



Ontario College
of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

FALL 2013 • VOLUME 20 NUMBER 4

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS



**LEARNING
PARTNERSHIPS
THAT BENEFIT ALL**



Ontario College of Pharmacists

Putting patients first since 1871

MISSION:

The Ontario College of Pharmacists regulates pharmacy to ensure that the public receives quality services and care.

VISION:

Lead the advancement of pharmacy to optimize health and wellness through patient-centred care.

VALUES:

Transparency - Accountability - Excellence

STRATEGIC DIRECTIONS:

1. Optimize the evolving scope of practice of our members for the purpose of achieving positive health outcomes.
2. Promote the use and integration of technology and innovation to improve the quality and safety of patient care, and to achieve operational efficiency.
3. Foster professional collaboration to achieve coordinated patient-centred care and promote health and wellness.
4. Build and enhance relationships with key stakeholders, including the public, the government, our members, and other health care professionals.
5. Apply continuous quality improvement and fiscal responsibility in the fulfilment of our mission.

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Elected Council Members are listed below according to District. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. U of T indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. U of W indicates the Hallman Director, School of Pharmacy, University of Waterloo.

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H Regis Vaillancourt	PM Aladdin Mohaghegh
K Esmail Merani	PM Gitu Parikh
K Mark Scanlon	PM Shahid Rashdi
(Vice President)	PM Joy Sommerfreund
L Jillian Grocholsky	U of T Heather Boon
L Michael Nashat	U of W David Edwards
L Farid Wassef	
M Tracey Phillips	Statutory Committees
(President)	• Executive
M Don Organ	• Accreditation
M Laura Weyland	• Discipline
N Bonnie Hauser	• Drug Preparation
N Christopher Leung	Premises
N Ken Potvin	• Fitness to Practise
P Jon MacDonald	• Inquiries Complaints &
P Rachelle Rocha	Reports
T Tracy Wills	• Patient Relations
TH Goran Petrovic	• Quality Assurance

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PM Corazon dela Cruz
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- Finance & Audit
- Professional Practice

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The objectives of Pharmacy Connection are to communicate information about College activities and policies as well as provincial and federal initiatives affecting the profession; to encourage dialogue and discuss issues of interest to pharmacists, pharmacy technicians and applicants; to promote interprofessional collaboration of members with other allied health care professionals; and to communicate our role to members and stakeholders as regulator of the profession in the public interest.

We publish four times a year, in the Fall, Winter, Spring and Summer.

We also invite you to share your comments, suggestions or criticisms by letter to the Editor. Letters considered for reprinting must include the author's name, address and telephone number. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.

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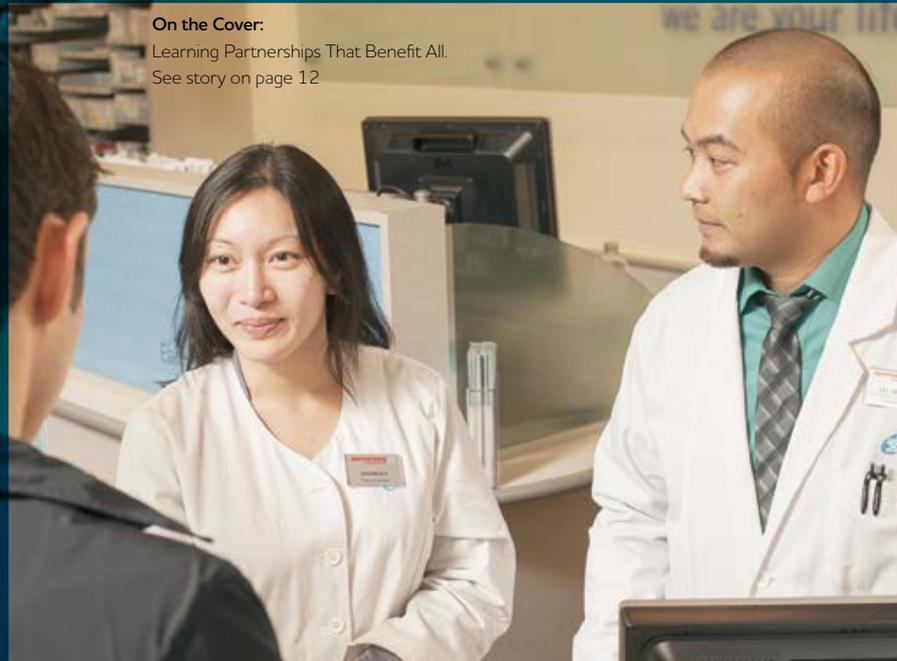
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On the Cover:

Learning Partnerships That Benefit All.

See story on page 12



PHARMACY CONNECTION

FALL 2013 • VOLUME 20 NUMBER 4

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Tracey Phillips,
R.Ph., B.Sc.Pharm./MBA
President

“... our greatest opportunity, the ability to deepen our relationships with our patients”

There's a familiar saying – when opportunity knocks, open the door! This expression comes to mind when I think of the thousands of pharmacists immunizing hundreds of thousands of Ontarians.

The numbers are impressive and pharmacists should be proud of the way we have stepped up to embrace this new authority.

However, beyond the obvious benefit – that greater access to flu shots through pharmacists' participation will likely bolster the province's overall immunization rate, as it has done in other jurisdictions like British Columbia – there is so much more that can be gained.

For many community pharmacies where – despite the greatest of intentions – the bulk of a pharmacist's time is still spent behind the dispensary counter, the interaction with patients that comes with the administration of a flu shot is providing unique opportunities.

We have long known that one of the biggest challenges to readily providing many of our cognitive services is our ability to appropriately

identify those patients who would benefit most from them. Pharmacists who are using the face-to-face opportunity that injection administration provides as a means to do this are discovering many benefits.

Aside from the obvious benefit of immunization, the dialogue is leading to qualified referrals for MedsChecks, specialty clinics dealing with diabetes or hypertension or the initiation of therapies such as smoking cessation. Beyond these tangible benefits however, lies our greatest opportunity – the ability to deepen our relationships with our patients. The true value of this should not be underestimated.

In today's patient-centric model of healthcare, it is more important than ever that patients clearly understand the role and value that each individual member of their healthcare team brings. For years, pharmacists have worked diligently as medication experts using their knowledge and skills to enhance the effectiveness of drug therapy for their patients, but much of this has happened behind the scenes where patients are simply not aware of it happening.

As a profession, we need to demonstrate our value. It is not enough to silently do; we must show and then tell. We need to feel confident that patients consciously identify us as not just a place where they can pick up their medications, get advice or now receive their flu shot, but rather as a primary member of their healthcare team. Patients must understand that our role is as a decision-maker in their drug therapy not one of simply carrying out someone else's directive.

As medication experts, the true value that we bring to the healthcare team is in our ability to act in this decision-making role. In this regard, our authority to renew and adapt prescriptions is our more valuable resource and one that we need to embrace with the same overt enthusiasm as we have injections.

To do this, we must take advantage of those face-to-face opportunities with our patients.

There's a knock at the door ... let's answer! 🚪

Council for the Ontario College of Pharmacists elects President and Vice-President

September 30, 2013 - At the September Council meeting of the Ontario College of Pharmacists, Tracey Phillips, R.Ph., was elected President and Mark F. Scanlon, R.Ph., Vice-President. Each will serve a one-year term from September 2013 through September 2014.

On behalf of his fellow Council members, Past-President Chris Leung congratulated his colleagues emphasizing, "Both Tracey and Mark have vast experience on Council and I am confident that their



Left to right:
OCP Registrar Marshall Moleschi, President Tracey Phillips, and Vice-President Mark Scanlon

combined leadership skills will effectively and efficiently guide the College over the coming year."

Tracey, who works and lives in the Toronto area, is a graduate of the Leslie Dan Faculty of Pharmacy, University of Toronto with 23 years experience as a retail pharmacist and has served on Council since 2005. During that time, Tracey has participated in many working groups and committees, having chaired both the Quality Assurance and Professional Practice committees. One of Tracey's many highlights includes the work done, under her leadership, by the Professional Practice committee on the regulations and guidelines for the profession's expanded scope of practice. In her current capacity as President, Tracey is also Chair of Council's Executive Committee. Tracey's passion for the profession and commitment to serve the best interest of the patient is well-known throughout the pharmacy community.

Mark F. Scanlon, a retail pharmacist currently practicing in Peterborough with more than 25 years experience, is also a graduate of the Leslie Dan Faculty of Pharmacy, University of Toronto. Mark first served as a Council member for a one-year term in 2002 – 2003, returning to Council in 2010. Throughout the years he has actively contributed on numerous committees including; Discipline, Registration, Fitness to Practise, Executive, Inquiries/Complaints and Reports (ICRC), and Quality Assurance in addition to participating on many working groups. As a third generation pharmacist, Mark's dedication to the profession and the public it serves is deeply rooted and he has been recognized by his colleagues for his many contributions.

"We are looking forward to working with both Tracey and Mark during this exciting time for pharmacy in Ontario," said OCP Registrar, Marshall Moleschi. "Under their leadership, OCP is in an ideal position to continue to uphold its mandate of public protection and can support members in understanding and embracing practice change as outlined in the College's strategic plan." 

SEPTEMBER 2013 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on September 9th and 10th, 2013.

COUNCIL ELECTS NEW PRESIDENT AND WELCOMES NEW COUNCIL MEMBERS

Ms. Tracey Phillips was elected College President for the 2013-2014 Council year. Also welcomed to the Council table were new members Ms. Jillian Grocholsky and Mr. Michael Nashat, from District L; Ms. Laura Weyland, from District M, Mr. Goran Petrovic from District TH and Dr. Heather Boon, Interim Dean of the Leslie Dan Faculty of Pharmacy.

2014 CAPITAL AND OPERATING BUDGET APPROVED

Council reviewed and approved the 2014 budget, which supports the strategic plan developed by Council in March 2012 with supporting Year Two operating plan presented to Council in June 2013.

There are no fee increases proposed for 2014 and the total reserves are expected to be around \$7.2 million. Of note is funding allocated for special committees to advise on Minor Ailments, Hospital Pharmacy Accreditation and continuation of the governance review through the Task Force on Governance. In addition, a Hospital Accreditation Program area will be created as indications are that the College will be called upon to provide the oversight of hospital pharmacy practice. This approach is similar to that taken with registered technicians where the program was created and the elements of registration developed in anticipation of regulatory authority. As well, a series of district meetings is anticipated in early 2014.

Council also approved the appointment of Clarke Henning LLP as Auditors for 2013 noting that as is customary, an external review of the auditing and financial services will be conducted in 2014.

COUNCIL APPROVES BY-LAW NO. 3

In September 2012, Council directed that a Special Committee of Council be appointed to conduct an overall review of the College's Operating By-law. Following extensive evaluation and consultation, the revised By-law No. 3 was approved by Council. By-law No. 3 has resulted in clarification of language, intent and process and eliminated redundant language where appropriate.

PROFESSIONAL MISCONDUCT REGULATION

The draft amended regulation to the Pharmacy Act to address professional misconduct was circulated for comment by stakeholders following the June 2013 Council meeting. At the close of the consultation (August 12), the College had received comments from 56 individuals and 4 organizations. While the member feedback raised several issues related to the profession, it will not lead to any substantive changes to the draft regulation itself. There is, however, a need to further communicate and educate stakeholders on these regulatory changes through meetings similar to those held by the College in the past. Council was in agreement that to take the additional time to provide the necessary clarification before ratifying this regulation will not jeopardize any of the College's current processes.



TRANSPARENCY PRINCIPLES CONSIDERED

This College, together with other regulatory Colleges, is working on a multi-staged initiative that will see us examine our information-sharing practices and determine how we might make more information available about decisions and processes. There is a growing sentiment that access to more information may assist members of the public in choosing a regulated health professional, enhance accountability, and better inform any evaluation of the performance of self-regulation of the profession.

A small group of health professional regulators (AGRE – Advisory Group for Regulatory Excellence),

whose membership includes this College, has developed draft transparency principles to guide regulatory college discussions about making more information publicly available. In developing the draft principles, the group had several objectives:

- To focus on principles only
- To keep the number of principles low, with good rationales and supporting evidence
- To strike a balanced tone, one that demonstrates openness to transparency, combined with a thoughtful, careful approach and recognition of the strengths of the existing legislative framework.

Council was requested to consider these principles and to provide

feedback to AGRE for consideration with a view to finalization of the principles by the end of 2013. Discussions about details of implementation, including specific categories of information, will occur after the principles discussions. 📧

NEXT COUNCIL MEETINGS:

Monday 9 December, 2013
 Monday 17 March, 2014
 Monday 16 June, 2014
 Monday 15 and Tuesday 16 September 2014

For more information respecting Council meetings, please contact Ms. Ushma Rajdev, *Council and Executive Liaison* at urajdev@ocpinfo.com

MEMBERSHIP RENEWAL REMINDER

Online renewal starts in January with a deadline of March 10, 2014

NOTE: no form will be mailed to you, however email reminders will be sent.

