BC Cancer Agency
CARE & RESEARCH

BCCA PHARMACY DIRECTIVES

MODULE 2

APPENDIX 2

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BC Cancer Agency
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Provincial Pharmacy Directive

III-20-01: Pharmacist Documentation Standards	
Effective Date: Nov. 3, 2010	**Approved by: Provincial Pharmacy Professional Practice Council**
Review Date:	**Revision Date:**

RATIONALE:

All care provided to patients by pharmacists should be appropriately documented in the permanent patient record to facilitate transfer of information between health care professionals. Pharmacists should utilize a standardized, consistent approach to health record documentation to ensure the accurate and timely communication of information.

DIRECTIVE:

Pharmacists will document electronically in the permanent patient record using the transdd function of CAIS. Pharmacists will document medication therapy recommendations and clinical pharmacist interventions and activities pertaining to the care of patients in the permanent health record. The DAP (D-Data, A- Assessment, P-Plan) method of documentation will be followed.

PROCEDURES:

Medication therapy recommendations that may be documented should be related to the identification and resolution of potential or actual drug-related problems[1] (DRPs). Example of DRPs may include, but are not limited to, the following:

- Untreated indication
- Failure to receive drug
- Drug without indication
- Improper drug selection
- Subtherapeutic dosage
- Overdosage
- Adverse drug reaction
- Drug interaction
- Patient non-compliance

Clinical pharmacist interventions and activities that may be documented should be related to the optimization of medication therapy for patients. Example of clinical pharmacist interventions and activities may include, but are not limited to, the following:

- best possible medication history
- therapeutic drug monitoring
- IV to PO step down
- drug information consultation
- patient education/counseling
- seamless care activities

Precautions for health record documentation[2]

1. do not make diagnostic statements in the health record
2. do not make unreasonable recommendations (e.g. lab tests not available at your institution)
3. do not alter another health care provider's documentations
4. do not alter your documentation, rather add an addendum note to the health record at a later time as required
5. do not remove or delete any part of the health record
6. do not use health record to criticize other health care providers

7. do not add superfluous wording; use clear and concise language
8. do not use abbreviations or brand names
9. do not include unfounded conclusions or opinions

Location of pharmacist health record documentation
Documentation should be typed as free text into the Pharmacy section under Support Services in CAIS.

Verbal Communication to support pharmacy health record documentation
Urgent clinical recommendations and related clinical interventions and activities should be discussed directly with other health professionals and the patient as appropriate prior to documentation in the health record. Furthermore, health record documentation should not replace verbal communication, which is the most efficient form of communication.

Timing of pharmacist health record documentation
Health record documentation should be completed as soon as possible after the clinical recommendation is made or the clinical pharmacist interventions or activities are completed.

Format of pharmacist health record documentation
Pharmacist health record documentation should adhere to a standard, consistent format. If available and appropriate, health record documentation should include several essential elements that include, but may not be limited to, the following:

Date and Time
Title: Purpose of Clinical Pharmacist Note
Identification: Patient age, weight, height, BSA, drug, indication
Body: This should follow the "DAP" format
Closing: Printed name, degree

Description of DAP format for pharmacist health record documentation
Not all components below may be available, relevant or required. Enough information should be included for the reader to understand how the pharmacist arrived at the assessment and plan.

D – Data (groups subjective and objective data together):
Pertinent clinical information provided to the pharmacist from the patient (i.e. what the patient/others have said about the problem). As well as**,** pertinent objective information relevant to the drug-related issue or clinical problem (i.e. data collected). This may include vitals, physical exam findings, lab data, diagnostic tests, current medication history.

A – Assessment
This section includes identification of the specific drug-related problems or clinical issue. An appropriate assessment should also consider the desired goals of therapy and therapeutic alternatives.

P – Plan
Clearly outline the direct patient-specific medication therapy recommendation or outcome. It should also contain any pertinent lab tests, drug levels, etc required as part of the monitoring plan. Patient re-evaluation timelines should also be included if appropriate.

