Unanswered Questions from ME PD Event – October 4th, 2022

1. **Should diphenhydramine and dimenhydrinate be dispensed by prescription only like Tylenol #1 to reduce harm to the public?**

   At this time, there is no strong evidence to indicate that diphenhydramine/dimenhydrinate should be moved from its current NAPRA schedule II status to a prescription status. However, over the counter medications (OTCs) such as diphenhydramine, dimenhydrinate, and pseudoephedrine are contributing to a rising number of medication-related deaths in Manitoba, especially when combined with other sedative and psychoactive medications.

   To improve patient safety, it is important for pharmacists, physicians/nurse practitioners, and patients to discuss the risks (and/or potential benefits) of over-the-counter medication use. Providing large quantities of diphenhydramine and/or dimenhydrinate to any patient is not advisable. Pharmacists are encouraged to keep all stock of these products behind the counter in packages containing no more than 30 tablets, necessitating an interaction and an assessment by the pharmacist prior to purchase. Although the risk of accidental medication overdose secondary to polypharmacy is substantially higher in patients taking other sedating and/or psychoactive medications, providing large quantities of any one medication (e.g., >30 dimenhydrinate tablets) can result in patient harm irrespective of other medication or substance use. All purchases of these medications should also be entered on patient profiles to track any potential misuse. Lastly, inquiring about the use of OTCs (including combination cold and flu products) should be routine when taking a medication history, and dangers of combining them with other sedating/psychoactive drugs must be emphasized during counselling.

   If concerning patterns are demonstrated by patients, particularly those on sedating/psychoactive medications and especially those on opioid agonist therapy (e.g., methadone, buprenorphine), CPSM strongly encourages communication and collaboration with the prescriber. Notifying the physician/nurse practitioner of concerning trends, patterns, or presentations is extremely helpful collateral to support effective communication with the patient. This collaboration also helps prescribers to re-evaluate medication dispensing intervals, the appropriateness of take-home dosing, and it is key to the overall safety plan.

   Should OTC-related deaths continue to increase in Manitoba, a provincial collaborative approach with all stakeholders involved will be required to mitigate the risks, which may include provincially strengthening the conditions of sale on products such as diphenhydramine/dimenhydrinate.

2. **The Standard states X Tabs every Y days, but it also says max 3 months and no more than 1 month supply. This is confusing to prescribers who then authorize 30 tabs every month. Why not 90 days max, 30 days max at a time?**

As noted during the talk, the essence behind these limitations is to promote regular follow up and more active monitoring of the effectiveness, appropriateness, and benefits compared to harms of these higher-risk medications (opioids/benzodiazepines/Z-drugs). The language used in the Standard of Practice (SOP) provides some flexibility to prescribers (some may wish to release medications every 28 days, every 30 days, etc.). However, the number of days worth of medication should not exceed the number of days for which is it dispensed. Again, in keeping with the intent of the SOPs, providing 1-month fills means fewer medications are circulating in the community at once, and the max 3-month prescription duration promotes more regular in-person assessments by physicians within a 3-month timeframe. CPSM encourages prescribers to assess patients being prescribed opioids, benzodiazepines, and Z-drugs, in-person, on a regular basis.

3. **A lot of the time patients place blame on the pharmacists for not dispensing in certain situations i.e., snowbirds - how would you approach this situation and what efforts have been made to show the public this is a multi-disciplinary task?**

CPSM understands and appreciates the impact that these prescribing SOPs have on pharmacists. We further recognize that pharmacists play an integral role in ensuring patient safety. Much joint collaboration between CPSM, CPhM, & CRNM occurs at the regulatory level, as well as addressing patient inquiries, to **share the message – one of collaborative effort to improve patient and public safety**. All members of the healthcare team are jointly responsible for communicating the same messaging to patients in a clear and effective manner. It is important to recognize and share with patients that current knowledge and best practices regarding the prescribing of benzodiazepines, Z-drugs, and opioids has changed (more is now known about the risks vs benefits of these medications).

