

# The Island Capsule

## Newsletter of the Prince Edward Island Pharmacy Board

December 2006

### PRINCE EDWARD ISLAND PHARMACY BOARD

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### MEMBERS

David McLeod, Chair and NAPRA Delegate  
(Lawton's St.Peter's Rd)  
Ken Ramsay, Vice-Chair (Ramsay's Ph)  
Wally Kowalchuk (Zellers Phcy)  
Jeff Jardine (The Drugstore Phcy)  
Kerry Murphy (Shoppers Drug)  
Iain Smith (QEH)  
Government Rep – Pat Crawford

### REGISTRATIONS

Pharmacists: 163  
Permits: 40 + 7 hospitals + Provincial Phcy  
Students: 25

*This newsletter is distributed to all licensed pharmacies in PEI, emailed and posted on our website. Decisions regarding all matters such as regulations, drug related incidents, etc. are published in it. The PEI*

*Pharmacy Board therefore assumes that all pharmacists are aware of these matters*

### ARE YOU AND YOUR STAFF CONNECTED?

Pharmacy Managers are reminded that mailings and faxes are only going to them at the pharmacy of employment. **Please ensure your staff pharmacists receive any documents forwarded – this includes newsletters, guidelines etc.** if they are not accessing E-Link.

Pharmacists can also go to [www.napra.ca](http://www.napra.ca) and click on PE to access newsletters and all other documents.

For the 2007/8 licensing year the CE requirements will be **20** CEUs. Professional Development Log and information on program accreditation can be found on the PEI section of the napra website.

### BOARD EMAIL SYSTEM

Your NAPRA email address has been your name ([jane.doe@peipb.napra.ca](mailto:jane.doe@peipb.napra.ca)). This will remain for those who use the email as their regular address. Your own access, to go into the address and retrieve email or have it set up to forward to another regular email account (such as hotmail or simpatico), will **soon** be your license # ([12345@peipb.napra.ca](mailto:12345@peipb.napra.ca)). This will prevent complications like same names, name changes in marriage, etc. when I forward a pharmacists' updated list to NAPRA for inclusion or removal of pharmacists. Once

you forward mail to another account, be sure to update this should you change servers (e.g. Eastlink instead of simpatico). Any questions on email addresses, passwords, etc can be directed to the Registrar.

**Please ensure you log on to activate your account. It will be needed for the next step. For those who were provided manual forms, please return them to the Registrar ASAP.**

### **PHARMACY DATABASE/REGISTRATIONS**

Renewals will be done through the Board's new database, on-line. You must have your NAPRA account activated, at which time I will be forwarding information on registrations and provision of information to this service.

### **NHPD MONTHLY COMMUNIQUE**

The *NHPD Monthly Communiqué* is a publication of Health Canada's Natural Health Products Directorate (NHPD), the federal department responsible for the regulation of natural health products sold in Canada. The communiqué is released to the Canadian public the first week of each month via the NHPD's electronic bulletin. Subscription to this e-bulletin is available at [www.hc-sc.gc.ca/dhp-mps/prodnatur/activit/education/list/index\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/prodnatur/activit/education/list/index_e.html)

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**List of Approved Natural Health Products.** The list of Health Canada – approved natural health products is accessible at: [http://www.hc-sc.gc.ca/dhp-mps/prodnatur/applications/licen-prod/lists/listapprhplisteapprpsn\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/prodnatur/applications/licen-prod/lists/listapprhplisteapprpsn_e.html) (underscore before e.html)

This list will be updated on a monthly basis until a more complete searchable database is available. Please note that to ensure accuracy of information being posted, there will be a delay of at least 60 days before

new products are added to this monthly update. All license numbers listed in the table are Natural Product Numbers (NPNs) or DIN-HMs.

NAPRA has identified a list of DIN products that are in our drug schedules that will be receiving a NPN. This has concerns for patient safety and Health Canada has agreed to take a closer look at these products and consider “scheduling” them as we do with DIN products. That would mean though they are natural health products by definition, there will continue to be some restrictions to place/conditions of sale.

