Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SUMMER 2012 • VOLUME 19 NUMBER 3

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

WHAT ROLE DO YOU *REALLY* PLAY?
EXPLORING YOUR PROFESSIONAL ROLE

REMINDER: PHARMACISTS MUST BE TRAINED PRIOR TO ADMINISTERING INJECTIONS

TECHNICIAN INTEGRATION AT BARRIE'S ROYAL VICTORIA HOSPITAL

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.

Ontario College of Pharmacists
483 Huron Street
Toronto, Ontario M5R 2R4

T 416-962-4861
F 416-847-8200
www.ocpinfo.com

COUNCIL MEMBERS

Council Members for Districts are listed below according to District number. 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 Doris Nessim
H Christine Donaldson
K Mark Scanlon
K Esmail Merani
L Tracy Wiersema
L Farid Wassef
L Saheed Rashid
M Sherif Guorgui (President)
M Tracey Phillips
M Don Organ
N Bonnie Hauser
N Peter Gdyczynski
N Christopher Leung (Vice President)
P Rachelle Rocha
P Jon MacDonald
T Amber Walker
TH Tracy Wills

PM William Cornet
PM Corazon dela Cruz
PM Babek Ebrahimzadeh
PM Jim Fyfe
PM David Hoff
PM Margaret Irwin
PM Javaid Khan
PM Lewis Lederman
PM Aladdin Mohaghegh
PM Gitu Parikh
PM Lynn Peterson
PM Shahid Rashdi
PM Joy Sommerfreund
U of T Henry Mann
U of W David Edwards

Statutory Committees

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

Standing Committees

- Communications
- Finance
- Professional Practice

COLLEGE STAFF

Office of the Registrar
x 2243, urajdev@ocpinfo.com

Office of the Deputy Registrar,
Director of Professional Development ,
Pharmacy Connection Editor
x 2241, ltodd@ocpinfo.com

Office of the Director of Professional Practice
x 2241, ltodd@ocpinfo.com

Office of the Director of Finance and Administration
x 2241, ltodd@ocpinfo.com

Registration Programs
x 2250, jsantiago@ocpinfo.com

Structured Practical Training Programs
x 2297, vclayton-jones@ocpinfo.com

Investigations and Resolutions
x 2274, membry@ocpinfo.com

Continuing Education Programs and
Continuing Competency Programs
x 2273, lsheppard@ocpinfo.com

Pharmacy Openings/Closings, Pharmacy Sales/
Relocation, ocpclientservices@ocpinfo.com

Registration and Membership Information
ocpclientservices@ocpinfo.com

Pharmacy Technician Programs
ocpclientservices@ocpinfo.com

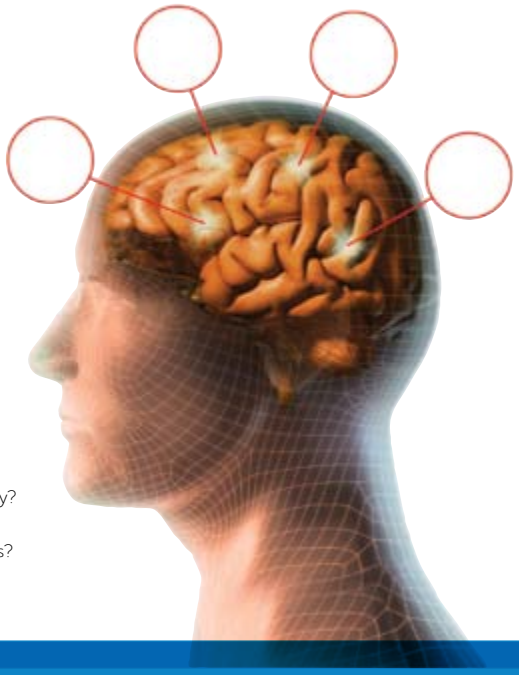
Publications x 2244, rvandoorn@ocpinfo.com

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.

ISSN 1198-354X



On the Cover:
What Role Do You *Really* Play? What kind of health care professionals are pharmacists?
See story on page 10

PHARMACY CONNECTION

SUMMER 2012 • VOLUME 19 NUMBER 3

CONTENTS

Della Croteau, R.Ph., B.S.P., M.C.Ed.
Deputy Registrar/Director of
Professional Development

> "Another challenge facing pharmacists as we move forward with our new scope is teamwork and collaboration."

Is it too good to be true? Is our new scope really just around the corner? It seems like we have been talking about getting ready for the new scope for a long time! So some pharmacists may be very ready and anticipating changes, while others are taking the "wait and see" attitude.

At our recent Council meeting, the OCP Professor in Pharmacy Practice from the University of Toronto made a presentation to Council about the "culture" of pharmacy, about our hesitancy to step forward and our fear of new responsibilities. This edition of Pharmacy Connection features an interview with Dr. Zubin Austin to explore this risk aversion. Our own view of ourselves as pharmacists and what our role should be may be the biggest barrier we will face in enhancing the scope of practice of pharmacists. With that in mind, the College is investing in a 5 year project at the Leslie Dan Faculty of Pharmacy to research what barriers exist to prevent practice change, to design and provide workshops to address these barriers, and to study whether we can achieve better practice outcomes.

One barrier to practice change has been that pharmacists have been responsible for every aspect of filling prescriptions. With the recent introduction of regulated technicians into practice sites, pharmacists are being freed up from the technical aspects of dispensing and more available to educate patients and solve drug-related problems. These regulated technicians will become even more valuable as pharmacists take on greater roles of prescribing for smoking cessation, adapting and renewing prescriptions, administering drugs by injection and inhalation and piercing the dermis. Pharmacists will need more time to review drug therapy and make clinical decisions in the best interest of patients, and will rely more on regulated technicians to make sure that prescriptions are dispensed accurately. We have been sharing some models of practice where technicians are being integrated and this edition presents an example from hospital practice.

Another challenge facing pharmacists as we move forward with our new scope is teamwork and collaboration. Not only will we be collaborating with regulated technicians in a new way, but the new scope will have us be more accountable for patient care and for working more closely with other health care professionals, especially other prescribers. It will be important for us to document and notify primary care providers to ensure continuity of care as we prescribe for smoking cessation, adapt and renew prescriptions, or teach our patients how to administer substances by injection and inhalation or how to monitor their own therapy by piercing the dermis with a lancet. This will require us to develop a different kind of relationship with other health care providers; one where we are working together and communicating with each other in the best interest of the patient.

And I know I have said this before, but the new scope really is coming soon. I encourage you to look where you can make a bigger difference for your patients and develop the new scope of practice in that area. There are many opportunities – yours for the taking.

Marshall Moleschi,
R.Ph., B.Sc. (Pharm), MHA
Registrar

> "I will be traveling the province this Fall / Winter holding District Meetings dedicated to communicating the new regulation."

As the regulatory authority for pharmacy in Ontario, whose primary objective is the protection of the public, it is our responsibility to ensure that as the profession evolves both current and future members are not just aware of their authorized scope of practice but perhaps more importantly that they understand how they will be held accountable. Given the realities of the legislative process however this can be tricky as practice standards can not be fully developed, and therefore communicated to members, until the scope of practice has been defined and proclaimed by government through regulation.

Currently the draft regulation contains the initial expanded scope activities of; initiating, adapting or renewing prescriptions, administering injections or inhalation for education and demonstration and procedure on tissue below the dermis. In addition, a recent amendment to allow "certain members of the College to administer influenza vaccine" has been posted for public consultation until August 20, 2012. In anticipation of government approval, early this fall, the College is developing a comprehensive communications strategy to assist members with understanding their new regulation.

It has already been determined and communicated that those members who are eligible and wish to administer injections must first successfully complete an OCP approved accredited training program and hold a valid certification in CPR and First Aid. Training programs are available now and all of the details, including registration information, can be found from the homepage of the College website (www.ocpinfo.com) under Fast Track / Continuing Education (CE).

Although the other expanded scope activities contained in the draft regulation do not require specific additional training prior to implementation the College appreciates that many members may benefit in receiving some support to ensure that they clearly understand their new scope and its corresponding standards of practice. Therefore, a comprehensive Orientation Manual is being developed which will clearly outline each of the expanded scope activities and assist with implementation by providing real practice examples and resource tools such as sample documentation and notification templates and a model for therapeutic decision-making.

Given the significance of these expanded scope activities the College will be asking members to self-declare, as part of their March 2013 renewal process, that they have read and understand the Expanded Scope Orientation Manual.

To further assist members in doing this, I will be traveling the province this Fall / Winter holding District Meetings dedicated to communicating the new regulation. This is a great opportunity to bring members together to learn about our evolving scope, share our experiences and address any questions or concerns. We anticipate the first of these sessions to take place early in October and will carry on into the new year. Should it not be convenient to attend one of the free live sessions an online version of the Expanded Scope Orientation will be available later in the fall.

Be sure to watch your email over the coming weeks for an eblast communication from the College outlining more details. Or, visit the College website (www.ocpinfo.com) regularly for updates.

JUNE 2012 COUNCIL MEETING

STRATEGIC PLAN UPDATE

Following approval of the Strategic Plan at its meeting in March, staff was directed to develop an Operational Plan. The Plan, as presented to Council for review, includes short term, intermediate and long term outcomes for each strategic direction, KPI's (Key Performance Indicators) and financial resources for various activities . Council will receive updates at each Council meeting to assess progress against the plan

COUNCIL APPROVES REVISED RULES OF PROCEDURE FOR THE DISCIPLINE COMMITTEE

Following a comprehensive review of the College's Discipline Committee's current rules, the Committee recommended additions and amendments to the Rules which will:

- afford the Committee greater procedural flexibility, transparency and efficiency
- provide greater procedural fairness to the parties (i.e. Members and the College)
- allow for smoother contested proceedings
- provide procedural mechanisms with respect to reinstatement and s. 23(11) of the *Health Professions Procedural Code ("Code")* applications
- provide protection to witnesses

The Revised Rules (which can be found on the College's website) were approved by Council and will bring the College into closer alignment with some of the other health regulatory colleges (including the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario).

REPORT FROM OCP PROFESSORSHIP IN PHARMACY

Council heard a presentation by Dr. Zubin Austin of the Leslie Dan Faculty of Pharmacy at the University of Toronto respecting the College's Professorship in Pharmacy. The report outlined research findings on the characteristics of pharmacists. Specifically, Dr. Austin addressed those behaviours that may be inhibiting pharmacists from confidently embracing the new scope of practice.

LESLIE DAN FACULTY OF PHARMACY TO ESTABLISH PROGRAM SUPPORTING PRACTICE CHANGE

In follow up to Dr. Austin's presentation, Dean Henry Mann of the Leslie Dan Faculty of Pharmacy at the University of Toronto presented a proposal respecting the establishment of a program to support the enhanced scope of practice of the profession through an investment




of $200,000 per year over five years. The Program will include 'live' and 'online' workshops for College members on supporting practice change as well as a research and evaluation component that will provide data to measure outcomes.

Council approved the proposal and the Registrar, in conjunction with Faculty members, will work together to finalize an agreement that will meet both our organizations' needs and mandates.

COUNCIL ENDORSES RESPONSE TO DRUG SUPPLY SHORTAGE

Since mid-March, the College has participated in regular stakeholder teleconferences conducted by the Emergency Management Branch of the Ministry of Health and Long-Term Care aimed at providing patients in Ontario with expedited access to medically necessary drugs while addressing patients' health and safety needs. The College website also maintains a "Drug Shortages Update" page and posts information as it becomes available on this issue.

