Council Members

Council Members for Districts 1-17 are listed below according to District number. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. DFP indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. DSP indicates the Director, School of Pharmacy, University of Waterloo.

1. Joseph Hanna
2. Elaine Akers
3. Sherif Guorgui
4. Tracey Phillips
5. Donald Organ
6. Fayez Kosa
7. Tracy Wiersema
8. Saheed Rashid
9. Bonnie Hauser
10. Gerald Cook
11. Christopher Leung
12. Peter Gdyczynski
13. Sanjiv Maindiratta
14. Stephen Clement
15. Gregory Purchase
16. Doris Nessim
17. Shelley McKinney

PM Jional Abdin
PM Thomas Baulke
PM Corazon dela Cruz
PM Babek Ebrahimzadeh
PM David Hoff
PM Margaret Irwin
PM Javaid Khan
PM Lewis Lederman
PM Aladdin Mohaghegh
PM Gitu Parikh
DFP Wayne Hindmarsh
DSP Jake Thiessen

Statutory Committees
• Executive
• Accreditation
• Complaints
• Discipline
• Fitness to Practice
• Patient Relations
• Quality Assurance
• Registration

Standing Committees
• Communications
• Finance
• Professional Practice

Special Committees
• Standards of Practice Working Group
• Pharmacy Technicians Working Group

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The mission of the Ontario College of Pharmacists is to regulate the practice of pharmacy, through the participation of the public and the profession, in accordance with standards of practice which ensure that our members provide the public with quality pharmaceutical service and care.
The objectives of Pharmacy Connection are to communicate information on College activities and policies; encourage dialogue and to discuss issues of interest with pharmacists; and to promote the pharmacist's role among our members, allied health professions and the public.

We publish six times a year, in January, March, May, July, September and November. We welcome original manuscripts (that promote the objectives of the journal) for consideration. The Ontario College of Pharmacists reserves the right to modify contributions as appropriate. Please contact the Associate Editor for publishing requirements.

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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Over the past month I have had the opportunity to meet with and listen to pharmacists and pharmacy leaders across North America. I attended the NABP (National Association of Boards of Pharmacy) annual meeting in Miami, and recently the CPhA (Canadian Pharmacist Association) conference in beautiful Halifax. It was very interesting to see where the profession is, in terms of scope of practice, prescribing, and utilization of technology and technicians across the different states and provinces. All jurisdictions across Canada appear to ultimately be headed in the same direction, in an attempt to improve access to health care and improved health outcomes for Canadians. The opportunities being proposed through Bill 179 will give pharmacists in Ontario greater authority to play a more integral role in the health care of our patients. Once the legislation is passed, the development of the regulations will take some time and will require a great deal of consultation and thought to ensure that the resulting responsibilities can be delivered safely and effectively.

Listening to the many innovative pharmacists who were giving presentations, what struck me most was the concept of separation of drug distribution and patient care. In order for pharmacists to have the time to provide enhanced services and to work to the full potential of an advanced scope of practice, the drug distribution system will have to become more efficient, while maintaining or increasing the safety. This is where regulated technicians and technology will have to come in to play. I have carried these concepts back to my own practice and am trying to look at every task that we do and every interaction that we have in the course of the day, to look for efficiencies and better use of resources to the ultimate goal of improvements in the care we are able to provide.

An update on the Blueprint for Pharmacy, an impressive document prepared by CPhA and pharmacy stakeholders was also presented in Halifax. The implementation plan involves looking at which organizations will take the lead in the necessary steps towards reality across the country.

While the government, Colleges, and associations across Canada will be working collaboratively to develop regulations, policies and standards to put pharmacy in a position to be able to deliver the Vision of “Optimal drug therapy outcomes for Canadians through patient-centred care” ultimately it will be pharmacists like you and me that will bring this vision to life in our day-to-day individual and collaborative practice settings. Existing models of practice will need to expand and adapt, as we anticipate and deliver the scope and quality of care that will be expected of us in the coming years. There has never been a more compelling opportunity to demonstrate the value and capacity of our profession. I look forward to seeing the impact that pharmacists across Ontario and across the country will have, on the health and wellness of Canadians. ☺
As of June 4, 2009 each of the health regulatory colleges in Ontario has three new OBJECTS.

8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

9. To promote inter-professional collaboration with other health profession colleges.

10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.”

And there has been a revision of a previous object, which now reads:

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competency and improvement among the members.

As well, the proposed changes to the RHPA in Bill 179 which has now had second reading proposes the following addition to that object:

4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.

These are significant changes as the profession of pharmacy moves forward. We are the profession of pharmacy with our unique body of knowledge, but in the future, we are expected to share that knowledge in a different way. These new objects call on pharmacists and all health care professionals to collaborate with each other, as well as to enhance our communications with the public and other stakeholders. The new objects also recognize the importance of having our members be able to respond to the changing practice environment.

It is no longer enough to just get along and work together. Health professionals are being asked to collaborate in a whole new way. Rather than protecting our unique body of knowledge, we are being asked to share it and to develop common standards with others who will also be carrying out authorized acts formerly only performed by us. Similarly, we will be expected to collaborate with those professions who have traditionally prescribed and administered medications so that we can share in their collective experience and wisdom about how to carry out these new authorized acts safely and effectively.

As well, as pharmacy technicians become regulated and begin to take on aspects of dispensing, selling and compounding drugs, this is an excellent opportunity for us to develop another collaborative partnership.

We must move away from an attitude of role protection towards a philosophy of teamwork so that the health needs of the public are best served. This may happen through the sharing of authorized acts or through adaptation to new practice environments. The anticipated result from all these changes is that pharmacists and all health professionals will work collaboratively to enhance patient care.
Strategic Plan Approved
As reported in the May/June 2009 issue of Pharmacy Connection, Council held a strategic planning retreat in early March. At the session, Council agreed on five key strategic directions for College-focused activity over the next three years. These directions were commended to the College management team to develop action plans with assigned responsibilities and timelines. The final report, 2009 Strategic Plan, was considered and approved by Council at the June meeting (see College website for a detailed plan) and over the summer, administration will use the plan, which serves as the foundation for College decisions respecting its activities, including human and financial resource allocation and budgeting, for developing a budget for approval by Council in September.

The strategic directions are:
1. Optimize the scope of practice of our members, as it evolves, for the purpose of achieving positive health outcomes.
2. Embrace the use of technology and innovation to integrate e-health initiatives in members’ practice, to improve the quality and safety of patient care, and to achieve operational efficiency.
3. Foster inter-professional collaboration to achieve coordinated patient-centred care and promote health and wellness.
4. Promote and enhance relationships with key stakeholders including the public, the government, our members, and other health care professionals through effective communication.
5. Fulfill our core mandate of self-regulation in an environment of continuous quality improvement in a fiscally responsible manner.

Consistent with previous years, the Strategic Plan will be monitored at every Executive Committee meeting and a progress report from the Committee will be provided to Council on a regular basis.

Capital Budget Approved
Council approved a further capital expenditure of $300,000 for transitioning internal College operations to a telecommuting platform.

Following approval of a preliminary $1.8 Million Project Budget for Telecommuting in December 2008, staff and the Building Committee worked with Mayhew Workspace Works!, the real-estate and design firm contracted by the College to undertake the analysis of our space needs and expectations, to finalize the details respecting the renovation to the College premises at 483 Huron Street. During this process, mechanical and electrical issues were detected which would leave the College in breach of the current building code if left unaddressed. Cost estimates, after tender results, indicate a projected cost of $1,527,400 on the initial budget of $1,355,300. In addition to the building project, projected costs for technological/work process are expected to exceed the initial $500,000 budget by $75,000 bringing the total additional funding required to $300,000.

Council noted for information that construction of the basement and first floor will be completed in mid July, followed by the second floor in early September and the third floor by late November. Approximately 55% of all staff has now been set up with remote access. Council further noted that the projected surplus reserves at year end 2009 will be in the order of $2.5 million ($4.3 mil vs. target of $1.8). The excess reserves, earmarked for facilities to address the anticipated increase in space required to accommodate growth in staffing, will adequately cover the total revised Project Budget for Telecommuting of $2.1 million.

Blueprint for Pharmaceutical Jurisprudence for Pharmacy Technicians Approved
Since Pharmacy Technicians will be regulated members of the College, sharing the same Code of Ethics, and entitled to perform the same authorized acts as pharmacists (subject to terms, conditions and limitations), consultations were held with stakeholders (pharmacists, pharmacy technicians, pharmacy technician educators, members of the jurisprudence writers group and Council members), during which time it was determined that a separate jurisprudence exam for pharmacy technicians was warranted.

At the June Council meeting, Council agreed that the proposed
blueprint, which is similar to the current blueprint for pharmacists, but distinct to reflect the role and practice of a pharmacy technician, be approved. A pilot exam will be offered to a selected group of technicians in the fall of 2009. It will serve to validate the blueprint and following administration of the pilot exam, an analysis will be completed to ensure that the exam has functioned as intended for the target population and any necessary revisions will be presented to Council for further approval. Once the blueprint is confirmed, the exam will be set and administered on a schedule and format consistent with the pharmaceutical jurisprudence exam for pharmacists (i.e. four times a year at several locations throughout the province).

Legislative Proposals to the DPRA
Subsequent to discussion at the Special Meeting of Council on April 22, 2009, the Registrar wrote to Deputy Minister Sapsford and advised him of Council’s ratification of the proposed amendments to the Drug and Pharmacies Regulation Act, and as directed by Council, also informed him of the need to be allowed sufficient time for consideration of the operational standards and terms and conditions respecting remote dispensing in Ontario. Council will be kept apprised of developments in this matter.

Labour Mobility/Bill 175
The Mobility Agreement for Canadian Pharmacists, as prepared by NAPRA, the National Association of Pharmacy Regulatory Authorities, has now been finalized for signature by all provinces, including Quebec, the Northwest Territories and Yukon. Council endorsed signing the Agreement, noting that it is not too different from the one originally signed in 2001 – the one significant difference amending the Entry to Practice Examination requirement such that all provinces will require the PEBC (Pharmacy Examining Board of Canada) qualifying examination or accept a graduate from a jurisdiction which has statutory oversight over their faculty programs, such as Quebec. (See the NAPRA website www.napra.org for a comprehensive version of the Agreement).

On a related matter, Council discussed Bill 175, recently introduced by the Ontario government, which speaks to changes to the registration regulation of every profession in Ontario to ensure that any applicants already holding a license to practice their profession in another Canadian jurisdiction can move seamlessly to Ontario without any additional requirements. While Council expressed concerns respecting consistency in the entry to practice requirements of other provinces, it was satisfied that the College is vigorously working with other Colleges across Canada, through NAPRA, to ensure uniformity in this matter.

NAPRA
Council received a report from the College’s representative, Mr. Peter Gdyczynski, respecting discussions at NAPRA’s (National Association of Pharmacy Regulatory Authorities) recent Annual Board Meeting. NAPRA continues to work with all pharmacy regulatory bodies across Canada and their recent accomplishments include obtaining consensus on various issues such as: Mobility Agreement for Canadian Pharmacists (as reported above); International Pharmacy Graduates (NAPRA will look at developing tools to assist applicants assess their skills); and Model Standards of Practice (which have been referred to the Professional Practice Committee for review and recommendations).

