College of Pharmacists of Manitoba

NEWSLETTER

SUMMER
2023

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Safety IQ Safety Feature

The College of Pharmacists of Manitoba (CPhM) distributed a Community Pharmacy Survey on Patient Safety Culture™ (SOPS®) for community pharmacy...

Medical Examiner Review

WE is a 30-year-old female who was found unresponsive on the floor of her home on April 20, 2022, surrounded with drug paraphernalia including a straw in her mouth and tin foil on the floor....

This Newsletter is published four times per year by the College of Pharmacists of Manitoba (CPhM) and is forwarded to every licenced pharmacist and pharmacy owner in the Province of Manitoba. Decisions of the CPhM regarding all matters such as regulations, drug-related incidents, etc. are published in the newsletter. The CPhM therefore expects that all pharmacists and pharmacy owners are aware of these matters.

The mandate of the College of Pharmacists of Manitoba is to serve and protect the public interest.

Our mission is to protect the health and well-being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice in collaboration with other health-care providers.

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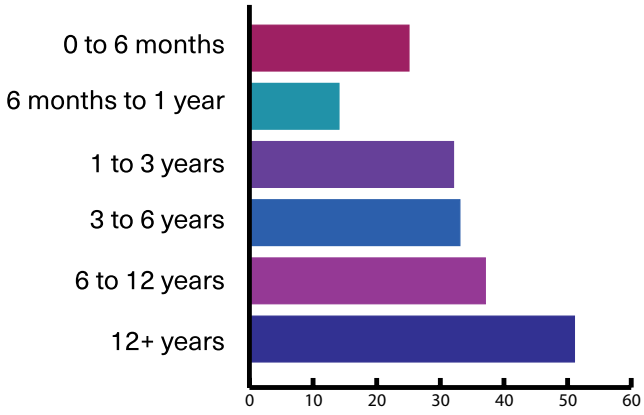
Safety Feature: Community Pharmacy Survey on Patient Safety Change

The College of Pharmacists of Manitoba (CPhM) distributed a Community Pharmacy Survey on Patient Safety Culture™ (SOPS®) for community pharmacy staff to assess their attitudes and opinions on patient safety and safety culture in their pharmacy. This survey was conducted to understand the state of safety culture in Manitoba and the gaps in knowledge or resources that are needed to support pharmacy professionals to build and improve safety practices. The responses are used to benchmark the measurement and monitoring of Safety IQ and its progress toward building sustainable safety cultures in Manitoba's community pharmacies.

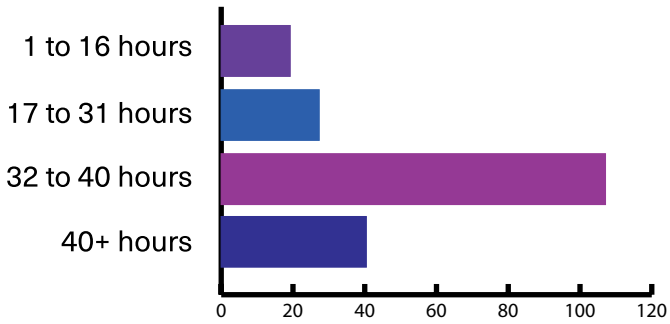
CPhM thanks everyone who provided their feedback to the SOPS®.

Respondent Demographics

Years of Experience



Hours Worked Per Week



Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. Here's the latest posts:

- Near-Miss Event Reporting: A Proactive Approach to Preventing Patient Harm

  Near-miss events in the community pharmacy system are both a warning and an opportunity. Learn more about how near-miss events can prevent incidents, reduce the chances of patient harm, and transform pharmacy practice on a national level.