Share with patients that as medical evidence evolves, doctors must adapt their prescribing (and similarly pharmacists must modify their dispensing) to align with new findings to further promote safe and ethical care. While it certainly can feel troublesome to be "blamed" or impacted by patients' frustration, maintaining a mindset of perspective, patience, and compassion can be helpful. Calls/inquires from providers and patients are also received by CPSM regarding the SOPs and CPSM attempts to remind registrants about the importance of this message via regular e-News and social media communications, many of which are publicly available for review (e.g., see the article Prescribing to Travellers or Snowbirds available on CPSM's website). CPSM promotes our focus on quality improvement in the practice of medicine, to registrants and the public, which includes supporting and fostering interdisciplinary communication between professions and with patients, as well as making the complaint process more accessible and supportive for patients.

CPhM has a companion document to assist pharmacists with the CPSM standard of practice. Included in the document are helpful resources for clinical use, including a communication tool to provide pharmacists with tips and strategies for effective conversations with patients about opioids.

4. **How do we as pharmacists handle situations where prescribers continuously do not follow these Standards of Practice, and make promises to patients that we cannot provide (i.e., giving 3 months at a time?) Even after providing reasoning, sending the current SOP's etc. to the prescribers and this still occurs, I'm hoping to know the best way to approach these situations.**

Statement VII of the CPhM Code of Ethics states that, "Pharmacists shall hold the health and safety of each patient to be of primary consideration". Similarly, CPSM states in their Code of Ethics for physicians, "Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient."

In the interest of patient safety and in adhering to the Code of Ethics, CPSM encourages physicians to collaborate and communicate with pharmacists, as required. Should communication prove to be ineffective, or if a physician is not following a CPSM Standard of Practice, CPSM's Prescribing Practices Program (PPP) can connect with the physician directly to provide resources and/or additional support in an educational manner. As a reminder, **CPSM Standards of Practice are *expectations* of care for physicians, not recommendations for practice. If there are patient safety concerns that are unable to be effectively addressed, pharmacists should also consider contacting CPhM for additional guidance.**

In order to address a concern, CPSM's PPP requires the patient and physician's name, a copy of at least one prescription, and a (brief) written summary of the concern. Without this information, there is limited support we can offer. Concerns can be submitted by secure (confidential) email or fax. If unsure, pharmacists can reach out (204-774-4344, ask for Prescribing Practices staff).

CPhM also often receives questions about the best course of action if prescribers are unwilling or resistant to collaborate on mutual patient safety concerns (e.g., prescribing is not in line with the CPSM Standards of Practice).

As a first step, pharmacists are encouraged to employ effective methods of communication with prescribers (e.g., faxed written case summaries with clear and direct recommendations, or utilizing fax templates that clearly request prescribing rationale, along with a follow-up phone conversation to determine next steps). Prescribers and pharmacists must work collaboratively and respectfully in providing safe and effective patient care, and both are strongly encouraged to proactively review the profiles of those patients who are actively receiving any opioids, benzodiazepines, or z-drugs. Both the pharmacist and prescriber must educate patients on the rationale for any recommended changes to their medication therapy.

As per the Ensuring Patient Safety Practice Direction, pharmacists must take the appropriate action to address any actual or potential drug related problems, in collaboration with the patient and the prescriber. The appropriate action may include discussing alternative solutions (e.g., dispensing a lesser quantity until discussions can be had with the prescriber, discussing potential alternative therapies, etc.). If a pharmacist believes that dispensing a medication may have the potential to cause patient harm, they are not obligated to dispense it, but pharmacists must again collaborate with the prescriber

in accordance with the Ensuring Patient Safety Practice Direction, and if necessary, refer the patient appropriately according to the Referring a Patient Practice Direction to ensure continuity of care for the patient.

All pertinent communication with patients and prescribers should be documented in an easily accessible manner regardless of the outcome, to ensure that the patient's care plan is continually visited and re-assessed by all of those involved in the patient's care. If any pharmacist requires support through this, they are encouraged to contact CPhM for guidance.