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REFERENCES:

1. Strand and Morley. Ann Pharmacother 1990;24: 1093-97
2. CSHP Pharmaceutical Care: Information Paper on the Documentation of Pharmaceutical Care in the Patient's Health Record, 1996.
3. ASHP Guidelines on Documenting Pharmaceutical Care in Patient Medical Records, 2003.
4. Ontario College of Pharmacists Documentation Guidelines for Pharmacists, 2004.
5. Zierler-Brown, S et al. Clinical Documentation for patient care: Models, concepts and liability considerations for pharmacists. Am J Health-Syst Pharm 2007; 64:1851-1858.

III-30-07: Medication Orders	
Effective Date: May 19, 2009	**Approved By: Provincial Pharmacy Professional Practice Council**
Review Date: Dec. 5, 2012	**Revision Date:**

RATIONALE

To ensure safe patient care, prescriptions and medication orders are reviewed by a Pharmacist prior to dispensing.

DIRECTIVE

All routine prescriptions and medication orders are reviewed by a Pharmacist prior to dispensing. In emergency and urgent situations or when there is no Pharmacist available, review of the prescriptions and medication orders is completed as soon as a Pharmacist is available.

DEFINITIONS

Emergency medications: Medications required to treat an injury or illness that is acute and poses an immediate risk to a person's life or long term health. These are often given by non-oral routes and may require training because of the complexity of administering them or because of adverse reactions that may occur as a result of their administration.

Urgent medications: Medications required to treat patients for acute, but non-life threatening conditions

Routine medications: Medications that are used in the customary activities of the provision of patient care services.

Verbal orders: Orders that are given orally in person by a Prescriber

Telephone orders: Orders that are given orally over the telephone by a Prescriber.

PROCEDURES

1. For BCCA inpatients, medication orders must be written by a BC Cancer Agency affiliated Prescriber using a “BC Cancer Agency Doctor’s Orders” Form No. FRC-3, a BC Cancer Agency Medication Reconciliation Hospitalization Form, BC Cancer Agency Medication Reconciliation Admission or Discharge Order Form, or a BC Cancer Agency pre-printed order form. Provincial Systemic Therapy Policy III-10 – Chemotherapy Process defines the Prescriber qualifications required to write prescriptions for chemotherapy.
2. For outpatients, prescriptions can be written by any authorized prescriber, as defined by the College of Pharmacists of BC. Provincial Systemic Therapy Policy III-10 – Chemotherapy Process defines the Prescriber qualifications required to write prescriptions for chemotherapy.
3. The Pharmacist will review all prescription and medication orders for accuracy and appropriateness prior to dispensing. The review includes the appropriateness of the medication; dose, frequency, and route of administration; any therapeutic duplication; actual or potential allergies or sensitivities; actual or potential interactions; variations from the medication’s intended use; and other medication-related issues or concerns.

III-30-07: Medication Orders	
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4. A complete medication order includes:
   - Patient's name and BCCA patient number
   - Date ordered
   - Medication name
   - Strength and dosage
   - Route of administration
   - Frequency of administration
   - Purpose of drug, when prescribed as a PRN medication
   - Name and signature of Prescriber

   For outpatient prescriptions, the following information is also required:
   - Quantity of the drug
   - Refill authorization if applicable, including number of refills and interval between refills
   - College Registration Number of the Prescriber
5. Pharmacists accept verbal orders for non-chemotherapy medications only in emergent or urgent situations.
6. Pharmacists accept telephone or faxed orders for non-chemotherapy medications only if the Prescriber is not in close proximity or is otherwise unavailable.
7. When recording a verbal or telephone order pharmacists must:
   - Record the time and date on the order sheet
   - Record the order given by the Prescriber
   - Read the order back to the Prescriber to confirm it is complete and accurate
   - Record the Prescriber's name on the order sheet, state "telephone order from ____", print the Pharmacist's name, sign the entry and identify the Pharmacist's status (e.g., registered Pharmacist)
8. Inpatient verbal or telephone orders are to be countersigned by the Prescriber within 24 hours. (Medical Staff Rules for the Provincial Health Services Authority, Board approved June 23, 2005)
9. As per Systemic Therapy Policy III-10, prescriptions for all IV or oral chemotherapy, targeted therapy and biological response modifiers must be written, not as verbal orders or telephone orders. Pharmacists accept faxed prescriptions and medication orders in the following circumstances:
   a) from non-BCCA Prescribers for take-home cancer treatment medications
   b) from BCCA and other authorized Prescribers for medication orders for inpatients

