Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SPRING 2014 • VOLUME 21 NUMBER 2

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

DISTRICT MEETINGS

PRINCIPLES AND PERSONALITIES: PRESCRIPTIONS TO PATIENT CARE

Ontario College of Pharmacists

Putting patients first since 1871

MISSION:

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

VISION:

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

VALUES:

Transparency - Accountability - Excellence

STRATEGIC DIRECTIONS:

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

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COUNCIL MEMBERS

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

H Christine Donaldson
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PM Shahid Rashdi
PM Joy Sommerfreund
U of T Heather Boon
U of W David Edwards

Statutory Committees

- Executive
- Accreditation
- Discipline
- Fitness to Practise
- Inquiries Complaints & Reports
- Patient Relations
- Quality Assurance
- Registration

Standing Committees

- Communications
- Drug Preparation Premises
- Finance & Audit
- Professional Practice

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

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

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

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PHARMACY CONNECTION

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CONTENTS

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

> "... these Principles underpin our practice and can lend so much to patient care."

Earlier this spring, I had the opportunity to join many of you at one of this year's District Meetings entitled "Principles and Personalities: Prescriptions to Patient Care". I really enjoyed attending these sessions and heard some excellent feedback from the members that were able to join us. College Registrar Marshall Moleschi and Professor Zubin Austin from the University of Toronto shared messages that were truly valuable and relevant to all of us. If you weren't able to attend one of the sessions, you can access an archived version of the live webcast on the College's website.

The focus of Marshall's presentation — and this issue of *Pharmacy Connection* — was on professional responsibility and practice expectations. Marshall shared the new Professional Responsibility Principles with members — concepts that Council initiated and endorsed at our March 2014 Council meeting. We developed these principles in the wake of last year's incident of alleged chemotherapy underdosing.

As you will recall, in March 2013 it was discovered that four hospitals in Ontario and one in New Brunswick administered diluted chemotherapy medication to patients. The Ontario government took immediate action including commissioning an independent review by Dr. Jake Thiessen. Although Dr. Thiessen's report on the incident found no particular individual at fault, it provided 12 recommendations intended to prevent future incidents and safeguard the drug distribution and supply chain. The government responded by endorsing each of the 12 recommendations and establishing a working group — to which the College is a key participant — to create a plan and track the progress of the recommendations. Updates on the five recommendations that look to the College and/or NAPRA to lead are provided on page 14.

In addition to the review and report by Dr. Thiessen, the government's Standing Committee on Social Policy initiated its own inquiry. In response to the Standing Committee's request that the College further examine the incident, Council established the Task Force on Professional Responsibility in Practice.

The mandate of the Task Force was to review pharmacists' and pharmacy technicians' practice responsibilities and make recommendations that raise awareness with members to ensure safe practice for patients. The Task Force developed five Professional Responsibility Principles that articulate practice expectations for members. Council unanimously endorsed these principles and has directed the College to share them with provincial and national stakeholders that are engaged in standard setting and educational development for the pharmacy profession, apply the principles to the review and development of College programs and strategic planning, and enact a comprehensive communications and education strategy to engage members in deepening their understanding and application of these principles in everyday practice.

I truly believe these Principles underpin our practice and can lend so much to patient care. They are applicable to all of us, regardless of our practice setting, and they remind us of our responsibilities as regulated healthcare professionals. These Principles and the concept of professional responsibility will reinforce the foundation of our practice for many years to come, and more information and insights on them will be shared with members in future workshops, on the website and in coming issues of *Pharmacy Connection*.

MARCH 2014 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on March 17th, 2014.

TRANSPARENCY PROJECT - UPDATE

Council received, for information, an update report on the transparency initiative led by a working group of AGRE – Advisory Group on Regulatory Excellence – which consists of representatives from the Colleges of medicine, nursing, dentists, pharmacy, optometry and physiotherapy. The working group was established to examine information-sharing practices and determine how regulators might make more member specific information available to the public.

Following the approval of the transparency principles by all AGRE Councils late last year, the working group has been focused on exploring how these principles could inform decision-making. Over the next several months additional consultation will be conducted, including public polling. The information gathered will be analyzed and recommendations for expanding the information to be made public are expected to be brought forward to AGRE member Councils for consideration later this year.

COUNCIL APPROVES AUDITED STATEMENTS FOR COLLEGE OPERATIONS FOR 2013

Council approved the Audited Financial Statements for the operations of the College for 2013 as prepared by Clarke Henning, LLP, Chartered Accountants. The audit and resulting financial statements were prepared in accordance with Canadian Auditing Standards. Council was particularly pleased to note that the auditors did not identify any major issues of concern. The summarized financial statements can be found in the College's Annual Report.

PRINCIPLES ON PROFESSIONAL RESPONSIBILITY IN PRACTICE WITH RECOMMENDATIONS FOR APPLICATION APPROVED BY COUNCIL

In March 2013, it was discovered that four Ontario hospitals and one hospital in New Brunswick had administered diluted chemotherapy drugs. The Ontario government took immediate action as a result of this incident, including launching an independent review of Ontario's cancer drug supply chain by Dr. Jake Thiessen. In addition, the Standing Committee on Social Policy initiated an investigation into the issue. Although they have not yet released their findings, in response to the Standing Committee's request that the College too further examine the chemotherapy under-dosing incident, Council established the Task Force on Professional Responsibility in Practice.

The mandate of the Task Force was to review pharmacists' and pharmacy technicians' practice responsibilities and make recommendations to raise awareness with members to ensure safe practice for patients. While the Thiessen report provided recommendations specific to the incident, the Task Force undertook to formulate findings and recommendations that would focus on the broader lessons that could be communicated to members.

The Task Force developed the following 'Professional Responsibility Principles' and made recommendations for their application both of which ¬¬were approved unanimously by Council.

Principles:

1. Members are relied on to use their knowledge, skills and judgment to make decisions that positively enhance health outcomes for patients and provide patient-focused care.
2. Pharmacists are responsible for applying therapeutic judgment in order to assess the appropriateness of therapy given individual patient circumstances.
3. Communication and documentation are central to good patient care when working in a team environment.
4. Trust in the care provided by colleagues and other health professionals must be balanced with critical evaluation.
5. Members must be diligent in identifying and responding to

Photos by DW Dorken

red flag situations that present in practice.

Application of Principles:

a) Share with provincial and national stakeholders, engaged in standard setting and educational development for the pharmacy profession, with a recommendation to utilize as appropriate to shape the development of ongoing work.
b) Apply to the review and development of College programs and strategic planning.
c) Enact a comprehensive communications and education strategy to engage members in deepening their understanding and application of these principles in everyday practice.

COUNCIL APPROVES REGISTRATION COMMITTEE'S RECOMMENDATION THAT THE COLLEGE'S INTERNSHIP TRAINING REQUIREMENT BE MET THROUGH GRADUATION FROM ONTARIO'S NEW PHARMD PROGRAMS

In 2013, the Universities of Toronto (UofT) and Waterloo (UofW) were granted approval to confer an entry-level PharmD degree upon their graduates. The PharmD programs, which will begin graduating students over the next few years, include significantly more hours of experiential learning.

Following a thorough review of the PharmD programs, the Registration Committee was satisfied that the new curriculum fulfils the College's entry-to-practice internship training requirements currently being met by successful completion of the Structured Practical Training (SPT) program. As such the Committee recommended that Council approve this change which effectively results in graduates from either of the Ontario Universities' PharmD programs being recognized as having met the required internship training.

In granting approval, Council was encouraged to learn that discussions with the dean and director of the pharmacy programs have identified a commitment by the universities to undertake ongoing evaluations of their programs and the performance of their graduates to ensure that they continue to be competent at entry-to-practice. Results from those evaluations are to be incorporated into future curriculum decisions and shared with the College.

TASK FORCE ON GOVERNANCE – UPDATE

Since its establishment in March 2013, the Task Force on Governance has held regular meetings to review the College's governance model and to develop new comprehensive governance documents. At this Council meeting, Council held a full discussion on several topics and provided the Task Force with direction and input on these issues. It is anticipated that at the June 2014 Council meeting, the Task Force will present to Council the finalized governance documents for Council's review and approval.

NEXT COUNCIL MEETINGS:

- Monday 16 June, 2014
- Monday 15 and Tuesday 16 September 2014

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

The Niagara Apothecary

A Pharmacy Museum

Located in Niagara-on-the-Lake, this mid-Victorian national historic site replicates a typical 1846 pharmacy. Visit the Apothecary and learn about pharmacy practice during the Confederation period. Retired pharmacists are available to answer questions about the building and its artifacts.

- 5 Queen Street, Niagara-on-the-Lake, Ontario
- Open *daily* from Mother's Day to Labour Day
- Open *weekends* from Labour Day to Thanksgiving

Visit this summer... a fun day for all ages!

For more information visit www.niagaraapothecary.ca

REMINDER: UPCOMING COUNCIL ELECTIONS

Districts M and P and a By-Election in District T

The College is holding Council Elections for three seats in District M (three-year term), two seats in District P (three-year term) and by-election for one seat in District T (two-year term).

As mentioned in e-Connect (the College's e-newsletter) and on the College website, only pharmacists with postal codes beginning with the letter M or P are eligible to nominate, be nominated and vote in this election. And only pharmacy technicians working outside of hospitals can do so in the by-election.

Your declared place of practice is used for election purposes, as indicated on your Annual Renewal. To ensure your place of practice information is up-to-date, login to your account on the College website (www.ocpinfo.com) and make any changes before noon on May 29, 2014.

YOU CAN SEND IN YOUR NOMINATIONS BY:

MAIL – Attention: Ushma Rajdev
c/o Registrar's Office
Ontario College of Pharmacists
483 Huron Street
Toronto, Ontario
M5R 2R4

EMAIL – urajdev@ocpinfo.com

FAX – 416-847-8246

The nomination form is posted on the College website.

IMPORTANT DATES

- Nominations open: Thursday, May 29, 2014
- Nominations close: Wednesday, June 18, 2014
- Voting closes: Wednesday, Aug. 6, 2014

For information regarding your voting district and eligibility, contact
Jessie D'Souza, Client Services Representative
416-962-4861 ext. 6231
jdsouza@ocpinfo.com

For information regarding the elections process, contact
Ushma Rajdev, Council and Executive Liaison
416-847-8243
urajdev@ocpinfo.com

WHAT IS THE COUNCIL OF THE COLLEGE?

Council is the policy-making group and board of directors for the College. Council's primary role is to ensure that the interests of the public are protected and maintained.

Members of Council include 15 elected pharmacists (two from hospital), two elected pharmacy technicians (one from hospital), two deans from the faculties of pharmacy at University of Toronto and University of Waterloo and nine to 16 members of the public who are appointed by government.

Term of office:
Maximum three years. Councillors may not serve more than three terms (nine consecutive years).

Council meetings:
Four times per year at the College.

Committees:
Each Council member is appointed to approximately two to three committees. Time commitments vary by committee.

Remuneration and Expenses:
See Article 6 of By-law No. 3.

Eligibility for Election:
See Article 4, section 4.9 of By-law No. 3.

THE NOMINATION PROCESS

To stand for election, you must be nominated by three members of the College who are eligible to vote in the electoral District for which you are nominated.

Your nomination paper must be accompanied by your signature which affirms your commitment to the objects of the College and that you undertake to comply with the College's policies, the By-Laws, Code of Ethics and Code of Conduct.

The nominations must be filed with the Registrar's Office no later than 5 p.m. on Wednesday, June 18, 2014.

After the nominations have closed, the College will send candidates additional information about the election, including a request for a brief biography, photo and campaign material.

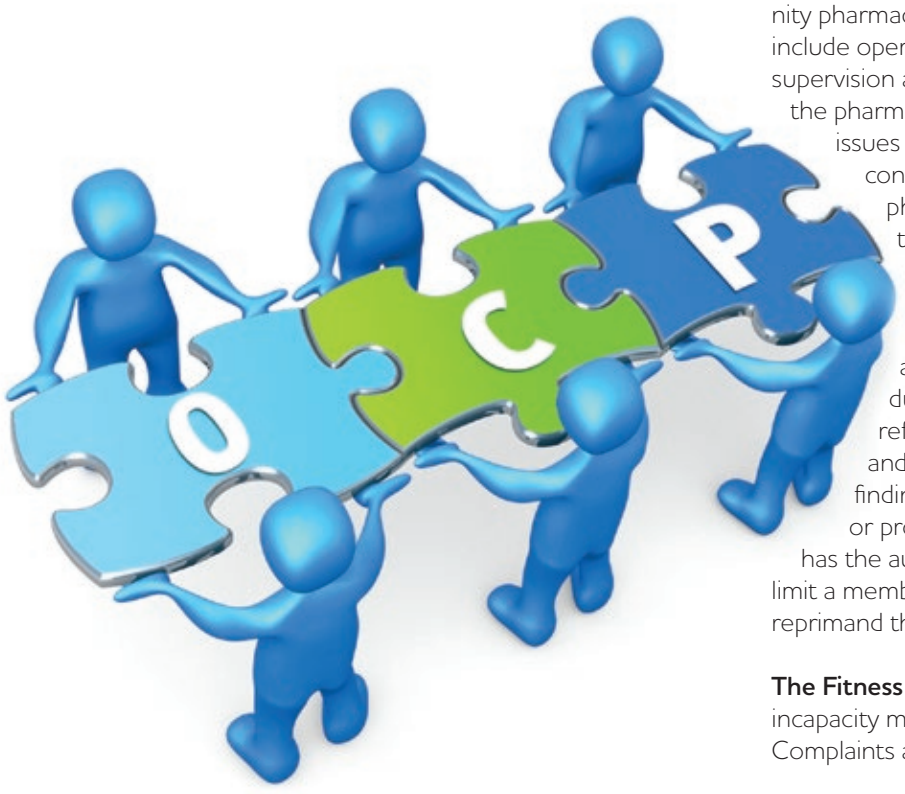
As part of the election process, the College will provide information about each candidate to the members in the relevant district. This information along with a photo for each candidate will be posted on the College website. The biography and campaign material help voters learn more about each candidate.

