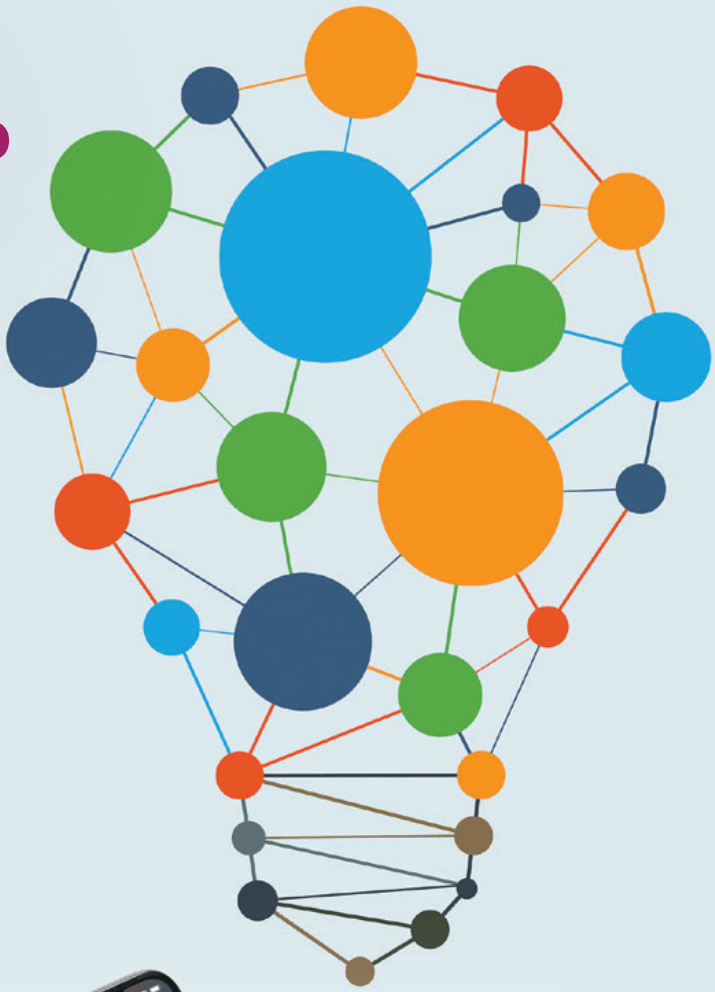
Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SUMMER 2021 • VOLUME 28 NUMBER 2
PHARMACYCONNECTION.CA

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

ONGOING LEARNING SUPPORTS ENHANCED PATIENT OUTCOMES



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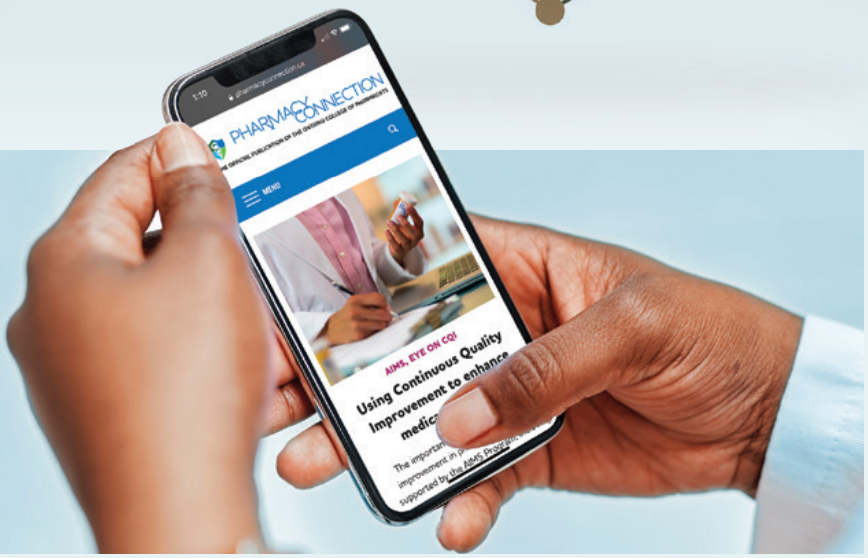

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BOARD OF DIRECTORS

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

Standing Committees
- Drug Preparation Premises
- Finance & Audit
- Governance
- Screening

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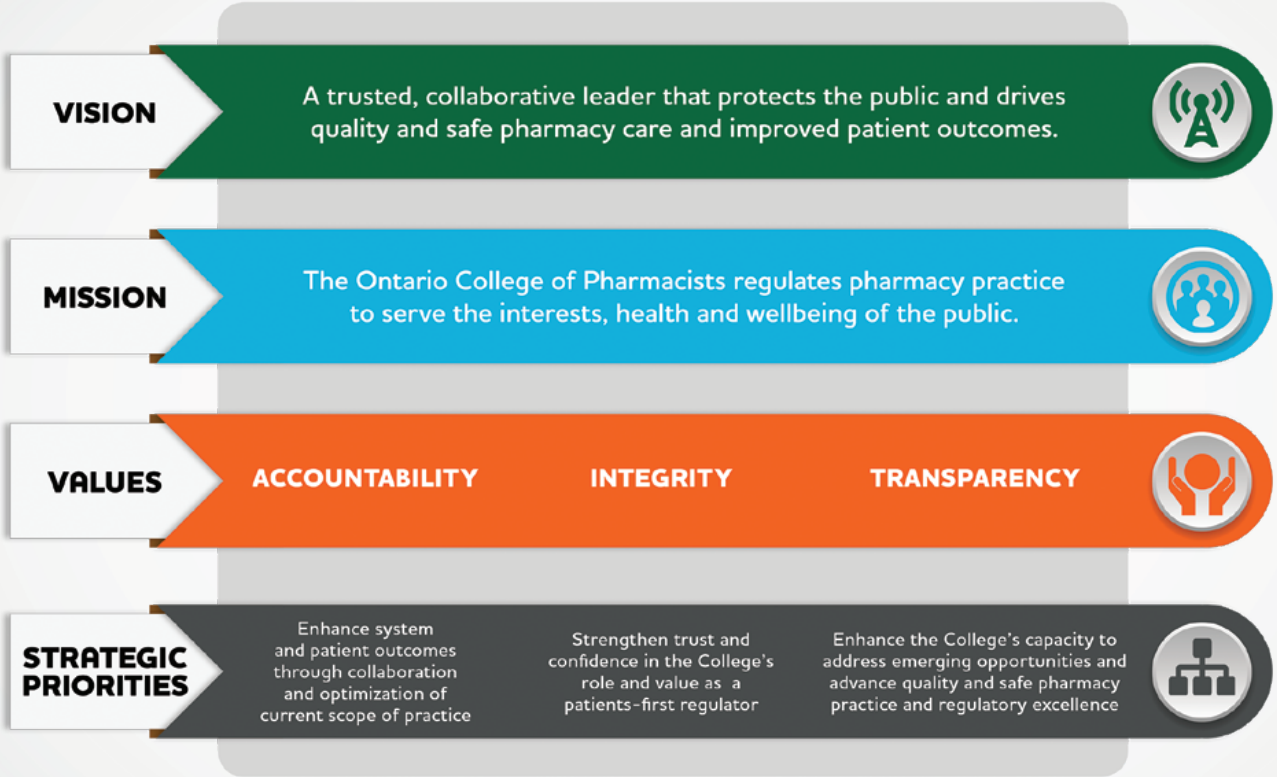
*(2019-2022/2023)** OCP STRATEGIC FRAMEWORK



*In September 2020, the Board reaffirmed the priorities expressed within the existing multi-year strategic framework and deferred strategic planning activities through to 2022 or 2023.

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 registrants with other allied health care professionals; and to communicate our role to registrants and stakeholders as regulator of the profession in the public interest.

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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PHARMACY CONNECTION

SUMMER 2021 • VOLUME 28 NUMBER 2

CONTENTS

Nancy Lum-Wilson,
R.Ph., B.Sc.Phm., MBA
CEO and Registrar

Dear Colleagues,

This edition of *Pharmacy Connection* marks the transition of the College's print magazine to a dynamic new digital publication that will improve timely access to important information, tips, news and updates relevant to practicing pharmacy professionals. It will also allow us to focus on publishing information that will be easy for you to find—no matter what device or platform you are using in your busy practice.

The enhanced *Pharmacy Connection* reflects input from registrants who shared feedback on its functionality and the type of information they valued most in their daily practice. I encourage you to continue telling us what you think of the digital edition so that we may continue to support a seamless, engaging experience going forward. Be sure to visit PharmacyConnection.ca to try the new features!

To show the relationship between continuous quality improvement (CQI), the College's mandatory Assurance and Improvement in Medication Safety (AIMS) Program, and the importance of establishing a culture of medication safety in pharmacies, we have launched a new feature called Eye on CQI. In our first installment we take a look at how each of these are vital components in enhancing patient safety and improving patient health outcomes. Pharmacy professionals are encouraged to use AIMS to inform CQI initiatives in their own pharmacy practice, and to embrace a just culture, which is essential for identifying risks, openly sharing learnings and developing actions to reduce the chance of medication incidents or near misses from occurring or recurring.

Pharmacies across the province are working to fully implement the NAPRA Standards for Pharmacy Compounding of Non-Sterile Preparations before the January 1, 2022 deadline, and we asked our College operations advisors to share some advice. The tips and resources they have provided will help pharmacies implement the standards and improve the health and safety of both patients and pharmacy professionals.

Part of the College's commitment to protecting the public is helping to ensure that pharmacy professionals maintain appropriate skills and knowledge throughout their careers. Through the Quality Assurance (QA) Program, the College has a mandate to ensure continued competence of the profession to provide safe, quality care. We do this by helping those who have challenges meeting standards and enabling those who are meeting standards to continually improve. In this edition, we share more about how the College has approached our QA Program, utilizing a right-touch and risk-based approach, and we focus on two key components of the Program: the knowledge assessment and practice assessments for pharmacists working in hospital or other healthcare facilities.

We continue to see the devastating effects of the opioid crisis right across Ontario, further heightened by the impact that the COVID-19 pandemic has had on the population. In 2020 alone, there were 2,426 opioid-related deaths in our province, representing a 60% rise from 2019. We know that pharmacy professionals have an important role to play in helping prevent harms to patients and communities. In this edition, we asked experts from the Centre for Addiction and Mental Health to highlight key guidance for pharmacy professionals as opioid use disorder treatment options continue to evolve.

I hope you enjoy this edition of *Pharmacy Connection*, and that you all have a safe, well-deserved summer break.

Sincerely,

Nancy Lum-Wilson

CEO and Registrar
Ontario College of Pharmacists

JUNE 2021 BOARD MEETINGS

These meetings were held via video and teleconference in consideration of provincial directives and physical distancing measures recommended by Public Health Ontario due to the COVID-19 pandemic.

As recorded following the Board of Directors' regularly scheduled meeting held on June 14, 2021.

BOARD DECISIONS

The Board discussed and made decisions on the following policies and By-Law amendments:

Virtual Care Policy

The Board approved an amended Virtual Care Policy to outline the practice expectations for registrants who choose to provide care to patients using virtual approaches. The policy's development was informed by a comprehensive review of pharmacy regulatory authorities across Canada and health professional regulators in Ontario, alongside a review of privacy legislation and guidance from external organizations, as well as from feedback gathered during a 60-day open consultation. The policy has been posted on the College's website, along with additional resources to guide registrants in their practice.