10. Pharmacists do not accept e-mail orders.
11. Emergency medications must be provided within 10 minutes of identified need. These will be available in ready to use formats in defined locations such as Cardiac Arrest carts/kits and Hypersensitivity Trays.
12. Urgent Medications should be provided within 60 minutes of receipt of a Prescriber's order. A limited formulary of medications used in acute, non-life threatening situations will be considered for inclusion as wardstock in appropriate patient care areas.
13. Routine medications should be provided according to the following guidelines:
    - IV Outpatient treatments – within 45 minutes of patient being ready for their scheduled chemotherapy appointment time if next day treatment; within 90 minutes of patient being ready for their scheduled chemotherapy appointment time if same day treatment
    - Oral Outpatient prescriptions – within 45 minutes of receipt of prescription for hormonal therapies; within 90 minutes of receipt of prescription for chemotherapy
    - Non chemotherapy inpatient orders – As per VCC Pharmacy Parenteral Service and Medication Dispensing Guidelines

REFERENCES

Accreditation Canada Qmentum Program 2012 Standards, Managing Medications.

College of Pharmacists of BC, HPA Bylaws Schedule F, Part 1 (Community Pharmacy) and 2 (Hospital Pharmacy) v2010.1 Jun 18, 2010

III-50-03: Final Check of Sterile Preparations	
Effective Date: Apr 22, 2013	**Approved By: Provincial Pharmacy Professional Practice Council**
Review Date:	**Revision Date:**

RATIONALE:

A final check of sterile preparations is conducted by a pharmacist or pharmacy technician prior to dispensing the product for administration to the patient. To ensure quality of product dispensed, a consistent approach to checking sterile preparations is necessary.

DIRECTIVE:

To ensure the highest quality of sterile product, the pharmacist or pharmacy technician will ensure that the following steps are carried out when checking a final preparation of a sterile product. This directive is intended to address the physical product check, and is in addition to any necessary clinical checks by the pharmacist.

PROCEDURES:

All final sterile preparations will be examined for defects and accuracy as follows:[1]

Defects inspection:

1. The final product will be visually examined for the presence of particulate matter. Where possible, the product will be inspected against a lighted white or black background for evidence of foreign or particulate matter.[1]
2. The container or syringe will be inspected to ensure container-closure integrity and any other apparent visual defect such as leakage.
3. If particulate matter or a visual defect is identified, the product will not be dispensed and a new product will be prepared.

   Exception: certain drugs may contain a small amount of easily visible, white, amorphous particulates (e.g., cetuximab).[2] Refer to the Chemotherapy Preparation and Stability chart to determine if white particulate may be expected. If small white particulates are identified in these preparations, it may be dispensed and administered to the patient using a low protein binding 0.22 micron in-line filter.[2]

Accuracy inspection:

1. Accuracy of the final product will be checked as per Module 2 – Pharmacy Medication Checks of the BCCA Pharmacy Practice Standards for Hazardous Drugs Manual and will include checking:
   a. Drugs, solution, dose, and label match medication order
   b. Reconstitution (if applicable)
   c. Volume(s) of drugs added
   d. Expiry and stability dating of ingredients

III-50-03: Final Check of Sterile Preparations	
Effective Date: Apr 22, 2013	**Approved By:** Provincial Pharmacy Professional Practice Council
Review Date:	**Revision Date:**

2. Final products will not be re-used unless there is evidence of 100% accuracy.

   Examples:

   a. A medication will be wasted when the volume marking on the empty syringe does not match the ordered dose.
   b. A medication will be wasted when the vial placed by the finished preparation for checking does not match the ordered drug

3. Medications that are incorrectly prepared for the specified order, but there is evidence of 100% accuracy of the drug and dose may be re-used if the final preparation will not have any clinical impact on the treatment plan.