- Enhancing Patient Safety in Community Pharmacies: 3 Improvements for Technical and Clinical Checks

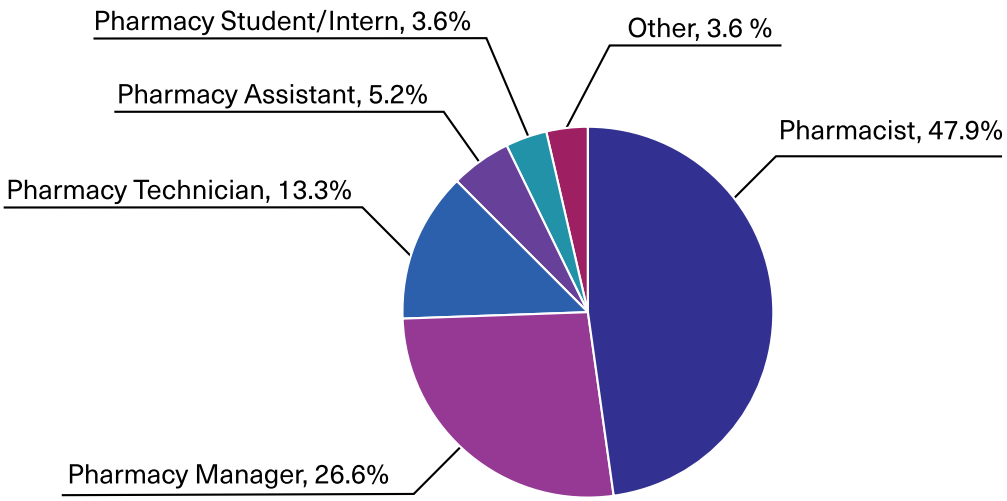
  Improvements to staff training and technical and clinical checks can enhance safety in your pharmacy. Learn how with these three improvements today.

- Safety Culture for Safer Compounding

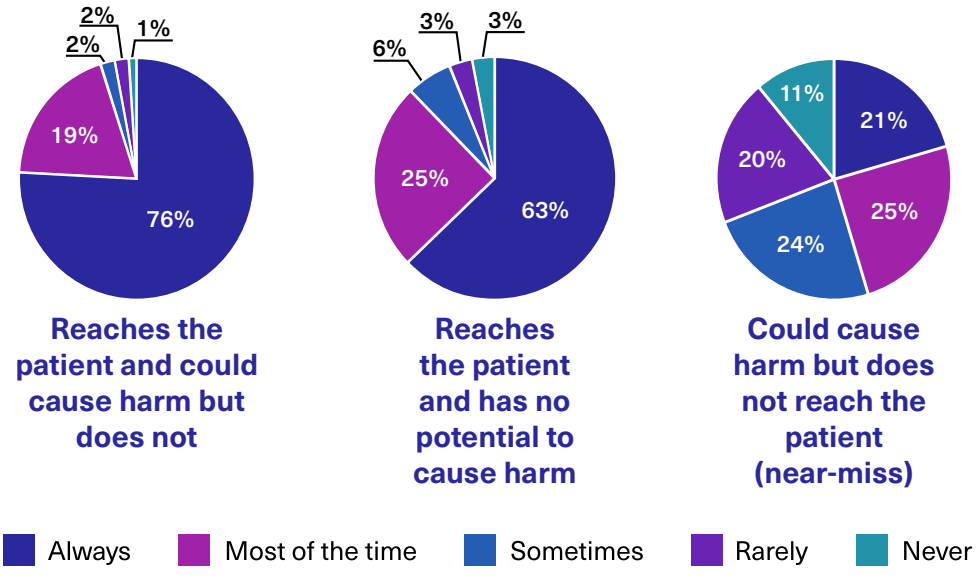
  Safety culture is essential to reducing the risk of patient harm from a compounding incident. Employ principles of safety culture to reduce risk in your pharmacy today.

Respondent Demographics

Pharmacy Staff Roles



Documenting Medication Incidents



Methods

SOPS® consisted of 44 survey items and 11 composite measures.

Analysis performed on the responses to a six point Likert Scale to open-ended questions.

SOPS® was distributed to all Manitoba pharmacy professionals from January 25 to March 8, 2023.