Registration Regulation Update
The College is in receipt of correspondence from the Hon. Jean Augustine, Fairness Commissioner, advising the College that subsequent to meetings between our two organizations, the new draft of our proposed registration regulation will be supported by her office. Essentially, the new draft changes certain sections [31(1), 37(1) and 46] and will allow candidates who successfully pass the PEBC Examination on their first attempt to have the Registration Committee of the College determine what, if any, further education or training is necessary. The new draft of the proposed regulation has been posted on the website since April 29, 2009 for member input. The Regulation will now require further changes to accommodate anticipated labour mobility legislation.
Introduction of Bill 179 - (Regulated Health Professions Statute Law Amendment Act, 2009)
The Minister of Health and Long-Term Care has introduced an omnibus bill that will increase access to health care services by the public of Ontario through expanding the scopes of pharmacists and other health care professionals. This piece of legislation will have an impact on the specific acts of other professions and the College will be reviewing the Bill in detail in order to prepare submissions for the government. At Council’s direction, a request has been made for the College to appear and present to the Standing Committee on Social Policy. Regular updates will be provided to Council as developments occur in this area.

Grants Approved
Council approved a grant of $2,000 in support of Educational Sessions at OB-CSHP’s Annual General Meeting to be held in Toronto at the Leslie Dan Faculty of Pharmacy building of the University of Toronto on November 14, 2009.

Council also endorsed the Executive Committee’s recommendation that the College sponsor an education session at OPA’s annual conference to be held in September 10-12, 2009. This year, the sponsorship, in the sum of $2,500, is being provided for the session entitled “Human Factors in Error Prevention”.

SPT Preceptor Criteria Approved
Revisions to the “Preceptor Criteria – Registered Pharmacy Student/Intern” were approved by Council, and can be found on the College’s website and in the SPT Manuals and application forms.

Essentially, the criteria have been revised to provide greater clarity and the key changes include the addition of “SPT” to clarify that these criteria are only applicable to preceptors supervising students or interns as part of the OCP’s Structured Practical Training (SPT) program. (Pharmacists supervising pharmacy students for experiential training as part of the University of Toronto or University of Waterloo programs are required to meet the criteria determined by those pharmacy degree programs.)

In addition, pharmacists may now supervise both an SPEP (Structured Practical Experiential Program at the University of Toronto), student and an SPT student/intern at the same time. This will not only ensure a greater availability of preceptors but will also provide shared learning opportunities for students, interns and preceptors.

Blueprint for Pharmacy
The College was recently invited to provide feedback respecting CPhA’s (Canadian Pharmacists’ Association) “Blueprint for Pharmacy Implementation Plan” and accompanying “draft Operational Framework”. Council strongly supported the principles incorporated in the Blueprint for Pharmacy, including the integration of international pharmacy graduates, the regulation of pharmacy technicians, an expanded scope of practice for pharmacists, and e-prescribing demonstration pilots, all of which are well underway in Ontario. The College’s Strategic Plan will ensure these initiatives continue and are well aligned with the principles and actions required to give effect to the Blueprint for Pharmacy.

However, Council had concerns respecting the far-reaching implications of the implementation plan and the operational framework proposed. Primarily, these include resource implications, both human and financial, as well as the potential for duplication of effort and CPhA has been advised that these issues might be ameliorated by establishing a regular reporting system through NAPRA as a means of tracking progress in individual provinces.

PEBC Update
Also included for Council’s information was a report from the Pharmacy Examining Board of Canada (PEBC) highlighting their progress on various initiatives. Of particular note is their work relating to the Pharmacy Technician Entry-to-Practice Examination. This College is committed to working closely with PEBC as they work towards providing a national, standardized assessment process that will ensure that entry-level pharmacy technicians have the necessary professional knowledge, skills, and abilities to practice safely and effectively.
Proposed PharmD Program Update
Council noted for information that while the Leslie Dan Faculty of Pharmacy, University of Toronto plan to develop and implement a new curriculum to replace the existing 4-year BScPhm program will not be realized for the 2010 cycle, the Faculty’s proposal for the PharmD program has been forwarded by the Ontario Ministries of Health and of Training, Colleges and Universities to the Pan-Canadian Coordinating Committee for review. Until this review has occurred, the curriculum for the BScPhm program, aside from already-planned and required revisions, will remain essentially unchanged for students admitted in September 2010.

Council Honours Dean Wayne Hindmarsh
Following adjournment of Council discussions on Monday, June 8, 2009, a Reception to recognize and honour Dean Wayne Hindmarsh on his retirement was attended by Council members. Dr. and Mrs. Hindmarsh were guests of honour at the Reception and Registrar Williams and President Wiersema took the opportunity to thank the Dean for his considerable input both at Council and committee levels during his tenure.

The next Council meeting will be held on September 14 and 15, 2009. For information, please contact Ushma Rajdev at urajdev@ocpinfo.com

Council Elections

District 3 – Mr. Sherif Guorgui - acclaimed
District 6 – Election to be held*
District 9 – Ms. Bonnie Hauser - acclaimed
District 12 – Mr. Peter Gdyyczynski - acclaimed
District 15 - No nominations received. A by-election will be held at a date yet to be determined
District 16 – Ms. Doris Nessim - acclaimed

PUBLIC MEMBERS REAPPOINTED FOR A FURTHER 3-YEAR TERM

Mr. Thomas Baulke, Collingwood
Mr. David Hoff, Oakville

CONGRATULATIONS TO ALL!

* Information respecting the elections has been forwarded to members in electoral District 6. Please note that votes must be cast by close of day on Wednesday, August 5, 2009.

Please also be reminded that for this year, all terms on Council are for one year and beginning next summer, elections will be held in accordance with the revised electoral districts as circulated to members in the May/June 2008 issue of Pharmacy Connection.
Prescription Delivery Regulation

**ONE YEAR LATER**

In 2008, the Drug and Pharmacies Regulation Act (DPRA) was modified to require pharmacies to obtain a signature from a patient or an agent when a prescription is delivered or mailed. The requirement was effective June 4, 2008. Pharmacies were given notification in Pharmacy Connection. A Practice Q&A article in the July/August 2008 issue of Pharmacy Connection went over specifics of the new delivery regulation.

The new requirement in the DPRA regarding deliveries is law, and all pharmacies must comply with it. A driver must obtain a signature before giving a prescription to a patient or agent; it is no longer acceptable to leave a prescription in the mailbox. Prescriptions sent by post must go as registered mail and be signed for. In order to meet the requirements that deliveries are “auditable and traceable” pharmacies have to keep the signatures for delivery on file at the pharmacy. A signature by the patient or the patient’s agent for Schedule I or prescription drugs is a legislated requirement of the DPRA. How other over-the-counter medications or sales are handled would fall under best practices for businesses.
Systems to Comply with the Regulations
There are two systems which inspectors have seen in practice that meet the new delivery regulations. The first involves having a delivery log set up listing the patients’ names and addresses, with a line for the patient or agent to sign. The second involves using delivery slips to which privacy labels for the prescriptions sent to the patient are attached and the patient or agent signs the delivery slip. Whatever the system used, it must ensure patient confidentiality. The name of the medications being delivered should not appear on the outside of the prescription bag.

Auditable and Traceable Delivery
The delivery system developed must be auditable and traceable. The patient or agent must sign for exactly what was sent. A patient could argue he or she has signed for only one medication if nothing is specified. The delivery log or system should list the prescription/transaction numbers of the medications sent and/or the number of prescriptions sent. In this way, the patient or agent knows exactly what they are signing for and the pharmacy has this record. With delivery of a compliance package, the patient or agent needs only to sign for the package (each medication does not need to be listed). Auditable and traceable delivery also requires that the pharmacist knows where the patient’s prescription is at all times. The driver or service should go directly to deliver prescriptions, unless other direction has been given or approved by the pharmacist.

Best Practices of Delivery
As a best practice, the pharmacy should receive the signatures from patients or agents daily from the driver. This helps to ensure that the driver or service is not keeping medications overnight. Professional judgement is required and regular contact with the driver may be necessary to ensure proper delivery of the medication. It is likewise a matter of professional judgement as to whether a pharmacist will send controlled substances by delivery. It is the pharmacist’s responsibility to prevent fraud and protect patient confidentiality until the delivery gets to the patient.

Maintenance of Delivery Records
The delivery signature is a requirement and must be kept on file at the pharmacy. The designated manager should create policies and procedures for maintaining these records. At present, we recommend pharmacies maintain their delivery records for at least three months.

Patients and the New Regulations
Some problems pharmacists have relayed to inspectors with the new regulation are that their patients do not want to change how they get their prescriptions. They are used to having them left in the mailbox and still want this, or their concierge is refusing to sign for the delivery. It is important that pharmacists explain to their patients that the change is mandatory. A pharmacist is responsible for the storage of the prescription and protection of the patient’s confidentiality until a patient or agent signs for the prescription. Do you, as a pharmacist, trust the storage of medication in a mailbox? If the medication is lost, who is at fault? Clearly, it is the pharmacist who is responsible until a patient or agent signs for the prescription. If a patient is unable to sign for a prescription due to a medical condition, a pharmacist must contact the patient or agent and discuss the new regulation and what can be done. Use professional judgement -- can the patient or agent make a mark on the delivery slip? If not, the driver may sign on behalf of the patient or agent.

Pharmacists are very good at ensuring that physicians sign their prescriptions before filling medications. They should be equally diligent in obtaining signatures from patients or agents before leaving a medication during delivery. It is required that all pharmacies in Ontario follow the DPRA regulations. If you have any questions or concerns, go to our website, http://www.ocpinfo.com, or contact our Practice Advisory department.
Are you, as a pharmacist, looking to make a difference in your patients’ lives? Are you interested in making a difference to future generations through educating youth about addiction? Do you get excited about partnering with other professionals and associations in the community to impact not only your patients’ lives but the lives of everyone in the community? If so, please read on, and you will find out how pharmacist Larry Boggio and his pharmacy team are positively affecting lives in their community through their methadone maintenance therapy (MMT) practice.

Many pharmacists are interested in pursuing an MMT dispensing practice, but may perceive barriers or have concerns. Pharmacy Connection interviewed Larry Boggio about his community pharmacy practice and how he began to dispense methadone. Larry shared his experiences of how he and his staff positively affect patient care, engage in the broader community, and educate for change in youth. Finally, he shared many examples of the feedback he has received from his MMT and former MMT patients about how their lives have changed — which provides him with the professional satisfaction that all of us, as pharmacists, seek: knowing the tremendous difference we make in the lives of our patients.

Larry graduated from the University of Toronto in 1981, but his career in pharmacy sprouted before university — Larry was a stock boy in a local community pharmacy in high school. As well, he comes by the profession naturally, as he has two older sisters also in pharmacy. He was out of school only about a year and a half before becoming a pharmacy owner. Always active in his community and professional associations (see sidebar for full profile), Larry began dispensing methadone over a decade ago when someone inquired whether his pharmacy provided MMT services. Two local doctors and the staff pharmacist attended the CAMH training together, which, Larry noted, helped to build inter-professional rapport from the start.

Boggio Pharmacy currently works with over 100 MMT clients and serves these clients seven days a week. From speaking with Larry and his other staff pharmacists, it is clear that in their experience, MMT patients are no different from any other patients. To pharmacists who have apprehensions about dress, manner, and behaviour of MMT patients, Larry would explain that he and his staff take a collaborative approach to harm reduction, with patient agreements that clarify boundaries and ensure respect is a two-way street. His patients look on the pharmacist as a health care provider who cares about them and is working with them, and for them. This is how pharmacists would want all their patients to view them.

