BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

Integrated, interdisciplinary model of opioid agonist treatment (IIMOAT)

Practice Update

December 2022

LAND ACKNOWLEDGEMENT

We would like to respectfully acknowledge that the land on which we work is the unceded territory of the Coast Salish Peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlililwətaʔɬ (Tsleil-Waututh) Nations.

IN THIS DOCUMENT

PURPOSE

The purpose of this document is to outline the responsibilities of the health care professionals involved in the care of people on opioid agonist treatment (OAT) in an interdisciplinary model. The upcoming changes in pharmacy and nursing practice seek to improve patient engagement in and retention on OAT through meeting patients where they are at and reducing the number of places they need visit to obtain health care support, including medication. In advance of the opioid use disorder (OUD) treatment guideline update, this bulletin provides detail on the practice changes, key roles and responsibilities, and a suggested workflow to support implementation.

Disciplines Impacted

This document outlines a model of care that includes pharmacists, nurses (RN, RPN and LPNs), nurse practitioners, physicians, and nurse prescribers.

Relevant Settings

This practice change applies to all outpatient settings, including ambulatory care and/or outpatient clinics of hospitals; except Corrections.

KEY PRACTICE CHANGES

For sites that adopt this model, these are some of the key changes in practice to facilitate partnership and shared care between pharmacies and clinics:

- Nurses can be authorized to provide witnessing and take-home doses of pharmacy-prepared medication when written on the patients' OAT prescription.
- Nurses are to document any changes made to pharmacy-prepared patient-specific medication—such as increased doses, decreased doses, or missed doses—on PharmaNet using the transaction medication update (TMU; see below for description) by the end of the clinic day or shift.
- In cases where the patient needs a dose or a take-home dose (e.g., bupe-to-go induction packages) and the pharmacy is unable to prepare, it can be prepared by nursing and provided through clinic stock. The exceptional reason must be documented and entered in PharmaNet by using the TMU transaction.

Foundational Activities in IIMOAT to Ensure Patient Safety in the Expansion of Practice Changes

Given this model will require the adoption by nurses of duties typically held responsible by pharmacists, there are key activities requiring training, clear process, and continuous communication in order to ensure patient safety and high-quality practice.

1. Ensuring correct use of medication:
    a. The nurse or qualified regulated health care professional is responsible for checking the pre-packaged medication against the patient-specific order to confirm it is accurate regarding the patient, dosage, frequency, and direction of use.

2. Informing prescriber and pharmacist of adverse reactions or other clinical issues with medication administration:
    a. The regulated health professional must provide the pharmacist and prescriber with any pertinent clinical information about the patient prior to the next prescription filling and/or writing, which includes—but is not limited to—adverse reactions to the drug provided (e.g., allergies, side effects) and changes in dose required. This information can be provided verbally or in writing.

3. Ensuring appropriate witnessing of doses:
    a. May be performed by a pharmacist, nurse, or other regulated health professional who has the appropriate scope and competence and who is responsible for the patient's care.
    b. If a nurse or other qualified regulated health care professional is authorized to witness a dose, they should clearly specify this in the "Directions for Use" portion of the prescription.

- An example:
  Buprenorphine/naloxone 16mg SL once daily
  Dispense 7 days' supply every 7 days in blister package
  Daily Witnessed Ingestion (DWI) by nurse at community clinic
  Rx: June 12–18, 2021

4. Ensuring take-home dose(s) are provided in a secure manner:

a. Packaging of prescribed take-home doses should be performed by the pharmacy. Medication instructions can also be provided directly to the patient by the pharmacist in person, by phone, or virtually. In cases where the patient needs a take-home dose and pharmacy is unable to prepare it, the dose can be provided through clinic stock and the exceptional reason for clinic stock use must be documented. Clinic stock take-home doses should be entered in PharmaNet by using the TMU transaction.

b. Take-home doses need to be specified on the order/prescription regardless of which health care professional is providing the doses to the patient.

c. Take-home doses must be packaged appropriately (e.g., in a child-resistant container).

d. The responsible regulated health professional must ensure that the patient has a safe and appropriately secure location to store their medication (e.g., lockbox) prior to providing take-home dose.

5. Documentation:

a. Pharmacists will follow all usual PharmaNet entry and internal controlled substances accountability steps as required by federal and provincial regulations, legislation, and professional practice policies. Once the medication is provided to the clinic, responsibility of safety and updates to PharmaNet records are transferred to the clinic.

b. The responsible regulated health care professional will ensure:

   I. All controlled medications received are signed for, recorded, and securely stored until provided to the patient, per appropriate legislation and requirements.

