH of 97.024 and a free T4 less than 0.09. The patient was started on intravenous levothyroxine and cortisol. Her condition continued to decline and she died on June 20, 2017.

SUMMARY OF EVENTS FOLLOWING LTCH ADMISSION

March 15, 2017	Admission lab work showed TSH 2.71 (within normal range)
April 11, 2017	Attending physician performed admitting history and physical and documented "hypothyroidism" in "past medical history." No rationale for not ordering l-thyroxine.
May 10, 2017	Consultant psychiatrist assesses for ongoing visual hallucinations, delusions and responsive behaviours, noting diagnosis of "hypothyroidism" and recommends that "thyroid function be optimized." Psychiatrist recommends initiation of risperidone 0.5 mg at bedtime. Escitalopram is discontinued. Risperidone gradually increased to total daily dose of 1.5 mg.
May 23, 2017	LTCH "Medication Regimen Review" completed, documenting changes in medications since admission and reviewed by a consulting pharmacist.
June 14, 2017	Noted to be sleepier and confused. Risperidone dose reduced to 0.75 mg daily
June 18, 2017	Somnolent and hypothermic; sent to hospital emergency department.

DISCUSSION

The Committee acknowledges that the patient died following a preventable medication error which occurred at the time of transition from one care setting to another. It stated that these transitions are a dangerous time for patients and it is critical that careful attention be paid to medication reconciliation.

The Office of the Chief Coroner and the Geriatric and Long Term Care Review Committee (GLTCRC) recommended the following for review by the Ontario College of Pharmacists to prevent similar events in the future:

- Consulting pharmacists are reminded that the pharmacy review of a new LTCH resident should occur in a timely manner according to LTCH regulations. This initial consultation should include a review of pre-admission medications.

- Pharmacists working in Long Term Care should be granted access to the "Ontario Drug Benefit Program Drug Profile Viewer" in order to optimize the accuracy and value of their consultation.

- A requirement for a process of standardized and formal medication reconciliation to occur with dedicated staff at times of admission and return (from hospital) to Long Term Care, should be added to the LTCH regulations.

The process of managing a transition of care is complex and requires effective processes and quality assurance mechanisms to mitigate risk. Pharmacists and pharmacy technicians play an important role in ensuring a seamless transition of care by conducting comprehensive medication histories and reconciliation.

In order to support the safe, effective and ethical provision of pharmacy services in Ontario, pharmacists and pharmacy technicians must understand and adhere to their professional responsibilities. These responsibilities are outlined in legislation, including Standards of Practice and the Code of Ethics and are reinforced through the Professional Responsibility Principles. Aspects of patient care outlined in the GLTCRC recommendations above are consistent with these expectations.

APPENDIX A: Patient Conditions

- Type 2 Diabetes (diet controlled)
- Hypothyroidism (l-thyroxine 0.112 mg daily)
- Hyperlipidemia
- Hypertension
- Congestive Heart Failure
- Dementia

APPENDIX B: Medications on admission to LTCH as indicated by Coroner's report

- Amlodipine 2.5 mg (daily)
- ECASA 81 mg (daily)
- Vitamin D 1000 IU (daily)
- Atenolol 25 mg (daily)
- Celecoxib 200 mg (daily)
- Vitamin C
- Furosemide 40 mg (each morning)
- Telmisartan 80 mg (daily)
- Memantine 10 mg (twice daily)
- Escitalopram 5 mg (daily)
- Galantamine ER (on hold, reason for hold not clear)

ADDITIONAL LEARNING:

1. ISMP Canada - Hospital to Home - Facilitating Medication Safety at Transitions https://www.ismp-canada.org/transitions/
2. Pharmacy Connection Fall 2016 - Coroner's Report: Transitions of Care, page 34
3. Pharmacy Connection Spring 2016 - The Role of the Pharmacist in Healthcare Transitions, page 8
4. (Ontario College of Pharmacists) Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities
5. Long Term Care Homes (LTCH) Act, 2007, & Ontario Regulations 79/10; Guide to the Long-Term Care Homes (LTCH) Act, 2007 and Regulation 79/10
6. eHealth Ontario Drug Profile Viewer (DPV) Info
7. ConnectingOntario ClinicalViewer