### **SOME MELATONIN PRODUCTS APPROVED FOR SALE**

Pharmacists are reminded that some melatonin products have been approved for sale in Canada. Melatonin is considered to be a Natural Health Product by Health Canada and therefore approved products will be listed on the Natural Health Products database as opposed to Health Canada's drug database. Approved melatonin products will bear a label that includes an NPN number, as opposed to a DIN number. Note that Natural Health Products do not fall under the jurisdiction of the National Drug Schedules administered by NAPRA, therefore products like melatonin will not be listed in NAPRA's National Drug Schedules.

### **PRANDASE IS NOW GLUCOBAY**

As many will already know, Bayer Healthcare has decided to change the trade name of their drug acarbose. Presently in Canada, the trade name is Prandase but the drug is known as Glucobay in the rest of the world. The dosage form, drug, strength, DIN and price will not change.

Accordingly, pharmacists can make the switch on existing prescriptions and all new prescriptions that are prescribed using the name Prandase. Clearly, it is important that the pharmacist advises the patient of this

name change and give the reassurance that this is only a name change not a change in the medication. The new named product was to be available this fall.

### **HEALTH CANADA'S METHADONE PROGRAM**

#### **New contact information:**

Michel St-Onge, BScPharm  
Evaluation and Authorization Officer  
Methadone Program  
Office of Controlled Substances  
MacDonald Bldg  
2<sup>nd</sup> Floor  
123 Slater St.  
Ottawa, ON K1A 0K9  
AL: 3502B  
Toll Free: 1-866-358-0453  
Fax: 1-613-952-8576

### **GUIDELINES TO PHARMACY COMPOUNDING**

In collaboration with Health Canada NAPRA developed the enclosed Guidelines to Pharmacy Compounding. The PEI Pharmacy Board also endorses them and are expecting Island pharmacists to utilize them in compounding practices. It is also recommended that when incorporating these guidelines into practice, please ensure provincial occupational health and safety legislation is consulted to account for safety implications of pharmacy personnel in the preparation of compounds. This is available on-line at [www.gov.pe.ca](http://www.gov.pe.ca) under government and statutes and regulations.

### **SAFETY INFORMATION: PROMETHAZINE HYDROCHLORIDE**

The US Food and Drug Administration has issued a safety alert that warns parents and health care professionals they should not give drugs containing promethazine hydrochloride to children younger than two. The use of the products has potential for fatal respiratory depression.

The warning includes all medications containing the drug, including syrups, suppositories, injectables and tablets.

Caution should also be used when administering promethazine HCl medications to pediatric patients over two years of age and older.

The complete FDA Advisory can be found at the FDA website at [www.fda.gov/cder/drug/InfoSheets/HCP/promethazineHCP.pdf](http://www.fda.gov/cder/drug/InfoSheets/HCP/promethazineHCP.pdf)

### **HEALTH CANADA ADVISORIES**

Health Canada posts safety alerts, advisories, warnings, recalls, health advisories and other notices from industry on the MedEffect section of its website. Pharmacists can join the MedEffect mailing list to receive email updates from Health Canada about these advisories, along with the most recent publication of the Canadian Adverse Drug Reaction Newsletter by going to the MedEffect section of the Health Canada website and simply providing your email address and clicking "subscribe". Health Canada Advisories are also on the NAPRA website at [www.napra.ca/PEI](http://www.napra.ca/PEI) pharmacists who have signed on to the PEIPB/NAPRA E-Link system are currently receiving these advisories through "Communications".

**It is the responsibility of all pharmacists and in particular pharmacists-in-charge to take reasonable steps to receive these critical safety notices and to take action to advise their patients where appropriate.**

### **STANDARDS OF PRACTICE**

Enclosed with this newsletter are *Model Standards of Practice for Canadian Pharmacists*. These Standards were developed by the National Association of Pharmacy Regulatory Authorities in 2003. The Board accepted these Standards into Regulation and are applicable to all levels of your practice.

Also enclosed are the *Supplemental Standards of Practice for Schedule II and III Drugs*. The Board has reviewed and adopted these Standards, which build upon the core Standards of Practice document developed in 2003 and which focus on the level of care expected of pharmacists when providing Schedule II and III drugs and services to clients. Pharmacists in PEI are expected to practice at the levels described in the documents.