In discussing this issue, Council agreed that the College emphasise the need for a coordinated response to minimize the effect of drug supply shortages on patients, and accordingly, endorsed the recommendations*:

1. Federal, provincial and territorial collaboration for a national vision and action plan;
2. Greater provincial oversight and coordination;
3. More incentives to guarantee supplies, and penalties for supply disruptions;
4. Better inventory management practices by manufacturers;
5. More flexibility by distributors to share drugs in a shortage and redistribute medically necessary drugs for the benefit of patients requiring ongoing treatment; and
6. Responsible practices by pharmacists including working in collaboration with physicians to identify priority patients and to share drugs that are in short supply

**These recommendations were originally proposed by the Working Committee on Drug Shortages, a coalition of Quebec organizations, and endorsed by the National Association of Pharmacy Regulatory Authorities in spring 2012.*

Council further agreed that the College continue to solicit support for the Committee's recommendations from Ontario stakeholders who may be positioned to influence governments, manufacturers and distributors to fast track solutions which would have the most immediate and positive impact on patient care and safety.

DOCUMENTATION GUIDELINES APPROVED

In order to provide members with clarity on the requirement to document clinical care, the Professional Practice Committee made recommendations to update the Documentation Guidelines. The Guideline, which was approved by Council, also took into consideration the imminent approval by government of an expanded scope of pharmacist practice as well as the members' obligations regarding scanning of written prescriptions. The guideline can be found on the College's website. (Please note that the 'Record Retention, Disclosure and Disposal Guideline' referred in the Documentation Guideline, is currently in the final stages of the approval process.)

COUNCIL APPROVES JURISPRUDENCE EXAMINATION BLUEPRINT

Council approved a revised Jurisprudence Examination Blueprint as well as a unified Examination for both pharmacists and pharmacy technicians. The blueprint for the pharmacist Jurisprudence (JP) exam was last reviewed in 2006 and no significant change to its main framework was recommended at that time. The blueprint for the Jurisprudence examination for pharmacy

Photos by DW Dorken

technicians was developed in 2008 and was based on the pharmacist JP exam blueprint. Following a recent review of both JP blueprints, it was determined that these blueprints were significantly similar in overall structure and should be considered as a single blueprint. Council accordingly approved both the updated/revised Blueprint as well as the unified examination. It is anticipated that an implementation plan will be put into place for a transition date for mid-to-late 2013 and will follow after the introduction of the JP modules which are expected to be in place by early 2013.

NATIONAL ASSOCIATION OF PHARMACY REGULATORY AUTHORITIES/PHARMACY EXAMINING BOARD OF CANADA UPDATES

Council noted for information the election of Ms. Tracy Wiersema, the College's representative to NAPRA's Executive Committee.

NAPRA's Board of Directors approved the Strategic Plan for the organization for the next three years (2012-2015), as well as the Operation Plan. Another key area was the approval of the Model Standards of Practice for Canadian Pharmacy Technicians and the competencies for Pharmacist Injection Education. Council also received for information a document entitled *"Pharmacy Practice Management Systems: Requirements to Support NAPRA Standards of Practice"* on which NAPRA is currently soliciting input by stakeholders.

Ms. Bonnie Hauser, the College's representative on PEBC provided highlights of the various activities at PEBC emphasizing in particular the results of the pharmacy technician examinations.

OPIOID PRESCRIBING, DISPENSING AND ADDICTION

Council received an update from Ms. Resnick, Director, Professional Practice Programs on three different areas relating to opioid prescribing, dispensing and addiction.

With respect to Narcotics Strategy, Council noted that the Ministry of Health and Long-Term Care (MOHLTC) has established a Narcotics Advisory Panel (NAP) to provide advice on appropriate prescribing, dispensing and utilization related to narcotics (particularly oxycodone) and pain management strategies.

Regarding the *Narcotics Safety And Awareness Act, 2010*, Council was advised that the College has participated in regular teleconferences with the MOHLTC and the Colleges of other affected health professions since November, for the purpose of developing appropriate and meaningful communication (Questions and Answers) from the Ministry to practitioners as well as to discuss implications and implementation of the monitoring system for tracking activities related to the prescribing of narcotics.

Ms. Resnick is also a member of the Minister's Expert Working Group on Narcotic Addiction, which was convened by the Minister of Health following receipt of notification by Purdue Pharma of its intent to cease production of Oxycontin. A report of the Working Group has been provided to the Minister and includes recommendations on short, medium and long-term solutions to respond to community needs following the removal of OxyContin from the Ontario Drug Benefit Formulary and its replacement with OxyNEO.

FUTURE COUNCIL MEETINGS

September 10 and 11, 2012

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

RESULTS OF RECENT COUNCIL ELECTIONS

DISTRICTS N & H (HOSPITAL)

Council elections are held each summer for 1/3 of Council's 17 elected members (15 pharmacists and 2 pharmacy technicians). This year elections were held in District N (3 seats for a 3 year term) and District H (2 seats for a 3 year term).
Terms for elected Council members commence at the beginning of the September Council meeting.

In **District N** a total of 3 candidates were nominated for the 3 available seats and subsequently all nominees were elected by acclamation:

Bonnie Hauser
Bonnie, who has served on Council since 2006, is a graduate of the University of Toronto (1975) and her current place of practice is Hauser's Pharmacy in Dunnville.

Chris Leung
Chris, who has served on Council since 2008, is a graduate of the University of Toronto (1998) and his current place of practice is Shoppers Drug Mart in Windsor.

Ken Potvin
Ken, who is new to Council, is a graduate of the University of Toronto (1983) and his current place of practice is the University of Waterloo – School of Pharmacy.

In **District H** (Hospital) a total of 4 candidates were nominated (Christine Donaldson, Sheri Howard, Darcy McLurg and Regis Vaillancourt) for the 2 available seats thereby requiring an election. The two nominees elected to Council are:

Christine Donalson
Christine, who has served on Council since 2011, is a graduate of the University of Toronto (1992) and her current place of practice is Hotel Dieu Grace Hospital and Windsor Regional Hospital in Windsor.

Regis Vaillancourt
Regis, who is new to Council, is a graduate of Laval University (1983) and his current place of practice is Children's Hospital of Eastern Ontario in Ottawa.

WHAT ROLE DO YOU *REALLY* PLAY?

10

AS SCOPE OF PRACTICE EVOLVES, U OF T PROFESSOR SAYS PHARMACISTS NEED TO EXPLORE THEIR PROFESSIONAL ROLE.

By Stuart Foxman

Don't get Zubin Austin started on a recent commercial that depicts a pharmacist going above and beyond – beyond clownish, he says. In the ad from U.S. retailer Walgreens, the pharmacist perks up when he hears a customer sneeze. He hops the counter, sprints through the aisles, hurdles displays, and slams into a rack of balls that go flying. Finally, he reaches the customer who, standing at the cold medications, smiles in relief.

"I was appalled by the ad," says Austin, the inaugural holder of the Ontario College of Pharmacists' Professorship in Pharmacy Practice at the Leslie Dan Faculty of Pharmacy, University of Toronto. "It turns what should be a professional into a buffoon, and overemphasizes a subservient customer service role – we'll do handsprings to keep you happy."

Against a backdrop of an evolving scope of practice and new opportunities for pharmacists in Ontario, how does the profession view itself?

Austin spends a lot of time pondering that question. An award-winning educator and researcher, he has written widely about the professional identity of pharmacists, how they perceive the people they serve, and their relationships with other health care professionals.

He has been a full-time member of the Faculty of Pharmacy since 1994, and spent some time earlier

in his career as a clinical pharmacist at Toronto's Mt. Sinai Hospital. To understand where you are and where you can go in the field, Austin says, consider what attracted you to it in the first place.

"What probably connects most people as pharmacists is extraordinary pragmatism", he suggests.

To him, this is not an "aspirational profession", and that's no criticism. While many young people dream of careers in medicine or law or teaching, for example, far fewer kids say "I want to be a pharmacist when I grow up".

The fact is that not all fields have a magnetic "greater than oneself" pull, he says. But pharmacy does have its own draw. As Austin points out, this choice "ticks a lot of practical boxes." He rattles off a list.

"Pharmacy offers the security and prestige of a profession," he says, but with a better work-life balance than, say, medicine. "There's no required residency or post-graduate training," he continues. You get a managerial role, with some flexibility in hours. The job is stable. And you know what you're doing – there's not a lot of ambiguity or blindsiding."

Like in any field, says Austin, pharmacists enjoy different dimensions of their work to different degrees. The makeup of the profession and their keen interests – from the technical and operational aspects, to working closely with people, to scholarship – varies. That diversity is a good thing, offers Austin.

Does he notice any attitudes changing among his pharmacy students? Austin says the more recent ones have a strong image of what it means to be pharmacy professional.

"They don't want just the routine of dispensing, they want more direct patient care responsibilities. They want to think of themselves as health care professionals first and business people second."

HELPING VS. CARING

What kind of health care professionals are pharmacists? It's a complex question, says Austin.

"Most pharmacists would say that what they do is more helping people than caring for them; let me give you options and help you make decisions for yourself."

The terminology – help vs. care – matters deeply. These aren't necessarily opposing concepts. You can do both. But the primary role isn't as apparent, Austin explains, as it is in other health care professions.

"It's clear what role physicians or nurses play; they're patient care providers. Because of the unique nature of a pharmacy, it's hard for pharmacists to know who they need to be moment by moment, person to person. That's one reason why we see tension around the changing scopes of practice."

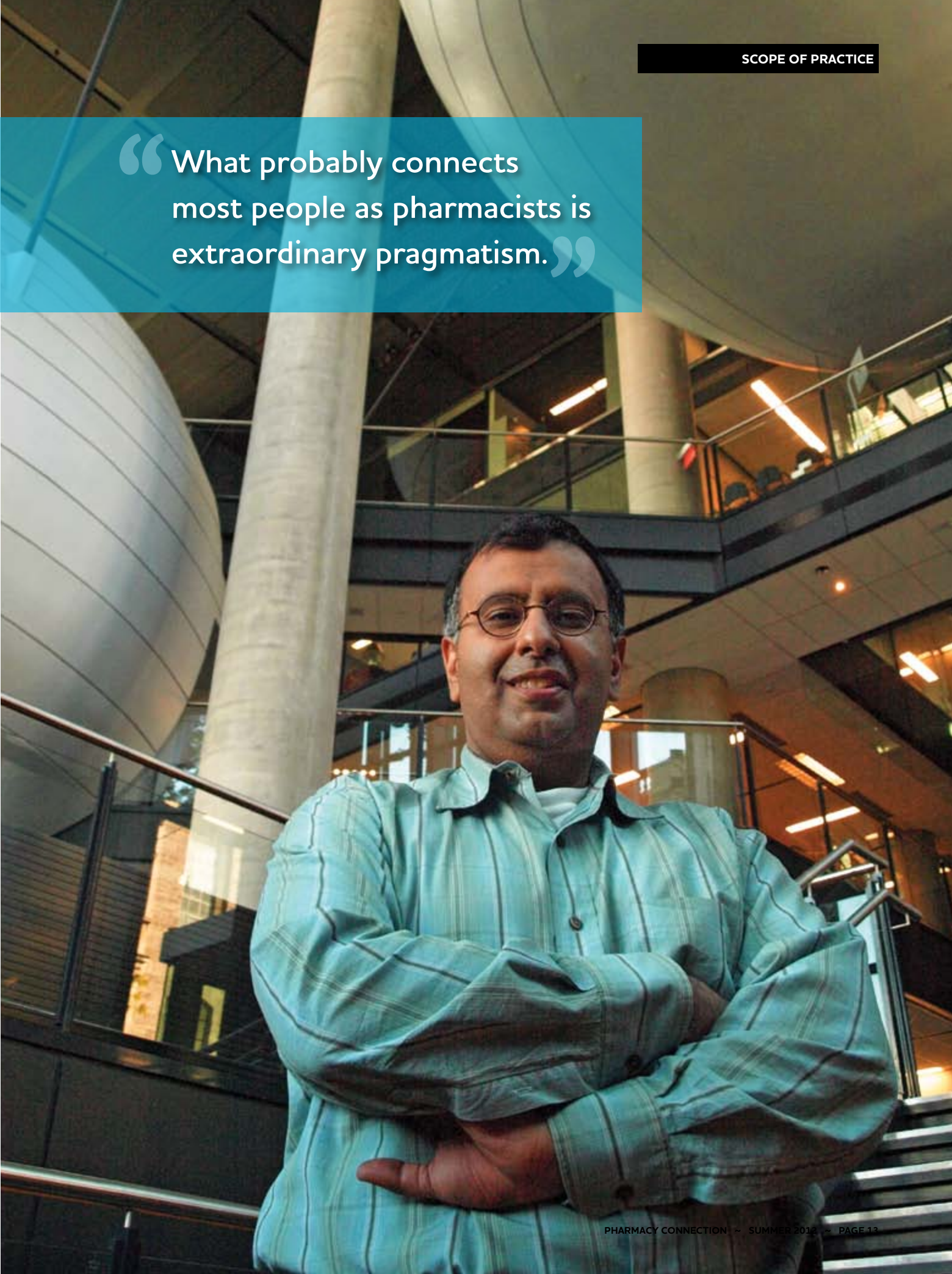
Other terminology has major implications too. In its vision, the Ontario College of Pharmacists talks about optimizing health and wellness through "patient centred care". The word "patient" is loaded with meaning, Austin says.

