

Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
Suite 806, Box 18
Toronto, Ontario, Canada M4V 2Y7
HPRACSubmissions@ontario.ca

Regarding: Dietitian Scope of Practice

I have serious concerns with the proposed expansion of the Dietitian scope of practice to include prescribing or dispensing, specifically for the adjustment of insulin and oral hypoglycemic regimens. Further in the document, there is reference to expand the list to cardiovascular medications.

Controlled Act #8 – Prescribing or dispensing, specifically for the adjustment of insulin and oral hypoglycemic regimens

It is proposed that RDs be authorized to make adjustments to the dose of existing insulin or oral hypoglycemic medications that have been prescribed by a physician or authorized healthcare practitioner.

Enabling RDs to make insulin adjustments for individuals with diabetes on existing insulin regimens supports effective interprofessional team-based care and contributes to patient self-management and safety by preventing hypoglycemia and reducing the risk of long term vascular complications

Professionals such as Dietitians, Nurses and Pharmacists who have become “Certified Diabetes Educators” are qualified to make insulin and oral hypoglycemic regimens due to the rigorous requirement (extensive experience and examination) required. There are processes such as Medical Directives which allow for this to occur in a collaborative practice model. However, in my 25 years of hospital experience at several institutions with Diabetes Education Programs, Dietitians who have not completed the Certified Diabetes Educators process are not qualified to adjust these medications.

In fact, insulin, oral hypoglycemic medications and Total Parenteral Nutrition are considered “High Alert” medications by the Institute of Safe Medication Practice. “High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients.” (see attachment)

In addition, Accreditation Canada which surveys and accredits Hospitals, Community Care Access Centres and other community services requires under the Managing Medications Standards numerous actions should occur for high alert medications: (see attachment)

*1.5 The organization arranges access to current protocols, guidelines, dosing recommendations, checklists, and/or pre-printed order forms for **high risk/high alert drugs**.*

*2.5 The organization defines and lists **high-risk/high-alert medications** available in the organization.*

*11.3 The pharmacy computer system performs dose range checks and warns providers about low and high doses for **all high alert medications**.*

*18.5 Service providers seek **an independent double check** before administering **high risk medications**. The **independent double check** may include verifying the drug, drug concentration, rate of infusion, client/patient identity, and line attachment. The **independent double check** may also be through the use of a barcode."*

Such patient safety requirements as described above or throughout the Accreditation Canada document are not available in a solo practice setting. As well, if a Dietitian does not have access to the patient's complete medication history (prescription, non-prescription and herbals) and/or is able access computerized decision support software to determine whether or not any potential drug interactions may exist, patients may be put at harm.

In addition, Dietitians adjusting the doses of the patient's insulin or oral hypoglycemic medications fragments patient care due to the fact that many diabetic patients are prescribed multiple agents such as cardiovascular, antiplatelet, renal protection and erythropoietin etc. Thus, the patient must be referred to another primary health practitioner for the remaining medications.

Finally, there is an inherent conflict of interest in prescribing and also dispensing medications. For patient safety reasons noted above, prescribing and dispensing should involve two different individuals to allow the independent double check for these high risk agents. It would be the expectation that all dispensing by Regulated Health Professions meet the standards as outlined in the Drug and Pharmacy Regulation Act which occur in pharmacy practice.

For the reasons outlined above, I do not support this expansion to the Dietitian Scope of Practice.

Respectfully submitted,

Shelley McKinney, RPh, MBA





ISMP's List of *High-Alert Medications*

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies like improving access to information about

these drugs; limiting access to high-alert medications; using auxiliary labels and automated alerts; standardizing the ordering, storage, preparation, and administration of these products; and employing redundancies such as automated or independent double-checks when necessary. (Note: manual independent double-checks are not always the optimal error-reduction strategy and may not be practical for all of the medications on the list).

Classes/ Categories of Medications
adrenergic agonists, IV (e.g., epinephrine, phenylephrine, norepinephrine)
adrenergic antagonists, IV (e.g., propranolol, metoprolol, labetalol)
anesthetic agents, general, inhaled and IV (e.g., propofol, ketamine)
antiarrhythmics, IV (e.g., lidocaine, amiodarone)
antithrombotic agents (anticoagulants), including warfarin, low-molecular-weight heparin, IV unfractionated heparin, Factor Xa inhibitors (fondaparinux), direct thrombin inhibitors (e.g., argatroban, lepirudin, bivalirudin), thrombolytics (e.g., alteplase, reteplase, tenecteplase), and glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)
cardioplegic solutions
chemotherapeutic agents, parenteral and oral
dextrose, hypertonic, 20% or greater
dialysis solutions, peritoneal and hemodialysis
epidural or intrathecal medications
hypoglycemics, oral
inotropic medications, IV (e.g., digoxin, milrinone)
liposomal forms of drugs (e.g., liposomal amphotericin B)
moderate sedation agents, IV (e.g., midazolam)
moderate sedation agents, oral, for children (e.g., chloral hydrate)
narcotics/opiates, IV, transdermal, and oral (including liquid concentrates, immediate and sustained-release formulations)
neuromuscular blocking agents (e.g., succinylcholine, rocuronium, vecuronium)
radiocontrast agents, IV
total parenteral nutrition solutions

