Branch Out
Fall, 2017

Canadian Society of Hospital Pharmacists | Société canadienne des pharmaciens d'hôpitaux

CSHP NL

PAM 2018 will be here before you know it!

CSHP-NL needs some members to volunteer to spearhead our efforts in hospitals in NL.

There is a National PAM Working Group which is looking for country wide representation.

If you are interested now's the time to get connected, contact Andrea (Advocacy Rep) at andrea.woodland@easternhealth.ca

Follow us on Social Media

Like Us on Facebook
CSHP NL Branch

Follow Us on Twitter
@CSHPNLBranch

Visit us at our home on the web: http://cshp-nl.com

Have a submission or an idea for a future Newsletter?

Contact:

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Editor and Communications Chair

Canadian Society of Hospital Pharmacists

Société canadienne des pharmaciens d'hôpitaux

EXCELLENCE

IN HOSPITAL PHARMACY • EN PHARMACIE HOSPITALIÈRE

Making a difference around these key themes:

Patient Engagement/Patient-Centredness

Best Practice, including Patient Safety

Effective Communication and Collaborative Practice

Values

The pharmacy team views patients as valuable, effective partners in shared decision-making.

- Presence of patient experience advisors participating on at least one pharmacy committee or working group.
- Implementation of tools for staff and leadership that include expectations regarding patient-centred care.

Listens

The pharmacy team listens to, understands, and respects the patient's story about experiences and expectations that will affect the use of medications.

- Extent of patient-reported communication with the pharmacy team.
- Extent of patient-reported satisfaction with their interactions with the pharmacy team.

Communicates

The pharmacist communicates the plan of care to the professionals who will assume responsibility for care of the patient at care transitions.

- Proportion of patients whose plan at transition of care is communicated to the appropriate health care provider.
- Proportion of patients who receive documented medication reconciliation at discharge (as well as resolution of identified discrepancies), performed by a pharmacist. (cpKPI[1])

15 measures, 6 principles, 3 themes, 1 reason

Improving patient health outcomes.

Cares

The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient's goals.

- Proportion of patients for whom a pharmacist has developed and initiated a pharmacy care plan. (cpKPI[1])
- Proportion of patients who receive education from a pharmacist about their disease(s) and medication(s) during their hospital stay. (cpKPI[1])
- Proportion of patients who receive medication education from a pharmacist at discharge. (cpKPI[1])
- Extent of patient-reported involvement in care decisions.

Collaborates

The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the healthcare team.

- Proportion of patients who receive comprehensive direct patient care from a pharmacist working in collaboration with the health care team. (cpKPI[1])
- Proportion of patients for whom a pharmacist participates in interprofessional patient care rounds to improve medication management. (cpKPI[1])
- Proportion of pharmacists whose practice includes advanced practice roles.

Implements

The pharmacy department implements risk-reduction strategies to improve the safety of the medication-use system.

- Implementation of medication system risk-reduction strategies.
- Evaluation of the impact of medication system risk-reduction strategies.

[1] Fernandes O, Tsoukas K, Pereira T, Lydon C, Bjelajac Mejia A, Shalansky S, et al. Canadian consensus on clinical pharmacy key performance indicators: knowledge mobilization guide. Ottawa, ON: Canadian Society of Hospital Pharmacists; 2015.

CSHP AGM Report
Lorie Carter, CSHP-NL National Delegate

Introduction

It is my pleasure as Delegate for CSHP-NL Branch to bring you updates from the recent board meetings and AGM in Fredericton September 27 – October 1st. With the recent arrival of my newest bundle of joy, I wasn't able to attend the meetings and would like to thank Heather Slaney for attending in my place. Heather and I have prepared this report for you together.

CSHP Projects & Member Benefits

Canadian Journal of Hospital Pharmacy

CSHP will be archiving the journal's table of contents online for the years 1990-1999 for easier access. Any desired articles can then be accessed by contacting the journal. Unfortunately full conversion of older journals to electronic format was too cost-prohibitive.

Residency

The Pharmacy Residency Application and Matching Service (PRAMS) is now fully online which enables a centralized application process for applicants, including applicants to the first-ever residency program in Newfoundland which is newly starting in Eastern Health!

New PSN

There is a new Pharmacy Specialty Network (PSN) called Medication Distribution. This is geared towards members working in a dispensary setting, and will also be applicable to pharmacy technician members.

Excellence in Hospital Pharmacy Program

The member survey for the Excellence program was recently released, and will serve as the project's baseline data. A patient survey has also been completed and the results of both surveys should be available this fall. The steering committee for the project has been restructured into one smaller steering committee and three working groups to improve efficiency.

Compounding

The Ontario branch of CSHP has developed an aseptic compounding training program, and the plan is to make this program available to all members in the future. It is currently being revamped and offered to BC members as a pilot project.

