Ontario College of Pharmacists

PHARMACY CONNECTION

WINTER 2016 • VOLUME 23 NUMBER 1

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

Baseline assessments on all of Ontario's 224 hospital pharmacies are complete

PAGE 8

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COUNCIL MEMBERS

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- Executive
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- Registration

Standing Committees
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- Professional Practice

Ontario College of Pharmacists
Putting patients first since 1871

Strategic Framework
2015-2018

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 Priorities	Core Programs Fulfillment of Mandate	Optimize Practice within Scope	Inter & Intra Professional Collaboration
Strategic Initiatives	Patients First Effective Communications Continuous Quality Improvement		

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

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

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

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

Although it may remain debatable as to whether it is a revolution or an evolution that is required, most would agree that some kind of change is necessary in order to enhance the quality of healthcare in Ontario. As outlined in the Ministry's *Patients First – Action Plan for Health*, the objective is clear — "put people and patients first by improving their healthcare experience and their health outcomes".

So what does all this mean for pharmacy? What is the role of pharmacists and pharmacy technicians to enhance the quality of healthcare and optimize patient health outcomes?

For decades, the profession of pharmacy has been struggling to answer to this question. What is the change that is required of us? What are the barriers to this change? How do we overcome these barriers? Although these continue to be valid questions, recently the College has taken a different perspective. Perhaps it is not so much about change, as it is about a shift in focus?

It is true that healthcare and pharmacy has evolved over the years, but the idea that as integral members of a patient's healthcare team, pharmacy professionals have a responsibility to deliver quality care with an objective of making patients better, is certainly not new. The Standards of Practice and Code of Ethics clearly outline the minimum expectations of practice and conduct necessary to deliver quality care. But are pharmacy professionals consistently meeting these expectations?

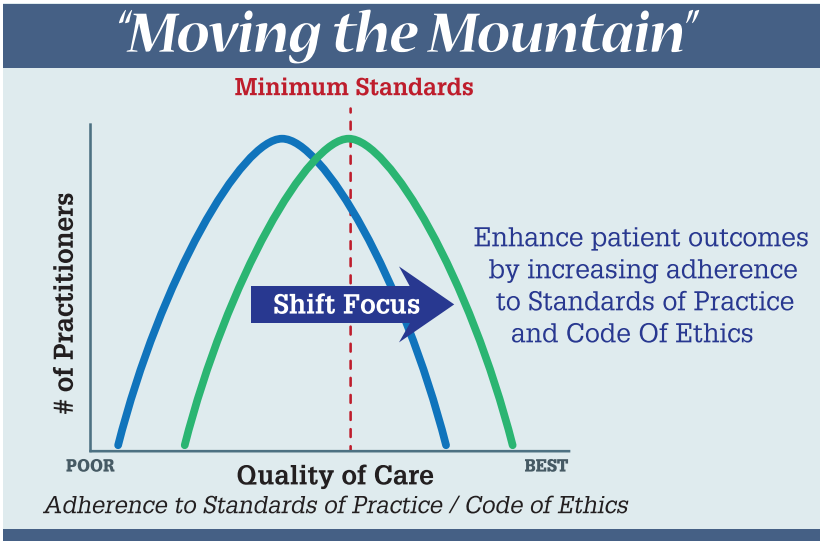
In examining recent findings from the baseline hospital pharmacy assessments and the individual practitioner assessments completed as part of the new community practice assessments, we believe that there is an opportunity for improvement. This concept is illustrated in the graphic below, titled "Moving the Mountain".

The vertical axis represents number of practitioners and the horizontal axis represents the quality of care. The red dotted line identifies the point along the quality of care spectrum where minimum practice and conduct expectations are met.

The blue bell curve (resembling the shape of a mountain) illustrates where we believe the profession currently is — with the majority of practitioners falling slightly short of consistently meeting minimum standards. The green bell curve shows our objective, which is to move the profession as a whole along the quality of care axis.

It is by shifting our focus — rather than a revolutionary change — that we believe we will be successful in 'moving the mountain'. For the College, it means a shift to coaching and mentoring pharmacists and pharmacy technicians to better understand and consistently practice to the minimum expectations outlined in the Standards of Practice and Code of Ethics. It's important to remember that your commitment to serve your patients — to help make them better — is equally as important to your commitment to protect them and minimize harm.

The article on page 31 explains Moving the Mountain in greater detail and provides links to excerpts of a recorded presentation now available on the College website and YouTube channel.



DECEMBER 2015 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on December 7, 2015.

NEW CODE OF ETHICS FOR PROFESSION OF PHARMACY APPROVED

Following an extensive collaboration and consultative process, a new Code of Ethics for the profession of pharmacy in Ontario was approved by Council. Amendments to the Code of Ethics (the Code) were required because the last significant update to the Code happened 20 years ago, and pharmacy practice has evolved significantly over the past two decades.

The role and purpose of a Code is to:

1) Outline the ethical principles and standards by which healthcare professionals are guided and held accountable;
2) Serve as a resource for education, self-evaluation and peer review;
3) Provide a benchmark for monitoring and addressing conduct of healthcare professionals; and
4) Serve as an educational resource for the public outlining the ethical obligations of the profession.

Although practice expectations have not changed in the new Code, it now more appropriately addresses current practice and clearly establishes the standards of ethical conduct for pharmacists and pharmacy technicians in Ontario, regardless of their practice setting.

Given the importance of the Code of Ethics as a foundational document for the profession, Council also approved a requirement for all members to declare that they have read and understood the Code in 2017. To assist members and other stakeholders, a comprehensive communications plan including educational resources will be put in place by College staff. More details regarding this will be communicated in the coming months.

The new Code is now in effect.

BY-LAW #4 APPROVED BY COUNCIL

In September 2015, Council approved proposed amendments to By-law No. 3 for public consultation. The amendments supported changes to the *Drug and Pharmacies Regulation Act* (DPRA) regulation, ongoing transparency initiatives within the College, and changes in the organizational structure and fees for the College.

Council considered 77 responses received during the consultation — including responses from organizations such as the Ontario Hospital Association (OHA), a Local Health Integration Network (LHIN) representing 25 hospitals in the North East region, the Ontario Pharmacists Association (OPA), and the Ontario Branch of the Canadian Society of Hospital Pharmacists (CSHP-OB).

The majority of respondents expressed disagreement with the proposed fee structure for hospital accreditation. It was felt that the fees were too high in relation to fees paid by community pharmacies and did not take into consideration a hospital's size, complexity, budget, services offered, or number of staff. As a result of the feedback, and following a review of the hospital inspection program and associated costs, Council approved a reduction to fees for hospital pharmacies.

The College's original proposal for hospital accreditation fees recommended opening fees of $6,000 and annual renewal fees of $5,000. The rationale for these fees was to recover the costs directly attributed to the hospital inspection program and included a flat rate for hospital pharmacy accreditation, regardless of the number of beds in the hospital or services provided.

The new fees for hospital pharmacies are now set at $4,000 at opening ($2,000 for application and $2,000 for issuance of a Certificate of Accreditation) and annual renewal fees of $3,500.

All other proposed amendments to the by-law were approved as circulated.

The by-law has been renamed to By-Law No. 4 and is now in effect.

Photos by DW Dorken

Hospital accreditation fees will come into effect upon the proclamation of the amended DPRA regulation.

COUNCIL DEBATES SHAREHOLDER/ OWNERSHIP REQUIREMENTS FOR PHARMACIES

In September 2015, Council tabled a motion that had been brought forward regarding proposed amendments to the shareholding requirements under the *Drug and Pharmacies Regulation Act* (DPRA).