Specific Medications
colchicine injection***
epoprostenol (Flolan), IV
insulin, subcutaneous and IV
magnesium sulfate injection
methotrexate, oral, non-oncologic use
opium tincture
oxytocin, IV
nitroprusside sodium for injection
potassium chloride for injection concentrate
potassium phosphates injection
promethazine, IV
sodium chloride for injection, hypertonic (greater than 0.9% concentration)
sterile water for injection, inhalation, and irrigation (excluding pour bottles) in containers of 100 mL or more

***Although colchicine injection should no longer be used, it will remain on the list until shipments of unapproved colchicine injection cease in August 2008. For details, please visit: www.fda.gov/bbs/topics/NEWS/2008/NEW01791.html.

Background
Based on error reports submitted to the USP-ISMP Medication Errors Reporting Program, reports of harmful errors in the literature, and input from practitioners and safety experts, ISMP created and periodically updates a list of potential high-alert medications. During February-April 2007, 770 practitioners responded to an ISMP survey designed to identify which medications were most frequently considered high-alert drugs by individuals and organizations. Further, to assure relevance and completeness, the clinical staff at ISMP, members of our advisory board, and safety experts throughout the US were asked to review the potential list. This list of drugs and drug categories reflects the collective thinking of all who provided input.

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CCHSA'S ACCREDITATION PROGRAM 2008

STANDARDS

Managing Medications

Accredited by ISQua



Canadian Council on Health
Services Accreditation
Conseil canadien d'agrément
des services de santé

CCHSA's standards for Managing Medications are intended for the interdisciplinary team of service providers responsible for the critical processes associated with safely using and managing medications in an organization. A collaborative approach is required to prevent adverse drug events.

The standards represent the flow of medication through an organization, beginning with selection and preparation in the pharmacy, and ending with the administration to and ongoing monitoring of clients.

Selected standards and criteria were adopted with permission from ISMP and ISMP Canada, based on the ISMP Medication Safety Self-Assessment® - Canadian Version.

The standards are divided into the following subsections:

- **Working Together to Promote Medication Safety**
- **Carefully Selecting and Procuring Medications**
- **Properly Labeling and Storing Medications**
- **Appropriately Ordering and Transcribing Medications**
- **Accurately Preparing and Dispensing Medications**
- **Safely Administering Medications to Clients**
- **Monitoring Quality and Achieving Positive Results**



Managing Medications

WORKING TOGETHER TO PROMOTE MEDICATION SAFETY

- 1.0 The organization's pharmacists and pharmacy's staff work closely with prescribing medical professionals and other service providers to support safe medication use.



Effectiveness

- 1.1 The organization's pharmacists and pharmacy staff are recognized as members of the interdisciplinary team.

Guidelines

In addition to pharmacists and other pharmacy staff, the interdisciplinary team should include all individuals involved in using medications and monitoring client care, such as medical staff, nurses, and other providers.

Pharmacists' clinical activities may include reviewing client records and drug orders, attending multidisciplinary meetings, and providing input into the selection and administration of drugs.



Effectiveness

- 1.2 The pharmacists and pharmacy staff are actively involved in designing the organization's medication use and medication management processes.

Guidelines

Pharmacists and pharmacy staff should be involved in designing all stages of the medication use and medication management process, including selecting and procuring medications, labeling and storing medications, prescribing, and transcribing medications, administering medications, and monitoring clients. They should also be involved in evaluating and redesigning the organization's processes as appropriate.



Accessibility

- 1.3 Prescribing medical professionals have access to accurate medication-related information.

Guidelines

Medication-related information includes pharmacy consultations, infusion charts, drug reference texts, information on IV administration, and drug information in electronic format.



Accessibility

- 1.4 The organization provides access to formally approved drug information tools.

Guidelines

Drug information tools may include pocket references, drug information cards, preprinted order forms, protocols or checklists, client drug education material, compounding recipes, computerized prescriber order entry (CPOE) decision trees, and clinical support protocols.

The tools should be reviewed, approved and updated regularly. The approval process should include a review by a pharmacist and other providers who will be using the tool.



Safety

- 1.5 The organization arranges access to current protocols, guidelines, dosing recommendations, checklists, and/or pre-printed order forms for high risk/high alert drugs.



Accessibility

- 1.6 The organization has a pharmacist available or accessible to answer drug information questions from service providers 24 hours a day.

Guidelines

The pharmacist should maintain adequate drug information resources to accurately respond to questions.





Worklife

- 1.7 The organization supports all staff and service providers to attend internal and external education programs related to safe medication use.



Safety

- 1.8 The organization gives all staff and service providers ongoing information and education about medication errors.