   II. Each patient's clinic record is updated to reflect outcome of the pharmacy-dispensed doses. This includes documentation of witnessed ingestion or whether the person missed a dose or was provided with an adjusted dose (e.g., due to the missed-dose protocol, per prescriber, or due to patient request).

   III. In circumstances in which what the patient receives differs from the prescription and/or what was dispensed by the pharmacy (e.g., doses are missed or are adjusted at the clinic site; see below for further details), the patient's PharmaNet record is updated via the TMU or other similar function by the end of the clinic day.

   IV. Complete all clinical documentation of patient encounter per clinic protocol.

6. MISSED-DOSE NOTIFICATION:

   a. The responsible regulated health professional must be familiar with the missed-dose protocol for each medication—including when doses must be held—and the prescriber and pharmacist must be contacted. See the *Guideline for the Clinical Management of Opioid Use Disorder OUD (BCCSU Opioid UD Guideline)* for missed-dose protocols.

   b. The responsible regulated healthcare professional must document and notify the prescriber and pharmacist of any missed doses, partial doses, or dose adjustments by the end of the clinic day. The prescriber must provide new prescriptions to the pharmacist in cases of consecutive missed doses cancelling the prescription or if new dose is warranted. The pharmacy must dispense new prescriptions to nurses as soon as possible.

   c. The responsible clinic health care professional is required to send a missed-dose notification (e.g., by fax), recognizing that it may not be viewed until the following day (e.g., if clinic and pharmacy hours do not fully overlap).

   d. The responsible clinic health care professional must complete the PharmaNet entry regarding missed or adjusted doses by the end of each clinic day. The Ministry of Health (Ministry) can assist with PharmaNet access through the PRIME process and software service providers for the clinic can assist with ensuring that the TMU function is available in each clinic site to note these missed or adjusted doses. Anyone responsible for PharmaNet entry will first need to enroll via the Ministry's PRIME[1] process. Private clinic sites will also need to register for PharmaNet in PRIME.

7. MISSED OR PARTIAL DOSES:

   a. Unused doses cannot be reused or saved and provided to the patient at a later date or provided to another patient. They must be destroyed onsite per clinic protocol in a timely manner. The destruction must be appropriately documented, or returned to the pharmacy for destruction as soon as possible.

8. PRESCRIPTION CANCELLATION DUE TO MISSED DOSES:

   a. If enough doses have been missed to require cancellation of the prescription as outlined in the *BCCSU OUD Guideline* or by documented collaborative agreed-upon drug administration protocol, the responsible regulated health professional must notify the pharmacist and the prescriber so a plan can be made regarding future care.

9. TRANSITIONING BETWEEN SITES OR MODELS:

   a. Communication between prescriber, pharmacist, and any other relevant members of the care team is required any time the patient transitions between sites (e.g., transferring from one pharmacy to another) or models (e.g., transferring from a patient receiving doses at the pharmacy to receiving doses at an OAT clinic).

[1] Note: The nurse who enters updates to PharmaNet using the TMU function must be registered with PRIME. More information about PRIME can be found here.

I. Communication between care team members should be documented. In some cases, parallel use of multiple models will be required (e.g., sites that have no coverage on weekends).

II. Prescriber must clearly articulate the regulated health professional responsible for daily witnessed ingestion on each day, as applicable.

    For example: Mon–Fri DWI by nurse, Sat–Sun DWI by pharmacist.

III. Relevant documentation must be confidentially transferred between the receiving site and pharmacy to facilitate transfer of care.

    For example: patient identification document, nursing medication administration record.

10. Ensuring Continuity of Care:

a. After assessment and if deemed appropriate, the pharmacist can renew the previous OAT prescription or offer an emergency supply for continuity of care.

WRITING PRESCRIPTIONS

When writing an OAT prescription that will utilize this model, the "Directions for Use" section should contain all of the required instructions for both the pharmacy and the regulated health professional who will be administering medication to the patient.

Example instructions

Note: individual approaches will vary based on patient circumstances and clinical judgment, but the field must not contain personal information or identify the clinics by name.

