

Hospital access to PharmaNet

Expanded access means better patient care

Hospital access to PharmaNet (HAP) is the latest offering from the province's eHealth initiative. Authorized pharmacists and other health professionals working in hospitals and designated mental health facilities can use PharmaNet to access patient medication histories just as community pharmacists do. Access to this new service will vary based on the priorities and plans of each health authority or hospital/facility.

For more information, visit one of the following sites.



Ministry of Health HAP policies and procedures – www.health.gov.bc.ca/das/hap.html

HAP compliance standard documents – www.health.gov.bc.ca/das/index.html

Perinatal exposure to drugs

New guide complete resource for health professions

CAMH (The Centre for Addiction and Mental Health) and the Motherisk program (Hospital for Sick Children, Toronto) will soon offer a new publication of interest to pharmacists.

Perinatal Exposure to Psychotropic Medications and Other Substances: A Handbook for Health Care Providers covers safe use and risks associated with medications and substances taken during pregnancy and breast-feeding. It is available at no cost.

Scheduled for publication in May 2007, the handbook can be ordered by contacting CAMH (see website listed). This comprehensive guide includes information on:

- Pregnancy myths and facts, and the use of psychotropic medications and substances.
- Key principles of caring for women with substance use or mental health issues.

what went wrong

Dear College:

Last week, the pharmacy delivered a blister pack for my sister containing Clozaril® 100 mg tablets in error, instead of Clozaril® 25 mg tablets.

My sister normally takes six Clozaril® 25 mg tablets at lunchtime. Shortly after taking her lunchtime dose last Monday, she told me that something was wrong; she was not feeling well and was unable to stay awake. I checked the blister pack and upon close examination, I realized the tablets dispensed looked different than expected. I had been given Clozaril® 100 mg tablets instead of Clozaril® 25 mg tablets, and took six of them for a total dose of 600 mg.

How could the pharmacist have made such a mistake? The label on the blister pack clearly read, "Clozaril® 25 mg" yet Clozaril® 100 mg tablets were put in the blister pack.

Concerned about Clozaril®

The pharmacist involved could not explain why this error occurred and described that his usual blister pack checking procedure involves:

1. Checking the prescription labels against the patient's blister pack medication summary sheet to make sure that the right medications are being dispensed.
2. Confirming that the number of tablets in each time slot matches the number indicated on the patient's blister pack medication summary sheet.

Steps this pharmacist can implement to prevent this type of incident from happening again:

- Use a checking system to compare the DIN on the inventory container with the DIN on the computer-generated label.
- Perform a visual check during the final checking process. Rather than relying on memory, compare the contents of the blister pack with the contents of the stock bottle to ensure you are dispensing the correct medication. Check the colour, shape, and markings of each tablet or capsule.

Situations like the one described above provide an excellent opportunity to reflect on your personal pharmacy practice and to make sure your pharmacy has a system in place to identify, prevent, manage, and report practice errors and omissions.

- Screening for substance and medication use in pregnancy.
- Counselling and the therapeutic relationship.
- Effects of the following drugs:
 - Alcohol
 - Amphetamines
 - Antidepressants
 - Antiepileptic drugs (AED)
 - Antipsychotics
 - Benzodiazepines
 - Caffeine

- Cannabis
- Club drugs
- Cocaine
- Inhalants and solvents
- Lithium
- Other sedatives
- Opioids (including methadone)
- Tobacco (cigarettes).



www.camh.net/Publications/index.html