Larry’s approach to care extends to the broader community, where he has established an excellent relationship with the physicians, hospital emergency staff, police, and schools (including teachers, students, and administration). In fact, he has been instrumental in working with other health care and non-health care professionals who may have erroneously attached stigmas to patients with addictions. Boggio Pharmacy pharmacists have been effecting change by providing educational sessions in the schools that have greatly altered how the community’s young people view addiction. Some students have been so inspired that they are now pursuing graduate-level education on the subject of addiction.
Larry views his MMT practice as an extension of the services he offers in his pharmacy. Larry shared his top five reasons a pharmacist should consider beginning an MMT practice:

1. Positive responses and feedback from the patients you’ve helped
2. The opportunity to change lives: getting people off the street and giving clients stability and new, more expanded choices
3. Educating and influencing future choices for youth
4. The opportunity for inter-professional collaboration and community-wide impact
5. Recognition as a pillar of the community, as well as an agent for change within it

It was truly inspirational to learn about all the ways in which Boggio Pharmacy has positively impacted patients’ lives. Because the pharmacist sees MMT patients on a daily basis, the opportunities to assist in quickly determining a change in a patient’s health status and ensuring proper follow-up care for the patient are enhanced. Many an adverse reaction, untreated infection, or unnoticed issue is caught by the pharmacist because they are seeing patients daily.

Patients’ feedback to the pharmacists has a common theme of how much impact the pharmacist and the MMT program has on patients’ lives. Patients often comment about how MMT has changed their lives, how they can’t thank the pharmacist enough, how their lives are going places, and how the program and the pharmacy has made such a difference.

For a pharmacist just starting out, Larry suggests speaking to a community of peers for mentorship, as an adjunct to the CAMH training course, as well as additional MMT and methadone training continuing education courses. Sharing best practices amongst colleagues is an excellent method of education, and he offers that any pharmacists starting out should feel free to contact him or Donnie Edwards, also a pharmacist at Boggio Pharmacy.

As staff at Boggio Pharmacy would suggest, MMT patients are not unlike other patients. The pharmacist’s goal of improving patient outcomes while acknowledging patient perspectives, maintaining boundaries, and being respectful to patients as people, is what calls pharmacists to the profession in the first place.
B E C O M E  A N  E F F E C T I V E  P H A R M A C I S T

Understand the Culture in Which You Practise

Lionel Laroche, Ph.D., P.Eng.

During one of the advanced workshops for preceptors on Managing Cultural Differences, one Canadian preceptor (Jim) related the conversation he had with his Middle Eastern intern (Ali) at the end of his internship.

Jim: What was the most memorable moment of your internship?
Ali: I think it was when you were filing some paperwork on the third day of my internship.

Jim: What do you mean?
Ali: You were completing some papers and I was watching you from the back of the pharmacy. At one point, you crumpled a piece of paper and threw it into the blue box. The blue box was full, so the paper fell on the floor. You leaned down, picked it up, and put it on top of the pile in the blue box. A few minutes later, you threw another
piece of paper into the blue box which again fell on the floor. You got up, picked up the blue box and emptied it into the blue bin at the back of the store.

Jim: What made this moment memorable for you?
Ali: In my home country, as a pharmacist, you would have called one of the pharmacy employees and told them to empty the blue box into the blue bin. The fact that you got up and emptied the blue box yourself was a complete surprise to me. I realized at that point that being a pharmacist does not mean the same thing in Canada as it does in my home country.

In most parts of the world, being a good pharmacist requires a solid knowledge of drugs -- their impact on patients, their side effects, their potential interactions -- and of the health care system and how to get paid for the work performed (the technical part of the job). It may also require a clear understanding of how to interact appropriately with patients and explain to them how to take their drugs in the most effective way (the interpersonal part of the job). When pharmacists move from one country to another, they may find that their work is similar. But there can be differences in the technical and interpersonal areas of practice.

There are differences in the technical areas because different diseases occur at different rates in different parts of the world. For example, diseases that pharmacists in Zimbabwe have to deal with these days, such as cholera or malaria, are not commonly found in Canada. Meanwhile, influenza is far more common during the winter in Canada than in Zimbabwe. Obviously then, Zimbabwean pharmacists need to know about drugs for tropical diseases that many Canadian pharmacists will encounter only very rarely, and Canadian pharmacists need to know vastly more about flu-fighting drugs and vaccines than their counterparts in Zimbabwe. There are also significant differences in the way medications are paid for around the world (by the patient, by private medical insurance, by public health insurance, etc.).

Pharmacists coming to Canada from other countries must deal with differences in the interpersonal areas of practice as well. Being a good manager (in that pharmacists manage pharmacy assistants and employees), a good employee (in the case of pharmacists who report to a pharmacy manager), or a good service provider requires that they behave in a manner appropriate to the cultural context. As a result, people who have completed their pharmacy studies outside of Canada and the United States and come to Canada to practice, need to learn how personal interactions are managed in a Canadian pharmacy practice setting.

Experience with both the International Pharmacy Graduate (IPG) program of the Leslie Dan Faculty of Pharmacy, University of Toronto, and its mentoring program, and the preceptor workshops for the Ontario College of Pharmacists, shows that most pharmacists handle differences in the technical area more easily than in the interpersonal area, for a very simple reason: they expect them. Indeed, most pharmacists are aware of the existence of these differences. In addition, pharmacists are interested in, and enjoy learning about, new diseases or new drugs, which makes overcoming these differences fairly easy.

By contrast, pharmacists encountering a difficult culture, at least initially, experience difficulties in the second area of differences, namely, interpersonal communication. In order to deal effectively with these differences, pharmacists first need to be aware that they exist. They are not usually discussed in pharmacy textbooks, and may be difficult to discern. Successfully dealing with them requires time, patience, practice, and feedback.

Let’s take a simple example: the smile. In the Canadian retail sector, the smile is absolutely essential. The number-one criterion by which North Americans evaluate a store is “Did the employee smile at me when I walked into the store?” This finding applies to pharmacies and pharmacists as well. Contrast this situation with countries like Germany or France. Germans say that they smile only when there is something to smile about. In Paris, smiling at a stranger, especially one of the same gender, is likely to make that individual think something like, “What is wrong with this person?” In other words, a pharmacist coming from a country where smiling at strangers is not as important or encouraged as in Canada will likely have to learn to smile when customers enter the pharmacy. Learning such behaviours often takes time and requires a conscious and deliberate effort in order to reach
the level of unconscious competence where one performs a task without even thinking about it. Feedback from a teacher or trusted mentor/preceptor can be invaluable in helping pharmacists know how effective these new behaviours are within a Canadian practice context.

Since most of the work performed by pharmacists involves interactions with other people, a clear understanding of cultural differences makes a significant difference in the daily professional activities of the average pharmacist. Pharmacists need to learn to communicate with culturally different patients, colleagues, managers, and employees, adapt their patient counselling skills to the needs and expectations of culturally different patients, and learn how to operate in a multicultural team.

Pharmacists today work in complex multicultural environments. They must apply their therapeutic and biomedical knowledge in situations where judgment is required. They must communicate effectively and diplomatically with physicians, nurse practitioners, dentists, and other professionals in order to resolve or prevent problems or errors. Pharmacists need effective conflict management and negotiation skills to work in increasingly multidisciplinary team settings with professionals of diverse backgrounds. In addition, pharmacists must manage busy dispensary settings, supervising a variety of different staff members, and ensuring adherence to laws and regulations governing practice. And, of course, pharmacists must work with patients and their caregivers, applying and communicating their therapeutic knowledge in an empathic and effective way, to ensure patients’ health care needs are met in a cost-effective manner. In all these situations, the pharmacist must be sure to maintain an appropriate, professional demeanour.

In order to become pharmacists in Canada, many International Pharmacy Graduates (IPGs) enroll in the IPG program offered by the Leslie Dan Faculty of Pharmacy at the University of Toronto, or in similar programs offered by the University of British Columbia. The combination of on-the-job and classroom training, with a significant emphasis on patient counselling skills, helps many IPGs develop the knowledge and skills necessary to safely and effectively perform the variety of roles required of pharmacists in Canada.

Given the differences in pharmacy practice expectations, the roles and responsibilities of pharmacists, and norms regarding interpersonal communication in different parts of the world, it is no surprise that some IPGs may not be aware of what is required and expected of them in Canada. Through its combination of lectures, small-group learning activities, and simulated-patient tutorials, the IPG program allows students to build upon their previous experience to work effectively within the Canadian health care system. To date, over 800 IPGs have enrolled in the program. Success rates on licensing examinations and in practice of IPG program graduates is comparable to that of Canadian graduates. More importantly, graduates of the program report feeling more confident in their skills and abilities, and better able to meet the needs of patients they see.

Similarly, the advanced training workshops for preceptors provided by the Ontario College of Pharmacists help preceptors learn how to be more effective when they are precepting or working with an IPG. This, in turn, enables them to help IPGs integrate more quickly into the profession. Preceptor workshops can provide pharmacists interested in working with IPGs with the knowledge, skills, and confidence to be more effective in their teaching and assessment activities. The College has offered an advanced preceptor workshop on “Managing Cultural Differences” over the past few years. A new workshop that will continue to focus on helping preceptors develop cultural competence is being planned for this fall. More information is available on the OCP website under Licensing > Training and Assessments > SPT.

The entire profession takes responsibility for successful integration of IPGs into practice. When practitioners, educators, regulators, and employers work together with the common goal of assisting IPGs to better understand how to apply their existing experience within a Canadian practice context, the results are positive and significant.

Lionel Laroche, Ph.D., P.Eng., is the President of MCB Solutions Inc., an organization that specializes in helping organizations and professionals reach their business / professional objectives in culturally unfamiliar environments. He can be reached at lionel@mcbsol.com
Coroner’s Inquest into death
due to Hyperthermnia

D.B. was a 36 year old man with a medical history of Schizophrenia and was on Benztrapine, Quetiaine, Zuclophenthioxol and Carbamazepine. He had been on these medications at the same dose since August 2002.

He was a roofer, part of a crew replacing a roof on a canning plant on May 29, 2006. It was the first hot and humid day of the year. The humidex that day during work hours ranged from 34 to 43 degrees C. Members of the crew felt ill and were taking frequent breaks and drinking significant amounts of water. Some time in the afternoon, D.B. was noted to be staggering and unsteady on his feet. He rested in the shade for 1 hour, and after that, was not answering appropriately and was ordered off the roof to rest for the rest of the day. D.B. changed his clothes, and was observed to be sitting in the truck, then staggering and stumbling outside the truck. He fell to the ground and a co-worker came off the roof and called 911. He was unresponsive and was transported to hospital where his core temperature was 42.2 C. Despite aggressive medical efforts, D.B. continued to deteriorate and was pronounced dead the next morning.

The coroner’s jury made three recommendations to the Ministry of Labour regarding policies for heat stress, and first aid training for heat stress. As well, three recommendations were made to the Ontario College of Pharmacists as follows:

**Recommendation 4**
The pharmacist will review annually the side effects of medication with the patient.

**Coroner’s Comments**
The jury heard evidence that the pharmacist discusses information about prescription drugs with the patient when the medication is first prescribed, when there are any changes in dose or dosing frequency, or if the patient has any problems or concerns. The pharmacist does not generally review the medication side effects etc. on medication renewals. The jury felt there should be regular reviews of the medication side effects between the patient and the pharmacist.

**Recommendation 5**
Provide a warning label on any medication that inhibits the body from temperature regulation.

**Coroner’s Comments**
The jury heard evidence that the information given in the drug information sheets does not specifically mention heat related side effects of heat stroke. There are stickers that are attached to pill bottles for certain potential hazards such as “may cause drowsiness” or “not to be taken with alcohol”. The jury felt that developing a sticker to be placed on the prescription pill bottle regarding the drug’s effect on temperature regulation would serve as a daily reminder to the patient of this potential serious effect.

**Recommendation 6**
Introduce a method of patient notification of any change to a drug’s characteristics or profile that may impact the patient’s health.