CSHP now has a new compounding self assessment tool for pharmacies, and a YouTube video:

https://www.cshp.ca/assessment-tool- aseptic-compounding
https://www.cshp.ca/safe-compounding-it-all-starts-you

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Publications & Communications

Advocacy

- CSHP experienced a big "win" this year when Health Canada issued a class exemption for inpatient use of methadone, meaning temporary physician exemptions are no longer required. This comes after almost 7 years of CSHP advocating to the Office of Controlled Substances for changes that would ease the burden of this work for hospital pharmacists.
- CSHP continues to advocate to the Special Access Program regarding difficulties hospital pharmacists experience in using this process, such as denied or delayed applications, or unclear expectations in the application process. This year CSHP submitted a long list of both positive and negative experiences received from CSHP members, to try to improve the SAP process. Meetings are ongoing.
- CSHP has made a commitment to increase advocacy efforts directed towards pharmacists working in primary care.

Response to the opioid crisis

- Recently CSHP has been engaged in a number of initiatives related to the opioid crisis. In collaboration with the federal minister of health, we have committed to the Joint Statement of Action to Address the National Opioid Crisis:
  https://www.canada.ca/en/health-canada/services/substance-abuse/opioid-conference/joint-statement-action-address-opioid-crisis.html
- By December 2017, CSHP plans to survey members on our needs for resources on the prevention, education, treatment, monitoring and surveillance, and enforcement of practices concerning controlled substances.
- CSHP participated in a roundtable discussion on the opioid crisis, hosted by HealthCareCAN on June 12, 2017 during the National Health Leadership Conference in Vancouver. Participants shared their insights about and experiences of best practices

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CSHP Operations

Review of CSHP Committees
Recently, executive has completed a full review of CSHP committees and working groups, to ensure they are operating in an efficient manner and that our reporting structure makes sense. Some changes will be implemented to the national committees in the near future as a result of this.

Finances
- Similar to what was reported to you at our AGM in May, CSHP ended the 2016-17 fiscal year with a surplus of $69,266.32, a significant improvement from the budgeted deficit of $161,400, however this is largely due to delays in hiring staff in the CSHP office. Some good news to report is that PPC (Professional Practice Conference) had a very successful year and our fiscal reserve remains above our target of 50% of the annual budget. As well, our Ottawa condo (which serves as an investment property and which has been vacant for over a year) has now been rented on a 2-year term.
- For the 2017-18 budget, CSHP is predicting a deficit of $188,600. As discussed in previous years, this is primarily due to the final wave of hiring necessary to implement the operational review.

Strategic Plan Update
As always at board meetings, the strategic plan and balanced scorecard (strategic plan progress tracking tool) were reviewed. Work is underway to prepare the balanced scorecard to continue tracking our progress into the 2019 and 2020 years now that the strategic plan has been extended.

Office Staff
There are currently 15 staff members and 2 contractors employed by CSHP. Their photos and bios are all available on the new website so that you can get to know them!

CASL (Canada Anti-Spam Legislation)
A reminder to everyone that as a result of this legislation, CSHP members are not permitted to advertise or distribute promotional information via email to non-members.

Conclusion

This was another successful round of board meetings, with a very dedicated and passionate group. Thanks once again to Heather for her dedication to our branch by taking on the role of representative in Fredericton! Our next board meetings will take place in Ottawa in April 2018 and I look forward to being able to attend in person once again. In the meantime please feel free to contact me at any time with any questions or concerns about what is happening within CSHP at the national level.

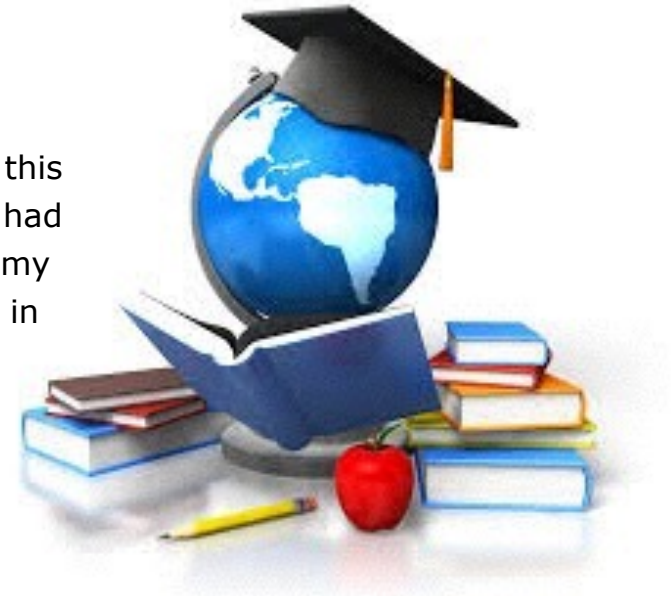
Update from the 2017 CSHP Professional Practice Conference — Ashley Buck, B. Sc. (Pharm)

This February I was given the wonderful opportunity of attending the Canadian Society of Hospital Pharmacists 2017 Professional Practice Conference in Toronto, Ontario. The travel award from our CSHP NL Branch, sponsored by Fresenius Kabi, made this a reality.