"So much of rhetoric over the last 20 years in pharmacy is framing everyone who comes into a pharmacy as a patient. The reality is they're not all patients. Patient care and customer service are two radically different ways of interacting with somebody."

As Austin has written, the term "patient" itself is not value-neutral. It indicates a certain dynamic in the relationship, based on levels of knowledge and skill. He finds it interesting that some other health care professionals prefer using "client" or "customer" to convey less hierarchical relationships in their fields.

To be most effective, says Austin, pharmacists need to recognize the shifting nature of their relationships. The most successful pharmacists are those who grasp who they need to be at any given moment, for any given person they encounter.

Of course, those encounters often fall into a pharmacist-patient



> What probably connects most people as pharmacists is extraordinary pragmatism.

> "There's an idealized view that each health care professional has their own scope, their own specialty, and will advocate for it. But that assumes a measure of equality between all of these professionals."

model. People who are seeking advice and consultation would be turned off – and perhaps lose their trust – if the pharmacist was merely transactional, operating in a customer service mode.

Conversely, many individuals have the opposite expectation when they walk into a pharmacy. All they want is basic service. For them, the term "patient" represents a specific type of relationship, usually associated with a physician or dentist. Even if they could self-identify as "patient" in some cases, in others they simply want service.

Austin gave an example in a pharmacy journal article. Consider an otherwise healthy woman, about to travel to the Amazon, who is seeking information on OTC anti-diarrhea drugs. She likely rejects the "patient" role; it's too needy, dependent and inappropriate for the level of help – not care – she expects. This encounter is all about expedience.

"If you view those types of encounters as patient centred, frankly you'll look overbearing and intrusive, asking invasive questions," says Austin.

The pharmacist's impulse to do his or her job, supporting the best health and preventing harm, is understandable. But what happens when that runs up against the individual who wants more of a business-like transaction model?

It's tricky, and partly because the person you're dealing with might think of themselves as a client when they really need to be a patient first, or vice versa. How do your respect those wishes? What is your role? The challenge and often the frustration, says Austin, lies in knowing which hat you should wear – and which hat the other person wants you to wear: "That's the complication."

Austin has said that many argue that the nature of the pharmacy enterprise is unique in retailing. Others, however, could disagree and make a case that dispensing pharmaceuticals is fundamentally no different than distributing other substances that may have certain toxicities if used incorrectly, such as anti-freeze or turpentine.

Austin isn't suggesting that pharmacists can be likened to the manager of a Canadian Tire. The point is more that for pharmacists, being a health care professional is about much more than the safety (or potential hazards) of the products they dispense. It's about forging the most appropriate relationships.

Clearly, the College promotes public protection by helping to ensure the provision of quality care and services. What Austin is saying is that at the pharmacy level, the ways of defining that care and service vary dramatically.

HANDLING INTERPROFESSIONAL RELATIONSHIPS

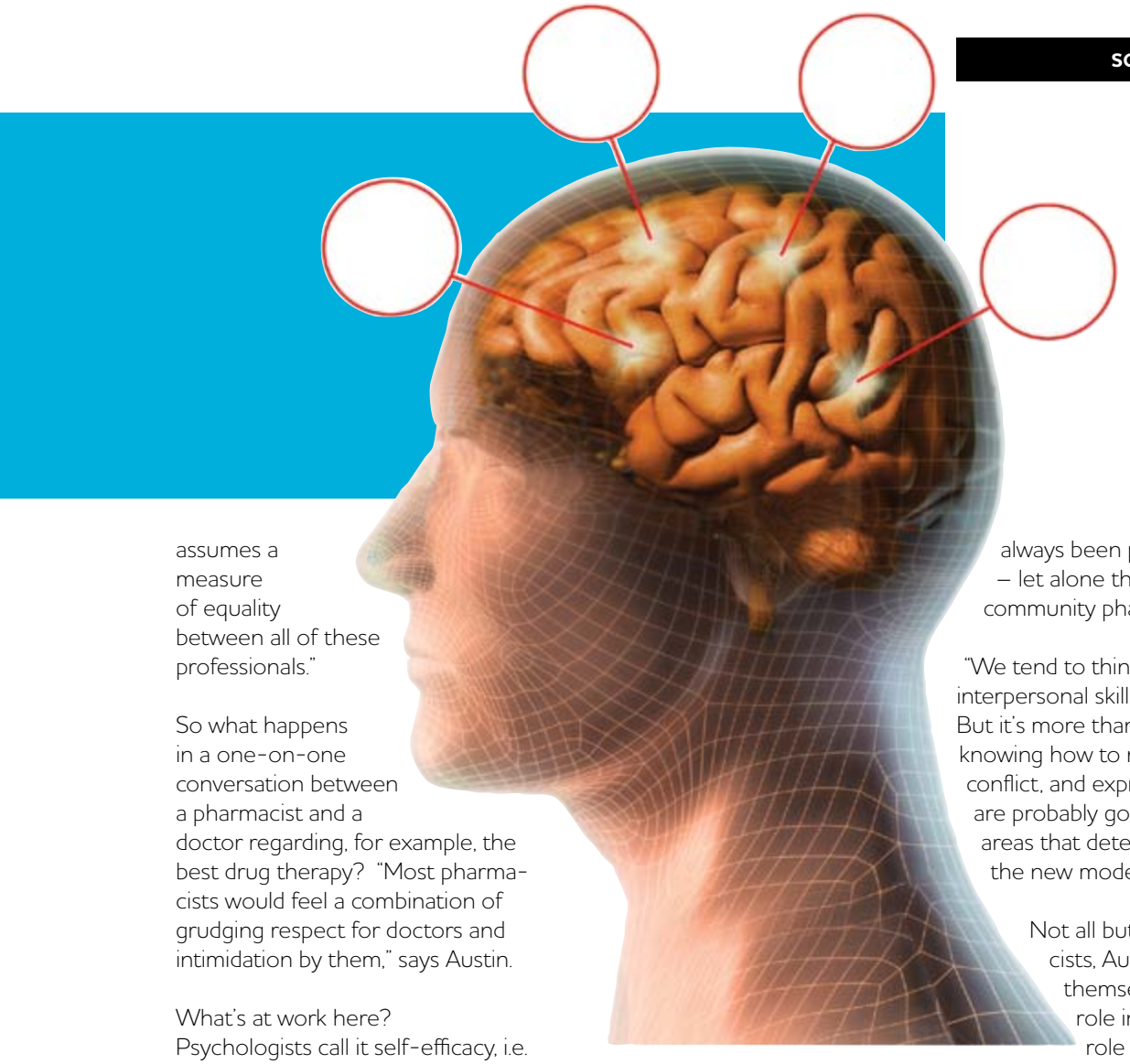
The relationship with patients/clients isn't the only one that poses a challenge. Today, the health care system is calling for more interdependence and cooperation than ever between care providers.

How do pharmacists tend to fare in interprofessional relationships? The toughest to handle is probably the one with doctors, says Austin. "There's a prevailing social attitude that's inescapable, and it puts health care fields into a pecking order."

That pecking order can be even more "ruthless" within professions, says Austin – like between GPs and surgeons – than between professions. But it exists. All health care professionals have to confront it, or at least recognize how it colours their interactions.

Pharmacists and doctors study from a common body of knowledge, take similar courses as part of their training, and then diverge. The reality is that not all pharmacists and not all doctors would view each other as peers, says Austin. It's not even something that's conscious, it's just implied, by both parties.

For health care professionals overall, "There's an idealized view that each health care professional has their own scope, their own specialty, and will advocate for it. But that



assumes a measure of equality between all of these professionals."

So what happens in a one-on-one conversation between a pharmacist and a doctor regarding, for example, the best drug therapy? "Most pharmacists would feel a combination of grudging respect for doctors and intimidation by them," says Austin.

What's at work here? Psychologists call it self-efficacy, i.e. a confidence in your own particular competence. That plays a huge role in how people think, feel and behave.

The pharmacist is in their sphere in offering information about different drugs. Drug A does this, and drug B does that. But will the pharmacist vigorously advocate for one over another in a discussion with a doctor? Not always, says Austin. That takes a lot of, as he says, "psychological strength".

Instead, this is frequently the prevailing attitude: "I'm like Mercury, a messenger. I did my job. I give advice and let other people make decisions."

"It looks like deference, but it's more complex than that," Austin continues. "To be a true collaborator, you have to be able to assert your point of view, and be willing to disagree in a respectful and confident way." To Austin, that doesn't happen as often as it should.

SOFT SKILLS WILL GAIN IMPORTANCE

What we don't want, says Austin, is a situation where each health profession "just smiles and nods and tells the regulators they're playing nice together, and then it's business as usual."

True collaboration will be transformative for the health care system, and for the people it serves. However, at a time when we're seeing more integrated health care teams, Austin says it's important to realize, that collaboration hasn't always been part of the work – let alone the strength – of community pharmacists.