Staff were directed to provide further background information and clarity on the issue to the Executive Committee to bring forward at the December Council meeting. The DPRA requires all corporations that operate pharmacies to have pharmacists/ members hold the majority of shares and the majority of director positions. It goes on to exempt corporations that operated a pharmacy as of May 14, 1954 from the majority shareholding requirement.

A broad review was undertaken to determine whether the current ownership structure of corporations operating pharmacies had an impact on the public's interest. It was noted that over the years, Council has discussed the issue of ownership, and that each time, no changes were recommended.

In 2001, Council approved a recommendation that would enable the College to hold all corporations who own or operate pharmacies in Ontario equally accountable, regardless of ownership structure. The concept of "proprietary misconduct' was introduced, which would give effect to such enforcement capability. Retaining the requirement to have a majority of the directors be pharmacists was determined to provide an added layer of accountability. Again, the Council of the day considered that, in the absence of any public safety issues — which is in the College's mandate — any proposal to make changes to ownership provisions would more appropriately be made by the association or individual lobbyists.

At the December 2015 meeting, Council considered a series of questions to help focus on the risk being managed by the two classes of pharmacy ownership and ultimately determined that the College should continue to rely on the existing regulatory framework that holds all corporations that operate pharmacies equally accountable, as there is no evidence that the current ownership structure presents a risk to the public within the context of the College's mandate.

Council further considered whether it was necessary for the College to scrutinize the conduct of shareholders as well as directors when determining if a corporation is suitable to operate a pharmacy. A question was raised as to what value shareholding scrutiny adds given the provisions under the DPRA that permit the College to hold the Designated Manager (DM) and/or the directors and/or the corporation itself accountable for failing to operate a pharmacy in accordance with the requirements. Furthermore, a recent jurisdictional review confirmed that, other than Quebec, no other province has a shareholding requirement for corporations operating a pharmacy. Character screening is also not performed in any other jurisdiction.

With this background in mind, Council agreed that it would be appropriate to discuss the removal of the reference to shareholders from the applicant qualification with the Ministry of Health and Long-Term Care. This approach would equalize the measures taken by the College for both pre and post-1954 corporations.

NEXT COUNCIL MEETING

Tuesday, March 29, 2016

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

Ontario College of Pharmacists

Putting patients first since 1871

MEMBERSHIP RENEWAL REMINDER

DUE MARCH 10, 2016

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

Before you begin your renewal you will need:

- Credit Card
- User ID: This is your OCP number
- Password: If you have forgotten your password, click "**Forgot your Password of User ID?**" A new password will then be emailed to you.

Once you're ready:

- Go to www.ocpinfo.com and click on "**Login to my Account**" and then click on "**My Account**"
- Enter your User ID (your OCP number) and your password
- Once you have successfully logged in, click on "**Annual Renewal**"

Baseline Assessments Reveal Opportunities for Hospital Pharmacies

Key findings around policies and procedures, traceability, compounding and professional responsibilities

By Stuart Foxman

Not every hospital pharmacy the team visited was accessible by car. This photo shows Community Practice Advisor Lisa Simpson (left) with Hospital Practice Advisor Melody Wardell, waiting for a water taxi to take them to a hospital pharmacy in the far north.

Following the completion of baseline assessments by the College, hospital pharmacies are eager to discover how to continually improve their efforts to ensure public safety as they prepare for OCP oversight.

That will come into effect once the government approves regulation amendments to the *Drug and Pharmacies Regulation Act*, expected this spring. The *Safeguarding Health Care Integrity Act, 2014* (Bill 21) lays out the authority for OCP to license and routinely assess hospital pharmacies.

To prepare, OCP hospital practice advisors conducted baseline assessments on all of Ontario's 224 hospital pharmacies throughout 2015. The goals were to review adherence to operational and practice standards, help pharmacies to prioritize their focus (based on identified risks), offer support around realistic action plans, and share best practices.

"As we left, all facilities felt it was worthwhile," says Ming Lee, RPh, a Hospital Practice Advisor for OCP. "They all learned something, and know what they have to work on."

The themes of OCP's findings can be divided into two broad categories, covering places (operation) and people (practice). The baseline assessment visits revealed several common opportunities for hospital pharmacies moving forward.

SAFE MEDICATION MANAGEMENT

Operationally, the hospital practice advisors saw opportunities to enhance safe medication systems through the effective use of policies and procedures.

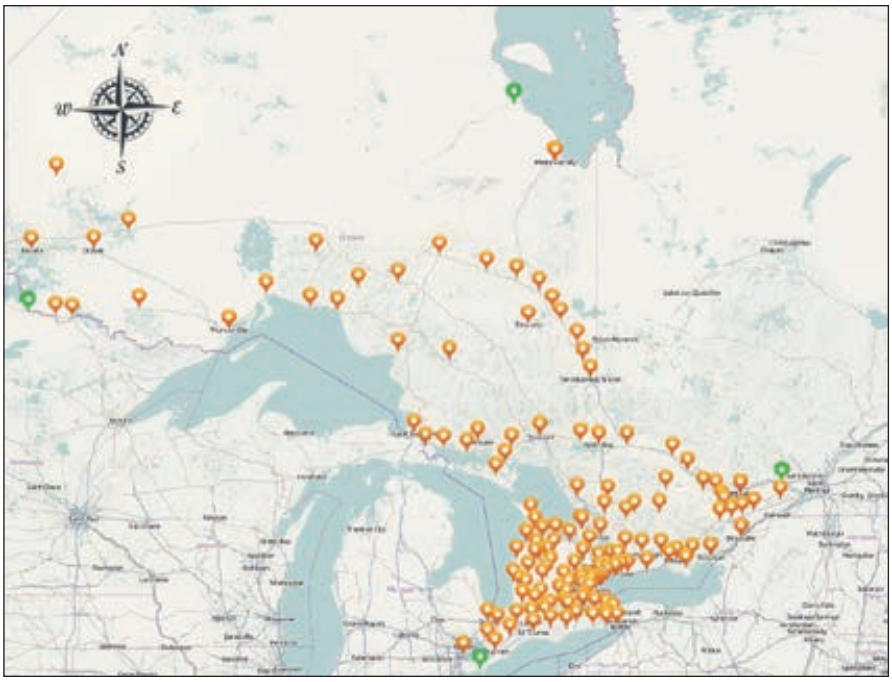
For example, automated dispensing cabinets are a helpful tool for ensuring safe medication practices. However, the technology on its

Prior to the start of the baseline assessments, draft criteria for hospital pharmacy assessments was developed through an extensive collaborative process. It involved a review of relevant standards and existing accreditation processes, and input from practicing pharmacy professionals from hospitals across the province. This photo shows Hospital Practice Advisor Ming Lee (right) with OCP consultant Marg Colquhoun collecting and analyzing the criteria before it was finalized for the baseline assessments. Now that these assessments are complete, College staff will collect feedback received during the year and make adjustments to evolve the criteria to ensure it accurately supports hospital practice.

BASELINE ASSESSMENT CRITERIA

OCP'S BASELINE ASSESSMENTS OF HOSPITAL PHARMACIES LOOKED AT EIGHT AREAS:

1. Systems to provide safe, effective and appropriate pharmacy services.
2. Order processing, verification, dispensing and distribution.
3. Preparation, packaging and labelling of medication.
4. Pharmaceutical compounding.
5. Safe medication use systems in patient care areas.
6. Medication therapy management.
7. Documentation and record keeping.
8. Evaluation of pharmacy services.