Before you begin your online renewal you will need:

- Credit Card or Interac (Debit Card) if paying online
- User ID - This is your OCP number
- Password - If you have forgotten your password, click "Forgot your Password or User ID?" and a new password will be emailed to you

Once you're ready:

- Go to www.ocpinfo.com and click on "**Login to my Account**"
- Enter your User ID (your OCP number) and your password
- Once you have successfully logged in, click on "**Member Renewal**" on the left hand side of the screen

OCP Council 2013/2014



Committee Appointments 2013/2014

EXECUTIVE

Elected Members:

Tracey Phillips – President & Chair
Mark Scanlon – Vice President
Chris Leung – Past President

Esmail Merani

Public Members:

David Hoff
Aladdin Mohaghegh
Joy Sommerfreund

Staff Resource:

Marshall Moleschi

ACCREDITATION

Elected Members:

Bonnie Hauser
Michael Nashat
Regis Vaillancourt

Public Members:

David Hoff (Chair)
Joy Sommerfreund

NCCM:

Timothy Brady
Tracy Wiersema

Staff Resource:

Tina Perlman

COMMUNICATIONS

Elected Members:

Jon MacDonald
Goran Petrovic
Ken Potvin

Public Members:

Javaid Khan
Joy Sommerfreund (Chair)

NCCM:

Gerry Cook

Staff Resource:

Lori DeCou

DISCIPLINE

Elected Members:

Heather Boon
Jillian Grocholsky
Chris Leung
Don Organ
Goran Petrovic
Rachelle Rocha
Mark Scanlon
Farid Wassef
Laura Weyland

Public Members:

Bob Ebrahimzadeh (Chair)
Javaid Khan
Lew Lederman

Norman MacDonald

Aladdin Mohaghegh

Gitu Parikh

Shahid Rashdi

NCCM:

Cheryl Bielicz

Larry Boggio

Erik Botines

Steve Clement

Debbie Fung

Jim Gay

Andrew Hanna

Mike Hannalah

Tony Huynh

Doris Nessim

Akhil Pandit Pautra

Jeannette Schindler

Connie Sellors

Dan Stringer

Tatjana Sunjic

David Windross

Babek Zandi

Staff Resource:

Maryan Gemus

DRUG PREPARATION PREMISES

Same membership as

Accreditation Committee

Staff Resource:

Susan James

FINANCE & AUDIT

Elected Members:

Bonnie Hauser (Chair)

Esmail Merani

Mark Scanlon

Public Members:

David Hoff

Gitu Parikh

Staff Resource:

Connie Campbell

FITNESS TO PRACTISE

Elected Members:

Chris Leung (Chair)

Regis Vaillancourt

Public Members:

Cora dela Cruz

Shahid Rashdi

Joy Sommerfreund

NCCM:

Barb DeAngelis

Staff Resource:

Maryan Gemus

INQUIRIES, COMPLAINTS AND REPORTS (ICRC)

Elected Members:

Heather Boon

Michael Nashat

Don Organ

Ken Potvin

Rachelle Rocha

Mark Scanlon

Farid Wassef

Laura Weyland

Tracy Wills (Chair)

Public Members:

William Cornet

Javaid Khan

Lew Lederman

Aladdin Mohaghegh

Gitu Parikh

NCCM:

Elaine Akers

Kalyna Bezchlibnyk-Butler

Gerry Cook

Mike Hannalah

Gurjit Husson

Eva Janecek-Rucker

Elizabeth Kozyra

Saheed Rashid

Satinder Sanghera

Beth Sproule

Amber Walker

Tracy Wiersema

Staff Resource:

Maryan Gemus

PATIENT RELATIONS

Elected Members:

Bonnie Hauser (Chair)

Michael Nashat

Public Members:

Cora dela Cruz

Javaid Khan

Lew Lederman

NCCM:

Karen Skubnik

Staff Resource:

Anne Resnick

PROFESSIONAL PRACTICE

Elected Members:

Esmail Merani (Chair)

Don Organ

Farid Wassef

Public Members:

David Hoff

Joy Sommerfreund

NCCM:

Heba Abdel Aal

Andrea Ball

Lap Chan

Mina Tadrus

Staff Resource:

Tina Perlman

QUALITY ASSURANCE

Elected Members

Christine Donaldson

Jon MacDonald (Chair)

Mark Scanlon

Public Members:

David Hoff

Aladdin Mohaghegh

Lew Lederman

NCCM:

Catherine Payne

Zita Semeniuk

Puja Shanghavi

Staff Resource:

Sandra Winkelbauer

REGISTRATION

Elected Members:

Christine Donaldson (Chair)

Jillian Grocholsky

Chris Leung

Tracy Wills

Public Members:

William Cornet

Norman MacDonald

Aladdin Mohaghegh

NCCM:

James Buttoo

Dean:

David Edwards

Ontario Pharm Tech Program Rep:

Sharon Lee

Staff Resource:

Susan James

NCCM = Non-Council

Committee Member

2013/2014 Members of Council



- H** Hospital
- T** Pharmacy Technician
- TH** Hospital Pharmacy Technician

Public Members



Corazon dela Cruz
Toronto



William Cornet
Ottawa



Babek Ebrahimzadeh
Woodbridge



David Hoff
Oakville



Javaid Khan
Markham



Lew Lederman
Ottawa



Norman MacDonald
Toronto



Aladdin Mohaghegh
Toronto



Gitu Parikh
Toronto



Shahid Rashdi
Mississauga



Joy Sommerfreund
London

Elected Members

District **H**



Christine Donaldson
Windsor



Regis Vaillancourt
Ottawa

District **K**



Mark Scanlon
VICE PRESIDENT
Peterborough



Esmail Merani
Carleton Place

District **L**



Jillian Grocholsky
Fonthill



Farid Wassef
Stouffville



Michael Nashat
Brampton

District **M**



Laura Weyland
Toronto



Tracey Phillips
PRESIDENT
Toronto



Don Organ
Toronto

District **N**



Chris Leung
Windsor



Bonnie Hauser
Dunnville



Ken Potvin
Waterloo

District **P**



Rachelle Rocha
Espanola



Jon MacDonald
Sault Ste. Marie

District **TH/T**



Goran Petrovic (TH)
Kitchener



Tracy Wills (T)
Windsor

Faculty of Pharmacy



Heather Boon, Interim Dean
Leslie Dan Faculty of Pharmacy
University of Toronto



David Edwards, Hallman Director
School of Pharmacy
University of Waterloo

LEARNING PARTNERSHIPS THAT BENEFIT ALL



12

PRECEPTORS, PRECEPTees AND PHARMACIES ALL GAIN FROM THE REWARDING EXPERIENCE – DON'T MISS YOUR OPPORTUNITY

By Stuart Foxman

When he was a pharmacy student in 2004, Felvante De Padua, RPh, recognized the importance of having an experienced mentor.

“There’s a steep learning curve when you’re new to an environment like a fast-paced pharmacy,” says De Padua, an Associate Owner at a Shoppers Drug Mart in London. “In some of my tougher student rotations, it was critical to have a preceptor. You want to be in the hot seat and get an appreciation for a community pharmacy, but also know that you have the support you need behind you.”

That’s one reason why De Padua has embraced the chance to be a preceptor himself. He has done so for eight individuals, including pharmacy students and interns, and pharmacy technician applicants.

Like De Padua, hundreds of pharmacy professionals have taken on the preceptor role through the College’s Structured Practical Training (SPT) program. SPT is the in-service training requirement for registration as a pharmacist or pharmacy technician in Ontario.

Participants in the SPT program – referred to by the College as preceptees – complete activities based on the NAPRA competencies (which are relevant to their pursuit, pharmacist or pharmacy technicians, and practice site), and complete self-assessments of their performance as they proceed through training. The preceptor also prepares written assessments, which document the preceptee’s progress and highlight areas for improvement.

Under SPT, pharmacists can train either

pharmacist or pharmacy technician applicants. Pharmacy technicians can precept people in the pharmacy technician stream.

“Doing this reinforces that the role of the pharmacist is to educate,” says De Padua. “We educate patients every day, so this is a natural step to educate our next generation of pharmacists.”

PUTTING LEARNING INTO PRACTICE

Preceptees typically enter the learning partnership filled with “enthusiasm to put their book learning into practice,” says Mahmoud Suleiman, Registration Advisor, SPT Lead for OCP. What makes for the most productive relationship with their preceptors?

Start with clear learning goals, formalize the support, and be open about your experiences, says Leslie Braden, R.Ph., who works at Orillia Soldiers’ Memorial Hospital.

She has precepted for pharmacy technicians, and educates by providing concrete examples of situations she has encountered in her practice and possible approaches. Braden says it’s important to set times for weekly (or even twice weekly) discussions to review questions. “In the pharmacy, people are pulled in different directions, so you have to make those meetings part of your job,” says Braden.

De Padua focuses on providing opportunities for pharmacy students and interns to share their therapeutic knowledge, do counseling and medication reviews, and form professional opinions with physicians. He also has them plan a clinic, e.g. on diabetes or smoking cessation.

Pharmacy students and interns come with a great knowledge base. De Padua sees part of

“They’re an incredible resource to increase your ability to provide counselling and reviews, so that helps the pharmacy team and your patients. It’s a win-win.”

Pharmacist Felvant De Padua



Pharmacist Felvant De Padua with intern Sherman Chiu

his role as helping them with what he calls the “grey area – what you do with all that information”.

For example, if a patient is on a medication that causes low blood sugar readings, De Padua might have his preceptee go through the profiles. The goal is to see if there’s a chance to go on another medication that wouldn’t lead to potential hypoglycemia. “It’s a matter of coaching them. Are they seeing what I’m seeing, and what can we do next?”

PRECEPTORS FIND THEIR OWN PROFESSIONAL GROWTH

While the preceptees gain from the experience, De Padua says that the pharmacy benefits too.

“Having them here means that we essentially have another pharmacist,” he says. “They’re an incredible resource to increase your ability to provide counselling and reviews, so that helps the pharmacy team and your patients. It’s a win-win.”

Braden adds that “You are training people who will work with you and become an indispensable part of your own team. So being a preceptor is in your own best interests.”

She says showing someone the ropes also helps you to look at the pharmacy from a different angle. For instance, you gain a fresh take on how the job functions or roles are interrelated, and that reinforces the importance of clear coaching and clear communications.

The preceptor experience has also made for a safer practice, says Braden. “You see the pitfalls, like what areas of dispensing might lead to a misunderstanding. Or you learn not to assume that someone always knows what to do if you ask for a medication



Pharmacist Leslie Braden with SPT technician preceptee Prestin Marshall

reconciliation. If you work with the technicians during the training period, you get a more standardized approach,” she says.

Many preceptors are motivated by altruistic reasons, says Suleiman: “They want to pay it forward, but it helps to reinvigorate their own practice too.”

De Padua agrees that being a preceptor has inspired him, and helped him grow as a professional.

“The pharmacy students and interns have a wonderful set of knowledge,

all evidence-based and current,” he says. “When I finished university, that was the peak of where I was as a generalist. In the environments you’re in, you develop a niche specialty. When I have a preceptee here, it keeps me striving to improve my own knowledge. It makes me look into my own portfolio to see where the gaps are. In that way, they are actually a great resource for me. I learn something from them almost every day.”

De Padua is also more conscious of being a strong role model. “I’m leading by example, so when a

“This is like a dress rehearsal for the roles you’ll have with each other. You’re building relationships that will help you to do a better job.”

Pharmacist Leslie Braden

preceptee is observing me I want to make sure that I’m fostering good habits for them. It keeps me on my ‘A’ game.”

To Braden too, the experience has made her a better pharmacist. “I appreciate the importance of communications, and that the roles are becoming more complex for both pharmacists and pharmacy technicians,” she says. “This is like a dress rehearsal for the roles you’ll have with each other. You’re building relationships that will help you to do a better job.”

Whether you are a pharmacist or pharmacy technician, becoming a preceptor – and having your community or hospital pharmacy accept preceptees – provides benefits for everyone. In addition to the College continuously recruiting preceptors accredited pharmacy and pharmacy technician educational institutes are also always seeking new sites for placement for their students – don’t miss out on the opportunities this experience can bring. 



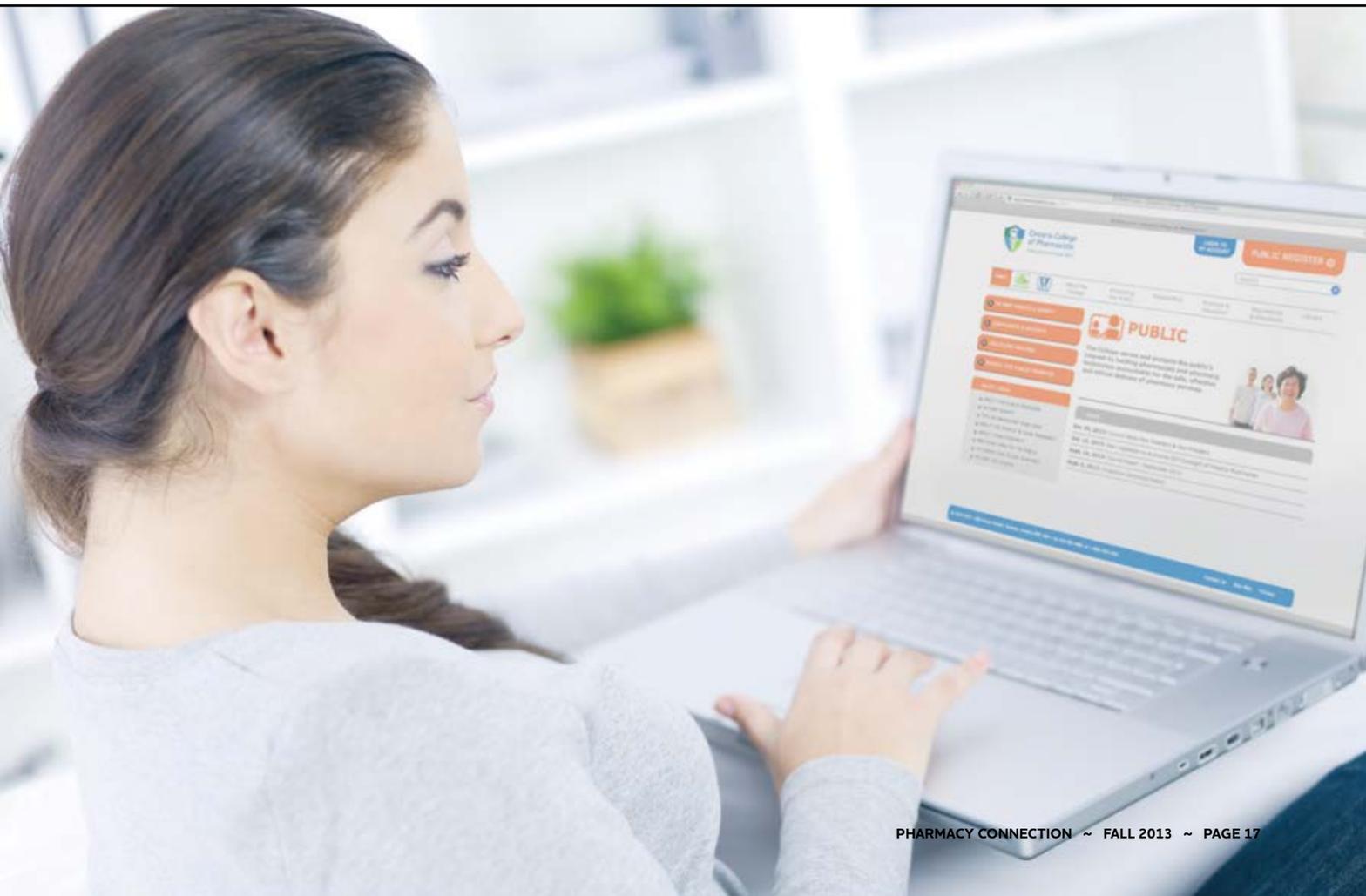
For information on how to become a preceptor and what’s involved, check the College website (www.ocpinfo.com). A series of orientation workshops offer instruction/reinforcement on feedback and assessment skills. See a list of workshops on page 45. The workshops are also a forum where preceptors can meet and exchange ideas. For seasoned preceptors, advanced workshops help them refine their feedback and assessment, and share their preceptoring experiences.