### **METHADONE CARRIES**

The Board has approved a change to the “Carries” permitted under the *Methadone Distribution Guidelines for a Methadone Maintenance Program* document. Previously a patient was only able to have a maximum of “4 carries or 400mg”, whichever is less. That has been changed to **a maximum of 6 carries, with no mg limit**. This document has been updated on the PE section of the NAPRA website.

### **COX-2-SELECTIVE DRUGS:HEALTH CANADA EVALUATION**

Health Canada has released two documents as part of its ongoing evaluation of COX-2-selective drugs. One is a report on the cardiovascular risks associated with COX-2-selective non-steroidal anti-inflammatory drugs; the other includes the department’s official comments on the advice from the COX-2 Expert Advisory Panel.

You can find these documents on the Health Canada website at [www.prodpharma/activit/sci-consult/cox2/index\\_e.html](http://www.prodpharma/activit/sci-consult/cox2/index_e.html).

### **Ibuprofen flagged as a concern**

The expert advisory panel flagged a concern about ibuprofen being available as an over-the-counter drug. The panel recognized that the indication for the OTC ibuprofen is for the short term relief of pain and fever only. However, panel members agreed that the drug was frequently being used chronically and at a high dose, despite the fact that the

OTC product is available only as a relatively low-dose pill.

The panel also recommended that ibuprofen only be sold after discussion with a pharmacist and that the risks of cardiovascular events be prominently displayed in material that individuals receive at the time they purchase the drug as well as any package inserts.

The scheduling of OTC ibuprofen has not changed as a result of the panel’s report. However, remember that you have a responsibility under the standards of practice to educate the patient on the appropriate use of the drug or non-prescription medication.

### **POTASSIUM PERMANGANATE – Controlled Drug Symbol**

Potassium permanganate (KMnO<sub>4</sub>) is considered a Class A precursor and is found in Schedule VI of the *Controlled Drugs and Substances Act*. Because it is a strong oxidizing agent, it can be used to accelerate chemical reactions, disinfect swimming pools and drinking water and to produce flame in camping survival kits. It can also be used to produce illicit drugs, particularly methcathinone, a recreational drug.

You can sell potassium permanganate legally, in compliance with the *Precursor Control Regulations* (PCR) and without a prescription, in quantities under 50kg per package and only to end users, not to distributors.

Section 91.96 of the PCR states that when a pharmacist, practitioner, or hospital sells or provides on a retail basis a Class A precursor, or possesses for the purpose of sale or provision, preparations or mixtures containing Class A precursors, the pharmacist or hospital must:

- Keep the product stored securely in the pharmacy
- Notify the police within 24 hours after discovering loss or theft of the product

- Notify the Office of Controlled Drugs and Substances (OCDS) within 72 hours of the loss or theft of the product
- Keep a record of notices sent to OCDS for future inspection

You may also provide potassium permanganate in compounded preparations made pursuant to verbal or written prescriptions. In these situations, potassium permanganate prescriptions may contain refills and be transferred from one pharmacist to another.

Additional questions about chemical precursors can be directed to:  
 Mark Kozlowski, Head  
 Chemical Precursors Section  
 Office of Controlled Substances  
 Health Canada  
 Tel: (613) 948-7352  
 Fax: (613) 948-3585

### **COLLECTION OF PROVINCIAL HEALTH NUMBERS**

Pharmacists are reminded that it is a requirement of our Regulations to collect patient's provincial health numbers (PHN) and record them on the patient profile. This number will be important when the province's Drug Information System (DIS) goes live (see below notice).

### **DIS IMPLEMENTATION 2007**

The PEI Department of Health is implementing a Drug Information System (DIS) that will capture all prescription medications dispensed to residents of PEI (All Drugs All People – ADAP). The rollout will begin in July 2007 using a vendor-by-vendor, store-by-store approach. ADAP will require pharmacists to submit the patient's Provincial Health Number (PHN) when dispensing a prescription. In preparation for the transition to ADAP, it is recommended that pharmacies begin capturing PHNs for their patients now. For more information on the DIS, please

contact Sherry McCourt, DIS Project Manager (368-6723 or [samccourt@ihis.org](mailto:samccourt@ihis.org)).

