NH Medication Safety & Quality Newsletter

Issue 8 - Fall 2019

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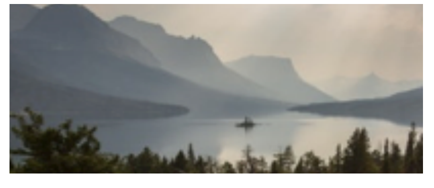


Heparin Drug Shortage Update: For Your Information

Managing drug shortages is an issue that continues to challenge NH Pharmacy Services. Drug shortages are caused by various circumstances such as failure of manufacturers and facilities to meet industry standards, supply shortages of active pharmaceutical ingredients (API), and other quality control issues.

One drug shortage that has recently received attention on a global scale is that of the anticoagulant medication, heparin. Heparin is an injectable drug commonly used for prophylaxis and treatment of venous thromboembolism for inpatients, especially for patients who also have reduced renal function. The issue is that the API for heparin is derived from pig intestine, and a recent outbreak of African swine fever in China has caused concerns about potential shortages of the API globally. While some manufacturers do rely on China as a major supplier of API for their product, there are other manufacturers that source their API from elsewhere.

What does this shortage mean for NH? Right now, there does not appear to be any approaching impact to patient care in Canada as the supply is able to meet demand. However, as with all relevant drug shortages, NH Pharmacy Services is monitoring the situation and will provide communication to NH staff on mitigation strategies and alternate medications if there is any sign of future impact to patients in NH.

10-110-6084 (IND Rev. 09/19)

Basaglar® and Lantus® Mix-Up and Sharing: Patient Incident

A recent patient incident occurred in NH where a patient was prescribed Basaglar® insulin in hospital and was using more than 1 insulin pen per day. Unfortunately, due to an error in refill alerts and absence of education, the patient was given Lantus® when the Basaglar® insulin pen was empty. This led to the patient receiving both Basaglar® and Lantus® intermittently without consultation with a prescriber or requests for additional insulin pens, until the error was identified. Since Basaglar® is biosimilar to Lantus® but not considered an exact generic equivalent, it is not advisable that patients are frequently changed back and forth between these brands at this time.

Additionally, staff are reminded that sharing insulin pens between patients is a **significant safety concern**. ALL insulin pens are patient-specific and should NEVER be shared.

Key learning points:

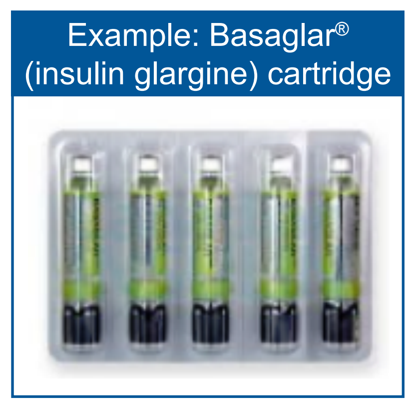
- Identify gaps in refill reports so wards always have patient-specific stock (resolved)
- Ensure staff are aware that Lantus® and Basaglar® are not automatically interchangeable and the patient should always receive the brand they are prescribed unless discussed with the prescriber
- Ensure all sites have after-hour stock of Basaglar® in one location and staff are aware of where to find the additional stock should they run out of supply when the pharmacy is closed or if they do not have a pharmacy on site
- Require staff to complete the Learning Hub Module NHA – CL - Insulin Pen Instructions for Use: BASAGLAR® Kwikpen that provides education on Basaglar® and its use in Northern Health to prevent similar medication safety incidents
- Reiterate ONE patient for ONE pen. Staff should **never share** insulin pens due to the significant risk of blood-borne pathogen cross-contamination amongst patients, even with a new needle. The backflow of blood into the insulin pen itself does not make it safe to EVER share insulin pens.

If there are further questions regarding this matter or educational materials available to staff, please contact the Medication Use Management pharmacists or your local Pharmacy Manager.

Insulin Administration: Prevention Patient Harm

Insulin doses must NEVER be manually withdrawn out of an insulin pen cartridge with an insulin syringe for administration.

Example: Basaglar® (insulin glargine) cartridge



NOT CORRECT

Withdrawing doses from an insulin pen cartridge is NOT recommended by manufacturers and has led to dosing ERRORS.