Restocking of MAiD Drugs

Due to the pandemic, a shortage of drugs used in the Medical Assistance in Dying (MAiD) drug protocol has impacted a number of patients. The Board has approved a policy on Restocking of Drugs Used for Medical Assistance in Dying (MAiD) During COVID-19, with the intent that it be in effect only for the duration of the current health emergency. Once the emergency order has been lifted in Ontario, the College will continue to monitor the status of the drug shortages and determine whether development of a permanent restocking policy is warranted. The policy has been posted on the OCP website, and additional information and resources to support registrants in the application of the policy in their practice, where appropriate, have been shared.

Governance Manual policies

The Board reviewed and approved policies in Sections 3, 4 and 5 of the Governance Manual. This is the final approval for a series of standalone policies which, once complete, will replace the current Governance Manual. The current manual, in effect since 2014, is comprehensive but lengthy and not easily amended. The new policies will come into effect at the start of the new Board year in September 2021, with orientation of new Board members centred around these new policies.

By-Law Amendments

To support improvement in governance practice and to strengthen trust in the College's mandate to serve and protect the public, the Board approved three By-Law amendments, including those related to the Selection of Committee Chairs, Conduct of Board Directors and Committee Appointees and Sanctions Process, and Board Meeting Rules of Procedure. The amended By-Laws will come into effect immediately, enabling the changes to be in place prior to the commencement of the next Board year in September 2021.

HONOURING NATIONAL INDIGENOUS HISTORY MONTH

To mark National Indigenous History Month, the Board welcomed Dr. Jaris Swidrovich, Canada's first self-identified First Nations Doctor of Pharmacy, who shared his thoughts on Indigenous Engagement, Cultural Safety, and Reconciliation. Improving Indigenous cultural competency within the College and among registrants is a Board-supported commitment, and the Board thanked Dr. Swidrovich for his insights about how pharmacy professionals can enhance care for Indigenous patients.

CROSS-JURISDICTIONAL SERVICES POLICY

Following a 60-day open consultation on a proposed Cross-Jurisdictional Services Policy, the College will update

the draft with amendments based on respondent input. Feedback suggested that potential unintentional barriers to cross-jurisdictional care could result if the policy was to be implemented as written, and some respondents requested the development of an accompanying practice resource to augment the policy and provide examples around expectations. Once amendments have been made, and a practice resource is developed to accompany the policy, the College will submit an amended policy for Board approval.

STRATEGIC PRIORITIES PROGRESS UPDATE

The College's CEO and Registrar delivered a report to the Board highlighting activities that have taken place since the last meeting, as well as progress on strategic initiatives. The Registrar shared the Q1 2021 Scorecard, which provides a snapshot of the performance of the College against the established objectives for the quarter, which are aligned with the Ministry of Health's College Performance Measurement Framework (CPMF).

BOARD RISK REPORT

The CEO and Registrar also presented the Board Risk Report, outlining identified physical, financial, operational and reputational risks and their mitigation strategies. The presentation outlined the College's 2021-2022 Risk Management Program and reported on the progress to mitigate risks identified in the 2021 Risk Register. To date, 82% of the strategies are implemented or underway. Throughout the fall, the College will develop the 2022 Risk Register for consideration by the Finance and Audit Committee and then the Board at the December Board meeting.

NEXT BOARD MEETING

The next regularly scheduled meeting will be held on September 20, 2021. Special Board meetings may be called at any time. Please see our website for information on upcoming Board meetings. Board meetings are open to the public and are typically held in the Board Chambers of the College at 483 Huron Street, Toronto, ON, M5R 2R4. Due to public health measures currently in place, Board meetings are being held virtually until further notice. If you plan to attend an in-person meeting or for more information, please contact Ms. Sharlene Rankin, Board and Committee Liaison at boardofdirectors@ocpinfo.com. Links for those who wish to observe a virtual meeting will be posted with meeting agendas. You can also follow highlights from the Board meetings via Twitter.

A summary of record of the Board of Directors' meeting held on June 24, 2021.

The Board approved governance and burden reduction recommendations in response to the Ministry of Health's request for input on *Regulated Health Professions Act*, 1991 (RHPA) reform opportunities.

In a letter to be shared with the government for consideration in potential amendments to the RHPA, the Board expressed its continued support for and approved the following governance reforms and principles, some of which have already been implemented at the College:

- Smaller Boards (Councils), reducing the size of the Board to 8-12 members and eliminating the Executive Committee.
- Separating the Board from statutory Committees, except where required by statute.
- Ensuring a 50/50 balance of elected professionals and appointed public directors to the Board, while eliminating academic appointments. The Board recommended ensuring academic representation be maintained in other ways, such as advisory groups.
- Maintaining the current model of competency based elections with aligned competency-based appointments of public Board directors.
- Changing nomenclature in the RHPA to refer to 'Council' as 'Board', and 'Members' as 'Registrants'.

The Board also expressed its support for additional burden reduction opportunities within the RHPA in response to the Ministry's request for feedback. Please read the full June 24, 2021 Board Report.

REGISTRAR'S Reflection

For more than a year now we have been talking about the pandemic and the many ways in which it has altered pharmacy practice. The changes that have been implemented to protect patients and pharmacy staff were nothing short of extraordinary, and their effectiveness has helped maintain access to safe, quality pharmacy care for Ontarians.

Pharmacy professionals met the public health crisis head-on, and showed remarkable resilience in the way they adapted to regulatory amendments and changing public health recommendations. Community pharmacies used PPE, screening protocols and physical distancing to prevent the spread of COVID-19 in their locations, establishing them as safe, accessible healthcare providers for patients. Hospital pharmacists and pharmacy technicians played an increasingly vital role in patient care as COVID-19 patient volumes soared. And pharmacy professionals in all settings became trusted sources of reliable COVID-19 information, helping patients make informed decisions for themselves and their families.

In addition, 16 months after the pandemic began, we are seeing the benefit of pharmacists, pharmacy technicians and other healthcare professionals supporting the government's COVID-19 testing and vaccination programs in communities across Ontario.

COVID-19 cases have declined substantially, and as of August 3 the number of adult Ontarians with at least a first dose of vaccine has exceeded 80% of the population, and over 70% have also received their second dose. This has relieved pressure on our hospitals, allowed a gradual re-opening of businesses and community services, and made it possible to see our friends, family and colleagues in person once again.

Yet while the end of the pandemic may be in sight, it is unlikely that we will completely return to business as usual. We can't predict what the future may hold, but we can take the lessons we have learned to improve the way safe patient care is provided going forward.

We know, for instance, that the pandemic created a demand for virtual care, and that emerging technology is making it easier and safer in a pharmacy setting. As a result, the College's Board of Directors recently approved a new Virtual Care policy, informed by feedback from an open consultation on our website. This policy sets expectations for the appropriate use of virtual care for pharmacies, and requires that pharmacy professionals consider certain factors such as maintaining a patient's right to privacy, the appropriateness of using a virtual approach to care, and ensuring the same quality as in-person care is provided.

And, while temporary, we saw the provincial government amend the *Regulated Health Professions Act, 1991* (RHPA) to allow a Part A pharmacist, intern, registered pharmacy student or pharmacy technician to administer the COVID-19 vaccine by injection. Though this amendment is only in effect until next March, it does demonstrate the value of authorizing pharmacy professionals to support the province's COVID-19 vaccination program, and could be reinstated or extended should Ontarians require booster doses in the future.

The College continues to monitor the evolution of pharmacy practice and government regulation as a result of the pandemic, and to collaboratively provide registrants with ongoing guidance and resources to support their safe delivery of pharmacy care. Please refer to our COVID-19 Information for Pharmacy Professionals web page for the latest updates.

The COVID-19 pandemic has brought many challenges and placed an extraordinary amount of stress on healthcare professionals. I want to thank you for your ongoing commitment to your patients throughout these challenging times. PC

Sincerely,
Nancy

PHARMACY PROFESSIONALS PLAY VITAL ROLE IN *Ontario's Safe Re-opening*

As Ontario's vaccination rates continue to climb and the province begins to re-open, pharmacy professionals are playing a key role in driving province-wide progress and improvements in health indicators. Through patient education, support and community vaccinations, pharmacy professionals are keeping Ontarians informed and healthy.

With evolving public health guidance, pharmacy professionals continue to be an important source of information and education for patients, including addressing questions and concerns about vaccines. It is important that pharmacists and pharmacy technicians educate themselves about the COVID-19 vaccines so that they are prepared to address questions and concerns from patients.

During the provision of pharmacy services, while engaging with their patients, pharmacy professionals are encouraged to ask patients whether they have received the first and second dose of a COVID-19 vaccine. If the patient has not received a vaccine, pharmacists can offer patient education around the safety and efficacy of the vaccine and discuss any concerns the patient may have.

Even if you are not providing vaccinations in your pharmacy, as a healthcare professional you play an important role in ensuring patients have the information they need to make an informed decision and helping them navigate the vaccination process when appropriate. Patients can also be reminded to seek out and rely on reputable and credible information sources.

TOP FIVE COVID-19 RESOURCES FOR PHARMACY PROFESSIONALS

The College provides a host of resources pharmacy professionals can use in their daily practice to help guide conversations with patients. The College continues to collaborate with the Ministry of Health, public health officials and other health system partners and professional associations to inform and support pharmacy professionals.

COVID-19: Information for Pharmacy Professionals
The College's dedicated COVID-19 webpage includes the latest updates on COVID-19, resources on supporting vaccine confidence and visually engaging health resources.

Canadian Vaccination Evidence Resource and Exchange Centre (CANVax)
Find resources focused on vaccine acceptance and uptake in Canada, including COVID-19 vaccine questions and answers for public health professionals.

University of Waterloo's School of Pharmacy COVID-19 health resources
Access health resources on COVID-19 vaccines, including FAQs, infographics and videos.

Immunize Canada
Immunize Canada is a national coalition whose mission is to promote the understanding and use of vaccines as recommended by the National Advisory Committee on Immunization. Access resources on education, misinformation and vaccine hesitancy.

Centre for Effective Practice COVID-19 webpage
The Centre for Effective Practice has evidence-based resources, including common COVID-19 questions from patients and key messages to use in responding.

PHARMACY CONNECTION GOES DIGITAL

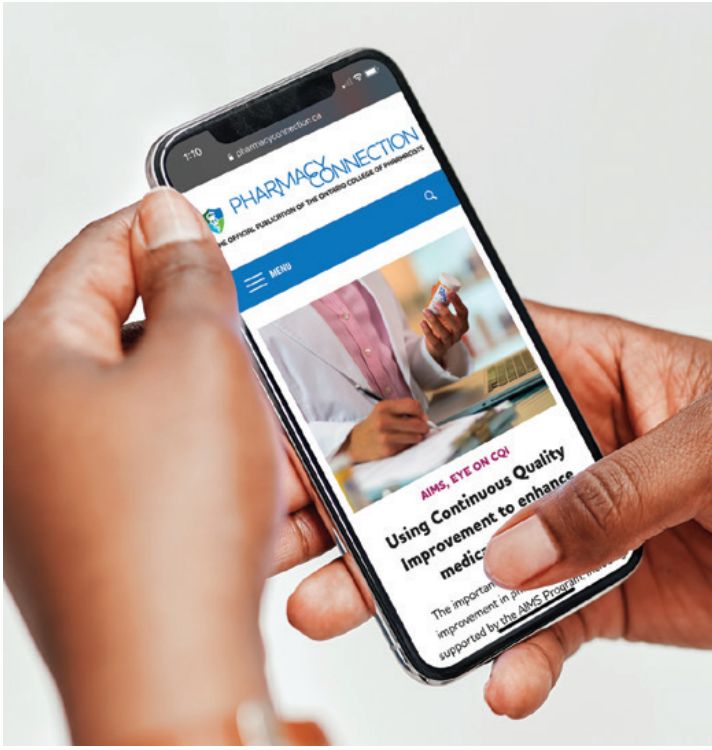
The College is excited to announce the launch of its new digital Pharmacy Connection, a web-based and mobile-friendly publication suitable for busy, on-the-go pharmacy professionals.