### **MESSAGE FROM PEI VETERINARY MEDICAL ASSOCIATION**

Further to a recent death of a cat from hypoglycemia after the owner had been buying insulin regularly from a human pharmacy without veterinary consultation. This went on for an extended period of time, and this likely contributed to inappropriate use of the insulin. They would like to remind pharmacists that the dispensing of any drugs for animals, be it prescription or not, is best done in consultation with an attending veterinarian. The majority of pharmacists would have no formal training in the use of most drugs in non-human patients and they would like pharmacists to insist on a prescription, or at least some verbal contact with a veterinarian before dispensing any drug for animals, as it is not uncommon for the dose and/or actions of a drug to differ substantially from what is acceptable in human patients.

### **PATIENT'S RIGHT TO CHOOSE THEIR OWN PHARMACY**

Pharmacists should be aware of the patient's "right to choose their own pharmacy". While the provision of medications to Nursing Home patients is generally done by one pharmacy who offers additional services to the facility for consistent care and patient safety, when a patient is obtaining their own medications and self-medicating, or being cared for independent of a long term care facility – no one can influence or dictate where they receive their medication. The only exception to this would be :

A) Where a patient, physician, and pharmacy agree that a patient can only obtain all or selected medications (e.g. narcotics) prescribed by one physician and from one pharmacy. In this case, the patient

has voluntarily restricted themselves to one pharmacy.

- B) Where, due to proven cases of prescription drug abuse, the provincial drug programs have indicated that they will only pay for prescriptions for a patient filled at one pharmacy. In this case, the patient is still free to fill prescriptions at any pharmacy, but government will only pay for those prescriptions filled at the designated pharmacy. This is done with full knowledge of the patient and only through a process where the patient has received numerous warnings and opportunities at rehabilitation.

The Registrar is receiving more and more complaints from other pharmacists as well as consumers (either the patient, or a patient's advocate) in this area. Unless the situation meets what was described above, it is a direct violation of our Code of Ethics, namely:

**Statement VI:**

**Pharmacists observe the law, preserve high professional standards and uphold the dignity and honour of the profession.**

Guideline for interpretation

1. Pharmacists obey the laws, regulations, standards and policies of the profession, ***both in letter and in spirit.***
2. Pharmacists do not condone breaches of the law, regulations, standards or policies by colleagues, co-workers or owners of a pharmacy and report, without fear, such breaches.
3. ***Pharmacists accept the ethical principles of the profession.***
4. Pharmacists do not engage in any practice, the conditions of which might cause pharmacists to compromise the laws, regulations, standards and policies of the profession.
5. Pharmacists do not practice under conditions which compromise their freedom to exercise professional

judgment or which cause a deterioration of the quality of their professional service or care.

6. ***Pharmacists do not enter into arrangements with prescribers that could affect the prescriber's independent professional judgment in prescribing or that could interfere with the patient's right of choice of a pharmacy.***

**Statement VII:**

***Pharmacists cooperate with colleagues and other health care professionals so that maximum benefits to patient care can be realized.***

Guidelines for interpretation:

1. ***Pharmacists respect the values and abilities of colleagues*** and other health care professionals.
2. Keeping confidentiality in mind, pharmacists consult with colleagues or other health care professionals to benefit the patient. If appropriate, pharmacists refer their patients to other health care professionals or agencies.
3. ***Pharmacists maintain professional relationships with colleagues*** and ensure patients' needs are met when supplying colleagues with transfer copies of prescriptions, inventory, etc.

Included in the definition of ***Professional Misconduct:***

- failing to abide by the Code of Ethics;
- having a conflict of interest;
- failing to comply with directions issued by the Board;
- performing an act associated with practice which in the judgment of the Board, without any negative vote, would reasonably be regarded by the vast majority of pharmacists as dishonourable...

If these complaints continue in the concept that they have, the Board will be forced to address it through the Investigations and Discipline process.

