Department/Category	Nursing, Pharmacy
Policy Name/ Unit Number	Medication Safety, Required Organizational Practices (ROP)
Location	Clinical Practice Manual
Approval Committees	☒CPC: November 6, 2020 ☒NAC: November 26, 2020 ☐MAC: Click here to enter a date. ☐P and T: Click here to enter a date. ☐Board of Trust: Click here to enter a date. ☐Senior Team: Click here to enter a date. ☐Patient and Family Advisory: Click here to enter a date. ☐Ethics: Click here to enter a date. ☒Patient Safety: November 16, 2020 ☐Quality Committee of the Board: Click here to enter a date.
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Staff Development/ Pharmacy	May 2008	October 2020	November 2020	

Introduction:

Woodstock Hospital is committed to providing patients with safe and effective care. We will ensure our medication system meets Accreditation Canada standards and strive for excellence in medication safety.

Protocol:

Required Organizational Practices Affecting Medication Use:

1. Antimicrobial Stewardship

A comprehensive, inter-disciplinary, evidence based antimicrobial stewardship program (ASP) is established that has developed a number of interventions based on local antimicrobial use and available resources. Antimicrobial Stewardship rounds in Critical Care are to take place weekly and data gathered through Cerner reporting is reviewed by the team. Discussion during rounds should include patient condition, current therapy in place, choice of antibiotic, dosing, route, duration and therapy currently in place. The report is to be distributed to pharmacy, Laboratory Services, Infection Prevention and Control and the Critical Care Unit. All antibiotic orders are to be reviewed by a pharmacist during the verification process, reviews with the prescriber or creates a clinical intervention for orders that may be 'suspect' in relation to dosing or antibiotic choice . There are several pharmacist activities like automatic renal dosing adjustments and ordering of serum drug levels that optimize antibiotic treatments

empirically. The ASP chair will maintain evaluative information of the program within the shared ASP drive for committee members to review

2. Concentrated Electrolytes
   The pharmacy department will evaluate and limit the availability of concentrated electrolytes to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas. This includes ensuring concentrated potassium salts, and sodium salts are not stored in patient care areas. In addition, other concentrated electrolytes such as magnesium sulphate, calcium gluconate and calcium chloride will only be kept in areas requiring these medications with precautionary measures in place to minimize risk. The choice of a concentrated electrolyte is verified by the pharmacist to ensure safe route (i.e. peripheral vs. central) and infusion duration is ordered.
3. High Alert Medications
   Oversight of managing high alert medications is the responsibility of the Pharmacy Department. The policy is to be reviewed every 3 years and revised as needed when new evidence emerges. Pharmacy works collaboratively with the staff development educators to ensure education is provided to the clinical team to ensure safe medication practices are followed to reduce risk. Strategies include standardized concentrations, using smart pump technology, warning labels, limiting high risk medications, providing training and independent double checks by both pharmacy and nursing. A high alert drug chart is located on the Artery as a Medication Resource that outlines strategies in place to ensure safety. When new technology is introduced (e.g. replacement of Unit Based Cabinets, Cerner enhanced functionality and infusion pump technology), evaluation of functionality should include a focus on ease of capturing and documenting independent double check processes. Change requests to the Master Drug Library (MDL) in relation to high alert medication will be managed through the MDL Committee to ensure requests are reviewed and evaluated in a safe and thoughtful manner before approval. Audits will be conducted by the pharmacy team to review safe storage practices, scanning compliance audits and monitoring of specific drug classes (e.g. oral anticoagulants). High alert medications are to be included as a standing agenda item for the Pharmacy and Therapeutics committee. Requests for additions to the hospital formulary are managed through the Pharmacy and Therapeutics committee and strategies are in place to ensure high alert medication lists are maintained and updated accordingly when changes are made.

4. Medication Concentrations
Having multiple concentrations or strengths of the same medication available increases the risk that clinicians will select, dispense, or administer the wrong concentration. Therefore the pharmacy department will work to minimize the number of different concentrations available at WH and to standardize these concentrations across the organization. Drugs would include but not be limited to injectable narcotics, anticoagulants including Heparin and low molecular weight heparins, CNS agents like Ketamine and Midazolam. When managing backorders, the introduction of an alternate concentration is carefully considered, communicated to affected staff and labelled to highlight the change.

5. Infusion Pumps Training
All employees, including students, who are required to use infusion pumps, must receive initial education and training during nursing orientation with ongoing training on the proper use of these devices occurring based on the schedule outlined in the Clinical Practice Manual Infusion Pump Management Policy located in Unit 9. This policy is reviewed every 3 years and revised as needed when emerging best practices or changes to the pump are required.

a. PCA/PCEA infusion pump – (for areas currently using): the quiz and skills checkoff list must be completed upon hire, return from extended leave and renewed annually to maintain competency. Just in time education will be provided for areas not currently using PCA as the need arises. This will be evaluated regularly to ensure safe patient care.
b. IV infusion pump – the education and skills checkoff list must be completed upon hire and return from extended leave to maintain competency. Biennial recertification will occur throughout the organization to maintain competency
c. Belmont Rapid Infuser - The associated e-learning and quiz must be completed upon hire, return from extended leave and renewed annually to maintain competency. A video is available on the Artery located in Clinical Resources under Surgical Services
d. Syringe pump - Certification must be completed upon hire, return from extended leave and renewed annually to maintain competency

Further, the hospital will work to standardize infusion pumps across the organization to reduce the number of devices that staff need to be trained on. When new equipment is required the MDL committee will be consulted in the evaluation of new devices to ensure consistency and safety in maintaining drug libraries and auditing capabilities.