This new digital publication will improve access to important information, tips, news and updates, and give registrants quick and easy access to practice-related information. The College's move to digital underscores our focus on providing a more responsive and timely resource that supports our important role in delivering relevant content that pharmacy professionals can use to help them provide safe and quality patient care. Delivering content that can be quickly shared and easily updated will help registrants align their practice to the latest policies and updates.

Shifting to this new, flexible digital platform means the College **is retiring the current print magazine format**. This edition of *Pharmacy Connection* will be the last to be printed and mailed to hard-copy subscribers. The redesigned, user-friendly PharmacyConnection.ca will allow readers to access current information, issues and engage with content anywhere, anytime. For those who prefer to read on paper, every story on PharmacyConnection.ca has a prominent and accessible print button, giving readers quick and easy access to a print-friendly version of the articles. In addition to printing articles, readers can engage with and share the stories with their peers via social media channels, including Facebook, Twitter and LinkedIn, or email.

As part of our commitment to supporting a positive reading experience, we will continue to seek feedback from registrants and make enhancements to support an engaging experience for readers.

Check out the new PharmacyConnection.ca for the latest news and updates!



HOW GOING DIGITAL BENEFITS YOU

RESPONSIVE

- Access more frequently updated content and timelier posts relevant to pharmacy regulation and practice
- Available across all devices, making it suitable for on-the-go pharmacy professionals

INTERACTIVE

- Access embedded videos and interactive content, enhancing your reading experience
- Easily share stories with your network and across social platforms

FLEXIBLE

- Digital content is not bound by a quarterly publication schedule, giving you access to news and updates as they happen
- Articles are published when they are most relevant and timely, and can be easily updated with new information

SUSTAINABLE

- Contribute towards an environmentally friendly initiative, eliminating the need for printing over a million pieces of paper a year
- Support the College's commitment to be a cost-effective and efficient regulator

THE CODE OF ETHICS: *Accountability*

Pharmacists and pharmacy technicians maintain the public trust by ensuring that they act in the best interest of their patients and society by practicing within scope, refraining from participating in unethical business practices and avoiding conflicts of interest.

Key ethical standards, among others, require pharmacy professionals to:

- *Assume responsibility for all decisions and actions they undertake in professional practice, including failure to make a decision and take appropriate action when necessary.*
- *Be diligent in identifying and responding to red flag situations that present in practice.*
- *Report professional incompetence or unethical behaviour by colleagues or other healthcare professionals to the appropriate regulatory authority.*
- *Ensure that when power imbalances exist in professional working relationships they do not exploit these relationships for personal, physical, emotional, financial, social or sexual gain.*
- *Recognize that their patient's best interests must always override their own interests or the interests of the business which they own, have a financial interest in or are employed by.*
- *Avoid dual relationships and other situations which may present a conflict of interest and potentially affect their ability to be impartial and unbiased in their decision-making.*

LEARN MORE ABOUT ACCOUNTABILITY

- Read the Code of Ethics
- Watch the e-Learning Module on Accountability
- Watch the e-Learning Module on the Code of Ethics
- Review the Framework for Ethical Decision Making

The Code of Ethics articulates the ethical principles and standards that must guide the practice of pharmacists and pharmacy technicians. As a way to draw attention to the Code of Ethics since its introduction almost five years ago, we have been featuring one ethical principle in the past few editions of *Pharmacy Connection*. This is the final installment. PC

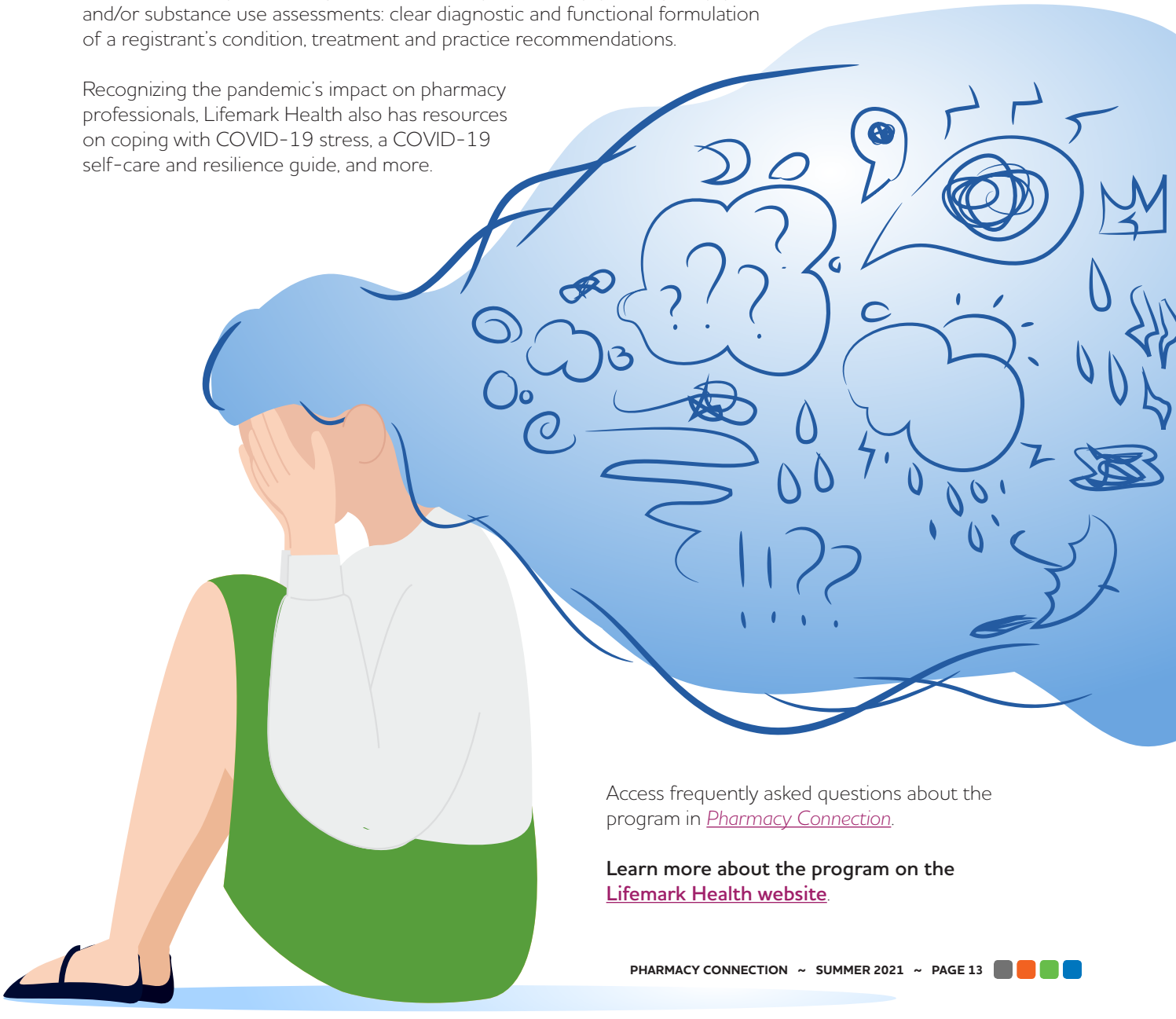
EXPERIENCING *Mental Health or Substance Use Challenges?*

Your mental health is just as important as your physical health. Take advantage of the free Ontario Pharmacy Health Program (OPHP) administered by Lifemark Health.

Registrants can access OPHP directly and remain anonymous to the College. Those who participate in the program will benefit from specialized assessment and treatment that addresses the unique needs of pharmacy professionals.

Lifemark Health provides registrants with comprehensive psychological, psychiatric and/or substance use assessments: clear diagnostic and functional formulation of a registrant's condition, treatment and practice recommendations.

Recognizing the pandemic's impact on pharmacy professionals, Lifemark Health also has resources on coping with COVID-19 stress, a COVID-19 self-care and resilience guide, and more.



Access frequently asked questions about the program in *Pharmacy Connection*.

Learn more about the program on the Lifemark Health website.

THE ROLE OF PROVIDER EXPERIENCE *in Quality Healthcare*

Like the focus on patient experience, measuring the experience of healthcare providers can help uncover important health system improvement opportunities.

There is a well-established link between healthcare provider experience and patient outcomes. For example, many studies of burnout among clinicians and staff in healthcare have shown the negative impacts on patient care and outcomes. Research demonstrates that physician burnout is associated with an increased risk of patient safety incidents and poorer quality of care due to low professionalism[i], dissatisfied physicians are more likely to prescribe inappropriate medications, which can result in expensive complications[ii], patient safety is threatened by nurse dissatisfaction, and many nurses report that their workload causes them to miss important changes in their patients' condition[iii].

Yet measuring the experience of community pharmacy professionals within the context of healthcare quality and outcomes has never been done before—a literature review conducted by the College found no community pharmacy-specific measures identified here in Canada or around the world.

As part of the College's Quality Indicators initiative, a working group of frontline pharmacy professionals, patients, and health and data experts has been formed to identify meaningful indicators that will measure provider experience. 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, it is relatively new territory for community pharmacy in Ontario, which is why it is the focus of this current indicators work. The working group has been reviewing existing indicators from other disciplines, and will recommend a shortlist of these indicators for public consultation this summer

A list of confirmed provider experience measures will be finalized based on stakeholder feedback and presented to the Board in December 2021. The College will also use the public consultation to explore options for collecting the data going forward.

COMMUNITY PRACTICE ENVIRONMENT

The work to develop provider experience indicators complements the Community Practice Environment Initiative, aimed at understanding and addressing the barriers to patient safety in community pharmacy. This initiative resulted in a set of shared accountability principles, approved by the College's Board of Directors in December 2020. These principles provide all pharmacy stakeholders with a foundation to guide decision making that supports consistent delivery of safe, high quality patient care at all times within a community pharmacy environment.

An implementation strategy is currently being developed that will involve each stakeholder playing an important part in the rollout, promotion and adoption of the principles throughout the profession.

While the selection of provider experience measures is a separate stream of activity, the environment that pharmacy professionals practice within does affect the experience of providing care. Therefore, the development of principles of shared accountability will inform the selection of provider experience measures and contribute to the College's efforts to support safe and effective patient care.

Information about the Community Practice Environment and the Quality Indicators initiatives will continue to be shared in future editions of *e-Connect* and *Pharmacy Connection*. Pc

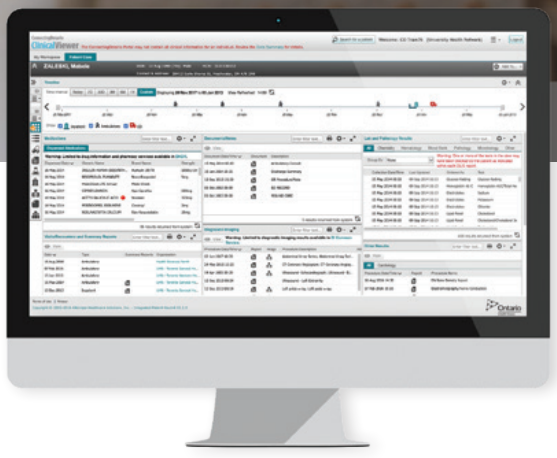
[i] Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., ... & Esmail, A. (2018). Association between physician burnout and patient safety, professionalism, and patient satisfaction: a systematic review and meta-analysis. *JAMA Internal Medicine*, 178(10), 1317-1331.