## Transdermal Fentanyl: A Misunderstood Dosage Form

In 2004, two adolescent deaths were reported to be associated with the use of fentanyl patches (Duragesic) in Canada.<sup>1</sup> In the first case, fentanyl patches were prescribed for a 15-year-old girl for relief of chronic headache; the girl was found unresponsive 21 hours after the first patch was applied. In the second case, fentanyl patches were prescribed for a 14-year-old boy to treat severe sore throat due to mononucleosis; respiratory arrest occurred 14 hours after the first patch was applied. ISMP (US) has also received reports of deaths linked to the fentanyl patch in the United States.<sup>2,3</sup> In the fall of 2005, the manufacturer, Janssen-Ortho Inc., in consultation with Health Canada, issued advisories to health care professionals<sup>4</sup> and to the public<sup>5</sup> highlighting important information for the safe and appropriate prescribing and use of Duragesic. Examination of the ISMP Canada database of voluntarily reported medication incidents indicates ongoing problems with the use of fentanyl patches. As of July 27, 2006, there have been 122 reports classified as errors, and 12 of these (9%) resulted in patient harm.

Fentanyl is a highly potent opioid. **One transdermal fentanyl patch 25 mcg/hour provides comparable analgesia to a daily dose of 60 mg to 134 mg of oral morphine.**<sup>6</sup> Because of the risk of life-threatening hypoventilation, fentanyl patches are **contraindicated** for opioid-naïve patients. This drug should NOT be used in the management of acute or post-operative pain and is NOT recommended for children under 18 years of age. The fentanyl patch is **indicated** in the management of persistent, moderate to severe chronic pain that cannot be managed by other means such as oral opioid products and in patients who:

- need continuous (around-the-clock) opioid analgesia for an extended period of time, and
- are already receiving opioid therapy at a total daily dose equivalent to at least 60 mg oral morphine.

Fentanyl patches should not be used for patients who do not meet these criteria, nor should they be used where compliance with correct patch administration is in question or where follow-up monitoring for adverse effects is not possible. (The most up-to-date product monograph is available at <http://www.janssen-ortho.com/JOI/en/product/products.asp>.)

### Types of Incidents Reported

Reports to ISMP Canada indicate that problems with the use of fentanyl patches exist in a variety of care settings (e.g., hospitals, nursing homes, patient homes) and involve various stages in the medication use process: *prescribing* (e.g., dose ordered not corresponding to manufacturer's available dose), *transcription* (e.g., wrong patient, incorrect timeframe, omission of order to discontinue); *administration* (e.g., previous patch not removed, dose omitted, incorrect administration times, incorrect dose), and *monitoring*. Although it is impossible to infer or project the probability of specific incidents on the basis of the voluntary

reports received by ISMP Canada, the information available can be used to identify issues that may require additional investigation or attention.

Analysis of reports in the ISMP Canada medication incident database provides insight into the types of incidents reported as illustrated in Table 1.

**Table 1.** Transdermal fentanyl: types of incidents reported

Type of Incident	Total Number (%) Reported (n=122)	Number Reported with Harm
Incorrect dose	25 (20.5%)	4
Dose omission	54 (44.3%)	3
Incorrect duration	13 (10.7%)	2
Incorrect strength or concentration	5 (4.1%)	1
Incorrect time	14 (11.5%)	1
Other	11 (9%)	1

When combined with the qualitative information received, the following examples highlight areas of ongoing concern.

### 1) Patches not removed

*"A patient was found to have new patches on their [sic] right upper arm, and old patches still on the left arm. The patient was responsive, but sluggish, with pinpoint pupils..."*

*"Patient was found with a 25 microgram patch which had not been removed before an opioid infusion was started. The patient had two patches of 25 micrograms applied, and the nurse had removed only one before starting the infusion."*

Fentanyl patches are generally administered every 72 hours (every 3 days). The previous patch must be removed at the time of application of the new patch. Incidents reported include cases in which the patch was not removed at the time of the next dose, more than one patch was required for dosing but not all of the previous patches were removed at the time of administration of the next dose, cases in which the wrong transdermal patch (i.e., wrong drug) was removed (from a patient receiving more than one drug by this mode of administration), and cases in which the patch was not removed when there was a change in the form of opioid therapy. After 72 hours, the fentanyl patch contains sufficient residual drug to potentially cause harm, particularly when combined with additional doses or other drugs with similar effects.