**Coroner’s Comments**
The jury heard evidence that the drug information database is constantly updated and that new information is incorporated in the drug information sheets that are given to the patient. However, if changes have occurred in the information after the patient receives the information sheets, continued on page 36
Summer is upon us and, as ever, we are mindful of the Standards of Practice for communicating with patients and educating them about their medications to provide optimal care and promote health.

A recent coroner’s inquest into the death of a patient due to complications from hyperthermia brings into focus a side effect of medications that is rarely considered: loss of the body’s ability to regulate temperature, possibly resulting in hyperthermia.

The regulation of a person’s core body temperature occurs in the delicate balance between heat production and heat loss. The goal is to keep the body temperature within an acceptable range. If a person’s body temperature begins to rise towards an unacceptable limit, the body automatically enacts cooling mechanisms (i.e., sweat production for cooling by evaporation).

The two most common forms of hyperthermia are heat exhaustion and heat stroke. Of the two, heat stroke is especially dangerous and requires immediate medical attention.

Heat stress occurs when a strain is placed on the body as a result of hot weather.

Heat fatigue is a feeling of weakness brought on by a high outdoor temperature. Symptoms include cool, moist skin and a weakened pulse. The person may feel faint.

Heat syncope is a sudden dizziness experienced after exercising in the heat. The skin appears pale and sweaty but is generally moist and cool. The pulse is weakened and the heart rate is usually rapid. Body temperature is normal.

Heat cramps are painful muscle spasms in the abdomen, arms, or legs following strenuous activity. Heat cramps are caused by a lack of salt in the body.

Heat exhaustion is a warning that the body is getting too hot. The person may be thirsty, giddy, weak, uncoordinated, nauseated, and sweating profusely. The body temperature is normal and the pulse is normal or raised. The skin is cold and clammy.

Heat stroke (or sunstroke) can be life-threatening and victims can die from multiple organ failure. A person with heat stroke usually has a core body temperature above 38.2 degrees Celsius. Other symptoms include confusion, combativeness, bizarre behaviour, faintness, staggering, strong and rapid pulse, and possibly delirium or coma. High body temperature is capable of producing irreversible brain damage. This is a medical emergency requiring immediate treatment.

General health and/or lifestyle may increase a person’s chance of suffering a heat-related illness. Health factors which may increase risk include:

- poor circulation
- inefficient sweat glands and changes in the skin caused by the normal aging process
- being substantially overweight or underweight
- consumption of alcoholic beverages
- heart, lung, and kidney diseases
- any illness that causes general weakness or fever
- high blood pressure, and
- other conditions that require changes in diet, for example, a salt-restricted diet may increase the risk of hyperthermia for a person taking diuretics, sedatives, tranquilizers, or certain heart and blood pressure drugs that make them unable to perspire.

Lifestyle factors that can increase risk are:

- unbearably hot living quarters
- lack of transportation which prevents people from seeking respite from the heat in shopping malls, movie houses, and libraries
- overdressing -- not feeling the heat, older people may not dress appropriately in hot weather
- visiting overcrowded places -- trips should be scheduled during off-peak times, and

Heather A. Arnott, B.Sc.Phm, Inspector, OCP
not understanding weather conditions -- older persons at risk should stay indoors on especially hot days.

The use of certain prescription medications can also increase an individual’s risk of developing hyperthermia. The drugs implicated in cases of hyperthermia decrease the body’s ability to dissipate heat, and also may impair a person’s perception of increased body temperature (which results in failure to seek relief from environmental factors contributing to the hyperthermia). The medications listed in the chart below have been shown to decrease the body’s ability to regulate internal temperature.

In light of the coroner’s findings, pharmacists should be mindful of the standards of practice for educating patients on their medications. As side effect profiles change with continued use of a medication in a clinical setting, it is important for pharmacy managers to be aware that Standards for Pharmacy Managers states that the manager shall ensure that all new, professionally relevant information directed to the pharmacy is immediately available to the staff pharmacists. Additionally, staff pharmacists are reminded that Standard 3 requires that the pharmacist identify, evaluate, interpret, and provide appropriate drug and pharmacy practice information to achieve safe and effective patient care.

With this in mind, and particularly in the warmer summer months, additional patient counselling should include general advice regarding prevention and treatment of heat-related symptoms:

- Know the signs and symptoms of heat-related illnesses.
- Block out direct sun or other heat sources.
- Use cooling fans or air conditioning; rest regularly.
- Drink lots of water: about one cup every 15 minutes.
- Wear lightweight, light-coloured, loose-fitting clothes.
- Avoid alcohol, caffeinated drinks, or heavy meals.

### References:
- eTherapeutics (online subscription)
- Health Encyclopedia – Diseases and Conditions: [www.healthscout.com](http://www.healthscout.com)
- [www.connpost.com/women/ci_9890519](http://www.connpost.com/women/ci_9890519)

<table>
<thead>
<tr>
<th>Anticholinergic drugs</th>
<th>benzotropine, biperiden, ethopropazine, procyclidine trihexyphenidyl</th>
<th>Impair the body’s ability to lower its temperature by perspiring.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenothiazines</td>
<td>chlorpromazine, perphenazine, thioridazine, trifluoperazine, fluphenazine</td>
<td>Neuroleptic malignant syndrome (very rare, but potentially fatal, reaction)</td>
</tr>
<tr>
<td>Butyrophenones</td>
<td>Haloperidol</td>
<td>Drug-induced hyperthermia</td>
</tr>
<tr>
<td>Tricyclic antidepressants</td>
<td>amitriptyline, imipramine, trimipramine, clomipramine, desipramine, nortriptyline</td>
<td>Interfere with heat dissipation mechanisms by increasing body temperature and exerting an anticholinergic effect.</td>
</tr>
<tr>
<td>Antihistamines, benzodiazepines, alpha-adrenergics, beta blockers, neuroleptics, diuretics</td>
<td>Increase the risk of inability to produce sufficient perspiration for body cooling.</td>
<td></td>
</tr>
</tbody>
</table>
Q Does the College have any training or certification requirements to demonstrate competency in specialty areas of pharmacy practice such as compounding, TPN preparation, sterile IV admixtures, methadone dispensing, or veterinary medicine?

Members should refer to the Standards of Practice and any guidelines or policies to assist them in their daily practice as well as to provide them with the expectations of the College. All pharmacists, regardless of practice settings, must continuously strive to gain knowledge and maintain professional competencies required to practice in their area of specialty.

In the Standards of Practice (2003), it is stated thus:

**Operational Component 2.4**
The pharmacist continuously strives to gain knowledge and maintain professional competence. 2.4.1 The pharmacist identifies learning needs and seeks, evaluates and participates in learning opportunities to meet these needs to enhance practice through education and experiential learning. 2.4.2 The pharmacist recognizes and practices within the limits of his/her professional expertise.

Policy and procedure manuals, quality assurance programs, appropriate resource materials, and safety and environmental policies should therefore be in place for the specific area of practice to ensure pharmacists and staff are properly trained and evaluated in their specific area of practice.

Frequency of training/recertification/maintenance of minimal competency is left up to the individual facility, using the above guidelines.

In the Standards of Practice (2003), it is stated thus:

**Standard 6**
The pharmacist applies knowledge, principles and skills of management as they pertain to the site of pharmacy practice, with the goal of optimizing patient care and inter-professional relations. Refer: Operational Components 6.1 - 6.3

As an example, Guidelines for Compounding Preparations (2007) expands and reinforces Standard 6 of the Standards of Practice (2003) for this particular area of practice.

Q I’ve been asked to join a Family Health Team as their clinical pharmacist. Does the College have a list of resources for pharmacists anything like the OCP Required Reference Guide for pharmacies?

The library or reference guide is a requirement for pharmacies. If you are working with a Family Health Team, you will not be operating a pharmacy, but, rather, will be employed as a pharmacist for your clinical expertise. As a pharmacist, you will be required to meet the Standards of Practice for Pharmacists. You will be expected to maintain resources related to the health team practice to which you belong, and to any specific or specialized practice that you will be involved in, to meet the standards. I would recommend you review the mandate of the team and your job description to determine what resources you will require.

In recent months, a number of break-ins and robberies have been reported to the College. There is no one specific area of the province or pattern. Pharmacists are asked to review their security and raise awareness with staff. It may be useful to check with the local police for advice on assisting staff should a theft occur. Please review the Inspector’s Corner article, “Securing Your Pharmacy” in the March/April 2008 Pharmacy Connection, available online at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Securing+Your+Pharmacy
June 10, 2009  Health Canada is advising Canadians to carefully read the labeling of iron supplement products as there is potential for confusion about dosage. Products currently on the Canadian market display the dose in different ways on the product label and consumers may misinterpret the amount of iron in the product and potentially take an incorrect dose.

June 5, 2009  Important Safety Information concerning Kappa 600/700/900 Series and Sigma 100/200/300 Series Implantable Pulse Generators – Medtronic of Canada Ltd. advises health care professionals to consider device replacement in pacemaker dependent patients and to continue routine follow up for pacemaker independent patients.

June 4, 2009  Cases of pure red cell aplasia (PRCA) have been reported in patients treated with CellCept (mycophenolate mofetil) in combination with other immunosuppressive agents.

June 4, 2009  Health Canada is warning consumers not to use the unauthorized product Slim Magic Herbal, which is promoted as a weight-loss product, as it was found to contain an undeclared pharmaceutical ingredient similar to the prescription drug sibutramine. Canadians who have this Slim Magic Herbal product are advised to immediately discontinue its use.

June 4, 2009  Health Canada is advising consumers not to use 6 foreign health products due to concerns about possible side-effects. The products are Fangocur Mineral Drink, Jia Yi Jian, Fortodol (which is also sold under the names Donsbach Miradin, Lepicol Miradin, Leppin Miradin, and Miradin); Shan Dian Qiang Xiao Shou, - Zencore Plus and Zhong Guo Shen Fang

May 25, 2009  Maxum Multi-Vite has been approved as a vitamin-mineral supplement for only the general public but lacks the required cautionary statement on the label regarding pregnant and/or breast feeding women. The product Maxum Matragen is being promoted by the company as a prenatal supplement; however, neither product has been authorized for sale by Health Canada for use by women who are pregnant or breastfeeding.

May 25, 2009  Novopharm Limited is recalling 1 lot of Dobutamine injection 250mg/20ml due to an error on the labels. The dosing instructions on these vials are labeled 2.5 to 10 mg/kg/min instead of 2.5 to 10 µg/kg/min. The lot being recalled is: Lot 1156283 (expiry date: March 31, 2010).

May 25, 2009  One lot of Rofact (rifampin) DIN 00343617, manufactured by Valeant Canada, is being recalled to the retail level. Some bottles of the lot 8K5467 may contain the drug clonazepam instead of the antibiotic rifampin.

May 19, 2009  Health Canada is warning consumers that there is a small possibility that some bottles of one lot of Rofact® (rifampin), an antibiotic used to treat tuberculosis (TB) and some other infections, may contain the drug clonazepam instead of the antibiotic rifampin.

May 19, 2009  BHM Medical Inc. advises Canadian healthcare professionals to visually inspect the slings prior to use and discard the products if there is thread breakage at the junction of the shoulder strap and sling body.

May 19, 2009  Fatal adverse reactions have occurred in patients with moderate hepatic impairment and advanced solid tumours treated with TARCEVA (erlotinib).

May 19, 2009  MedXL Inc. advises Canadian healthcare professionals to visually inspect the prefilled saline and heparin syringes prior to use and not to use the products if the solution is discolored or contains a precipitate.

May 4, 2009  Health Canada is aware of the public warning issued by the U.S. Food and Drug Administration (FDA) Warning on May 1, 2009 regarding certain Hydroxycut products. The FDA is advising U.S. consumers to stop using Hydroxycut products as there have been reports of liver injuries potentially associated with this product in the United States.