Transparency – evolving the way we think about what we share

It would be virtually impossible and definitely irresponsible to ignore the public's growing call – particularly towards organizations with a public interest mandate – for greater transparency. As the regulatory body for the profession of pharmacy in Ontario, the College has always understood that the public's trust is contingent on our ability to demonstrate our accountability to this mandate.

Mr. Steven Lewis, a health policy consultant and adjunct professor of health policy at Simon Fraser University speaking on this topic to the College of Physician and Surgeons of Ontario's Council said, "public trust has taken a huge hit in the last 20 years. The result is a citizenry deeply skeptical about the motives of institutions."

This has led to a worldwide social movement of transparency and a



demand for access to information long kept private. And if that information is not provided willingly, it will often be taken forcibly. If organizations are not opening up, people will be prying them open, said Lewis.

Lewis does not believe that maintaining the status quo is an option for any organization, especially one with a mandate to protect the public interest concluding, "the culture has changed irreversibly".

Respecting this reality, this College, as part of a small group of health professional regulators (AGRE – Advisory Group of Regulatory Excellence), is working on a multi-staged initiative that will see us examine our information-sharing practices and determine how we might make more information available about decisions and processes. The approach recognizes that access to more information may assist members of the public in choosing a regulated health professional, enhance accountability, and better inform any evaluation of the performance of self-regulation of the profession.

The first step in this initiative has been the development of transparency principles which will ultimately guide regulatory colleges' future decisions about making more information available to the public.

In developing the draft principles (at right), the group – which consists of representatives from medicine, nursing, dentistry, pharmacy, optometry and physiotherapy – had several objectives:

- To keep the number of principles low, with good rationales and supporting evidence; and
- To strike a balanced tone, one that demonstrates openness to transparency, combined with a thoughtful, careful approach and recognition of the strengths of the existing legislative framework.

It is important to note that the principles are not meant to relate to member-specific concerns only, such as the outcome of complaint investigations. But also to address broader transparency issues, including information about processes and aggregate data about outcomes.

The eight draft principles can be summarized briefly as follows:

1. Public requires information to trust that the system is works;
2. More information improves choice and accountability;
3. Information should be relevant, credible and accurate in order to support #2;
4. How information is provided matters – it must be timely, easy to find and understand, and have context;
5. Remediation protects the public and requires confidentiality;
6. Discussions about transparency should balance the principles of public protection and accountability, with fairness and privacy;
7. More risk requires more transparency; and
8. Consistency – the public should be able to expect to obtain the same kind of information about any regulated healthcare professional in Ontario.

These principles which were approved by College Council at their September meeting are currently in the final stages of consultation and are expected to be finalized by the end of 2013. Following this, the working group, under the direction of AGRE, will recommend means by which all regulatory colleges could adopt and operationalize these transparency principles to guide decisions regarding disclosure and access to information.

The concept of transparency however is not new to the College; in fact it is one of the College's three core values as outlined in Council's strategic plan. As such, there are a number of recent changes that demonstrate our ongoing commitment to this concept. For example, the most recent updates to College by-laws included the addition of the public posting of the status and outcome of routine inspections of community pharmacies and drug preparation premises.

Additionally, in the re-design of the College's website, scheduled to launch in early 2014, one of the principles driving the design has been to ensure that information currently available to the public is easily accessible. This principle is based on the understanding that transparency is an equal blend of disclosure and accessibility.

Although there is still much to debate, one thing is clear; the conversation on transparency is evolving the way we think about what we share. 

1. College of Physicians and Surgeons of Ontario (DIALOGUE – Issue 3, 2013) "greater transparency, more accountability". Available at <http://www.cpso.com>

Transparency Principles

Principle 1: *The mandate of regulators is public protection and safety. The public needs access to appropriate information in order to trust that this system of self-regulation works effectively.*

Principle 2: *Providing more information to the public has benefits, including improved patient choice and increased accountability for regulators.*

Principle 3: *Any information provided should enhance the public's ability to make decisions or hold the regulator accountable. This information needs to be relevant, credible and accurate.*

Principle 4: *In order for information to be helpful to the public, it must:*

- *be timely, easy to find and understand.*
- *include context and explanation.*

Principle 5: *Certain regulatory processes intended to improve competence may lead to better outcomes for the public if they happen confidentially.*

Principle 6: *Transparency discussions should balance the principles of public protection and accountability, with fairness and privacy.*

Principle 7: *The greater the potential risk to the public, the more important transparency becomes.*

Principle 8: *Information available from Colleges about members and processes should be similar.*

New website delivers easier access to the information you need

The College is happy to announce the launch of our new website – happening this January, 2014

The re-designed website provides you with quick, easy access to services and information that you need, and includes several exciting new features that will significantly improve your online experience.

We created an entirely new website with brand new navigation and fresh content that offers a tailored experience for each of the different user groups that visit our website. Our main visitors –

College members, applicants and members of the general public – can now access the information they need on pages that have been designed specifically for them.

The website is intuitive, transparent, and provides visitors with several options for easy navigation. It is also completely accessible by all types of mobile devices and assistive technology devices like screen readers for the visually impaired.

Sneak Peeks – Here’s What You Can Expect On The New Website:

THE HOME PAGE



The home page directs you to the information that is most relevant to you. Click on the blue “member” button and easily find the information that you need. There’s also a news feed tailored just to you.

PUBLIC PAGE



The public portal has clear, transparent information for members of the general public. If a patient has a concern about the care they have received or wants to understand more about how the College protects the public – this is the place to go. The public can find out their rights as a patient, tips on managing their care, and how to use the Public Register to find a pharmacy, pharmacist or pharmacy technician.

MEMBER PAGE



We asked members what they wanted to do on our website – this page collects the information that members need most frequently. Whether you have a question about practice, need to read a regulation or practice standard, want information about the inspection process, or need to submit a form to change the DM of your pharmacy – it's all here.

PRACTICE TOOLS

The Practice Tools section is a new addition to the College's website. From the member page you can quickly access information about a number of different practice issues from one central location. Find information about:

- Compounding
- Designated Managers
- Drug Preparation Premises
- Expanded Scope
- Immunizations
- Infection Control
- Interprofessional Collaboration & Teamwork
- Medication Incidents
- Methadone and Buprenorphine
- Narcotics
- Patient Relationships
- Pharmacy Technicians
- Prescription Information & Labelling
- Professional Fees
- Record Keeping, Scanning & Documentation
- Remote Dispensing & Pharmacies Operating Internet Sites
- Standards for Accreditation & Operation

APPLICANT PAGE



Pharmacy students, interns and pharmacy technician applicants told us what they wanted on the College's website – and we're about to deliver. New pathways to register as a pharmacist or pharmacy technician clearly show what applicants have to do to become registered in Ontario. Quick access to information about SPT, SPE, Jurisprudence & the PEBC Exam make this a great reference for how to register in Ontario. 

MOBILE DEVICES



The new website also works on mobile devices – *have a practice question but no computer access?* Look us up on your smartphone or tablet and get the answer quickly!

The Importance of Missed Doses in Methadone Maintenance Treatment (MMT)

Anne Kalvik, Pearl Isaac
Centre for Addiction and Mental Health, Toronto
Leslie Dan Faculty of Pharmacy, University of Toronto

Methadone safety is a critical issue. The June 2013 issue of CPSO's Methadone News (1), discusses newly-released information from the Office of the Chief Coroner which highlights an increase in methadone-related deaths from 60 in 2009 to over 100 in 2011. A study published this year, also noted an increase in methadone related deaths in Ontario from 2006 to 2008, most of them accidental (2). The last issue of Pharmacy Connection published an analysis of medication incidents involving methadone processes. (3)

A major clinical issue affecting patient safety is the impact of missed methadone doses.

FIVE POINTS TO CONSIDER:

1. WHY THE CONCERN ABOUT PATIENTS WHO MISS DOSES?

Pharmacists, as part of their daily practice, motivate all their patients to take medication as prescribed. This takes on special significance with methadone maintenance treatment.

Tolerance to opioids, including methadone, is lost rapidly. If the regular dose of methadone is given after a period of missed doses, there is risk of overdose and death. Missed doses are an important indicator of patient instability and may be a symptom of a variety of problems, including relapse to alcohol or other drug use. (4)

The pharmacist is usually the first member of the interprofessional team to become aware that a patient has missed doses.

2. PHARMACISTS MUST BE ABLE TO EASILY TRACK MISSED DOSES.

All pharmacy dispensary staff need to be able to easily retrieve information to accurately determine if a patient has missed doses. Communication tools (e.g. patient calendars, other patient alerts, etc.) should be in place within each pharmacy to track patients' missed doses. The OCP Methadone Policy (5) requires that the time and date of methadone dose ingestion be recorded.

Even though patients may be in a hurry, and the pharmacy may be busy, pharmacists should always take the necessary time to check for missed doses and verify that it is safe to give the methadone dose. It's useful for pharmacists to advise patients at the outset of treatment, that time will be needed in the dispensary to medicate them safely.

3A. IN THE 1ST 2 WEEKS OF TREATMENT (EARLY STABILIZATION PHASE), THE DOSE SHOULD NOT BE INCREASED UNLESS THE PATIENT HAS BEEN ON THE SAME DOSE FOR 3 CONSECUTIVE DAYS (4).

Whether or not indicated on the prescription, it needs to be cancelled if 2 or more consecutive doses are missed. No dose increase should be implemented until the patient has been on the same dose for at least 3 consecutive days prior to the dose increase. This early stabilization phase is a critical period associated with high risk for overdose.

3B. FOR PATIENTS AT A STABLE DOSE, A CLINICALLY SIGNIFICANT LOSS OF TOLERANCE TO OPIOIDS MAY OCCUR WITHIN AS LITTLE AS 3 DAYS WITHOUT METHADONE (4)

Whether or not indicated on the prescription, it needs to be cancelled if 3 or more consecutive doses are missed.

Implementation of a dose increase on the day after a dose has been missed is not recommended. A consultation with the prescriber is best practice in this situation.

AFTER ANY PERIOD OF MISSED DOSES, THE METHADONE DOSE SHOULD BE ADJUSTED BY THE PRESCRIBER ACCORDING TO INFORMATION OUTLINED IN THE TABLE BELOW FROM THE CPSO MMT PROGRAM STANDARDS AND CLINICAL GUIDELINES (4).

TABLE 08: MANAGEMENT OF MISSED DOSES

PHASE OF TREATMENT	MISSED DOSES	ACTION	DOSE CHANGE
Early Stabilization (0-2) weeks	1 day missed	No dose increase	<ul style="list-style-type: none"> Resume same dose. Do not increase dose until 3 consecutive days at the same dose.
	2 consecutive days missed	<ul style="list-style-type: none"> Reassess patient in person Cancel remainder of prescription 	<ul style="list-style-type: none"> Restart at initial dose (10-30 mg) for at least 3 days Reassess after 3rd consecutive dose.
Late Stabilization/ Maintenance	1-2 days missed	<ul style="list-style-type: none"> Provide usual prescribed dose if patient is not intoxicated. Assess patient in 1-2 weeks to determine clinical stability 	<ul style="list-style-type: none"> No change
Late Stabilization/ Maintenance	3 consecutive days missed	<ul style="list-style-type: none"> Reassess patient in person Cancel remainder of prescription Reassess every 3-4 days if dose is increased daily 	<ul style="list-style-type: none"> Restarted at 50% of regular dose or decrease to 30 mg Then increase dose to no more than 10 mg daily for maximum of 3 days, then reassess by day 3-4. There after, dose increase of 10- 15 mg every 3 -5 days until 80 mg Then 10 mg every 5-7 days for dose increases above 80 mg
Late Stabilization/ Maintenance	4 or more consecutive days missed	<ul style="list-style-type: none"> Re-assess patient in person Cancel remainder of prescription 	<ul style="list-style-type: none"> Restart at 30 mg or less Then increase dose no more than 10-15 mg every 3-4 days until 80 mg Then increase 10 mg every 5-7 days for dose increases above 80 mg.

4. ALL MISSED METHADONE DOSES NEED TO BE COMMUNICATED TO THE MMT PRESCRIBER IN A TIMELY FASHION

It is good practice for pharmacists who provide MMT services, to report missed doses to the prescriber, whether or not this is specified on the prescription. Prescribers who do not have timely access to this information may make clinical decisions which may jeopardize patient safety.