OCP's Hospital Practice team visited 224 hospital pharmacies across Ontario in 2015. This map shows the locations of all hospital pharmacies they visited — including those in the furthest four corners of Ontario. In the north, they ventured all the way to see the pharmacy at Weeneebayko Area Health Authority, Fort Albany Hospital. In the south, they met with the team at Leamington District Memorial Hospital. To the east, they paid a visit to Hawkesbury & District General Hospital. And finally, to the west, they assessed Riverside Health Care Facilities, Rainy River Hospital.

own isn't enough. Policies and procedures should also be in place to allow hospitals to maximize the safety features, so that they exceed what's possible in manual processes.

The hospital practice advisors found some gaps around the security of narcotics, with not all being appropriately secured. This applies not only to the pharmacy, but to any patient care areas where medications are stored.

Another safety gap involved therapeutic checks. Lee says hospital pharmacies should look at various methods – whether through policies or staffing – to review orders more consistently for therapeutic appropriateness prior to the administration of the first dose.

On the compounding side, NAPRA is developing national standards for the preparation of sterile and non-sterile products. Each regulatory body in Canada will consider adopting or adapting the standards.

Enhancing or creating new compounding areas is a way to increase patient safety, but it's only one option. Hospitals can take many concrete steps in complying with standards for compounding. As Lee says, people are the biggest source of contaminants that enter the clean room. It's vital to ensure that staff are well trained around hand hygiene, personal protective equipment, housekeeping and maintenance. The focus should be on people and processes as the first step.

"If you train staff to work and garb appropriately, and perform quality checks of processes, you can ensure it's safer all around," says Lee.

Along with safe medication systems and compounding, a third area of focus on the operations side was traceability, auditability and record keeping. That means the ability to identify the lot number and expiry date of each dose administered to the patient. This is the goal for all doses, but for now the College is asking hospitals to focus on their high-risk products (e.g. chemotherapy, methadone and patient-specific compounds).

Records must be easily retrievable. For instance, within 30 minutes, can you find what particular dose a patient got three years ago at 8:25 a.m.? The solution will be unique to each site, says Judy Chong, RPh, Manager, Hospital Practice.

Barcode capabilities and searchable systems are an obvious plus, but Chong says it's also important to look at how you organize paper-based records. Are lot numbers and expiry dates documented? Are the records stored in a way that makes them simple to retrieve and audit? "Don't just wait for new technology – do what you can do now," says Chong.

ALWAYS REMEMBER ACCOUNTABILITY

In travelling to all corners of the province, the OCP hospital practice advisors saw great attention to the task at hand. That's fundamental,

but just as important is paying attention to your overall professional responsibility and thinking of the big picture.

As Chong puts it, "Of course pharmacists have to ensure that orders are entered correctly, but they also have to understand if it's therapeutically appropriate for the patient."

The patient and not merely the process needs to be front and centre, explains Melody Wardell, RPhT, Hospital Practice Advisor. "You have your scope of practice, and have to work within it and take accountability for what you're doing," says Wardell.

This is true for any pharmacy setting, but has an added dimension in hospitals. Unlike the case in a community pharmacy, many other healthcare professionals are working in a hospital. The pharmacist often doesn't interact directly with the patient. There are many steps before medication gets to a patient in a hospital.

These realities only heighten the need for members of the pharmacy team to assume their professional responsibility, whether intra-professional (pharmacists and pharmacy technicians) or inter-professional (working with other practitioners).

Pharmacy professionals have knowledge and expertise regarding medication, and should always be diligent in applying it. Never assume what another healthcare professional knows or has done; always feel free to question and to act on your own professional responsibilities.

"We did see good collaboration for the most part, and you need that for safe patient care," says Wardell.

What does effective collaboration look like? Wardell gives the example of new technology implementation, where you see different professions at the table. "So all parties involved are talking, in order to make the safest possible system," she says.

Between professions, "Collaboration is about drawing on and accessing each other's knowledge," adds Debra Moy, RPh, Hospital Practice Advisor. She says that can mean everything from attending rounds to being part of discharge planning. A question to ask: is pharmacy part of decision-making, at the patient and corporate levels?

With all hospital pharmacies having successfully completed the baseline assessments, the College is ready to license these facilities as soon as final authority is provided by government. In the meantime, the

PROPOSED FEE FOR HOSPITAL PHARMACIES REDUCED AFTER CONSULTATION

In September 2015, the College posted proposed amendments to its By-law No. 3 for public consultation. Some of the amendments supported changes to the *Drug and Pharmacies Regulation Act* (DPRA) regulation, and included new fees for hospital accreditation.

The College received 77 responses during the consultation, mostly from pharmacy professionals. Many submissions expressed disagreement with the proposed fee structure for hospital accreditation, noting that the fees were too high and did not take into consideration the hospital's size, complexity, budget, services offered, or number of staff.

OCP's original proposal for hospital accreditation fees recommended opening fees of $6,000 and annual renewal fees of $5,000. The rationale for these fees was to recover the costs directly attributed to the hospital assessment program. They included a flat rate for hospital pharmacy accreditation, regardless of the number of beds in the hospital or services provided. This is consistent with community pharmacies as they all pay the same fee for accreditation, regardless of prescription volumes or specialty services.

However, the overwhelming feedback prompted a review of the program approach and associated costs. The program was examined to find savings through a less aggressive timeline and more efficiency through alternative approaches to physical site visits.

As such, before approving the proposed by-laws at their December 2015 meeting, Council recommended a reduction to fees for hospital pharmacies. The new fees are now set at $4,000 at opening ($2,000 for application and $2,000 for issuance of a Certificate of Accreditation) and annual renewal fees of $3,500.

Hospital accreditation fees come into effect upon the proclamation of the amended DPRA regulation.

OCP's Hospital Practice team (from left to right) Debra Moy, Hospital Practice Advisor; Judy Chong, Manager, Hospital Practice; Amanda Mohamed, Program Assistant; Ming Lee, Hospital Practice Advisor; and Melody Wardell, Hospital Practice Advisor.

College is reviewing the criteria used in the baseline assessments, and will incorporate lessons learned to finalize the criteria that will be used going forward.

The hospital practice advisors say that continuous improvement plans in hospital pharmacies should be prioritized based on areas of highest risk. OCP also recognizes the opportunity to bring best practices from different practice environments.

While there's work to do, Chong says the baseline assessments showed that hospital pharmacies are already doing many things extremely well, and are open to ways to get even better. "We were welcomed into these organizations." says Chong. "People saw that we were trying to coach and mentor, so it became a learning opportunity."