This years conference had a lot to offer for educational advancement. The speakers were all experts in their respective fields and the topics were very interesting. Selecting only one topic to share through this article was very challenging. One speaker I would like to highlight outside of this article was Dr. David Juurlink of Sunnybrook Health Sciences Center on the topic of "The North American Opioid Crisis". It was truly an eye opener and I would highly recommend partaking in his lectures if given the opportunity.

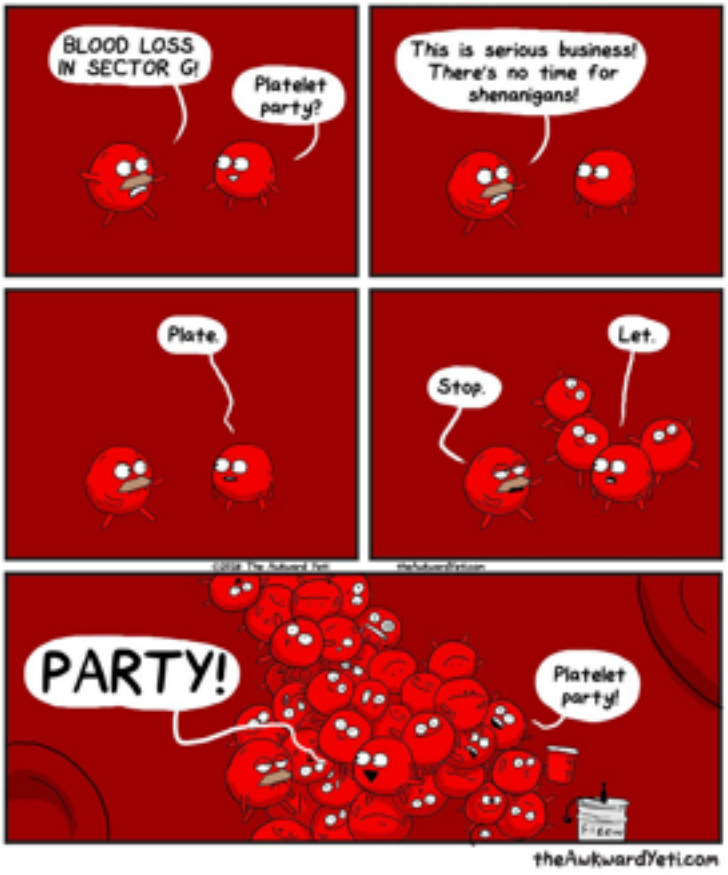
For this article I chose to write about the use of acetylsalicylic acid (ASA) for deep vein thrombosis (DVT) prophylaxis in major orthopedic surgery. This subject came out of the lecture "Plotting to Prevent Clotting: A pharmacist workshop on VTE prophylaxis". Presented by Celia L Culley, BSP, ACPR, PharmD and Patricia Dool, BSP CDE. CSHP PPC, February 7, 2017.

The effectiveness of this practice has been recently questioned within our dispensary. For this reason I thought a summary of the discussion had within the DVT lecture would prove helpful to my colleagues when presented with this regimen in the future.



The use of ASA for DVT prophylaxis in major orthopaedic surgery — PPC Update

To start off, ASA irreversibly inhibits COX-1 and 2 decreasing the formation of prostaglandin precursors and thus inhibiting platelet aggregation. It is inexpensive, requires no lab monitoring and can be taken orally. These reasons along with the argument that patients on an ASA regimen are less likely to develop bleeding related complications and therefore less likely to return to the OR theatre is why the practice is being used more and more by the orthopedic surgeon community. But is it right?



The speaker presented 3 different study types. The first was a pooled analysis of 14 randomized controlled trials (RCTs) assessing VTE prophylaxis in major orthopedic surgery. The findings were that there was no difference in symptomatic VTE rates with ASA vs vitamin K antagonist (VKA) vs low molecular weight heparin (LMWH) vs pentasaccharides. There were statistically higher operative bleed rates with VKA (RR 4.9), LMWH (RR 6.4), and pentasaccharides (RR 4.2) vs ASA.