Guidelines

The information and education should address internal medication errors, error-prone situations, errors occurring in and shared by other organizations, and strategies to prevent errors.



Worklife

- 1.9 The organization conducts baseline competency evaluations of all service providers before they can participate independently in the medication use process.

Guidelines

Organizational policy and regulatory college guidelines provide the basis for baseline competency evaluation for all service providers.



Worklife

- 1.10 The organization conducts annual competency evaluations of service providers involved in the medication use process.

Guidelines

Organizational policy and regulatory college guidelines provide the basis for annual competency evaluation for all service providers.



CAREFULLY SELECTING AND PROCURING MEDICATIONS

2.0 The organization maintains an up-to-date and evidence-based list of available medications.



Effectiveness

2.1 The organization follows written criteria for adding medications to and removing medications from the list.

Guidelines

The list of medications available for use may be called a formulary.



Effectiveness

2.2 When selecting medications, the organization considers the needs of clients and prescribing medical professionals, safety, effectiveness, cost, and the need to avoid duplicating products with generic equivalents.

Guidelines

The list of medications is designed to limit drug choice.



Effectiveness

2.3 The organization investigates a medication's benefits and risks before adding it to the list.

Guidelines

The investigation should cover the available research, evidence, and expert opinion such as pharmacy personnel or a therapeutics committee.

The review should address the drug's potential for error and other risks to client safety such as possible interactions, possibility and likelihood of sentinel events, and potential for abuse.



Effectiveness

2.4 The organization communicates with the appropriate staff and service providers about which drugs are included in and excluded from the list.

Guidelines

This process should include making the list available to staff and service providers.



Safety

2.5 The organization defines and lists high-risk/high-alert medications available in the organization.



Worklife

2.6 The organization educates staff and service providers about newly available medications.

Guidelines

Before the medication is used internally, the organization educates staff and service providers about its uses, protocols, guidelines and restrictions.



Worklife

2.7 The organization educates staff and service providers about new uses for existing drugs.

Guidelines

Before using an existing drug in a new way, the organization educates service providers about the associated protocols, guidelines, and restrictions.





Effectiveness

- 2.8 The organization reviews the list of available medications annually and updates safety or efficacy information, as available.



Effectiveness

- 3.0 The organization minimizes the medications it procures and has available.

- 3.1 Where available, the organization purchases commercially manufactured medications to minimize manufacturing in the pharmacy.



Effectiveness

- 3.2 The organization has a process to approve and procure in a timely manner medications that are not on the approved list.

Guidelines

Medications not included on the approved list should be procured and used only when therapeutically necessary.



Safety

- 3.3 To help differentiate products with similar labeling/packaging, the organization obtains products from different manufacturers.

Guidelines

The organization examines the packages and labels of drugs being considered for selection to identify any potential for confusion.



Safety



- 3.4 **REQUIRED ORGANIZATIONAL PRACTICE:** The organization standardizes and limits the number of drug concentrations available.

Guidelines

Multiple strengths (concentrations) of the same medication increase the risk that clinicians will select and either dispense or administer the wrong strength. Standardizing and limiting drug concentrations reduce variation and the chance for error.

An organization can reduce the risk of these errors by limiting the number of concentrations, e.g. by providing only one strength of each medication, or as few strengths as possible, and by standardizing the concentrations available across the organization.

Test(s) for Compliance

- 3.4.1 Drug concentrations (strengths) are standardized and limited across the organization.



Effectiveness

- 3.5 The organization has a policy and process to manage the availability of sample medications.



Effectiveness

- 3.6 The organization has a policy and process for reviewing, approving, supervising, and monitoring the use of investigational medications.





Effectiveness

- 3.7 The organization has processes to address medication shortages and outages.

Guidelines

The processes should include communicating with staff and service providers involved in medication use or medication management, developing substitution protocols for affected medications, educating staff and service providers about the substitution protocols, and procuring medications in the event of a disaster or emergency.



Safety

- 3.8 The organization's procurement processes include evaluating all medications received.

Guidelines

Evidence shows that an evaluation of the medications received is needed to reduce risk to clients. The evaluation helps to identify shipment errors, shipments that have a different-than-usual appearance or shipments that are different but look similar to those already in stock.



Safety

- 3.9 When a problem with a medication shipment is identified, the organization's pharmacists take steps to reduce the possibility of error.

Guidelines

Depending on the magnitude of the problem, the pharmacy may decide to return the medications to the manufacturer or to provide staff and service providers with additional information, education, and warnings.



PROPERLY LABELING AND STORING MEDICATIONS

4.0 The organization reduces the possibility of errors with drug product nomenclature, labeling, and packaging.



Effectiveness

4.1 The organization regularly reviews current research and evidence to identify problems with drug labeling, packaging, and nomenclature.

Guidelines

The review should include the ISMP Medication Safety Alerts.



Effectiveness

4.2 The organization uses alerts to inform staff and service providers about problematic drug names, packaging, or labeling.