1. All OAT is to be provided by daily witnessed ingestion at the clinic:
    a. **Pharmacist:** Dispense 7 days' supply every 7 days to clinic nurses
    b. **Clinic Nurses:** DWI by nurse
2. A combination of daily witnessed OAT ingestion at clinic plus take-home OAT doses is to be provided:
    a. **Pharmacist:** Dispense 7 days' supply every 7 days
    b. **Clinic Nurses:** DWI by nurse 5 days/week and provide the pharmacy-dispensed take-home doses to patient for 2 days
3. All OAT is to be provided as take-home doses, to be picked up at the clinic:
    a. **Pharmacist:** Dispense 7 days' supply every 7 days
    b. **Clinic Nurses:** Provide pharmacy-dispensed take-home doses to patient every 7 days

Key Staffing Roles & Responsibilities and Proposed Workflow in IIMOAT

All those providing services must work collaboratively and within their professional scope of practice, education, training, and the requirements of the federal and provincial regulatory structure and any applicable exemptions.

1. Prescribers will:
    a. Assess the patient, review the patient's PharmaNet profile, determine a treatment plan with the patient, and provide a prescription that meets the regulatory requirements for OAT for a patient in the specific practice setting (e.g., Controlled Prescription Program (CPP) duplicate pad for community settings). Components of this include:
        II. Indicate frequency of dispensing and/or witnessing—including by whom—on the prescription.
        III. Discuss the treatment plan with the patient and the care team, and determine

which regulated health professional will be responsible for administration of medication at what location and delegation of transport of the prescription from the pharmacy to the clinic.

IV. Provide patient education as informed by the patient's treatment goals, health needs, and risk for overdose.

V. Discuss a safety plan with the patient. This can include where to obtain naloxone, use of mobile apps that can support using alone, safe storage of medication, services in community that could support patient, or recovery-based supports depending on the patient's preferences.

VI. Provide referrals to psychosocial supports and other health care services/ referrals as needed.

VII. Ensure all care is documented in the patient's chart.

2. PHARMACISTS WILL:

a. Review the patient's PharmaNet profile, identify and resolve any medication issues or drug therapy problems as necessary, fill the prescription if appropriate, and provide any counselling information required directly to the patient, or to the nurse or physician at a community health facility[2] or program prior to dispensing the medication to the facility for administration to the patient.

b. Provide pharmacist-patient consultations through one of two mechanisms, based on patient agreement and clinical judgement.

   If authorized by the patient, the pharmacist can convey counselling information to the nurse or physician who then provides this information to the patient.

c. The pharmacist provides the patient counselling information directly to the patient, either in person, by phone, or virtually.

d. Recognize that after the medication leaves the pharmacy, the clinic or community health facility assumes the responsibility for administration of that prescription, including counselling and PharmaNet updates using the Transaction Medication Update (TMU) by the end of clinic day for that day's dose, if not administered to the patient (please see Appendix: TMU Entry Guidance).

e. Follow Health Canada's *Controlled Drugs and Substances Act*, Subsection 56(1) Class Exemption for the Person in Charge of a Hospital and/or a Pharmacist who Supplies Controlled Substances to a Community Health Facility when supplying a controlled substance to a community health facility.

f. Destroy returned unused stock per pharmacy protocols and procedures. Once a prescription has left the community pharmacy, the prescription may not be reused or returned to stock. Unused medications must be destroyed onsite per clinic protocol, with destruction appropriately documented or returned to the pharmacy for destruction as soon as possible.

[2] Per Health Canada, a community health facility "means a facility where health care services are delivered and managed by a nurse as part of the nurse's professional practice."

3. Clinic nurses will:

a. Follow the rules set out in Health Canada's *Controlled Drugs and Substances Act*, Subsection 56(1) Class Exemption for Nurses providing Health Care at a Community Health Facility or applicable controlled drugs and substances regulations for that facility.

b. Upon receipt of the medication, ensure it is recorded and securely stored, per federal and provincial regulations and clinic or program protocols.

c. Follow their clinic procedures for provision of prescriptions to a patient if available. If not available, ensure medication safety standards (BCCNM) are met prior to administration and conduct their assessment of the patient.

d. Following their assessment, provide any counselling information to the patient as identified through their assessment, and/or discussion with pharmacist and/or prescriber.

    I. Document the nurse-patient encounter in patient chart.

e. If on a long-acting injectable OAT medication, administer the medication.

    I. Clinic nurses are able to administer extended-release injectable buprenorphine with a prescriber's order, provided they have the adequate knowledge, skills, and competencies to administer extended-release injectable buprenorphine.

f. Provide pharmacy-prepared medication to patients per prescriber's order (e.g., witness OAT or take-home prescriptions).

g. Record all medication provision in the medication record for that patient.

h. Record all missed doses, onsite clinic dose adjustments or doses provided by clinic (ward) stock using the PharmaNet TMU transaction to update the patient's PharmaNet dispense record by end of clinic day.[3] Please see Appendix: TMU Entry Guidance for how to use TMU.