Northern Health Look-Alike Sound-Alike (LASA) Medications List – New Tools

Medication Safety team and front line Pharmacy Teams collaborated to tackle a LASA list that would be specific to NH medication practices for the following:

- Generic drug names only as is standard throughout NH computer generated and preprinted documents
- Canadian drug names only unless a Special Access Program medication.
- Drugs which have been found to be error prone in NH are identified by the White on Black lettering employees and staff will see on some of the preprinted documents i.e. narcotic book HYDROmorphone.

The complete lists can be found on Document Source under order numbers:

10-110-6114 Look-Alike Sound-Alike Drug Name Medications List

10-110-6115 Look-Alike Sound-Alike Drug Name Medications List Cards

Both will be a polyester laminated documents for durability and can be wiped down when needed. The complete 'List' is in a backwards and forwards mirror format for alpha search ease. The short 'List Cards' are separate for posting in storage areas and are not mirrored.

Narcotic and Controlled Drug Record – New Tools

You may notice in the coming days some adjustments in the Narcotic and Controlled Drug Records. The changes are to help guide nurses, pharmacy staff and auditors in meeting the requirements for narcotic and controlled drugs record keeping.

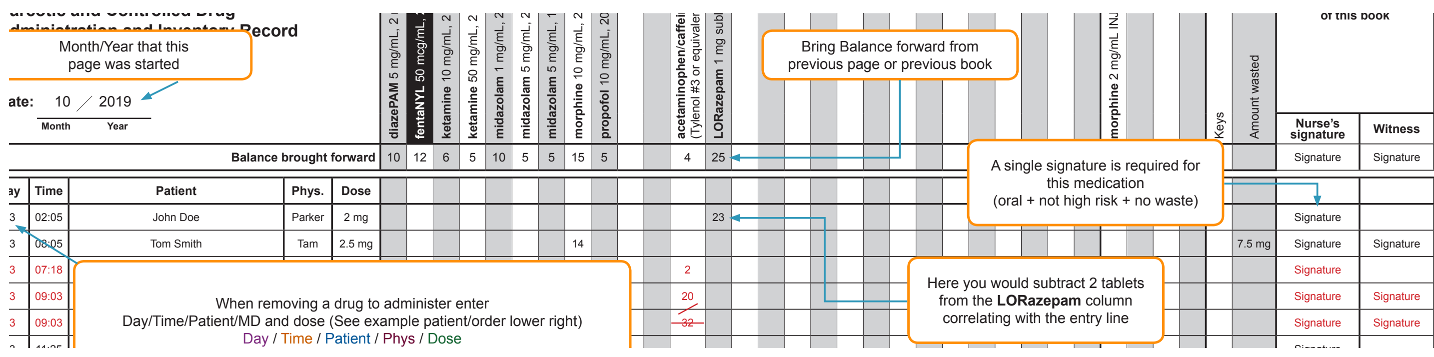
In addition to the changes in the narcotic book template, additional documents have been created with further details to have on hand for reference tools for current and new staff.

The **Narcotic Book Teaching Tool** (10-110-6118) has some detailed tasks that are commonly required on a day to day basis with action processes for each of the items you will come across. Example below:

Narcotic Book Teaching Tool

Need to Complete	Action Process
Carry forward balances from previous book and previous pages	• Add the month/year to upper left hand date field on the new page (you will only need to add the day to the columns below). • In **black ink** add in the quantities of the inventory on hand. • Double check all your entries are in the correlating medication lines in the Balance brought forward row. • A witness will need to sign for bringing balances forward from a previous book ***Or*** • If adding to a new page in the same book a witness signature is not required
Removing stock for administration	• In **black ink**, add the day, time, patient name, physician and dose. Note: dose is either the number of mcg or mg. ***Only exception***: a combination product can be written as i.e. 1 tab. • Adjust the quantity in the correlating column to the medication you are removing i.e.: quantity on hand 25 and