   Examples:

   a. Medication is prepared in the wrong diluent, but the drug is deemed to be stable. A new label with the correct diluent information must be applied.
   b. Drugs dispensed in syringes: the volume measured is incorrect. Syringes may be corrected to the right dose and dispensed.

REFERENCES:

1. USP 35-NF 30 General Chapter <797> Pharmaceutical Compounding – Sterile Preparations. 2012 U.S. Pharmacopeia, page 21.
2. Product monograph: Erbitux (cetuximab) intravenous injection, cetuximab 2 mg/mL. Manufactured by ImClone LLC, Distributed by Bristol-Myers Squibb Canada. Dec 2012

BC Cancer Agency
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Provincial Pharmacy Directive

VI-90-01: Use of TALLman Lettering for Medication Nomenclature	
Effective Date: February 1, 2011	**Approved By:** Provincial Pharmacy Professional Practice Council
Review Date: Nov 21, 2012	**Revision Date: July 3, 2013**

RATIONALE:

Many drug names are known to cause confusion and errors because they are similar in appearance or sound. These are known as Look-Alike/Sound-Alike drugs. TALLman lettering is a risk reduction strategy that reduces errors by printing sections of the drug name in capital letters to emphasize differences between similar pairs of drugs. TALLman lettering is recommended by the Institute for Safe Medication Practices (ISMP) for incorporation into all forms of drug communication. As such, it has become a widely accepted method for distinguishing confusing drug names in the healthcare setting in order to avoid unintended interchange of Look-Alike/Sound-Alike drugs.

DIRECTIVE:

TALLman lettering used at BCCA will follow the ISMP Canada guidelines for TALLman Lettering for Drugs used in Oncology and ISMP US recommendations. (Appendix A) Medications not on the TALLman list will be expressed as lower case.

PROCEDURES:

TALLman lettering will be incorporated into:

- All databases that communicate drug information and their related outputs (screens, labels, free-format labels, reports, medication administration records, medication profiles etc), with the exception of systems that are unable to support TALLman lettering. Applicable systems include:
  - WORx
  - Smart pumps
  - Unit-dose packagers.
- Forms such as narcotic registers and wardstock sheets
- Labels of all medication storage areas e.g. inventory shelves, patient care area medication rooms.
- Publications:
  - Protocols and pre-printed orders.
  - Grammatical conventions for drug names may be used in memos, newsletters, policy documents and the Cancer Drug Manual. TALLman lettering will be applied where appropriate.

REFERENCES:

ISMP Canada Bulletin: Application of TALLman Lettering of Drugs Used in Oncology. Nov 2010.
http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2010-08-TALLmanforOncology.pdf

ISMP US: FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters. 2011
https://www.ismp.org/tools/tallmanletters.pdf

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APPENDIX A:

ALPRAZolam	IDArubicin
amLODIPine	lamiVUDine
azaTHIOprine	lamoTRIgine
buPROPion	levETIRAcetam
carBAMazepine	LORazepam
CARBOplatin	medroxyPROGESTERone
ceFAZolin	metFORMIN
cefOXitin	methylPREDNISolone
cefTAZidime	methylTESTOSTERone
chlordiazePOXIDE	metroNIDAZOLE
chlorproMAZINE	mitoXANTRONE
chlorproPAMIDE	NIFEdipine
CISplatin	OLANZapine
clomiPRAMINE	oxyCODONE
clonazePAM	PACLitaxel
cloNIDine	PARoxetine
cycloSPORINE	PENTobarbital
DAUNOrubicin	PHENobarbital
dimenhyDRINATE	prednisoLONE
diphenhydrAMINE	predniSONE
DOBUTamine	QUEtiapine
DOCEtaxel	quiNIDine
DOPamine	quiNINE
DOXOrubicin	RABEprazole
DULoxetine	riTUXimab
ePHEDrine	rOPINIRole
EPINEPHrine	SORAfenib
fentaNYL	sulfaSALAzine
FLUoxetine	SUMAtriptan
fluPHENAZine	SUNItinib
fluvoxaMINE	traMADol
glyBURIDE	traZODone
guaiFENesin	valACYclovir
hydrALAZINE	valGANciclovir
HYDROmorphone	vinBLAStine
hydrOXYzine	vinCRIStine