REFERENCES:

1. ISMP Canada Medication Reconciliation
2. Accuracy at Every Step: The Challenge of Medication Reconciliation

TAKING STEPS TO *Safeguard Health Records*

Abandonment of health records results in serious implications for the privacy of individuals and the security of their health information. Under Ontario's health privacy law, pharmacy professionals, as health information custodians, have a duty to safeguard health information until such records are appropriately transferred to another legally-authorized custodian.

Pharmacy professionals must take reasonable steps to ensure personal health information in their custody or control is protected against privacy breaches.

The Office of the Information and Privacy Commissioner of Ontario (IPC) has developed a new fact sheet "Succession Planning to Help Prevent Abandoned Records." This document outlines best practices to help custodians prevent abandoned records.

As well, you are encouraged to review the Record Retention, Disclosure, and Disposal guideline on the College website.

If you have any questions or concerns about abandoned records or the duties and obligations of custodians, please contact IPC at info@ipc.on.ca or 1-800-387-0073.

IMPORTANT NOTE:
SECURING PHARMACIES WITH A SHARED SPACE

If your pharmacy shares, or will be sharing, a space with a medical clinic or other establishment, the accredited pharmacy area must be designed, constructed and maintained so that it is physically separate and securable from the non-accredited area.

The manner in which the entire pharmacy is secured must completely restrict access by physical impediments when the pharmacy is closed or the pharmacist is not present. This is important for safeguarding the inventory and patient records under the pharmacy's control.

Designated managers are advised to review the College's Opening a Pharmacy webpage and ensure the pharmacy's security is compliant with the Standards of Accreditation and Operation. If an existing accredited pharmacy is non-compliant, please take action to address any gaps in security. If material changes are required to the physical layout, refer to the Pharmacy Renovations webpage.

Ontario College of Pharmacists
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2018 ANNUAL REPORT

MEASURING PERFORMANCE | IMPROVING OUTCOMES

The College recently published its 2018 Annual Report. The report, with the theme of ***Measuring Performance: Improving Outcomes****, features highlights from the calendar year, including:*

- *New initiatives, such as the launch of our medication safety program, that will ultimately help to reduce the risk of preventable patient harm due to medication errors in community pharmacies;*
- *Emerging opportunities that we are embracing – and leading – related to the development of a common set of quality outcome indicators for pharmacy to promote better patient care and enable greater system accountability and performance;*
- *How we are working with health system partners to inform and influence quality and safe pharmacy care through a systems-based approach to a number of our regulatory activities. One example is the development of new regional approaches to promoting standards compliance in partnership with the Local Health Integration Networks; and*
- *Our new Strategic Plan and strategic priorities for 2019-2021.*

SEE THE **(MOBILE AND TABLET FRIENDLY!)** HIGHLIGHTS AT
ocpannualreport2018.ca

A full PDF version of the annual report, which includes financial information and links to discipline decisions from 2018, can be downloaded online.

THE

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ANTIMICROBIAL STEWARDSHIP:

Sore Throat Largely Caused by Viral Infection

By Mark McIntyre, Pharm.D., ACPR

Antimicrobial stewardship (AMS) remains an important topic in the role of pharmacy professionals in any practice environment and is becoming increasingly so for those in community practice settings. Pharmacy Connection welcomes contributors from the Antimicrobial Stewardship Program team at the Sinai Health System and University Health Network in Toronto to share their insights and perspectives.

This is the fourth and final in their series about the role of community pharmacy professionals in AMS which reinforces important information for practitioners while providing practical tips and access to resources to support ongoing AMS efforts within our health system. In this issue, we are focusing on acute pharyngitis (sore throat).