For more information on elections visit the College website.

Interested in Serving on a College Committee?

Why not participate as a non-council committee member?

Under the *Regulated Health Professions Act*, the College committee structure requires the appointment of members who are not elected members of Council to its various committees. In addition, members with particular experience or expertise are also required from time-to-time to serve on various special committees, working groups and task forces. The statutory and standing committees that require participation by a non-council committee member (NCCM) are listed below, along with a brief description of their terms of reference.



STATUTORY COMMITTEES:

The Accreditation Committee considers matters relating to the operation of community pharmacies in Ontario. These matters include operational requirements, ownership, supervision and the distribution of drugs in the pharmacy. The Committee also reviews issues relating to pharmacy inspections conducted by field staff where the pharmacy has failed to comply with the requirements.

The Discipline Committee*, through selected panels, hears allegations of professional misconduct and proprietary misconduct as referred by the Inquiries, Complaints and Reports Committee (ICRC). Upon finding a member guilty of professional or proprietary misconduct, the panel has the authority to revoke, suspend or limit a member's registration, impose a fine or reprimand the member.

The Fitness to Practise Committee considers incapacity matters referred by the Inquiries, Complaints and Reports Committee.

The Inquiries, Complaints and Reports Committee* (ICRC) is the screening committee that deals with all complaints and all member-specific concerns that arise from mandatory reports and other sources relating to professional misconduct, incompetence and incapacity.

The Patient Relations Committee advises Council with respect to the patient relations program which enhances relations between members and patients. It also deals with preventing and handling matters relating to sexual abuse of patients by members.

The Quality Assurance Committee is responsible for developing and maintaining the College's Quality Assurance Program, which includes a two-part Register, continuing education, minimum practice requirements and a practice review process. The goal of the Quality Assurance Program is to support continued competence and to encourage continuing professional development of members.

The Registration Committee* provides guidance to Council on matters concerning registration, examinations and in-service training required prior to registration. The committee maintains familiarity with the curricula of all pharmacy and pharmacy technician programs that have been accredited. Registration panels review all applications of individuals who do not meet the registration requirements to determine if any further education, training or examination is necessary prior to registration.

**The Discipline, ICRC and Registration Committees all operate using panels comprised by alternating committee members. Members of the committee will be selected to serve on panels to consider the matters presented and panels are convened approximately once a month.*

STANDING COMMITTEES:

The Communications Committee provides direction and guidance to Council, through the Executive Committee, on all matters supporting public education and outreach.

The Drug Preparation Premises Committee considers matters relating to the operation of drug preparation premises in Ontario

The Professional Practice Committee provides direction and guidance on matters pertaining to professional practice and is responsible for the development and ongoing review of standards of practice for the profession.

TO BE ELIGIBLE FOR CONSIDERATION FOR APPOINTMENT, YOU MUST:

- hold a valid Certificate of Registration as a pharmacist or as a pharmacy technician
- either practise or reside in Ontario
- not be in default of payment of any fees prescribed in the by-laws
- not be the subject of any disciplinary or incapacity proceeding
- not have your Certificate of Registration revoked or suspended in the six (6) years preceding the date of the appointment
- not have your Certificate of Registration subject to a term, condition or limitation other than one prescribed by regulation
- not be disqualified from serving on Council or a committee within the six years immediately preceding the appointment
- not have a conflict of interest in respect of the Committee to which you are to be appointed
- not be the owner or designated manager of a pharmacy that, within the six years immediately preceding the appointment, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection, and
- not be an employee or an elected or appointed member of the governing body of any local, regional, provincial or national professional association of pharmacists or pharmacy technicians

Non-council committee members are required to serve a one-year term and the President, in conjunction with the chairs of the committees, makes committee appointments at the beginning of each Council year. The number of days required by members to serve on each committee varies according to the frequency of meetings and agenda. For more information regarding terms or reference, composition, remuneration, please refer to the by-laws on the College website.

If you are interested in being considered for an appointment to a committee, you will need to submit a letter of interest **by August 15, 2014,** to Ms. Ushma Rajdev, Council and Executive Liaison, at urajdev@ocpinfo.com. In your letter, please state the committee(s) on which you would like to serve, and provide a brief resume together with any other information you deem useful.

You will be contacted after the Council meeting has taken place (September 15 and 16, 2014) *if you have been appointed* to serve on a committee.

PRINCIPLES & PERSONALITIES:

Prescriptions to Patient Care

DISTRICT MEETINGS EMPOWER PHARMACISTS & PHARMACY TECHNICIANS TO PROVIDE BETTER PATIENT CARE

OCP Registrar Marshall Moleschi (below) and Professor Zubin Austin (left) teamed up, during the recent District Meetings, to discuss professional responsibilities and patient care.

Kicking off with an enthusiastic and inspired crowd in Scarborough, this year's District Meetings entitled "Principles & Personalities: Prescriptions to Patient Care" brought hundreds of pharmacists and pharmacy technicians together to hear messages about professional responsibility and patient care.

College Registrar Marshall Moleschi and Professor Zubin Austin from the Leslie Dan Faculty of Pharmacy at the University of Toronto teamed up for six in-person sessions and one live webcast to provide insight and support to enhance members' understanding and implementation of their professional responsibility in practice.

Registrar Moleschi shared the newly developed Professional Responsibility Principles and discussed how College processes are shifting to better support the delivery of patient-focused care. The Principles — recently endorsed by College Council — collectively articulate practice expectations for members regardless of their role or practice setting. Over the coming months and years these Principles will be shared with all pharmacists and pharmacy technicians and used by the College to guide the development of any new or revised programs, policies or guidelines. More information on the Professional Responsibility Principles and their application is available on page 18.

Professor Austin — the lead in a multi-year research initiative between the College and the University — shared some insights on how who pharmacists are, shapes what they do. Dr. Austin shared some of the results of his research, including insights on common characteristics of pharmacists and family physicians and common barriers to practice. He also offered a case study that prompted discussion around building more effective relationships that support a commitment to patient-focused care.

DID YOU MISS IT?

Don't worry — a recorded version of the live webcast is available on the College's website. Go to www.ocpinfo.com for more information and to watch the video!

WE ASKED YOU!

We asked participants to identify the most important lessons learned during the session. Here's what you said:

"It's about patient-focused care. Pharmacists must put the patient's needs ahead of their own and step up."

"Pharmacists' involvement in patient care is evolving and we need to take on these new responsibilities now."

"Avoiding making a decision is a decision itself. Doing nothing for a patient can have severe consequences. Why send a sick person to emerg when you have the skills and knowledge to help them yourself?"

"The person in front of me is my patient, not my customer."

"We have to look at our profession from a different vantage point now and understand that we are authorized (and expected) to make decisions in the best interest of the patient."

"It is my responsibility to help my patient."

"This presentation was empowering. I am so proud to be a pharmacist."

Update on Thiessen Report Recommendations

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In response to last year's incident of alleged chemotherapy under-dosing, the government commissioned Dr. Jake Thiessen to do an independent review and produce a report — *A Review of the Oncology Under-Dosing Incident* — which was released to the public by the Minister of Health and Long-Term Care on Aug. 7, 2013. The report included 12 recommendations — subsequently endorsed by government — intended to prevent future chemotherapy incidents and mitigate identifiable risks.

Five of Dr. Thiessen's recommendations looked to the College and/or the National Association of Pharmacy Regulatory Authorities (NAPRA) for leadership in implementation. This article provides an update on these recommendations.

RECOMMENDATION #6: The Ontario College of Pharmacists (OCP) (and by extension the National Association of Pharmacy Regulatory Authorities [NAPRA]) shall work quickly with Health Canada to define best practices and contemporary objective standards for non-sterile and sterile product preparation within a licensed pharmacy.

The College is an active participant on a special committee led by NAPRA that is currently looking at Dr. Thiessen's Recommendation #6 in two stages. The first stage is the development of national standards for sterile compounding, and the second stage is the development of national standards for non-sterile compounding. Once finalized and approved both sets of standards will be used

Update on Thiessen Report Recommendations

by Health Canada, pharmacy education programs and the national examining board to update existing curriculum and assessment tools. The standards will also influence inspection criteria and evaluation process.

STERILE COMPOUNDING STANDARDS

The committee thoroughly reviewed and analyzed existing guidelines and began initial consultations regarding the sterile compounding standards with key stakeholders earlier this year. The NAPRA Board reviewed the proposed standards at its April 2014 meeting and approved them for further stakeholder consultations to occur over the summer. The final standards for sterile product preparation are scheduled to be finalized at NAPRA's November 2014 Board meeting.

NON-STERILE COMPOUNDING STANDARDS

The committee will apply the same process to develop the non-sterile compounding standards. The NAPRA Board will review the proposed standards at its November 2014 meeting and further stakeholder consultation will take place into early 2015. The final standards for non-sterile product preparation are scheduled to be finalized at NAPRA's April 2015 Board meeting.

RECOMMENDATION #7: **The OCP (and by extension NAPRA) shall stipulate specialized electronic material records and label requirements for non-sterile and sterile product preparation within a licensed pharmacy.**

NAPRA's Pharmacy Practice Management Systems (PPMS) project was completed in November 2013 and involved setting minimum requirements for hospital and community pharmacy software. As a continuation of this project, NAPRA — with input from the College — has developed a draft supplement to the PPMS that outlines the requirements for traceability and labeling. Stakeholders were asked for feedback and the draft requirements were shared with the NAPRA Board in April 2014. A national consultation will occur over the summer months and final requirements will be presented to the NAPRA Board in November 2014 for approval and publication.

RECOMMENDATION #8: **The OCP (and by extension NAPRA) shall consider a special designation and licence for any licensed pharmacy engaged in large volume non-sterile and sterile product preparation. Such pharmacies shall be inspected annually.**

In May 2013 the government announced a regulation authorizing the College to inspect drug preparation premises where pharmacists and pharmacy technicians engage in or supervise drug preparation activities. Since then, inspection criteria, an inspection process, inspection standards and inspection schedules have been finalized. The College has visited all drug preparation premises in Ontario and plans to do so annually. Moving forward, the College will collaborate with Health Canada and NAPRA to develop a national approach for oversight of large volume compounding pharmacies. The outcome and/or status of all inspections are posted on the College's website.

"OCP to Inspect Hospital Pharmacies"

RECOMMENDATION #9: The OCP shall specify credentials beyond education and licensing for personnel engaged in non-sterile and sterile product preparation practices within a licensed pharmacy.

As per recommendation #6, NAPRA is currently developing national standards for non-sterile and sterile product preparation practices. In conjunction with this step, NAPRA is also drafting compounding competencies to go alongside the compounding standards. The draft compounding competencies were shared with the NAPRA Board in April 2014 and consultation with national stakeholders will follow during the summer months. In the future, the compounding competencies will be incorporated into educational program curricula and pharmacy personnel will be required to demonstrate their competence before engaging in compounding activities.

RECOMMENDATION #12: The OCP shall license all pharmacies operating within Ontario's clinics or hospitals.

In response to this recommendation, the government introduced *Bill 117: Enhancing Patient Care and Pharmacy Safety Act* in October 2013. The draft legislation, when passed, would give the College the authority to inspect and regulate hospital pharmacies.

In advance of this legislation passing, the College has taken several steps toward developing the accreditation process for hospital pharmacies, including hiring a Manager of Hospital and other Healthcare Facilities to lead the initiative.

One of the first milestones along the way to OCP oversight of hospital pharmacies is the development of inspection criteria. The draft criteria for hospital inspections is being created by a project team assisted by a working group and advisory committee made up of hospital pharmacists and pharmacy technicians, and other relevant stakeholders. The document was developed by studying the criteria for hospital inspections from other Canadian provinces, consulting with hospital pharmacists and pharmacy technicians, and reviewing the criteria for inspections of community pharmacies and most recently drug preparation premises.