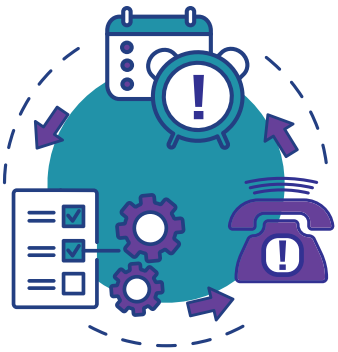
Areas of Excellence

Based on the composite results, community pharmacies excelled in the following patient safety culture dimensions (scores are based on a positive percent composite):

Patient Safety Culture Dimension	Score
 **Patient Counselling** We encourage patients to talk to pharmacists about their medications. Pharmacists spend enough time talking to patients about how to use their medications and tell patients important information about their new prescriptions.	91%
 **Organizational Learning** The pharmacy tries to figure out what problems in the work process lead to mistakes and makes changes to keep mistakes from happening again	83%
 **Communication Openness** Staff feel comfortable asking questions when they are unsure about something and it is easy for them to speak up to their supervisor/manager about patient safety concerns. The pharmacy values staff ideas and suggestions	82%
 **Teamwork** Staff treat each other with respect, clearly understand their roles and responsibilities, and work together as an effective team.	82%

Areas for Improvement

Based on the composite results, community pharmacies could improve the following patient safety culture dimensions (scores are based on a positive percent composite):

Patient Safety Culture Dimension	Score
 **Physical Space and Environment** The pharmacy is well organized, free of clutter, and the physical layout of the pharmacy supports good workflow.	78%
 **Staff Training and Skills** Pharmacy Technicians receive the training they need to do their jobs. Staff have the skills they need to do their jobs well, receive adequate orientation, and get enough training.	77%
 **Staffing, Work Pressure and Pace** Staff take adequate breaks during their shifts, and there are enough staff to handle the workload. Staff feel rushed when processing prescriptions, and interruptions/distractions make it difficult for staff to work accurately (negative wording).	44%

Recommendations

The SOPS® outcomes suggest that community pharmacies should focus on improving physical space and environment, staff training and skills, and staffing work pressure and pace. You can use the following resources to improve the safety and efficiency of your pharmacy.

Improve Physical Space and Environment

Improve Pharmacy Workflow in 6 Steps

This article outlines six steps to improve workflow in the pharmacy:

- Evaluate your workflow
- Streamline movement
- Implement stations
- Consider automation
- Practice the workflow
- Review processes regularly

Institute for Safe Medication Practices Canada (ISMP Canada) Medication Safety Self Assessment® (MSSA®) for Community

This self-assessment is designed to help community pharmacy teams to identify and address vulnerabilities that could lead to medication incidents and patient harm. The MSSA® for Community Pharmacy includes focused content related to high-risk processes, use of high-alert medications and treatment of vulnerable populations. The MSSA® for Community Pharmacy focuses on seven key areas:

- Patient Engagement and Partnership
- Medication Storage and Handling
- Use of Technology and Devices
- Quality Assurance and Continuous Quality Improvement
- Addressing Known Areas of Risk
- Considerations for Selected Clinical Situations
- Considerations for Selected High-Alert Medications and Classes

Enhance Staff Training and Skills

Strategies To Improve Communication Between Pharmacy Staff and Patients: Training Program for Pharmacy Staff

This training program is designed to introduce pharmacists to the problem of low health literacy in patient populations and to identify the implications of this problem for the delivery of healthcare services. The program also explains techniques that pharmacy staff can use to improve communication with patients who may have limited health literacy skills.

AHRQ Patient Safety Education and Training Catalog

This catalog offers a database of patient safety education and training programs to help pharmacy staff further their knowledge of patient safety practices and principles. Programs are available as in-person meetings or online webinars. Opportunities are updated monthly and can be searched by event location, cost, CE/CME availability, and other fields. The programs are national in scope and identified from not-for-profit organizations, academic institutions, government agencies, and member associations.