Guidelines

Alerts may be monitored by staff or built into computer software.



Safety

4.3 The organization places auxiliary warnings or other label enhancements on drug packages and storage bins with problematic names, packages, or labels.

Guidelines

Changes to product location may also be made for drugs with problematic names, packages, or labels.



Safety

4.4 The organization reports drug labeling, packaging, and nomenclature problems.

Guidelines

Reports may be made to ISMP Canada, Health Canada, or manufacturers.

5.0 The organization clearly and legibly labels all drug concentrations.



Safety

5.1 The organization uses medication labels that are clear, distinctive, and free of unclear abbreviations and nonessential information.

Guidelines

The clear and accurate identification of drugs is required. Each label should contain the medication's generic name and strength.

In addition to labels, other forms of identification may be used such as laser impressions or readings.

A list of abbreviations and symbols reported as being frequently misinterpreted and involved in harmful medication errors is available from ISMP Canada.



Safety

5.2 The organization labels commercially available IV infusion containers.

Guidelines

Labels should identify the base solution and the total amount of any additives, and should be optimally positioned so they are clearly visible to service providers.



Safety

5.3 The organization positions IV infusion containers to allow a clear view of the manufacturer's label.



Safety

- 5.4 The organization's pharmacy-prepared IV admixture containers are labeled.

Guidelines

Labels affixed to the pharmacy-prepared IV admixture containers should include the total volume of solution in the container, the base solution, and the concentration and total amount of drug additives in the container.

Information on the label is intended to support client safety. Excessive information may be confusing. For example, including the concentration of drug additives on the label may be important only for some solutions, such as those for continuous infusion where the infusion rate is calculated based on the concentration.

- 6.0 The organization provides suitable space for drug storage in pharmacies and client/unit medication areas.



Effectiveness

- 6.1 The pharmacy's staff members maintain medication storage areas that are orderly and free of clutter.



Worklife

- 6.2 The organization equips medication areas with sufficient lighting so that staff members can clearly read important drug information.

Guidelines

Important drug information includes labels and information sheets.



Safety

- 6.3 The organization stores all medications in secure areas accessible only by authorized staff.



Effectiveness

- 6.4 The storage conditions protect the stability of medications.



Safety

- 6.5 The organization separates or isolates look-alike, sound-alike drugs; different concentrations of the same medication; high-risk/high-alert medications; and all expired, damaged, and contaminated medications pending removal.

Guidelines

Separating or isolating certain medications in the storage areas prevents confusion and promotes client and staff safety.



Safety

- 6.6 The organization's storage areas meet legislated requirements for controlled substances.





Effectiveness

- 6.7 The organization regularly inspects all of its medication storage areas.

Guidelines

The inspection should ensure that no unapproved medications are stocked and all stocked medications are not beyond the expiry date. Inspections should be documented in accordance with organizational policy.

- 7.0 The organization carefully selects stock drugs for each client area.



Effectiveness

- 7.1 When selecting stock drugs for each client area, the organization considers the needs of each client service area, service provider expertise and familiarity with specific drugs, the risk of error with each drug, and the age and diagnoses of typical clients being treated.



Safety



- 7.2 **REQUIRED ORGANIZATIONAL PRACTICE:** The organization has removed all concentrated electrolytes from client areas/units.

Guidelines

There is widespread agreement that concentrated electrolytes are extremely high risk and should not be kept in client service areas. The organization should determine which concentrated electrolytes (beyond potassium chloride, potassium phosphate, and sodium chloride >0.9%) pose a threat to safety and therefore should be removed.

The general rule is that drugs stocked in client service areas should be carefully selected for each area by considering the needs of each client service area, staff and provider expertise and familiarity with specific drugs, the risk of error with each drug, and the age and diagnoses of typical clients being treated.

- 7.3 When commercially available and when practical, the organization stocks drugs in client care units in a ready-to-use format.

Guidelines

Drugs stocked in care areas should not be bulk supplies.



Effectiveness

- 7.4 The organization stores medications intended for administration in client care units in labeled, unit-of-use containers.

Guidelines

The containers should be labeled and contain unit doses that are ready for administration. Exclusions to the above (e.g. topical preparations, antacids, otic/ophthalmics, multi-dose vials, carded doses) are defined by organization policy. Barcodes may be used to enhance the safety of medication dispensing.



Safety

- 7.5 The organization's unit dose oral medications remain in the manufacturer's or pharmacy's packaging up to the point of drug administration.



Safety

- 7.6 The organization's emergency medications and supplies are consistently available, controlled, and secure in client care areas.

Guidelines

Medications available for emergency cases include analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrhythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.



Safety





Effectiveness

- 7.7 The organization has a process to safely manage medications brought into the organization by clients/families.

Guidelines

The process should be based on policies regarding when and how such medications can be used, visually evaluating the medication's integrity and prohibiting the use of medications that cannot be identified with reasonable effort, appropriately storing the medication, and the returning of medication to the client at discharge or transition.