Currently the inspection criteria is still in its draft form and will be circulated for consultation to members and other stakeholders in the early summer months. Once the consultation period has closed the project team, working group and advisory committee will consider the feedback received. The College will pilot the draft inspection criteria in the late fall. While waiting for the enactment of legislation the College will visit hospitals on a volunteer basis and anticipates all hospital pharmacies in Ontario will be visited by the end of 2015.

A PRINCIPLED APPROACH TO DELIVERING PATIENT-FOCUSED CARE

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Just as individual practitioners must constantly reflect on their practice in order to learn and grow so must the regulatory College. We do this by extracting and sharing best practices when things go well – but must be equally diligent in identifying the lessons learned when they do not. The alleged incident of chemotherapy under-dosing that occurred in March of last year is one such example.

Although significant attention was given to investigating the incident itself including an independent report by Dr. Jake Thiessen which found no individual fault, College Council felt strongly that there were broader lessons that could be learned and shared with all pharmacists and pharmacy technicians. Council established the Task Force on Professional Responsibility in Practice with a mandate to review pharmacists' and pharmacy technicians' practice responsibilities and formulate findings and recommendations that would focus on identifying the broader lessons.

The result was the development and unanimous Council approval of Professional Responsibility Principles designed to articulate a member's professional responsibility in practice regardless of role or practice setting. The principles reflect the reality that the healthcare environment and member practice is continuously evolving and may not incorporate a traditional pharmacist-patient relationship or practice setting. Members must consider these principles in the context of their current practice environment and in conjunction with the Standards of Practice.

PRINCIPLE 1: *Members are relied on to use their knowledge, skills and judgment to make decisions that positively enhance health outcomes for patients and provide patient-focused care.*

An understanding of individual patient needs and circumstances is paramount in providing patient-

A PRINCIPLED APPROACH TO DELIVERING PATIENT-FOCUSED CARE

focused care. Members are required to assert professional judgment to act in the best interest of the patient and must balance professional versus organizational responsibilities to ensure best patient outcomes and safety. When making decisions, the member's relationship with the patient is of primary importance to ensure the patient's best interests are represented. This necessitates open communication with the patient and all health professionals involved in the patient's care. Members must consider the big picture and be cognisant of the intended and unintended consequences of their actions or inactions.

PRINCIPLE 2: *Pharmacists are responsible for applying therapeutic judgment in order to assess the appropriateness of therapy given individual patient circumstances.*

Pharmacists must practice medication therapy management (MTM) and use therapeutic judgment when providing patient care. MTM optimizes therapeutic outcomes for individual patients utilizing a pharmacist's unique knowledge and experience. As a practice model, MTM supports a coordinated and integrated approach to providing patient care within the broader healthcare delivery system. Applying therapeutic judgment requires a pharmacist to assess the appropriateness of a drug independent of the technical accuracy of a prescription or order, and necessitates consideration of the context in which the drug will be utilized. When a pharmacist determines that additional information is required, he or she has the responsibility to evaluate applicable evidence-based resources to resolve actual or potential drug therapy problems in order to ensure the best patient outcomes. Achieving an appropriate treatment outcome is also dependent on being able to guarantee the quality and safety of drug procurement and distribution systems.

PRINCIPLE 3: *Communication and documentation are central to good patient care when working in a team environment.*

Patient care teams consist of both the intra-professional team with multiple members of the same profession, and the inter-professional team with a variety of healthcare professionals from different professions working collaboratively to deliver quality care within and across settings. A member needs to be conscious that the composition of the care team may vary and everyone who contributes to patient care is a part of the care team. As practice and treatment evolves, members may need to reflect on the changing needs of the patient to determine with whom information is shared. When sharing in the care of a patient it is essential that all appropriate team members are informed of the care plan and that each health professional assumes responsibility for identifying and communicating actual or potential issues to the rest of the team. Effective communication requires an assessment of information that is required and a strategy to obtain this information in addition to sharing information the member possesses. Caution and attention to detail must occur during transitions between team members to ensure appropriate transfer of information and uninterrupted patient care. Members are encouraged to effectively use technology to record patient information in a central location to facilitate information sharing.

PRINCIPLE 4: *Trust in the care provided by colleagues and other health professionals must be balanced with critical evaluation.*

Finding the correct balance between trust and independent evaluation is of utmost importance in order to deliver high quality patient care while not

paralyzing practice to investigate every situation. When providing patient care there must be a level of trust between team members but that trust should not be blind as members need to evaluate information based on the circumstances. Members need to apply professional judgment to determine when critical evaluation is required, and effectively communicate research and findings to other health professionals.

PRINCIPLE 5: *Members must be diligent in identifying and responding to red flag situations that present in practice.*

Members must be innovative, attentive and agile to identify and respond to "red flag" situations that may arise in practice. Practice that has the potential for a high degree of harm to patients requires additional scrutiny by members. This might include practicing in non-traditional settings, initiating a new practice or process, working with an unfamiliar or high-alert drug such as chemotherapy, or working with complex and vulnerable patient populations. Members must use professional judgment and experiential knowledge to identify situations that do not seem to conform to expected practice circumstances to ensure that these situations are addressed and that appropriate information is gathered to support practice decisions. Clarity regarding patient circumstances is of utmost importance.

> "... healthcare environment and member practice is continuously evolving and may not incorporate a traditional pharmacist-patient relationship or practice setting."

A SHIFT IN FOCUS

Practicing with these professional responsibilities in mind requires a conscious shift in our focus from the individual task at hand to the bigger picture of patient-focused care. The principles remind us of our overriding responsibility as regulated healthcare professionals, to uphold our ethical and fiduciary duty to put the best interest of our patients, above our own. This fundamental accountability is rooted in the social contract that exists between society and all regulated healthcare professions, and forms the fragile foundation of trust to which self-regulation exists.

We must always remember that our patients have put their most precious asset – their health and well-being – in our hands. We are the holders of power in the patient-practitioner relationship and our patients trust that we will use the knowledge,

> "... our patients trust that we will use the knowledge, skills and abilities that we have to make decisions that positively enhance their health outcomes."

skills and abilities that we have to make decisions that positively enhance their health outcomes.

In order to support pharmacists' and pharmacy technicians' efforts in actively practicing these Professional Responsibility Principles and the Standards of Practice, the College is shifting its focus as well. Routine pharmacy inspections will evolve from observing "what" is being done to focusing on evaluating actual practice behaviours and interactions with patients and colleagues. Time will be spent on the areas of practice that most directly impact patient and public safety. The emphasis will be on coaching and sharing of best practices to provide members with opportunities and resources to evolve their practice and enhance health outcomes for their patients.

NEXT STEPS

Understanding and internalizing these Professional Responsibility Principles is a critical component toward our consistent delivery of patient-focused care. Throughout the coming months and years the College will continuously share and reinforce these principles with all pharmacists and pharmacy technicians. Additionally, the principles will be used by the College to guide the development of new or revised programs, policies and guidelines and will be shared with pharmacy stakeholders, provincially and federally, to ensure that foundational elements like curriculum and standards of practice are appropriately aligned with these important concepts.

The current constraints on the healthcare system, limited resources and an aging population, will undoubtedly continue to influence public policy. The result will be a growing increase in overlapping scopes of practice as the system struggles to balance efficiencies and access with the safe delivery of healthcare services. In this increasingly complex model of healthcare the patient remains the common denominator.

Practicing with these Professional Responsibility Principles in mind will ensure that we continue to establish ourselves as integral members of the healthcare team who, as medication experts, are dedicated to using our knowledge, skills and abilities to enhance the health and well-being of patients. Regardless of our role or practice setting we must remain diligent in our delivery of patient-focused care. Remembering, if not us, now . . . then who, when? Pc

Ontario College of Pharmacists
Putting patients first since 1871

Professional Responsibility Principles

Principle 1: *Members are relied on to use their knowledge, skills and judgment to make decisions that positively enhance health outcomes for patients and provide patient-focused care.*

Principle 2: *Pharmacists are responsible for applying therapeutic judgment in order to assess the appropriateness of therapy given individual patient circumstances.*

Principle 3: *Communication and documentation are central to good patient care when working in a team environment.*

Principle 4: *Trust in the care provided by colleagues and other health professionals must be balanced with critical evaluation.*

Principle 5: *Members must be diligent in identifying and responding to red flag situations that present in practice.*

Navigating Electronically Generated Prescriptions

One of the most frequently asked questions by members at the College is what the responsibility of the pharmacist is when they are presented with an electronically generated prescription (i.e. a prescription generated from an Electronic Medical Record). Confusion among prescribers and pharmacists regarding what constitutes e-prescribing, and how prescription technology can be used responsibly has further compounded this issue. This article builds on the Position Statement, Authenticity of Prescriptions using Unique Identifiers for Prescribers, which was released by the College in 2013. Clarification of e-prescribing and electronic prescriptions generated by EMR is provided to support members' understanding of prescription technology and enable informed dialogue with prescribers. Within this article are some considerations to keep in mind when working with electronically generated prescriptions.

A prescription cannot be dispensed in a pharmacy unless it is authorized by a prescriber, verbally, or by signature. Health Canada has broadly defined "signing" as "whatever is determined to be necessary to authorize and validate the order" which no longer refers only to a pen-and-ink signature.

EVALUATING THE AUTHENTICITY OF A PRESCRIPTION GENERATED BY A COMPUTER-BASED SYSTEM

It is sometimes difficult to verify whether a signature is unique when a prescription generated by an EMR and printed with a digitized signature affixed to it is presented at a pharmacy. As outlined in the Standards of Practice, a pharmacist is required to verify a prescription with the physician when it seems inappropriate for the patient, by using their judgment to assess the entire circumstances around the prescription. An assessment of the authenticity of any prescription should not be determined based solely on the unique identifier used to authenticate the prescription. The pharmacist is not responsible for ensuring the prescriber has complied with relevant College of Physicians and Surgeons of Ontario (CPSO) policies and guidelines, or legislative requirements, nor is he or she responsible for assessing appropriateness of any unique identifier used in a prescription authorization process. The responsibility of the pharmacist when verifying a prescription is to ensure that the prescription is authentic and is appropriate for the patient.

ELECTRONIC PRESCRIBING (E-PRESCRIBING) VERSUS PRESCRIPTIONS GENERATED BY AN ELECTRONIC MEDICAL RECORD (EMR)

E-prescribing

E-prescribing is the secure electronic creation and transmission of a prescription between an authorized prescriber and a patient's pharmacy of choice, using clinical Electronic Medical Record (EMR) and pharmacy management software.[1] E-prescribing is completely paper-free without intermediary faxes or scanned images of paper prescriptions. [2] Paper-free e-prescribing is not currently deployed in Ontario. E-prescribing would permit health care professionals to rely upon a system's security features to support prescription authentication and the protection of patient privacy during prescription transmission. This would be accomplished through the implementation of a standardized process with controls for all prescriptions, regardless of the number of prescriber systems involved. Prescriptions would be transmitted as an electronic message to a jurisdictional prescription "hub" which electronically re-transmits the prescription to a pharmacy's computer. Regular e-mail (i.e. not a secure web mail portal) is not a secure medium for prescription transmission and therefore is not permitted. [3]

Prescriptions Generated by an EMR

EMR systems are generally stand-alone operating systems that do not link to a province-wide system, therefore "paperless" (i.e. no fax or digitized image of a prescription) transmission from an EMR can only occur within a closed network (e.g. within a family health team, or a hospital). EMR generated prescriptions can use multiple types of technological substitutes for a handwritten signature combined with one of the available prescriber authentication techniques (discussed in the College's position statement). These systems rely on computer-generated faxes or a digitized image of a prescription to transmit the final prescription to the pharmacy. Current practice in Ontario which uses facsimile transmission of EMR generated prescriptions, and the transmission of a digitized image of a prescription within a closed network, does not constitute true e-prescribing.

1. Canadian Medical Association, Canadian Pharmacists Association. e-Prescribing Joint Statement. Retrieved at http://www.pharmacists.ca/cpha-ca/assets/File/ePrescribingStatementENG2013.pdf

2. eHealth Ontario. Canada's First ePrescribing Program Launches in Ontario (2009). Retrieved at http://www.ehealthontario.on.ca/en/news/view/canadas-first-eprescribing-program-launches-in-ontario

3. Information and Privacy Commissioner Ontario. Privacy Protection Principles for Electronic Mailing Systems (1994). Retrieved at http://www.ipc.on.ca/images/Resources/email-e.pdf

Visit the new Continuing Professional Development (CPD) Portal

Earlier this spring the College launched its newly re-designed Continuing Professional Development (CPD) Portal. With its fresh look and several new features, maintaining your professional development has never been so simple or convenient!

Pharmacists and pharmacy technicians can use the College's CPD Portal for assessing their own needs, creating a personal learning plan and evaluating the effectiveness of their education.