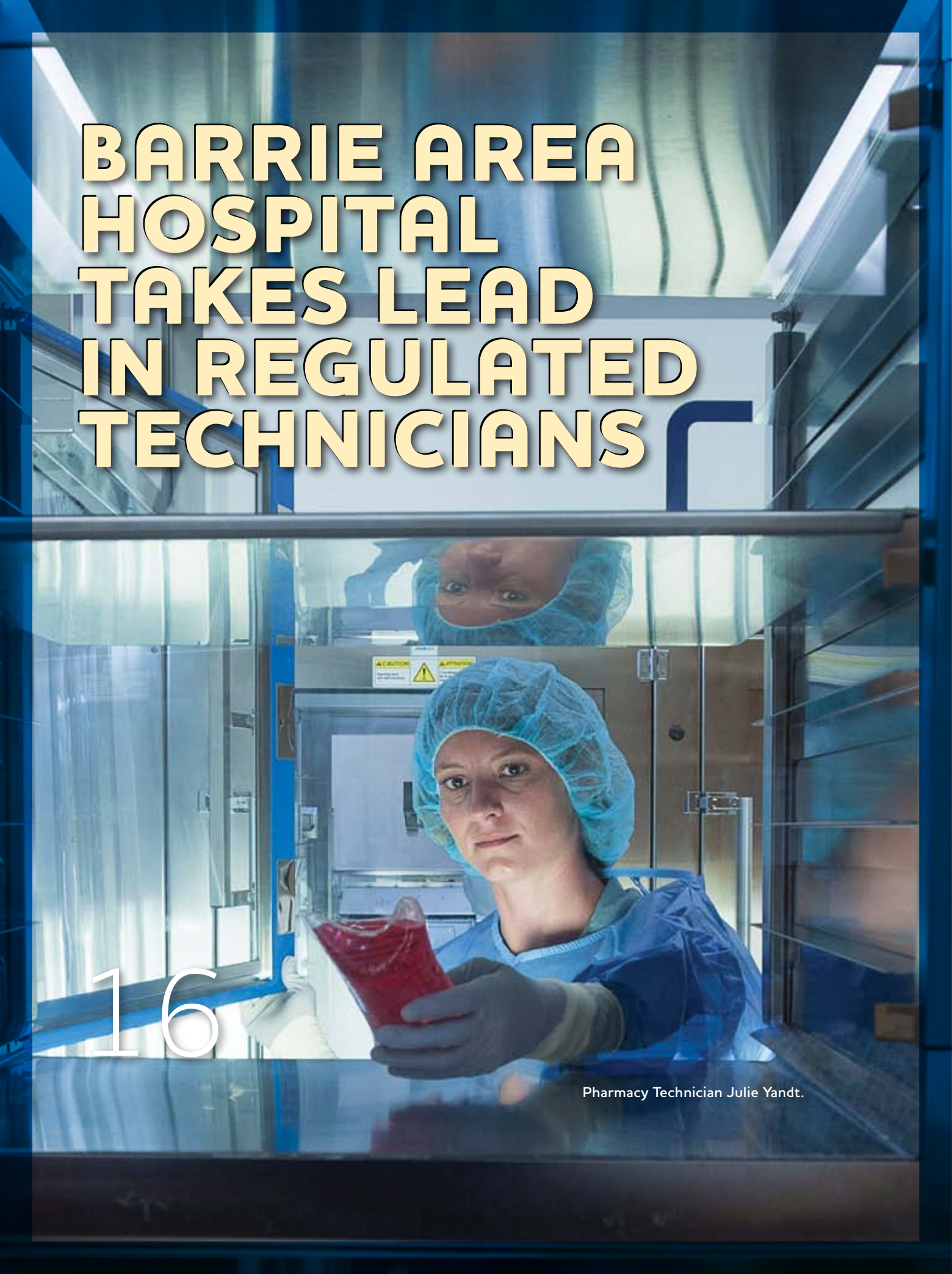
"We tend to think of soft skills as interpersonal skills – getting along. But it's more than that. Skills like knowing how to negotiate, manage conflict, and express an opinion are probably going to be the areas that determine success in the new model of practice."

Not all but many pharmacists, Austin says, "see themselves in a helper role instead of a leader role or decision-maker role." Yet the changing scope of practice means that pharmacists will be taking on more and more autonomous and independent decisions: "That's a substantial change."

Some pharmacists will eagerly embrace this reality, others might welcome it but find it stressful, still others will have some difficulty with it, and most will fall somewhere in the middle, says Austin. Mentoring, role modeling, and soft skills training will all be invaluable to help pharmacists become more comfortable with an evolving practice.

"I think it's an extraordinarily exciting time," says Austin. "Everything points to some interesting and amazing opportunities for pharmacists who want to take them."

BARRIE AREA HOSPITAL TAKES LEAD IN REGULATED TECHNICIANS



Pharmacy Technician Julie Yandt.

The previous two issues of Pharmacy Connection have showcased how a community pharmacy practice (Winter 2012) and pharmacies that cater to long-term care centres (Spring 2012) have successfully integrated registered pharmacy technicians. Now we offer an example of how a hospital pharmacy operation is doing the same.

AS TECHNICIANS BROADEN SCOPE, PHARMACISTS AT ROYAL VICTORIA REGIONAL HEALTH CENTRE GAIN MORE TIME FOR CLINICAL ROLES

By Stuart Foxman

When Elizabeth Boyce, RPhT, deals with the nurses at the Royal Victoria Regional Health Centre (RVH) in Barrie, they sometimes ask her if she's a pharmacist.

"I say, just a tech. They say, no, you're not just a tech. They look at me more as a fellow professional. I'm getting more appreciation and recognition," says Boyce.

Becoming a regulated pharmacy technician is voluntary, but in a health centre environment that process typically is being mandated, towards a deadline of 2015. RVH has been even more progressive, moving that date to the end of 2012.

Technicians like Boyce, as well as the health centre's pharmacists, say that this transition is providing major opportunities to expand scopes of practice and ultimately to influence patient care.

Many hospitals have been providing pharmacy assistants with greater responsibility through delegation protocols[1]. Delegating authority to pharmacy assistants is easy enough to do, but the accountability still rests with the pharmacists who are doing the delegation, notes Judy Chong, RPh, RVH's Director of Pharmaceutical Services.

"When you go through that, you have someone telling you what to do. We wanted people to take ownership. Everyone should be accountable."

1. Under the Regulated Health Professions Act, controlled acts ("selling, dispensing and compounding a drug") are only to be performed by professionals with the legislated authority to do so. When delegation is used, the professional who transfers the authority to perform the act remains accountable for the performance of the person to whom they have delegated. It is reasonable to expect that as more pharmacy assistants become regulated employers will restrict performance of these controlled acts to regulated professionals.

> “It will free up the pharmacists to do more clinical work on the floor instead of being in the dispensary. We’ll have more time to counsel patients.”
>
> Pharmacist Paula Bouchard-Howe

Left to right: Paula Bouchard-Howe, Diana Hayzer, Judy Chong (front), Shelley Murphy, Julie Yandt, Alena Saunders and Elizabeth Boyce.

Chong acknowledges that the delegation process can be labour intensive and difficult to manage. Based on RVH's resources, it would be hard to always staff the pharmacy department with the levels of technical support needed. As well, she says that for a health care setting the current group of pharmacy assistants had been underutilized. When the College decided to move to regulation for technicians, Chong made a presentation to the health centre's senior leadership team.

"We talked about the scope of practice, what regulated technicians could do, and what it can look like in our organization. We have the chance to have a lot of extended roles for the technicians."

The decision to move aggressively on the regulated technician front also fit with the health centre's implementation of a new medication management system.

"We thought it would go hand in hand with the changes, and give us the ability to use technicians to their fullest scope," says Shelley Murphy, RPhT, Senior Pharmacy Technician.

PHARMACISTS ADD HOURS A WEEK ON FLOORS

Currently at RVH, a pharmacist screens all of the orders written by the health centre's physicians. A technician then enters the orders on the computer and fills them. The pharmacist does a final check before the order goes to the floor.

"When we use regulated technicians to their full capability, they will be able to do the final checks," says Paula Bouchard-Howe, RPh.

What will that mean to the pharmacists?

Bouchard-Howe explains: "It will free up the pharmacists to do more clinical work on the floor instead of being in the dispensary. We'll have more time to counsel patients."

Just being more visible on the units will be beneficial, to assist doctors and nurses with prescribing, says Bouchard-Howe. She estimates that the pharmacists now each work about 10-12 hours a week in the dispensary. When the technicians do the final checks, maybe half that time can be spent instead on the floor. Those additional five to six hours per pharmacist, Bouchard-Howe says, "will make a significant impact on patient care."

Colleague Alena Saunders, RPh, agrees that all of the pharmacists would prefer to devote more time to clinical tasks. She says that discharge management, for instance, is a huge issue. Saunders suggests that pharmacists are among the best positioned health care professionals to ensure a smooth and safe transition for patients back into the community. Now they'll be able to devote more attention to that.

The technicians look forward equally to being used in different ways. One possible role is gathering lab data to help pharmacists make clinical decisions. Boyce talks about how she has been doing best possible medication histories, and enjoying more interactions with patients. "I'm really excited to learn and experience new things," she says, "and work to my fullest potential."

For her part, Murphy is working with Saunders and another regulated technician, Diana Hayzer, RPhT, on a medication management initiative to improve safety in the system. The project involves a switch from a traditional ward stock system to a 24-hour

patient specific unit dose system, and implementation of automatic dispensing cabinets (ADUs).

Bouchard-Howe loves to see that sort of involvement. "It's good to have the perspective of the technicians also, instead of just the pharmacists."

"With the proper training and policies and procedures in place," adds Murphy, "I am game to move forward."

GO AT YOUR PACE AND FIND REWARDS

What do RVH's technicians think about the process of becoming regulated?

The hardest part was finding the time, says Hayzer, but she appreciated the earlier 2012 deadline. "Having that timeframe," she says, "made me get it done."

Murphy admits that she also found the work-education-life balance tough. Still, the 20-year RVH veteran was one of the first assistants at the hospital to get regulated. "I took two of the courses before we even got the notice that it would be mandatory. I took it on as a challenge."

Her advice to others who are considering going through the process – "It's a lot of work, but take it at the pace you can handle and just keep trudging forward," Murphy says. "The rewards will be there in the end."

What helped greatly, says Murphy, was having some of RVH's pharmacists teaching the courses, and also having several colleagues taking the courses at the same time. That support was important, she says. "We had study groups together, and could bounce questions off each other."

For pharmacists like Bouchard-Howe, the process was a commitment too. "It took me away from clinical time to do structured practical evaluation and practical

> "...you're not just a tech. They look at me more as a fellow professional. I'm getting more appreciation and recognition."
>
> Pharmacy Technician Elizabeth Boyce

training for assistants, but I always kept in the back of my mind that it was a worthy cause, good for the health centre. You have to look at the big picture."

Are there obstacles to becoming regulated?

Murphy says that some people could be intimidated or worried about taking a bridging program. Others could have financial barriers. "Organizations can put some money aside to support us," she says.

Still others might feel that it's not worth the effort because they are close to retirement (that happened in a few cases at RVH), or because they feel that they'll be taking on added responsibility without added pay.

But the benefits – new scope for regulated technicians, more time for pharmacists to pursue vital roles – are worth it, say RVH's pharmacy personnel.

Do hospitals and or health centre's perceive the benefits of regulated technicians differently than retail pharmacies?

Certainly, in hospitals and or health centres the pharmacist has a particular clinical role, and a need to be on the floors where orders are written. The presence of regulated technicians, in the right numbers, supports that goal.

In community pharmacy settings, Bouchard-Howe suspects that the idea of regulated technicians still hasn't been fully embraced, even though "most retail pharmacists would enjoy the opportunity to spend more time with their customers and patients instead of on dispensing duties."

Regulated technicians, too, note the opportunities for them in a hospital or health centre.

"I used to work in a retail pharmacy," says Boyce, "and I've done so much more in a health centre setting, and learned so much more about patients, drugs, teamwork and other professionals."

While hospitals and health centres tend to be comfortable with the move to regulated technicians, Chong says that for the best outcomes it's essential to have a vision of how the technician and pharmacist roles will work together.

"By the end of year when we have everyone regulated, we hope to push the envelope in what the full scope of practice can be," says Chong, "like divesting the pharmacists of the day-to-day technical activities of medication management."

Photos by DW Dorken

When the College decided to move to regulation
Pharmaceutical Services) made a presentation to

"We talked about the scope of practice, what it can look like in our organization. roles for the technicians."

Pharmacist Judy Chong

"The technicians that we have are all very capable of taking on that role," she continues. "We already have some of our technicians involved in taking the best possible medication histories, so they'll have more direct patient contact and interactions with other health care professionals. It's really about how we can do the work more efficiently."

With regulation, says Bouchard-Howe, "I feel that the technicians are much more confident, and feel more part of the team and more professional. They showed that when going through their evaluations."

Murphy agrees that regulation has brought on a different attitude. "I like the idea of being a regulated professional when we are surrounded by them all day. It makes me feel better about what I do."