    I. For extended-release injectable buprenorphine, PharmaNet must be updated if:

        1. A patient is provided a dose from clinic (ward) stock.
        2. A patient receives a dose that differs from that dispensed by the pharmacy.
        3. A dose is missed if the patient does not received the pharmacy dispensed dose within the clinic protocol or clinically appropriate treatment interval.

i. Inform the pharmacist and prescriber of any missed doses or dose changes, as required by the Missed-Dose Protocol, by the end of the clinic day so the pharmacist can take appropriate action in response. This is because:

    I. The prescription may need to be cancelled if multiple consecutive doses have been missed.

    II. A new prescription may be needed.

    III. Reasons for missed doses need to be explored and considered, and care planning may need to be adjusted.

[3] Note: The nurse who enters updates to PharmaNet using the TMU function must be enrolled with PRIME. More information about PRIME can be found here.

1. Note: In certain circumstances in which prescriber, pharmacist, and nurse develop an agreed-upon drug administration protocol to be followed, this model can be used to support a site-specific collaborative practice agreement that outlines exceptions to the missed dosing protocol, where it is in the patient's best interest.
    a. The exceptions and rationale for using the agreement must be documented in the patient's health record.

j. Destroy all unused medications onsite per clinic protocol with destruction appropriately documented, or return unused medication to the pharmacy for destruction as soon as possible, per Health Canada's *Controlled Drugs and Substances Act*, Subsection 56(1) Class Exemption for Nurses Providing Health Care at a Community Health Facility.

k. Keep all required controlled substances records and onsite prescriptions per federal, provincial, and clinic regulations and protocols.

l. Meet all documentation requirements related to the storage and administering of onsite prescriptions.

4. Clinic sites will:

a. Ensure there is appropriate staffing, resources, facility infrastructure (physical and security), education and training, controlled substances policy and procedures, and other program requirements in place for safe handling of controlled substances.

b. Implement and follow controlled substances standard operating procedures to receive, store, administer, dispense, transport, send, deliver, destroy, and oversee, per applicable federal and provincial regulations.

RELEVANT RESOURCES AND POLICIES

- *Guideline for the Clinical Management of Opioid Use Disorder (2017)*
    - See also the BCCSU's *Opioid Use Disorder: Practice Update* (2022), which updates the 2017 guideline
- Health Canada's *Controlled Drugs and Substances Act* Subsection 56(1) Class Exemption for Nurses Providing Health Care at a Community Health Facility
- Health Canada's *Controlled Drugs and Substances Act* Subsection 56(1) Class Exemption for the Person in Charge of a Hospital and/or a Pharmacist who Supplies Controlled Substances to a Community Health Facility
- Health Canada's *Controlled Drugs and Substances Act Subsection* 56(1) Class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada
- BC College of Nurses and Midwives requirements, including limits and conditions, for RN and RPN prescribing for opioid use disorder:
    - Acting Within Autonomous Scope of Practice
    - Medication
    - Prescribing
- BC College of Nurse's and Midwives requirements for NPs:
    - Standards for prescribing
    - Limits and conditions for prescribing, specific to controlled drugs and substances
    - G: Prescribing for Opioid Use Disorder and/or Pharmaceutical Alternatives for Safer Supply (bccnm.ca)
- College of Pharmacists of BC relevant requirements and Professional Practice Policies
    - *Pharmacy Operations and Drug Scheduling Act Bylaws*
    - Community Pharmacy Standards of Practice
    - Professional Practice Policy-66 Opioid Agonist Treatment
- Ministry of Health PRIME user enrolment
    - PRIME site registration
    - PRIME information

APPENDIX: TMU ENTRY GUIDANCE

How to annotate patient PharmaNet records when providing addiction treatment

It is critical for continuity of care and patient safety that health professionals keep patient medication histories up to date in PharmaNet.

In the context of addiction treatment, such as oral and injectable opioid agonist therapy (OAT) and prescribed safer supply, health professionals in emergency departments and community health facilities (clinics, programs) must update a patient's PharmaNet record when:

Access to PharmaNet and PRIME

Prescribers and nurses must be authorized to access PharmaNet to view and add notes to patient profiles.

Request access by enrolling in PRIME. See www.gov.bc.ca/pharmanet/PRIME

- Emergency department take-home doses are provided. e.g., buprenorphine-naloxone
- Clinic (ward) stock is dispensed
- The patient receives a higher or lower dose at the point of care than the pharmacy-dispensed prescription
- Patient misses a dose(s)

Updating PharmaNet

Some health professionals with access to PharmaNet can add a record to a patient's PharmaNet profile.