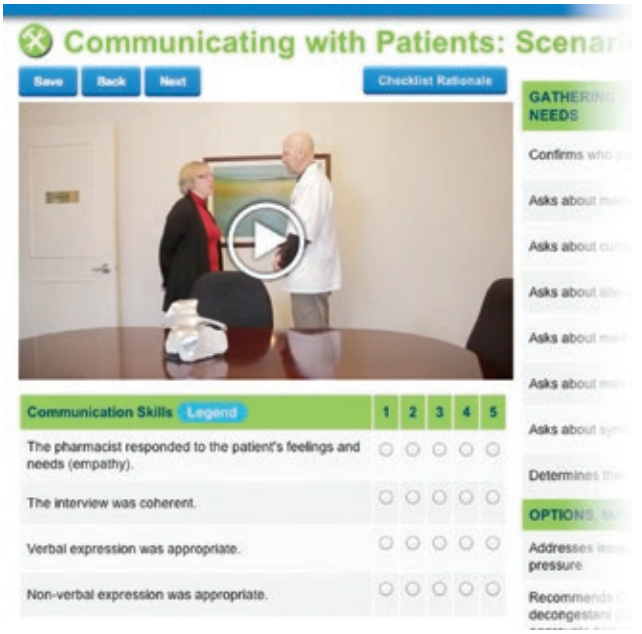
The main features of the new CPD Portal are the Self-Assessment Tool and the Learning Portfolio.

THE SELF-ASSESSMENT TOOL

The Self-Assessment Tool helps practitioners identify their learning needs and plan their learning based on the Standards of Practice. Ideally, both pharmacists and pharmacy technicians should use the tool annually as one of its primary benefits is to help identify specific areas of learning that practitioners can use to guide decisions regarding their ongoing continuing education activities.

ASSESSING COMMUNICATION WITH PATIENTS

In the Self-Assessment Tool section for pharmacists, you can view two quick videos about communicating with patients — you'll be asked to rate the pharmacist's interaction with the patient using a checklist, and then reflect on your own skills in communicating with patients. This tool is especially useful to remind pharmacists that every interaction with a patient is unique and there may be several viable options to any given situation. The Communicating with Patients section emphasizes the need for using professional judgment to make and rationalize decisions that are in the best interest of our patients.



THE LEARNING PORTFOLIO

All pharmacists and pharmacy technicians must engage in continuing education activities and document their learning, keeping a record of these learning activities for a minimum of five years. The College offers a Learning Portfolio, a tool to assist members in identifying and documenting their continuing education.

NEW SEARCH FEATURE

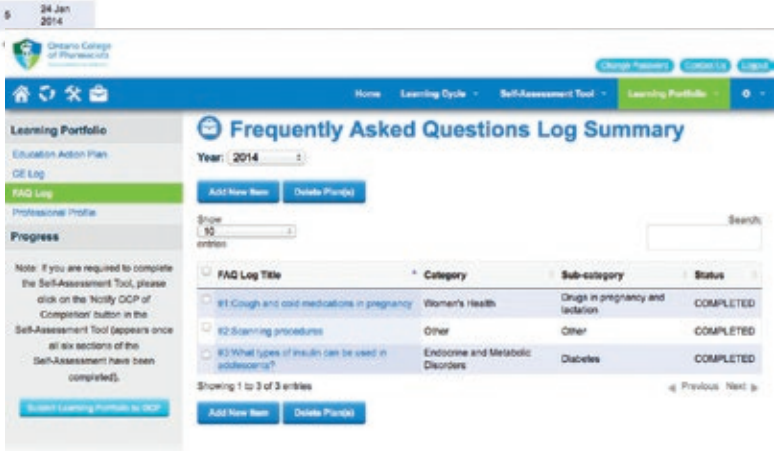
The new Learning Portfolio also has a sophisticated search feature that helps you organize and find your past CE entries and frequently asked questions.

SEARCH THE CE LOG

For example, if you would like to find your diabetes learning activities, enter "diabetes" into the search field and the results will show the CE you have previously entered that is related to diabetes. The new search feature is a quick and easy way to categorize and sub-categorize your CE.

SEARCH THE FAQ LOG

You can also use the new search feature to help organize your frequently asked questions. This is a great tool to help you keep track of tough questions or topics you get asked frequently but have a hard time remembering. Enter a question and supporting information into your Learning Portfolio and you'll have easy access to these questions and topics when you need them.



Visit the new CPD Portal today — go to www.ocpinfo.com and visit "Login to My Account" then click on "My Learning"

ACCESS ON THE GO

The CPD Portal is now accessible from your smartphone or tablet, making it easy to login and keep track of your learning activities while on the go. Login while you are attending an event and record the details of your learning before you forget. You can also login while at work to record work-based learning or make note of questions asked by your patients.

Preventable Medication Errors – Look-alike/Sound-alike Drug Names

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INTRODUCTION

The existence of look-alike/sound-alike drug names is one of the most common causes of medication error and is of concern worldwide. As more medicines and new brands are being marketed in addition to the thousands already available, many of these medication names may look or sound alike (some examples are illustrated in Table 1). Thus, the potential for error due to confusing drug names is very high. In addition, when patients take multiple prescription medications and/or receive care from different health care providers, medication history information may be less reliable and more difficult to verify.[1] As a result, the problem of Look-Alike/Sound-Alike drug names has become a significant challenge to pharmacists, pharmacy technicians, patients, and prescribers.

Simplicity, standardization, differentiation, lack of duplication, and unambiguous communication are important concepts that are relevant to the medication-use process.[1-3] Many factors could contribute to the confusion of medication names, such as illegible handwriting, knowledge deficit on drug names, and similar indications of drugs. Medication incidents are often resulted from a combination of several factors.[1-3]

Medication incidents involving Look-Alike/Sound-Alike drug names can cause serious patient harm. It is often difficult to detect the error, as the dispensed medication is presumed to have been the one that is prescribed for the patient.[3] In a community pharmacy, these errors can occur at any point in the medication use system, including prescribing, order entry, dispensing, administration and/or monitoring.[1] Incident reporting can be used to gain a deeper understanding of contributing factors or potential causes leading to medication incidents involving look-alike/sound-alike drug names.

TABLE 1: EXAMPLES OF LOOK-ALIKE/SOUND-ALIKE DRUG NAMES
(Brand name is shown in bold. Generic name is shown in italics)

BRAND NAME *(Generic name)*	**BRAND NAME** *(Generic name)*
Celebrex® *(Celecoxib)*	**Celexa®** *(Citalopram Hydrobromide)*
Losec® *(Omeprazole)*	*Lasix® (Furosemide)*
Lamictal® *(Lamotrigine)*	*Lamisil® (Terbinafine Hydrochloride)*
Reminyl® *(Galantamine Hydrobromide)*	**Amaryl®** *(Glimepiride)*
Seroquel® *(Quetiapine Fumarate)*	**Seroquel XR®** *(Quetiapine Fumarate)*
Yaz® *(Drospirenone and Ethinyl Estradiol)*	**Yasmin®** *(Drospirenone and Ethinyl Estradiol)*

The Community Pharmacy Incident Reporting (CPhIR) Program (available at http://www.cphir.ca) is designed for community pharmacies to report near misses or medication incidents anonymously to ISMP Canada for further analysis and dissemination of shared learning from incidents.[4] CPhIR has allowed the collection of invaluable information to help identify system-based vulnerable areas in order to prevent medication incidents.[4] This article provides an overview of a multi-incident analysis of medication incidents involving look-alike/sound-alike drug names reported to the CPhIR program.

MULTI-INCIDENT ANALYSIS OF MEDICATION INCIDENTS RELATED TO LOOK-ALIKE/SOUND-ALIKE DRUG NAMES IN COMMUNITY PHARMACY PRACTICE

Reports of medication incidents involving "look-alike/sound-alike" were extracted from the CPhIR Program from April 2010 to March 2012. In total, 540 incidents were retrieved and 342 incidents met inclusion criteria and were included in this qualitative, multi-incident analysis. They were independently reviewed by two ISMP Canada Analysts and categorized into four main themes: (1) individual factors, (2) environmental factors, (3) technological factors and (4) unique factors, as shown in Table 2. (Note: The "Incident Examples" provided in Table 2 were limited by what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.)

HIERARCHY OF EFFECTIVENESS IN PREVENTING MEDICATION INCIDENTS ASSOCIATED WITH LOOK-ALIKE/SOUND-ALIKE DRUG NAMES

Many possible recommendations with varying degrees of effectiveness are available to prevent medication errors. It is often difficult to select the best strategy

TABLE 2: THEMES FROM THE MULTI-INCIDENT ANALYSIS

THEME 1: INDIVIDUAL FACTORS

Individual factors take into account human capabilities, limitations, and characteristics, such as confirmation bias, illegible handwriting, knowledge deficit, etc.

INCIDENT EXAMPLE	POSSIBLE CONTRIBUTING FACTORS	COMMENTARY
A prescription was written for Mebendazole 100mg, 2 doses with 2 weeks apart. The pharmacist interpreted the prescription as metronidazole 1000mg, 2 doses with 2 weeks apart. The prescriber's handwriting was hard to read, and Metronidazole was commonly prescribed by this prescriber. When the pharmacist was discussing with the patient in terms of therapeutic indications of the prescription, it was discovered that the patient was supposed to be treated for worms, not bacterial infection.	• *Knowledge deficit* • *Confirmation bias* • *Illegible handwriting on the prescription* • *Lack of independent double checks*	In order to clearly indicate medication, dosage, and instructions on prescriptions, physicians should consider using standardized pre-printed order forms.[1] Warning flags should be incorporated into the pharmacy computer systems to alert for potential mix-up during drug selections.[3] Independent double checks should be performed throughout the entire pharmacy workflow.[5] This may include a verification with the patient or the patient's agent regarding the indication of the medication during drop-off or pick-up of prescription. To avoid incidents related to confirmation bias, indications for each medication should be included on the prescription.[3] It is recommended to highlight information related to look-alike/sound-alike drug names as part of pharmacy staff training and communications.[6]
A physician wrote a prescription for Hydrocortisone 1% in Mycostatin®; however, Hydrocortisone 1% in Miconazole (Monistat®) was filled. The pharmacy staff member thought Mycostatin® and Miconazole were the same thing.		

TABLE 2: THEMES FROM THE MULTI-INCIDENT ANALYSIS *(Continued)*

THEME 2: ENVIRONMENTAL FACTORS

Environmental factors refer to issues in the work environment or within the workflow process, such as drug storage, environmental distractions, drug shortage, etc.

INCIDENT EXAMPLE	POSSIBLE CONTRIBUTING FACTORS	COMMENTARY
A pregnant patient was prescribed Diclectin®, but Dicetel® was filled. The patient had been on Dicetel® many times in the past.	• *Confirmation bias* • *Lack of independent double checks*	To avoid incidents related to confirmation bias, indications for each medication should be included on the prescription.[3] Independent double checks should be performed throughout the entire pharmacy workflow.[5]
A pharmacy student entered two prescriptions correctly for the same patient. The technician who was filling prescriptions scanned out the proper drugs, but mislabeled vials with each other's label. The pharmacist found out the mistake while checking prescriptions.	• *Fill multiple prescriptions for the same patient simultaneously* • *Environmental distractions*	The pharmacy dispensing environment should be organized to create a safe and efficient working area.
Due to the shortage of Apo®-Amilzide, Novamilor was filled for the patient. When Apo®-Amilzide became available, the pharmacy staff member planned to switch back to it. However, the Apo®-Amiloride was chosen instead of Apo®-Amilzide. Apo®-Amilzide was a combination drug including amiloride and hydrochlorothiazide. Patient noticed the yellow color tablets when picking up the prescription and questioned the pharmacist. The patient's profile was checked and the error was noticed.	• *Drug shortage* • *Proximity of storage of look-alike/sound-alike drug pairs* • *Lack of independent double checks*	The look-alike/sound-alike drug pairs should be stored in separate locations or in non-alphabetical order on shelves.[6] Independent double checks should be performed throughout the entire pharmacy workflow.[5] This may include a verification of patient's prior medication use in the patient profile prior to dispensing.

for each situation. However, it is recommended to choose the most effective solution that is reasonable and/or possible given the circumstances.[8] Based on the potential contributing factors that have been identified from this multi-incident analysis, the following hierarchy of effectiveness in preventing medication incidents associated with look-alike/sound-alike drug names is summarized in Table 3. The recommendations are listed in order from the most effective to the least effective solution. For example:

- "Simplification / Standardization" helps eliminating illegible handwriting and standardizing safe order communication, but it relies in some part on human vigilance and memory.[9]
- "Reminders, Checklists, Double Checks" and "Rules & Policies" are often used to remind or control people, not necessarily to fix systems. Therefore, they should be used primarily to support more effective recommendations that are designed to fix systems.[9]
- "Education & Information" is an important strategy when it is combined with other approaches that strengthen the system.[9]

Although all the listed actions can play important roles in error prevention, it is recommended to select the

TABLE 2: THEMES FROM THE MULTI-INCIDENT ANALYSIS *(Continued)*

THEME 3: TECHNOLOGICAL FACTORS

Technological factors are related to the use of pharmacy computer systems, such as copying prescriptions and scanning barcodes.