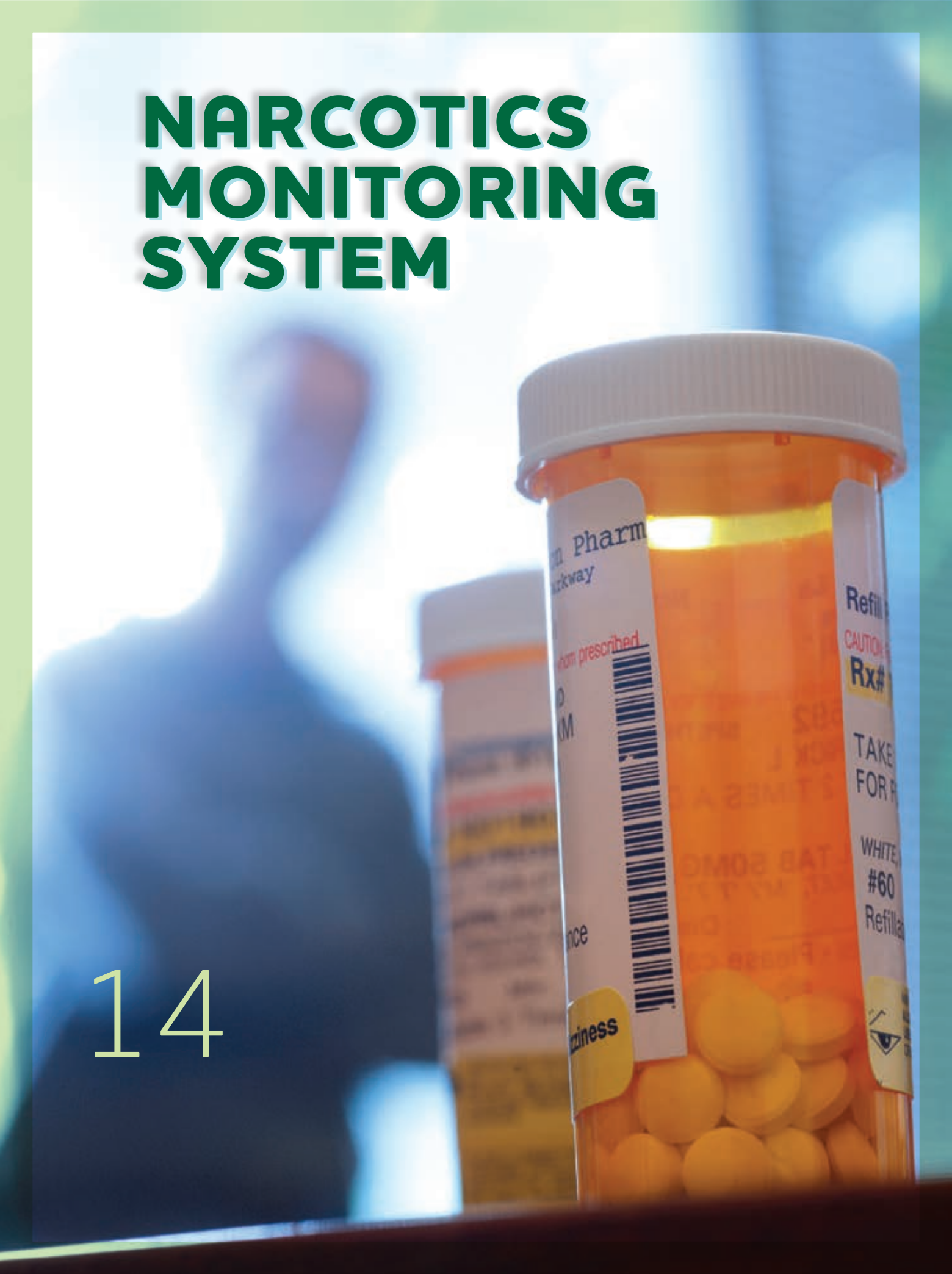
Proposed Amendments to the DPRA Awaiting Approval

The passing of Bill 21: *Safeguarding Health Care Integrity Act*, 2014 extends the College's authority to license and inspect pharmacies within public and private hospitals, as well as future authority over institutional pharmacy locations. As a result, the current regulation to the *Drug and Pharmacies Regulation Act*, (DPRA) which only addresses community pharmacy practice, requires amendments.

Proposed regulation amendments were circulated for public consultation and were approved by Council in June 2015. They are currently awaiting approval by government. Stay tuned to www.ocpinfo.com, e-Connect and *Pharmacy Connection* for updates.

For more information about proposed changes to the DPRA and the College's pending oversight of hospital pharmacies, visit the Key Initiatives section on the OCP website at www.ocpinfo.com/about/key-initiatives/

NARCOTICS MONITORING SYSTEM



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SIX IMPORTANT TIPS

Since 2012, pharmacies in Ontario have been submitting information about monitored drugs to the Narcotics Monitoring System (NMS). The purpose of the NMS is to review dispensing and prescribing activities for prescription narcotics and other controlled substance medications in community healthcare. The NMS helps to identify and alert pharmacies of potential misuse issues with monitored drugs, such as patients who are potentially double-doctoring or making visits to multiple pharmacies.

Pharmacies are asked to submit several pieces of information to the NMS when dispensing a monitored drug. Required information includes:

- Prescriber's registration number
- Prescriber ID reference (identifying the professional College to which the prescriber belongs, e.g., member of CPSO, RCDSO, etc.)
- Identification number of the patient
- Name of the person for whom the monitored drug is prescribed
- Date of birth and gender of the person for whom the monitored drug is prescribed
- Date on which the monitored drug is dispensed
- Drug identification number
- Quantity of the monitored drug dispensed
- Length of therapy, in number of days, of the monitored drug
- Prescription number
- Pharmacist ID (registration number from OCP)
- Pharmacy ID

However, a recent analysis of NMS usage suggests that errors are being made when entering data into the system. The following are six important things to remember when using the NMS:

1. Do not use the NMS for inter-store transfers

The NMS is meant for capturing data resulting from dispensing monitored drugs to patients — do not use it to capture inter-store or stock transfers between pharmacies.

2. Do not use the NMS to account for destroyed medications

Similarly, the NMS should not be used to capture information about monitored drugs that are damaged, expired, unusable, returned or otherwise need to be destroyed. It is meant for capturing data about patients receiving monitored drugs — it is not for inventory management. Adding information about destroyed medications to the NMS may trigger an inaccurate alert. Refer to OCP's Fact Sheet on the Destruction of Narcotics, Controlled Drugs and Targeted Substances for more information.

3. Enter the proper information for drugs that are for "office use"

Monitored drugs that are for "office use" should be captured in the NMS. However, there are two important pieces of informa-

tion that must be included in the NMS entry. First, the prescriber is never the dispensing pharmacist — if a physician or dentist has ordered monitored drugs for office use, then that practitioner is the prescriber and must be noted as such. Second, the days supply must be noted as 999. Entering 999 in the days supply field is the official signifier for "office use" drugs in the NMS. Find other details on how to make submissions for office use drugs here: http://www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/exec_office_odb_20120924.pdf

4. Enter the day's supply as accurately as possible

Correctly predicting a day's supply can sometimes be difficult. However, providing a thoughtful estimate is critical to avoiding incorrect warnings and/or providing intervention when required. It's unlikely that dispensers will perfectly predict the day's supply, but thoughtful consideration is necessary. Do not enter 1 or 100 in place of making an informed estimate for the day's supply.

5. Confirm the prescriber's name

You must always confirm that the name of the prescriber is accurate. Recent analysis of NMS data revealed an issue wherein prescribers with terms or conditions on their license were inappropriately prescribing narcotics or other controlled substances. However, it appears that the actual mistake is occurring at data entry when a patient's prescriber has changed, but the dispenser did not update the prescriber's name on the NMS record. This error has resulted in unnecessary investigations by regulatory Colleges.

6. Make submissions in a timely manner

In order for the NMS to function as intended, records must be as timely as possible. For example, if a prescription was filled and the patient did not come to pick it up — and the pharmacy has not reversed the entry in the NMS — the system could trigger an inaccurate alert if the patient attempts to fill the prescription elsewhere.