[ii] Williams, E. S., & Skinner, A. C. (2003). Outcomes of physician job satisfaction: a narrative review, implications, and directions for future research. *Health Care Management Review*, 28(2), 119-139.

[iii] McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs*, 30(2), 202-210.

CLINICAL VIEWERS

Now Available to All Community Pharmacies



Ontario Health is now offering patient care information to pharmacies, including laboratory results, dispensed medications, and acute care data, through one of two provincial clinical viewers (ConnectingOntario and ClinicalConnect) that are designated by region.

The viewers provide a dynamic, near real-time view of patients' health information to support the delivery of pharmacy services such as medication management and counselling, MedsChecks, Pharmaceutical Opinions, and other patient care services at no cost to pharmacies.

With access to the clinical viewers pharmacists can make faster, more informed care decisions, and improve workflow and efficiencies at the point of care with a more complete picture of a patient's health profile, available 24/7.

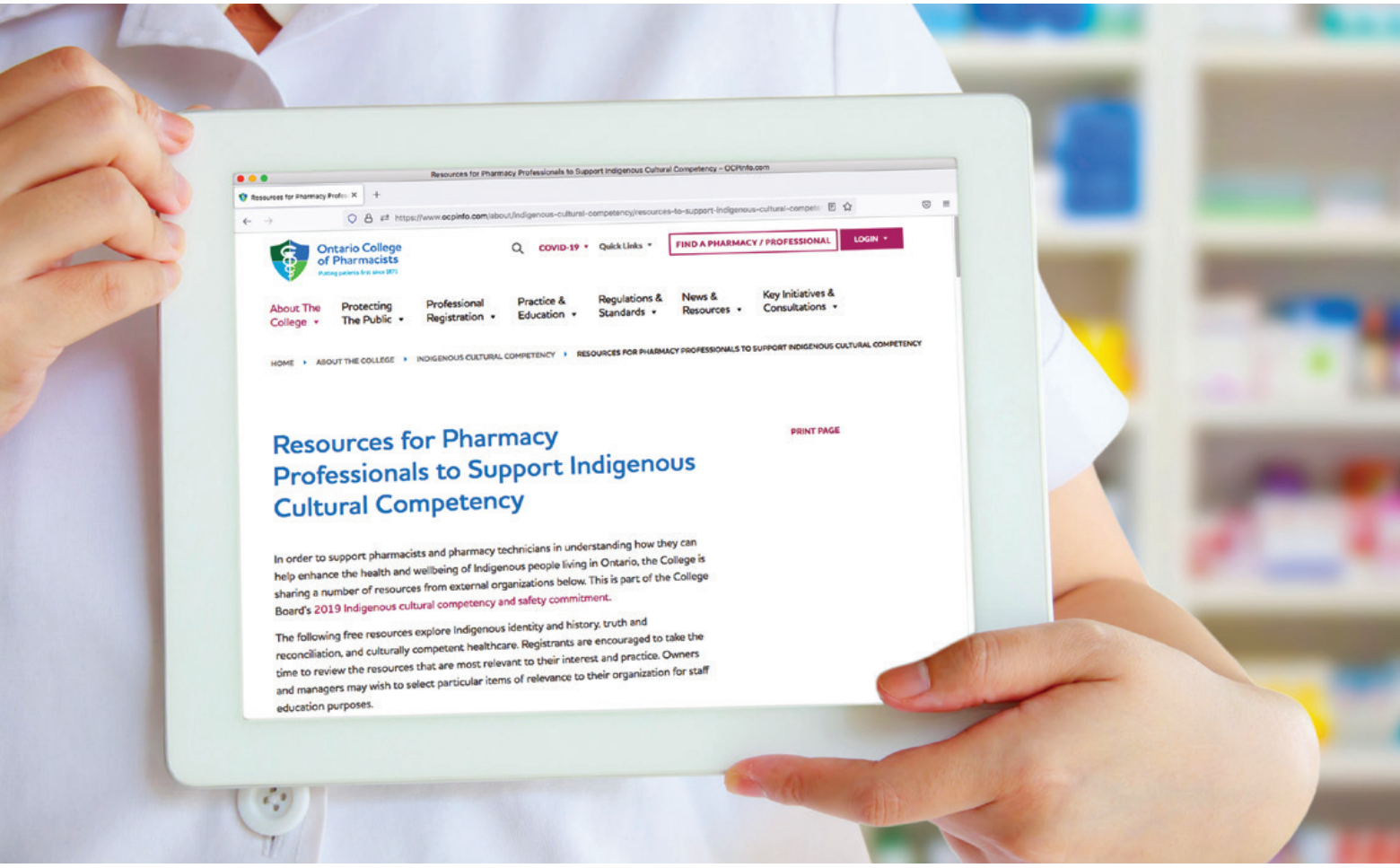
Sign up today and take advantage of Ontario Health's new, streamlined signup process. You'll also benefit from support every step of the way from an Ontario Health Lead who will address any questions you have and help your pharmacy complete the access requirements.

To sign up, the pharmacy's Designated Manager or Director Liaison can complete a request on Ontario Health's website. The College encourages all pharmacy professionals to take advantage of this great opportunity for your pharmacy to access these valuable clinical viewers, which will help pharmacists make more informed decisions and provide enhanced patient care.

Questions about the clinical viewers and sign up process can be directed to Ontario Health at oh-ds_connectingontario@ontariohealth.ca.

Resources for Pharmacy Professionals

TO SUPPORT INDIGENOUS CULTURAL COMPETENCY



In 2019, the College's Board of Directors made an Indigenous cultural competency and safety commitment. As part of this, the College committed to sharing resources with pharmacists and pharmacy technicians that would help them enhance the health and well-being of Indigenous peoples living in Ontario.

The new Resources for Pharmacy Professionals to Support Indigenous Cultural Competency webpage provides links to a number of free resources that explore Indigenous identity and history, truth and reconciliation and culturally competent healthcare. Registrants are encouraged to take the time to review the resources that are most relevant to their practice.

These resources have been curated from a variety of sources, including government websites, healthcare organizations, advocacy bodies and Indigenous-led organizations. Additional resources will continue to be added to this page, so you are encouraged to check back regularly. If you know of any resources that the College should consider including in this list, please email communications@ocpinfo.com.

USING CONTINUOUS QUALITY IMPROVEMENT TO ENHANCE MEDICATION SAFETY

It is often said that all improvement requires change, but not all change results in improvement. That's where the concept of continuous quality improvement, also known as CQI, comes in.

In pharmacy, the objective of CQI is to improve all aspects of practice with the goal of increasing patient safety. This may include learning from medication incidents and implementing error prevention strategies to reduce the chances of recurrence, such as process standardization or improvements.

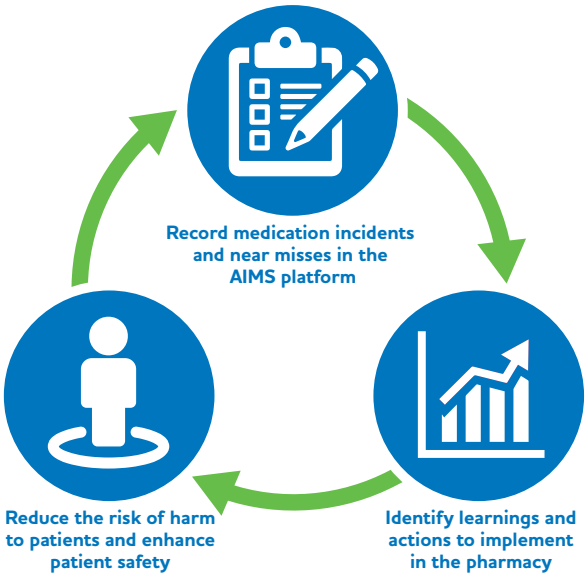
CQI is about change, and increasing the chances that the changes made in pharmacy result in improved patient safety. To achieve safer care for patients, CQI must focus on both system improvements as well as the tasks that individual practitioners perform.

How AIMS supports CQI

The College's mandatory Assurance and Improvement in Medication Safety (AIMS) Program is based on a CQI approach. With the goal of reducing the risk of patient harm caused by medication incidents in, or involving, Ontario pharmacies, AIMS enables practitioners to learn from medication incidents and better understand why they happen and how they can be prevented.

As shown in the diagram on the next page, pharmacy professionals record medication incidents and near misses in the AIMS Pharmapod platform, and analyze the incident to identify learnings and actions that can be implemented in the pharmacy to reduce the risk of harm to patients and enhance patient safety.

How AIMS Supports CQI



The data recorded in the AIMS Pharmapod platform is then de-identified and aggregated with data from other pharmacies across the province to create a snapshot of trends or opportunities for system-level improvements. A sub-set of this data is available on the OCP website as an interactive tool, and the College is currently working with a group of subject matter experts from various environments that have experience related to medication safety, such as community pharmacy, academia and health data analysis, to support the AIMS program goals of sharing lessons learned across the province.

Creating a culture of medication safety

For AIMS to effectively inform CQI, pharmacy owners and Designated Managers must enable a just culture that supports learning and a system-based approach to incident analysis over a blame and shame culture that focuses on human behaviours.

A culture of medication safety can be described as shared values, norms, competencies and attitudes towards patient safety among individuals within an organization.[1] Members of a safety culture report incidents without fear of blame, learn from incidents to make improvements, and trust their organization will deal with them fairly when something goes wrong.[2] A culture of medication safety encourages staff to engage in open, honest discussions about medication incidents and near misses. It also permits staff to identify the causes of incidents and to share lessons learned with an emphasis on preventing errors from recurring and supporting meaningful, sustainable change at the pharmacy level and, eventually, across the health system.

It is an expectation that all pharmacy operations are conducted in a manner that supports the AIMS program and the requirements outlined in the Supplemental Standards of Practice (sSOP) that were designed to enable pharmacy professionals to meet this goal.

Resources to support AIMS

Creating a culture of medication safety is a journey, and the College has compiled a number of resources to support pharmacies on that journey as they integrate CQI and AIMS into their workflows.

- AIMS Program e-training: Community pharmacy staff must complete the six e-Learning modules that introduce the AIMS Program and provide information on the expectations for pharmacy professionals and on how to use the AIMS Pharmapod platform. The modules take less than one hour to complete. After completing each module, registrants can print a certificate of completion to confirm they have reviewed the content. This certificate of completion may be kept for your own records and does not need to be submitted to the College.

- Pharmacy Safety Self Assessment (PSSA): Community pharmacies are required to complete the PSSA for the first time by **December 31, 2021**. A Pharmacy Safety Self-Assessment User Guide has been developed to support Designated Managers and pharmacy staff in the PSSA completion.

- *Pharmacy Connection* articles about AIMS: Review past articles written about AIMS in *Pharmacy Connection*.