This has many benefits, including the opportunity for the team to intervene early when doses are beginning to be missed. Although typically a prescription for a patient on a stable dose is cancelled after 3 consecutive missed doses, some patients never miss 3 days in a row. Some miss 1 or 2 days very frequently –some may miss 3 to 4 doses per week and cannot be considered as being stable.

At times, even one missed dose has clinical significance, e.g., early in treatment (see above) or in someone with “full carries”. For the latter, a missed dose can be a very meaningful indicator of loss of stability, especially if it happens frequently.

5. PHARMACISTS PROVIDING MMT WORK COLLABORATIVELY WITH THE PHYSICIAN TO PROVIDE METHADONE IN A SAFE MANNER TO THEIR PATIENTS.

Pharmacists receiving a prescription which is not in accordance with the CPSO MMT Standards and Guidelines are encouraged to follow up to discuss appropriate dosing with the MMT prescriber. This may need to include a discussion about whether the prescriber has had the opportunity to review missed dose information.

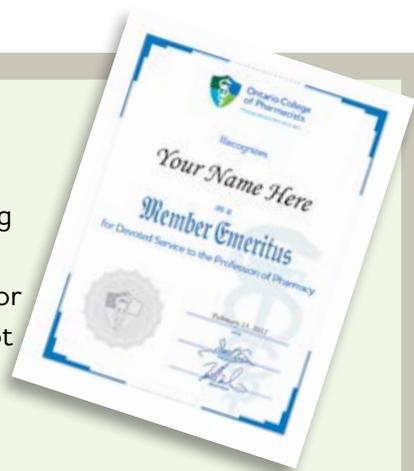
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1. CPSO Methadone News June 2013 <http://us1.campaign-archive1.com/?u=773dd093054349d1dfd6d4d3d&id=7d16e18995>
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3. Kawano A, Kong JH, Ho C, Methadone Medication Incidents: A Multi-Incident Analysis by ISMP Canada, Pharmacy Connection Summer 2013, 38
4. CPSO Methadone Program, Methadone Maintenance Treatment, Program Standards and Clinical Guidelines, 4th Edition February 2011 <http://www.cpso.on.ca/uploadedFiles/members/MMT-Guidelines.pdf>
5. Ontario College of Pharmacists Methadone Maintenance Treatment and Dispensing Policy, 2010. <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/d12550e436a1716585256ac90065aa1c/721a475f62e5768d852577f40071f438?OpenDocument&Highlight=2.methadone.policy>

Members Emeritus

Any pharmacist who has practiced continually in good standing in Ontario and/or other jurisdictions for at least 25 years can voluntarily resign from the Register and make an application for the Member Emeritus designation. Members Emeritus are not permitted to practice pharmacy in Ontario but will be added to the roll of persons so designated, receive a certificate and continue to receive Pharmacy Connection at no charge.

For more information, contact Client Services at 416-962-4861 ext 3300 or email ocpclientservices@ocpinfo.com



Audit of Self-Declaration Results – Less than Perfect!

In the previous issue of Pharmacy Connection (Summer 2013) members were informed that the College would be commencing a random audit of member compliance with self-declaration. The article explained that although self-declaration is used to improve operational efficiency, by allowing members to demonstrate their compliance with a number of legislative requirements without having to submit actual evidence to the College, it must always be balanced against ensuring accountability.

As part of the annual registration renewal process members are asked to positively respond to a number of self-declaration statements to affirm their compliance. One of these statements addresses the obligation of members, as outlined in Article 2 of the College by-laws (see sidebar on following page) to hold personal professional liability insurance. It was regarding this requirement that the College focused its initial audit.

Several hundred members, who had indicated their adherence to this

requirement on their annual registration renewal form, were randomly selected and asked to submit to the College their actual personal professional liability insurance policy. These policies were then reviewed to ensure that they did in fact meet the criteria outlined in the College's by-law.

Although the majority of those audited were compliant, the results were less than perfect. There were a significant number of members who allowed their coverage to lapse throughout the registration year, only reinsuring when renewing their annual registration with the College. Others relied on vague statements from employers about insurance without obtaining evidence of the coverage. In one case where it appears a member intentionally falsified their declaration the member has been referred for investigation of alleged professional misconduct.

These findings are concerning to the College as our primary responsibility is to assure the public that practitioners are upholding their ethical and legal obliga-

Personal 1 Personal 2 Practice 1 Practice 2 Contact Declarations 1 Declarations 2 Payment

Declaration

I have read and understand both the regulation and the information in the Expanded Scope of Practice Orientation Manual.

Please select ▼

I maintain personal professional liability insurance coverage as prescribed in Article 2 of College By-Law and I will continue to maintain this insurance throughout the registration year.

Please select ▼

Back Next

**ONTARIO COLLEGE OF PHARMACISTS –
BY-LAW NO. 3
Article 2
PROFESSIONAL LIABILITY
INSURANCE**

2.1 Insurance Requirements for a Certificate of Registration.

A member who holds a certificate of registration as a Pharmacy Technician, Registered Pharmacy Student, Intern or Pharmacist listed in Part A of the Register, must maintain personal professional liability insurance as follows:

2.1.1 Limit of Liability. The policy of insurance must contain limits of a minimum of \$2,000,000 per claim or per occurrence and \$4,000,000 in the annual aggregate.

2.1.2 Definition of Insured Services. The definition of Insured Services under the policy must include all professional services in the practice of pharmacy as regulated by the College.

2.1.3 Retroactive Date. The policy must not contain a retroactive date and must provide for full prior acts protection.

2.1.4 Extended Reporting Period (ERP). If the policy is a "claims made" policy, it must contain an extended reporting period provision for a minimum of three years.

2.1.5 Personal Professional Liability Insurance Coverage. The policy must be issued in the name of the individual Member and provide that Member with mobility and coverage wherever in Ontario that Member practises.

2.1.6 Legal Defence Payments. Legal defence payments for regulatory proceedings or other legal proceedings potentially afforded by a personal professional liability policy must not erode the minimum limits of liability under the policy.

2.2 Evidence of Insurance.

A Member shall, upon the request of the Registrar, provide proof of professional liability insurance in the required amounts and form, and a copy of the Member's professional liability insurance policy.

tions to comply with all legislation and standards. We need to be confident that utilizing a self-declaration process is not inadvertently putting the public at risk.

Based on the findings of this initial audit, it is important to remind members of their obligation to the College and the significance of their declarations:

MEMBERS ARE OBLIGATED TO RESPOND TO COLLEGE REQUESTS

As the regulatory body for the profession, the College has the authority to request specific information from members who are then obligated to respond in a timely manner. Failure to do so can result in the College suspending the member's registration for a period of time.

MEMBER IS RESPONSIBLE FOR THEIR SELF-DECLARATION

It is the sole responsibility of the individual practitioner to ensure that they have carefully read and understood each of the self-declaration statements and be confident that they comply. This responsibility can not be passed to someone else, such as an employer or third party.

SERIOUS CONSEQUENCES FOR FALSE DECLARATION

Where the College believes a member intentionally falsified their declaration the member could be referred for investigation of alleged professional misconduct.

The College will continue to audit the use of self-declaration as we balance our goal for operational efficiency with effective accountability. 

With the annual registration renewal process only a few months away, members are advised to pay particular attention to these self-declaration statements when completing their renewal.

ALMOST 60% OF COMMUNITY PHARMACISTS NOW TRAINED TO ADMINISTER INJECTIONS!

Although it has only been a little more than a year since pharmacists received the authority to administer injections over 5,400 pharmacists have successfully completed and registered their required training with the College. This increase in qualified practitioners has significantly impacted

the number of community pharmacies participating in Ontario's Universal Influenza Immunization Program (UIIP) – growing from 600 pharmacies last year to some 2,000 this year.

With this year's program having only just begun it is difficult to know the impact that the addition of this number of immunization sites will bring, but early reports are impressive. According to the Ministry's Health Network System (HNS), approximately 227,000 influenza vaccine claims were submitted by pharmacies from September 28, 2013 to October 31, 2013. In comparison, the total number of claims attributed to pharmacies for the entire UIIP season last year was only slightly more than this at 250,000.

It's not too late for patients to receive a flu shot as the UIIP typically runs well into January and even February. More information regarding the UIIP can be found at www.ontario.ca/flu 

LEFT: Ontario College of Pharmacist's receptionist Donna Ortolan receives her flu shot from pharmacist Jim Snowdon, during the College's staff flu clinic held at Snowdon's Pharmacy.



ABOVE: Ontario Minister of Health and Long-Term Care, Deb Matthews, receives the flu shot from Shoppers Drug Mart pharmacist Hitesh Pandya.

An alternative for the destruction of narcotics and controlled drugs in pharmacies and hospitals

Section 56 class exemption for pharmacists and persons in charge of a hospital for the sale or provision of narcotics and controlled drugs to licensed dealers for destruction

On September 18, 2013, Health Canada issued a class exemption (at right) for pharmacists and persons in charge of a hospital for the sale or provision of narcotics and controlled drugs destined for destruction pursuant to section 56 of the *Controlled Drugs and Substances Act*.

The exemption authorizes the sale or provision of narcotics and controlled drugs under circumstances which are not currently addressed in the *Narcotic Control Regulations (NCR)* and Part G of the *Food and Drug Regulations (FDR-Part G)*.

This exemption gives authority to a pharmacist and a person in charge of a hospital to sell or provide narcotics or controlled drugs for the sole purpose of destruction to a licensed dealer (LD) who is licensed to destroy narcotics or controlled drugs pursuant to a written order signed and received from the LD. Records of the name, quantity and strength per unit, name of the pharmacist that requested the destruction, name and address of the LD to whom it was sold or provided and the date of the transaction must be retained for a period of two years, in a manner that permits an audit to be made. This exemption does not prohibit pharmacists from returning narcotics and controlled drugs to the



licensed dealer who initially provided them, nor does it exempt persons in charge of a hospital from adhering to the provisions of section 65 of the NCR and section G.05.003 of the FDR-Part G as applicable.

Furthermore, it is always possible for a pharmacist to locally denature expired narcotics or controlled drugs after receiving authorization from the Office of Controlled Substances (OCS). Destruction requests sent to the OCS should ensure that the total quantity of the product can be easily calculated. For example, either the total quantity of the controlled substance to be destroyed should be specified or the concentration AND volume of the product should be indicated. The request should indicate the trade names of the substances and include the pharmacist's signature with his/her licence number issued by his/her Provincial Licensing Authority. The destruction request form is available on request from the National Compliance Section of the OCS.

Any questions concerning this notice should be directed to the National Compliance Section of the Office of Controlled Substances by e-mail at: national_compliance_section@hc-sc.gc.ca 



Health Santé
Canada Canada

SECTION 56 CLASS EXEMPTION FOR PHARMACISTS AND PERSONS IN CHARGE OF A HOSPITAL FOR THE SALE OR PROVISION OF NARCOTICS AND CONTROLLED DRUGS TO LICENSED DEALERS FOR DESTRUCTION

Pursuant to section 56 of the *Controlled Drugs and Substances Act* (CDSA) and subject to the terms and conditions herein, pharmacists and persons in charge of a hospital are hereby exempted in the public interest from the application of the following provisions of the *Narcotic Control Regulations* (NCR) and Part G of the *Food and Drug Regulations* (FDR-Part G) when selling or providing narcotics and controlled drugs to a licensed dealer who is licensed to destroy narcotics and controlled drugs:

Pharmacists

- a. Subsections 5(1) and 5(2) of the CDSA.
- b. Subsection 31(1) of the NCR.
- c. Section G.03.002 of the FDR-Part G.

Persons in Charge of a Hospital

- a. Subsections 5(1) and 5(2) of the CDSA.
- b. Subsection 65(1) of the NCR.
- c. Subsection G.05.003(1) of the FDR-Part G.

This exemption gives authority to a pharmacist to sell or provide narcotics or controlled drugs, and to a person in charge of a hospital to permit narcotics and controlled drugs to be sold or provided, to a licensed dealer who is licensed to destroy narcotics or controlled drugs. This exemption is applicable only if the following conditions are met:

1. The sale or provision of narcotics and controlled drugs pursuant to this exemption must occur for the sole purpose of destruction.
2. Narcotics and controlled drugs sold or provided pursuant to this exemption may only be sold or provided to a licensed dealer who is licensed to destroy narcotics or controlled drugs.
3. Sale or provision pursuant to this exemption may only occur pursuant to a written signed order from the licensed dealer to whom the narcotic or controlled drug will be sold or provided for destruction. The written order must specify the name, quantity and strength per unit of the narcotic or controlled drug and must indicate that the sole purpose of the order is destruction.
4. A pharmacist must keep a record, and a person in charge of a hospital must keep a record or cause a record to be kept, of the name, quantity and strength per unit of a narcotic or controlled drug sold or provided under this exemption, the name of the pharmacist that requested the destruction as well as the name and address of the licensed dealer to whom it was sold or provided, a means of identifying the written order and the date on which it was sold or provided.
5. Any record or written order required under this exemption is a record required to be retained for a period of two years, in a manner that permits an audit to be made pursuant to sections 41 and 64 of the NCR, and sections G.03.011 and G.05.002 of the FDR-Part G.

This exemption will remain in effect until revoked.