As part of the province's Narcotics Monitoring Strategy, the NMS helps to promote the proper use, prescribing and dispensing of prescription narcotics and other controlled substance medications, while ensuring that the people who need them can access them.

Ultimately, correct use of the NMS will help to reduce the misuse, addiction, unlawful activities and deaths related to monitored drugs.

HELPFUL LINKS

General information about the NMS and Ontario's Narcotics Monitoring Strategy: http://www.health.gov.on.ca/en/pro/programs/drugs/ons/about.aspx

Frequently Asked Questions: (http://www.health.gov.on.ca/en/pro/programs/drugs/ons/ons_faq.aspx)

A notice from the Executive Officer re: proper submissions to the NMS: (http://www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/exec_office_odb_20120924.pdf)

PATCH4PATCH

Fentanyl, a prescription-only drug, is a synthetic opioid used primarily to treat severe pain. Fentanyl is available in many forms, including as an injection and as a transdermal patch that slowly releases the medication through the skin. When used incorrectly, or abused, fentanyl can pose significant health risks.

A recent report from the Canadian Centre on Substance Abuse indicates as many as 655 Canadians may have died between 2009 and 2014 as a result of fentanyl overdoses. The diversion of pharmaceutical fentanyl patches is one means by which fentanyl is finding its way into the illicit drug market. This non-medical use of fentanyl creates a risk of overdose because of the high potency of the drug.

Bill 33 *Safeguarding our Communities Act (Patch for Patch Return Policy), 2015*, received royal assent on December 10, 2015. The bill establishes a framework for implementing a regulated Patch4Patch program in Ontario. In addition to establishing requirements that apply to prescribers, the legislation sets out the rules that apply to persons who dispense fentanyl patches. The provisions of the Act that refer to fentanyl patches apply to all controlled substances patches. It is anticipated that regulations supporting the provisions in the Act will be developed by government and implemented in 2016.

Stay tuned for more information about fentanyl and the Patch4Patch program.

CANADIAN SOCIETY FOR HOSPITAL PHARMACISTS: PROFESSIONAL PRACTICE CONFERENCE 2016

OCP attended the 47th annual CSHP Professional Practice Conference held Jan. 30 to Feb. 3, 2016 at the Sheraton Centre Hotel in Toronto. College representatives spoke with hospital pharmacists and pharmacy technicians from across the province about their experiences with the baseline assessments and ways to continue improving their efforts to ensure public safety in preparation for OCP oversight. Pictured here (left to right), Judy Chong, Manager, Hospital Practice; Marshall Moleschi, Registrar and CEO; and Jasmine Graham, Communications Specialist.

PRACTICE TIP!

GET A NEW PRACTICE TIP EVERY WEEK ON TWITTER

As you may be aware, the College has an official Twitter account. On a daily basis, we tweet out helpful regulatory news and updates, new practice tools, important member reminders, and much more. Recently, we launched an initiative where every week we give you a new practice tip (followed by the hashtag #OCPPracticeTip).

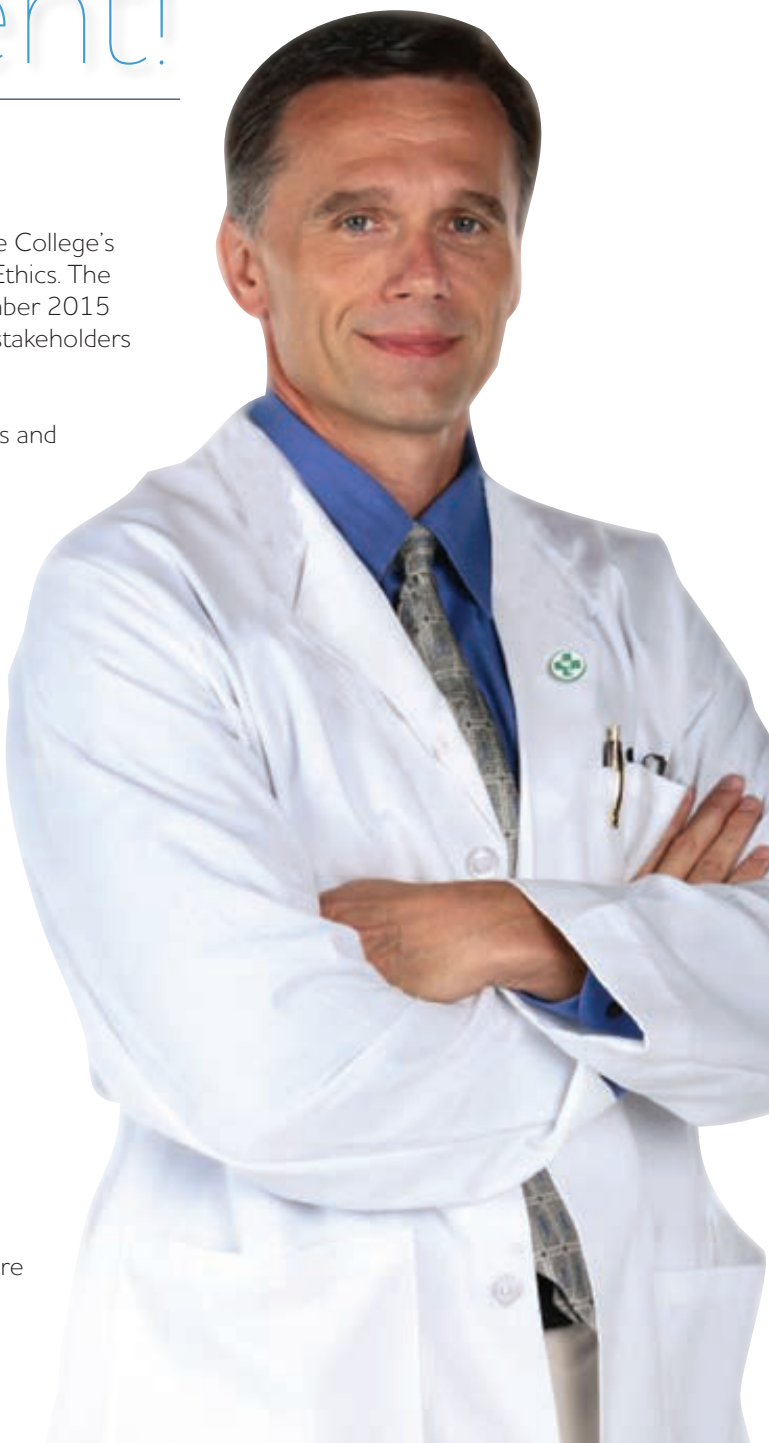
Tips are developed from actual observations and encounters in practice and include: record keeping and documentation, methadone dispensing, narcotics reconciliation, clinical decision making, patient counselling, and much more.

You may have noticed practice tips scattered throughout this issue of *Pharmacy Connection*. These are tips that we've previously tweeted out as part of this new initiative. Enjoy!

Be sure to follow OCP on Twitter so you can see each new tip once it is published!

It's Not About You, It's About The Patient!

PART 4 OF 4



This article is the last in a four-part series about the College's recent initiative to revise the profession's Code of Ethics. The new Code was approved by Council at their December 2015 meeting after extensive collaboration with various stakeholders and public consultation.

The new Code, which is applicable to all pharmacists and pharmacy technicians in Ontario, regardless of where they practice or work, is comprehensive, and brings together concepts from the previous Code, the Standards of Practice, the Principles of Professional Responsibility, and relevant legislation.