Sore throat is one of the most common reasons for infection-related primary care assessment.[1] Pain and concern about complications of bacterial infection are often the key drivers of patient presentation.[2] While the vast majority (>80-90 per cent) of pharyngitis in adults is caused by viral infection, Group A Streptococci (GAS) causes up to 37 per cent of pharyngitis in pediatric patients.[3] Decision aids help identify patients less likely to have streptococcal disease and thus not benefit from antimicrobial treatment.[4] Despite tool availability, prescription of antimicrobials for pharyngitis that is likely viral remains common.[5] In one recent study, nearly 30 per cent of those presenting for care received antimicrobials inappropriately. Of those prescribed antimicrobials, 85 percent received either the incorrect antibiotic, dose or duration.[6]

GROUP A STREPTOCOCCI

Determining the etiology of pharyngitis (viral versus Group A streptococci versus other bacteria) and thus the need for antimicrobial treatment can be confusing for patients and clinicians. Generally, GAS is an acute onset "single system" disease of the pharynx and is not associated with nasal, other upper or lower respiratory or gastrointestinal symptoms.[7] Assessment of uncomplicated pharyngitis is supported by the McIssac/modified Centor score (below).[8,9]

Age	Score
3-14 14-44 ≥45	1 0 -1
Symptoms	
Fever ≥ 38C No cough Red tonsils/pustular exudate Anterior cervical lymphadenopathy (swollen lymph nodes in the neck)	1 1 1 1

Limitations exist in applicability of this tool to all populations such as caregivers of young children (parents/educators) or in the setting of epidemic disease owing to a higher pre-test probability of GAS. This scoring tool should not be used if signs of complicated infection exist.

If the score is ≤1, no testing or antimicrobial therapy is suggested. If the score is 2-3, testing using a rapid diagnostic test (RADT) and/or throat culture is advisable. Antibiotic therapy should be initiated if testing is positive. Note that in children, a negative RADT may prompt a throat culture for confirmation.[7,10] if the McIssac/modified Centor score is ≥ 4, empiric antimicrobial treatment should be started with antibiotics stopped if testing is negative as noted above.

SIGNS AND SYMPTOMS OF COMPLICATED PHARYNGITIS REQUIRING URGENT REFERRAL

- Difficulty swallowing
- Drooling
- Severe unilateral neck swelling/pain
- Severe headache
- Confusion
- Skin rash
- Vital sign instability (rapid heart rate, rapid breathing, low blood pressure)

EDUCATING PATIENTS

The easiest way to avoid unnecessary testing and treatment of pharyngitis is to avoid getting sick in the first place. Proactive stewardship solutions including hand hygiene and cough etiquette serve to reduce the transmission of both bacterial and viral pathogens and reduce the incidence of sore throat. Educating your patients about the difference between sore throat and "strep throat" can highlight when a "tincture of time" is appropriate and when patients should seek medical advice.

When patients present with pharyngitis symptoms, assess severity and the likelihood for GAS using the McIssac score. If there is a low risk of bacterial infection, educate them about the anticipated duration of viral sore throat (90 per cent self-resolve in less than seven days) and self-management steps for symptomatic relief (OTC analgesics, etc.). Reinforce that antibiotics have no benefit for viral infection. Should symptoms persist or worsen, patients should seek medical advice.

When patients come with a prescription for antibiotics, confirm the indication and assess the choice of antibiotic and duration. Group A streptococci has no documented resistance to penicillin, which remains the optimal choice for the treatment of confirmed GAS pharyngitis.[7] All penicillin allergies require clarification to ensure optimal therapy.[11,12] Symptomatic management of pain with OTC analgesics, particularly NSAIDs, can be suggested as appropriate. Lastly, ensure the appropriate duration of antimicrobial therapy. There is an increased infection recurrence rate when patients are treated with five versus 10 days of therapy for GAS pharyngitis infection.[7] Help ensure patients get the right antibiotics when they need them.