Original signed by Johanne Beaulieu

Director, Office of Controlled Substances, CSTD/HECSB for and on behalf of the Minister of Health

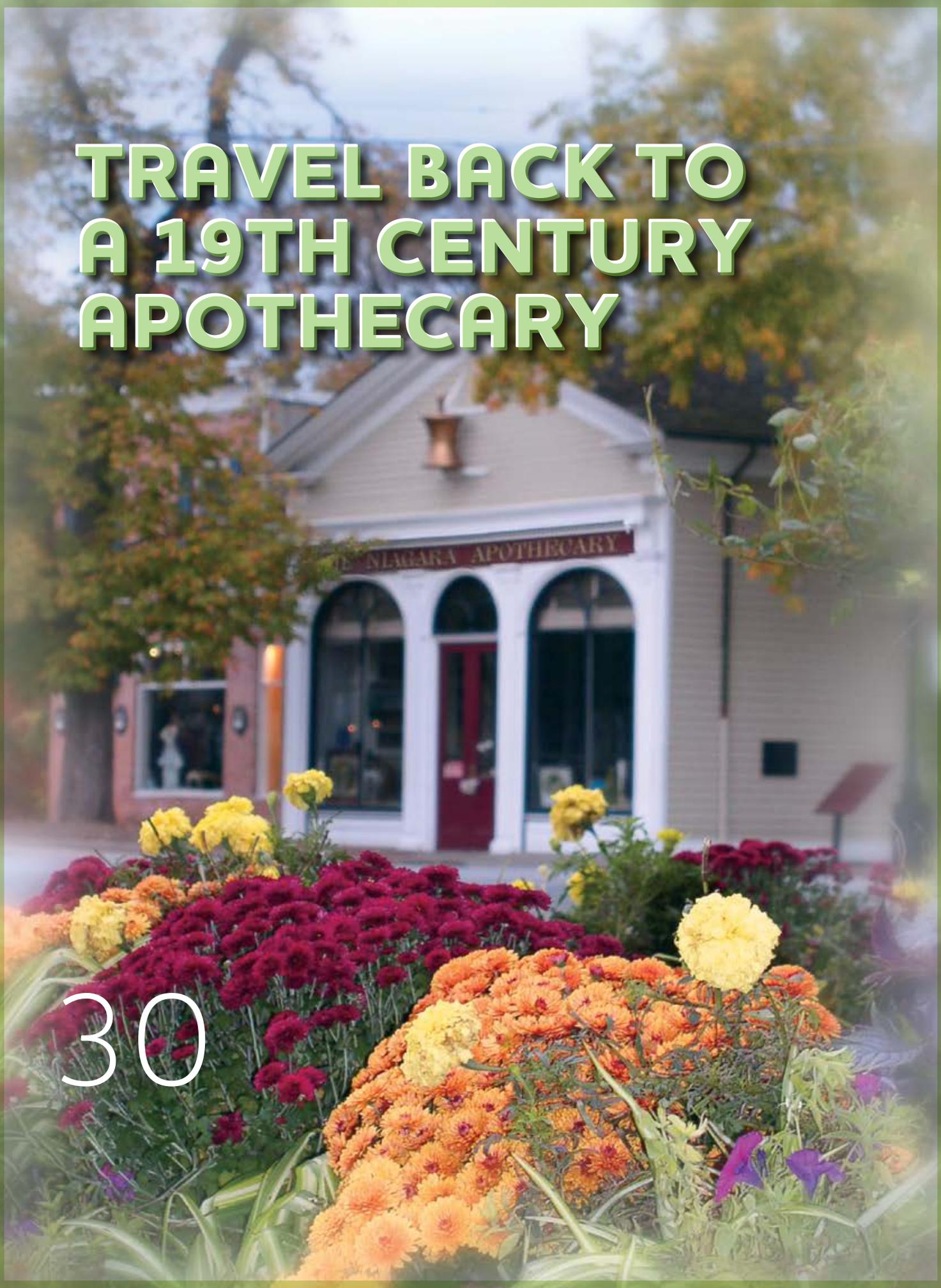
Effective date: Sept 18, 2013

Canada

TRAVEL BACK TO A 19TH CENTURY APOTHECARY

THE NIAGARA APOTHECARY

30



NIAGARA-ON-THE-LAKE MUSEUM HONOURS PROFESSION'S HERITAGE

By Stuart Foxman

Imagine the surprise of several visitors to the Niagara Apothecary across from the Prince of Wales Hotel in Niagara-on-the-Lake. "They'll come in and start describing their problems," says manager Jim Hauser. "I have to interrupt them and send them to a pharmacy that's two minutes away. They're taken aback at first."

Is Hauser turning away customers? Not quite. The building he manages is a restored apothecary, a museum that celebrates the heritage and art of the Confederation-era pharmacist.

As Hauser says, in certain parts of the world pharmacies still somewhat resemble the interior of this museum. That might explain why some people mistake it for a working pharmacy.

For visitors, Niagara Apothecary is a chance to explore a unique Canadian museum, one dedicated to the days gone by of a healthcare profession.

The actual Niagara Apothecary operated for nearly 150 years, from around 1820 to 1964, under a succession of six owners in various locations. The building that now houses the museum, located on the main commercial stretch of Queen Street, opened its doors as a pharmacy in 1869. It is one of the only surviving buildings from that period in the town.





In 1969, the Ontario Heritage Foundation (now Heritage Trust) acquired the property in concert with the local Niagara Foundation. The Ontario College of Pharmacists accepted the responsibility to restore the interior to reflect an operating pharmacy circa 1869.

This national historic site opened as a museum in 1971, with the College underwriting its operation. The single-storey clapboard building features an arched transom, bordered by two large Italianate windows. Above the door is a three-dimensional mortar and pestle. Inside, the restored counters and floor are all original.

"When people enter the building, they get swept back into another timeframe, not just of a pharmacy but of medicine," says Jim Dunsdon, the curator.

Dunsdon started his career as a community pharmacist in Brantford 50 years ago. He joined OCP in 1970 as an inspector, and eventually served as Registrar. He says the museum is about far more than nostalgia: "It's an appreciation, a respect for our roots."

WINTERGREEN AND LEECHES

The first thing that visitors notice? "The smell," says Dunsdon. "We put some oil of wintergreen on the vents. You get a sort of medicinal scent

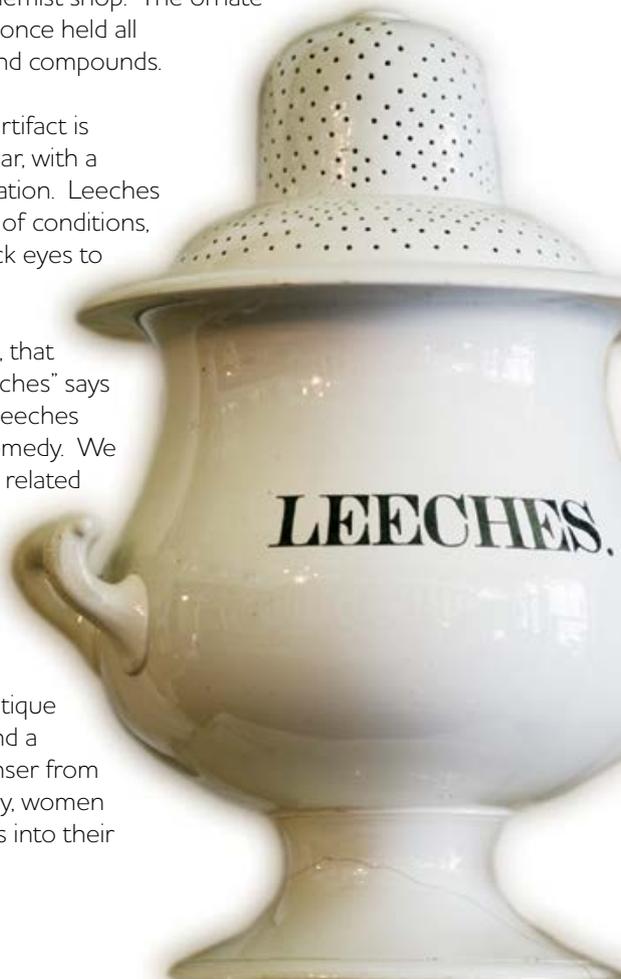
that people relate to an old-time pharmacy."

The second thing that hits visitors, he says, is the arrangement of apothecary, with high shelving, exotic looking bottles that cover a wall, and show globes symbolizing a chemist shop. The ornate dispensary would have once held all sorts of elixirs, tonics and compounds.

Perhaps the favourite artifact is the glazed china leech jar, with a perforated lid for ventilation. Leeches were used for a variety of conditions, from headaches to black eyes to bruising.

"That fascinates people, that you could purchase leeches" says Dunsdon. "Back then, leeches were quite a popular remedy. We also have a few devices related to bloodletting, a common treatment in those days."

Other items on display include an enema box, an oak cash register, antique scales, chests of dye, and a novelty perfume dispenser from the 1890s. For a penny, women could squirt a few drops into their





handkerchiefs. "The catch phrase was a scent for a cent," says Dunsdon.

Special exhibits include pill making, patent or proprietary medicines and their advertising, remedies of the First Nations, and pharmacy symbols.

Originally, the apothecary was more like a general store, with a dispensing practice only a part. The first proprietor would have sold goods in bulk from large storage containers.

The website of the museum (<http://www.niagaraapothecary.ca>) is worth a visit itself, as it goes into great detail of the history of the six owners. The first, Rodman Starkwather, identified the practice as Niagara Apothecary at the Sign of the Golden Mortar opposite Smith's Tavern. After Starkwather took on a partner, the name changed to Niagara Apothecary and Cheap Cash Store.

It's a reminder of how different pharmacy practices were in the early and mid 19th century. Ads offered whiskey by the barrel, dry goods, crockery, and paints and varnish, as well as a variety of patent remedies.

Eventually, the practice developed enough so the owners could discontinue their dry goods business and change the name

to the more professional Niagara Apothecary – that was progress.

MANY PRINCIPLES HAVE SURVIVED

The pharmacy has evolved dramatically since the period depicted at the museum. Yet Hauser is struck by many parallels to today's practice.

"Some aspects really haven't changed at all," says Hauser, who was a community pharmacist in Dunnville (south of Hamilton). "The Niagara Apothecary depicts a lot of compounding, and that's becoming a specialty now. You also see a lot of homeopathic remedies. Back then, they were treating people with the best products of the time, whatever was most effective, and we're doing that now too."

"You realize that many principles in the profession have survived," agrees Dunsdon. "Products change and technology advances, but the core values remain. We still treat pain, give advice and manage medication. We have all these sophisticated ways of doing it today, but pharmacists were doing it 150 years ago too."

The Niagara Apothecary draws about 80,000 visitors a year. About one-third come from Canada, one-third from the U.S., and one-third from the rest of the world.

Many people just wander in, an unplanned visit on a trip to Niagara-on-the-Lake. Yet a large number of visitors – often pharmacists – make the museum a must-see stop. Pharmacists have come from as far as China, Japan, England, France, Jordan, Israel, South Africa, and New Zealand.

For any visitors, the Niagara Apothecary is an interesting trip back in time, and a lesson in social history. For the pharmacists who visit, suggests Hauser, the museum resonates in another way. "To know where you're going," he says, "you have to know where you've come from." 📷

While the Ontario College of Pharmacists manages the museum operations, the artifacts are owned by the Ontario Heritage Trust. Individuals inquiring about donating period specific pieces to the museum should contact the Trust directly.

*Ontario Heritage Trust
10 Adelaide Street East
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Proposed legislation authorizes OCP oversight of hospital pharmacies

In early October the Ontario government announced the introduction of proposed legislation (*Bill 117, an amendment to the Drug and Pharmacies Regulation Act*) that, if passed, would allow the Ontario College of Pharmacists to license hospital pharmacies in Ontario and conduct routine inspections to monitor compliance with licensing requirements and standards.

Currently, pharmacies in the community are overseen by OCP, whereas those within hospitals are the responsibility of individual hospital corporations. Expanding the College's authority to regulate hospital pharmacies will ensure they meet consistent standards across the province. This structure is also in place in other jurisdictions including British Columbia, Newfoundland and Labrador, Prince Edward Island and New Brunswick.

This proposed legislation is in response to government's commitment to implement recommendations, specifically recommendation 12, contained in Dr. Jake Thiessen's review (*A Review Oncology Under-Dosing Incident*) of the province's drug supply system. Earlier this year, Dr. Thiessen conducted a detailed investigation into the discovery of under-dosing chemotherapy drugs at four Ontario hospitals and one in New Brunswick. A listing of Dr. Thiessen's recommendations, which are fully supported by the College, are included in this article (at right) with access to his full report available on the Ministry's website (www.health.gov.on.ca).

In support of this announcement College Registrar Marshall Moleschi commented, "expanding the oversight and inspection authority of the College to include hospital pharmacies will help ensure the drug supply is monitored and inspected more closely, with the same rigorous standards across the province."

Should the proposed legislation be enacted there are many more details to be worked through including the crafting of new regulations that will establish the requirements and standards for licensing and inspection of hospital pharmacies.

This process will be a collaborative one – drawing heavily from the many relevant practice standards and inspection criteria that already exist and relying on feedback from a wide variety of subject-matter experts and stakeholder groups.

As Anthony Dale, Interim President and CEO, Ontario Hospital Association commented during the Ministry's announcement, "Ontario's hospitals

and their pharmacists are fully committed to providing the best possible patient care. We look forward to working closely with the Ontario College of Pharmacists and the Ministry of Health and Long-Term Care to implement this proposed legislation."

Although there is much work to be done, the College has already taken some initial steps. This includes the recent hiring of Judy Chong to the newly created position of Manager, Hospital and Specialized Practice. Judy, a graduate of the University of Toronto's Faculty of Pharmacy has more than 30 years of hospital pharmacy experience with her most role as Director, Pharmaceutical Services with the Royal Victoria Hospital in Barrie.

Over the coming months the College will continue to lay the foundation for this pending authority and is committed to keeping all stakeholders engaged and informed throughout the process. 



THIESSEN'S REPORT—RECOMMENDATIONS

extracted from:

A Review of the Oncology Under-Dosing Incident - Jake J. Thiessen, Ph.D.
A Report to the Ontario Minister of Health and Long-Term Care - July 12, 2013

The recommendations are intended to prevent future oncology incidents of this nature and to mitigate identifiable risks in the broader realm of non-sterile and sterile product preparation within licensed pharmacies and other enterprises.