Despite this, should a pharmacist's continued attempts to communicate patient safety concerns be unsuccessful, pharmacists are advised to bring the matter forward to the prescriber's respective professional regulatory body. Regulatory bodies exist to protect the public and regulate the quality of registrants' professional practice, including the assurance of competent, safe, and appropriate prescribing practices. **As a patient safety issue, it is within the mandate of the regulator to investigate and intervene as appropriate, including providing education, support, and mentorship as required**.

5. **As an FYI, WRHA staff (OT/PT/pharmacists) lead a class/program called "Living well with chronic pain" for patients/clients that focuses on non-medication strategies to live well despite pain. Registration (free) is available at www.WRHA.mb.ca/groups/**

   Thank you and yes! There are comparable groups running out of some ACCESS and Wellness centers for patients living with certain chronic illnesses. In keeping with the SOP, supporting patients with recovery and wellness requires a multipronged, patient-centered, and trauma-informed approach. Maximizing non-pharmacotherapy interventions, particularly those that focus on patient coping and skill-building (e.g., CBT, DBT), strength-based approaches, healthy movement, and collaboration and connection have great evidence for long-term management of chronic illness. While slow to take effect at times, and patients are often reluctant to try at first, sharing this message and regularly offering resources can lead to progress.

6. **Since long term care residents have 24/7 medical oversight, like in hospital, why are they not exempt from this standard? Medication reviews are done every quarter; however, if the 90-day cutoff occurs prior to the medication review the consultant pharmacist may need to request a review of the benzodiazepine even if the med review will occur in one week. This can cause great frustration amongst the prescribers.**

   A similar inquiry was addressed by CPSM in 2021. To best address any outstanding concerns, these can first be brought to the attention of CPhM, who may in turn communicate with CPSM, if further discussion is required.

7. **Can opioids like tramadol prescriptions be written for more than 3 months? I have recently seen a prescription for Tridural being prescribed for 6 months.**

All opioid, benzodiazepine, and Z-drug prescriptions must follow the CPSM Standards of Practice for Prescribing Opioids and for Prescribing Benzodiazepines/Z-drugs. As tramadol is an opioid, all formulations of tramadol must comply with the CPSM Standard of Practice for Prescribing Opioids.

8. **Do the Standards of Practice (3 months rule) apply to Clobazam for seizure disorder, or can doctors prescribe it for 1 year?**

As noted in the CPSM Standard of Practice for Prescribing Benzodiazepines/Z-drugs, the SOP does not apply to the use of these drugs in the treatment of cancer, palliative and end-of-life patients, seizure disorders, bipolar/psychotic disorder, and acute alcohol withdrawal. To facilitate timely access to medication, if prescribing for any of these conditions, physicians should include the medical condition on the prescription for the awareness of the pharmacist (as explicitly stated in the SOP).

If a patient has a documented medical history of seizure disorder and the benzodiazepine is prescribed for this condition, the 3-month total quantity that a prescription can be written for (according to the SOP for Prescribing Benzodiazepines and Z-drugs) does not apply. Of note, prescribing and dispensing of opioids/benzodiazepines/Z-drugs/controlled medications should be in accordance with current medical knowledge, best practices, and sound professional judgement. Dispensing large quantities of these medications, even for the conditions above, can still increase the risk of adverse effects, and non-fatal/fatal overdose, and may not be advisable; this requires case-by-case consideration. Excluding the above-mentioned conditions from the SOP is not to imply that similar safety practices could not be considered, given awareness of these risks. Exemption of these conditions is based on carefully weighed specialist consultation and the SOP working group's review of evidence and feedback that placing limitations on patients with these conditions may cause more harm than benefit in some circumstances. This again brings us back to the intent of the SOPs to balance individual patient needs with patient and public safety considerations.