- 8.0 The organization stores hazardous chemicals away from clients, service providers, and drug preparation areas.



Effectiveness

- 8.1 The pharmacy's staff routinely assesses bulk chemicals contained in the pharmacy.

Guidelines

Bulk chemicals are assessed to determine if they are necessary and regularly used.

- 8.2 The pharmacy's staff eliminates bulk chemicals that are not regularly used or considered dangerous.



Effectiveness

- 8.3 Staff members appropriately label all bulk chemicals in the pharmacy.

Guidelines

The information on the label should include the contents, the date the product was first opened, and the manufacturer's expiration date (if applicable).



Effectiveness

- 8.4 The organization complies with the Workplace Hazardous Materials Information System (WHMIS) regulations for bulk chemicals in the pharmacy.



Safety

- 8.5 The organization securely stores chemotherapy agents in an isolated area with adequate ventilation.



Safety



ORDERING AND TRANSCRIBING MEDICATIONS APPROPRIATELY

9.0 The organization maintains accessible and up-to-date client information.



Effectiveness

9.1 The organization obtains a medication history for each client upon admission or initial encounter.

Guidelines

The medication history should include prescription and over-the-counter medications, vitamins, herbal products, and illicit drugs. It should also identify drug allergies and possible drug interactions.

9.2 The client's medication history and ongoing medication profile are maintained in a pharmacy computer system.

Guidelines

The ongoing profile should include a current list of medications and drug therapy records for each episode of service received by the organization.



Effectiveness

9.3 When prescribing medications, providers have access to the client's information, including medication profile.

Guidelines

Essential client information includes age, gender, diagnosis, co-morbidities or concurrently occurring conditions such as hypertension, diabetes or renal or liver impairment, relevant laboratory values (inpatient or outpatient), and allergies and past sensitivities. Essential information may also include weight and height, pregnancy and lactation status, as appropriate to the client.

Evidence has shown that a failure to access and review essential client information, including laboratory test results, prior to prescribing or ordering medications can jeopardize client safety.



Accessibility

9.4 The organization protects the privacy and confidentiality of client information.



Client-centred
Services

10.0 The organization communicates drug orders and other drug information in a standardized way.



Safety

10.1 Prescribing professionals write or electronically enter complete medication orders, reorders, or reassessments upon admission, discharge, or transfer to another level of care.

Guidelines

Examples of inappropriate orders include "resume the same medication" or "take medications from home".

10.2 The organization uses a computerized prescriber order entry (CPOE) system with the capacity to guide the use of accepted drugs and established protocols, and alert attention to unsafe orders during input.



Safety

Guidelines

Unsafe orders may relate to allergies, maximum doses, and interactions.





Effectiveness

- 10.3 In organizations without CPOE systems, prescribing professionals use preprinted forms to order routine medications.

Guidelines

Preprinted forms may be used for preoperative and postoperative clients, inpatient critical care admissions, and oncology.

The organization regularly reviews and updates preprinted order sheets.



Safety

- 10.4 The pharmacy receives a complete, clear, and readable medication order that includes drug interaction and allergy information.

Guidelines

The organization has requirements for a complete order; a list of acceptable abbreviations; a policy regarding the use of generic vs. brand names; requirements for "when needed" medications are ordered; a list of special precautions; and a process for when the order is not legible or is incomplete.

Basic information on orders may include client name, birth date, gender, weight, height, allergy information, physician, organization location, and organization ID number.

Orders may come to the pharmacy via addressograph imprints, stickers on hard-copy, facsimile, or electronic transmission.



Safety

- 10.5 The pharmacy follows a process when medication orders are incomplete, illegible, or unclear.

Guidelines

The process should go beyond double-checking the order in the pharmacy. The pharmacy is responsible for checking the accuracy of an incomplete, illegible, or unclear order with the prescribing medical professional.



Safety

- 10.6 The pharmacy accepts verbal and telephone orders only in emergencies.

Guidelines

Each verbal or telephone order should be verified with a read-back process and co-signed by the prescribing professional within 24 hours.

The organization does not accept verbal or telephone orders for chemotherapy.



Safety

- 10.7 Prescribing medical professionals use special precautions when communicating orders for sound-alike and look-alike drugs.



Effectiveness

- 10.8 The pharmacy follows clear requirements for the acceptability of orders.

Guidelines

Order requirements may include PRN orders, standing orders and resume orders, and blanket reinstatement of previous orders.



Safety

- 10.9 The pharmacy's staff properly enters and codes clinically-accurate, known adverse drug reactions and client allergy information in the pharmacy computer system.

Guidelines

Client allergies should be a required field and names of allergens should be spelled correctly. Evidence has shown that a failure to properly assess and note possible drug interactions and clients' drug allergies increases the risk of medication-related adverse events.





Worklife

- 10.10 The organization provides quiet work areas where drug orders are written, transcribed, and entered into computer systems.

Guidelines

The quiet work areas minimize distractions and noise.