May 4, 2009  Health Canada is advising Canadians not to purchase products claiming to fight or prevent H1N1 flu virus (human swine flu). While there are approved antiviral drugs that may help prevent or reduce the symptoms associated with the flu in general, there are currently no products authorized for sale in Canada that are indicated specifically for the treatment of H1N1 flu virus (human swine flu).
An Overview of Ontario’s Cosmetic Pesticide Ban

Nadia Sutcliffe, BSc Phm, RPh

As of April 22, 2009, Ontario’s cosmetic pesticide ban has taken effect. By the introduction of this new legislation, all municipal bylaws have been superseded. Now there is one set of rules across our province for the sale and use of pesticides.

All pharmacies which sell these products should take heed of the new requirements and obligations under the new Act to ensure that they are compliant with this new legislation.

Under the new Cosmetic Pesticides Ban Act, pesticides can no longer be used for cosmetic purposes on lawns, gardens, patios, driveways, cemeteries, parks and school yards. There are no exceptions made for pest infestations. There is an exception for the use of pesticides for the promotion of public health or safety. They can be used for:

• The destruction, prevention or control of animals that bite, sting are venomous or carry disease (such as wasps, mosquitoes and ticks)
• The destruction, prevention or control of plants that are poisonous to humans by touch (poison ivy, poison sumac and giant hogweed), or
• The destruction, prevention or control of plants, fungi or animals that affect public works and other buildings and structures (carpenter ants and termites)

Certain biopesticides and lower risk pesticides, such as acetic acid, will be allowed to control weeds, insects and plant diseases on lawns and gardens.
An Overview of Ontario’s Cosmetic Pesticide Ban

The new legislation also affects the sale of pesticides in retail outlets. As of April 22, 2009, a General or Limited vendor may sell class 5 & 6 domestic pesticides, as well as class 7 controlled sales pesticides with conditions. They are no longer able to sell class 8 pesticides, such as weed/insect control products for lawns and gardens. An Unlicensed vendor may sell Class 6 domestic pesticides, and Class 7 controlled sales pesticides — only until January 1st, 2010. As of that date, you must hold a vendor license to sell Class 7 products. To get information about obtaining a license, refer to the ministry website at http://www.ene.gov.on.ca/en/land/pesticides/licensing.php. To get information about the specific classes of pesticides, use the following link to the ministry website: http://www.ene.gov.on.ca/en/land/pesticides/class-pesticides.php. Also, as of April 22, 2011, licensed vendors will also be required to display Class 7 pesticides such that consumers do not have ready access to the pesticides.

Another requirement of the legislation is that the vendor must give written information, which would have been approved by the ministry, directly to the consumers at the time of purchase of Class 7 pesticides. This written information must state that only certain uses of these products are legal. The requirement is that this information must be handed to the purchaser. It cannot be in the form of an auxiliary sticker on the product or a neck hanger. A handout is available from the Ministry of the Environment (MOE); this can be downloaded and printed from their website: http://www.ene.gov.on.ca. The retailer can also incorporate the approved wording into the cash receipt. If you want to deliver the information in another form, you must get prior approval from the Director of the Ministry of the Environment’s Standards Development Branch. As a retailer, you are required to educate your staff as to which products are Class 7 pesticides and that written information must be given to the purchaser at the time of purchase of any of these products.

Under the new Cosmetic Pesticides Ban Act, there are storage and display requirements for Class 1 to 8 pesticides. They must be stored in a clean orderly area of good repair, in such a manner that they do not affect the health or safety of any person. There must be a Chemical or Pesticide warning sign displayed in the area, along with emergency phone numbers for the fire department, hospital and poison control centre. They cannot be stored in a manner where they are likely to come into contact with food or drink intended for human/animal consumption. The suggestion is to not display the pesticides within 1 metre (left, right, above, below or behind) of any food, drink or personal use items, such as toiletries, sunscreen, clothing, toys, kitty litter, etc. If they are not packaged in child proof containers, they should be displayed so that they are not accessible up to at least 1 metre from the floor. More detailed information can be obtained by viewing the following link: http://www.ene.gov.on.ca/en/land/pesticidesfactsheets/fs-properstoragepesticides.pdf.

The retailer is also responsible for submitting annually a written notice to the local fire department detailing what pesticides are kept and where they are stored in the store. Forms can be obtained by calling the MOE, Environmental Assessment and Approvals Branch at 1-800-314-8001. If there is a spill involving the pesticides stored in your store, it must be reported to the Spills Action Centre at 1-800-268-6060.

A lot has changed with the enactment of the Cosmetic Pesticides Ban Act. Retailers have a responsibility to educate their customers who are purchasing pesticides about their proper use. There are specific storage and display requirements which must be followed. Retailers also have certain reporting obligations with regards to pesticides as well. As pharmacists, we are very familiar with operating within boundaries as set out by legislation. Let us ensure that we are well educated and prepared to deal with the changes regarding sales of pesticides within the province of Ontario.
Q Why are Canadian pharmacy graduates able to begin internship before having passed the PEBC Qualifying Exam, whereas international pharmacy graduates may have to first pass the Qualifying Exam and be considered by a panel before they can start training?
Graduates from CCAPP and ACPE-accredited pharmacy programs and international pharmacy graduates who have successfully completed the International Pharmacy Graduate (IPG) Program at the University of Toronto and structured practical training at the student level may start internship before passing the PEBC Qualifying Exam.

Your question refers to situations where an international pharmacy graduate wants an exemption from an entry-to-practice requirement. For international pharmacy graduates, 32 weeks of studentship is comprised of successful completion of 16 weeks of the IPG Program and 16 weeks of structured practical training at the student level. A period of internship follows successful completion of studentship. Currently, an international pharmacy graduate who has not completed the IPG program may make a request to a panel of the Registration Committee. An IPG who wants to start training without completing the IPG program must make a request and provide supporting evidence. Successful completion of the PEBC Qualifying Exam is one piece of evidence a panel might consider in granting an exemption from the IPG program. Past panels have granted applicants who have successfully completed the PEBC Qualifying Exam, and who have little or no Canadian experience, permission to begin training as a student, but have required up to 32 weeks of structured practical training at the student level. A panel may also consider, in addition to the Qualifying Exam, other evidence such as Canadian experience as a pharmacy assistant to reduce the studentship from 32 weeks. Please note that, while panels have granted such exemptions in the past, we cannot speak for future panels.

Q When does PEBC release its Qualifying Exam results?
PEBC releases its results approximately 6-8 weeks from the exam date. In 2009, Part I of the exam was written on May 19 and 20, and Part II (OSCE) on May 24. We expect the results to be available during the first week of July. The fall offering of the exam is scheduled for November 4 and 5 (Part I) and November 7 (Part II), with results expected to be released in mid-December.

Q Can I go to panel before the PEBC results are released?
College staff cannot prevent you from going to panel, but they will advise you that past panels have denied requests for exemptions from the IPG program or reductions in training in the absence of proof of successful completion of both Parts I and II of the Qualifying Exam. When panels deny a request, the candidate loses his/her application fee.

College staff will coach you in preparing your submission to the panel. They will advise you to get in all your information for upcoming panels. Panel deadlines are the first day of the month before the panel meets. Therefore, the deadline for the August panel is July 1 and for the January panel, December 1. The College gets notification from PEBC only for candidates who are successful on both parts of the Qualifying Exam. If the only information outstanding from your submission is your PEBC result, we will place you on the agenda for the next panel. If you are not successful on the Qualifying Exam, we will pull your file from the agenda so you will not forfeit your application fee. For more information, go to www.ocpinfo.com >licensing>member registration>registration panel requests. You can also contact Deborah Byer, Registration Program Assistant, at 416-962-4861 x260.

1 Canadian Council for Accreditation of Pharmacy Programs (CCAPP) and the Accreditation Council for Pharmacy Education (ACPE) accredit pharmacy programs in Canada and the United States, respectively.
Susan James
Project Director, Pharmacy Technician Regulation

Q I am concerned that I do not have access to the Bridging Program in my community, and that I may not be able to meet the deadlines set for completion of the Program. How much longer will I have to wait?

The Bridging Program is still in development and early stages of implementation, and the proposed date of completion is not until January 1, 2015, which means that you have plenty of time to complete the four courses. By the end of this year, the Program will be ready for full implementation, and will be widely available throughout the province. This will be accomplished through three different types of program delivery: in the classroom, on-line, and by prior learning assessment.

Classroom Delivery
Each of the four courses will be available throughout the province in a classroom setting. Three courses (Professional Practice, Pharmacology, and Drug Distribution) have been introduced in this format, and the fourth course (Product Preparation) will be available for the fall 2009 semester. Each of the CCAPP-accredited community colleges may administer the program within their own organization, or in partnership with other community colleges or organizations throughout the province. Many such partnerships already exist and are listed on the Bridging Education Program registration page on the College website (www.ocpinfo.com). In some cases these partnerships have been established through the efforts of pharmacy technicians and pharmacists in the local community. Check the website to see which communities already offer, or are in process of offering, the program. If your community is not on the list, you may contact any one of the CCAPP-accredited community colleges (also listed on the website) to explore how to organize something in your area.

On-line Delivery
Each of the four courses will be offered in an on-line format. The first of these courses will be available for the fall 2009 semester (Professional Practice and Pharmacology). Registration for this format will also be managed by the accredited community colleges. OCP will send an e-mail notification and post the registration information on the website when it is available. These courses, similar to classroom delivery, will run over a number of weeks, and will have a limited number of students in each class. Instruction, however, will be delivered on-line, so you will not have to travel to a classroom. The other two courses (Drug Distribution and Product Preparation) will be available on-line for the winter 2010 semester.

Prior Learning Assessment (PLA)
Individuals who believe they already have the knowledge and skills addressed in the Bridging Program may choose to complete a course through a prior learning assessment. This format will be available for three of the four courses (Professional Practice is not eligible for PLA). Registration will likewise be managed by the CCAPP-accredited community colleges, which will offer an opportunity to complete a challenge exam, by which individuals can demonstrate that they have the knowledge and skill needed to meet the course objectives. PLA for Pharmacology and Drug Distribution will be available for the fall 2009 semester. For Product Preparation, it will be available for the winter 2010 semester.

Want more details on the Bridging Education Program? Visit the Pharmacy Technician section of the College website to learn all about the Program’s requirements and the process of becoming registered with the College.

Want more details on the Bridging Education Program? Visit the Pharmacy Technician section of the College website to learn all about the Program’s requirements and the process of becoming registered with the College.
ALERT: Fatal Outcome after Inadvertent Injection of Epinephrine Intended for Topical Use

Four years ago, the ISMP Canada Safety Bulletin highlighted a substitution error involving inadvertent injection of epinephrine 1 mg/mL (epinephrine 1:1,000) intended for topical application during an elective, outpatient ENT (ear, nose, throat) procedure.1 Recently, a similar incident with different underlying circumstances led to the death of a patient. The reporting hospital for the more recent incident has since implemented enhancements to its medication-use system. This bulletin was developed collaboratively as a call to action.

Medication Incident

During a day surgery ENT procedure, the surgeon requested local anesthetic for injection (specifically lidocaine 1% with epinephrine 1:100,000) and was handed a pre-drawn syringe. The surgeon injected the medication into the surgical site. Immediately afterward, the patient experienced a cardiac arrhythmia leading to cardiac arrest. Despite full resuscitation measures, the patient died.

Information gathered after the incident indicated that the syringe contained epinephrine 1 mg/mL (1:1,000) intended for topical use, rather than the local anesthetic for injection that was requested. The facility subsequently contacted ISMP Canada for information about strategies to improve its medication-use system, with the ultimate goal of preventing recurrences of this problem. ISMP Canada shared a number of resources with the facility, including the Operating Room Medication Safety Checklist. As a result of working with the hospital to understand the underlying circumstances in this case, ISMP Canada updated the checklist (please see sidebar on page 3) to include targeted strategies for preventing similar incidents.