The new Code provides pharmacy professionals with a solid framework to understand their ethical obligations as it aligns with core principles of healthcare ethics, which all healthcare professionals are bound by. All pharmacists and pharmacy technicians must use these principles — not their own beliefs or values — to inform their behaviour and conduct, and serve as a compass for their actions and decision-making in practice. As a reminder, the four core principles of healthcare ethics that the new Code is founded on are:

1. **Beneficence**
2. **Non-maleficence**
3. **Respect for persons/justice**
4. **Accountability (fidelity)**

Abiding by these principles is not optional. In fact, understanding and committing to them is part of your overriding role and responsibility as a healthcare professional.

A QUICK RECAP

Each article in this four-part series about the Code of Ethics discussed these core principles of healthcare ethics. The first article in the series — "What's Ethics Got To Do With It?" — explained the origins of the principles and offered brief definitions of each. The second article — "Revising Our Code of Ethics...Why Now?" — examined how and why the College used these principles as the foundation in the development of the new Code.

The third article, "Is It Enough to 'Do No Harm'?", examined beneficence and non-maleficence in depth. The article provided detailed definitions for these first two core ethical principles, explained how they work in tandem, and examined some of the specific responsibilities of pharmacy professionals when it comes to both benefiting patients and preventing harm.

As a quick recap, beneficence refers to a healthcare professional's responsibility to actively and positively serve and benefit their patients and society — to help their patients get better. Non-maleficence, on the other hand, is about a healthcare professional's obligation to be diligent in efforts to do no harm and, whenever possible, to prevent harm from occurring.

The third article asked pharmacy professionals to consider if they spend just as much time and attention to applying the principle of beneficence as they do with non-maleficence. For example, a pharmacist might ensure a prescription has been filled accurately, check that the patient has no known drug allergies and verify that there are no known contraindications for the medication— the pharmacist has applied the principle of non-maleficence and was diligent to ensure no harm will come to the patient. But, did the pharmacist spend the same time and attention ensuring that the prescription is actually what the patient needs, that the therapy will help the patient, and that it will optimize the patient's health outcomes?

PART FOUR

This article will discuss the last two foundational principles of healthcare ethics that the new Code is founded on — respect for persons/justice and accountability (also known as fidelity). However, it's important to remember that all of these principles work together, and as we discuss respect for persons/justice and accountability in this article, we will inevitably be drawn back to the discussions about beneficence and non-maleficence. Ultimately, practitioners need to internalize and use these principles to inform their actions and decisions in practice. It will be the application and implementation of these principles that will ensure patients receive safe, effective and ethical pharmacy services.

WHAT IS RESPECT FOR PERSONS/JUSTICE

As outlined in the Code, the ethical principle of respect for persons/justice refers to your dual obligation as a healthcare professional to respect and honour the intrinsic worth and dignity of every patient as a human being, and to treat all patients fairly and equitably.

The Code outlines standards that describe the specific actions and behaviours expected of you in order to demonstrate your commitment to this foundational principle. For example, you must recognize the vulnerability of patients, value their autonomy and dignity, and treat them with sensitivity, care, consideration and respect. Although these sound reasonable, and support a societal

New Code of Ethics Now in Effect.

expectation to "treat others as you would want to be treated yourself", a scan of complaints raised with regulatory colleges, including OCP, indicates that there is some room for improvement in this area. The recent *Close-Up On Complaints: The Importance of Sensitivity & Communication* article featured in the Fall 2015 issue of *Pharmacy Connection* illustrates this point.

Perhaps part of what makes this challenging is, that as a healthcare professional, you must uphold this principle for all patients, in all circumstances — not just for those patients whose values and decisions align with your own. Respecting your patient means that you do not allow your views about a patient's personal life, religious beliefs, or other morally irrelevant factors such as race, gender, identity, sexual orientation, age, disability, martial status, etc. influence how you treat the patient or affect the quality of care you provide.

You also demonstrate your commitment to this principle when you obtain patient's consent, uphold their confidentiality, and respect their autonomy to make their own decisions about their healthcare. This includes their right to accept or refuse services and their right to choose the pharmacy and/or pharmacy professional they wish to receive services from.

IT'S NOT ABOUT YOU, IT'S ABOUT THE PATIENT!

The last fundamental principle of healthcare ethics that the new Code is founded on is accountability (also known as fidelity). This principle requires you to be a responsible and faithful custodian of the public trust, accountable not just for your own actions and behaviours, but for those of your colleagues as well.

As explained in the Code, this principle directly ties pharmacists and pharmacy technicians to the professional promise that all healthcare professionals share — to always and invariably act in the best interest of your patient, not your own. This concept of putting someone else ahead of yourself is not easy to consistently uphold, but is at the core of your ethical obligation as a healthcare professional.

As this principle is overarching, the specific standards included in the Code cover a range of responsibilities and are divided into three sections:

1. **General responsibilities**
2. **Participate in ethical business practices**
3. **Avoid conflict of interest**

For the purposes of this article, let's explore a few of these more closely.

"DUTY TO REPORT" PROFESSIONAL INCOMPETENCE OR UNETHICAL BEHAVIOUR

One of the standards (4.10) under the accountability principle states that you are responsible to "report professional incompetence or unethical behaviour by colleagues or other healthcare professionals to the appropriate regulatory authority." Lets consider the following situation to illustrate the application of this standard in practice. Assume that you work for a corporation as a pharmacy manager. You have strong evidence to support the fact that one of your staff pharmacists has engaged in unethical behaviour. What do you do? Report them to head office? Terminate their employment?

In many jobs, reporting the employee or terminating their employment may be enough. But, as a healthcare professional your obligation extends beyond that. By releasing this individual from your employment, you may have protected the patients at your pharmacy from any future unethical conduct from this individual — but what about other patients?

Being a responsible and faithful custodian of the public trust means that — like all other healthcare professionals — your obligation to protect the best interest of patients extends to all patients and, in fact, to society at large. This can be challenging because in situations like the one described here, you are required to formalize a report to the regulatory College about the conduct of this colleague.

Upholding your responsibility and duty to report is particularly important in circumstances where there is a significant breach of patient trust, such as an incident of sexual abuse. In cases like these, your duty to report is not only ethical, but also legal.

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YOUR PRIMARY COMMITMENT IS TO DIRECTLY BENEFITING PATIENTS

As pointed out in the Code of Ethics the most important feature or characteristic that distinguishes a healthcare professional from another type of professional is that healthcare professionals are committed, first and foremost, to the direct benefit of their patients and only secondarily to making a profit.

This doesn't mean that pharmacies are expected to operate without making a profit. It means that the actions and decisions that pharmacists and pharmacy technicians make must consider their patient's best interests first. The patient's interest must come before the interests of the pharmacy professional, their business, or their employer's business.

Given how closely entwined the profession of pharmacy is with retail business, it's likely not surprising to learn that a significant number of the concerns raised to the College are related to allegations that a practitioner has put their own interests, or those of their business, ahead of their patients.

This line can easily blur, as it's not always our natural tendency to think of others first. Often, if a person has to make a decision that could affect someone else, they start by considering what works best for them, and then they consider if the other person would be okay with their decision. While this approach might be acceptable for a business owner who is juggling the needs of their business with the desires of their customers, it is not appropriate for a healthcare professional.

As a healthcare professional, your obligation is first and foremost to consider the best interests of your patient ahead of your own. Your own considerations, or those of the business, should not influence your thought process at all, and should certainly not frame your thinking. Adopting the mantra – it's not about me, it's about the patient – may be an effective way of ensuring that you always begin your thought process with the right end in mind.