In PharmaNet these records are called transaction medication updates (TMUs). Intervention codes are used to help ensure accurate collection of data for monitoring and evaluation.

Intervention Codes are a mandatory field in TMU, please use the following:

- SA = safer alternative - prescribed safer supply every fill/dispense, OR
- UA = consulted prescriber and filled Rx as written (not safer prescribed supply)

All entries must be made by end of clinic day or end of emergency department shift during which action occurred.[i]

The following table provides guidance on when and where to record controlled substance dispenses in TMU (e.g. opioids, stimulants, benzodiazepines).

[i] For extended-release injectable buprenorphine, PharmaNet must be updated if a) a patient is provided a dose from clinic (ward) stock, b) receives a dose that differs from that dispensed by the pharmacy, or c) a missed dose, if the patient does not receive the pharmacy-dispensed dose within the clinic protocol or clinically appropriate treatment interval

Clinic (ward) stock used (enter PIN in DIN field)		**Patient-specific pharmacy-dispensed changes** (enter PIN in DIN field)		
Clinic (ward) stock dose used to provide dose when there is no pharmacy-dispensed prescription	**Buprenorphine/naloxone induction doses** given on site or "to go" to an outpatient	**Patient missed all or some doses** at the clinic from the pharmacy-dispensed prescription	**Dose increased at clinic visit** and patient received a dose that was more than the pharmacy-dispensed prescription	**Dose decreased at clinic visit** and patient received a dose that was less than the pharmacy-dispensed prescription
PIN: **66128342** **Directions**[i]**:** drug, dose and directions, time **Quantity:** # of tablets/ capsules/ patches, volume of injection (mL) **Days' supply:** 1 **Intervention code: UA or SA** **Prescriber name:** add if different than person entering *Please do an entry for each molecule/drug provided by clinic stock (excluding bup/naloxone-next column)	**PIN: 66128346** **Directions:** standard dosing, microdosing**,** or total dose taken/provided, **Days' supply: as appropriate** **Intervention code: UA** **Prescriber name:** add if different than person entering	**PIN**: **66128343** **Directions:** drug, record which dose(s) missed, **Days' supply**: **as appropriate** **Intervention code**: UA **Prescriber name:** add if different than person entering	**PIN: 66128344** **Directions:** Drug name, total dose taken **Days' supply**: **as appropriate** **Intervention code**: UA **Prescriber name**: if different than person entering *Only use this one PIN, even if providing with clinic stock	**PIN**: **66128345** **Directions:** Drug name, total dose taken **Days' supply: as appropriate** **Intervention code**: UA **Prescriber name:** add if different than person entering
Example: **PIN:** 66123342 **Directions:** Fentanyl patches 100 mcg, apply to skin and replace every 3 days **Days' supply:** 3 **Intervention code: SA** **Prescriber name:** Dr Bond	**Example:** **PIN** in DIN field**: 66128346** **Directions:** Microdosing regimen, take home **Days' supply:** 5 **Intervention code: UA** **Prescriber name:** Dr. Tran	**Example 1:** Patient has pharmacy-dispensed diacetylmorphine iOAT three times daily **PIN**: 66128343 **Directions:** diacetylmorphine injectable, 100 mg Dose 1 and 150 mg Dose 2 **Days' supply:** 1 **Intervention code: UA** **Prescriber name**: Dr. Pate **Example 2:** **Directions:** Kadian, 700mg, daily **Days' supply:** 1 **Intervention code:** UA **Prescriber name:** Dr. Day	**Example 1:** Patient has pharmacy-dispensed Fentora 400 mcg qid **PIN** in DIN field: 66128344 **Directions:** Fentora, 600 mcg, 3rd and 4th doses **Days' supply:** 1 Intervention code: UA Prescriber name: Dr. Da **Example 2:** Patient has pharmacy-dispensed Suboxone 8mg/2mg. **PIN** in DIN field: 66128344 **Directions:** Suboxone 16mg/4mg **Days' supply:** 1 **Intervention code:** UA **Prescriber name:** Dr. Fleur	**Example:** Patient has pharmacy-dispensed sufentanil 1000 mcg five times per day prn **PIN** in DIN field: 66128345 **Directions:** sufentanil, 900 mcg 5th dose, new Rx **Days' supply:** 1 **Intervention code**: UA Prescriber name: Dr. Yu

[ii] TMU Directions field has a maximum of 80 characters