SUGGESTED TREATMENT OF SUSPECTED OR CONFIRMED GROUP A STREPTOCOCCAL PHARYNGITIS[7]

	Adults/Adolescents	Children
1st line	Penicillin VK 600mg PO BID x 10 days	Penicillin VK: 40-50mg/kg/day divided BID to TID x 10 days (maximum 750mg/day)
Alternate	Amoxicillin 1000mg PO daily x 10 days Amoxicillin 500mg PO BID x 10 days	Amoxicillin 50mg/kg/day PO once daily or divided BID x 10 days(maximum 1000mg/day)
Allergy (non – anaphylaxis)	Cephalexin 500mg PO BID x 10 days	Cephalexin 40mg/kg/day divided BID (max 1000mg/day) x 10 days
Allergy (anaphylaxis)	Clindamycin 300mg PO TID x 10 days Clarithromycin 250mg PO BID x 10 days Azithromycin 500mg PO x 1 dose on day 1, followed by 250mg PO daily x 4 days	Clindamycin 20 mg/kg/day divided TID x 10 days (max 900mg/day) Clarithromycin 15mg/kg/day divided BID x 10 days (max 500mg/day) Azithromycin 12mg/kg x once on day 1 followed by 6mg/kg once daily x 4 days

ADDITIONAL SOURCES:

SHS-UHN ASP Website https://www.antimicrobialstewardship.com/upperrespiratory

Do Bugs Need Drugs? Sore Throat http://www.dobugsneeddrugs.org/guide/sore-throat/

Choosing Wisely Canada https://choosingwiselycanada.org/colds-flu-respiratory-illnesses-dont-rush-antibiotics/

INESSS Pharyngitis-Tonsillitis in Children and Adults https://www.inesss.qc.ca/fileadmin/doc/INESSS/Outils/GUO/Anglo/Guide_Pharyngite-Amygdalite_EN_WEB.pdf

CDC – Group A Streptococcal Disease https://www.cdc.gov/groupastrep/diseases-hcp/index.html

Public Health Ontario - Systematic Antibiotic Allergy Verification - https://www.publichealthontario.ca/apps/asp-strategies/data/pdf/ASP_Strategy_Systematic_Antibiotic_Allergy_Verification.pdf

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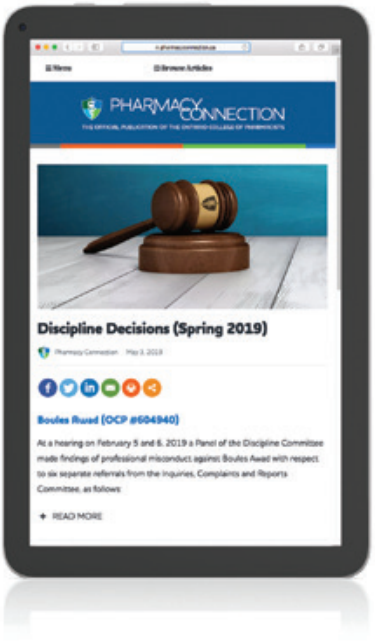
DISCIPLINE DECISIONS

The College has moved Discipline Decisions online to pharmacyconnection.ca.

These easy-to-access decisions facilitate greater accessibility among pharmacy professionals, stakeholders and members of the public and allow us to share decisions more widely via e-connect, our website and social media. As always, pharmacy professionals are encouraged to view these decisions as opportunities to examine and enhance their own practice. Decisions also remain available to view on the public register and CanLii.



LIST OF SPRING 2019 DECISIONS:

Boules Awad (OCP #604940)

Michael Yamasaki (OCP #72141)

Mohamed Khandwalla (OCP #608621)

Elizabeth Wright (OCP #105686)

Anthony Evans (OCP #9857)

2549363 Ontario Inc., c.o.b. as FYP Pharmacy (Accreditation #306094), and David Bedggood (OCP #82791), sole director of 2549363 Ontario Inc., and the designated manager of FYP Pharmacy

Ahmad Abdullah (OCP #214485)

Colin Peters (OCP #607131)

The full text of these decisions is available at www.canlii.org.
CanLii is a non-profit organization managed by the Federation of Law Societies of Canada. CanLii's goal is to make Canadian law accessible for free on the Internet.