Moderate Under-staffing, Work Pressure, and Pace

Reducing Distractions and Interruptions

This article describes eight ways to reduce interruptions or improve lines of defense in pharmacies using human factors engineering principles:

- Consider the physical design of the dispensary
- Provide situation awareness to patients
- Provide situation awareness to pharmacy staff (create a “No Interruption Zone”)
- Appropriately time necessary interruptions
- Use checklists for safety-critical processes
- Ensure there is a mobile device policy in place in your pharmacy
- Reduce frequency of alerts, alarms, and noises
- Plan safety-critical processes for when mental resources are higher

Beating Behind-the-Counter Job Stress

Heavy workloads and long hours make stress management a critical skill for pharmacists. With a basic knowledge of coping strategies, pharmacists can overcome stress to achieve their personal best. This feature in Pharmacy Times defines stress in the pharmacy and identifies possible solutions for handling the stress.

4 Strategies to Cope with Understaffing in Pharmacies

Pharmacy staff shortages can be due to a multitude of factors, such as inappropriate workload, inefficient workflow, and lack of consideration for adequate work scheduling. This article describes four risk reduction strategies to cope with understaffing in the pharmacy:

- Enhance the workflow
- Improve scheduling
- Stress management
- Identify high-risk situations

Results

Based on the composite results, community pharmacies excelled in the following patient safety dimensions:

Patient Safety Dimension	Score
Patient Counselling	**91%**
We encourage patients to talk to pharmacists about their medications.	91%
Pharmacists spend enough time talking to patients about how to use their medications.	87%
Pharmacists tell patients important information about their new prescriptions.	94%
Organizational Learning	**83%**
We try to figure out what problems in the work process led to a mistake.	89%
When the same mistake keeps happening, we change the way we do things.	87%
Mistakes have led to positive changes.	73%
Communication Openness	**82%**
Staff ideas and suggestions are valued.	77%
Staff feel comfortable asking questions when they are unsure about something.	88%
It is easy for staff to speak up to their supervisor/manager about patient safety concerns.	81%
Teamwork	**82%**
Staff treat each other with respect.	84%
Staff clearly understand their roles and responsibilities.	81%
Staff work together as an effective team.	80%
Communication About Mistakes	**81%**
Staff discuss mistakes.	81%
When patient safety issues occur staff discuss them.	83%
We talk about ways to prevent mistakes from happening again.	80%
Overall Perceptions of Patient Safety	**79%**
The pharmacy is good at preventing mistakes.	78%
The way we do things reflects a strong focus on patient safety.	83%

Results

Based on the composite results, community pharmacies excelled in the following patient safety dimensions:

Patient Safety Dimension	Score
Communication About Prescriptions Across Shifts	**79%**
We have clear expectations about exchanging prescription information across shifts.	82%
We have standard procedures for communicating prescription information across shifts.	76%
The status of problematic prescriptions is well communicated across shifts.	80%
Response to Mistakes	**79%**
Staff are treated fairly when they make mistakes.	86%
The pharmacy helps staff learn from their mistakes rather than punishing them.	83%
We look at staff actions and the way we do things to understand why mistakes happen.	82%
Staff feel like their mistakes are held against them.	64%
Physical Space and Environment	**78%**
The pharmacy is well organized.	85%
The pharmacy is free of clutter.	72%
The physical layout of the pharmacy supports good workflow.	77%
Staff Training and Skills	**77%**
Technicians receive the training they need to do their jobs.	78%
Staff have the skills they need to do their jobs well.	84%
Staff who are new receive adequate orientation.	71%
Staff get enough training.	74%

Safety Measures

Data Reports from the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies bring awareness to the common types of incidents and near-miss events in Manitoba and can focus the improvement efforts of pharmacy professionals and the College. Here are the latest provincial and national reports from the NIDR:

NIDR for Community Pharmacy Manitoba Safety Brief: Incorrect Dose/ Frequency Top Contributor to Manitoba Incidents

The NIDR Manitoba Safety Briefs are your report data in action. Use them as a tool to talk about medication incidents, near-miss events, and potential improvements in your pharmacy. The Manitoba Safety Brief for October 2022 – April 2023 focuses on the order entry stage of the medication use process. **About 50 per cent of the medication incidents reported to the NIDR for Community Pharmacies involved order entry.** You will also learn more about the incidents reported during this period, including:

- Prevention strategies for order entry;
- Number of incidents received by the NIDR;
- Top five types of incidents reported; and
- Level of harm from reported incidents.