Regulation makes a contribution not only to professional roles, but ultimately to the optimal functioning of the organization.

"If as a team we can ensure that we use our resources properly, everyone working to the right scope," says Chong, "that increases the safety of the system."

ROYAL VICTORIA REGIONAL HEALTH CENTRE - PROFILE

Royal Victoria Regional Health Centre (RVH) is the only health centre in Barrie, a fast-growing city of over 125,000 residents, an hour north of Toronto. The health centre is part of the North Simcoe Muskoka Local Health Integration Network, which has a population of approximately 454,000 and encompasses the District of Muskoka (most of the County of Simcoe and a portion of Grey County). Recently, RVH marked one of the largest single hospital expansions in Ontario. The $450 million project doubles the size of the health centre, and features capacity for 165 additional inpatient beds, triples the size of the Emergency Department, and significantly expands the Imaging Department and Laboratory. The redevelopment also includes two new operating suites, as well as the Simcoe Muskoka Regional Cancer Centre.

RVH currently is a 319-bed acute care bed facility and logs more than 340,000 patient visits a year. RVH has a team of over 1,000 dedicated volunteers, 330 skilled physicians, 2,500 caring staff members, which includes 22 pharmacists, and 30 pharmacy technicians.

for technicians, Judy Chong (Royal Victoria's Director of the hospital's senior leadership team:

what regulated technicians could do, and

We have the chance to have a lot of extended

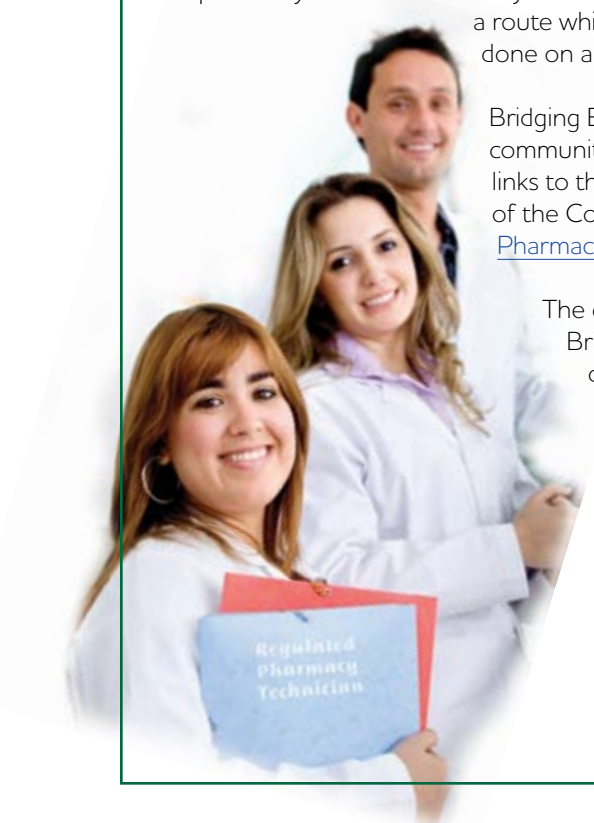
ROAD TO REGULATION NEEDS A PLAN!

Must successfully complete the Bridging Education Program by January 1, 2015

If you are a pharmacy assistant who is currently working through the Bridging Education Program, required as part of the process to become a Regulated Pharmacy Technician, you need to be aware that you must successfully complete all four educational modules by January 1, 2015.

Given this deadline the last offering of 'classroom' or 'online' bridging courses will be in the fall of 2014 and Prior Learning Assessment (available for all courses with the exception of Professional Practice) will only be available until the Summer of 2014.

These deadlines are not new. It has always been communicated that this bridging path to regulation was not permanent and had been established as a means to allow qualified pharmacy assistants, currently working in the profession who wished to become regulated, a route which recognized their prior experience and could be done on a part-time basis while continuing to work.



Bridging Education Program courses are available at a variety of community colleges across the province. More information and links to the various providers can be found from the homepage of the College website (www.ocpinfo.com) under Fast Track / Pharmacy Technician.

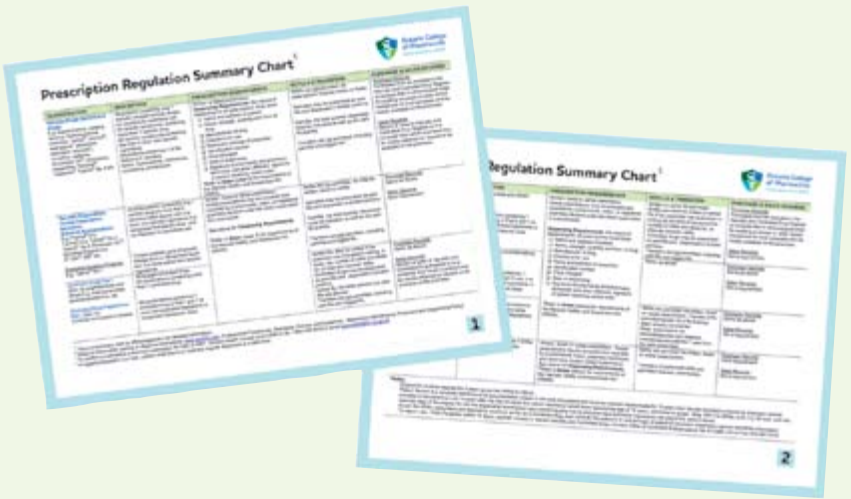
The consequence of not successfully completing the Bridging Education Program by the January 1, 2015 deadline is that assistants would have to obtain the required education to become regulated by graduating from one of the many accredited pharmacy technician programs currently offered in community and career colleges.

Be sure that you have a plan to get this done in the timeline required!

PRESCRIPTION REGULATION SUMMARY

(Updated July 2012)

The Prescription Regulation Summary chart presented on the following two pages, summarizes the Federal and Provincial Laws Governing Prescription Drug Ordering, Records, Prescription Requirements and Refills.



For your convenience this chart, should you wish to post and reference in your pharmacy, is downloadable in PDF format from the College website www.ocpinfo.com under the Professional Practice, Laws and Regulation tab.

Prescription Regulation Summary Chart[1]

Ontario College of Pharmacists
Putting patients first since 1871

CLASSIFICATION	DESCRIPTION	PRESCRIPTION REQUIREMENTS	REFILLS & TRANSFERS	PURCHASE & SALES RECORDS
Narcotic Drugs (Schedule N drugs) E.g. buprenorphine, codeine, fentanyl, hydromorphone, ketamine, Lomotil®, Marinol®, methadone[2] (prescriber exemption required[3]), morphine, nabilone, Novahistex DH®, oxycodone, meperidine, Percocet®, Tussionex®, Tylenol® No. 4 etc.	All products containing only 1 narcotic (straight narcotic drugs). All narcotics for parenteral use. All narcotic compounds containing more than 1 narcotic drug. All narcotic compounds containing less than 2 other non-narcotic ingredients. All products containing 1 of the following 5 narcotics: heroin, hydrocodone, methadone, oxycodone, pentazocine	Written or faxed prescription. **Dispensing Requirements**: the record of dispensing for all prescriptions must show: ❑ Name and address of patient ❑ Name, strength, quantity and form of drug ❑ Manufacturer of drug ❑ Directions for use ❑ Name and address of prescriber ❑ Identification number ❑ Price Charged ❑ Date of dispensing ❑ Signature of pharmacist and pharmacy technician and when different, signature of person receiving verbal order. *Refer to **Notes** (page 2) for requirements of the Narcotic Safety and Awareness Act (NSAA).	Refills are <u>not</u> permitted. All prescriptions must be written or faxed. Narcotics may be prescribed as part-fills and dispensed in divided portions. Part-fills: the total quantity dispensed must be indicated as well as the part-fill quantity. Transfers are <u>not</u> permitted, including part-fills and logged Rx[4].	<u>Purchase Records:</u> Purchases must be recorded in the Narcotic and Controlled Drug Register or invoices filed in chronological order for auditing purposes or other record maintained for such purposes and be readily available on the premises. <u>Sales Records:</u> Record of sales in Narcotic and Controlled Drug Register or in a computer from which a printout may be readily obtained on request or be available on the premises.
Narcotic Preparations (Verbal Prescription Narcotics) **Schedule N preparations** E.g. Fiorinal®-C½, Fiorinal®-C¼, Tylenol® No.2, Tylenol® No.3, Robitussin AC®, Dimetane Expectorant C®, 282®, 292® etc. <u>Exempted Codeine Products:</u> E.g. Tylenol® No.1	All combinations containing only 1 narcotic drug (not from the 5 narcotics listed above) and 2 or more non-narcotic ingredients in a recognized therapeutic dose and not intended for parenteral use. Contain codeine up to 8mg/solid dosage form or 20mg/30ml liquid and 2 or more active non-narcotic ingredients.	Written, faxed or verbal prescription. Verbal prescriptions may be accepted and recorded by a pharmacist, intern, or registered pharmacy student under the direct supervision of a pharmacist. See above for **Dispensing Requirements**. *Refer to **Notes** (page 2) for requirements of the Narcotic Safety and Awareness Act (NSAA).	Refills are <u>not</u> permitted. Rx may be written, faxed or verbal. Narcotics may be prescribed as part-fills and dispensed in divided portions. Part-fills: the total quantity dispensed must be indicated as well as the part-fill quantity Transfers are <u>not</u> permitted, including part-fills and logged Rx.	<u>Purchase Records:</u> Same as Above <u>Sales Records:</u> *Not a requirement.*
Controlled Drugs Part I (Sch. G) amphetamines and others E.g. methylphenidate, dextroamphetamine, etc. Controlled Drug Preparations Part I (Sch. G) *(Currently not available in Canada)*	All straight controlled drugs. All combinations containing more than 1 controlled drug. All combinations containing 1 controlled drug in Part I and 1 or more non-controlled ingredients in recognized therapeutic dose.		Written Rx: May be refilled if the prescriber has indicated in writing, or faxed, the number of refills and dates for, or intervals between refills. Controlled drugs may be prescribed as part-fills and dispensed in divided portions. Verbal Rx: No refills allowed but part-fills are allowed. Transfers are <u>not</u> permitted, including part fills and logged Rx.	<u>Purchase Records:</u> Same as Above. <u>Sales Records</u>: Record of sales in Narcotic and Controlled Drug Register or in a computer from which a printout may be readily obtained on request or be available on the premises.

[1] This is a summary; refer to official legislation for detailed information.
[2] Steps to follow when starting to dispense Methadone: www.ocpinfo.com, Professional Practice tab, Standards, Policies and Guidelines, "Methadone Maintenance Treatment and Dispensing Policy".
[3] To confirm a methadone prescriber's exemption for Pain or MMT: Contact Health Canada at 613-946-5139, 1-866-358-0453 or email exemption@hc-sc.gc.ca
[4] A logged prescription is a new, unfilled order that is on hold and may be dispensed at a later time.