RECOMMENDATION #1:

Notwithstanding the under-dosing incident, the continued use of Group Purchasing Organizations (GPOs) to negotiate vendor product preparation pharmaceutical services shall not be discouraged. However, improvements are needed in the GPO-based processes.

RECOMMENDATION #2:

Every GPO shall review its procurement process to ensure that risk for patients is considered an essential evaluation and adjudication criterion when considering proposals.

RECOMMENDATION #3:

Every GPO shall develop and adopt a standardized product and/or service specification description that outlines the requirements for contracted sterile or non-sterile pharmaceutical preparation services.

RECOMMENDATION #4:

Annually in January, each GPO shall publicize information regarding the contracted pharmaceutical services provided by all its vendors.

RECOMMENDATION #5:

Marchese Hospital Solutions (MHS) shall review and revise its product preparation processes to ensure that all its products meet the specifications required by professionals in treating patients effectively and safely.

RECOMMENDATION #6:

The Ontario College of Pharmacists (OCP) (and by extension, the National Association of Pharmacy Regulatory Authorities [NAPRA]) shall work quickly with Health Canada to define best practices and contemporary objective standards for non-sterile and sterile product preparation within a licensed pharmacy.

RECOMMENDATION #7:

The OCP (and by extension, NAPRA) shall stipulate specialized electronic material records and label requirements for non-sterile and sterile product preparation within a licensed pharmacy.

RECOMMENDATION #8:

The OCP (and by extension, NAPRA) shall consider a special designation and licence for any licensed pharmacy engaged in large volume non-sterile and

sterile product preparation. Such pharmacies shall be inspected annually.

RECOMMENDATION #9:

The OCP shall specify credentials beyond education and licensing for personnel engaged in non-sterile and sterile product preparation practices within a licensed pharmacy.

RECOMMENDATION #10:

Health Canada shall license all enterprises that function beyond the product preparation permitted within a licensed pharmacy; that is, all product preparation enterprises not within a licensed pharmacy shall be licensed.

RECOMMENDATION #11:

The Ontario Hospital Association (OHA) shall conduct a formal review/audit to determine the efficiency and traceability of computer-based clinic and hospital records for patients and their treatments, and report the findings to the MOHLTC.

RECOMMENDATION #12:

The OCP shall license all pharmacies operating within Ontario's clinics or hospitals.

Note: On September 12, 2013 the Ministry of Health and Long-Term Care established an Implementation Task Force to oversee the implementation of Dr. Thiessen's recommendations. The task force includes representatives from a variety of health and government sector partners, including the Ontario Hospital Association, the Ontario College of Pharmacists, Health Canada and the Ministry of Government Services. The task force is currently establishing timelines for the completion of its work.

UPDATE:

College's Quality Assurance Program

A standing item on the agenda for Council meetings is a general update from one of the four key function areas of the College – Registration, Quality Assurance, Professional Practice or Investigations & Resolutions. At their most recent meeting Council received an update on the College's Quality Assurance Program – highlights from that presentation are provided here.

INTRODUCTION

The requirement to have a mandatory quality assurance program — which directs practitioners to participate in professional development activities — is not unique to the profession of pharmacy. In fact, the *Regulated Health Professions Act* directs all regulated healthcare professions in Ontario to establish, administer and monitor a quality assurance program for their members. Although programs will vary amongst professions, the Act (s.80.1) provides some general guidance:

- 80.1 A quality assurance program prescribed under section 80 shall include,
- (a) continuing education or professional development
 - (b) self, peer and practice assessments; and
 - (c) a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program.

The intent of quality assurance programs is two-fold; ensure that practitioners remain

engaged in Continuous Professional Development (CPD) throughout their careers to enhance their knowledge and skills as practice evolves, and to provide a means by which the College can hold practitioners accountable to do this.

CURRENT PROGRAM

The Ontario College of Pharmacists' current Quality Assurance Program, for practicing pharmacists, consists of a number of components (table 1). Each component has specific requirements and objectives.

Table 1:

Quality Assurance Program for Pharmacists
Learning Portfolio
Self-Assessment
Peer Review

LEARNING PORTFOLIO:

All practicing pharmacists must engage in continuing education activities and document their learning. Records of learning activities must be maintained for a minimum of five years. The learning portfolio is an online tool provided by the College to assist members in identifying and documenting their continuing education. Recent research by the College indicated that 73% of pharmacists found the learning portfolio to be a useful tool.

In order to best reflect the various practice settings and individual learning preferences of practitioners there is no set amount or type of learning activities required. Everything from traditional accredited programs (CEUs) to a documented dialogue with a colleague, as an example, would be acceptable. The only expectation is that learning is ongoing, documented and should be relevant to the practitioner's current or future practice.

Practitioners are advised to keep their learning records up-to-date as the College may request access to a learning portfolio at any time.

SELF-ASSESSMENT:

The self-assessment is an online tool designed to assist practitioners in identifying learning needs and plan learning based on the standards of practice. In the College's recent research, which surveyed over 3,000 pharmacists who had completed the self-assessment, nearly 83% felt the tool assisted them in identifying learning opportunities (table 2).

Once in every five-year cycle pharmacists are directed by the College to complete a self-assessment. Ideally practitioners should use this tool annually as one of its primary benefits is to help identify specific areas of learning that members can use to guide decisions regarding their ongoing continuing education activities.

PEER REVIEW:

The final component of the College's current quality assurance program is the peer review. Each year, via random selection, approximately five per cent of eligible pharmacists are required to participate, in person at the College's office in Toronto. The peer review consists of three components:

1. Learning Portfolio Sharing Session,
2. Clinical Knowledge Assessment, and;
3. Objective Structured Clinical Examination (OSCE).

Table 2: **SELF ASSESSMENT:
Helped to Identify Learning Opportunities**

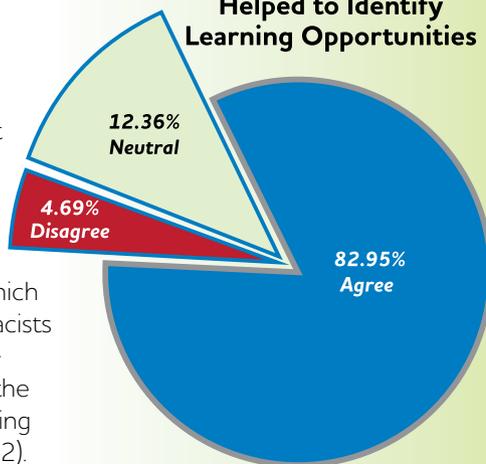
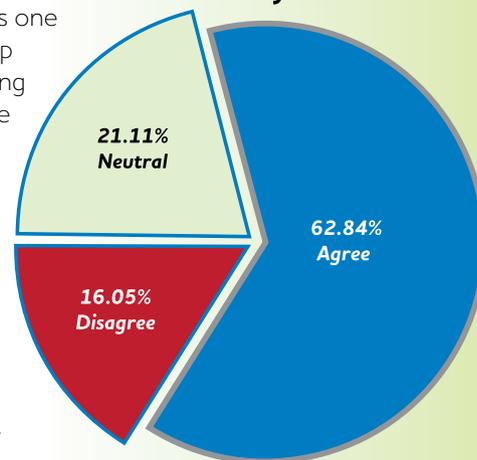


Table 3: **PEER REVIEW:
Resulted in a Change to my Practice**



Each component is designed to assess different aspects of practice. The knowledge assessment exam focuses on a practitioner's clinical knowledge. The OSCE uses a series of standardized patient interviews to assess how a practitioner interacts with patients, their ability to apply knowledge and their communication skills.

Feedback from participants in the peer review is quite positive with nearly 78% indicating that the experience improved their confidence with their patients. Additionally, 73% felt that undergoing the peer review actually improved care for one or more of their patients and 63% expressed that the experience resulted in an actual change to their practice (table 3). Given that one of the primary objectives of the Quality Assurance Program is continuous quality improvement (CQI) the findings from the College's most recent research is extremely valuable. 

From time-to-time the College reprints articles relevant to the profession that may be of interest to members. This issue of Grey Areas touches on a number of topics including competence, transparency and governance through self-regulation.



A FUTURIST LOOKS AT PROFESSIONAL REGULATION

by Richard Steinecke
October 2013 - No. 180

Earlier this month Steven Lewis, a popular health policy consultant, made a presentation at an international conference of regulators on the future of professional regulation.

Lewis identified a number of challenges to the traditional model of credentialing and regulating individual practitioners. For example, in the health care sector, nurses are successfully performing services previously only done by highly trained physicians such as anaesthesia, endoscopy and primary care. Offshore interpretations of radiographs are often of a high quality. Skilled technicians with a few months' training are doing high quality cataract surgery in places such as India and Africa. Personal support workers are multi-tasking in community care with good results. The concept of requiring highly trained certified professionals as the exclusive providers of highly skilled services needs to be re-examined.

At the same time there are chal-

lenges to the traditional approaches of educating professionals. There are examples of self-taught people successfully passing entry-to-practice examinations in traditional occupations such as law. On-line courses compete with traditional forms of classroom learning. In the teaching profession vastly different certification requirements internationally produce similar student outcomes.

The reality is that "a lot of bad stuff happens" in spite of regulation. Increased educational requirements are not producing breakthroughs in quality. In many professions the structure in which the service is provided (e.g., how the provision of services is organized, workplace culture, policies and procedures) and team dynamics have at least as much of an influence on performance as does individual competence. Regulators focusing on individual performance may become largely irrelevant.

Also, in the borderless world, mobility makes traditional local-jurisdiction regulatory requirements

and standards impractical. Economic unions and labour mobility agreements require a broader perspective for regulation. For example, these pressures are resulting in a decoupling of competencies from credentials when registering or licensing professionals.

Added to these developments is a decline in public trust in public institutions including professional regulators. Examples are frequently in the headlines including the investment banking debacle and economic collapse of 2008, various accounting scandals and repeated health care failures in accredited institutions by certified practitioners (e.g., radiology misinterpretations). Ironically, however, the response to these events is usually to call for increased regulation with greater accountability and stronger sanctions.

So, Lewis asks, is the solution more, less or different regulation? He posits five trends in professional regulation that seem to be inevitable:

1. Entry-to-practice credentials will matter less and demonstrated career-long competency will matter more. In fact, the tide of increasing credentials should probably be turned back as it is proving unhelpful to quality and a barrier to accessing reasonably priced services. View competence as an ongoing process rather than an event.
2. The emphasis on core standards for practitioners and even quality assurance will have to give way to continuous quality improvement. Greater trust will be put in real-time performance data (e.g. outcome statistics) than formal stamps of approval.
3. Regulators will be expected to anticipate more and react less. While Lewis did not get into specifics, perhaps this means that regulators will need to anticipate trends by evaluating the information that is already in their files or that is readily available to them. Or perhaps it will mean that regulators will have to engage in a more deliberate and intense risk-management analysis of their activities and the practice trends within the profession they regulate.
4. Siloed and distinct regulation of individual professions must transition into integrated and fluid regulatory activities. If practitioners work in teams, why cannot regulators do so?
5. The culture of professional autonomy will almost certainly be replaced with a culture of collaborative and joint accountability.

Obviously this will mean that regulators will have to learn new ways of regulating professional activity. In one of his illustrations, Lewis indicated that while it is much more difficult to assess the quality of work of a team and to design methods of enhancing its performance, the benefits of such quality improvement activities would probably far outweigh individual quality assurance of the team's individual members.

Lewis concluded with a challenge to regulators to "own the future". Openness, transparency and candour are keys to maintaining public trust. Put one's assumptions (e.g., that more education means higher quality services) to the test of research and evaluation. Regulators should design alternatives to the exclusive self-regulation model before others design them independent of regulators. Finally, regulators need to adapt structures and processes to a world of rapid knowledge turnover and team-based practice. 📧

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Stepping into the Shoes of Community Pharmacists – Drug Shortage and Patient Safety

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

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INTRODUCTION

Since Avalide® (irbesartan and hydrochlorothiazide) 150/12.5 mg was backordered; the patient was given the 300/25 mg strength and was told to take $\frac{1}{2}$ of a tablet. However, the Avalide® 300/25 mg strength was on backorder as well and the regimen was changed to irbesartan 150 mg and hydrochlorothiazide 12.5 mg daily. The Avalide® 150/12.5 mg tablets became available again, and so the prescription was reversed, and the prescription was filled off or copied from the previous Avalide® 300/25 mg prescription. However, the directions were not changed from the $\frac{1}{2}$ tablet to a full tablet. During counseling, the patient was counseled properly on the directions for use by the pharmacist. When the patient went home, she discovered that the directions on the bottle did not match with what the pharmacist had said.

The above scenario is a classic example of a medication incident that is related to drug shortages. Drug shortages have been increasingly affecting pharmacy practice, often leading to adverse effects on patient care.¹ As such, the problem of ongoing drug shortages has been a source of frustration for pharmacists, patients, and prescribers.

The causes of drug shortages are multifactorial. For instance, the drug may not be available due to supply or manufacturing problems, safety concerns, and discontinuation of products, etc. It may also be attributed to an increase in demand, such as during disease outbreaks, or a shift in clinical or prescribing practice,

etc. Drug shortage is rarely owed to any one of the above listed contributing factors, but rather a combination of several causes.^{2,3}

The issue of drug shortages is one that presents a significant challenge to pharmacists in both hospital and retail pharmacy settings today. Several reports have published the myriad of issues that drug shortages have posed to patient safety in acute care settings.⁴⁻⁶ However, the same may not apply to community pharmacy setting; and hence, the impetus for this multi-incident analysis.