We appreciate your dedication to continuous quality improvement. Every report you provide to the NIDR adds to the collective knowledge at provincial, national, and global levels regarding medication incidents and near-miss events. Your contributions play a vital role in the widespread effort to enhance pharmacy practices and minimize the potential for patient harm.

NIDR for Community Pharmacies National Snapshot: Missing Critical Patient Inofrmation

Use the Missing Critical Patient Information report to review the national data on these medication incidents and your pharmacy's practices in the collection and verification of patient information.

Resources for Professional Development

ISMP Canada Safety Bulletins

- When the Antidote Causes Harm: Preventing Errors with Intravenous Acetylcysteine (August 24, 2023)
- Confusion between Vaccine Expiry and Beyond-Use Dates Leads to Multi-Patient Incident (July 20, 2023)

ISMP Canada Learning Opportunities

The following learning opportunities are available at https://ismpcanada.ca/education/:

- Incident Analysis and Proactive Risk Assessment
- Multi-Incident Analysis and Medication Safety Culture Assessment
- Medication Reconciliation and Best Possible Medication History
- Keeping Pediatric Patients Safe: Pediatric Safety Consideration for Community Pharmacists
- Application of TALLman Lettering for High Alert Drugs in Canada
- Medication Safety Considerations for Compliance Packaging

Presidents Address

Dear Colleagues,

I trust you've had a pleasant summer and have been enjoying the warmth of these past few weeks. I'm thrilled to welcome you to another edition of the newsletter, where we share the latest news, insights, and highlights from the College of Pharmacists of Manitoba (CPhM).

As we continue to evolve and innovate within the pharmacy profession, I am delighted to announce a significant development in our pursuit of patient safety excellence. CPhM, in collaboration with pharmacy professionals across Manitoba, has embarked on a journey to assess and enhance patient safety culture in our community pharmacies. The Community Pharmacy Survey on Patient Safety Culture™ (SOPS®) was conducted to understand the current state of safety culture, identify areas for improvement, and bridge knowledge gaps to support pharmacy professionals in building and sustaining safe practices. Your responses have provided invaluable insights, enabling us to benchmark Safety IQ's progress and chart a path toward nurturing sustainable safety cultures within Manitoba's community pharmacies.

In the spirit of continuous learning and self-improvement, I encourage you to read the latest Medical Examiner de-identified case study on page 12 from our Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office. This study offers a unique opportunity for education and self-reflection for all pharmacy professionals. By delving into real-world scenarios and exploring the intricacies of each case, we empower ourselves to elevate our practices and the quality of patient care we provide.

On the global stage, World Patient Safety Day 2023 held great significance for healthcare professionals, including pharmacists. This year's theme, "Engaging Patients for Patient Safety," underscores a vital opportunity for the pharmacy profession. It challenges us to explore patient engagement strategies that enhance pharmacy practices and reduce the risk of harm. By empowering patients with knowledge, skills, and resources to protect and enhance their health, we reinforce our commitment to patient safety.

I encourage you to delve into our latest Safety IQ article, Engaging Patients for Patient Safety: A Call to Action for World Patient Safety Day 2023, which delves deeper into this important theme. Read the full article here.

In closing, I want to express my heartfelt thanks to all of you for your dedication and commitment to the pharmacy profession. Your hard work makes a big difference in patient care and the progress of our field. Let's continue to aim for excellence, encourage innovation, and promote ongoing improvement as we navigate the dynamic world of pharmacy practice.

Sincerely,

Jane Lamont
President, CPhM

"It challenges us to explore patient engagement strategies that enhance pharmacy practices and reduce the risk of harm."