## 2) Patches manipulated for unusual doses

Dosing for elderly or debilitated patients may not be met by commercially available products. When very low dosages or unusual dose combinations are prescribed, practitioners may manipulate the patch to accommodate the prescribed dose. This may include cutting the patch, in the belief that this is the appropriate way to administer the correct dose. However cutting the patches can result in leakage and uncontrolled release of medication which could result in the absorption of a potentially fatal dose of fentanyl.<sup>6</sup> Commercially manufactured products with these low doses are not yet available in Canada, although at the time of writing Ortho-Janssen has received Health Canada approval to market Duragesic 12 mcg/h patch.

## 3) Patches not applied

*“Patch not applied on due date and the omission was noted one day later. The patient experienced pain and required morphine.”*

Omission of doses may lead to a requirement for additional analgesia for pain control. Reports to the ISMP Canada database suggest that this can be problematic if the cause of the breakthrough pain is not recognized.

## Contributing Factors

ISMP Canada, in conducting our analysis and receiving input from the reporters, has identified the following contributing factors:

- Lack of knowledge or awareness of indications and pharmacokinetics (effects of the fentanyl patch can continue for 24 hours or more following removal, due to the effect of a subcutaneous depot of fentanyl).
- Lack of understanding among practitioners, patients/residents, and families that this noninvasive route of fentanyl administration is highly potent.
- Use of doses requiring multiple patches of various strengths to be identified, calculated and administered.
- Use of fentanyl patches in combination with other opioid analgesics, CNS depressants (*e.g.*, benzodiazepines and sedating antihistamines), or drugs that affect the metabolism of fentanyl (*e.g.*, CYP 3A4 inhibitors increase or prolong the effect of fentanyl [*e.g.*, erythromycin, diltiazem, clarithromycin, ketoconazole]).
- Application of a heat source to the patch (*e.g.*, heating pad, hot packs), resulting in increased release and absorption because of increased skin permeability. Fever may also enhance this potential.
- Lack of clear communication among multiple caregivers regarding
  - date, time, and location of application of a patch;
  - date and time when next patch is due to be applied.
- Inadvertent contact with the patch due to
  - lack of child-resistant packaging or failure to ensure secure storage alternatives;
  - patches falling off; and
  - unsafe disposal.<sup>3,7</sup>

- Prescription of smaller doses (or smaller dose increments) than are available from the manufacturer, which can lead to inappropriate manipulation of a patch, compromising its integrity and compromising the sustained release of fentanyl.

## Recommendations

Recommendations to reduce medication incidents associated with fentanyl patches include the following:

- Apply the following criteria for the prescribing, dispensing, and administration of fentanyl patches<sup>6</sup>:
  - Use only for **adult** patients who are already receiving opioid therapy at a total dose of at least 60 mg/day oral morphine or its equivalent.
  - Use for the management of persistent, chronic moderate to severe pain, NOT for the management of acute or post-operative pain.
  - Use only for patients who require continuous (around-the-clock) opioid administration for an extended period of time.
  - Use only for patients whose pain cannot be managed by other means such as oral opioid products.
- Require a pharmacist to review all new orders for fentanyl patch before administration.
- Avoid having fentanyl patches available through override from automated dispensing cabinets.
- Ensure that the current documentation process clearly communicates the date, time, and location of patch administered and the date, time, and location of patch to be removed (*e.g.*, by providing prompts on the MAR).
- Provide an alert on the MAR for patients receiving more than one medication via the transdermal route.
- Assess pain management and check patch placement on each patient every shift.
- Ensure that policies, procedures, and guidelines on the use of transdermal fentanyl are readily available to practitioners and ensure that this documentation covers indications for use, requirements for monitoring, safe and secure disposal, and treatment and monitoring protocols in the event of toxic effects or overdose.
- Ensure that applicable alerts are generated from various sources (*e.g.*, automated dispensing cabinets, pharmacy computer systems, computerized physician order entry).
- Provide written information to the patient (*e.g.*, product monograph, part III: Consumer Information), and review instructions with patients and/or patient's family to ensure that important information is not overlooked and that they understand the risk of inappropriate handling of the product.