- ISMP Canada Safety Bulletin, March 30, 2021: Review articles on Never Events for Community Pharmacy and Analysis of Findings from Safety Assessments of Community Pharmacies. Pc

[1] https://www.ismp-canada.org/download/hnews/201802-HospitalNews-MedSCIM.pdf

[2] https://cphm.ca/wp-content/uploads/Resource-Library/SafetyIQ/CPSC-Toolkit-FINAL.pdf

IMPLEMENTATION OF NON-STERILE COMPOUNDING STANDARDS:

Tips from the College's Operations Advisors

As pharmacies work to fully implement the NAPRA Model Standards for Pharmacy Compounding of Non-Sterile Preparations in advance of the final Phase 3 deadline of ***January 1, 2022****, College operations advisors continue to engage pharmacy professionals during pharmacy assessments on their obligations under the standards.*

Pharmacy Connection **asked the College operations advisors to each name one piece of advice they would give to registrants to support implementation of the standards and contribute to health and safety at the pharmacy for both patients and pharmacy professionals.**

READ THE STANDARDS AND RESOURCES

Read both the Model Standards and the companion guidance document for Pharmacy Compounding of Non-Sterile Preparations, in their entirety.

Review the *Pharmacy Connection* articles addressing requirements, common questions and additional resources to support implementation.

RESOURCES

- Model Standards for Pharmacy Compounding of Non-Sterile Preparations
- Guidance Document for Pharmacy Compounding of Non-Sterile Preparations
- Non-Sterile Compounding articles in *Pharmacy Connection*

LOOK AT YOUR PRACTICE AS A WHOLE, NOT JUST INDIVIDUAL COMPOUNDED PREPARATIONS

Apply the risk-based approach to your entire compounding practice: identify risks, assess them and mitigate them through safety measures and administrative controls. Consider the cumulative risk associated with all preparations being compounded by the pharmacy.

RESOURCES

- Frequently Asked Questions – Risk Assessment and Mitigation
- Non-Sterile Preparations Assessment Criteria to assess gaps between current practices and requirements of the standards
- November 4 Webinar Slides Part Two – Risk Assessments and Requirements

SAFETY FIRST

The standards are designed first and foremost to keep patients and pharmacy personnel safe. How can you reduce the risk of errors during preparation of the prescription? How can you create a safe work environment and protect those performing the compounding from potential hazards?

RESOURCES

- November 4 Webinar Slides Part One – Rationale for Standards
- Frequently Asked Questions – Risk Assessment and Mitigation
- Implementing the Non-Sterile Compounding Standards: A Closer Look at Personal Protective Equipment – *Pharmacy Connection* Summer 2019

FOCUS ON THE PATIENT: ASSESS THE PRESCRIPTION AND EVALUATE THE NEED FOR COMPOUNDING

Ask yourself, is the compounded preparation the most appropriate for the patient? Is there a suitable manufactured product commercially available? Can it be safely compounded in your pharmacy? Remember to document and defend any decision you make.

RESOURCES

- November 4 Webinar Slides Part Three – Patient Assessment
- Staying on Track for Full Implementation of Non-Sterile Compounding Standards – *Pharmacy Connection* Spring/Summer 2020

REVIEW ALL OF THE COMPOUNDS YOU ARE MAKING AND ENSURE APPROPRIATE DOCUMENTATION IS AVAILABLE

Ensure you have the appropriate record for each compound that the pharmacy prepares. Do you have up-to-date Master Formulation Records, which include all necessary information to compound the preparation, for every specific non-sterile preparation?

RESOURCES

- Master Formulation Records and Compounding Records: What's the Difference? – *Pharmacy Connection* Winter/Spring 2021

KEEP PROGRESSING AND TAKE IT ONE STEP AT A TIME

Break down the required tasks into smaller chunks and set timelines for completion. What can you plan for this month, next month and the month after that to move your pharmacy forward?

RESOURCES

- Fillable Checklist Overview of Phases 1, 2 and 3

WHAT ARE COLLEGE OPERATIONS ADVISORS LOOKING FOR DURING A PHARMACY ASSESSMENT?

During assessments of pharmacies performing non-sterile compounding, College operations advisors will be looking for completion of Phase 1 and Phase 2 activities as those deadlines have now passed.

While the College recognizes the impact of the pandemic on the pharmacy environment, it remains vital that pharmacies and staff remain focused on meeting the requirements linked to these standards. These efforts will allow for feedback from the College operations advisors during the assessment to outline where the pharmacy is meeting standards as well as opportunities for improvement. College operations advisors can also help answer questions about the Phase 3 implementation. PC

UPDATE ON OPIOID USE DISORDER TREATMENT

A Changing Landscape

Beth Sproule, RPh, BScPhm, PharmD [1,2]
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Opioid-related mortality continues to increase significantly in Ontario. In 2020 alone, there were 2,426 opioid-related deaths in our province, representing a 60% rise from 2019.[1] The illicit fentanyl supply is a key driver of the current opioid crisis as it directly contributed to 87% of the deaths in 2020.[1] The COVID-19 pandemic has only worsened this public health crisis, likely related to changes in the illegal drug supply due to supply disruptions, less access to services and harm reduction supports, and greater use of substances to cope with stress.[2]

SO HOW CAN PHARMACISTS HELP?

The roots of the crisis lie, in part, in the rise of prescription opioid availability over the last two decades and those risks are still present.[3-5] Continuing to advance and improve our opioid stewardship activities is critical in helping to prevent our patients from developing opioid use disorder and other iatrogenic opioid-related sequelae. Also, our take-home naloxone kit distribution efforts are vital in preventing overdose-related deaths. Between July 1, 2017 and June 30, 2018, Ontario pharmacies dispensed 91,456 take-home naloxone kits, accounting for 62% of all kits distributed in the province.[6]

Unfortunately, the impact may be dampened as many deaths occur without anyone else present to intervene.[1] Knowing this, pharmacists can ensure that their patients who use drugs know of local resources such as safe consumption/injection sites, and other harm reduction practices such as using drugs with a trusted family member or friend, in a space where they could be found quickly, and/or utilizing supports available, such as the National Overdose Response Service hotline (nors.ca) or technology such as Brave App or Lifeguard App.

For individuals living with opioid use disorder, there is an additional evidence-based effective method to saving lives where pharmacists play a central role—treating opioid use disorder. Pharmacotherapy is the most effective treatment for opioid use disorder, and we know that opioid agonist therapy (OAT) saves lives. The mortality risk is significantly reduced for people with opioid use disorder while in OAT treatment compared to out of OAT treatment—even in the era of illicit fentanyl.[7]

At the same time, the approach to providing OAT services is evolving as the opioid crisis advances, and we are experiencing fundamental change in Ontario. The most significant shift is the change in the role of the College of Physicians and Surgeons of Ontario (CPSO) in setting the standards of practice for methadone treatment. The CPSO Methadone Maintenance Treatment Program Standards

and Clinical Guidelines from 2011 were rescinded in March 2021.[8] This decision was taken because it was perceived that the exceptional status of methadone, and the high degree of oversight, disincentivized physicians in offering the service, thus limiting access for patients.[8] This is similar to the rationale for Health Canada's 2018 decision to remove the Section 56 exemption requirement for methadone prescribers—to improve access to treatment.[9] Other recent practice changes include the adoption of non-traditional techniques for initiating buprenorphine (e.g., microdosing and/or home inductions)[10], the availability of new long-acting buprenorphine formulations (i.e., extended release injection and subdermal implant)[10], modified approaches for methadone treatment for people using fentanyl[11], increasing acceptance of slow-release oral morphine (SROM) for opioid use disorder[12], injectable OAT treatment options (i.e., hydromorphone, diacetylmorphine)[13] and the growing availability of safer supply programs.[14,15] The goal of this article is to help pharmacists navigate these changes by highlighting the current guidance available and key messages.

KEY RESOURCES FOR PHARMACISTS

Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder

Release date: May 2021

Developed by: Centre for Addiction and Mental Health with medical regulatory authorities across Canada including the College of Physicians and Surgeons of Ontario

Place in practice: Detailed national guideline on opioid agonist therapy synthesized from provincial standards and guidelines with updates and additional expert opinion

OAT discussed: Buprenorphine, methadone, slow-release oral morphine, and injectable OAT

Topics covered: Broad ranging (e.g., engaging patients, building relationships, expectations of prescribers, how to choose treatments, best practice summaries)

Take note: Updated guidance on the value of urine drug testing and ECGs, non-traditional buprenorphine induction strategies, when to use SROM

Methadone treatment for people who use fentanyl: Recommendations

Release date: June 30, 2021

Developed by: Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META:PHI), a provincial initiative based at Women's College Hospital

Place in practice: For experienced prescribers who are able to apply clinical judgment when using these methadone treatment recommendations for people who use fentanyl as they have uniquely high opioid tolerance

OAT discussed: Methadone only, specifically for people who use fentanyl

Topics covered: How to initiate, titrate, and stabilize methadone treatment, balancing the risks of methadone toxicity with the significant dangers associated with illicit fentanyl use if OAT is not available or if treatment needs to be restarted

Take note: Recommendations around when and how to use the upper end of the dose ranges, add slow-release oral morphine to prioritize engagement and retention in treatment. Likewise, alternative management of missed doses is suggested to avoid treatment drop-out. A webinar recording and a plain language summary are also available through META:PHI.

COVID-19 Opioid Agonist Treatment Guidance

Release date: March 2020; last updated December 2020

Developed by: Collaborators from CAMH, META:PHI, Ontario Medical Association (OMA)

Place in practice: Helps clinicians navigate buprenorphine and methadone treatment as it relates to the COVID-19 pandemic restrictions specifically.

OAT discussed: Buprenorphine and methadone

Topics covered: Modified buprenorphine and methadone take-home doses, frequency of visits

Take note: Focuses on increasing the number of take-home doses for patients to reduce the need for pharmacy visits. The changes during the pandemic are being evaluated to help determine whether the take-home dose strategies should go back to usual after the pandemic or not. An accompanying guide for pharmacists was developed by CAMH.

OTHER EMERGING PRACTICES

Injectable forms of OAT (i.e., injectable hydromorphone and diacetylmorphine) have a well-developed evidence base over many years supporting their use for people who have not responded to oral OAT options.[16] iOAT programs function similarly to other OAT programs, however, patients visit the clinic multiple times per day to inject prescribed pharmaceutical diacetylmorphine or hydromorphone. The clinics are staffed by trained healthcare professionals and peer support workers who can intervene quickly in cases of overdose. These programs have limited availability in Ontario, however, there is ongoing work to develop resources, raise awareness, provide support and identify and address barriers to this evidence-based treatment.[17] A significant hindrance is the limited availability of funding support. Clinical and operational guidance are available for clinicians and health administrators through the Canadian Research Initiative in Substance Misuse.

Safer Supply Programs function as an additional response to the overdose crisis, with the goal to reduce the risk of overdose and overdose deaths by providing pharmaceutical opioids as an alternative to the toxic illicit supply. This harm reduction approach is intended to support those who continue to meet criteria for opioid use disorder despite being in OAT programs and/or individuals who face barriers in accessing OAT. Safer supply programs are generally offered through primary care settings (Community Health Centres or primary care clinics) allowing engagement in other health and social supports. A common model utilized is to provide a supply of SROM (daily observed dosing) in combination with take-home hydromorphone immediate-release tablets. Health Canada is supporting safer supply programs in Ontario allowing expansion of current programs and the development of new programs.[14,18,19] These include programs that provide scheduled dispensing through machines accessed using biometrics (MySafe Project).[20] Evaluation of these programs is underway to help guide the way forward. It will be helpful to have more information on the benefits of these programs (reduced harms related to opioid use, improved health and social outcomes), as well as how to mitigate potential unintended consequences (e.g., health complications from injecting tablets, tablet diversion to new users). A guidance document is available at Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams. More information is available through the Safer Opioid Supply Ontario Community of Practice.