INCIDENT EXAMPLE	POSSIBLE CONTRIBUTING FACTORS	COMMENTARY
A patient took Tri-Cyclen® LO before and received a new prescription from the doctor for Tri-Cyclen®. The pharmacy staff member copied from previous prescription on patient's profile and filled as Tri-Cyclen® LO. The patient noticed the medication package was the same as before and was anticipating a change. The patient returned to the pharmacy before she took the pills.	• *Confirmation bias* • *Copying previous prescriptions* • *Lack of independent double checks*	The copy functionality is available in all pharmacy software systems to enhance pharmacy workflow. In order to prevent confirmation bias, policies may be considered within the pharmacy to limit the process of copying from previous prescriptions (where applicable). The inputted prescription information should be verified against the original prescriber-generated prescription order. When providing medication counselling, pharmacists should encourage patients/caregivers to actively participate in the conversation (e.g. confirm the appearance of the medication, discuss the use, and verify indication and appropriate technique for administration of the medication, etc.)[1]
A patient called the pharmacy to refill Zopiclone; however, the technician refilled the existing prescription for Zoloft® (Sertraline). When the patient got home, she realized that she got the wrong medication.	• *Confirmation bias* • *Lack of independent double checks*	Independent double checks should be performed throughout the entire pharmacy workflow.[5] For verbal prescriptions, order takers should be able to increase the source volume or have quiet areas to take orders. Spoken communication of drug names can be made safer by reading-back, spelling out the name, providing the indication for the drug or using both brand and generic names.[7] Alternatively, encourage patients to use Prescription Numbers when ordering refills over the phone. Independent double checks should be performed throughout the entire pharmacy workflow.[5]

most effective solutions that are designed to develop system-based improvements.

CONCLUSION

Look-alike/sound-alike drug names continue to be an inevitable issue that often lead to negative impacts on patient safety. A multifactorial approach is essential to overcome the threats to patient safety from look-alike/sound-alike drugs names as seen in Table 3. Everyone in healthcare has a role in reducing medication errors. The benefits of empowering and encouraging consumers to ask questions about their medications should not be underestimated as patients play a key role in advancing safe medication practices. The results of this multi-incident analysis are intended to educate health care professionals about the vulnerabilities within our healthcare

TABLE 2: THEMES FROM THE MULTI-INCIDENT ANALYSIS *(Continued)*

THEME 4: UNIQUE FACTORS

Unique factors are special characteristics pertaining to look-alike/sound-alike drug pairs themselves, such as similar dose, similar indication, same ingredients available in multiple formulations, etc.

INCIDENT EXAMPLE	POSSIBLE CONTRIBUTING FACTORS	COMMENTARY
The prescription was written for Hydrocortisone 1% ointment; however, Hydrocortisone 1% cream was dispensed.	• *The look-alike/sound-alike drug pairs has similar or same therapeutic indications*	Warning flags should be incorporated into the pharmacy computer systems to alert for potential mix-up during drug selection.[3]
A patient was prescribed Carbamazepine CR 200mg; but Carbamazepine 200mg was dispensed.	• *The look-alike/sound-alike drug pair is available in similar or same strength*	Auxiliary alerts should be placed on medication storage bins or shelves, where look-alike/sound-alike drugs are potentially stored.[1]
A pharmacist dispensed Advair® 250 Diskus instead of Advair® 250. The second pharmacist noticed the error and corrected it before giving to the patient.	• *The same active ingredient is available in multiple formulations* • *Lack of independent double checks*	Independent double checks should be performed throughout the entire pharmacy workflow.[5]

system. Additionally, community pharmacists can mitigate and prevent the likelihood of negative outcomes from occurring through understanding the common themes as seen in Table 2 and implementing safeguards within practice settings. The following is a list of online resources that may be helpful for pharmacies with respect to differentiating look-alike/sound-alike drug names.

Canadian Resources for Differentiation of Look-alike/Sound-Alike Drug Names:

Visual Differentiation in Look-alike Medication Names (Canadian Patient Safety Institute (CPSI))
http://www.patientsafetyinstitute.ca/English/research/cpsiResearchCompetitions/2008/Documents/Gabriele/Report/Visual%20Differentiation%20in%20Look-alike%20Medication%20Names%20-%20Full%20Report.pdf

Look-Alike/Sound-Alike Drug Names: Can We Do Better in Canada? (ISMP Canada)
http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2004-02DrugNames.pdf

U.S. Resources for Differentiation of Look-Alike/Sound-Alike Drug Names:

Separate Drugs That Look or Sound Alike (Institute for Healthcare Improvement (IHI))
http://www.ihi.org/resources/Pages/Changes/SeparateDrugsthatLookorSoundAlike.aspx

ISMP's List of Confused Drug Names (ISMP US)
https://www.ismp.org/tools/confuseddrugnames.pdf

FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters (ISMP US)
https://www.ismp.org/tools/tallmanletters.pdf

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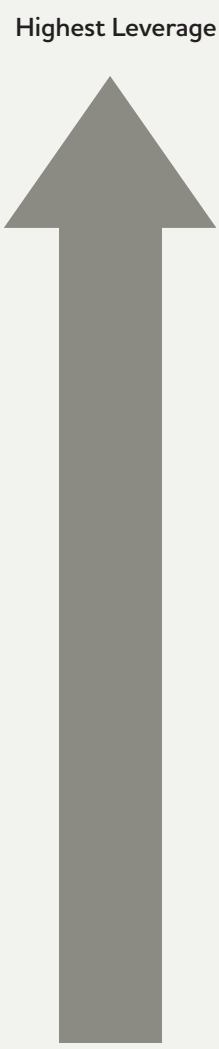
TABLE 3: HIERARCHY OF EFFECTIVENESS IN PREVENTING MEDICATION INCIDENTS INVOLVING LOOK-ALIKE/SOUND-ALIKE DRUG NAMES[8, 9]

SUMMARY OF RECOMMENDATIONS	HIERARCHY OF EFFECTIVENESS CATEGORIES
• Include both generic and brand names in pharmacy order entry system • Use standardized pre-printed order forms	Simplification / Standardization
• Incorporate warning flags into pharmacy computer systems to alert for look-alike/sound-alike drug names • Place auxiliary alerts on medication storage bins or shelves, where look-alike/sound-alike drug pairs are potentially stored • Perform independent double checks • Verify all verbal orders by repeating it back, spelling out the drug names, providing the indication of the drug to the caller	Reminders, Checklists, Double checks
• Include indications for each medication on the prescription • The copy functionality is available in all pharmacy software systems to enhance pharmacy workflow. Limit the process of copying from previous prescriptions (where applicable). The inputted prescription information should be verified against the original prescriber-generated prescription order. • Store look-alike/sound-alike drug pairs in different locations	Rules & Policies
• Highlight the importance of look-alike/sound-alike drug names as part of pharmacy staff trainings and internal communication	Education & Information



References

1. Ciociano N, Bagnasco L. Look alike/sound alike drugs: a literature review on causes and solutions. Int J Clin Pharm. 2014; 36(2):233-242.
2. Rataboli PV, Garg A. Confusing brand names: nightmare of medical profession. J Postgrad Med. 2005; 51(1):13-16.
3. ISMP Canada. Look-alike/sound-alike drug names: Can we do better in Canada? ISMP Canada Safety Bulletin 2004; 4(2):1-2. Available from: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2004-02DrugNames.pdf
4. Ho C, Hung P, Lee G, Kadija M. Community pharmacy incident reporting: A new tool for community pharmacies in Canada. Healthcare Quarterly. 2010; 13:16-24. Available from: http://www.ismp-canada.org/download/HealthcareQuarterly/HQ2010V13SP16.pdf
5. ISMP Canada. Lowering the risk of medication errors: Independent double checks. ISMP Canada Safety Bulletin 2005; 5(1):1-2. Available from: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2005-01.pdf
6. ISMP Canada. Risk of mix-ups between Ephedrine and Epinephrine. ISMP Canada Safety Bulletin 2007; 7(2):1-2. Available from: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2007-02Ephedrine.pdf
7. Lambert BL, Dickey LW, Fisher WM, et al. Listen carefully: the risk of error in spoken medication orders. Soc Sci Med. 2010; 70(10):1599-1608.
8. Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012. Available from: http://www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF
9. Grissinger M. Medication error-prevention "toolbox". P&T. 2003; 28(5):298. Available from: http://www.ptcommunity.com/ptjournal/fulltext/28/5/PTJ2805298.pdf

2013 Annual Report

The College publishes its Annual Report each March. The report includes audited financial information and statistics on pharmacists, pharmacy technicians, pharmacies and OCP programs. The following page includes highlights from the 2013 Annual Report. For more — including detailed financial information — go to www.ocpinfo.com/library and select Annual Reports.

Total number of pharmacists: 13,881

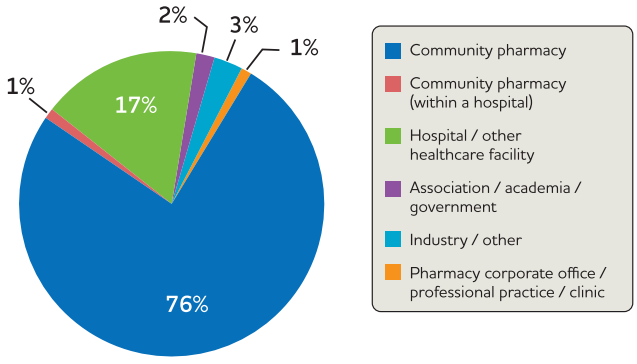
Average age of pharmacist: 45

Total number of pharmacy technicians: 1,826

Average age of pharmacy technician: 39

Pharmacists by Employment Type

As of Dec. 31, 2013

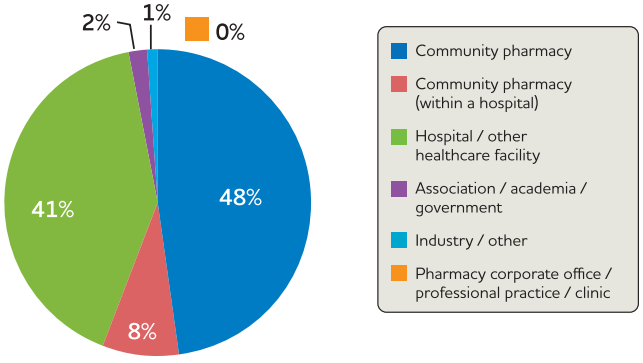


Note: Chart excludes pharmacists who did not record a workplace

All practitioners are required to notify the College of their primary place of employment each year.

Pharmacy Technicians by Employment Type

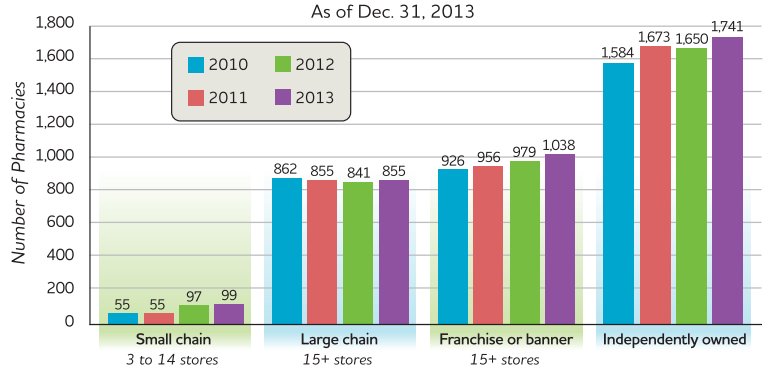
As of Dec. 31, 2013



Note: Chart excludes pharmacy technicians who did not record a workplace

Accredited Community Pharmacies by Type

As of Dec. 31, 2013

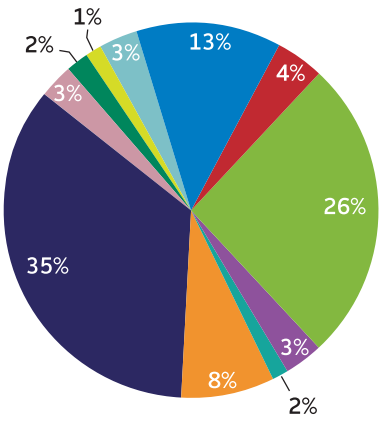


As of Dec. 31, 2013 there were 3,733 accredited community pharmacies in Ontario.

Complaint Issues

Jan.1 – Dec. 31, 2013

Of the complaints considered by the ICRC this year, 35 per cent were related to the provision of professional services. This included problems with communication or issues concerning counseling a patient, performing MedsChecks, or ending the pharmacist-patient relationship.