AVOIDING CONFLICT OF INTEREST

Finally, under the principle of accountability, the Code deals with the challenge of conflict of interest, and reminds practitioners to avoid situations that are or may reasonably be perceived to be a conflict of interest.

Standard (4.29) outlines the responsibility pharmacists and pharmacy technicians have to "declare any personal or professional interests and inform the relevant party(s) if they are involved in a real, perceived or potential conflict of interest and resolve the situation in the best interests of the patient and public safety as soon as possible".

While avoiding conflict of interest is not always possible, ensuring that you appropriately identify and manage these situations is critical to your ability to remain an objective decision-maker. Avoiding dual relationships whenever possible, and limiting treatment of yourself and members of your immediate family to minor conditions and emergency circumstances only (unless another appropriate healthcare professional is not readily available), are examples of how to manage conflict.

LEARNING RESOURCES

The College is currently developing a number of e-learning modules to support pharmacists and pharmacy technicians in understanding and applying the new Code of Ethics. The modules will cover key concepts and principles from the Code, and will use video case studies to illustrate the application of the Code in practice. The first of these modules is expected to be available this spring, with the full series complete by the fall. Stay tuned to *Pharmacy Connection* and e-Connect for more information.

Vaccine Medication Incidents in the Community

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

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INTRODUCTION

The value and global impact of vaccinations on public health cannot be overstated. The World Health Organization acknowledges that vaccinations are only second to clean water in reducing the burden of infectious diseases.[1] A 2015 report from the C.D. Howe Institute highlighted policy changes that could ameliorate immunization coverage in Canada.[2] One such recommendation is that a further expansion on pharmacists' scope of practice concerning vaccine administration will improve overall immunization rates by reducing costs and barriers associated with accessing immunization services.[2,3] Patient-reported accessibility and convenience of pharmacist-administered vaccinations can be further evidenced by a 2015 national survey which revealed that nearly 4 in 5 of Canadians would consider a pharmacist-administered vaccination.[3,4] Considering (1) the pressure exerted on the Ontario Government to incorporate additional vaccines to pharmacists' scope of practice, (2) the increasing public acceptability of pharmacist-delivered vaccinations, and (3) the rapidly changing landscape of pharmacist-delivered immunizations in other provinces, it would be prudent for Ontario pharmacists to begin establishing system-based error prevention models that go above and beyond exercising individual vaccine vigilance.[5,6,7,8]

According to the United States Vaccine Adverse Event Reporting System (VAERS) 2015 statistics, the most common type of vaccination errors are related to scheduling (27%), storage/dispensing (23%), and vaccine type (15%).[9] The data also suggests that while errors do occur during the prescribing and dispensing stage, the most common stage of the medication system during which vaccination errors occur is administration.[10] This is particularly important as Ontario pharmacists' role in vaccine administration continues to grow and evolve. When taking into consideration the increasing complexity of provincial immunization schedules and the ever-expanding array of available vaccine products, left unchecked, these factors could potentially compound the number of vaccine errors in the future.[11,12]

On a small scale, vaccination errors may potentially lead to patient harm, inconvenience related to patient recall, increased costs, wasted time and vaccine, and possible unwanted media attention.[9,13,14] Furthermore, such an error can diminish or eliminate the immunological effectiveness of the vaccination.[15] On a large scale, this translates into both compromised patient care and, through herd immunity, public protection against serious infectious diseases.[15] Considering the ongoing public concern regarding adverse effects of vaccines, minimizing vaccination errors is paramount in maintaining confidence in the healthcare system.[9]

Reports using US vaccination error data have been published in abundance (i.e. ISMP's Vaccine Error Reporting Program (VERP) and CDC's and FDA's VAERS).[9,10,15] The paucity of reports using Canadian data is the justification for this multi-incident analysis (MIA). The following are the primary objectives of the analysis: (1) to foster a greater comprehension for the scope and impact of vaccination errors on

patient safety in Canada, (2) to expose specific stages throughout the medication use system that are considered high-risk for generating system-based errors, and (3) to propose recommendations that aid in pharmacist's vigilance for potential violations in the "rights" of vaccine administration.[13]

MULTI-INCIDENT ANALYSIS OF VACCINE MEDICATION INCIDENTS

The Community Pharmacy Incident Reporting (CPhIR) Program (available at http://www.cphir.ca) is designed for community pharmacies to report near misses or medication incidents anonymously to ISMP Canada for further analysis and dissemination of shared learning from incidents.[16] CPhIR has allowed the collection of invaluable information to help identify system-based vulnerable areas in order to prevent future medication incidents.16 This article provides an overview of a multi-incident analysis of medication incidents involving vaccine errors reported to the CPhIR program. Incidents were extracted using vaccine brand names and their corresponding abbreviations and infections from the Public Health Agency of Canada's "Types and Contents of Vaccines Available for Use in Canada" (http://www.phac-aspc.gc.ca/publicat/cig-gci/p01-14-eng.php) as search terms. A total of 839 incidents were retrieved from April 2010 to September 2015. From this, 707 incidents were excluded from the analysis because they fulfilled any one or more of the following criteria: (1) incident report did not provide sufficient detail or narrative for subsequent theme classification, (2) incident was unrelated to the topic, (3) incident report was a duplicate incident entry, or (4) underlying problem in the incident was not specific to vaccines (e.g. third party billing issues, refills, etc.). Consequently, 132 incidents contained relevant and sufficient narrative description and were included in the analysis. These medication incidents were analyzed and categorized into 7 main themes and further divided into subthemes. The main themes in this analysis are intended to represent violations of "The 6 'Rights' of Vaccine Administration" which originate from nursing literature.[13] These themes were adapted from an administration focus to expand and include common errors found in storing, preparing, and dispensing of vaccines. This accurately represents the unique environment of a community pharmacy which includes nearly all stages of the medication-use system.

For the purposes of this article, the following definitions will be used for "selected" and "dispensed". A vaccine is "selected" when it is chosen from the pharmacy inventory, during either the order entry or the prescription preparation stage. A vaccine is "dispensed" when it is released from the pharmacy to the patient or the patient's agent. (Note: The "Incident Examples" provided in Tables 2 to 8 were limited by what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.)

TABLE 1. Themes and Subthemes of the Vaccine Multi-Incident Analysis

Themes	Subthemes
Wrong Vaccine/Drug Product or Incomplete Vaccine	Wrong Vaccine or Drug Product Prescribed
	Wrong Vaccine or Drug Product Selected at Pharmacy
	Wrong Formulation Selected at Pharmacy
	No Diluent Dispensed
Wrong Dosage	Wrong Dosage for Age Prescribed
	Wrong Dosage for Age Selected at Pharmacy
Wrong Time	Inappropriate Dosing Schedule Prescribed or Vaccine Dispensed too Early/Late
	Expired Medication Dispensed/Administered
Wrong Storage	Wrong Storage in Patient's Home
	Wrong Storage in Pharmacy
Wrong Patient	(No subthemes identified)
Wrong Documentation	(No subthemes identified)
Wrong Manner/Route	(No subthemes identified)