Other resources that may be useful for pharmacists, particularly those who are looking for a primer into opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder which provides high-level guidance on selecting between various opioid agonist treatments, without detailing exactly how to prescribe them.

Additionally, the Health Quality Ontario Opioid Use Disorder Quality Standard includes a strong statement confirming OAT as first-line treatment, and clear guidance for what people with opioid use disorder should expect from Ontario treatment providers. Lastly, for pharmacists working with older adults, the Canadian Guidelines on Opioid Use Disorder Among Older Adults make recommendations tailored to this population including prevention measures and treatment approaches.

SUMMARY

These guidance documents all speak to the importance to improving access to OAT for people with opioid use disorder, as well as ensuring quality of care to meet their needs. The focus on engaging and retaining people in treatment is a direct response to the current, still worsening opioid crisis. Understanding the patient, their situation and treatment goals is key to informing clinical decisions. This is facilitated by effective communication between pharmacists and prescribers. Good clinical documentation also assists pharmacists within practice settings. The CAMH guidance specifically for pharmacists (*Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorder*[21]) is being revised to continue to support practice. Many of the same tenets still apply, but clinical judgement and decisions tailored to the patient situation are essential. During this time of changing guidance, the significance of effective communication and collaboration cannot be overstated. Patient safety and their retention in treatment depend on it. Pc

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HELPING PREVENT

Opioid-Related Harms

Two recent reports look at the increase of opioid-related harms as a result of the pandemic, and the experience of those who make use of the Ontario Naloxone Program for Pharmacies.

Pharmacy professionals are encouraged to review the selected key resources to help guide their opioid-related discussions with patients.

OPIOID-RELATED DEATHS DURING COVID-19 INCREASED SIGNIFICANTLY

A joint report from the Ontario Drug Policy Research Network, the Office of the Chief Coroner for Ontario/ Ontario Forensic Pathology Service and Public Health Ontario highlights the patterns surrounding opioid-related deaths in 2020 during the pandemic. The report, titled "Changing Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic," compares circumstances of opioid-related deaths in Ontario pre-pandemic (March 16 – December 31, 2019) and during the pandemic (March 16– December 31, 2020).

The report illustrates how public health restrictions introduced during the COVID-19 pandemic increased risks of drug-related overdose and death in Ontario:

60% rise in opioid-related deaths in 2020 from 2019

1,109 opioid-related deaths during the pandemic occurred among people aged 25 to 44, representing an increase of 501 deaths compared to before the pandemic

76% of opioid-related deaths during the pandemic occurred among men

139% increase of opioid-related deaths during the pandemic among people experiencing homelessness

UNDERSTANDING PATIENT EXPERIENCES WITH THE ONTARIO NALOXONE PROGRAM FOR PHARMACIES

One of the ways that pharmacy professionals can help reduce the risk of opioid-related harms is through the provision of naloxone. In-depth interviews conducted by the Ontario Drug Policy Research Network with those who access naloxone from pharmacies identified a number of themes from their experiences, including:

A lack of privacy and a fear of being judged by pharmacy staff and customers could deter some people from accessing the drug in pharmacies.

Participants in environments where opioid overdoses can occur were motivated to access naloxone to protect themselves and their communities. There was **less motivation to access naloxone among participants taking opioids for chronic pain**, who often did not perceive themselves to be at risk of overdose.

Pharmacists can create safer spaces for people who use opioids by **avoiding judgmental language and improving their understanding** of the social and structural determinants of drug-related harm.

KEY RESOURCES FOR PHARMACISTS TO GUIDE DISCUSSIONS WITH PATIENTS ABOUT OPIOIDS AND NALOXONE

Pharmacist Clinical Tool for Initiating Naloxone Discussions
This resource from the Ontario Pharmacists Association can help pharmacists navigate how to initiate a conversation with patients about naloxone. It also provides guidance on identifying patients at highest risk of opioid-related respiratory depression.

Pharmacist's Virtual Communication Toolkit: Engaging in Effective Conversations About Opioids
This interactive tool from the National Association of Pharmacy Regulatory Authorities provides an overview of the three stages for engaging in conversations with patients, including strategies, behaviours and sample dialogue.

Language matters: Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma
This guidance document from the Canadian Public Health Association helps healthcare professionals have conversations with patients in a respectful and non-judgmental manner, with a focus on sensitive topics, including substance use. To assist healthcare professionals, the document lists terms to avoid or use with caution, an explanation of why they are problematic and what to use instead.

A New Opioid Prescription: What Should You Consider?
This *Pharmacy Connection* article walks through what a pharmacist should consider when deciding whether to dispense an opioid prescription and how to communicate with and educate the patient.

Opioid Policy
The College's Opioid Policy provides expectations for pharmacy professionals regarding opioids with the aim of promoting safe and appropriate opioid use through education and training, sharing of evidence-based best practice and outlining expectations.

Canadian national consensus guidelines for naloxone prescribing by pharmacists
This article from the Canadian Pharmacists Journal provides practical tips for pharmacists to help increase naloxone kit uptake by patients at risk of opioid overdose. Pc

Practice Insight:
RESPONSIBILITIES OF DESIGNATED MANAGERS

Practice Insight explores concerns reported to the College as part of the complaints and reports process that present learning opportunities for pharmacists and pharmacy technicians. This ***close up on a complaint*** *highlighted below reminds Designated Managers of their responsibilities, including for staff training and oversight, policies and procedures, and management of medication incidents.*

A MISSED MEDICATION REFILL RESULTS IN PATIENT HARM

A patient telephoned the pharmacy to request a refill of anti-epileptic medication and was told to pick it up a couple of days later. When the patient attended the pharmacy, they were told by the pharmacy assistant that the medication was not available. As a result of missing several doses of medication, the patient suffered a seizure that resulted in a dislocated shoulder requiring surgery and the loss of their driver's license.

OUTCOME FROM THE INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE

Upon reviewing the complaint, a panel of the College's Inquiries, Complaints and Reports Committee noted that the pharmacy assistant did not follow the procedures in place regarding what should happen when a medication is unavailable. In particular, the pharmacist was not informed about the lack of medication.

The panel observed that the Designated Manager of a pharmacy is responsible for ensuring that policies and procedures are in place, and that staff receive adequate training and are consistently following those policies and procedures. Therefore, this complaint focused on the responsibilities of the Designated Manager of the pharmacy at the time of incident.

The panel highlighted the expectation that a Designated Manager takes an active role in conducting an investigation following a medication incident, including performing a root cause analysis, following up with the patient and formulating an action plan to prevent future occurrences. In this case, the panel noted that the Designated Manager, in her response to the complaint, did not show insight into the seriousness of the incident, her own role and responsibilities, and how the incident could have been prevented.

The panel provided the Designated Manager with advice/recommendations to assist her in how she may be more thoughtful in her practice when supervising unregulated staff and when addressing medication incidents.

LEARNINGS FOR DESIGNATED MANAGERS

As defined in the *Drug and Pharmacies Regulation Act, 1990*, it is the Designated Manager's responsibility to ensure that the pharmacy conforms to the requirements set out in legislation.

The Standards of Practice require that pharmacists who are managing a pharmacy develop policies and procedures that ensure a safe and effective system of medication supply is maintained at all times. In addition, all pharmacists must ensure that staff for whom they are responsible competently perform delegated pharmacy-related activities.

One of the key principles of the College's Designated Manager – Professional Supervision of Pharmacy Personnel Policy is that the Designated Manager must provide staff members with the appropriate tools and resources to deliver safe and effective patient care. Designated Managers must ensure that appropriate risk assessment and management systems are in place to mitigate risks to patient safety and prevent medication incidents. The Designated Manager must establish job descriptions and a performance measurement and improvement system for pharmacy employees, and also ensure that, at all times, staffing in the pharmacy supports the pharmacist(s) in their cognitive and patient care functions.

The supplemental Standard of Practice (sSOP) and Standards of Operation require Designated Managers to integrate continuous quality improvement into the pharmacy's work processes and establish a safety culture such that pharmacy professionals and staff can be successful in meeting the requirements of the Assurance and Improvement in Medication Safety (AIMS) Program. The sSOP expect pharmacy professionals to record and analyze all medication incidents, document quality improvement plans and share learnings from the incident with the pharmacy team to prevent recurrence and support shared accountability and patient safety.

The recent *Pharmacy Connection* article "Understanding, Managing and Responding to Complaints," explains the College's expectation that the Designated Manager trains unregulated staff to a degree in which they can provide high quality pharmacy services. To prevent concerns regarding unregulated pharmacy staff, Designated Managers are expected to develop and facilitate a training program for new staff.

All Designated Managers are encouraged to complete the College's new Designated Manager e-Learning module, which provides an overview of many of their key responsibilities, including those related to managing the premises, the equipment and systems, and personnel. Pc

USE OF CAS REGISTRY NUMBERS® AS UNIQUE IDENTIFIERS IN COMPOUNDING PROCESSES

has the potential to reduce medication errors

By: Tracy Gallina, R.Ph., Clinical Director, HealthPRO Procurement Services Inc.

The death of a young child due to a compounding error made by a pharmacy in 2016 is a reminder that although a fundamental part of pharmacy practice, compounding is also a high-risk process.

The National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Non-Sterile Preparations include verifying the identity of all ingredients as an important step before preparing a compound, and the Institute for Safe Medication Practices (ISMP) Canada recommends that each ingredient in compounding formulas should have a unique identification number. The availability of unique identifiers such as the Drug Identification Number (DIN) or Natural Product Number (NPN) helps accurately identify many ingredients. However, Active Pharmaceutical Ingredients (APIs) or bulk chemicals used in compounding do not have these identifiers.

Verifying an API's identity can be challenging because synonyms exist for many chemical compounds, and they can be described in multiple different ways. The Chemical Abstracts Services (CAS) Registry Number® (CAS RN®), displayed on many chemical product labels distributed in Canada, is specific to only one substance. Because the CAS RN® is a unique, unmistakable and internationally recognized numeric identifier for chemical substances, similar to the DIN for drugs or NPN for licensed natural products, it can be added to a compounding worksheet as the secondary check to help prevent adverse medication events.

The CAS RN® can also be used to help select the right product during the purchasing process.

Pharmacy staff should be aware that the CAS RN® does not identify the pharmaceutical grade of a product, nor does it identify the manufacturer. Still, it is a tool that makes the identification of chemicals easier. Pc

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 SUMMER 2021 DECISIONS:

Imelda Castillo (OCP #612932)
Li Ping Zhang (OCP #613277)
Angela MacLellan (OCP #537061)
Yasser Ibrahim (OCP #213405)
Umair Nasim (OCP #215241)
Sameet Bawa (OCP #605630)
Atef Besada (OCP #106836)
Nimet Lalji (OCP #200976)
Rana Rizk (OCP #619875)
Mona Bannis (OCP #90557)
Soutsada Vongsaly (OCP #603942)

The full text of these decisions will be 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.

REFLECT, THEN ACT:

Implementing New Practices Requires Critical Self-Reflection

Note: The College thanks the Alberta College of Pharmacy for permission to adapt their Critical Reflective Pathway series for this article.