Billing Irregularities	27	Professional Service	75
Confidentiality	9	Records	6
Dispensing Error	56	Reduction of Quantity	4
Expired Product	7	Restriction of Choice	3
Labelling Error	3	Unauthorized Prescriptions	7
Miscellaneous	17		

UNIVERSAL INFLUENZA IMMUNIZATION PROGRAM

As the 2013-2014 flu season comes to an end and we prepare for the third year of pharmacists' involvement in the Universal Influenza Immunization Program (UIIP), it's clear that pharmacists have stepped up to help stop the spread of influenza in Ontario.

More than 750,000 Ontarians visited a community pharmacy and received their flu shot from a certified pharmacist during the 2013-2014 flu season.

The uptake is clear – more pharmacies are participating, more pharmacists are trained and more patients are getting their flu shot from a pharmacist.

As per the *Pharmacy Act*, pharmacists may only administer the influenza vaccine within the context of Ontario's UIIP.

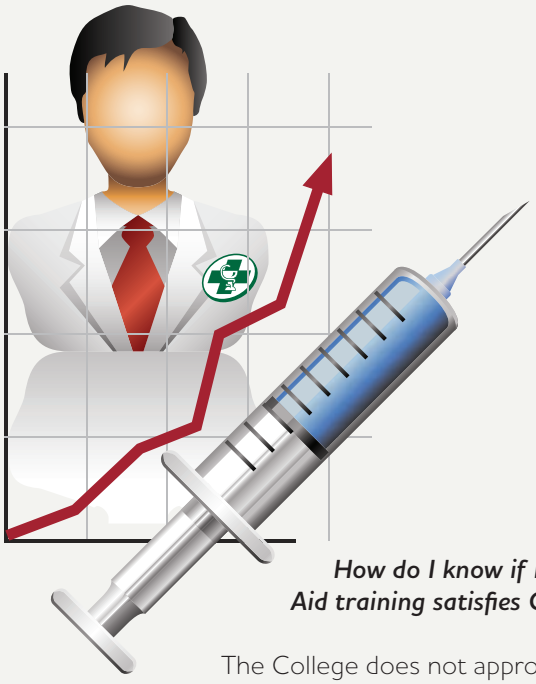
In order to participate in the UIIP pharmacists must complete an OCP-approved injection training course and register their training with the College.

Apply Soon to Participate in the 2014-2015 UIIP

Information and applications for participation in the 2014-2015 UIIP are available on the Ministry of Health and Long-Term Care's website at www.health.gov.on.ca/en/pro/programs/publichealth/flu/

Note: Newly accredited pharmacies who receive their OCP Accreditation Number between July 1, 2014 and October 15, 2014 will have a separate application process. The ministry will send information directly to these newly accredited pharmacies.

2012-2013	2013-2014
First year pharmacies participated in the UIIP	**Second year pharmacies participated in the UIIP**
600 pharmacies participated	**2,000** pharmacies participated
2,500 pharmacists trained and registered to administer injections	**6,000** pharmacists trained and registered to administer injections
250,000 flu shots administered to Ontarians	**750,000** flu shots administered to Ontarians



FREQUENTLY ASKED QUESTIONS

Here are some of the common questions we heard over the last UIIP season. Please consider these as your pharmacy plans for the 2014-2015 influenza immunization season.

What training do I need to have in order to administer injections?

Prior to administering injections in Ontario, pharmacists must successfully complete an OCP approved course for pharmacist injection training and have and maintain valid certification in CPR and First Aid (the equivalent of the Red Cross Standard First Aid with CPR "C" + AED Course level). Once all of these requirements are complete, pharmacists must declare this training by registering with the College. Visit the continuing education section at www.ocpinfo.com for more information on OCP-approved injection courses and to register your training

Do graduates from the University of Waterloo and the University or Toronto receive this injection training as part of their curriculum?

Graduates of the University of Waterloo (2012 onward) and graduates of the University of Toronto (2013 onward) will have received the appropriate injection training as part of their curriculum. They also need to have valid CPR and First Aid (the equivalent of the Red Cross Standard First Aid with CPR "C" + AED Course level) before registering their training with the College.

How do I know if my level of CPR and First Aid training satisfies College requirements?

The College does not approve of or specify any particular CPR or First Aid course. The only requirement is that the training taken is equivalent of the Red Cross Standard First Aid with CPR "C" + AED Course level. It is the responsibility of the pharmacist to determine if the course taken is equivalent. Pharmacists are encouraged to contact the company or course coordinator directly for assurance of equivalence prior to course completion.

Can a pharmacy intern or registered pharmacy student administer the influenza vaccine?

No. The legal authority to administer to administer the influenza vaccine is limited to Part A pharmacists only. As per regulations made under the Pharmacy Act only a "...Part A pharmacist is authorized to administer influenza vaccine by injection to a patient who is five years of age or older, if the Part A pharmacist...administers the vaccine in accordance with Ontario's Universal Influenza Immunization Program...". [2]

Am I required to purchase additional personal professional liability insurance if I participate in Ontario's UIIP?

In accordance with Article II, section 2.2 of College By-Law, all members engaged in the practice of pharmacy, including Students, Interns, Pharmacists and Pharmacy Technicians, are required to maintain personal professional liability insurance coverage. In order for the product you purchase to meet the

college requirement, the insured services of the mandated professional liability product will need to incorporate professional services in the practice of pharmacy as regulated by OCP. Therefore, as long as you are acting within the scope of the pharmacy profession as deemed by the OCP you will have coverage under your policy. Please consult with your insurance broker to ensure the definition of insured services complies with the OCP by-law.[3]

What considerations are required when choosing an appropriate location to administer the influenza vaccine?

When administering the influenza vaccine pharmacists must ensure they provide an environment that is clean, safe, private and comfortable for the patient.[4]

I have patients that would prefer an intranasal influenza vaccine. Pursuant to a prescription and in exercising expanded scope of practice for pharmacists, can I administer an intranasal influenza vaccine?

No. As per the expanded scope of practice regulations members may only administer by inhalation listed drug products[5] for the purpose of patient education and demonstration. Intranasal vaccines are not listed in Table 2 to the regulation and providing immunization does not meet the criteria of education or demonstration.

Where can I find more information about the UIIP and administering injections?

Additional resources for questions about the UIIP include:

- The Ministry of Health and Long-Term Care
  - o UIIP User Agreement
  - o Question and answer documents
- The Ontario Pharmacists Association
  - o Online tools and forms
- The College Practice Tools page on Administering Injections

For more frequently asked questions about administering injections visit www.ocpinfo.com/practice-education/practice-tools/faqs/

1 Available at https://www.opatoday.com/professional/resources/for-pharmacists/tools-and-forms/uiip

2 Ontario Regulation 202/94 made under the Pharmacy Act, 1991. Section 34(4)

3 OCP FAQ on Personal Professional Liability Insurance. Retrieved at http://www.ocpinfo.com/regulations-standards/policies-guidelines/prof-liability-insurance/

4 Ontario Regulation 202/94 made under the Pharmacy Act, 1991. Section 34(3)

5 Ontario Regulation 202/94 made under the Pharmacy Act, 1991. Table 2.

Members Emeritus

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

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

Professionalism and Ethical Decision Making

A revised Professional Misconduct Regulation was reviewed and approved by Council in December 2013 and subsequently submitted to the Ministry where it is awaiting final approval and enactment. The proposed regulation outlines the College's expectations for members in practice. Regulation sets the legal framework for professional practice, but it is only meaningful in conjunction with the requirement for accepted skills, knowledge and judgment, and in the context of professional responsibility, codes of ethics and standards of practice.

Professionalism has been described as "a set of attitudes, skills and behaviours, attributes and values, which are expected from those to whom society has extended the privilege of being considered a professional".[1] Professionalism incorporates both character and behaviour.[2] The Principles of Professional Responsibility, Code of Ethics and Standards of Practice adopted by the College guide a member's behaviour when interacting with colleagues, other healthcare professionals, and patients.

While the Principles of Professional Responsibility, Code of Ethics and Standards of Practice provide a blueprint for what is considered professional behaviour and practice, good character is a trait that needs to be continuously developed and refined. Good character is the "grey" area of professionalism, and is a quality which members are expected to bring to clinical decision-making. When faced with difficult situations a member must always act with professionalism and use the resources discussed above to make decisions that reflect good character.

PRINCIPLES OF PROFESSIONAL RESPONSIBILITY

Principles are fundamental propositions that serve as the foundation for a system of behaviour.[3] To ensure patient safety and the best patient outcomes a member must exercise all of his or her responsibilities, even when he or she is not working in a traditional pharmacy setting. The Principles of Professional Responsibility collectively articulate and are foundational to a member's professional responsibility. When making decisions a member must reflect on these principles to ensure he or she is thinking about his or her responsibility in delivering care within the broad context of the healthcare system during the decision-making process. Integration of these principles into the decision-making process will support members in being engaged, responsible and accountable as a part of a larger system of care than just the immediate task at hand.

CODE OF ETHICS

Ethics refer to the principles of conduct governing an individual or a group.[4] The purpose of an ethical code is to describe a general approach for the provision of care within a moral environment.[5] The Code of Ethics provides members with principles for ethical decision-making and outlines the Colleges' expectations regarding members' behaviour. The Code of Ethics provides principles that can be applied in relation to any situation that poses an ethical dilemma or conflict of interest. The ability to identify and apply these principles is one of many factors that ensure decisions reflect principled pharmacy practice. The Code of Ethics is not prescriptive and is meant to aide members in making ethical decisions; application of the Code of Ethics is the responsibility of individual members. There are no 'right' or 'wrong' solutions when confronting an ethical dilemma or conflict of interest, a member must uniquely consider each situation, given the relevant facts, to determine the best approach to achieve the outcome that serves the patient's best interest.

STANDARDS OF PRACTICE

Standards of Practice (SOP) outline essential competencies that define the profession and the generally accepted minimum level of practice for the profession. The purpose

of the standards of practice are to distinguish the minimal accepted practice against which a members' performance can be evaluated when undertaking the activities required for safe and effective pharmacy practice.[6] The standards define the levels of proficiency for members and help members assess their practice relative to the expectations of peers, colleagues and the profession as a whole. Standards provide a guide to the knowledge, skills, judgment and attitudes members should apply to their practice to provide patients with safe and ethical care. When faced with an ethical dilemma or conflict of interest, a member should consider if there are SOP that apply to the situation.

THE SOP FOR PHARMACISTS USE FOUR BROAD DOMAINS TO CATEGORIZE PRACTICE;

- Expertise in medications and medication-use
- Collaboration
- Safety and Quality
- Professionalism and Ethics

The SOP for pharmacy technicians are identical except for the first domain where 'Expertise in drug distribution systems' replaces 'Expertise in medications and medication use'. The first two domains outline expectations with respect to central responsibilities for members, the latter two domains refer to critical attributes required to support successful delivery of practice.

STEPS FOR ETHICAL DECISION MAKING

When evaluating options it is important to keep in mind that there is not one correct option to resolve an issue. The best option for the patient depends on many factors including: the patient's treatment history and conditions; the prescription history; the patient's current condition; and the pharmacist's knowledge and skill. A member needs to apply his or her professional judgment to determine which option is in the best interest of the patient in each individual circumstance.

The framework below can be used to assist a member in assessing a situation that poses a ethical dilemma or conflict of interest.

1. Recognize and describe the ethical issue.

a) What is the underlying issue?
b) What are the facts of the situation?
c) Identify the principles related to the situation.
d) Reflect to recognize your motives and ensure they do not influence your decision.
e) Consider if you need further information or clarification.

The following example provides an illustration of how to apply the Steps for Ethical Decision-Making.

The parents of an adult child, age 23 years, who are long-time patients at your pharmacy, come to you with concerns that they are unable to obtain information regarding their daughter and that they are worried about her. She is being treated for diabetes mellitus and chronic pain secondary to injuries sustained in a motor vehicle accident two years previously. The parents have noticed their daughter has become increasingly withdrawn, moody and secretive and that her personality has changed. You have recently spoken to their daughter when she was picking up a new prescription for an antidepressant and she confided in you that she has been feeling very depressed since the accident. You are not sure if her physician is aware of the extent of the recent changes to her mood. They have asked you to provide them with a list of her current medications and any information you may have about her current condition.

1. Recognize and describe the ethical issue.

In this scenario the pharmacist has known the patient's parents for a long period of time and needs to determine what information, if any, he can provide regarding their daughters current therapy. Members are required to preserve the confidentiality of patient information and not divulge this information except where authorized by the patient, required by law, or where there is a compelling need to share information in order to protect the patient or another person from harm.

2. Identify information required to assist in developing options

A member is not able to disclose personal health information without the consent of the patient except under specific circumstances outlined in the *Regulated Health Professions Act, 1991*, which includes if there are reasonable grounds that disclosure is necessary to prevent risk of harm to the patient or public.[1] A member is required to use his or her professional judgment to assess whether the patient poses a risk to herself or others and determine who should be notified of his or her concerns for the patient's well-being. The pharmacist does not have reason to believe the patient is at risk of harming herself or others at this time.

