Methadone Dispensing Incidents: Contributing Factors, Key Learnings and Important Resources

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This resource highlights key points from the Pharmacy Connection article Methadone Dispensing: Learning from Recent Incidents. Any error involving methadone is a significant risk to patient safety.

CONSIDER THESE POTENTIAL CONTRIBUTING FACTORS TO RECENT MEDICATION INCIDENTS INVOLVING METHADONE:



Equipment limitations for low dose prescriptions



Wide range of therapeutically appropriate doses



Misinterpretation of the prescription volume



Pharmacists acting in a temporary or relief position in the pharmacy

ASSESS YOUR OWN PRACTICE AND IDENTIFY ANY AREAS FOR IMPROVEMENT, WHICH COULD INCLUDE:



Creating, amending and/or reviewing written policies and procedures at the pharmacy specific to issues that may arise with the dispensing of methadone to ensure consistency of care



Designing the dispensing workflow to allow for multiple checks to verify correct entry, dose preparation and labelling



Ensuring that every prescription has been assessed for therapeutic appropriateness prior to being dispensed and that standards of practice on patient assessment and documentation are met



Verifying that staff have the necessary and up-to-date knowledge, skills and judgment to provide MMT before they engage in dispensing

ENSURE YOU ARE FAMILIAR WITH KEY RESOURCES RELATED TO METHADONE DISPENSING:

- Key Requirements for Methadone Maintenance Treatment Fact Sheet
- Opioid Policy
- Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders (CAMH)
- Opioids and Opioid Use Disorder Practice Tool