Contributing Factors

This case differs in several important ways from the case described in the 2004 bulletin.1 In the earlier case, the topical and injectable medications had each been placed in a small, open glass container, and a substitution error had occurred. In the case described in the current bulletin, the epinephrine had been drawn into a syringe and was later mistaken for the local anesthetic to be injected.

Several factors may have contributed to this incident:

- Epinephrine 1 mg/mL for topical use was on back order, so epinephrine 1 mg/mL for injection was made available for use in the operating room (OR). As a result, the nurse used a needle and syringe to withdraw the contents from the vial, rather than directly pouring the epinephrine from the manufacturer’s container into a sterile open container with pledgets (a type of sterile gauze packing).
- The syringe containing epinephrine 1 mg/mL was not labelled.
- Preparation for the surgery was behind schedule, and the OR nurse was interrupted after she had drawn the epinephrine 1 mg/mL into a syringe. The syringe containing the epinephrine 1 mg/mL was placed on the back table. When the surgeon requested the local anesthetic for injection, the nurse placed the syringe containing the epinephrine 1 mg/mL on the metal stand beside the OR table. However, at this point, the anesthetic solution for injection had not yet been prepared, a step that was ultimately omitted because the syringe on the metal stand was believed to contain the local anesthetic for injection.
- Both medications (the epinephrine for topical application and the local anesthetic for injection) were often prepared before the start of the procedure, by one nurse, typically in one area of the OR.

Recommendations

The practice of withdrawing a medication intended for topical use into a parenteral syringe poses a risk for a substitution error and/or inadvertent injection. All facilities that perform procedures requiring the use of epinephrine 1 mg/mL (1:1,000) for topical application should review their processes.

The following recommendations and considerations are provided:

- Develop distinct processes for preparing and handling epinephrine for topical application. In particular, medications such as epinephrine intended for topical application should not be placed into a parenteral syringe. Conversely, a medication intended for injection (e.g., local anesthetic) should not be placed into an open container.1
- Supply epinephrine for topical use in a pour-bottle format. Additional precautionary measures will be needed to deal with back orders (e.g., having the
pharmacy prepare the epinephrine in a distinct, ready-to-use pour-bottle format).

- Always label all syringes and containers. Sterile and preprinted labels are available to facilitate labelling in operating room areas. Discard any unlabelled syringes and containers.

- Keep local anesthetics for injection in their original vials, and withdraw such medications into a syringe (and label the syringe) immediately before use. This allows the surgeon to participate in a reliable verification process using the manufacturer’s product and the syringe label.
  - At the hospital where a similar event occurred a few years ago, the surgeons now infiltrate (i.e., inject) the surgical site with local anesthetic before scrubbing and gowning for ENT procedures. Subsequent infiltration is seldom needed, but if it is required, additional local anesthetic is withdrawn directly from the vial.

- Ensure that point-of-care communication is provided by the pharmacy when a product is changed because of a new supplier or because of a product back order.

- Do not stock the multidose vial of injectable epinephrine 1 mg/mL (a high-alert drug) in any OR.

- Ensure that the word “TOPICAL” appears on the label of any container used to hold a solution intended for topical application.

- Store and prepare medications intended for topical use in distinctly separate areas from those used for storing and preparing medications for injection.

A Note about Packaging for Manufacturers of Topical Medications

Various OR practitioners have brought to the attention of ISMP Canada a specific concern about packaging for topical medications such as epinephrine. Although these medications are manufactured for topical use, the packaging may be similar to packaging used for vials containing injectable medications, consisting of a rubber stopper held in place by a metal ferrule (see examples in Figure 1). This may lead some practitioners to use a needle and syringe to withdraw the medication before transferring it to an open container. ISMP Canada has conveyed this concern to ERFA Canada Inc., the manufacturer of epinephrine 1 mg/mL (1:1,000) for topical application. The manufacturer has been receptive and is planning to make changes.

All manufacturers are urged to review products such as epinephrine intended for topical use to ensure that they are supplied in a format distinct from that used for medications intended for injection (in particular, the design should not lead practitioners to use a syringe to withdraw the medication from the container).

The review undertaken in writing this bulletin also revealed that some hospitals routinely supply to the OR multidose vials of epinephrine 1 mg/mL for injection, with the intention that this product be used for topical application. In some hospitals the pharmacy adds a label alerting practitioners that the product is provided “for topical use”. All facilities and clinics that offer ENT surgical procedures (and any other procedure requiring epinephrine 1 mg/mL for topical use) are urged to carefully review the processes for supply and preparation of topical medications and to consider the potential risk of the type of error described in this bulletin. Distinct and separate processes are needed for preparation and handling of medications intended for topical application and those intended for injection.

Figure 1: An example of 30 mL vials of epinephrine 1 mg/mL (1:1,000) currently available in Canada. Both the product intended for injection (left) and that intended for topical use (right) have a rubber stopper held in place by a metal ferrule. The topical product has a tab which, when pulled, is intended to remove the metal ferrule, yielding a “pour-bottle” format.
Acknowledgements

ISMP Canada gratefully acknowledges expert review of this bulletin by (in alphabetical order):

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References


NEW:
Version 2 of the Operating Room Medication Safety Checklist®

ISMP Canada is pleased to announce the release of Version 2 of the Operating Room Medication Safety Checklist. This checklist facilitates knowledge translation of medication safety principles into operating room (OR) practices.

The OR medication safety checklist has been developed by ISMP Canada in collaboration with the Canadian Anesthesiologists’ Society, the Operating Room Nurses Association of Canada, and ISMP (US).

The Operating Room Medication Safety Checklist complements the Medication Safety Self-Assessment® (MSSA) for Hospitals and represents a standardized approach to identifying opportunities for medication safety enhancements in the OR. The checklist is a web-based program whereby results from an individual facility can be compared with the aggregate results of other respondents both nationally and regionally. The program supports evaluation of ongoing improvement efforts over time.

More information is available from:
https://www.ismp-canada.org/operatingroomchecklist/

Health Canada Advisory on Cough and Cold Medicine for Children

Health Canada has issued an advisory on the use of cough and cold medications for children. Health Canada is requiring manufacturers to re-label over-the-counter cough and cold medicines that have dosing information for children to indicate that these medicines should not be used in children under 6 years of age. The advisory is available from:
http://www.hc-sc.gc.ca/dhp-mps/medeff/eng.cough_toux.htm

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

Medication Incidents (including near misses) can be reported to ISMP Canada:
(i) through the website: http://www.ismp-canada.org/err_report.htm or (ii) by phone: 416-733-3131 or toll free: 1-866-544-7672.
ISMP Canada can also be contacted by e-mail: cmirps@ismp-canada.org. ISMP Canada guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

A Key Partner in the Canadian Medication Incident Reporting and Prevention System
College inspectors are in a unique position within the profession in that they can gain insight that comes from visiting hundreds of different community practices every year. Exposure to a wide range of practice environments and various processes and procedures employed in them is often useful to inspectors when advising members of compliance solutions that work well or, conversely, of those that are problematic.

This article focuses on some factors in pharmacy design and operation which potentially impact the area directly around the dispensary, and how these factors combine to form the professional image of the pharmacy. White and sterile surroundings do not necessarily equate to a positive professional image. The observations in this article may appear to be common sense, but pharmacists and the environments in which they work in are anything but common!

Professional Image

The term “professional image” refers to the overall image that a pharmacy projects to current and potential patients. A pharmacy’s professional image has a large subjective component based primarily on observations made from outside the dispensary looking in. The professional image can be indirectly assessed using the requirements laid out in the Drug and Pharmacies Regulation Act (DPRA), along with first-hand observations made by the inspector. Ultimately, a pharmacy’s professional image not only impacts how the public views the
practice location, but also affects how pharmacy staff and other health professionals who attend at the pharmacy perceive the integrity of the pharmacist in the dispensary.

The Visible Environment

The DPRA regulations define the minimal operational requirements for the safe and adequate storage of drugs, available free working space, basic dispensing/compounding equipment, and maintenance of physical components (i.e., walls, ceilings, floors, etc.). As each practice location has site-specific physical challenges or limitations (e.g., space constraints, prescription volume, etc.), the regulated requirements are the objective measure that inspectors use when assessing the professional image of any location.

Members of the public formulate their opinion of a pharmacy’s professional image based on what they can see when presenting a prescription, seeking advice, and/or waiting for their prescription to be processed. With this in mind, try to assess your practice site from the other side of the dispensary counter, noting both the visible elements that contribute to, and those which detract from, the pharmacy’s professional image.

Meeting the minimal physical requirements for a pharmacy does not necessarily achieve a positive professional image. While the dispensary fixtures available for storage may be adequate in size and number, clean, and dust-free, the age and uniformity of the fixtures can have a huge impact on the pharmacy’s professional image (e.g., chipped, faded, mismatched shelving units). In addition, the view of the items stored on those fixtures can influence the public’s perception of whether the dispensary is organized and free of clutter. Shelves visible from the front of the shop will appear more organized if they can be faced up whereas filing, overstock, and prescriptions awaiting pickup are difficult to maintain in an organized fashion, and should be kept out of sight. Likewise in the waiting area, it is important to be conscious of what patients will be looking at when sitting there.

Other visible elements of professional image are communicated by the attire of staff working behind the dispensary and the presence, or absence of other environmental aspects to produce a particular effect.

The areas of a dispensary visible to a person presenting a prescription or seeking professional advice are the first ones to address in improving the professional image of the pharmacy. Many patients will be using the waiting area while their prescriptions are being processed. Perhaps the best way to objectively assess what image your pharmacy projects is to occasionally sit in the waiting area or stand in front of the dispensary, where your patients stand. Be sure to critically examine the condition of the floor, doorways into or around the dispensary, walls, and the ceiling. In addition, look carefully at the lower shelves of end displays, the condition of the chairs in the waiting area, the cleanliness of the blood pressure machine (if you have one), and the way various signs, notices, and/or printed materials are mounted or organized.

It is also important not to underestimate the impact of outdated stock and dusty merchandise on the pharmacy’s professional image. The public, in general, will view the existence of expired products in the front shop very negatively. And dust that has built up, imperceptible to those working in the pharmacy every day, will be very obvious to someone who attends the pharmacy periodically (like an inspector), and will be perceived just as negatively.
The Invisible Environment
The invisible environment in a pharmacy, no less than the visible, influences a patient’s assessment of professional image and your ability as a pharmacist to effectively communicate with them. Sounds, air quality, level of physical comfort, and atmosphere can have a positive or a negative effect on both patients and staff of the pharmacy. As with the visible elements, assessing the invisible elements requires making observations from the public’s perspective.

The number one auditory concern affecting the pharmacy’s image is the existence of a quiet, private, comfortable, and convenient location for patient counselling. Conscious attention to this promotes accessibility to the pharmacist, affords access to current health information and advice, and, most importantly, demonstrates that patient confidentiality is being taken seriously by the pharmacy.

Other auditory considerations, such as type and volume of background music, location of noisy equipment relative to counselling and waiting areas, or the processing of non-prescription transactions, can influence a pharmacy’s professional image. An additional concern is whether normal conversations between dispensary staff required during processing of prescriptions can be overheard in the front shop.

Air quality is often overlooked in assessing the professional image of a pharmacy. While air filters may be changed regularly, the ducts through which the air circulates can accumulate dust, moulds, and other allergens which, in turn, can directly impact both patients and staff of the pharmacy. Addressing air quality may also address some maintenance issues (e.g., excessive dust) influencing professional image.