Education from the Adult Inquest Review Committee Meetings of the Chief Medical Examiner's Office

The College of Pharmacists of Manitoba attends meetings at the Chief Medical Examiner's Office to review deaths which may have involved prescription drugs, focusing on opioids and other drugs of abuse. A de-identified case study based on information obtained from these meetings is presented in each Newsletter to provide an opportunity for education and self-reflection for all pharmacists.

Introduction

WE is a 30-year-old female who was found unresponsive on the floor of her home on April 20, 2022, surrounded with drug paraphernalia including a straw in her mouth and tin foil on the floor. First responders performed resuscitation and administered naloxone which successfully returned spontaneous circulation after approximately 30 minutes. However, WE became progressively hemodynamically unstable and after repeated episodes of pulseless electrical activity. She was later declared brain dead and the decision to withdraw care wasb made. Her reported past medical history included polysubstance use including opioids, possible use of methamphetamine, and ethanol. An autopsy was performed, and the immediate cause of death was determined to be a hypoxic-ischemic brain injury due to or as a consequence of fentanyl/acrylfentanyl intoxication.

Results

The following chart represents the results of the toxicology report. Drugs that were above the therapeutic range are indicated by an asterisk (*):

Drug	Level in blood (ng/mL)	Therapeutic Range (if applicable) (ng/mL)
Codeine (free) Morphine (free)	12 0	10 – 100 10 – 80
Fentanyl*	7	Within 24 hours of application of a 100 ug/hr transdermal patch, the expected serum concentration is 1.9 – 3.8 ng/mL
Zopiclone*	135	25 – 65
Acetaminophen, clonazepam, trazodone, diazepam	Detected but not quantified	Various

WE's DPIN history below includes a summary of medications relevant to her toxicology report:

Generic Name	Date Dispensed	Strength	Quantity	Days' Supply	Prescriber	Pharmacy
Acetaminophen/Caffeine/ Codeine	Apr 3, 2022 Feb 24, 2022 Jan 22, 2022 Jan 5, 2022 Dec 3, 2021 Nov 16, 2021 Nov 1, 2021	300/15/8 mg	100 100 100 100 100 100 100	30 30 30 14 14 14 14	Pharmacist A Pharmacist A Pharmacist A Pharmacist A Pharmacist A Pharmacist B Pharmacist B	ABC Pharmacy
Clonazepam	Nov 16, 2021	0.25 mg	5	5	Dr. C	DEF Pharmacy
Escitalopram	Nov 16, 2021	20 mg	28	28	Dr. C	DEF Pharmacy
Codeine/ Pseudoephedrine/ Triprolidine	Dec 9, 2021	10/30/2 mg per 5 mL	100	7	Dr. C	ABC Pharmacy
Trazodone	Nov 21, 2021	50 mg	28	28	Dr. C	ABC Pharmacy

Discussion

WE had a known history of polysubstance use, including opioids, possible methamphetamine, and ethanol, and her toxicology report indicates high blood levels of fentanyl and zopiclone which were never prescribed for her, according to the DPIN history. WE was prescribed exempted codeine products by two pharmacists from a pharmacy location that was far from her place of residence. While codeine was not implicated in WE's death, the learnings from this case will focus on the pivotal role of pharmacists with regards to the safe prescribing of exempted codeine products.

As of February 1, 2016, prescriptions are required in Manitoba for exempted codeine products and pharmacists can only prescribe quantities of up to 100 tablets or 250 mL with an option of a part fill.[1] If part-fills are used, the total quantity should not exceed 200 tablets or 500mL.[1] As per the College of Pharmacists of Manitoba's Prescribing Practice Direction, pharmacists must document the rational for their prescribing decision based on their professional judgement.[2]

Prior to issuing an exempted codeine prescription, the pharmacist must assess the patient in person, review DPIN thoroughly, take into account all the risks and benefits to the patient, and conclude that the medication would be in the best interests of the patient.[1] The Assessment and Prescribing Template for Pain Management developed by Pharmacists Manitoba is a helpful guide which carefully assesses the patient's level of pain and functioning, as well as the use of any pain-relieving medications within the past few months.[3] Prescribing pharmacists can also use a template that evaluates the patient's medical history, pain, quality of life, and adverse effects, and this tool is available on the College of Pharmacists of Manitoba website.[4] Pharmacists should employ an empathetic approach during patient assessment by establishing good rapport with the patient through open body language, such as eye contact, and actively listening to the patient's concerns.[5]

