Pharmacist data collection

National initiative builds HR resource

The Canadian Institute for Health Information (CIHI) is starting to "fill in the gaps" and the College of Pharmacists of B.C. has a role to play. Currently, human resources data on several health-care professions, including pharmacy, is scant and varies across the country.

To address this information deficiency and to ensure national pharmacy HR data is as comprehensive as similar information for doctors and nurses, regulatory bodies like the CPBC are participating in a data-collection initiative. The goal of this process is to achieve a number of benefits, including:

- Development of national standards – the pharmacy profession will have a uniform system for collecting relevant human resources data.
- Comparable data – information collection will occur annually and be regularly maintained, providing a robust database that can be sorted and compared in a variety of ways, for instance, by region/jurisdiction.
- Availability of data – a dedicated databank will provide research opportunities and effective planning resources.
- Access to data – information free of personal identifiers will be available to regulatory bodies, professional associations, policy makers, and individuals, in accordance with CIHI privacy and information access guidelines.
- Increased profession exposure – the existence of a comprehensive database will underscore pharmacy's essential health-care role and illustrate the resources and tools pharmacists need to contribute to better patient outcomes.

CPBC registrants are an important part of this program. Beginning with January 2007 college registration renewal forms, registrants will be asked to provide information such as employment status, hours worked per week, and education level.

what went wrong

Dear college:

In July 2006, a prescription was ordered for my late father at a hospital outpatient pharmacy. He was diagnosed with a myeloproliferative disorder and was prescribed 6-mercaptopurine 50 mg, one tablet daily. However, the prescription provided to my father was 6-mercaptopurine, six tablets daily.

After starting this incorrect regimen, my father became noticeably ill. He had major fatigue, shortness of breath, and developed a chronic chest cough. While the dosage error was not the cause or reason for my father's death, and the cause of death was natural in the course of a myeloproliferative disorder, this error should not have happened.

When I contacted the doctor, he indicated the pharmacist was in error and when I contacted the pharmacist, she indicated the doctor was in error. Where did this problem originate?

Distraught daughter

The pharmacists involved report:

- On the evening of July 30, 2006, a physician called and asked if the pharmacy had mercaptopurine 50 mg tablets in stock. I replied affirmatively. Thereafter, the physician ordered "6 mercaptopurine 50 mg daily for three days, then 6 mercaptopurine 50 mg every second day for 30 doses" for the patient. I repeated back the prescription and asked the physician if he wanted "6 tabs daily for three days, then 6 tabs every second day." The physician replied affirmatively. Before I dispensed the prescription, I determined the patient had not taken this medication before by checking the local hospital pharmacy software and PharmaNet. Once prepared, the prescription was stored in a paper bag.
- At the time of pick-up, a pharmacist verified the patient's name and the name of the drug before giving it to the patient.

The hospital pharmacy manager reports the following procedural changes have been made to reduce the likelihood of a recurrence:

- Only written prescriptions for anti-neoplastic drugs will be accepted, except for hormonal therapy.
- All anti-neoplastic dosing regimes "of concern" will be verified through a regional clinical pharmacy oncology specialist before dispensing.

What additional changes could be made to avoid this incident?

1. When taking verbal prescriptions, repeat the prescription to the prescriber, enunciating clearly and slowly. Avoid stating the dose in number of tablets. Instead, state the dose in units of weight. For example, in this incident rather than saying aloud, "six tablets daily" say "300mg daily."
2. Before dispensing anti-neoplastic drugs that you are unfamiliar with, consult reference texts, such as the BC Cancer Agency *BCCA Cancer Drug Manual* – see website below – or contact the Drug and Poison Information Centre (604-682-2344 ext. 62126, info@dpic.bc.ca) if needed.
3. When appropriate, use clear plastic bags to store prescriptions awaiting pick up. If paper bags are used, remove the contents at the time of pick up to facilitate proper counselling and ensure that the right patient receives the right drug.
4. For outpatient prescriptions, supply pre-printed written materials to supplement counselling. Well-informed patients play a key role in the detection of dispensing errors.
5. Counselling needs to take place for all prescriptions dispensed, even if they are refills. Often, errors are caught during counselling before a patient leaves the pharmacy.

Go www

www.bccancer.bc.ca/HPI/DrugDatabase/default.html

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.