2. Identify information required to assist in developing options.

a) Is there any relevant legislation, policies, standards or guidelines, literature, research or best practice?
b) Consult with colleagues.
c) Have a discussion with the patient to get an understanding of the patient's expectations.
d) Members must provide patients with the information required to make an informed decision.

3. Identify the best options based on facts and professional judgment

a) Apply the principles and take into account any legislation, regulation, standard, guideline, or policy that applies.
b) Consider the outcome that would provide the best solution for the patient giving consideration to the patient's wants and needs.
c) What would be the possible consequence of each option?
d) Use professional judgment to assess the options and document all options considered.

4. Choose the best option

a) How would I feel if I was the patient in this situation?
b) How would I feel if my actions were made public or presented to colleagues?
c) What would happen if all practitioners did this?
d) Could I explain how my solution best benefits the patient?

5. Implement and reflect on your choice

a) Document your rationale.
b) Notify other healthcare professionals if applicable.

The Principles of Professional Responsibility, Code of Ethics and Standards of Practice are tools that help members to make ethical decisions but are not unto themselves the answer and must all be considered in conjunction with the current practice environment. A member must reflect on his or her obligations as a healthcare provider when making decisions and use these tools to guide the decision-making process.

1. uOttawa Faculty of Medicine. Professionalism "About Professionalism". Accessed at http://www.med.uottawa.ca/students/md/professionalism/eng/about.html January 9, 2014
2. Eisele, David. Professionalism: Why it Should Matter to Us. Presidential Address at 2011 American Head and Neck Society Annual Meeting. Accessed at http://www.ajustnhs.com/wp-content/uploads/2012/06/professionalism-2011.pdf November 26, 2013
3. Oxford Dictionary. Definition of Principle.
4. Merriam-Webster. Definition of Ethics.
5. Alexander E. Limentani. An ethical code for everybody in health care. BMJ. 1998;v.316(7142):1458. Accessed at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113129/ November 14, 2013.
6. National Association of Pharmacy Regulatory Authorities. Model Standards of Practice for Canadian Pharmacists.

3. Identify the best options based on facts and professional judgment

Potential options may include:

a) Provide the parents with the requested information as you have a longstanding relationship with them, do not want them to feel worried about their daughter, and do not want them to be upset with you.

b) Inform the parents that you cannot provide information about their daughter's therapy and refer them to speak to her physician about their observations.

c) Inform the parents that you cannot provide information about their daughter's therapy but assure them you will speak to her to assess her current condition. Privately call the patient to follow-up on her antidepressant therapy and also follow-up with the patient's physician to ensure that he or she is aware of the information provided by the parents.

4. Choose the best option

Of the potential options outlined above, the most appropriate option in this particular case – since the pharmacist does not currently have reason to believe that the patient is at risk of harming herself or others – would be option c. This option preserves patient confidentiality and allows the pharmacist to open dialogue with the patient to further assess the situation, while ensuring the patient's physician is aware of the important information provided by her parents. If the pharmacist had chosen option a he would have violated patient confidentiality which is integral to the pharmacist-patient relationship. Choosing to do nothing as in option b would have maintained patient confidentiality, but the pharmacist would not have exercised his professional practice responsibilities and would not have demonstrated patient-centered care.

5. Implement and reflect on your choice

After calling the patient and her physician the pharmacist would document the dialogue in the patient record.

1. RHAP, 1991 s.36(1)

DISCIPLINE DECISIONS

42

Member: Sameh Guirguis

At a hearing on February 13, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Guirguis in that he

- created a misleading and/or inaccurate dispensing record by backdating dispensing records to a date different than the date on which the records were created, without appropriately documenting that fact;
- dispensed drugs pursuant to a prescription without ensuring the information prescribed by s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, was recorded on the container on which the drugs were dispensed;
- dispensed different drugs than those authorized by the prescriber, contrary to s. 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and s. G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, made under the Food and Drugs Act, R.S.C. 1985, c. F-27;
- dispensed Schedule 1 drugs in quantity greater than that authorized by the prescriber, contrary to s. 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and s. G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, made under the Food and Drugs Act, R.S.C. 1985, c. F-27;
- dispensed drugs pursuant to a prescription while incorrectly recording the quantity and/or strength of the drug dispensed, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed drugs pursuant to a prescription while incorrectly recording the date on which the drug was dispensed to the patient, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- refilled a prescription for a controlled drug for patient L.P. when the prescriber did not indicate the dates for or the intervals between refills, contrary to s. G.03.006 of the Food and Drug Regulations, C.R.C., c. 870, made under the Food and Drugs Act, R.S.C. 1985, c. F-27, on or about November 12, 2011.

In particular, the Panel found that Mr. Guirguis

- failed to maintain a standard of practice of the profession;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included the following:

1. A reprimand;
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:

   (a) that the Member complete successfully, at his own expense, within 12 months of the date of the Order, the following course and evaluation:
   (i) CPS I Module 5 (Professional Practice & Pharmacy Management 1) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
   (b) that the Member shall be prohibited from acting as a Designated Manager in any pharmacy until the later of:
   (i) a period of 12 months from the date of the Order, and
   (ii) the date the College is notified that the Member has successfully completed the course and evaluation set out in paragraph 2(a)(i) above;

(c) that the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College in such number and at such time or times as the College may determine, for a period of 12 months beginning 12 months from the date of the Order and continuing until 24 months from the date of the Order. The Member shall cooperate with the College during the inspections and, further, shall pay to the College in respect of the cost of monitoring, the amount of $600.00 per inspection to a maximum of 4 inspections, such amount to be paid immediately after completion of each of the inspections.

3. A suspension of two months, with one month of the suspension to be remitted on condition that the Member completes the remedial training. The suspension commenced on February 13, 2014 and continued until March 12, 2014, inclusive.
4. Costs to the College in the amount of $2,000.

In its reprimand to the Member, the Panel asked the Member to remember that, as a pharmacist, he was a member of a self-governing profession and that self-regulation is a privilege. The Panel noted that the Member's actions had jeopardized public trust and safety, and that the Panel was hopeful the Member would learn from the courses he has been ordered to take.

Member: Ngu Hoa

At hearing on March 20, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Hoa in that, from on or about May 8, 2007 to on or about May 7, 2009, while engaged in the practice of pharmacy as director, shareholder, Designated Manager and/or dispensing pharmacist at Nhatrang Pharmacy in Toronto, Ontario, he

- submitted accounts or charges for services that he knew were false or misleading to the Ontario Drug Benefit Program for one or more drugs and/or products; and/or
- falsified pharmacy records relating to his practice in relation to claims made to the Ontario Drug Benefit Program for one or more drugs and/or products.

In particular, he was found to have

- failed to maintain a standard of practice of the profession;
- falsified records relating to his practice;
- submitted accounts or charges for services that he knew to be false or misleading;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular sections 5 and 15(b) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder;
- engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

At the hearing on March 20th, Mr. Hoa acknowledged that he submitted false and misleading claims for payment to the Ontario Drug Benefit Program in the amount of $65,682.08 for drugs or products that were never obtained from suppliers or dispensed to patients.

The Panel imposed an Order which included the following:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   a. that the Member complete successfully, at his own expense, within 12 months of the date of the Panel's Order, the ProBE Program – Professional/Problem Based Ethics, offered by the Centre for Personalized Education for Physicians, or an equivalent program acceptable to the College;
   b. that the Member shall be prohibited, for a period of 3 years from the date the Order of the Discipline Committee is imposed, from acting as a Designated Manager in any pharmacy;
   c. that the Member shall be required, for a period of three years from the date the Order is imposed, to provide to the Manager of Investigations and Resolutions or any representative of the College assigned to conduct an inspection pursuant to the Order, forthwith when requested any records requested by the College in relation to sales of any drugs or products by the Pharmacy, including but not limited to electronic sales reports and records, records of billings to insurers, drug usage reports;
   d. that the Member shall be required, for a period of three years from the date the Order is imposed, to provide to the Manager of Investigations and Resolutions or any representative of the College assigned to conduct an inspection pursuant to the Order, forthwith

when requested any records requested by the College in relation to purchases of any drugs or products by the Pharmacy, including but not limited to purchase invoices, manufacturer/wholesaler reports, electronic purchase reports, summary of purchases;

e. that the Member shall be required, in addition to any requirements imposed by statute or regulation to retain records, to retain all purchase and sales records in relation to the Pharmacy so that they are available to be provided to the Manager of Investigations and Resolutions or any representative of the College assigned to conduct an inspection, as provided for in the Order for a period of three years from the date the Order is imposed;

f. that the Member's practice, and all activities at his pharmacy will be monitored by the College for a period of 3 years from the date the Order is imposed by means of inspections by a representative of the College at such times as the College may determine. The monitoring inspections may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. The Member shall cooperate fully with the College during the inspections, and, further, shall pay to the College in respect of such monitoring the amount of $650.00 per inspection, such amount to be paid immediately after each inspection, with the total amount paid by the Member not to exceed $3,900.00, regardless of the number of inspections;

g. that the Member shall be required, for a period of three years from the date the Order is imposed by the Discipline Committee to notify the College in writing of any employment in a pharmacy;

h. that the Member, for a period of three years from the date the Order is imposed by the Discipline Committee, if he is employed at a pharmacy shall ensure that his employer has confirmed in writing to the College that they have received and reviewed a copy of the Discipline Committee Panel's decision in this matter and their Order, and confirming the nature of the Member's remuneration.

3. A suspension of 10 months, with one month of the suspension to be remitted on condition that the Member completes the remedial training. The suspension commenced on March 20, 2014 and continues until December 19, 2014, inclusive.
4. Costs to the College in the amount of $12,000.

In its public reprimand to the Member, the Panel reminded the Member he is part of a self regulated profession and as such has a responsibility to serve the public, as well as uphold the confidence and trust of the public. The Panel observed that the Member had disregarded the ethical standards of the profession. The Panel stated that it hopes the monitoring requirements and education would assist the Member in becoming a better pharmacist.

Member: Atossa Babaie-Nami

At a hearing on April 1, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Babaie-Nami in that she

- failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping and documentation, and billing the Ontario Drug Benefit Plan; and/or
- failed to actively and effectively participate in the day-to-day management of the Pharmacy, including, but not limited to drug procurement and inventory management, record keeping and documentation, and billing.

In particular, she was found to have

- failed to maintain a standard of practice of the profession;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, sections 5, 6 and 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c 0.10, and sections 25 and 27 of Regulation 201/96 under the Ontario Drug Benefit Act;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order as follows:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or

limitations on the Member's Certificate of Registration, and in particular:

a. that by April 1, 2015, the Member successfully complete at her own expense the ProBE Program on professional/problem-based ethics for health care professionals;
b. that, for the three year period following April 1, 2014, the Member:
   i. shall be prohibited from having any proprietary interest in a pharmacy of any kind;
   ii. shall be prohibited from acting as a Designated Manager in any pharmacy;
   iii. shall be prohibited from receiving any remuneration for her work as a pharmacist other than remuneration based only on hourly or weekly rates, and not on the basis of any incentive or bonus for prescription sales; and
   iv. must notify the College in writing of any employment in a pharmacy.

3. A suspension of 6 months, with one month of the suspension to be remitted on condition that the Member completes the remedial training. The suspension commenced on April 1, 2014 and continues until September 1, 2014, inclusive.
4. Costs to the College in the amount of $6,500.

In its reprimand to the Member, the Panel reminded the Member that integrity and trust is paramount in the profession of pharmacy. The Panel expressed disappointment in the Member's conduct, underscoring for the Member that the fact she had not financially benefited from her conduct did not mean she was free to abrogate her duties as a Designated Manager. The Panel found the Member's actions to be dishonourable, disgraceful and conduct unbecoming of a pharmacist, and furthermore, that her conduct had had a detrimental impact on the profession's relationship with the public. The Panel cited its expectation that the Member would learn from this process and work to regain the trust of others that had been diminished through her actions.

Member: Ut Phan

On April 8, 2014, the College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Ms. Phan. The allegations are as follows:

- she submitted accounts or charges for services that she knew were false or misleading to the Ontario Drug Benefit program for one or more drugs and/or products;
- she falsified pharmacy records relating to her practice in relation to claims made to the Ontario Drug Benefit program for one or more drugs and/or products

In particular, it is alleged that she

- failed to maintain a standard of practice of the profession;
- falsified records relating to her practice;
- submitted accounts or charges for services that she knew to be false or misleading;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular sections 5 and 15(b) of the Ontario Drug Benefit Act, R.S.O. 1990, c. 0.10, as amended, and/or Ontario Regulation 201/96 made thereunder;
- engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regarding to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional

The College brought the motion before the Discipline Committee in light of the fact Ms. Phan entered into an Undertaking, Agreement and Acknowledgment with the College whereby she resigned permanently as a member of the College, irrevocably surrendered his Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario.

Accordingly, the parties made a joint submission to the Discipline Committee to issue an Order for a stay of the allegations of professional misconduct against Ms. Phan. On the basis of the Undertaking, Agreement and Acknowledgment Ms. Phan entered into with the College, the Discipline Committee accepted the joint submission of the parties and issued an Order staying the allegations of professional misconduct against Ms. Phan.