Prescription Regulation Summary Chart[1]

Ontario College of Pharmacists
Putting patients first since 1871

CLASSIFICATION	DESCRIPTION	PRESCRIPTION REQUIREMENTS	REFILLS & TRANSFERS	PURCHASE & SALES RECORDS
Controlled Drugs, Part II (Sch. G) butorphanol and barbiturates E.g. phenobarbital Controlled Drug Preparations Part II (Sch. G) E.g. Bellergal Spacetabs®, Tecnal®	Most barbiturates and others All combinations containing 1 controlled drug in Part II and 1 or more non-controlled ingredients in recognized therapeutic dose.	Written, faxed or verbal prescription. Verbal prescriptions may be accepted and recorded by a pharmacist, intern, or registered pharmacy student under the direct supervision of a pharmacist. **Dispensing Requirements**: the record of dispensing for all prescriptions must show: ❑ Name and address of patient ❑ Name, strength, quantity and form of drug ❑ Manufacturer of drug ❑ Directions for use ❑ Name and address of prescriber ❑ Identification number ❑ Price Charged ❑ Date of dispensing ❑ Signature of pharmacist and pharmacy technician and when different, signature of person receiving verbal order. *Refer to **Notes** (below) for requirements of the Narcotic Safety and Awareness Act (NSAA).	Written or verbal Rx permitted. Refills permitted for written or verbal Rx if the prescriber has authorized in writing (at the time of issuance) the number of refills and dates for, or intervals between refills. Controlled drugs may be prescribed as part-fills and dispensed in divided portions. Transfers are <u>not</u> permitted, including part-fills and logged Rx.	<u>Purchase Records:</u> Purchases must be recorded in the Narcotic and Controlled Drug Register or invoices filed in chronological order for auditing purposes or other record maintained for such purposes and be readily available on the premises. <u>Sales Records:</u> Not a requirement.
Controlled Drugs, Part III (Sch. G) E.g. testosterone etc. Controlled Drug Preparations Part III (Sch. G) *(Currently not available in Canada)*	Anabolic Steroids and Derivatives All combinations containing 1 controlled drug in Part III and 1 or more non-controlled ingredients in recognized therapeutic dose.		Same as above.	<u>Purchase Records</u>: Same as above <u>Sales Records:</u> Not a requirement.
Benzodiazepines & Other Targeted Substances E.g. alprazolam, diazepam, flurazepam, lorazepam, chlordiazepoxide, clobazam, clorazepate, midazolam, oxazepam, temazepam, triazolam, etc.	All drugs listed in the schedule to the Benzodiazepines and other Targeted Substances Regulations.		Refills are permitted via written, faxed or verbal prescriptions. Transfer of Rx permitted except for a Rx that has been already transferred. Note: prescriptions for benzodiazepines and targeted substances are valid for 1 year from the date prescribed.	<u>Purchase Records</u>: Same as above <u>Sales Records:</u> Not a requirement.
Other Prescription Drugs (Sch. I of NAPRA) E.g. digoxin, ramipril, zopiclone etc.	All drugs listed in Schedule F of the Food and Drugs Regulations.	Written, faxed or verbal prescription. Verbal prescriptions may be accepted and recorded by a pharmacist, intern, *pharmacy technician* and pharmacy student (direct supervision). See above for **Dispensing Requirements**. *Refer to **Notes** (below) for requirements of the Narcotic Safety and Awareness Act (NSAA).	Refills are permitted via written, faxed or verbal prescriptions. Transfers of authorized refills are permitted between pharmacies.	<u>Purchase Records</u>: Not a requirement <u>Sales Records</u> : Not a requirement

***Notes:**

Original Rx must be retained for 2 years as per the DPRA S.156 (2).

Patient Record is a complete reference of all documentation related to the care of a patient and must be retained electronically for 10 years from the last recorded professional pharmacy service provided to the patient or until 10 years after the day on which the patient reached or would have reached the age of 18 years, whichever is longer. (Reg. 58/11 to DPRA, S.55 (1)). Of note, both the scanned copy of the original Rx and the dispensing record (hard copy containing pharmacist and pharmacy technician signatures) are part of the patient record.

As per the NSAA, prescribers are required to record on an Rx for a monitored drug, their CPSO#, the patient's ID and the type of patient ID provided; dispensers have to record the information.

To report Loss, Theft, Forgeries (within 10 days), expired, unused or wasted Narcotic and Controlled drugs: Contact Office of Controlled Substances at Tel. 613-954-1541or Fax: 613-957-0110.

The Niagara Apothecary

The Apothecary is open from Mother's Day to Labour Day, daily from 11 a.m. to 6 p.m.;
Labour Day to Thanksgiving, weekends only.
Retired pharmacists are available to provide information and
answer questions about this heritage building.
Admission is free; donations welcome.

Don't miss the chance to visit this summer!

For more information visit the Apothecary's website at:

www.niagaraapothecary.ca

Documentation Guidelines

Title: Documentation Guidelines

Approved: June 2012

Effective Date: June 28, 2012

Published: January/February 2004; June 28, 2012

Revised date: 2008; 2012

Review date: 2015

Legislative References: *Personal Health Information Protection Act, 2004; Drug and Pharmacies Regulation Act, 1990*

Related Resources and References: Model Standards of Practice; Code of Ethics; Guide to the Personal Health Information Protection Act; Record Retention, Disclosure, and Disposal Guideline; Policy on Medical Directives and Delegation

College Contact: Professional Practice

INTRODUCTION

Documentation is a key element of every health profession's standard of practice and one of the most basic professional responsibilities. A member demonstrates accountability and responsibility for their actions, and evidence of the application of their medication and medication therapy management expertise, through documentation. Documentation should be organized in such a manner that all professional actions on behalf of a patient are accurately described.

Documentation supports the inter- and intra- professional delivery of patient care, and demonstrates a member's professional judgment through the interventions and recommendations made on behalf of the patient.[1] Consistent documentation of patient contacts in the context of medication therapy management leads to improved continuity of care through the availability of up-to-date therapeutic information within a practice location and within the context of the circle of care.[2] Continuity of care in the treatment of chronic health conditions, such as diabetes, is associated with lower health care costs and higher patient satisfaction. [3]

PRINCIPLES

1. Patient records support the continuity of care and collaboration between and among health professionals;
2. The documentation of patient

care optimizes decision-making, helps to reduce duplication of services and demonstrates the member's decision-making process;

3. Good documentation has four important characteristics. It should be: 1) factual; 2) complete; 3) current (timely); and 4) organized.

DEFINITION:

Patient Record

A patient record is the complete account of a patient's care, including: the patient profile; patient and provider identifying information; data collected; assessment; notes documenting critical thinking and judgment, recommendations, interventions and discussions between members, other health care providers and patients; and prescriptions, records and reports that pertain to the patient's care.

GUIDELINE

The collection, use, disclosure, retention, and disposal of personal health information is governed by the *Personal Health Information Protection Act, 2004*. As the legislation regarding the collection and use of personal health information is complex, it is recommended that members review the *Guide to the Personal Health Information Protection Act* published by the Information and Privacy Commissioner and materials provided by the Ministry of Health and Long-Term Care in order to fully understand and execute their obligations. [4, 5]

The owner of the pharmacy is ultimately accountable for the personal health information collected and retained within the pharmacy, including with respect to a remote dispensing location, if any. The *Drug and Pharmacies Regulation Act, 1990* establishes specific responsibilities for the Designated Manager of the pharmacy to ensure it meets the requirements established through legislation and regulation and that patient health information is collected and stored appropriately. The College has created a *Record Retention, Disclosure and Disposal Guideline* to assist members in this area.

The patient record contains all the information required to effectively manage a patient's drug therapy. Documentation in the record includes any written or electronically generated information about a patient that describes the care or services provided. Supporting data and evidence for clinical decision-making, such as laboratory results, are referenced and, where appropriate, the scanned copies of test results are included.

A member uses professional judgment in determining the extent of documentation and information that should be contained in the

> "Documentation is a key element of every health profession's standard of practice and one of the most basic professional responsibilities."

patient record. Members should avoid extraneous information and only document what is important. The meaning of any entry into a patient record should be clear to a health care professional reading the record. The level of detail will vary depending on each situation, including when necessary:

- Date;
- Identifying information, including that of the member documenting the patient contact;
- Patient presenting symptoms or concerns (e.g. medication assessment, pharmaceutical opinion, follow-up, etc.);
- Patient history summary and care plan if developed. (The record should acknowledge whether a care plan was available. If a care plan is part of the patient record it should be acknowledged in the documentation);
- Documentation of patient's voluntary and informed or implied consent[6], or that of their substitute decision maker, if any;
- Information provided to or received from other caregivers;
- Collaboration undertaken with other caregivers, including outcomes, and/or proposed courses of action;
- Assessments, interventions, and recommendations where professional judgment was exercised along with the evidence on which the recommendations are based; and
- A follow-up plan that is sufficiently detailed to monitor the patient's progress and ensure continuity of care by the pharmacist, and other regulated health professionals or caregivers, if applicable.

Documentation will include pertinent discussions with the patient and prescriber/health care provider, including notes related to patient education, contact information and any communication which occurred or was attempted, information regarding drug use that is deemed important to patient care, or other patient information pertinent to the situation. A sample documentation/notification template that can be utilized or adapted by the member can be found on page 33 or on the College's website.

All documentation must be legible and non-erasable. Written entries are made in ink, and electronic entries are non-alterable. Notes should not be rewritten, or removed from any files or records; however, changes to recorded information are sometimes required to ensure the accuracy of the record. Where such modifications are made, incorrect information should be clearly labeled as being incorrect when a change is made. In a manual record, errors should be crossed out with a single line and initialed. Notes made by other health professionals or members are not to be altered.

DOCUMENTATION STYLES

Systematic documentation has the advantage of encouraging completeness and consistency of data presentation, as well as improving organization of thought. However, in some circumstances, documentation can prove to be time-consuming, onerous, and confusing (particularly if a pharmacist is unclear as to how to categorize certain types of information). There are a range of documentation styles to choose from that may address this issue, including the use of unstructured notes, semi-structured notes, and the creation of systematic records using established codes. Each style has certain advantages and disadvantages and the appropriate approach should meet the needs of the specific practice site.

1. Unstructured notes are free-form records of patient encounters and care. These notes must be dated and at a minimum identify the member who is making them. The notes should also conform to general conventions of appropriate language use, including the use of accepted abbreviations in a pharmacy setting. The advantages of unstructured notes are that they can be quickly written and can provide an "impressionistic" overview of a situation. Disadvantages of unstructured notes are that they are often incomplete, lack consistency, and have limited value as

Documentation Guidelines

communication with other health care providers.

2. Examples of approaches to documentation include SOAP, FARM, DRP, DAP and DDAP. These acronyms refer to the general categories of information which are documented:

   - SOAP: information is documented under the categories of Subjective (findings), Objective (findings), Assessment, and Plan;
   - FARM: categories are Findings, Assessment, Recommendations, and Monitoring (and follow-up);
   - DRP: stands for Drug-Related Problem, Rationale, and Plan;
   - DAP: is Data, Assessment, and Plan;
   - DDAP: refers to Drug-Related Problem, Data, Assessment, and Plan.[7]

   Other documentation approaches may be used as long as they are consistent with the therapeutic thought process.

3. Semi-structured approaches use a blend of both systematic and unstructured documentation systems. In these approaches, pharmacists may complement a structured note with additional free-form text to either provide more in depth information or to provide unusual and important details that may not be easily categorized elsewhere. Semi-structured notes can have the same advantages of both unstructured and structured notes, although they often take more time to compose, and may not be as clear and consistent as structured notes. Structured notes may be most appropriate in circumstances where monitoring and follow up are required. Semi-structured or unstructured notes may be more appropriate where general impressions are noted, but no specific action on the part of the pharmacist is required at the time.

DELEGATION OF CONTROLLED ACTS

Any delegation of controlled acts will be documented and will follow the principles and practices outlined in the College Policy on *Medical Directives and Delegation*.