It is essential for the pharmacist to provide the patient with adequate information about the exempted codeine preparation as well as therapeutic alternatives so that the patient can make an informed decision.[1] Pharmacists are also reminded that authorization does not equal obligation. This means that pharmacists may refuse prescribing or dispensing of a prescription if they believe that the medication will result in patient harm. This may include inappropriate therapy, drug interactions, over dosage of acetaminophen, recreational use concerns, and potential diversion of medications.[6]

Pharmacists prescribing exempted codeine products for patients with a history of polysubstance use should exercise caution and frequently conduct re-evaluations. A study by Konefal et al. has shown that the rate of drug-related poisoning deaths in Canada nearly doubled from 6.4 to 11.5 deaths per 100,000 population between the years 2014 and 2017.[7] This was associated with the substantial increase in polysubstance use poisonings which mainly involved opioids and CNS stimulants.[7] It is crucial for pharmacists to ask patients about the use of unregulated substances, cannabis, alcohol, and non-prescribed prescription medications to help assess the appropriateness of codeine products and to determine if safer pharmacotherapy options are available. This can include a single pre-screening question (e.g., "How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?") or screening tools (e.g., opioid risk tool, TAPS, CRAFFT)[8,9], while letting the patient know that these questions are meant to identify potential drug interactions, reduce risk to patient safety, and to assist with exploring treatment options.

Based on WE's entire DPIN history, she did not fill her prescriptions consistently at one regular pharmacy. The pharmacy where she would fill her codeine prescriptions at was located far from her listed residence. Pharmacists have a role in educating the patient that it is in their best interest to select a single pharmacy for all their medications, if possible, as this will reduce the risk of medication incidents, such as duplicate therapy. Otherwise, the pharmacist must seek to understand the patient's rationale for going to multiple pharmacies and develop a plan with the patient to address any concerns. If the patient would like to continue utilizing multiple pharmacies, the expectation is that pharmacists at different locations collaborate to ensure the patient receives the best quality care.

It is a pharmacist's primary responsibility to ensure patient safety when dispensing a prescription medication. All members are reminded of their professional obligation to ensure that each prescription is reviewed thoroughly, and all potential issues are addressed, even if this entails difficult patient encounters. Measures must be taken to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists do not have the obligation to dispense or prescribe medications that they believe may cause patient harm. In such cases, the patient must be referred appropriately according to the Referring a Patient Practice Direction.

References:

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2. Practice Direction: Prescribing. College of Pharmacists of Manitoba. https://cphm.ca/wp-content/uploads/Resource-Library/Practice-Directions-Standards/Prescribing.pdf. Published 2014. Accessed July 29, 2022.

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5. Allinson M, Chaar B. How to demonstrate empathy and compassion in a pharmacy setting. The Pharmaceutical Journal. https://pharmaceutical-journal.com/article/ld/how-to-demonstrate-empathy-and-compassion-in-a-pharmacy-setting. Published 2019. Accessed July 29, 2022.

6. Booker B. Exempted codeine preparations: Prescribing for Manitoba pharmacies. College of Pharmacists of Manitoba. https://cphm.ca/wp-content/uploads/Practice-and-Education/Continuing-Competency/Recorded-PD-Programs/Exempted-Codeine_Prescribing_Presentation.pdf. Published 2016. Accessed July 29, 2022.

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8. SAMHSA Screening, Brief Intervention, and Referral to Treatment (SBIRT). Available: https://www.samhsa.gov/sbirt/resources. Accessed May 31, 2023.

9. National Institute on Drug Abuse (NIDA). Screening and Assessment Tools Chart. Available: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools. Accessed May 31, 2023.

In Memorium

In loving memory...

Louis Prefontaine	July 2, 2023
Morley Rypp	August 11, 2023