Safety

- 10.11 The organization monitors compliance with its processes for prescribing medications.

- 11.0 The pharmacy reviews all prescriptions or medication orders for accuracy and appropriateness.



Safety

- 11.1 A pharmacist reviews all prescription or medication orders prior to dispensing and administration.

Guidelines

Outside normal operating hours, e.g. when the pharmacy is closed, or in emergency situations, the organization should have a process to verify that this review is done by another qualified medical professional.

The review process should include the appropriateness of the drug, dose, frequency, and route of administration; any therapeutic duplication; any real or potential allergies or sensitivities; any real or potential drug interactions; variation from organizational criteria for use; and other relevant medication-related issues or concerns.



Safety

- 11.2 The pharmacy verifies and assesses allergy and drug interaction information.

Guidelines

Prior to dispensing and administration, the pharmacy's staff verifies the possible drug interactions and client drug allergies identified by the computer system.



Safety

- 11.3 The pharmacy computer system performs dose range checks and warns providers about low and high doses for all high alert medications.



Safety

- 11.4 Prescribing professionals follow a policy for weight-based dosing in pediatrics.



Safety

- 11.5 Prescribing professionals follow a policy for body surface area (BSA) prescribing for chemotherapy.





- 11.6 The pharmacy contacts the prescribing medical professional in the event of a concern or change with an order and documents any discussions or amendments in the client medication profile.



ACCURATELY PREPARING AND DISPENSING MEDICATIONS

12.0 The pharmacy prevents contamination when preparing medications.



Worklife

12.1 The organization makes workspaces available to pharmacy staff for preparing medication orders.

Guidelines

Preparation areas should be organized, clutter-free, properly ventilated and lighted, and temperature controlled.



Accessibility

12.2 The organization makes policies and procedures for the safe preparation of medications available to pharmacy staff and service providers.



Safety

12.3 The organization compounds sterile medications and IV admixtures in the pharmacy using aseptic technique and appropriate safety materials and equipment.

Guidelines

Some exceptions include emergencies, after hours, or if the medications have a short stability.



Safety

12.4 When preparing pharmaceutical products by aseptic technique, the pharmacy's staff wears appropriate clothing and uses appropriate handwashing/hand hygiene procedures.



Safety

12.5 The pharmacy staff prepares IV products in a segregated admixture area using a certified laminar flow hood.

Guidelines

The IV preparation area has minimal distractions and is separate from the main medication area.



Safety

12.6 The pharmacy uses a biohazard hood for antineoplastic products.



Safety

12.7 Staff members follow established procedures to avoid direct physical contact with loose oral solid products.



Effectiveness

12.8 The pharmacy's staff visually inspects the final product.





Effectiveness

12.9 The pharmacy's staff document all medications prepared.



Accessibility

13.0 The pharmacy dispenses medications in a safe, accurate, and timely way.

13.1 The pharmacy makes policies and procedures for dispensing medications available to pharmacy staff and service providers.



Effectiveness

13.2 The pharmacy's policies and procedures for dispensing medications meet applicable laws and regulations.



Effectiveness

13.3 The pharmacy dispenses the most ready-to-administer form of the medication.



Effectiveness

13.4 The pharmacy dispenses medications using a unit dose packaging system.



Safety

13.5 The pharmacy dispenses tablet medications in a dose that can be tapered.

Guidelines

Evidence has shown that a failure to issue tablet medications in a dose that can be tapered when needed can seriously affect client safety.



Accessibility

13.6 The pharmacy sets and follows realistic criteria for dispensing emergency, urgent, and routine medications.

Guidelines

The criteria should address definitions of and dispensing times for emergency, urgent, and routine medications.



Safety

13.7 The organization has a quality control procedure to prevent dispensing errors.

Guidelines

The procedures may include barcode verification.

It may also include refusing to dispense medications when an issue with an order is unresolved.

14.0 When there is no internal pharmacy or when the pharmacy is closed, the organization has a system to safely dispense medications.





Accessibility

- 14.1 The organization provides designated service providers with access to a night cabinet or a limited selection of urgently required medications.

Guidelines

Controlled-access cabinets or automated dispensing units may be used for after-hours services to provide client-linked access to medications.



Effectiveness

- 14.2 A pharmacist or other qualified service provider reviews at the earliest opportunity all medications dispensed after hours or from a special access cabinet.

Guidelines

The review should include the appropriateness of the drug, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions with other medications or food; laboratory values for current or potential medication impact; and other contraindications.



Effectiveness

- 14.3 The organization regularly evaluates its system for dispensing medications when the pharmacy is closed or when there is no internal pharmacy, and makes improvements as needed.

- 15.0 The pharmacy transports medication in a safe, secure, and timely manner way.



Effectiveness

- 15.1 The pharmacy directly controls the physical delivery of medications from the pharmacy to client service units.

Guidelines

The medication delivery system may make use of trained staff or automation.