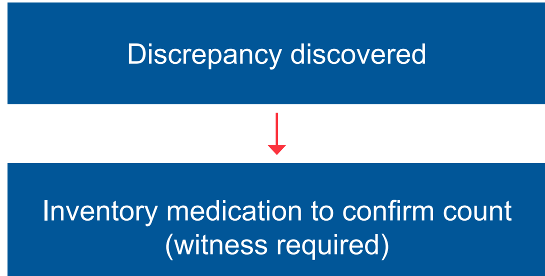
Narcotic Book Workup – Making Entries (10-110-6108) is a visual aid of how to complete the record to meet requirements with entry examples such as below:



In the event of narcotic or controlled drug discrepancy Decision Tree's are available for **Pyxis** (10-110-6116) and **Non-Pyxis** (10-110-6117) users to assist in the next steps upon discovering the discrepancy. Example below:

Narcotic and Controlled Drug Discrepancy Decision Tree

Narcotic Counts Every Shift for Non-Pyxis Wards



High Risk High Alert – Labelling and Storage – New Tool

Often questions have arisen regarding the labelling and storage of high risk/high alert (HRHA) medications. **A High Risk High Alert Labelling and Storage Chart** (10-110-6120) was created to help dispel confusion regarding labelling and storage requirements for medications that could cause severe harm or death if given incorrectly or in error to a patient. This tool will be useful to pharmacy and nursing staff who provide or access pharmaceutical inventories. Example of one item below:

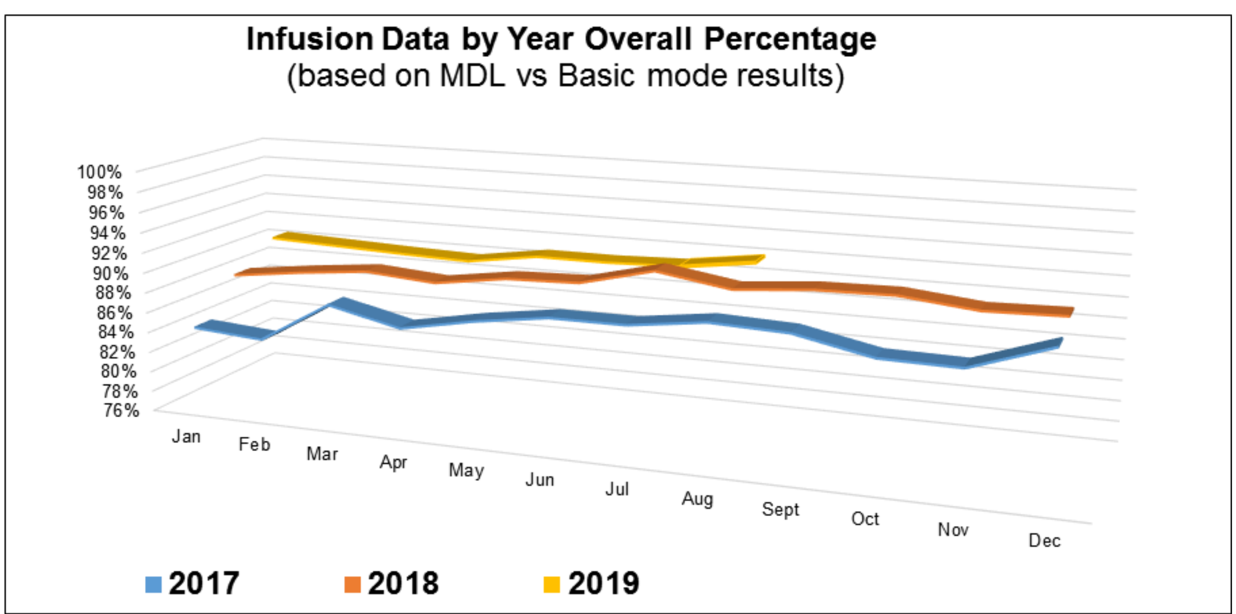
Concentrated Electrolytes/Solutions:	Labelling on drug	Labelling on Bins or Bags	Wardstock	Variance
calcium (all salts): concentrations greater than or equal to 10%	HIGH ALERT DOUBLE CHECK *	HIGH ALERT DOUBLE CHECK *	Red bin or flagged with red tape on the Pyxis cubby inside or out	Required with the exception of Prefilled Syringes Variance Request: 10-110-7018
dextrose hypertonic, 20% or				

You can order the new tools listed above individually by their document number or all of them in the complete bundle (can be added to a key ring for simple storage solutions).
Acute Care Collection: 21129 • Long Term Care Collection: 21130

Alaris Infusion Pump Statistics

The Medication Safety Team tracks the progress of all the acute care NH facilities using the Alaris Infusion Pumps. The target for the MDL use is 90% or greater. Anything less than 80% is considered unsafe and warrants action to improve practice.

