Institute for Safe Medication Practices Canada
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A KEY PARTNER IN
CMIRPS Canadian Medication Incident Reporting and Prevention System
SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

ISMP Canada Safety Bulletin

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Strategies for Safer Telephone and Other Verbal Orders in Defined Circumstances

Medication orders (prescriptions) conveyed verbally by telephone or in person are prone to errors. Problems can arise if a medication order is miscommunicated, misheard, or incorrectly transcribed. ISMP Canada encourages the use of written orders, including electronic orders, to prevent medication errors.[1] However, the current pandemic has increased the need for and frequency of telephone and other verbal orders. This bulletin shares recommendations for practitioners to minimize the risk of errors when communicating medication orders verbally.

INCIDENT EXAMPLE

Temporary changes in federal legislation now permit the use of telephone orders for controlled substances. A community pharmacy reported to ISMP Canada that a miscommunication in a telephone order for hydromorphone led to dispensing of the oral liquid formulation instead of the intended injectable formulation. The oral product was injected by a home care nurse, which resulted in harm to the patient.

ISMP Canada has published several bulletins describing medication errors associated with telephone and other types of verbal orders.[2-5] Various contributing factors have been identified, including sound-alike drug or patient names, similar-sounding numbers, a practitioner's use of unfamiliar terminology or acronyms with multiple meanings, background noise and other factors affecting reception clarity, workflow disruptions, and caregivers' lack of familiarity with individual patients and their needs.[6,7]

RECOMMENDATIONS FOR COMMUNICATING TELEPHONE AND OTHER VERBAL ORDERS[6,8]

ISMP Canada continues to recommend the use of written orders, including electronic orders, as preferred practice. However, when this is not feasible, the following safe practices are provided.

Practitioners who are prescribing medications[6,9]

- Allow sufficient time to state the order clearly ***and for the person receiving it to read it back***.[8,10]
- State your name, licence number, and contact information.
- Say and then spell out the patient's name and provide a second identifier (e.g., address, birth date).
- Incorporate all the elements of a complete medication order, including drug name, dosage form, dose and strength (if applicable), route of administration, directions for use, and quantity to be dispensed and/or duration of therapy; for prescriptions that are given to community pharmacies, also provide the number of refills and/or the refill interval.
  - Communicate drug names by first saying and then spelling them out. Provide both the generic and brand names, especially for recognized ***look-alike, sound-alike medication pairs***.[11] It may be helpful to use a phonetic alphabet to distinguish between sound-alike letters (e.g., "m" as in Mary or "n" as in Nancy).

- Explicitly state the indication for the drug, to reduce the risk of misinterpretation.
- Communicate numbers using two different approaches. For example, because the number 15 can easily be misheard as 50, a prescription for "15 mg" should also be communicated as "one-five-milligrams".
- Fully verbalize all instructions, avoiding any abbreviations. For example, replace "BID" with "twice a day", and replace "PO" with "by mouth" or "orally".
- Include the patient's weight for pediatric patients and for all weight-based medication orders.

Practitioners who are receiving prescriptions and medication orders[7,9]

- Obtain the prescriber's name, licence number, and contact information at the start of the call.
- Immediately transcribe or enter the medication order into its permanent record (e.g., patient chart, pharmacy hard copy and/or profile) to facilitate accurate documentation of the prescription. Delaying this documentation step can contribute to erroneous transcription.[8]
- Ask the prescriber to state the indication for use of the medication, if it is not provided as part of the order.
- Clarify any ambiguous aspects of the prescription.
- Read the complete order back to the prescriber as documented, for verification and to catch any errors (the "read-back" technique).
- Request confirmation from the prescriber that the read-back matches the intended order.

CONCLUSION

Although telephone and other verbal orders are known to be susceptible to error, they may be necessary in some circumstances. Good communication practices, especially use of the read-back technique, can help to mitigate risk. This bulletin is provided as a reminder of safety practices for communicating telephone and other verbal orders.

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COVID-19: Updated Requirements for Post-Consumer Returns


THE CONTROLLED SUBSTANCES BULLETIN

PRODUCED BY THE OFFICE OF CONTROLLED SUBSTANCES

April 22 2020

This bulletin provides pharmacists with information on temporary exceptional measures for post-consumer returns containing controlled substances.