REFERENCES

1. Kennie, et. al. Demonstrating value, documenting care: Lessons learned about writing comprehensive patient medication assessments in the IMPACT project PART I: Getting started with documenting medication Assessments. Canadian Pharmacists Journal. Retrieved at: http://www.cpjournal.ca/doi/pdf/10.3821/1913-701X%282008%29141%5B114%3ADVDCLL%5D2.0.CO%3B2

2. 'Circle of Care' is a term commonly used to describe the ability of certain health information custodians to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA. More information on the term and guidance on access to patient information, is outlined in the document created by Ontario's Information and Privacy Commissioner: Circle of Care: Sharing Personal Health Information for Health Care Purposes available at www.ipc.on.ca

3. Lee, et al. (2006). The Evaluation of the Continuity of Care at the Group Health Centre, A Unique Multi-specialty, Multi-disciplinary Health Service Organization. Canadian Health Services Research Foundation. Retrieved on the World Wide Web on May 16, 2011 at: http://www.chsrf.ca/Migrated/PDF/ResearchReports/OGC/lee_final.pdf

4. Information and Privacy Commissioner. A Guide to the Personal Health Information Protection Act. December 2004. Retrieved at: http://www.ipc.on.ca/images/Resources/hguide-e.pdf

5. Ontario Ministry of Long-Term Care. Health Information Protection Act, 2004. Retrieved at: http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/priv_legislation.html

6. Implied consent is a form of consent which is not expressly granted by a person, but rather inferred from a person's actions and the facts and circumstances of a particular situation (or in some cases, by a person's silence or inaction).

7. Kennie, et. al. Demonstrating value, documenting care: Lessons learned about writing comprehensive patient medication assessments in the IMPACT project PART I: Getting started with documenting medication

Assessments; p.118. Canadian Pharmacists Journal. Retrieved at: http://www.cpjournal.ca/doi/pdf/10.3821/1913-701X%282008%29141%5B114%3ADVDCLL%5D2.0.CO%3B2

Appendix 1: Documentation – Sample template

Patient Information	Pharmacist Information
Name: _____	Name: _____
Address: _____	Registration: _____
_____	Pharmacy: _____
_____	_____
Telephone: _____	_____
	Telephone: _____
Provided Consent? ❑Yes ❑No	Fax:
Who? _____	

Prescription Information

Original Prescription Information	Adapted/Renewed Information
Original Prescription No.: _____	Date: _____
Date of Original Rx: _____	Adapted/Renewed Rx Details:
Original Rx Details (name,strength, quantity, duration):	_____
_____	_____
_____	**Original Prescriber Information**
Copy attached? ❑Yes ❑No	Name: _____
	Contact (phone/fax): _____

Rationale for Prescribing

(Consider Patient Assessment, Laboratory Tests Information, Circumstances etc.)

_____

_____

_____

_____

_____

Monitoring/Follow-up Plan

_____

_____

_____

_____

_____

Notification Information

Names of Prescriber/Practitioner notified: _____

Date of Notification: _____

Method of Notification:

Fax # _____ Phone # _____ Other _____

Reminder: Pharmacists must be trained prior to Administering Injections

With the expanded scope regulation, members of the College are able to administer injections or inhalation for education and demonstration. As well, the government is currently circulating a proposal for pharmacists to administer flu vaccines. Pharmacists are reminded that prior to administering injections for any purposes they are required to have successfully completed specified training and should register with the College. It's as easy as 1, 2, 3 . . . . and 4.

Step 1: Complete an Ontario College of Pharmacists (OCP) approved course for injection authority:

Given that this is a new scope of practice pharmacists who wish to administer injections are required to successfully complete an OCP approved training program. OCP approved programs, which have received Stage 2 (see sidebar) Accreditation by the Canadian Council on Continuing Education in Pharmacy (CCCEP), ensure that all of the 15 nationally identified competencies for pharmacist injection education, which have been approved by College Council, are covered in the course curriculum.

To access information on current OCP approved courses, including registration information, please visit the OCP website at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Continuing+Education+(CE)

Step 2: Obtain/ Maintain CPR and First Aid Certification

In addition to OCP approved injection training, pharmacists are required to 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 is required.

Step 3: Register with OCP

Once the required training (OCP approved course for injection authority, CPR and First Aid certification) has been completed pharmacists should register with OCP:

- Access OCP's Online Services through https://members.ocpinfo.com/ and log in
- Click on My Profile – Practice
- Click on Injection Authority
- Complete acknowledgement of required CPR / First Aid training
- Select the appropriate Injection Training Course and the year completed

Note: In order to assist the public in identifying qualified pharmacists the College's Public Register will indicate those members who have registered their injection authority. This Register will not go live until the regulation is proclaimed.

Step 4: Await approval of regulations

The proposed expanded scope regulations do not take affect until they are approved by Cabinet, which is expected in the early fall. Prior to this, qualified pharmacists are not authorized to exercise this authority.

Once government approval is obtained however, pharmacists who have completed the required education and therefore qualified will be able to offer injection services for the purposes of demonstration, education and influenza immunizations to patients aged five and older.

CCCEP STAGE 2 ACCREDITATION

In addition to the standard CCCEP accreditation (Stage 1), OCP approved courses undergo a second accreditation process which examines the learning objectives and content of a program to determine the extent to which the program addresses each of the 15 nationally identified competencies for pharmacist injection education.

- **Stage 1**: Review (addressing accuracy and relevancy) for a CCCEP-accreditation as a continuing education program.
- **Stage 2**: Review the extent to which the program addresses the 15 required competencies.

Make sure you're ready to go!

MEDICATION INCIDENTS REPORTED TO AND REVIEWED BY THE ICRC:

An Analysis by ISMP Canada

Edgard Petrov, BScPhm Candidate
School of Pharmacy,
University of Waterloo
Analyst, ISMP Canada

Certina Ho, BScPhm, MISt, MEd
Project Manager, ISMP Canada
Adjunct Assistant Professor,
School of Pharmacy, University of Waterloo

In a collaborative effort to enhance patient safety, the Institute for Safe Medication Practices Canada (ISMP Canada) reviews medication incidents reported to the Inquiries, Complaints, and Reports Committee (ICRC) at the Ontario College of Pharmacists (OCP) on a regular basis. ISMP Canada reviewed 78 medication incidents that were reported to the ICRC between January 1st, 2007 and December 31st, 2008. A previous review was completed which analyzed 229 medication incidents reported to the OCP from 2001 to 2006.[1]

The purpose of this review is to look for trends that may aid in the discovery of system-wide issues affecting patient safety, highlight areas of interests and concerns in community pharmacy, and make recommendations in order to prevent similar incidents from occurring in the future. The information gathered from these incidents gives ISMP Canada and OCP insight towards the development of possible strategies to prevent or mitigate the risk of medication incidents in community pharmacy practice.

This report highlights the most significant findings of a quantitative analysis of 78 medication incidents *(refer to sidebar: Limitations of Analysis)* with a main focus on:

- Degree of harm to patient due to incident
- Type of incident
- Areas of concern in community pharmacy practice
- Medication system stages involved in the incident
- Common medications reported
- Possible contributing factors

DEGREE OF HARM TO PATIENT DUE TO INCIDENT

Of the 78 incidents, 56.4 % were associated with "no error" (i.e. near miss) or "no harm" (i.e. medication is dispensed to patient, but no symptoms were detected and no treatment was required). On the other hand 42.3% of the errors resulted in "harm" (which ranges from mild, moderate, to severe harm) and 1.3% (i.e. 1 incident) resulted in "death" (i.e. there is reason to believe that the incident caused the patient's death or hastened the patient's death). Although the number of incidents included in this analysis is small, it is still important to consider the healthcare resources associated with the "harm" or "death" cases and, particularly, the grief and suffering caused to the patient and the patient's family.

TYPE OF INCIDENT

The three most common types of incident reported were:

1. Incorrect dose/frequency/duration (33%)
2. Incorrect drug/dosage form (27%)
3. Incorrect strength/concentration (10%)

A number of factors might have contributed to the incidents mentioned above. Some of these factors include the use of dangerous abbreviations, look-alike/sound-alike drug names, and proximity of storage of look-alike packaging in the pharmacy. ISMP Canada has undertaken

various analyses and strategies to address many of these issues via the distribution of recommended system safeguards through the Safety Bulletins (available at http://www.ismp-canada.org/ISMPCSafetyBulletins.htm). For example, a list of "Do Not Use Dangerous Abbreviations, Symbols and Dose Designations" can be retrieved from http://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf.

AREAS OF CONCERN IN COMMUNITY PHARMACY PRACTICE

Documented Allergy:

Patient is allergic to clindamycin and the allergy is documented in the pharmacy computer. A verbal prescription was received for 28 Dalacin 150mg capsules. The prescription was entered and eventually dispensed. The patient took 2 doses. Within a short time, her back was itching and inflamed. The itch was spreading all over the body. The throat was also becoming raspy / hoarse. She went to the emergency room and was given IV medications for several hours. She was furious that she was dispensed clindamycin because it had been listed in the pharmacy records.

Documented allergies accounted for about 6% of the incidents reviewed. A potential gap in the dispensing process was identified. It is possible that the computer-generated drug utilization review (DUR) or allergy alert that is flagged by the DUR program of the dispensing system during order entry was an oversight or being overridden. Although allergy alerts are typically shown or displayed on the hard copy of the prescription printout, they are often printed in relatively small fonts that can easily be missed during the prescription-checking process.

Compliance Aids or Blister Packs:

A patient in a retirement home is on blister packs. After undergoing treatments in the hospital for dementia and Alzheimer's disease, he was sent back to the retirement home and prescribed Seroquel 25mg. After 3 weeks, the medication was discontinued by the doctor but the pharmacist kept putting the medication in the blister packs.

Incidents involving compliance aids and/or blister packs accounted for about 9% of the incidents reviewed. Changes in therapy are often difficult to manage with blister packs.

Compounding:

An 8 year old patient was prescribed clonidine suspension for attention deficit hyperactivity disorder. During compounding, the technician mistook microgram for milligram and therefore the suspension was dispensed with 1000 times the intended strength. The patient was found sitting and breathing shallowly shortly after administration and was admitted to the hospital.

The misinterpretation between the dosage units of "µg" and "mg" contributed to this 1000 fold overdose error. ISMP Canada has also received several reports of 1000-fold compounding errors involving the preparation of oral clonidine suspension.[2]

MEDICATION SYSTEM STAGES INVOLVED IN THE INCIDENT

Our analysis indicated that the dispensing/delivery stage accounted for the most number of medication incidents, followed by the order entry/transcription stage. These two stages are the two core

LIMITATIONS OF ANALYSIS

Although the number of medication incidents analyzed in this report is small (78) and therefore the results cannot be extrapolated as a true reflection of community pharmacy practice they do reveal the nature of some of the incidents that occur and their possible contributing factors. Some of the limitations of this analysis include:

- Given the small sample size and lack of statistical analysis it is impossible to eliminate "chance" as a possible explanation for our results.
- This report only reviews medication incidents submitted to OCP's ICRC. Therefore our results cannot be used to obtain a true estimate of the incidence and type of medication errors occurring in community pharmacy practice.
- To balance the purely quantitative nature of the data analysis reported here, it might be more appropriate to study detailed descriptions or investigation reports of specific medication incidents reported to OCP and analyze the data qualitatively.

processes occurring in a typical community pharmacy. Additionally, since most of these reports were discovered and reported to OCP by patients and/or their caregivers, it is doubtful that other stages of medication use (i.e. prescribing, administration, and monitoring) would have been acknowledged in the initial incident reports.

COMMON MEDICATIONS REPORTED

The top four drugs associated with the 78 medication incidents were:

Synthroid®	8 of 78 cases
Amlodipine	5 of 78 cases
Clindamycin	3 of 78 cases
Warfarin	3 of 78 cases

While warfarin is recognized as one of the high-alert medications by a previous ISMP Canada incident analysis on the "Top 10 Drugs Reported as Causing Harm through Medication Error"[3], further research with larger sample size is needed in order to determine if the other three drugs are indeed high-risk medications in community pharmacy practice. In fact, the above are quite commonly prescribed/dispensed medications in primary care and community practice. Therefore, it would be too pre-mature to consider these medications as high-risk or red-flag medications in community pharmacy practice based on this analysis.