It is also important to acknowledge that human memory is affected by the sense of smell. While “bad” smells are rarely, if ever, encountered by inspectors, there may be an opportunity to enhance how patients remember their last visit to your pharmacy.

Actions taken by a pharmacy to minimize the risk of transference of infections between patients will have a positive impact on patient health and increase patient confidence in the pharmacy. This may involve, in addition to a supply of hand sanitizer, regular cleaning of those surfaces around the dispensary commonly touched by patients and staff.

Conclusion
Why should pharmacists be concerned about their professional image, when most patients try to minimize the time spent in the pharmacy anyway? Consider two overriding objectives: improved health of patients, and their continued patronage of the pharmacy. Many of the factors influencing patronage are the same factors considered in the assessment of a pharmacy’s professional image.

Regardless of motivation, it is important to periodically place yourself in the position of one of your patients. Does your current practice site promote a comfortable, calming, and confidential environment for your patients? Does your current practice site promote a comfortable, calming, and confidential environment for your patients? Do patients feel confident their counselling sessions will not be overheard, and are distractions minimized? What message do the physical attributes and general appearance of the area directly around the dispensary convey to patients? Are those areas of the dispensary visible to the public being utilized in a manner that promotes a positive professional image? Answering “yes” to the above questions should indicate a positive professional image.
**Case 1**

Offence relevant to suitability to practice

**Member:** David Bythell  
**Hearing Date:** March 25, 2009

The Member notified the College that in 2006, he was convicted of indecent assault relating to conduct that occurred between 1965 and 1970, before he was a member of the College. After an investigation, specified allegations of professional misconduct relating to the conviction were referred to the Discipline Committee.

The College presented the Panel with an Undertaking signed by the Member, wherein he indicated his wish to retire and resign permanently as a member of the College. He also undertook never again to practise pharmacy in Ontario, never to reapply for membership in the College, and never to have an ownership interest in a pharmacy. The College and the Member jointly sought an order staying the allegations of professional misconduct, in light of the member’s Undertaking. Upon reviewing the Member’s Undertaking and hearing submissions by the College, the Panel ordered that the allegations of professional misconduct be stayed for as long as the Undertaking is in effect and the Member complies with all its terms and conditions.

**Case 2**

Failure to report finding of professional misconduct by another regulatory body; disgraceful, dishonourable or unprofessional conduct

**Member:** Robert Arlen Rosenberg  
**Hearing Date:** February 17, 2009

**Facts**

This case addressed three allegations of professional misconduct against the Member arising from the revocation of his licence to practise medicine by the Discipline Committee of the College of Physicians and Surgeons of Ontario (CPSO) in connection with the sexual abuse of, and/or sexual impropriety with, a patient. The allegations against the Member were that he contravened a term, condition or limitation on his Certificate of Registration, and breached the regulations under the *Pharmacy Act,* by failing to provide the Registrar with details of the CPSO’s findings of professional misconduct. It was further alleged that while he was a member of the College, the Member engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional with respect to the CPSO’s findings and the Member’s failure to report these findings to the College.

The hearing proceeded without the Member or his counsel in attendance. The Panel was presented with material that allowed the Panel to conclude that the Member was aware of the allegations against him and of the hearing date, that the Member had counsel in the period immediately before the hearing date, that the Member was aware he could participate in the proceedings, and that the Member elected not to participate or send his counsel. The Panel ruled that the hearing could proceed in the Member’s absence. The Panel assumed that had he been present, the Member would have pled not guilty to the allegations against him.

The Member is an Ontario pharmacist who, while he was also an Ontario physician, engaged in a sexual relationship with a patient that resulted in his licence to practice medicine being revoked by the Discipline Committee of the CPSO in March, 2003, as a result of the automatic revocation provisions of the *Regulated Health Professions Act, 1991* ("RHPA"). The Member appealed the revocation to both the Divisional Court and the Ontario Court of Appeal, unsuccessfully, on the basis that the patient was a long-time love interest who should have qualified for a spousal exemption.

**Issues**

The Panel had to consider two issues. First, did the Member fail to report and provide details to the College of the revocation of his medical licence by the CPSO, and, if so, did this constitute an act of professional misconduct? Second, was it disgraceful, dishonourable or unprofessional for the Member to have (a) engaged in sexual abuse of a patient, as a physician, while also a pharmacist, and to have
(b) failed to provide the College with the professional misconduct findings of the CPSO? The Panel was not to decide whether the Member engaged in sexual abuse of a patient while practising pharmacy.

**Failure to Report Findings of Misconduct**

The College presented evidence that the 2007 Pharmacist Annual Fee Form asked members the following question: “In the past year have you been charged and/or found guilty of an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs, or relating to any criminal offence?” This question was left blank by the Member, although he had completed other portions of the form and had signed the document, which he dated February 2, 2007. The College presented evidence that the Member would have received a follow-up letter indicating that his form was incomplete. The College apparently never received a response from the Member to this letter replying “Yes” or “No” to the question about criminal and drug-related offences.

The College also presented evidence that it was not aware of the Member’s discipline history with CPSO until it received an anonymous telephone call in June, 2007, indicating that the Member had had his licence to practise medicine revoked by the CPSO for sexual abuse. The Panel was directed to the decision(s) of the Discipline Committee of the CPSO.

While the College’s witnesses were not subject to cross-examination, the Panel accepted their evidence as credible and believed that the documents presented not only spoke for themselves, but that they were explained, and their contents supported, by the witnesses. The Panel found that the Member did fail to provide the College with the findings of professional misconduct by the CPSO as alleged, and that failure does constitute professional misconduct as alleged in the Notice of Hearing.

**Relevance to Suitability to Practice Pharmacy**

With respect to the relevance of these offences to the practice of pharmacy, the Panel considered (i) how the revocation of the Member’s license for sexual abuse of a patient at the CPSO and his failure to report it were relevant to his suitability to practise pharmacy, and (ii) how that should lead the Panel to conclude that this behaviour was disgraceful, dishonourable or unprofessional before this College.

The College argued that the connection between the Member’s conduct as a physician and the impact on him as a pharmacist was the concurrency of these roles. The Member operated his pharmacy practice out of his medical practice. When he was operating as a physician, he was essentially operating as a pharmacist. He was not wearing different hats. He was engaged in both health professions simultaneously, and when he engaged in misconduct of a sexual nature with a patient as a physician, that must impact on his status as a pharmacist. Counsel argued that an act committed in another health profession should be considered a breach of pharmacy standards before this College.

The Panel reviewed several past Discipline Committee and court decisions concerning the interpretation of the misconduct provision alleging that a member “engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.” The Panel observed that the cases illustrate that prior discipline panels of this College and the court, in general, have taken a very broad approach to the meaning of the phrase “relevant to the practice of pharmacy” in the misconduct provision.

The Panel concluded that the Member’s conduct as a physician must impact on his suitability as a pharmacist. The two roles/professional designations are intertwined on the facts of this case. He was physician and pharmacist at the same time. If his behaviour in one professional context brings that profession into disrepute – which the CPSO revocation certainly did in regard to the Member’s status as a physician – it must bring the other professional designation into disrepute as well. Sexual abuse of anyone is degrading and demeaning behaviour. But when it is practised by a health professional with a patient, the Panel believed, the behaviour is all the more disturbing and unprofessional, as it exploits the health provider/patient relationship, plays on an imbalance of power, and breaches a fundamental trust on
which pharmacy practice must be based.

The College did not spend a lot of time on the allegation of disgraceful, dishonourable or unprofessional conduct in regard to the Member’s failure to report the finding against him by the CPSO. However, the Panel believed it merited attention. The Member’s ignorance or conscious choice to avoid reporting the CPSO findings to this College calls into question the Member’s commitment to, and respect for, the professional standards governing the practice of pharmacy and the regulatory authority of the College. This too impacts on the “relevancy” to the Member’s “suitability to practise pharmacy.”

The evidence reflected that the Member did not appreciate the impact on this College of the revocation of his licence by the CPSO. Revocation is the most serious penalty a member can receive from a self-regulating body. As a member of this College, the Member’s actions stained the reputation of all pharmacists. The Panel found that the Member concealed the revocation of his CPSO license and that, in doing so, he misled the College. The Panel found this conduct not only troubling, but also disgraceful, dishonourable and unprofessional.

With the comfort of the precedents presented to the Panel and the broad definition of the phrase “relevant to the practice of pharmacy,” the Panel had no difficulty finding the Member guilty of professional misconduct for engaging in conduct or performing an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional.

**Penalty**

The College proposed a penalty that would include a reprimand to be administered according to the directions of the Panel, a six-month suspension of the Member’s Certificate of Registration, and costs of $10,000, to be paid within thirty days.

The Panel noted that the College did not propose any remediation in the form of course work for the Member. Rather, the College highlighted that the Member, who currently practises medicine in Arizona, was required to take a course on professional boundaries as a requirement to become licensed in that jurisdiction by its Medical Board.

The College submitted that as a result of the Member’s absence, there would be no mitigating factors presented to the Panel. Furthermore, the College argued that the Member’s failure to appear demonstrated a disregard for the disciplinary process and/or his obligation to maintain communications with the College.

The Panel was conscious that while the Member had received a significant and onerous penalty from his other governing college, the Panel could not let that influence the strength or weakness of any penalty ordered by the Discipline Committee of this College. The Panel was cognizant of the need to devise a penalty based on the Member’s standing as a pharmacist and to weigh his behaviour only in regard to the allegations made against him as a pharmacist.

In evaluating the College’s proposed penalty, the Panel was concerned about how to implement a reprimand with the Member currently residing in Arizona, about the lack of course work or other rehabilitation that was being proposed, and about the fact that the Member could avoid the impact of a suspension by simply staying in Arizona and practising medicine while the time elapsed.

In the Panel’s view, a suspension served in this form would have no deterrent effect on the Member whatever. Given the Member’s disregard for the College’s regulatory authority, as demonstrated by his failure to report to the Registrar and his failure to attend his own discipline hearing, the Panel believed the Member’s physical attendance in Ontario is required before the suspension can be commenced, in order to heighten its impact, obtain the maximum remedial result for the Member, and increase the deterrent effect on other members of this College.

The Panel was not prepared to conduct a reprimand in writing. To make an impact and be a productive element of the penalty, the Panel requires the Member to appear and face the Panel either in person or by telephone and receive the reprimand orally. Accordingly, the Panel’s order sets out a timeline by which the Member must contact the College to schedule the reprimand. The Panel believed the option of appearing by teleconference is an accommodation to the Member that recognizes both that he lives outside the province, and that it would be unnecessarily costly
in this case to require him to incur the expense to travel to Ontario for a brief appearance before the Panel. The Panel believed that there is a value to course work for this Member. Education and learning is always of benefit, regardless of one’s level of seniority and experience. The Panel believed it is necessary for the Member to fully appreciate the impact of his behaviour, and that course work is rehabilitative and instructive. The Panel acknowledged the boundary training that the Member underwent in Arizona, but believed there is added value in the Member attending the “Applied Ethics in Pharmacy Practice” course offered at the University of Toronto. The Panel therefore ordered the successful completion of this course as a specified term, condition or limitation on the Member’s Certificate of Registration. This course will ensure that the Member thoroughly understands his ethical responsibilities as a pharmacist and his participation in a regulated health profession.

The Panel accepted the $10,000 costs recommendation and set the deadline for payment in line with the timeline for scheduling the reprimand. To address the Panel’s concerns about the suspension being able to be served without any effort on the part of the Member, the Panel made it a requirement that the suspension period cannot be triggered until the Member receives the reprimand, physically attends in Ontario for the course work, and pays the costs as ordered.