The Community Pharmacy Incident Reporting (CPhIR) Program (available at <http://www.cphir.ca>) is designed for community pharmacies to report near misses or medication incidents to ISMP Canada for further analysis and dissemination of shared learning from incidents.⁷ CPhIR has allowed the collection of invaluable information to help identify system-based vulnerable areas in order to prevent medication incidents. This article provides an overview of a multi-incident analysis of drug-shortage-related incidents reported to the CPhIR program.

MULTI-INCIDENT ANALYSIS OF NEAR MISSES AND MEDICATION INCIDENTS RELATED TO DRUG SHORTAGES IN COMMUNITY PHARMACY PRACTICE

Reports of medication incidents involving “Drug Shortage” were extracted from the CPhIR Program from November 2010 to June 2012. In total, 75 incidents

were retrieved and 62 of them met inclusion criteria and were included in this qualitative, multi-incident analysis. The outcome of the majority of the incidents were reported as “no error” (i.e. near misses), meaning that an error was made, but it was intercepted or corrected before the medication was dispensed to the patient.

The 62 medication incidents were independently reviewed by two ISMP Canada Analysts. They were

analyzed and categorized into two major themes: (1) deviation from the intent of the original prescription and (2) near misses. The two major themes were further divided into subthemes, as shown in Table 1 and Table 2, respectively. (Note: The “Incident Examples” provided in Tables 1 and 2 were limited by what was inputted by pharmacy practitioners to the “Incident Description” field of the CPhIR program.) 

TABLE 1. THEME 1 – DEVIATION FROM THE INTENT OF THE ORIGINAL PRESCRIPTION

SUBTHEME	INCIDENT EXAMPLES	COMMENTARY
Risk of Overdose	A prescription called for acebutolol 200 mg tablets. At the time of dispensing, the pharmacy had insufficient quantities of acebutolol from one manufacturer so the prescription was filled using two different brands of acebutolol from two different manufacturers in separate vials to make up the final quantity. However, the patient began taking tablets from both vials at the same time and took double the dose of acebutolol, which continued for approximately a month.	In such cases where a certain brand of a medication is on backorder, it is best to dispense one brand of a medication (and create a balance owing, if necessary), rather than multiple brands at the same time, whenever possible. This would avoid confusion among pharmacy staff and to the patient. If this is not possible (e.g. the patient lives far away and/or pharmacy accessibility would be difficult), providing clear instructions for use and ensuring patient’s understanding is necessary before they leave the pharmacy.
	Since there was a shortage of Avalide® (irbesartan and hydrochlorothiazide) 150/12.5 mg tablets, the pharmacy team dispensed irbesartan and hydrochlorothiazide separately. However, hydrochlorothiazide was dispensed as 25 mg tablets instead of 12.5 mg. The pharmacist discovered this the next time the patient was in the pharmacy asking questions.	
Risk of Under-dose	In looking for another brand of atorvastatin to cover for a shortage, a different brand of atorvastatin was chosen, but at a lower strength than the original. The patient had been taking 20 mg, but it was filled as 10 mg tablets.	When adapting or making alternative arrangements for a prescription during drug shortages, independent double checks should be performed for each prescription during the order entry and dispensing process. ⁸
	[Drug unknown] A physician called to refill a medication and was reviewing the doses with the pharmacist on duty. It was discovered that while switching between brands due to a shortage of one brand of the medication, that the strength of the capsule was inadvertently switched from 100 mg to 25 mg, resulting in a total decreased dose from 200 mg to 50 mg. The patient suffered decreased control of her mental state.	
Incorrect Drug	Patient was prescribed Amiloride 5 mg, but Amiloride/Hydrochlorothiazide 5/50 mg was dispensed instead. The drug dispensed was a combination drug, which included the right drug he was used to get, but had an additional fluid pill in it.	

continued

SUBTHEME	INCIDENT EXAMPLES	COMMENTARY
Patient Confusion & Misunderstanding	<p>A patient presented with a prescription for carbamazepine 200 mg and asked for it to be logged (i.e. put on hold). However, there was a shortage of the medication and the CR (controlled-release) formulation (i.e. not the regular strength) was selected. The logged prescription was subsequently filled as the CR formulation. The patient had inquired as to why the tablets looked different.</p>	<p>There are two opportunities where this incident should have been intercepted or caught during the checking process:</p> <ol style="list-style-type: none"> 1. When prescription was logged; and 2. When prescription was dispensed and checked against the original prescription. <p>Best practices would be for the pharmacist to ensure the accuracy and appropriateness of a prescription at the time it is logged and “sign off” accordingly.</p> <p>Independent double checks should be performed for each prescription during the order entry and dispensing process.⁸</p>
	<p>A prescription vial was labeled as Endocet[®], but the Apo brand of the therapeutic equivalent was dispensed. This was discovered by the patient, since the tablets appeared smaller than usual.</p>	<p>Counseling patients on the identity of the altered medication (where applicable), the different or appropriate directions for use, etc. will help avoid misunderstanding and inappropriate use of the medication.</p> <p>Follow-up with patients or monitoring is important, especially in cases where an alternative brand or product was dispensed due to drug shortages.</p>

TABLE 2. THEME 2 – NEAR MISSES

SUBTHEME	INCIDENT EXAMPLES	COMMENTARY
Patient Confusion & Misunderstanding	<p>A patient presented to the pharmacy after having a one-off fill of Tri-Cyclen[®] 21 at another pharmacy due to a shortage at that pharmacy of the 28-day pack. The patient was going to forego the last seven days of the 21-day pack thinking it was the same as the last seven days of the 28-day pack. She returned to taking the 28-day pack but was advised to finish the last seven days of the 21-day pack first.</p> <p>A pharmacy normally had Ventolin[®] in stock, but since it was backordered, Apo[®]-Salvent was ordered instead. The inhalers look different between the two brands, and the patient was not informed of the brand change. The patient went home and was worried that he/she received the wrong medication.</p>	<p>Counseling patients on the identity of the altered medication (where applicable), the different or appropriate directions for use, etc. will help avoid misunderstanding and inappropriate use of the medication.</p> <p>Follow-up with patients or monitoring is important, especially in cases where an alternative brand or product was dispensed due to drug shortages.</p>
Association Error	<p>Commercially available [oral] solution (Teva-Ranitidine) was backordered from the manufacturer. An alternative was compounded for the patient, but it was a different, lower-strength [product]. When changing the prescription over, the directions/quantity was not updated to reflect taking more of the new, lower-strength product, and the label was not updated.</p> <p>There was a shortage of Citalopram 10mg and we had to switch to the 20mg strength. We copied the prescription but forgot to change the directions to reflect the new dose.</p> <p>Betahistine 16 mg was backordered, and a patient at the</p>	<p>When adapting or making alternative arrangements for a prescription during drug shortages, independent double checks should be performed for each prescription during the order entry and dispensing process.⁸</p> <p>The process of copying from previous prescriptions should be restricted or eliminated to prevent confirmation bias.</p>

SUBTHEME	INCIDENT EXAMPLES	COMMENTARY
	<p>pharmacy was taking 1 tablet BID (twice daily). We called the doctor and he changed the prescription to Betahistine 24 mg 1/2 tablet BID. When the 16 mg was available again, we notified the doctor, who changed the prescription back to one 16 mg tablet BID, but the unit dose on the patient's compliance label did not get changed; a pharmacy staff member left it as 1/2 tablet BID in the pill-packs.</p> <p>A drug shortage forced pharmacy staff to use a different brand of Apo[®]-Amilzide, and was therefore switched to Novamilor. When Apo[®]-Amilzide became available again, the plan was to switch back to the original Apo[®]-Amilzide, however a staff member chose [Midamor[®]] instead of Apo[®]-Amilzide. The patient noticed the yellow color of the tablets when picking up her prescription, saying that she had never been on yellow tabs – pharmacy staff checked file and noticed the error.</p>	
Incorrect Brand Selected	<p>A prescription for warfarin was filled with the wrong generic brand since it was backordered, but the error was found upon checking the prescription and corrected before dispensing. The incorrect generic for methylprednisolone 40 mg/ml was chosen off shelf as the generic brand that is normally carried in the pharmacy for this medication was backordered.</p>	<p>When adapting or making alternative arrangements for a prescription during drug shortages, independent double checks should be performed for each prescription during the order entry and dispensing process.⁸</p>
Incorrect Strength	<p>There was a manufacturer shortage of Levodopa-Carbidopa 100/10 mg. As a result, the brand of this medication was changed, and in doing so, the 100/25 mg strength was selected by mistake.</p> <p>While switching between manufacturers due to a shortage, brand name Gliclazide MR 30 mg was chosen instead of the regular Gliclazide 80 mg. The error was picked up while checking.</p>	

PATIENT SAFETY KEY LEARNING POINTS

Although many of the incident reports related to drug shortages were near misses and did not lead to patient harm, a substantial number of cases did cause patient confusion and misunderstanding. If left unresolved, these could potentially lead to negative outcomes such as non-compliance and/or incorrect use of the medication.

Pharmacies should be encouraged to adopt a workflow that allows independent double checks to verify stages of order entry, dispensing, and monitoring in the medication-use process. Having a dialogue with the patient when the medication is being picked up may also serve as an independent double check to ensure that the right medication is dispensed to the right patient.

It is important to recognize the need to communicate with patients when a drug shortage has affected their

medication regimen, especially when it involves altering the medication or prescription in some way. Counseling patients on the identity of the altered medication, the different or appropriate directions for use, etc. will help avoid misunderstanding and inappropriate use of the medication.

Follow-up or monitoring is also important in dealing with issues of drug shortages, especially in cases where an alternate brand of the medication has been dispensed, as some patients may be sensitive to brand changes and thus respond differently (better or worse) compared to the previous brand of the medication they were taking for a condition.

CONCLUSION

The incidents gathered from this multi-incident analysis have reinforced the negative impact that drug shortages can have on patient safety. Although drug

shortages continue to be an inevitable issue that many pharmacists, patients, and healthcare providers must face on a regular basis, actions can be taken to mitigate and prevent the likelihood of negative outcomes from occurring. Such actions include identifying which medications are likely to be unavailable or in limited supply (where possible), assessing the utilization of these medications in the pharmacy, preparing for a possible shortage of these medications, communication among staff members of drug shortages, as well as education on policies and procedures for potential problems that may be encountered when dealing with certain drug shortage situations.² The following is a list of Canadian resources that may be helpful for pharmacies with respect to handling drug shortages.

CANADIAN RESOURCES FOR HANDLING DRUG SHORTAGES

National drug shortages online reporting system

- <http://www.drugshortages.ca>

Drug Shortages: A Guide for Assessment and Patient Management (Canadian Pharmacists Association (CPhA))

- <http://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/DrugShortagesGuide.pdf>

Drug Shortages (University of Saskatchewan medSask)

- <http://medsask.usask.ca/professional/drug-shortages/index.php>

FridayPM

- <http://www.fridaypm.ca>

Drug Shortages and Medication Safety Concerns (ISMP Canada)

- http://www.ismp-canada.org/download/safetyBulletins/2012/ISMPCSB2012-03_Drug_Shortages.pdf

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ISMP Canada would like to acknowledge support from the Ontario Ministry of Health and Long-Term Care for the development of the Community Pharmacy Incident Reporting (CPhIR) Program (<http://www.cphir.ca>). The CPhIR Program also contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (<http://www.ismpcanada.org/cmirms.htm>). A goal of CMIRPS is to analyze medication incident reports and develop recommendations for enhancing medication safety in all healthcare settings. The incidents anonymously reported by community pharmacy practitioners to CPhIR were extremely helpful in the preparation of this article. 

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Wednesday April 23rd	Ottawa	Orientation
Tuesday May 6th	Toronto	Orientation
Wednesday May 21st	Sudbury	Orientation
Thursday May 29th	Burlington	Orientation
Thursday June 5th	Toronto	Orientation
Tuesday June 24th	Toronto	Orientation
Wednesday July 23rd	Toronto	Orientation
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To arrange a workshop in your community, please ask your CE Coordinator to contact
Vicky Clayton-Jones:

416-962-4861 • 1-800-220-1921 x 2297 • regprograms@ocpinfo.com

DISCIPLINE DECISIONS

Member: Majid Haditaghi

At a hearing on October 15, 2013, a Panel of the Discipline Committee found Mr. Haditaghi guilty of professional misconduct in that he



- failed to maintain records as required;
- improperly stored drugs;
- dispensed reduced quantities without written authorization;
 - incompletely transcribed verbal authorizations.

In particular, Mr. Haditaghi was found to have

- failed to maintain the standards of practice of the profession;
- failed to keep records as required respecting his patients;
- contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and/or 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, and section 59 of Regulation 551 under the Drug and Pharmacies Regulation Act;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section C.01.003 and C.01.004 of the Food and Drug Regulations, C.R.C., c. 870, and section 9 of

the Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c. P.23;

- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
 - o that the Member complete successfully, at his own expense, within 18 months of the date of the Order, the following courses and evaluations:
- Root Cause Analysis from the Institute for Safe Medication Practices Canada;
- CPS I Module 5 (Professional Practice & Pharmacy Management 1) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
- CPS II Module 5 (Professional Practice & Pharmacy Management II) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
 - o that the Member shall be

prohibited, for a period of 18 months from the date of the Order, from acting as a Designated Manager in any pharmacy;

- A suspension of five months, with two months of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of \$7,500.

The Panel's reprimand delivered to the Member cited its concern that the Member was appearing once again before the Discipline Committee for similar issues. The Panel was disturbed by the Member's repeated breaches of the Standards of Practice, and ultimately regarded the Member's actions as unprofessional.

Member: George Oduro

At a hearing on October 23, 2013, a Panel of the Discipline Committee found Mr. Oduro guilty of professional misconduct in that, during the period 2010 - 2011, as the owner and/or operator of the Medical Ergonomics Clinic in Mississauga, Ontario, he engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in that he and/or an employee or employees of Medical Ergonomics Clinic issued invoices or claims for health care services which he knew or ought to have known were false or misleading with respect to one of more of the following patients:

- (i) D.E.
- (ii) N.M.
- (iii) S.L.
- (iv) D.F.
- (v) A.G.