POSSIBLE CONTRIBUTING FACTORS

The most common causes of medication incidents were environmental factors (i.e. noise and distraction in the pharmacy), staffing or workflow problems, followed by education issues (both patient and staff education) and miscommunication of drug orders. It is possible that the contributing factors presented in this report may not be truly reflective of all possible causes of medication errors associated with community pharmacy practice. However, they do provide a good indication or bench mark as to where most incidents may originate from. Also, it is important to keep in mind that one incident may have multiple causes.

Acknowledgment

The authors would like to acknowledge Roger Cheng, Project Leader, ISMP Canada, and Dilpreet Bhathal, BScPhm Candidate, School of Pharmacy, University of Waterloo; Analyst, ISMP Canada, for their assistance in conducting the incident analysis of this report.

RECOMMENDATIONS

1. All healthcare practitioners are encouraged to report medication incidents and near misses to ISMP Canada's Medication Incident and Near Miss Reporting Program (available at https://www.ismp-canada.org/err_ipr.htm) for the purpose of shared learning.
2. Patients are also encouraged to report medication incidents via the ISMP Canada Consumer Reporting portal at http://www.safemedicationuse.ca/report/.
3. Engage your pharmacy team in continuous quality improvement (CQI) or medication safety initiatives offered by ISMP Canada, which include:
   - Community Pharmacy Incident Reporting (CPhIR) (available at http://wwww.cphir.ca) which facilitates community pharmacists to report, share the lessons learned from medication incidents, and prevent similar incidents from occurring.
   - Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy™ (available at http://www.ismp-canada.org/amssa/), which can help identify system improvement opportunities within your own pharmacy.
   - Root Cause Analysis (RCA) (available at http://www.ismp-canada.org/rca.htm) that can be used to perform a comprehensive, system-based review of critical incidents.
   - Failure Mode and Effects Analysis (FMEA) (available at http://www.ismp-canada.org/fmea.htm) which is a proactive assessment of work environment, equipment and procedures to identify system deficiencies and potential error sources.

1 Ho C. Medication Incidents Reported to OCP: A Review by ISMP Canada. Pharmacy Connection 2008; September/October: 28-29.

2 ISMP Canada. Oral Clonidine Suspension: 1000-Fold Compounding Errors Cause Harm to Children. ISMP Canada Safety Bulletin 2011; 11(1): 1-3. [Available at: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2011-01-ClonidineSusp.pdf.]

3 ISMP Canada. Top 10 Drugs Reported as Causing Harm through Medication Error. ISMP Canada Safety Bulletin 2006; 6(1): 1-2. [Available at: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2006-01Top10.pdf.]

FOCUS ON ERROR PREVENTION

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

DEACTIVATING PREVIOUSLY PRESCRIBED DOSAGES

Patients with chronic medical conditions often experience a change in their drug therapy over time. This could result in the presence of multiple prescriptions in the patient's profile for the same drug at different dosages. Failure to deactivate the previously prescribed dosages can result in a number of 'active' prescriptions with the potential for error.

CASE:

A seventy five year old patient has been taking levodopa/carbidopa 100/25mg for an extended period of time to treat her Parkinson's symptoms. On a recent visit to her physician, the dose was increased from one and a half tablet five times daily to two tablets five times daily.

The patient took the prescription to her regular pharmacy. However, she asked that the prescription not be processed at that time as she had many tablets remaining from her previous prescription at home. She indicated that she will return to process the prescription when her current supply was depleted. The prescription was therefore logged on her profile for future processing.

Approximately six weeks later, the patient contacted the pharmacy by phone and asked that her prescription for levodopa/carbidopa be processed. Not being aware of what had occurred six weeks earlier, the pharmacy assistant checked her prescription profile and refilled the last prescription processed for levodopa/carbidopa. The quantity and directions for use provided to the patient was therefore incorrect, as it did not reflect the physician's latest prescription.

Upon arriving home, the patient read the prescription label and noticed the error. She then contacted the pharmacy and expressed her concerns about the potential for taking the wrong dose if the label instructions were followed.

POSSIBLE CONTRIBUTING FACTORS:

- On receiving the new prescription with an increase in quantity and dosage, the pharmacy staff failed to deactivate the previous prescriptions for levodopa/carbidopa which should no longer be dispensed due to the change in dosage.
- No note was added to the patient's profile to indicate the change in dose.
- The pharmacy had no system in place to readily identify the presence of logged prescriptions on the patient's file when prescriptions are being processed. Though the logged prescription is the last item to be entered into the patient profile, it is displayed at the end of the list of the patient's prescriptions.

RECOMMENDATIONS:

- If there is a change in a patient's dosage or drug therapy, establish a system to deactivate all previously dispensed medications which should no longer be dispensed. Add a notation to link these deactivated prescriptions to the new prescription.
- Contact your software vendor to discuss the addition of system alerts to indicate the presence of a related logged prescription, when a repeat prescription is being processed. At a minimum, the logged prescription should be easily seen in the patient's profile without the need to search for it.
- Provide clear verbal and written communication to patients, especially when there is a change in dosage or therapy.
- Use a highlighter to indicate changes.

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

DISCIPLINE DECISIONS

40

Member: Gregory Melville

At a hearing on April 11, 2012, a Panel of the Discipline Committee found Mr. Melville guilty of professional misconduct. The allegations of professional misconduct against Mr. Melville related to dispensing and selling narcotics for an improper purpose, a criminal conviction for trafficking a narcotic, amongst other things.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar to immediately revoke Mr. Melville's Certificate of Registration; and
- Costs to the College in the amount of $15,000.

Member: Ihab Ibrahim and Ashraf Hanna

At a hearing on March 29, 2012, a Panel of the Discipline Committee found Mr. Ibrahim guilty of professional misconduct. The allegations of professional misconduct against Mr. Ibrahim related to a dispensing error and falsification of a record. The allegations of professional misconduct against Mr. Hanna were withdrawn.

The Panel imposed a penalty on Mr. Ibrahim which included:

- A reprimand;
- That the Registrar impose specified terms, conditions or limitations on his Certificate of Registration, and in particular:
  - i. that he complete successfully within 12 months of the date of the Order, the following courses and evaluations:
    - a. The ISMP Root Cause Analysis course;
    - b. OPA Workshop on Confronting Medication Incidents;
    - c. ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, or an alternative program on ethics for health care professionals acceptable to the College;
    - d. College's Jurisprudence seminar and evaluation; and
  - ii. that he be prohibited from acting as a Designated Manager in any pharmacy for a period of 36 months from the date of the Order;
- A suspension of Mr. Ibrahim's Certificate of Registration for a period of five (5) months, with one (1) month of the suspension to be remitted on condition that he complete the remedial training exercises specified above;
- Costs to the College in the amount of $25,000.

Member: Mohamed Hanif

At a hearing held on June 14, 15, 20 and 21, 2012, a Panel of the Discipline Committee found Mr. Hanif guilty of professional misconduct. The allegations of professional misconduct against Mr. Hanif related to sexual abuse of a patient and failing to maintain the professional boundaries of the pharmacist-patient relationship.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions and limitations on Mr. Hanif's Certificate of Registration, and, in particular, that he complete successfully, at his own expense, within twelve months of the date of the Order, the ProBE Program–Professional/Problem Based Ethics for Healthcare Professionals, or an alternative program on ethics for healthcare professionals acceptable to the College; and
- Directing the Registrar to revoke Mr. Hanif's Certificate of Registration; the penalty order for the revocation is suspended in effect, or stayed, pending the disposition of the application regarding Mr. Hanif's constitutional challenge.

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

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

CONTINUING EDUCATION

Visit the College's website: www.ocpinfo.com for a complete listing of upcoming events and/or available resources. A number of the programs may also be suitable for pharmacy technicians.

For local live CE events in your area, contact your regional CE coordinator by going to www.ocpinfo.com and searching on "Regional Coordinators".

GTA

September 9, 23, 30 and October 14, 2012
Injection and Immunization Certificate Program
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

September 16, 2012
2012 Natural Health Products Symposium – Toronto, ON
Drugstore Canada
Contact: maria.krillis@rci.rogers.com

September 19-21, 2012, Oct-Jan (online), Jan 17-18, 2013
Advanced Cardiology Pharmacy Practice
Leslie Dan Faculty of Pharmacy, University of Toronto
http://www.pharmacy.utoronto.ca/cpd/id/registration
To register, contact Ryan Keay at 416-978-7562

September 22, 2012
Methadone Education Program
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

September 26, 2012
Root Cause Analysis Workshop for Pharmacists
Institute for Safe Medication Practice (ISMP Canada), Toronto, ON
http://www.ismp-canada.org/education/
Contact Medina Kadija at mkadija@ismp-canada.org

September 29, 2012
Infectious Diseases/Critical Care Conference
Leslie Dan Faculty of Pharmacy, University of Toronto
http://www.pharmacy.utoronto.ca/cpd/id/registration
To register, contact Ryan Keay at 416-978-7562

September 29, 2012
New and Expectant Mothers Program
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

October 13, 2012
Nutrition for Pharmacists Certificate Program

INTERESTED IN EXPANDING YOUR NETWORK AND GIVING BACK TO THE PROFESSION?

OCP IS LOOKING FOR REGIONAL CE COORDINATORS

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

As a Regional CE Coordinator, you will help identify CE needs of local pharmacists in your region and organize CE events with fellow team members. Interested pharmacists should submit their resume to rovais@ocpinfo.com

Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

October 24-26, 2012
Primary Care: Providing Patient Care in a New Practice Environment
University of Toronto - Toronto, ON
http://cpd.phm.utoronto.ca/primarycare.html

October 26 – 28, 2012
Infectious Disease Program
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

November 2 - 4 & 23 – 25, 2012
Certified Geriatric Pharmacist Preparation Course
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

November 7 - 9, 2012
Thrombosis Management
Leslie Dan Faculty of Pharmacy, University of Toronto
http://www.pharmacy.utoronto.ca/cpd/id/registration
To register, contact Ryan Keay at 416-978-7562

November 17, 2012
The 64th Ontario Branch CSHP Annual General Meeting and Educational Sessions
http://www.cshpontario.ca/

November 30 – December 2, 2012
Psychiatry Certificate Program
Ontario Pharmacists Association
http://www.opatoday.com/
Contact: education@dirc.ca

NATIONAL

October 9–12, 2012
19th International Congress on Palliative Care
Montreal, Quebec
Register online at http://www.palliativecare.ca/

ON-LINE/ WEBINARS/ BLENDED CE

Canadian Pharmacists Association
Home Study Online education programs accredited by the Canadian Council on Continuing Education in Pharmacy (CCCEP), including Diabetes Strategy for Pharmacists, QUIT: Quit Using & Inhaling Tobacco and Respiratory care
http://cpha.learning.mediresource.com/Default.aspx

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

Canadian Healthcare Network
On-line CE Lessons
www.canadianhealthcarenetwork.ca

Centre for Addiction and Mental Health (CAMH)
On-line courses with live workshops in subjects including mental health, opioid dependence, motivational interviewing, interactions between psychiatric medications and substances of abuse.
www.camh.net

Clinical Tobacco Interventions for Health Care Professionals
Online CE
www.opacti.org

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/

Ontario Pharmacists Association (OPA)
Online certificate programs in therapeutic areas including Pain and Palliative care and Diabetes level 1.
Online complimentary programs in therapeutic areas including Methadone, Smoking Cessation, Practical Management of Cough and Cold, Ulcerative colitis and Vitamin D in osteoporosis.
www.pharmacisteducation.ca.
Contact: education@dirc.ca

RxBriefcase
On-line CE Lessons (Clinical and Collaborative care series) and the Immunization Competencies Education Program (ICEP).
www.rxbriefcase.com

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

CANADA POST #40069798

Ontario College of Pharmacists
Putting patients first since 1871