**Order**

1. A reprimand to be scheduled and received by the Member within 60 days of the Order, by teleconference or in person;
2. Terms, conditions, and 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, Applied Ethics in Pharmacy Practice, offered by Professor Zubin Austin at the Leslie Dan Faculty of Pharmacy at the University of Toronto;
3. Costs to the College of $10,000; and
4. A suspension of six months, with the suspension to commence only after the Member has complied with the rest of the Order and has declared his intention to return to the practice of pharmacy in Ontario.

This Order was in effect as of February 17, 2009, the date of the hearing.
Coroner’s Inquest into death due to Hyperthermia

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the patient is not made aware of the changes. The jury felt that there needs to be a mechanism of informing the patient of the changes in drug information that may impact on their health.

Editors message:

We have printed this summary and recommendations to remind pharmacists of the importance of regular dialogue with their patients regarding their medications. The MedsCheck program, launched in July 2007, provides an opportunity for members of the public who are taking three or more medications to have a consultation with their pharmacist once a year to review the medications they are taking. It also provides an opportunity for pharmacists to ensure that the public are getting the most from their medications, and to review current information regarding the medications, as well as the lifestyle of the patient.

As we are in the summer months, it is most important that pharmacists consider the classes of drugs that could potentially affect temperature regulation and conditions that contribute to temperature disruption in individuals. It is a time when pharmacists are already warning patients about sunblock, sun sensitivity and drugs which can increase sun sensitivity. This unfortunate case teaches us that we must also be vigilant about drugs and temperature regulation. For the information of pharmacists, we have also included an article in this issue titled “Hyperthermia – Are your Patients at Risk?” outlining the potential for heat stroke, and medications which affect the body’s ability to regulate temperature.

Coroner’s Inquest into death due to Hyperthermia

coroner’s report

Coroner’s Inquest into death due to Hyperthermia

coroner’s report

Coroner’s Inquest into death due to Hyperthermia

Carla Babb recently joined the College as a Business Analyst/Project Manager. Carla has over 8 years of I.T. experience having previously worked in Financial Systems and Insurance Systems. Carla is experienced in all aspects of business systems analysis and deployment, technical/business solutions implementations, testing, documentation, and business process reengineering.

Stay Informed!

If you’d like to receive e-mail notifications about new developments in the regulation of pharmacy technicians, please visit the college’s website, www.ocpinfo.com, and click on the green “Pharmacy Technicians” button on the left menu. Once the page opens see “Stay Informed!” and click to submit your name and email address.
During the outbreak of H1N1 influenza, pharmacists are often the first point of contact for patients seeking advice and guidance for their flu-like symptoms. Pharmacists have also seen an increased demand for antiviral medications such as oseltamivir for the treatment of influenza. However, pharmacists must be aware of the potential for error when dispensing Tamiflu® oral suspension.

Case:

The above prescription for an eleven-year-old child was presented to a pharmacy technician for processing. The technician entered the instruction for use into the computer as “Give one teaspoonful twice daily”. The pharmacist checked all the components of the prescription and accurately reconstituted and dispensed the Tamiflu oral suspension.

However, both the computer entry technician and the dispensing pharmacist were unaware that the oral syringe provided by the manufacturer did not include markings to identify the volume of liquid to be administered. Instead, the markings identified doses of 30, 45, or 60 mg only (see Figure 1). The child’s parent would therefore be unable to identify ‘one teaspoonful’ on the oral syringe as the label instructions indicated. Fortunately, during patient counseling, the pharmacist identified the potential for error and changed the label instructions to read “Give 60 mg twice daily”.

Possible Contributing Factors:

• The dosage of oral liquids is usually identified on the prescription label in units of volume (milliliters) while the manufacturer of Tamiflu® provides a syringe that identifies the dosage in units of mass only (milligrams).
• Prior to the H1N1 outbreak, Tamiflu® oral suspension was dispensed infrequently. As a result, both the computer entry technician and the dispensing pharmacist were unaware of the limitation of the markings on the oral syringe.

Recommendations:

• The manufacturer of Tamiflu® oral suspension should include on the oral syringe, the dose to be administered in milliliters.
• When dispensing oral liquids to pediatric patients, always provide an oral syringe that clearly identifies the volume of liquid to be administered. Mark-A-Dose™ is a clear pressure sensitive adhesive label that can be attached to the oral syringe to identify the correct dosage.

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com. ▶

focus on error prevention

Tamiflu® oral suspension

Ian Stewart, R.Ph., B.Sc.Phm
Toronto Community Pharmacist

Figure 1
ONTARIO

August 8-11, 2009
Canadian Society of Hospital Pharmacists (CSHP)
Summer Educational Session
(formerly 'AGM')
Winnipeg, MB
Contact: Desarae Davidson, 613-736-9733, ddavidson@cshp.ca; www.cshp.ca

GTA

SEPTEMBER 10-12, 2009
Ontario Pharmacists’ Association (OPA) Annual Conference
Toronto, ON
Contact: Penny Young @ 416-441-0788 ext. 2209, pyoung@dirc.ca

September 21, 2009
Analyzing Medication Incidents Effectively to Enhance Medication Safety
Institute for Safe Medication Practices Canada
Sheraton Centre Toronto Hotel, 123 Queen St, Toronto
Contact: Sibylle von Guttenberg @ svonguttenberg@ismp-canada.org
http://www.ismp-canada.org

September 25-27
Oncology for pharmacists – Module III
Common malignancies, complications and palliation
Leslie Dan Faculty of Pharmacy, University of Toronto
Contact: Ryan Keay @ 416-978-8458
http://cpd.phm.utoronto.ca/oncology.html

October 1-4, 2009
Asthma and COPD Patient Care – CAE/CRE Preparation Course
Ontario Pharmacists’ Association
BMO Institute for Learning, 3550 Pharmacy Avenue, Toronto
Contact: Penny Young @ 416-441-0788 ext. 2209, pyoung@dirc.ca
http://www.opatoday.com/CE_A-COPD09.asp

October 1-4, 2009
Clinic Days
Ontario Pharmacists’ Association
BMO Institute for Learning, 3550 Pharmacy Avenue, Toronto
Contact: Penny Young @ 416-441-0788 ext. 2209, pyoung@dirc.ca
http://www.opatoday.com/CE_A-COPD09.asp

INTERNATIONAL

September 3-8, 2009
International Pharmaceutical Federation (FIP) 69th International Congress
Istanbul, Turkey
http://www.fip.nl/istanbul2009/

ON-LINE/WEBINARS

http://www.rxcertified.ca
Online fee-based certificate courses developed by the Drug Information and Research Centre (DIRC) and

rxBriefCase.com. Currently available:
- Diabetes Patient Care Level I
- Obesity Program
Vitamin D in Osteoporosis
Drug Information and Research Centre (DIRC)
http://www.opacti.org/
Online Clinical Tobacco Interventions for Health Care Professionals
http://www.pharmacygateway.com
On-line CE lessons
http://www.rxbriefcase.com/
On-line CE lessons
CE lessons on the CPhA Home Study Online Learning Centre

For local live CE events in your area, contact your regional CE coordinator (a list of regional CE coordinators is available on the College’s website, www.ocpinfo.com).
Drug and Pharmacies Regulation Act (DPRA) * ▲
Amended June 4, 2008

Regulations to the DPRA:
Regulation 545 – Child Resistant Packages
Regulation 297/96 Amended to O.Reg. 173/08
Regulation 551 Amended to O.Reg. 172/08

Drug Schedules **

Summary of Laws
June 2007 OCP

Canada’s National Drug Scheduling System – June 15, 2009 NAPRA (or later)

Regulated Health Professions Act (RHPA) * ▲
Amended April 23, 2009

Regulations to the RHPA:
Regulation 39/02 - Amended to O.Reg. 666/05
Regulation 107/96 – Controlled Acts
Regulation 59/94 – Funding for Therapy or Counseling for Patients Sexually Abused by Members

Pharmacy Act (PA) & Regulations * ▲
Amended June 2007

Regulations to the PA:
Regulation 202/94 Amended to O.Reg. 270/04
Regulation 681/93 Amended to O.Reg. 122/97

Standards of Practice ▲
Standards of Practice for Pharmacists, 2003
Standards of Practice for Pharmacy Managers, 2005

Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations * ▲
Amended June 2007

Regulations to the DIDFA:
Regulation 935 Amended to O.Reg. 354/08
Regulation 936 Amended to O.Reg. 205/96

Ontario Drug Benefit Act (ODBA) & Regulations * ▲
Amended June 2007

Regulations to the ODBA:
Regulation 201/96 Amended to Reg. 94/09

Controlled Drugs and Substances Act & Regulations (CDSA) **
Act current to May 20, 2009
All regulations current to May 27, 2009
Benzodiazepines and Other Targeted Substances Regulations
Marihuana Medical Access Regulations
Narcotic Control Regulations
Precursor Control Regulations
Regulations Exempting Certain Precursors and Controlled Substances from the Application of the Controlled Drugs and Substances Act

Food and Drugs Act (FDA) & Regulations ** ▲
Act current to May 20, 2009
Amending FDA Regulations, Project 1590 - Lenalidomide to Schedule F (May 13, 2009)
Amending FDA Regulations, Project 1584 - Naproxen and salts to Schedule F (May 13, 2009)
Amending FDA Regulations, Project 1583 – 6 medicinal ingredients and salts to Schedule F (May 13, 2009)
Amending FDA Regulations, Project 1578 – 4 medicinal ingredients and salts to Schedule F (May 13, 2009)
Amending FDA Regulations, Project 1540 - Dasatinib, Deferasirox, Lumiracoxib, Posaconazole and Telbivudine to Schedule F (May 13, 2009)
Amending FDA Regulations, Project 1576 - Oxaliplatin and Ranibizumab to Schedule F (September 5, 2008)
Amending FDA Regulations, Project 1575 - Inhaled human insulin to Schedule F (June 25, 2008)
Amending FDA Regulations, Project 1550 – Acamprosate, Varenicline and its salts to Schedule F (June 15, 2008)
Amending FDA Regulations, Project 1536 – Micafungin, Sitaxentan and its salts to Schedule F (June 25, 2008)
Amending FDA Regulations, Project 1530 – Pimobendan, Pirlimycin and its salts to Schedule F (June 25, 2008)
Amending FDA Regulations, Project 1508 - Nicotinic acid (June 25, 2008)
Amending FDA Regulations, Project 1541 - Diclofenac and its salts (April 3, 2008)
Amending FDA Regulations, Project 1551 - Lanthanum salts (February 7, 2008)

OCP By-Laws By-Law No. 1 – June 2009 ▲
Schedule A - Code of Ethics for Members of the Ontario College of Pharmacists - December 2006
Schedule B - “Code of Conduct” and Procedures for Council and Committee Members - December 2006
Schedule C - Member Fees - Effective January 1, 2009
Schedule D - Pharmacy Fees - Effective January 1, 2007
Schedule F - Privacy Code - Dec. 2003

Reference ▲
OCP Required Reference Guide for Pharmacies in Ontario, May 13, 2009

* Information available at Publications Ontario (416) 326-5300 or 1-800-668-9938 www.e-laws.gov.on.ca
** Information available at www.napra.org
▲ Information available at Federal Publications Inc. Ottawa: 1-888-4FEDPUB (1-888-433-3782)
Toronto: Tel: (416) 860-1611 • Fax: (416) 860-1608 • e-mail: info@fedpubs.com
▲ Information available at www.ocpinfo.com
Looking Back... As Our Profession Advances

Photo taken at the Niagara Apothecary - One of Canada’s first retail pharmacies – located in Niagara-on-the-Lake
Photographer – Mathew Rossi