Pharmacists must use their professional judgment in determining what would be an appropriate quantity to dispense, and collaborate with the prescriber, taking into consideration patient and community safety. Pharmacists must be confident in justifying the rationale for dispensing large quantities of these medications, and effectively document both the collaboration and rationale for the approach to care.

9. **Using DPIN, could CPSM send letters to physicians that are prescribing a benzo/z drug, and an opioid (and other psychoactive meds) so they could have an informative letter sent to them prior to a death or hospitalization, rather than waiting for a death?**

Providing informational letters based on Medical Examiner review work is one example of CPSM intervention to provide case-specific feedback relevant to a physician's practice. CPSM certainly does engage in education, support, and mentorship with physicians to improve prescribing through other means and in other contexts for patients. Working with prescribers on a case-by-case basis provides an opportunity for high-impact and focused

education with our registrants. Supporting physicians in this way continues to build capacity and proficiency. This supports CPSM's mandate to promote quality in the practice of medicine and inherently improves patient safety.

As DPIN data is only one piece of care picture, it may not always be an accurate reflection of comprehensive patient care. Pharmacists (and physicians) are best positioned to address their patients' immediate and longer-term needs, and CPSM encourages pharmacists to collaborate with prescribers. CPSM offers support, education, and further intervention as required, through various means and informational sources.

As described in question 4, according to the Ensuring Patient Safety Practice Direction, pharmacists must take the appropriate action to address any actual or potential drug related problems, in collaboration with the patient and the prescriber. The appropriate action may include discussing alternative solutions (e.g., dispensing a lesser quantity until discussions can be had with the prescriber, discussing potential alternative therapies, etc.). If a pharmacist believes that dispensing a medication may have the potential to cause patient harm, they are not obligated to dispense it, but pharmacists must again collaborate with the prescriber in accordance with the Ensuring Patient Safety Practice Direction, and if necessary, refer the patient appropriately according to the Referring a Patient Practice Direction to ensure continuity of care for the patient.

10. Why aren't physicians required to provide the diagnosis for the prescription like Nurse Practitioners?

Although not required, physicians are encouraged to provide a patient's diagnosis on a prescription, especially when the dose and/or treatment is unconventional. This may also prevent delays in a patient receiving their prescription due to confirmation with the prescriber.

11. How do we refer the patient to CARMA program? Is there a waiting time? please share the link or webpage.

Details about the CARMA clinic and referral can be found on CPSM's website HERE. The waitlist for the CARMA clinic is variable. Please note referrals from the *prescribing* physician/nurse practitioner seeking consultation can be submitted via letter by fax (204-787-3996), and should include a detailed patient history, demographics, relevant labs/investigations, and medication list. Please note patients do not necessarily need to have identified substance use issues or disorder(s) to be referred for consultation. Many are referred simply for recommendations around mediation use and deprescribing. Diagnostic clarification and education are sometimes the only intervention needed. Alternatively, if a substance use disorder is identified, patients can further benefit from education, recommendations, and access to appropriate treatment. This info sheet can be shared with prescribers and patients, including resources on page 2. If you believe a patient could benefit from referral, discuss this collaboratively and compassionately with the patient and prescriber, noting that the clinic can provide helpful education and recommendations to support patients with deprescribing to improve quality of life and function.

12. Are there any exceptions or medical conditions where a patient can use more than one benzodiazepine, for example lorazepam and temazepam? (e.g., if the patient's condition is not well controlled).

Please refer to question 8 and note that CPSM Standards of Practice apply to all Manitoba physicians. The SOP for Prescribing Benzodiazepines and Z-drugs advises, "only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper." Should *exceptional circumstances* be identified, the prescriber should document in the patient medical record their assessment, evidence of benefits outweighing harms, and rationale for prescribing two benzodiazepines/Z-drugs concurrently. Again, communication and collaboration between pharmacist and prescriber is key; if questions or concerns arise about such concurrent prescribing, as per the Ensuring Patient Safety Practice Direction, reach out to the prescriber for more information.