The full text of these decisions is available at www.canlii.org
CanLii is a non-profit organization managed by the Federation of Law Societies of Canada. CanLii's goal is to make Canadian law accessible for free on the Internet.

BULLETIN BOARD

E-CONNECT: A VALUABLE COMMUNICATIONS TOOL

Launched in January 2014, e-Connect is the College's first e-newsletter and the official method of communication to pharmacists and pharmacy technicians registered with the College.

Designed to keep members up-to-date with College news, e-Connect introduced a new way for the College to quickly share important information and resources to over 20,000 subscribers.

One of the main advantages of e-Connect is its mobile-friendly feature, which allows us to send news and updates directly to your inbox, whether you're at work, home or on the go.

And according to our statistics, e-Connect is a popular and well-received tool that's engaging our members. Over 55 per cent of subscribers are reading articles and accessing links while on the go – primarily from smartphones and tablets. We will continue to use e-Connect to share information

on regulatory and practice issues, tips and tools to enhance standards of practice, key responsibilities and any changes to legislation, regulations, by-laws and more.

Stay subscribed to e-Connect for important information from the College that's useful to you. And if you've missed an issue or looking to catch up on previous news, you can browse through e-Connect archives on the College website.

PRACTICE EVOLUTION — OPA CONFERENCE 2014

Hundreds of pharmacy professionals will gather at the Scotiabank Convention Centre in Niagara Falls from June 19-21 for the Ontario Pharmacists Association's annual conference.

Conference 2014 is focused on the evolution of the profession of pharmacy and the role of the pharmacist. In order to succeed, one must learn and evolve along with the changing times. The conference will equip participants with the knowledge and tools they need to succeed in the changing pharmacy landscape and ensure they have the greatest impact possible.

Be sure to visit the College's booth in the Exhibit Hall – open from 1p.m. to 7:30p.m. on Friday.

June 19-21, 2014
Scotiabank Convention Centre
Niagara Falls, Ontario
Visit www.opatoday.com to register

OCP"S NEW WEBSITE

Unveiled in January 2014, the College's newly re-designed website offers new navigation and fresh content that is tailored for each user. Our main visitors — College members, applicants and members of the general public — can access the information they need on pages that were specially designed for them.

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

Approximately 200,000 users have visited the College's website since its launch earlier this year and the College has heard a good number of positive comments from members, applicants and the public.

FOCUS ON
ERROR PREVENTION

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

VACCINES

To obtain the optimal benefit of vaccine administration, patients must receive the correct vaccine, at the correct dosage and at the correct time and interval. The variety of vaccines and dosing schedules available can be confusing and may lead to administration errors. Pharmacists can play a key role in preventing errors associated with vaccine administration.

CASE 1:

Rx
Havrix® 0.5ml
Sig: As directed
Mitte: 1 vial

The above Havrix® vaccine was prescribed for a twenty-one year old patient. Havrix® 1440 (Adult) contains 1ml of a sterile suspension containing formaldehyde-inactivated hepatitis A virus adsorbed onto aluminum hydroxide, while Havrix® 720 Junior contains 0.5ml of the same sterile suspension[1].

The above prescription as written therefore requires that Havrix® 720 Junior be dispensed. Since the patient is twenty-one year old, a call was made to the prescriber to confirm his intent. The physician confirmed that his intention was to prescribe the **1ml** Havrix® 1440 product. He apologized for the prescribing error.

CASE 2:

Rx
Twinrix®
Sig: As directed
Mitte: 1 vial

The above Twinrix® vaccine was prescribed for a ten year old child. The standard dosage for patients aged one to eighteen years old is Twinrix® **Junior** at 0, 1 and 6 months[2]. The pharmacist therefore assumed that the prescriber intended to prescribe Twinrix® Junior. The Twinrix® Junior vaccine was therefore prepared and dispensed.

While counselling the child's mother on the administration and dosing schedule of the vaccine, the pharmacist explained that the child will require two additional doses at the one month and six month interval. However, the mother explained that the physician informed her that the child will require only two doses and not three.

A call was therefore made to the prescriber to clarify his intention and to confirm that the prescription was for Twinrix®. The physician indicated that he did indeed intend to prescribe Twinrix® (Adult) for the ten year old patient.

He explained that he chose the alternate dosing schedule which includes only two Twinrix® (Adult) doses instead of the standard three Twinrix® Junior doses. Patient convenience was the main factor cited in making the decision.

RECOMMENDATIONS:

- Though computer generated prescriptions can minimize medication errors due to illegible handwriting, be aware that new types of errors may be introduced including computer entry errors.
- When dispensing vaccines, always consult an appropriate reference to confirm and adhere to the recommended vaccination schedule. Be aware of alternate dosing schedules.
- When counselling patients on vaccines, review the specific dosing schedule and the importance of adhering to this schedule. Suggest that they record the necessary dates on their calendar.
- Always contact the prescriber to clarify/confirm all prescriptions that appear ambiguous or incorrect.

REFERENCES:

1. Havrix® Product Monograph.
2. Twinrix® Product Monograph

Continue to send reports of medication errors in confidence to: Ian Stewart at ian.stewart2@rogers.com Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

CONTINUING EDUCATION (CE)

This list of continuing education activities is provided as a courtesy to members. The Ontario College of Pharmacists does not necessarily endorse the CE activities on this list.
For information on local live CE events in your area you may wish to contact your Regional CE coordinator (list available on the OCP website).

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

LIVE

May 26 - 29 2014 (Ottawa, ON)
CPHA 2014 Annual Conference
Canadian Public Health Association
Contact: http://www.cpha.ca/

May 28, 2014 (Toronto, ON)
Primary Health Care Research Day – Trillium 2014
Western Centre for Public Health and Family Medicine
Contact: http://www.trilliumresearchday.com

May 29–31, 2014 (Toronto, ON)
CAMH Summer Training Institute: CBT Essentials for Depression, Social Anxiety and Panic Disorder
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/cbt_si.aspx

May 31 - June 3, 2014 (Saskatoon, SK)
Canadian Pharmacists Conference 2014
Canadian Pharmacists Association
Contact: http://www.pharmacists.ca/index.cfm/news-events/events/conference/

June 19 – 21, 2014 (Niagara Falls, ON)
OPA Conference 2014: Leading Practice Evolution
Ontario Pharmacists Association
Contact: https://www.opatoday.com/professional/events/conference2014

August 20, 2014 (Toronto, ON)
Confronting Medication Incidents
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

September 10, 2014 (Toronto, ON)
Multi-Incident Analysis Workshop
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 24, 2014 (Toronto, ON)
Root Cause Analysis (RCA) Workshop for Pharmacy Practice
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 25, 2014 (Toronto, ON)
Proactive Risk Assessment in Pharmacy Practice: Using Failure Mode and Effects Analysis (FMEA)
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 27, 2014 (Toronto, ON)
Infectious Diseases/Critical Care Conference
University of Toronto
Contact: http://www.pharmacy.utoronto.ca/cpd/id

October 4, 2014 (Toronto, ON)
Humber Pharmacy Technicians Conference
Healthmark
Contact: http://www.healthmark.ca/18-95-EVENTS/Humber-Pharmacy-Technicians-Conference_en.html

October 3 - 5, 2014 (Toronto, ON)
Intermediate CBT Institute: How to Become a Highly-Rated Cognitive Behavior Therapist
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/cbt_intermediate.aspx

October 9 - 10, 2014 (Toronto, ON)
Enhancing Cognition and Function in Older Patients with Schizophrenia: A Focus on Cognitive Behavioral Therapy and Social Skills Training
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/CBSST.aspx

October 25, 2014 (Toronto, ON)
Medication Therapy Management for Older Adults

– CGP Preparation Course
Ontario Pharmacists Association
Contact: https://www.opatoday.com/224009

November 1, 2014 (Toronto, ON)
Cardiovascular Patient Care Certificate Program
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

November 1, 2014 (Mississauga, ON)
Trillium Pharmacy Technician Conference
Healthmark
Contact: http://www.healthmark.ca/18-96-EVENTS/Trillium-Pharmacy-Technician-Conference_en.html

December 6, 2014 (Toronto, ON)
Psychiatric Patient Care – Level II
Ontario Pharmacists Association
Contact:
http://www.opatoday.com/professional/live-courses

December 13, 2014 (Toronto, ON)
Infectious Disease Management Certificate Program
Ontario Pharmacists Association
Contact:
http://www.opatoday.com/professional/live-courses

Multiple dates and locations – contact course providers
Immunizations and Injections training courses
Ontario Pharmacists Association: https://www.opatoday.com/223957
College of Pharmacists of Manitoba http://mpha.in1touch.org/site/pdprograms?nav=qa
Dalhousie University http://www.dal.ca/faculty/healthprofessions/pharmacy.html
Pear Health http://www.pearhealthcare.com/training-injection-training.php
University of Toronto http://www.pharmacy.utoronto.ca/cpd/injections
RxBriefcase, CPS and PHAC http://www.advancingpractice.com/p-68-immunization-competencies-education-program.aspx

ONLINE/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)
Online courses with live workshops in subjects including: The TEACH Project (Training Enhancement in Applied Cessation Counselling and Heath, Core Course: A Comprehensive Course on Smoking Cessation – Essential Skills and Strategies), Basic Pharmacology in Mental Health and Substance Use, Collaborating with Families Affected by Concurrent Disorders, Legal Issues in Mental Health Care in Ontario, Recovery-Oriented Approach, Youth Drugs and Mental Health, Concurrent Disorders Core, Concurrent Disorders in Primary Care, Fundamentals of Addiction, Fundamentals of Mental Health, Interactions Between Psychiatric Medications and Drugs of Abuse, Medications and Drugs of Abuse Interactions in ODT Clients, Safe and Effective Use of Opioid for Chronic Non-Cancer Pain, Youth, Opioid Use Disorders and Treatment Options, (Complimentary from CAMH) Opioids Basics and School Communities – Part 1 & 2
Contact: http://www.camh.ca/en/education/

Canadian Pharmacists Association (CPhA)
Home Study Online accredited education programs

including the Diabetes Strategy for Pharmacists, The How to of Managing Diabetes: A Prescription for Pharmacist, ADAPT Patient Skills Development certificate program, QUIT: Smoking Cessation Program.
http://www.pharmacists.ca/index.cfm/education-practice-resources/

Canadian Society of Hospital Pharmacists (CSHP)
Online education programs accredited by CCCEP
www.cshp.ca

Canadian Healthcare Network
Online CE Lessons
www.canadianhealthcarenetwork.ca

Communimed
A Practical Guide to Successful Therapeutic Drug Monitoring and Management (TDM & M) in Community Pharmacy: Focus on Levothyroxine
www.tdm-levothyroxine.ca

Continuous Professional Development – Leslie Dan Faculty of Pharmacy, University of Toronto: Infectious Diseases Online Video Lectures and Slides, Influenza DVD
http://www.pharmacy.utoronto.ca/cpd/

Continuous Professional Development – Complimentary from OCP and Leslie Dan Faculty of Pharmacy, University of Toronto: Collaborative Care: Conflict In Inter-Professional Collaboration; Pain: Chronic Non-Cancer Pain; Pharmacists Role: Who Do We Think We Are? The '10 Minute Patient Interview' webcast; Physical Assessment for Pharmacists.
http://www.ocpinfo.com/practice-education/continuing-education/listings/pharmacists/

Ontario Pharmacists Association (OPA)
Online courses with live workshops in subjects including Lab Tests, De-prescribing, Infant Care and Nutrition, Infectious Disease – Foundations for Pharmacy, Interpretation of Lab Values, Introduction to Geriatrics and an Overview of the Beers Criteria, Multi-Sesssion Package, Natural Health Products, New Anticoagulants, QUIT Smoking Cessation Program, Serving Travel Medicine Needs in the Pharmacy, The Transition from Hospital to Community.
Complimentary online courses include: Head Start in Migraine Management , Methadone Education Program, Methadone and Buprenorphine, Ontario Drug Benefit blood glucose test strip reimbursement policy: Support tools for pharmacists, Practical management of Cough an Cold, Smoking Cessation, Ulcerative Colitis, Vitamin D in Osteoporosis, Why the Common Cold and Flu Matter: A Look at Prevention,
http://www.opatoday.com/professional/online-learning

rxBriefcase
Online CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).
http://www.rxbriefcase.com/

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

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

Interested in expanding your network and giving back to the profession?

OCP is looking for additional regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 17 (Brantford area), 25 (Sault Ste. Marie area), 27 (Timmins area). A complete list of CE coordinators and regions by town/city is available on our website.

To apply, submit your resume to ckuhn@ocpinfo.com

REMINDER

UPCOMING COUNCIL ELECTIONS: DISTRICTS M AND P, AND BY-ELECTION FOR DISTRICT T

SEE PAGE 9 FOR DETAILS

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Putting patients first since 1871