COVID-19 – Updated to Requirements for Post-Consumer Returns Containing Controlled Substances

In response to the evolving health risk posed by the COVID-19 pandemic, the Office of Controlled Substances (OCS) is taking temporary measures to reduce the likelihood of spreading COVID-19 between consumers and pharmacists when returning products that may contain controlled substances to a pharmacy.

Firstly, in instances where pharmacists choose not to accept returns during this time, they should advise consumers on the proper storage of these products in their homes until such time that they can be safely returned to the pharmacy. Ideally, products that contain controlled substances should be locked and kept out of reach of children.

Should pharmacists choose to continue accepting post-consumer returns during this time, the OCS has recommendations to allow for reduced contact between consumers and pharmacists when returning products that may contain controlled substances to a pharmacy.

Pharmacists are still required to do their best to ensure post-consumer returns containing controlled substances remain secure.

The following recommendations may be considered by pharmacists to help reduce the risk of spreading COVID-19:

Health Canada / Santé Canada

Canada

Health Canada's Office of Controlled Substances published a bulletin to provide pharmacists with information on temporary exceptional measures for post-consumer returns containing controlled substances to reduce the likelihood of spreading COVID-19 between consumers and pharmacists.

In instances where pharmacists choose not to accept returns during the pandemic, they should advise consumers on the proper storage of these products in their residences until the pharmacy resumes accepting returns. Ideally, the medications should be stored in a locked cabinet and kept out of reach of children.

In cases where pharmacists choose to continue accepting post-consumer returns, reduced contact between the consumer and the pharmacist must be maintained:

- A tray or basket can be provided to the consumer while maintaining the appropriate physical distance. Pharmacy staff can then empty the tray into the post-consumer returns bin, while taking all necessary precautions, such as wearing gloves, handwashing, and disinfecting the tray or basket.
- Once the returns bin is full, the pharmacist should follow existing guidelines regarding the destruction of these products.

Pharmacists are also reminded to follow the directions of the Public Health Agency of Canada regarding safety measures to help contain the spread of COVID-19, especially as information evolves about the viability of the COVID-19 virus on containers, bins, or cartons. The primary source of information on COVID-19 is canada.ca/coronavirus.

ISMP Canada was grateful to have the opportunity, along with the Health Products Stewardship Association (HPSA), to share information with Health Canada to help inform the development of these temporary measures. The complete bulletin from the Office of Controlled Substances is available here: healthsteward.ca/wp-content/uploads/2020/04/Post-consumer-returns-bulletin_revised.pdf

Intravenous Tubing Extensions to Preserve Personal Protective Equipment

In an effort to conserve personal protective equipment (PPE), hospital staff have found various ways to reduce the need to enter the rooms of patients who have COVID-19. These strategies include virtual meetings, combined administration of intravenous (IV) medications (when the drugs are compatible), and use of IV tubing extensions to keep pumps outside patients' rooms.

The use of IV tubing extensions is the most complex of these strategies. In a recent newsletter, the Institute for Safe Medication Practices (US) described the experiences of 2 hospital practitioners who have used this strategy.[1] As with any change to an established process, the risks need to be carefully considered, and ISMP Canada has already received a report about concerns related to this practice. In addition to the potential risks, there are technical aspects to be considered when such changes are contemplated, as described in a report by the ECRI Institute.[2] These technical considerations include the effect of added tubing on the flow rate, required changes to priming and flushing, and the effect of flow rates on occlusion alarms.

With so many factors affecting the successful delivery of medications through extended tubing, each situation must be carefully analyzed to determine whether the anticipated benefits outweigh the potential unintended risks. With the ever-changing environment of the COVID-19 pandemic, it is likely that supporting guidance will continue to evolve.

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Canadian Medication Incident Reporting and Prevention System
Système canadien de déclaration et de prévention des incidents médicamenteux

The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.

HIROC

The Healthcare Insurance Reciprocal of Canada (HIROC) provides support for the bulletin and is a member owned expert provider of professional and general liability coverage and risk management support.

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The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

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