Efficiency

- 15.2 The pharmacy has a medication delivery turn-around time consistent with established time frames for emergency, urgent, and routine medications.

Guidelines

These timeframes may be set externally or internally.



Worklife

- 15.3 The organization protects the health and safety of service providers who transport, administer, and dispose of cytotoxic drugs.

Guidelines

The toxicity of cytotoxic drugs dictates that the exposure of service providers to these drugs should be minimized.



Safety

- 15.4 The organization has a readily accessible hazardous spill kit for chemotherapy agents.



Effectiveness

- 15.5 The organization has a process to determine when, or if, medications can be returned to the pharmacy.

Guidelines

The process may include procedures to account for and prevent diversion of returned drugs.





Effectiveness

15.6 The pharmacy has a quality control mechanism to return restocked products to the correct location.



SAFELY ADMINISTERING MEDICATIONS TO CLIENTS

16.0 The organization educates clients about their medications and delivery devices, and ways to prevent errors.



Client-centred
Services

16.1 The organization's providers educate clients upon admission or intake to ask questions about their medications.

Guidelines

Clients' education may include advising them of the appropriate questions to ask, to show staff their proper identification (e.g. name bracelet or other form of identification such as barcode), and to state their names clearly before medications are administered.



Client-centred
Services

16.2 Prior to the initial dose, and when the dosage is adjusted, the providers communicate with the clients and family about the recommended drug therapy and any potential drug reactions or interactions.

Guidelines

Service providers communicate with clients information about the drug's potential benefits and adverse effects, how to use the drug safely and properly, the risks of non-adherence, and the financial cost. Both written and verbal information should be simple and easy to understand.



Client-centred
Services

16.3 Providers instruct clients on who and when to call with concerns or questions about their drug therapy after discharge or transfer of service.



Client-centred
Services

16.4 During the education process, service providers actively seek to understand and respond to any client concerns about their medication.



Effectiveness

16.5 Providers record any information that is given to the client in the client health record.

17.0 The organization follows a process to allow and monitor clients' self-administration of their medications.



Safety

17.1 The organization has explicit selection criteria for clients to safely self-administer medications.



Client-centred
Services

17.2 Service providers determine the client's competency to self-administer medications and obtain the client's informed consent.



Client-centred
Services

- 17.3 The organization provides clients who self-administer medications with appropriate education and supervision.



Effectiveness

- 17.4 The organization's policies for clients' self-administration of medications meet applicable laws and regulations, and protect the organization's liability.

- 18.0 The organization safely and accurately administers medications.



Safety

- 18.1 The organization identifies the minimum qualifications for providers and staff to administer medications.

Guidelines

The organization should identify the minimum qualifications required to administer medications, both with and without supervision.

Minimum qualifications may differ by drug class and by administration route.



Safety



- 18.2 **REQUIRED ORGANIZATIONAL PRACTICE:** Service providers use at least two identifiers before administering medications.

Guidelines

Client identifiers include identification wrist bands, verification protocols, double witnessing, client identification cards, and client barcodes. The client's room number should not be used for identification purposes.

Test(s) for Compliance

- 18.2.1 Service providers use at least two client identifiers before administering medications.



Safety

- 18.3 Service providers have access to the client's medication administration record for reference during drug administration.

Guidelines

Exceptions include when the client is in isolation or for other infection control-related reasons.



Safety

- 18.4 Service providers verify the medication's accuracy before administration.

Guidelines

The verification of accuracy is done by checking the order vs. label, the expiration date and visual integrity, and confirming there are no obvious contraindications.



Safety

- 18.5 Service providers seek an independent double check before administering high-risk medications.

Guidelines

The independent double check may include verifying the drug, drug concentration, rate of infusion, client/patient identity, and line attachment. The independent double check may also be through the use of a barcode.





Safety

18.6 The organization follows standard times for scheduled drug administration.



Safety

18.7 Before administration, service providers validate that medication is given at the proper time, at the prescribed dose, and by the correct route.



Effectiveness

18.8 The appropriate service provider documents the time of administration in the client record as soon as possible after administration.



Safety

18.9 Service providers address any medication-related concerns with a physician or pharmacist and follow established guidelines for notifying the prescribing medical professional of adverse drug events.



Effectiveness

18.10 The organization tracks lot numbers to identify and inform providers when a client has received recalled medication.

19.0 The organization reduces the risk of error through careful procurement, maintenance, use, and standardization of medication delivery devices.



Safety

19.1 The organization reviews, through a proactive risk assessment process, the error potential for all new medication delivery devices.

Guidelines

The risk assessment process may include Failure Mode and Effects Analysis (FMEA). The results of the assessment should be seriously considered and addressed before a decision is made to purchase and use any delivery device.



Safety

19.2 The organization limits the variety of general-purpose infusion pumps, syringe pumps, and PCA pumps available internally or at its sites.

Guidelines

Limiting the variety of equipment should maximize competency with their use.



Effectiveness

19.3 The organization establishes and follows criteria to determine which client populations, specific medications, and rates of infusion require delivery of solutions via an infusion control pump.