Pharmacy professionals who are considering undertaking new activities, services or areas of expertise within their scope of practice should complete critical self-reflection before deciding how to proceed. This reflection includes identifying their motivations, deciding whether they need additional information, skills or expertise, planning for next steps, and considering risks related to the situation. It's important to note that just because a pharmacy professional has the legal authority to perform an act (i.e. it is within the pharmacy professional's scope of practice as defined by the *Pharmacy Act*), doesn't mean that they necessarily have the knowledge, skills, ability or environment to facilitate the safe provision of this care.

Ultimately, appropriate reflection supports care that is in the best interest of patients and aligned with the Code of Ethics, Standards of Practice and other expectations established in policies and guidelines.

For example, if a pharmacist wanted to begin providing specialized care at the pharmacy, such as opioid agonist treatment, or a pharmacy technician wanted to engage in non-sterile compounding, they would need to reflect both on whether they should commence the activity, and, if so, how they can ensure the safety of their patients by thinking through the self-reflection points below. Other examples may include providing injection services, travel clinics or point of care testing. Situations may also present themselves where a current patient requires specialized care, complex medication regimes, or treatments unfamiliar to the pharmacist.

WHAT DOES SELF-REFLECTION LOOK LIKE?

Self-reflection could include questions like the following, considering them in the context of your professional judgment, knowledge and skills:

- Why do I want to do this? Is it in the best interest of my patient(s)?
- Does this activity fit within my scope of practice? What about the Code of Ethics? Is this activity supported in my practice setting?

- Am I the healthcare professional best suited for this role or activity? If I am referring to another healthcare provider, how do I ensure continuity of care?
- Do I have the necessary knowledge, skills and attitudes/aptitudes to implement it into practice?
- What learning sources do I need? How can I make sure they are the right ones?
- Who can I learn from? Do I have colleagues I could ask or collaborate with a mentor? Who can assess my competency/skills?
- What kind of risks could there be for my patients, colleagues or myself?
- What will I do if something goes wrong?
- Can I meet all of the requirements required for this action (i.e. safety, privacy, documentation, and training)?

Designated Managers and owners would have additional considerations, including the skills and knowledge of staff at the pharmacy, requirements for additional staff training, the policies and procedures that may need to be implemented as well as the physical facilities and equipment that may be required to optimally support their regulated pharmacy staff in undertaking the proposed pharmacy services. Training of unregulated pharmacy staff may also be required to support the work of the regulated pharmacy staff.

Once self-reflection has been completed, the planning of next steps can proceed. This could include reviewing clinical guidelines or journal articles, verifying policies or regulations, speaking with colleagues, practicing skills, attending courses or webinars or notifying the relevant organizations/individuals. If the situation in question involves a specific patient (vs. starting a new practice altogether at the pharmacy), then ongoing communication with the patient may be necessary, including gathering any additional information that is needed.

Ongoing evaluation is also important. As the pharmacy professional is engaging in this new idea, skill or service, they can be reflecting on how they are doing, considering whether they need additional collaboration or connection with other healthcare professionals, exploring additional areas of growth and continuing to find learning sources to support the evolution of their knowledge and skills.

As always, pharmacy professionals need to ensure that their actions and decisions are in alignment with the Code of Ethics and Standards of Practice.

RESOURCES TO ASSIST IN REFLECTION

The College's website includes a number of resources to assist pharmacy professionals in reflecting on their next steps.

Determining whether an activity falls within scope of practice/ethical standards

- Federal and provincial acts and regulations
- Code of Ethics
- Standards of Practice for Pharmacists and Pharmacy Technicians
- Standards of Operation
- Practice policies and guidelines

Decision-making tools

- Practice Tools
- Framework for Ethical Decision Making
- What Would You Do?

Training and learning opportunities

- Continuing education resources for pharmacists
- Continuing education resources for pharmacy technicians

Self-Assessment tool (CPD Portal)

QUALITY ASSURANCE:

Enhanced Patient Outcomes Through Improving Practice

Part of the College's commitment to protecting the public is helping to ensure that pharmacy professionals maintain appropriate skills and knowledge throughout their career. The Quality Assurance (QA) Program assures the public that pharmacists and pharmacy technicians are practicing to the standards of the profession, and are engaged in safe and quality care. Through the QA Program, the College has a dual mandate:

(1) For those registrants who are not meeting standards, to identify their gaps and help them remediate

(2) For those registrants who are meeting standards, to validate the things they are doing well and to assist in improving practice

A HOLISTIC APPROACH TO QUALITY ASSURANCE

In building its QA Program, the College started with the question, "What does competency mean?" Essentially, competency is comprised of what a registrant "can do" (i.e. has required the knowledge, skills and attitude) and what a registrant "does do" (i.e. engages in the right processes in practice) in order to provide a complete picture of an individual's overall competency. The next questions in developing the QA program were "How do professionals maintain competency in these areas?" and "How can the College measure a registrant's maintenance of competency in these areas?"

QA PROGRAM COMPONENTS

With the ultimate and long-term goal of all quality assurance activities enhancing patient outcomes, the QA Program components work together to drive this goal forward by ensuring pharmacy professionals have up-to-date knowledge and skills and are engaging in the right patient care activities.

The four components of the QA Program are:

- **Learning portfolio:** independently engaging in ongoing professional development to maintain competency and advance practice based on specific place of practice and patients
- **Self-assessment:** identifying learning needs to inform self-directed professional development
- **Knowledge assessment:** focusing on knowledge and skills needed to provide appropriate care through a standardized computer-based assessment (see more on the next page)
- **Practice assessment:** focusing on the processes used to deliver patient care through conversation with a College practice advisor at the place of practice

Learn more about the College's QA Program components in "Quality Assurance: Supporting Safe and Quality Care."

NAPRA COMPETENCIES AND COLLEGE ASSESSMENTS

The table below indicates how the National Association of Pharmacy Regulatory Authorities' Professional Competencies for Canadian Pharmacists at Entry to Practice align with the assessments completed as part of the QA Program, as well as part of the College's assessments of pharmacies. As illustrated by the table below, no single assessment addresses all of the competencies; multiple assessments are needed so that they can work together to address the various competencies.

NAPRA Competencies for Pharmacists	Practice Assessment	Knowledge Assessment	Future Development	Pharmacy Assessment (not part of QA Program)
Ethical, Legal & Professional Responsibilities		X	X	X
Patient Care	X	X		
Product Distribution				X
Practice Setting				X
Health Promotion			X	
Knowledge & Research Application		X	X	
Communication & Education	X		X	
Intra- and Inter-Professional Collaboration	X			
Quality & Safety				X

Note: The Competencies are used instead of the Model Standards of Practice for Canadian Pharmacists as they were more recently updated.

APPLYING A RIGHT-TOUCH AND RISK-BASED APPROACH

The QA Program incorporates a right-touch, risk-based approach that supports the College's mandate of public protection. For the majority of registrants who are meeting standards, the College validates the work they are doing well and helps identify areas for improvement. For the small percentage of registrants who are not meeting standards, the College focuses on helping them access appropriate remediation.

Right-touch means that the College focuses quality assurance activities on those things that will make the biggest difference for patients (i.e. assessments to ensure that pharmacy professionals have the right knowledge and skills and are applying these in practice). The risk-based approach focuses on activities or behaviours that have the highest risk for patients and identifies registrants for whom remediation is necessary. For example, with the existing practice assessment, only registrants who do not meet the standards after two separate practice assessments are required to undergo a quality assurance assessment that involves evaluation and remediation by the Quality Assurance Committee.

Ultimately, the QA Program is meant to be educational and collaborative, not punitive. This approach benefits both patients, through better health outcomes, and pharmacy professionals, through ongoing skill and knowledge development, validation of their practice, and support to identify areas for improvement. Pc

KNOWLEDGE ASSESSMENT:
Focusing on the Knowledge and Skills Needed to Provide Appropriate Care

In 2022, the College will introduce knowledge assessments for pharmacists as part of the QA Program that already includes learning portfolio, self-assessment and practice assessment components. A knowledge assessment quality assurance activity for pharmacy technicians will be developed in subsequent years.

THE ROLE OF THE KNOWLEDGE ASSESSMENT

The knowledge assessment for pharmacists will focus on ethics, professionalism, patient care and knowledge and research translation. It provides an opportunity to assess knowledge of changing legislation, scope of practice and the ability to take new emerging research and apply it to patient care cases/scenarios that reflect current practice.

As referenced in the article "Quality Assurance: Enhanced Patient Outcomes Through Improving Practice," the knowledge assessment is part of the way the College can assess a registrant's knowledge, skills and attitude — the "can do" component of overall competency.

The purpose of the knowledge assessment is to encourage continuing professional development by supporting pharmacy professionals to identify any gaps in their knowledge and seek appropriate education or resources to address those areas for development. The knowledge assessment is intended to be an educational and positive experience for registrants.

It is distinct from the practice assessment, which focuses on the processes a practitioner engages in to deliver patient care ("does do").

The table below illustrates how the College approaches measuring "can do" and "does do" competency through the Quality Assurance program.

HOW THE KNOWLEDGE ASSESSMENT WILL WORK

The knowledge assessment will take the form of a multiple choice "open book" online exam taken remotely from a home or workplace, with a time allowance of up to three hours. Registrants will have access to resources and references of their choice and will be required to apply relevant information to make patient care decisions. Accessing appropriate resources reflects real practice where pharmacists are expected to use reliable, evidence-based and current references to support patient care.

Competency component	How do professionals maintain competence?	How does the College measure?	Short and intermediate outcomes	Long-term outcome
Can Do (Knowledge, Skills)	By engaging in the right Continuing Professional Development (Self-Assessment; Learning Portfolio) to maintain knowledge and skills	**Activity: Knowledge Assessment** • Identifies learning needs • Feedback provided through report	• Engagement in professional development to maintain competency and advance practice • Increased knowledge and skills • Increased confidence	Enhanced patient outcomes
Does Do (Behaviour)	By engaging in the right processes in patient care: patient assessment, decision making, documentation, communication and education	**Activity: Practice Assessment** • Identifies learning needs • Feedback provided through report	• Increased engagement in patient care activities (for example, increased patient assessment, decision making, communication/education and documentation) • Practice is validated and best practices are reinforced	Enhanced patient outcomes

Part A pharmacists will be selected to undergo the knowledge assessment approximately every five years. Individuals who are selected will take part in an un-proctored exam, i.e. there will be no direct supervision during the remote online assessment.

Materials such as an exam blueprint with topics to be tested as well as other tools will be available to support those in preparing for the assessment.

Registrants who have been identified as having knowledge gaps through a current practice assessment or a previous unsuccessful knowledge assessment, and those requesting to move from Part B to Part A of the Register, will need to undergo the knowledge assessment online with a remote proctor. This is in line with the College's mandate to protect the public through identifying appropriate remediation where there has been an identified need that may pose a risk to patients.

Knowledge assessments are anticipated to begin in 2022. More information will follow with ample notice and flexibility in timing and dates provided for selected pharmacists to plan for the scheduling of this knowledge assessment.

KNOWLEDGE ASSESSMENT BLUEPRINT

The blueprint below describes the key competencies from the NAPRA Professional Competencies for Canadian Pharmacists at Entry to Practice that will be assessed during the knowledge assessment for pharmacists.