**References:**

1. Health Canada. Transdermal fentanyl (Duragesic): respiratory arrest in adolescents. Can Adverse React Newsl. 2004 [cited 2006 Jun 2];14(4):1-2. Available from: [http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/carn-bcei\\_v14n4\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/medeff/bulletin/carn-bcei_v14n4_e.html)
2. Institute for Safe Medication Practices. Little patches...big problems. New safety warnings about fentanyl patches – Part 1. ISMP Med Saf Alert Community/Ambulatory Ed. 2005;4(8):1-3.
3. Institute for Safe Medication Practices. Little patches...big problems. New safety warnings about fentanyl patches – Part 2. ISMP Med Saf Alert Community/Ambulatory Ed. 2005;4(9):1-3.
4. Health Canada endorsed important safety information on Duragesic (fentanyl transdermal system). Ottawa (ON): Health Canada; 2005 Sep 16 [cited 2006 Jun 2]. Available from: [http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2005/duragesic\\_hpc-cps\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2005/duragesic_hpc-cps_e.html)
5. Public advisory: Health Canada endorsed important safety information on Duragesic (fentanyl transdermal system). Ottawa (ON): Health Canada; 2005 Sep 16 [cited 2006 Jun 2]. Available from: [http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/public/2005/duragesic\\_pa-ap\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/public/2005/duragesic_pa-ap_e.html)
6. Duragesic [product monograph]. Toronto (ON): Janssen-Ortho Inc.; 2005 [cited 2006 Jul 17]. p. 20. Available from: [http://www.janssen-ortho.com/JOI/pdf\\_files/Duragesic\\_E.pdf](http://www.janssen-ortho.com/JOI/pdf_files/Duragesic_E.pdf)
7. Avoiding Fatal Overdoses with Fentanyl Patches. FDA Patient Safety News. Available from: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=44#2>

### Canadian Anesthesiologists' Society Commitment to Sharing Information about Medication Incidents

The Canadian Anesthesiologists' Society (CAS) web homepage ([www.cas.ca](http://www.cas.ca)) now provides a link to the individual practitioner reporting component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS), operated by the Institute for Safe Medication Practices Canada ([www.ismp-canada.org/cmirps.htm](http://www.ismp-canada.org/cmirps.htm)).

Anesthesiologists are encouraged to report near misses or adverse medication incidents to the CMIRPS. Although each event may be unique, there are likely to be patterns in the sources of risk. The CAS Patient Safety Committee, working together with ISMP Canada, will use this information to identify needed system improvements and to establish practice recommendations, best practice guidelines and educational programs.

### 12-Month Fellowship on Safe Medication Management

ISMP Canada offers specialty fellowship learning and training in medication safety.

The fellowship curriculum includes:

- orientation to error reporting systems
- learning about principles and tools of interdisciplinary error prevention strategies
- contributing to publications and new projects
- activities in academia, research and education related to patient safety
- patient safety conference attendance
- working with ISMP Canada staff on medication safety projects
- opportunity to visit ISMP (US).

This fellowship offers an excellent stipend plus full benefits.

Qualifications: Applicants must be graduates of a health profession (e.g. pharmacy, nursing, medicine) with a keen interest in medication safety.

Qualified individuals are invited to send a completed application form and resume by September 30, 2006 to:

ISMP Canada  
4711 Yonge Street, Suite 1600  
Toronto, Ontario M2N 6K8  
1-866-544-7672  
Fax: 416-733-1146  
email: [info@ismp-canada.org](mailto:info@ismp-canada.org)

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ISMP Canada is a national voluntary medication incident and 'near miss' reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

To report a medication error to ISMP Canada: (i) visit our website [www.ismp-canada.org](http://www.ismp-canada.org), or (ii) e-mail us at [info@ismp-canada.org](mailto:info@ismp-canada.org), or (iii) phone us at 416-480-4099. ISMP Canada guarantees confidentiality and security of information received. ISMP Canada respects the wishes of the reporter as to the level of detail to be included in our publications.

***A Key Partner in the Canadian Medication Incident Reporting and Prevention System***