Safety



- 19.4 **REQUIRED ORGANIZATIONAL PRACTICE:** The organization provides all staff and service providers with ongoing, effective training on all infusion pumps.

Guidelines

It is the organization's responsibility to offer ongoing, effective training to all service providers and users on all infusion pumps. The training includes factors such as staff competency, staff continuity, infusion pump technology, and the physical location of the pumps (e.g. hospital, community, home).

This training is particularly important given the number of service providers (mostly nurses) who work at more than one health care organization. These providers may need to be competent in the use of numerous types of infusion pumps.

Test(s) for Compliance

- 19.4.1 There is documented evidence of ongoing, effective training on infusion pumps.



Safety

- 19.5 The organization's service providers use commercially-prepared premixed IV solutions whenever they are appropriate and available on the market.



Safety

- 19.6 Wherever possible, service providers use manufacturers' pre-filled syringes for injectable products.

Guidelines

Pre-filled syringes should be used rather than vials or ampoules.



Safety

- 19.7 The organization minimizes the use of multi-dose vials.

- 20.0 The organization monitors clients following medication administration.



Effectiveness

- 20.1 The organization's service providers monitor the beneficial effects of medication on clients.

Guidelines

Beneficial effects may include the client's own perceptions, laboratory results, vital signs, and clinical response/efficacy.

Research has shown that failure to adequately monitor the clinical effects of medications can compromise client safety and increase the risk of medication-related adverse events.



Safety

- 20.2 Service providers monitor clients for possible and actual medication-related adverse events.

Guidelines

The identification and response to possible adverse events may be promptly identified by alarms on client monitoring systems. Evidence has shown that client safety may be seriously compromised by turning off/disabling alarms on monitoring equipment.





Effectiveness

20.3 Service providers document all medication-related effects in the client record.

MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

21.0 The organization has a coordinated risk management program to reduce medication-related errors and sentinel events.



Effectiveness

21.1 The organization's risk management program is supported by senior management and the governing body.



Safety

21.2 The organization's error prevention strategies target the system, not the individual.

Guidelines

The organization's risk management program and error prevention strategies should emphasize shared accountability.



Effectiveness

21.3 The organization uses a drug use evaluation (DUE) process for medications with heightened error potential.

Guidelines

This process should monitor compliance and success with established prescribing, administering, and monitoring safeguards.



Safety

21.4 The organization has a policy and process for reporting medication errors and hazardous situations in a timely way.

Guidelines

Potential adverse events and hazardous situations that have the capacity to cause harm should be given the same priority for analysis and error prevention strategies as errors that actually cause client harm. This information will be used to design and implement systems to support safe medication administration and provider performance.

The policy and process should define to whom medication errors must be reported, such as appropriate internal and external parties.



Safety

21.5 The organization considers as reportable errors hazardous situations that could lead to an error, in addition to actual errors.

Guidelines

Reported events may also include those that have been detected and corrected before they reach the client.



Safety

21.6 The organization establishes a multidisciplinary group to investigate and review all medication-related sentinel events and medication error summary reports.

Guidelines

Multidisciplinary group members may include risk management/quality improvement professionals, pharmacists, nurses, physicians, and senior management.

The review of sentinel events may consist of a root cause analysis or another similar process.

The multidisciplinary group review may also include analyzing and using published error experiences from other organizations to proactively target improvements in the medication use process.





Worklife

- 21.7 The multidisciplinary group includes service providers who are directly involved in the medication error in the review process.

Guidelines

Participation from service providers may include providing information to support a root cause analysis, and recommending system enhancements to reduce the potential for future errors.

Client-centred
Services

- 21.8 The organization discloses in a timely way medication-related sentinel events involving clients to the clients and their families.

Guidelines

Sentinel events and medication errors should be disclosed regardless of whether or not the client is harmed. The process for disclosure is consistent with the organization's processes for disclosing other errors and sentinel events.



Effectiveness

- 21.9 The organization uses the findings of the sentinel event investigation/review to identify and implement improvements.



Effectiveness

- 21.10 The organization provides service providers with regular feedback about reported errors, hazardous situations, and error reduction strategies that are being implemented.

- 22.0 The organization regularly monitors and evaluates the quality of the medication management and pharmacy system.



Effectiveness

- 22.1 The organization selects and monitors process and outcome indicators for medication use and medication management.

Guidelines

The indicators should include medication management risk points.



Efficiency

- 22.2 The organization monitors medication use with an ongoing utilization review.

Guidelines

The utilization review should also address using medication in accordance with legal requirements and standards of practice.



Effectiveness

- 22.3 The organization carries out an internal quality control program for the pharmacy.

Guidelines

The quality control program should include participation in an external quality control or accreditation program.



Effectiveness

- 22.4 Based on the data collected and analyzed, the organization identifies and addresses areas for improvement.

Guidelines

Data collection may also include reviewing literature for best practices and new technology.