The Panel imposed an Order which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular that the Member complete successfully, at his own expense, within 12 months of the date of the Order, the ProBE Program on professional/problem-based ethics for health care professionals;
- A suspension of three months with two months of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of \$3,000.

The Panel's reprimand delivered to the Member noted that although the conduct in this case was not directly related to the Member's work as a pharmacist, it nonetheless reflected badly on the Member insofar as the Member had acted unprofessionally. The Panel expressed its hope that the Member would make the necessary adjustments in his role as a health-care provider.

Member: Andrij Chabursky

At a hearing on November 13, 2013, a Panel of the Discipline Committee found Mr. Chabursky guilty of professional misconduct in that, while engaged in the practice of pharmacy as director and shareholder of AOC Company Ltd., 1391478 Ontario Inc., Best Drug Mart, Markland Wood Pharmacy Ltd. and/or Symington Drugs, and/or designated manager of Best Drug Mart and Symington Drugs in Toronto, Ontario, he

- requested and/or accepted rebates totaling approximately

\$3.2 million from generic drug manufacturers contrary to the Ontario Drug Benefit Act, section 11.5 and/or the Drug Interchangeability and Dispensing Fee Act, section 12.1, as then in effect, with respect to the following activities, in or about January 2007-December 2008:

- (a) accepting rebates characterized as professional allowances in excess of the 20% limit for the manufacturer's drug products reimbursed under the Ontario Drug Benefit Act, as specified in O.Reg. 201/96, section 1(9);
- (b) accepting rebates characterized as professional allowances for activities other than the activities permitted for professional allowances, under the Ontario Drug Benefit Act, as listed in O.Reg. 201/96, section 1(8) or otherwise in accordance with the Code of Conduct in O.Reg. 201/96, Schedule 3; and/or
- (c) accepting rebates characterized as professional allowances for activities other than the activities permitted for professional allowances, under the Drug Interchangeability and Dispensing Fee Act, as listed in Regulation 935, section 2(1) or otherwise in accordance with the Code of Conduct in Regulation 935, Schedule 1.

In particular, Mr. Chabursky was found to have

- failed to maintain a standard of practice of the profession;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs;
- permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to

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FOCUS ON ERROR PREVENTION

By Ian Stewart B.Sc.Pharm., R.Ph.

LOGGED PRESCRIPTIONS

When a patient requests a prescription refill, the need to retrieve the original prescription before the medication is dispensed is rarely required. However, pharmacists must be aware that when dispensing medications that have been logged and not previously dispensed, it is best practice to retrieve the original prescription to ensure accuracy and optimal patient outcomes.

CASE:

Rx

Ventolin Nebules 1mg/ml

Sig: 2ml bid

Mitte: 50ml

Pulmicort Nebuamp 0.25mg/2ml

Sig: 1 Ampule q4-6h prn

Mitte: 40ml

The above medications were prescribed for a one-year old child. The computer generated prescription was taken to a local community pharmacy for processing by the child's father. The parent requested that only the Ventolin Nebules be dispensed.

The pharmacy assistant entered the Ventolin Nebules prescription into the computer and prepared the medication for checking by the pharmacist. The pharmacist checked and dispensed the Ventolin Nebules accurately.

After the father received the Ventolin Nebules, the pharmacy assistant entered and logged the Pulmicort Nebules into the computer. However in error, she selected Pulmicort Nebules 0.25mg/ml instead of 0.25mg/2ml as prescribed. The pharmacist continued to serve patients waiting for prescriptions and therefore did not immediately check the incorrectly logged prescription.

Shortly after leaving the pharmacy, the father drove

to a second pharmacy and requested the Pulmicort Nebules. The pharmacist at the second pharmacy therefore called the original pharmacy and requested a transfer of the Pulmicort Nebules prescription. Unfortunately, this occurred before the pharmacist was able to check the logged prescription for accuracy.

Not knowing that the pharmacist had not yet checked the logged prescription, the pharmacy assistant selected the logged Pulmicort Nebules on the patient's file and transferred the prescription. Though the pharmacist was made aware of the transfer, he was not aware that the prescription being transferred was not yet checked for accuracy. The incorrect strength of Pulmicort Nebules was therefore transferred.

Approximately two hours later, after all waiting patients had been served, the pharmacist was able to check the logged prescription. The computer entry error was identified. The pharmacist therefore called the second pharmacy to advise them of the error, and transferred the corrected logged prescription. However, by that time, one dose of the incorrect strength was given to the child. The father of the child was understandably upset when advised of the error.

POSSIBLE CONTRIBUTING FACTORS:

- It was a busy period of time in the pharmacy. The staff therefore wanted to provide the needed medication (Ventolin) as soon as possible and enter the logged medication (Pulmicort) into the computer at a later time.
- The pharmacy staff was not aware that the parent had intended to go to another pharmacy for the Pulmicort Nebules.
- Both medications were not entered into the computer at the same time. Therefore, the pharmacist was not able to check both prescriptions at the same time.
- Pulmicort Nebules are listed in the pharmacy computer as 0.25mg/ml and 0.125mg/ml. However, the strength on the prescription was provided per

DISCIPLINE DECISIONS

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ampoule. That is, 0.25mg/2ml. The pharmacy assistant failed to notice the difference in concentration and selected the 0.25mg/ml strength in error.

- The pharmacist dispensing the Pulmicort Nebules did not have a copy of the original prescription to check for accuracy before the medication was dispensed. The pharmacist also failed to notice the relatively high dose of Pulmicort for a one-year old child.

RECOMMENDATIONS:

- When dispensing medication from a logged prescription, since the medication is being dispensed for the first time, it is best practice to retrieve the original prescription to ensure accuracy. Therefore, if the logged prescription was transferred from another pharmacy, I recommend requesting a copy of the original prescription. A complaint which highlights this issue can be seen on the College's website, www.ocpinfo.com, by searching the term "logged prescriptions"
- Since it is unknown when a request for transfer of a prescription may occur, all logged prescriptions should be checked for accuracy as soon as possible.
- Before transferring a prescription to another pharmacy, check the date entered into the computer to ensure that the logged prescription had been checked for accuracy.
- Always double check pediatric doses for appropriateness. 

Please continue to send reports of medication errors in confidence to:

Ian Stewart at: ian.stewart2@rogers.com

Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

the sale of drugs by a corporation of which he was a director;

- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included:

- A reprimand;
- That the Registrar impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully, at his own expense and within 12 months of the date of the Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, or an alternative program on ethics for healthcare professionals acceptable to the College;
- That the Registrar impose further specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, prohibiting the Member from acting in the capacity of a Designated Manager of any pharmacy for a period of 4 years from the date of the Order;
- A suspension of 15 months, with one month of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of \$30,000.

In its public reprimand to the Member, the Panel noted that the Member's conduct in this case was driven by greed and had tainted the profession. The Panel reflected that the Member had taken the first steps in rehabilitation by admitting and acknowledging his conduct, and underscored for the Member that this was the Member's last chance before the Discipline Committee. 

The full text of these decisions is available at www.canlii.org

CanLii is a non-profit organization managed by the Federation of Law Societies of Canada. CanLii's goal is to make Canadian law accessible for free on the Internet.

CONTINUING EDUCATION (CE)

This CE list is provided as a courtesy to members and is by no means exhaustive. Inclusion of a CE on this list does not imply endorsement by the Ontario College of Pharmacists. For information on local live CE events in your area you may wish to contact your Regional CE coordinator (list available on the OCP website).

Visit www.ocpinfo.com for an up-to-date list of Continuing Education.

LIVE

December 5-6, 2013 (Vancouver, BC)

An Introduction to Network Meta-Analysis Workshop

Canadian Agency for Drugs and Technologies in Health

Contact: www.cadth.ca

December 6 - 8, 2013 (Toronto)

Psychiatric Patient Care Program – Level 1 & 2

Ontario Pharmacists Association

Contact: <http://members.opatoday.com/live-courses>

December 7 - 8, 2013 (Toronto)

January 25 - 26, 2014 (Kitchener)

Beyond the Counter Series: Maximizing Your Pharmacy Services Business

Ontario Pharmacists Association

Contact: <http://members.opatoday.com/live-courses>

December 14 - 15, 2013 (Toronto)

Minor Ailments: A Look Beyond OTC's

Ontario Pharmacists Association

Contact: <http://members.opatoday.com/live-courses>

January 20 - 22, 2014 - Part 1 (Toronto)

February - April 2014 - Part II (Online)

April 14 - 15, 2014 - Part III (Toronto)

Advanced Cardiology Pharmacy Practice

University of Toronto

Contact: <http://www.pharmacyutoronto.ca/cpd/cardiology/>

January 20 - 21, 2014 (Toronto)

TEACH Specialty Course:

Tobacco Interventions for Women Across the Lifespan

Centre for Addiction and Mental Health

Contact: <http://www.teachproject.ca>

January 23, 2014 (Toronto)

Canadian Public Health Association 2014 Annual Conference

Canadian Public Health Association

Contact: <http://www.cpha.ca/en/default.aspx>

January 25, 2014 (Toronto)

Methadone, Buprenorphine, and the Community Ontario Pharmacists Association

Contact: <http://www.opatoday.com>

February 1 - 5, 2014 (Toronto)

Professional Practice Conference

Canadian Society of Hospital Pharmacists

Contact: http://www.cshp.ca/events/ppc/index_e.asp

February 8 - 9, 2014 – Part 1 (Toronto)

April 26 - 27, 2014 – Part 2 (Toronto)

Introductory Psychopharmacology for Clinicians

University of Toronto

Contact: <http://www.pharmacyutoronto.ca/cpd/psychopharmacology>

February 19, 2014 (Toronto)

BPMH Training for Pharmacy Technicians:

Understanding the hospital pharmacy technician's role in medication reconciliation

Institute for Safe Medication Practices (ISMP)

Contact: <http://www.pharmacyutoronto.ca/cpd/psychopharmacology>

April 2 - 4, 2014 (Toronto)

Thrombosis Management

University of Toronto

Contact: <http://www.pharmacyutoronto.ca/cpd/thrombosis/>

April 2 - 5, 2014 (Montreal)

XIV International Symposium on Oncology Pharmacy Practice

International Society of Oncology Pharmacy Practitioners

Contact: <http://www.isoppxiv.org/>

April 5, 2014 (Ottawa)

Update Mise a jour 2014 – 31st Annual Conference

Ottawa Valley Regional Drug Information Service

Contact: www.rxinfo.ca

May 2 – 4, 2014 (Niagara Falls)

Professional Development Conference

Canadian Association of Pharmacy Technicians

Contact: http://www.capt.ca/Capt_PDC.aspx

May 26 – 29, 2014 (Toronto)

Multi-Incident Analysis Workshop – Analyzing medication incidents one group at a time

Institute for Safe Medication Practices

Contact: <http://www.ismp-canada.org/index.htm>

Multiple dates and locations – contact course providers

Immunizations and Injections training courses

Ontario Pharmacists Association <http://www.opatoday.com/>

Pear Health [http://www.pearhealthcare.com/training-](http://www.pearhealthcare.com/training-injection-training.php)

injection-training.php

RxBriefcase, CPS and PHAC <http://www.advancingpractice.com/>

University of Toronto <http://www.pharmacyutoronto.ca/cpd>

ON-LINE/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)

On-line courses with live workshops in subjects including mental health, safe and effective use of opioids, opioid dependence treatment core course (with additional elective courses), motivational interviewing, interactions between psychiatric medications and substances of abuse.

Contact: <http://www.camh.ca/en/education/>

Canadian Pharmacists Association (CPA)

Home Study Online accredited education programs including the ADAPT Patient Skills Development certificate program, Diabetes Strategy for Pharmacists, Micronutrients, QUIT: Quit Using & Inhaling Tobacco and Respiratory care <http://www.pharmacists.ca/index.cfm/education-practice-resources/>

Canadian Society of Hospital Pharmacists (CSHP)

Online education programs accredited by CCCEP

www.cshp.ca

Canadian Healthcare Network

On-line CE Lessons

www.canadianhealthcarenetwork.ca

Communimed

A Practical Guide to Successful Therapeutic Drug Monitoring and Management (TDM & M) in Community Pharmacy. Focus on Levothyroxine

www.tdm-levothyroxine.ca

Continuous Professional Development - Leslie Dan Faculty of Pharmacy, University of Toronto

Infectious Diseases Online Video Lectures and Slides, Influenza DVD

<http://www.pharmacyutoronto.ca/cpd/>

Ontario Pharmacists Association (OPA)

Complimentary online programs in therapeutic areas including Cough & Cold, Physical Assessment for Pharmacists, Methadone, Practical Management of Cough and Cold, Smoking Cessation, Ulcerative Colitis and Vitamin D in Osteoporosis.

<http://www.opatoday.com>

Contact: onlinelearning@opatoday.com

RxBriefcase

On-line CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).

www.rxbriefcase.com

Ontario is fortunate to have a dedicated team of regional CE Coordinators, who volunteer their time and effort to facilitate CE events around the province.

OCP extends its sincere appreciation and thanks to each and every member of these teams for their commitment and dedication in giving back to the profession.

ADDITIONAL CE COORDINATORS NEEDED:

For members interested in expanding their network and giving back to the profession, OCP is looking for regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 17 (Brantford area), 25 (Sault Ste. Marie area), 27 (Timmins area). A complete list of CE coordinators and regions by town/city is available on our website. To apply, please submit your resume to ckuhn@ocpinfo.com.

REMINDER:

ONLINE MEMBERSHIP RENEWAL BEGINS IN JANUARY 2014

**WATCH FOR MORE INFORMATION ON DEADLINES AND ENSURE WE HAVE YOUR
UPDATED E-MAIL ADDRESS AS MEMBERSHIP RENEWAL IS OFFERED ONLINE**