NAPRA Competency	Key Competencies	Weighting	Topics
1. Ethical, Legal and Professional Responsibilities Pharmacists practice within legal requirements, demonstrate professionalism and uphold professional standards of practice, codes of ethics and policies	1.1. Practice within legal requirements	20%	Examples: **Controlled substances** **Standards of practice** **Scope of practice** **Ethics**
	1.2 Uphold ethical principles		
	1.3 Manage actual and potential illegal, unethical, or unprofessional actions or situations in practice		
	1.4 Apply principles of professionalism		
	1.5 Document activities of practice in compliance with federal and provincial/territorial legislation, standards and policies		
2. Patient Care Pharmacists, in partnership with the patient and in collaboration with other health professionals, meet the patient's health and drug-related needs to achieve the patient's health goals	2.3 Assess the patient's health status and concerns	80%	Examples: **Cardiovascular** **Endocrine** **Gastrointestinal** **Respiratory** **Musculoskeletal** **Neurologic** **Mental health** **Infectious disease**
	2.4 Determine the patient's actual and potential drug therapy problems		
	2.5 Develop the patient's care plan in partnership with the patient and in collaboration with other health professionals		
	2.6 Implement the patient's care plan		
	2.8 Monitor the patient's progress and assess therapeutic outcomes		
6. Knowledge and Research Application Pharmacists access, retrieve, critically analyze and apply relevant information to make evidence-informed decisions within their practice with the goal of ensuring safe and effective patient care	6.1 Apply knowledge, research skills and professional judgement to the decision-making process		
	6.2 Respond to questions using appropriate strategies		
	6.3 Apply relevant information to practice		

Addressing Common Questions About Practice Assessments

FOR PHARMACISTS WORKING IN HOSPITAL, LONG-TERM CARE AND FAMILY HEALTH TEAMS

In January 2021, the College launched practice assessments for Part A pharmacists working in hospital and other healthcare facilities, including family health teams and long-term care. This article answers some common questions the College receives about these assessments.

WHY ARE PRACTICE ASSESSMENTS NECESSARY?

Practice assessments are a part of the College's Quality Assurance Program and are an evaluation of a registrant's ability to practice to the standards of the profession. The transition to assessments at the individual's place of practice reflects evolving public and patient expectations that the College regularly engages with pharmacists and pharmacy technicians to ensure that safe and appropriate patient care is being provided.

All Part A pharmacists, regardless of practice setting, participate in regular practice assessments. While the assessment processes are similar for registrants working in community and hospital or other healthcare facilities, each type of assessment focuses on specific criteria and activities that are relevant to the place of practice.

Quality assurance activities are designed to help pharmacy professionals enhance their skills and knowledge, validate and reinforce that their practice is meeting standards, and identify areas for improvement in order to support better patient health outcomes.

WHAT HAPPENS BEFORE A PRACTICE ASSESSMENT?

Pharmacists are provided with advanced notice of a practice assessment via email, typically 2-3 months in advance. They are encouraged to use the assessment criteria to do a self-assessment of their practice before the assessment takes place.

The practice advisor will advise the registrant whether the assessment will take place remotely via video conferencing platform. If the assessment is remote, the pharmacist will be requested to submit specific documentation ahead of time. This documentation includes a number of patient cases from their practice to help demonstrate how they solve drug therapy problems for patients—these will be discussed during the assessment.

WHAT IS BEING ASSESSED?

It's important to know that this is not an assessment of clinical or therapeutic knowledge. **The focus of the practice assessment is on the individual's process**, specifically using the four domains of the assessment criteria: Patient Assessment, Decision Making, Documentation and Communication.

For registrants where their practice is particularly unique or specialized, the practice advisor will work with them to ensure that the conversation addresses the four domains while also being relevant to the care provided by the pharmacist.

WHAT HAPPENS DURING AN ASSESSMENT?

During a practice assessment, practice advisors use the practice assessment criteria to evaluate a registrant's practice. The practice advisor uses a peer-to-peer approach, using their experience in hospital and other settings to help facilitate these discussions.

Throughout and following the assessment, the practice advisor provides feedback outlining areas of practice where the pharmacy professional is doing well and meeting standards as well as areas where there is an opportunity for improvement. They offer support through coaching and conversation, pointing out opportunities to enhance practice, probing the thinking behind certain actions and decisions, and indicating where to access helpful resources. With an emphasis on educating, the goal of the practice assessments is to increase adherence to practice standards, help pharmacy professionals use their full scope, and ultimately support optimal health outcomes.

THE GOAL OF THE PRACTICE ASSESSMENTS:

- increase adherence to practice standards
- help pharmacy professionals practice to their full scope
- support optimal health outcomes for patients

WHAT HAPPENS IF THE STANDARDS ARE NOT MET DURING THE ASSESSMENT?

If the pharmacy professional does not meet the standards indicated on their first assessment, they are given the opportunity to spend time with a quality assurance (QA) coach. This coach is not a College staff member, but rather a peer who can provide support specifically in areas where there is room for improvement. This half-day interactive session is designed to enhance the professional's practice and the care that is provided to patients. Following the session with the QA coach, the pharmacy professional will be reassessed by a different practice advisor.

If there are still significant areas of practice that require improvement following this second assessment, a QA assessment will take place and the results will be sent to the QA Committee for consideration. The QA Committee determines whether remediation is required to help the professional meet standards, always recognizing that patient safety is the first priority.

The results of a practice assessment are confidential and are not shared with employers, owners, colleagues or any College committee, other than the QA Committee.

QUICK FACTS ABOUT HOSPITAL PRACTICE ASSESSMENTS

2-3 hours on average to complete

13 performance indicators

51 assessments completed in Q1 2021

WHAT WE HEARD FROM PHARMACISTS WHO HAVE COMPLETED PRACTICE ASSESSMENTS

"The hospital practice assessment gave me the opportunity to highlight the importance of leading by example. The experience was extremely collaborative and allowed me to gain valuable feedback on my practice, putting into focus the importance of clinical oversight in leadership roles."

- Danielle Del Frate,
Clinical Manager, Pharmacy

"The hospital practice assessment process was very balanced and the assessor put me at ease with her understanding of everyday practice challenges. I found it was an enriching experience to review my professional practice and internal processes."

- Michal Racki,
Hospital Pharmacist

"The practice advisor clearly outlined the expectations and was very non-judgmental and patient with questions. She made me feel at ease that the process was not punitive but learning and that was reassuring. During the assessment, I felt like I was just illustrating what I do and how I do it. Her feedback was professional and appreciated."

- Heather Hadden,
Family Health Team Pharmacist

FOCUS ON ERROR PREVENTION

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

During the current pandemic, a large number of physicians are providing virtual healthcare. As a result, a larger number of prescriptions are being faxed into pharmacies for processing.

The lack of key patient identifiers on many faxed prescriptions along with a patient not being present when the prescription is being entered into the computer can be contributing factors to patient identity errors.

CASE:

Rx1:
Patient: "Jane Andersen"
Drug: Zoplicone 7.5mg
Sig: One at bedtime when necessary
Mitte: 30

Rx2:
Patient: "James Smith"
Drug: Selegiline 5mg
Sig: One tablet at bedtime
Mitte: 30

A physician's office faxed the above two prescriptions to a community pharmacy for processing.

At a glance, the two handwritten prescriptions looked very similar. In addition, since they were faxed and received together as page one and page two, the pharmacy assistant retrieving the prescriptions from the fax machine assumed that they were both for the same patient.

As a result, both prescriptions were scanned and entered into the profile of "Jane Andersen", a 37-year-old patient.

The dispensing pharmacist failed to identify the computer entry error during the verification process and failed to conduct a thorough assessment of this "new" prescription against the patient's existing medication profile. As a result, both medications were dispensed to "Jane Andersen".

At the pick-up counter, the agent picking up the medications was a friend of the patient.

The pharmacist chose not to discuss personal information regarding the patient's medication with a friend. A note was therefore made to call the patient later to provide counselling by telephone. However, the pharmacist forgot to follow through and the counselling never took place.

Upon receiving the two medications, the patient was puzzled why her physician would prescribe selegiline in addition to her sleeping pill. A call was made to her physician who confirmed that selegiline was never prescribed for her.

The patient then called the pharmacy to inquire why selegiline was dispensed to her when her physician never prescribed the medication.

After some investigation, the computer entry error was identified.

POSSIBLE CONTRIBUTING FACTORS:

- The pharmacist's assessment of the "new" prescription was inadequate and thus did not identify the likely inappropriateness of selegeline for a 37-year-old patient.
- Both prescriptions were faxed together. Though the patient's name was included on both prescriptions, no other patient identifier (e.g. date of birth, health card number, etc.) was included on the prescriptions.
- Both the pharmacy assistant and the dispensing pharmacist failed to confirm the patient's identity.
- Counselling did not take place largely because the medication was picked up by a friend.
- The pharmacy does not have a process in place to communicate with patients regarding all prescriptions that are faxed in prior to processing and dispensing.

RECOMMENDATIONS:

- When assessing the prescription for appropriateness, *always* consider the possible indication for use. What are the possible reasons that a 37-year-old patient would take Selegiline?
- In addition to the patient's name, always use at least one additional patient identifier to confirm the patient's identity at computer entry and at the pick-up counter. In this case, because the prescription was faxed in, the pharmacy may consider developing a process to contact patients who have new prescriptions sent in to obtain additional information prior to processing and performing a patient identity confirmation at the same time.
- Develop a dependable system to identify and follow through on prescriptions requiring counselling by telephone, such as prescriptions being delivered.
- At pick-up, always confirm the number of medications the patient is expecting to receive. Investigate any discrepancy.

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com. Sharing your experience can prevent similar occurrences at other practice sites.

Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

Please be reminded that as part of the AIMS program, pharmacists and pharmacy technicians must:

- Anonymously record all medication incidents and near misses via the AIMS medication event reporting platform.
- Document appropriate details of medication incidents and near misses in a timely manner to support accuracy.
- Analyze the incident in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident.
- Promptly communicate the appropriate details of a medication incident or near miss, including causal factors and actions taken as a result, to all staff.

PUTTING THE AIMS PROGRAM INTO PRACTICE USING THIS INCIDENT EXAMPLE

Imagine you are the pharmacist who answers the phone when the patient calls to inquire about why selegiline, which was not prescribed by her doctor, was dispensed. After remedying the situation and reassuring the patient you will look into what could have caused the mix up, you are ready to record the incident on the AIMS Pharmapod platform.

You identify the incident type as "incorrect patient" and describe briefly what happened from your perspective. If you were not directly involved with the incident, you may choose to discuss with staff members who were directly involved to gain a more thorough understanding of the incident.

Once you have a clear understanding of what took place you can begin to think about what factors may have contributed to the incident. In this case, you would select the following contributing factors in the recording platform: "critical patient information missing" (rationale: the prescriptions that were faxed in did not include the patient's date of birth or health card number) and "lack of quality control or independent check system" (rationale: the pharmacist's assessment of the selegiline prescription was not sufficient to identify the likely inappropriateness of this medication for a 37-year-old. Also, the pharmacy assistant processing the prescription failed to double check the name on the prescription against the profile it was entered into.) The incident recording form also includes selections for the stage of the dispensing process in which the incident occurred – in this case the primary stage is "order entry" and the secondary stage "patient communication/education."

Thinking through the incident using the structured format of the incident recording form allows you to gain a better understanding of what happened, why it happened and where in the dispensing process it happened. This information allows for the development of impactful solutions that, once implemented, would reduce or eliminate the recurrence of similar incidents in the future. The recommendations on the previous page are examples of solutions that can be implemented in any pharmacy to prevent similar incidents. The process of thinking about medication incidents and near misses in this way promotes continuous quality improvement in your pharmacy's work processes leading to improved patient safety and reduced patient harm. Recording incidents and near misses in AIMS also contributes towards shared learnings throughout the province and broader system improvements. Pc

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