FOCUS ON ERROR PREVENTION

By Ian Stewart R.Ph, B.Sc.Phm.

Always clarify potentially ambiguous and non-standard abbreviations with the prescriber.

The misinterpretation of a prescriber's intent is a leading cause of medication errors. A common contributing factor is the inappropriate use or misinterpretation of abbreviations in practice.

Abbreviations are often used to prescribe medications (e.g. MTX – methotrexate), indicate the frequency of dosing (q.i.d. – four times daily), etc.

However, medical abbreviations may have multiple meanings or can be misinterpreted if poorly written as the following cases highlight.

CASE 1:

A community pharmacist received a hospital discharge prescription with a list of medications. One of the medications was listed as CPZ 100mg to be taken bid. The pharmacist initially interpreted CPZ as chlorpromazine. However, upon checking the patient profile, he noticed that the patient was taking carbamazepine 100mg bid before entering the hospital.

The pharmacist decided to call the prescriber to confirm their intention. Upon speaking with the physician, he confirmed that he indeed intended to prescribe carbamazepine and assumed CPZ was the short form for carbamazepine.

CASE 2:

A senior patient presented a prescription to a community pharmacy for 100gm "Canesten HC 1% PV". The pharmacist assumed that the compounded product was to be inserted into the vagina.

A pharmacy with expertise in the compounding of vaginal products was contacted resulting in the decision to transfer the prescription to the specialized compounding pharmacy.

After receiving the transfer, the pharmacist reviewed the prescription and noticed key information was missing including the quantity/dose to be inserted intravaginally. The pharmacist also considered the

amount of hydrocortisone that would be included in a typical 5gm vaginal applicator.

A call to the prescriber confirmed that she had intended for the cream to be applied topically in the vaginal area and not inserted into the vagina. Hence, the original pharmacy could have compounded the topical product.

RECOMMENDATIONS:

- Avoid the use of abbreviations whenever possible. Especially those abbreviations known to be associated with medication errors. This includes when recording a verbal prescription.
- Always contact the prescriber to clarify potentially ambiguous and non-standard abbreviations.
- The patient's medication history should be consulted to identify previous drug use and potential misinterpretation errors.
- Before a specific drug is dispensed, consider all aspects of the prescription for appropriateness. Factors to be considered include the patient parameters, medication history, indication for use, the dose, dosing interval, duration of therapy, etc.
- Whenever possible, educate prescribers regarding the risks associated with the use of medical abbreviations. Discourage the use of abbreviations and suggest the information be written in full. Encourage the use of computerized printed prescriptions to minimize the misinterpretation of abbreviations.
- Be aware of the potential for error when interpreting abbreviations. Below is an abbreviated list of problematic abbreviations. A more comprehensive list can be accessed at: https://www.ismp.org/recommendations/error-prone-abbreviations-list Accessed May 1st, 2019.

ABBREVIATION	INTENDED MEANING	MISINTERPRETATION
AU	Aurio uterque (each ear)	Mistaken for OU
IU	International Unit	Mistaken as IV (intravenous)
µg	Microgram	Mistaken for "mg" when handwritten
o.d. or OD	Once daily	Misinterpreted as "right eye"
per os	Orally	The "os" can be mistaken for "left eye".
q.d. or QD	Every day	Mistaken as q.i.d., especially if the period after the "q" or the tail of the "q" is misunderstood as an "i"
q.o.d. or QOD	Every other day	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written.
sid - semel in die (used by veterinarians)	Once daily	Misinterpreted as bid when poorly written.
U or u	Unit	Misinterpreted as zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44").

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com . Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

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