June 2018 saw the first time NH overall average hit targets. Target has been reached a total 10 months over the last year.



Thank you to all those who have dedicated themselves to their improved use of the MDL and Nursing Leadership for continually sending the message out to staff to use the Guardrails Drug Library and the Guardrails IV Fluid library.

As new medications or changes in existing medications become available there may be the rare time that a medication is not built into the MDL library or not built for a new recommended concentration or rate. You may need to use the Basic infusion option in this instance.

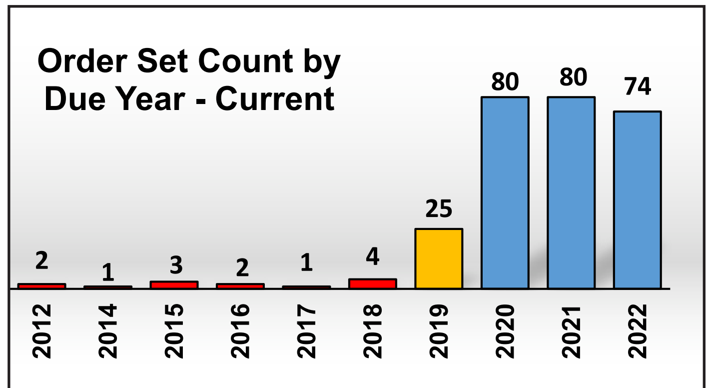
If you need to run an infusion in Basic mode, afterwards you can add a new or adjust an existing medication in the MDL by completing the fillable PDF IV Drug Library Feedback and Change Request form and clicking the e-mail button once you have completed the fields. This will be evaluated by the Medication Safety and Quality team for addition to the MDL.

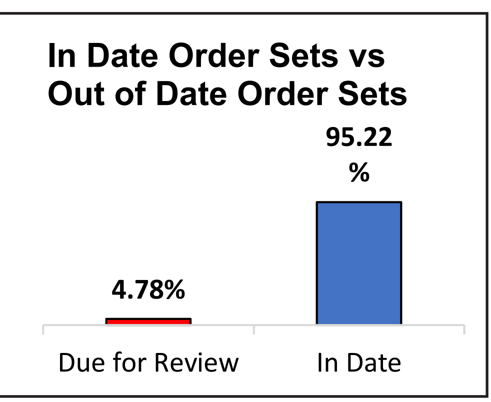
E-learning modules are available on the Learning Hub for new staff and to support ongoing Infusion Device Competency Validation.

If you have any questions or barriers to using the MDL please contact any one of the members of the following Medication Safety team members Carey-Anne.Lawson@northernhealth.ca; Arlene.Crawford@northernhealth.ca; Nicole.Dahlen@northernhealth.ca

Order Set Updates

Incredible progress has been made in Order Set Clean-Up. The Medication Safety Team thanks all those who have participated in the creations and reviews as we move forward. It could not have happened without a consistent collaborative effort from all sites and all disciplines across NH!





Contact us: Medication Safety and Quality Team

- Arlene Crawford – Regional Medication Safety Officer – Registered Nurse
- Nicole Dahlen – Regional Medication Safety & Informatics – Pharmacist
- Carey-Anne Lawson – Regional Clinical Application Analyst – Pharmacist
- Jessica Brecknock – Regional Medication Use Management – Pharmacist
- Ryan Doerksen – Regional Medication Use Management – Pharmacist
- Stefan Krampe - Regional Manager Pharmacy Solutions – CIS Pharmacy
- Kendra Clary – Regional MedSystems – Pharmacy Technician

DID YOU KNOW?

1 in 18 Canadian hospital patients experience harm from preventable errors (5.6%)