6. Two Patient Identifiers

All employees, including students who administer medications to patients at WH, must use at least two patient identifiers before administering medication. The patient is asked to state their full name and date of birth. This information is verified by checking the patient's armband. Also scanning of patient ID band before medication administration is an expected practice to ensure that the right

patient is receiving the right medication at the right time based on the medication administration record. (ED and OR). Monthly patient and medication scanning audits by users are sent to Clinical Directors. The hospital maintains a policy related to two client identifiers which is reviewed and revised as needed every 3 years.

7. Heparin Safety
   The pharmacy department will evaluate and limit the availability of heparin (unfractionated and low molecular weight) products to ensure that formats and concentrations with the potential to cause harmful medication incidents are not stocked in client service areas. Where possible pharmacy will provide ready-to-use unit dose formats of Heparin products. An Independent Double check is required for the initiation and dose adjustments for administration of IV Heparin. Staff are to follow the policy as outlined in Unit 9 of the Clinical Practice manual located on the Artery.

8. Narcotic Safety
   The pharmacy department will evaluate and limit the availability of narcotic products to ensure that formats with the potential to cause harmful medication incidents are not stocked in client service areas. This includes removing high dose, high potency formats from patient care areas. Where possible pharmacy will provide ready-to-use premixed solutions for narcotic infusions. Tallman lettering is used on all labeling. Independent double checks are in place in both the preparation and administration of continuous narcotic products. Random narcotic tracers are performed by pharmacy with quarterly reports forwarded to Medication Safety Committee and Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutic committee will be responsible for reviewing and approving limited use and availability of narcotics for clinical care to minimize risk of error. The policy for Narcotic, Controlled Drugs and Targeted Substances dispensed for the Unit Based Cabinet is to be reviewed for revisions every 3 years or as emerging best practices are identified.

9. Medication Reconciliation at Care Transitions

   Medication Reconciliation processes are to be followed as per the Medication Reconciliation policy found in the Clinical Practice Manual- Unit 5 on the Artery. The policy will be reviewed every 3 years or sooner should emerging best practices be identified. With the involvement of the patient, family or caregiver, a Document Medication by History will be updated and completed in Powerchart and used by the provider to reconcile the patient's medications at transitions of care. Upon admission to the organization, a patient's home medications will be collected with the involvement of the patient and or SDM including information about compliance and sources of the information. Admission medication reconciliation is a way to document and communicate changes to medication therapy upon admission to hospital

   Upon transfer to another service within WH, or to an external organization, or discharge, a patient's medications are to be reconciled, with the involvement of the patient. Medication reconciliation is a way to collect and communicate accurate information about patient medication. The goal of medication

reconciliation at end of service is to reconcile the medications the patient was taking prior to admission with those initiated in hospital and with those that should be taken at end of service. Poor communication about medication at transition points can cause errors and adverse events. Medication reconciliation is a shared responsibility, which must involve the patient or family. The Medication Safety committee monitors compliance through regular Medication Reconciliation audits and improvements which are then shared through the Pharmacy and Therapeutics Committee, Patient Safety Committee and Quality Committee to the board.

10. Do Not Use Abbreviations

All providers and clinicians, including students, are to comply with the Abbreviations and Symbols – policy found in the Clinical Practice manual Unit 1 (located on the Artery) and corresponding list of abbreviations, symbols, and dose designations that are not to be used in the organization. All medication orders must comply with the abbreviation list. Although there are no dangerous abbreviations in the order sentences within Powerchart, free text information in communication orders or comment fields must not contain any dangerous abbreviations, symbols or dose designations as outlined in the policy**.** Random audits of communication orders are performed monthly by members of the Medication Safety Committee. The compliance is shared through the Pharmacy and Therapeutics Committee, Patient Safety Committee and Quality Committee to the board.

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Responsibility:	Director of Patient Care/Director of Pharmacy
Reference:	1) Accreditation Canada ROP Handbook 2020
Cross Reference:	1) Accepted Abbreviations and Symbols- Clinical Practice Manual (CPC): Unit 1 2) Medication Reconciliation- Unit 7 CPC Manual 3) High Alert Medications Independent Double Check- Unit 7 CPC Manual 4) Infusion Pump Management- Unit 9 CPC Manual 5) Patient Safety: Two Patient Identifiers- Management Methods Manual 6) Continuous IV Heparin Dose Adjustment-Unit 9 CPC Manual 7) Narcotic infusion-Intermittent and Continuous-Unit 5 CPC Manual 8) Narcotic and Controlled Drugs-UBC- Unit 5 CPC Manual