The second data type to be presented was three registries. The first two were large registry cohort studies (one for total knee arthroplasty and the other for total hip arthroplasty), with over 1000 patients each. The studies took place in England during the 2003 to 2009 time period and compared ASA to LMWH (dose duration not specified). 75% of patients had mechanical prophylaxis as well. There was no difference found in the number of pulmonary embolisms (PE), symptomatic DVT, death, CVA, or GI bleed. The third registry was American and looked at total knee arthroplasty only, consisting of 1000 patients. The findings showed no difference in outcomes between LMWH vs ASA, but a higher VTE rate with warfarin. There was no difference in bleeding. The registries did have several limitations including: higher risk VTE patients (cancer, prior VTE, higher BMI) were excluded, ASA dose or duration was not provided, it was retrospective and there were lower than expected event rates.

The use of ASA for DVT prophylaxis in major orthopaedic surgery — PPC Update

The last to be discussed was the EPCAT study. A RCT, double blind, multicenter, non-inferiority study preformed in Canada between 2007 and 2010, with a 90 day follow up. This study compared the use of Dalteparin 5000 units subcutaneously daily for 10 days and then ASA 81 mg daily (+ placebo injection) for 28 days to Dalteparin 5000 units subcutaneously for 10 days, and then continued for 28 days (+ placebo tablet). The study contained 786 patients who were receiving elective total hip arthroplasty. Exclusion criteria included bleeding, active peptic ulcer disease or gastritis, heparin induced thrombocytopenia or allergy, CrCl< 30ml/min, platelets <100 $X10^9$, hip fracture in the past 3 months, metastatic cancer and life expectancy of less than 6 months. Study results showed that the non-inferiority criteria were met, but not superiority for proximal DVT/PE at 90 days (0.3% vs 1.3%). The difference seen between treatment protocols for clinically relevant non-major bleeding, wound infection, death, MI and stroke were not statistically significant. The study however was not without limitations. It was stopped early due to slow recruitment, had inadequate sample size (calculated at 1100 patients) and initially excluded patients on long term ASA but later allowed patients taking a dose less than 100 mg/day (patients randomized to Dalteparin or ASA 81mg/day in addition to usual ASA dose).

The EPCAT II study is not yet published but is very similar to the first EPCAT. It compares Rivaroxaban to ASA for total hip and knee arthroplasty DVT/PE prophylaxis.

I hope the information I have presented in this article will help you when assessing the next ASA for DVT/PE prophylaxis regimen for major orthopedic surgery that makes its way into the dispensary. There seems to be some sound evidence to support the practice but there is more research that needs to be done. Evidence has not shown a standard dose or treatment duration and the use of a parenteral agent in initial days after surgery seems to be hit or miss depending on practice site. Hopefully in the days to come a more consistent treatment plan will be studied and agreed upon by the orthopedic community.

One last thing that I would like to mention is the potential for oversight of an ASA prescription on discharge for these patients. The speaker noted that due to ASA being an OTC it had been overlooked on discharge at her practice site. A prescription was not written and due to lack of proper discharge counselling and/or understanding by the patient the ASA was not taken and patient was left unprotected. Situations like this show the importance of a pharmacist involvement at discharge.

Ashley Buck, B.Sc. (Pharm)

Complimentary RxFiles for NL Branch Members
Sponsored by Teva

Thanks to the generous sponsorship provided by Teva again this year, all active members of CSHP NL Branch will receive a complementary subscription to RxFiles for the 2017-18 membership year.

If you are member of a group partnership with individual username sign in please do the following steps:

1. Go to www.rxfiles.ca and sign up for new account with username and password. If you already have an account with username and password you have used previously, please continue to use this username and password and just "login".
2. Click on "join a partnership group" link in the right hand corner of the membership box once you are signed in with your username
3. Click on CSHP-NL 2017-18.
4. Your name will be sent to me for verification and I will check it against the list provided by your governing body and then send you an email indicating your subscription has been activated.
5. Since this subscription now is tied also to the new RxFilesPLUS app, then go to Apple iTunes or Google Play Store and download the RxFilesPLUS

RxFiles Plus App - Using the app with a personal RxFiles subscription
Link: https://youtu.be/zU6-Ssm6kSM

If you have any questions, please contact Lisa Bishop at ldbishop@mun.ca

Lucy Ruth Carter, born August 15th at 9 lbs 9 oz.

Lorie and Jarratt Carter are thrilled to announce the birth of their daughter, Lucy Ruth Carter.

Proud big brother Jace loves to give her kisses, and mom is even getting some sleep this time around!

CSHP Award Winners

AlfredG. Dawe Distinguished Service Award	Sponsored by Apotex	Kristi Parmiter
CSHP Branch Leadership in Pharmacy Practice Award	Sponsored by Apotex	Rebecca Tobin
CSHP NL Branch New Practitioner Award	Sponsored by Apotex	Nicole MacDonald
Fresenius Kabi Educational Travel Grantto PPC	Sponsored by Fresenius Kabi	Debbie Kelly

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