TABLE 2: Theme One – Wrong Vaccine/Drug Product or Incomplete Vaccine

Subtheme: Wrong Vaccine or Drug Product Prescribed

Incident Example	Possible Contributing Factors	Commentary
A physician prescribed polio vaccine (Imovax® Polio) for a patient. The patient's mother came to the pharmacy and realized that it was the incorrect vaccine by the difference in cost of the polio vaccine compared to the cost of the rabies vaccine (Imovax® Rabies) that she expected to be picking up.	Unfamiliarity with the vaccine, particularly its indications.[9] Failure to check or verify the indications or appropriateness of the vaccine.[9] Confusion due to look-alike/sound-alike vaccine or drug product names.[9]	Differentiate the appearance of similar vaccine/medication names on computer screens by highlighting dissimilarities (e.g., Imovax® **POLIO** vs. Imovax® **RABIES**).[9] *[Simplification/standardization]* Place Public Health Agency of Canada's "Table 1: Types and Contents of Vaccines Available for Use in Canada" hardcopy near – or a desktop link on – the prescriber computer as a readily accessible reference. (http://www.phac-aspc.gc.ca/publicat/cig-gci/p01-14-eng.php) *[Education & Information]*

Subtheme: Wrong Vaccine or Drug Product Selected at Pharmacy

Incident Example	Possible Contributing Factors	Commentary
A prescription was brought into the pharmacy for Havrix® Junior. It was entered as Havrix® Junior but Twinrix® Junior was selected from the fridge and labeled. The error was discovered by the pharmacist upon checking.* *Note: Havrix® is Hepatitis A vaccine; Twinrix® is Hepatitis A and B vaccine.	Unfamiliarity with the vaccine, particularly its indications.[9] Failure to check or verify the indications of the vaccine.[9] Confusion due to look-alike/sound-alike vaccine/drug product names and ambiguous labeling and packaging.[9] Unsafe storage arrangements (e.g., stored too close to similar-looking vaccines).[9]	Implement barcode scanning at prescription preparation which requires scanning of the vaccine barcode to prevent inadvertently labeling the wrong vaccine. *[Automation/computerization]* To prevent potential order-entry errors, differentiate the appearance of similar vaccine/medication names on computer screens by highlighting dissimilarities (e.g., TALLman lettering: HAVrix® vs. TWINrix®).9 *[Simplification/standardization]* Separate/segregate vials and syringes into bins or other containers according to vaccine type and formulation. Never store different vaccines in the same containers.[9] *[Simplification/standardization]* Store vaccines with similar packaging or names on different shelves within the refrigerator/freezer, or in separate refrigerators/freezers, to lessen the risk of errors.9 *[Rules & policies]* To prevent potential order-entry errors, inquire about/confirm the indication for the vaccine with the patient at prescription drop-off or pick-up. *[Rules & policies]* To prevent potential order-entry errors, place Public Health Agency of Canada's "Table 1: Types and Contents of Vaccines Available for Use in Canada" hardcopy near – or a desktop link on – the order-entry computer as a readily accessible reference. (http://www.phac-aspc.gc.ca/publicat/cig-gci/p01-14-eng.php) *[Education & Information]*

Subtheme: Wrong Formulation Selected at Pharmacy		
Incident Example	**Possible Contributing Factors**	**Commentary**
A prescription was written for and entered as Gardasil® 9, but was filled and dispensed as Gardasil®. The error was discovered by the physician when the vaccine was brought in to be administered.* *Note: Gardisil® – protects against 4 types of HPV; Gardisil® 9 – protects against 9 types of HPV.	Unfamiliarity with the vaccine, particularly its new formulations.[9] Failure to check or verify the potential formulations of the vaccine.[9] Confusion due to look-alike/sound-alike vaccines and their formulations.[9]	Implement barcode scanning at prescription preparation which requires scanning of the vaccine barcode to prevent inadvertently labeling the wrong vaccine formulation. *[Automation/computerization]* To prevent potential order-entry errors, differentiate the appearance of vaccine formulations on computer screens by highlighting dissimilarities (e.g. Gardasil® **ORIGINAL** vs. Gardasil® **9 VALENT**) .[9] *[Simplification/standardization]* Separate/segregate vials and syringes into bins or other containers according to vaccine type and formulation. Never store different vaccine formulations in the same containers.9 *[Simplification/standardization]* Store vaccine formulations with similar packaging or names on different shelves within the refrigerator/freezer, or in separate refrigerators/freezers, to lessen the risk of errors.[9] *[Rules & policies]*
Subtheme: No Diluent Dispensed		
Incident Example	**Possible Contributing Factors**	**Commentary**
A pharmacy dispensed Zostavax® II to a patient who subsequently brought the vaccine to their physician for administration. The physician then called the pharmacy to inform them that the diluent was not dispensed along with the vaccine. The pharmacy delivered the diluent to the physician's office.* *Note: Not all vaccines are available as a prepared, ready-to-inject, pre-filled syringe. Many have two vials that require mixing prior to administration: one containing the concentrated vaccine powder, and a second, which is the diluent.	No system to ensure co-dispensing of both vaccine and diluent.[9]	Establish barcode scanning during dispensing that requires scanning the barcodes of both the vaccine and corresponding diluent. *[Automation/computerization]* Affix or dispense labels with illustrated mixing directions to the outside of the designated vaccine storage baskets in the fridge to remind staff to dispense/mix the vaccine with its corresponding diluent (http://www.cdc.gov/vaccines/recs/storage/guide/vaccine-storage-labels.pdf). *[Reminders, checklists, double checks]* Label the specific locations where vaccines are kept to remind staff to combine the contents of vials as indicated.9 *[Reminders, checklists, double checks]* Dispense the products together in a bag (or attached with rubber band) with an auxiliary label to remind staff to include both vials. *[Reminders, checklists, double checks]* Establish a process to store vaccines and their corresponding diluents in the pharmacy together if storage requirements do not differ (e.g. attached using rubber band or label tape).[9,15] *[Rules & policies]* Establish ongoing education of staff involved in dispensing and administering vaccines, which includes discussion of safety issues with vaccines and specific diluents.[9] *[Education & Information]*

TABLE 3: Theme Two – Wrong Dosage

Subtheme: Wrong Dosage for Age Prescribed

Incident Example	Possible Contributing Factors	Commentary
Upon checking, the pharmacist noted that the adult Havrix® dose that was prescribed was not indicated for the 17 year old patient. The pharmacist contacted the prescribing physician and recommended Havrix® Junior.* *Note: Patients aged 1-18 year(s) require Havrix® Junior.	Unfamiliarity with the vaccine, particularly its dose and age specifications.[9] Failure to check or verify the vaccine age indication and the patient's age.[9]	Prior to prescribing a vaccine, verify the patient's age by asking the date of birth (if the patient is available) and referencing the patient's health record, or immunization record, and verifying the indicated age range for the vaccine.[9] *[Rules & policies]* Place easily accessible links to vaccine manufacturer monographs or a chart with vaccine brand names, age-specific formulations, and corresponding indicated ages at/near prescriber computer as an accessible reference. *[Education & Information]*

Subtheme: Wrong Dosage for Age Selected at Pharmacy

Incident Example	Possible Contributing Factors	Commentary
A prescription was brought into the pharmacy requesting Twinrix®. The patient's age, 18 years old, was explicitly written on the prescription. The pharmacy filled and dispensed Twinrix ® adult strength. The error was discovered by the physician before the vaccine was administered.* *Note: Patients aged 1-18 year(s) require Twinrix® Junior.	Unfamiliarity with the vaccine, particularly its dose and age specifications.[9] Failure to check or verify the vaccine age indication and the patient's age.[9]	Work with pharmacy software developers to create a pop-up reminder that appears when the patient's age does not fall within the indicated age range for the prescribed vaccine. This pop-up should only be bypassed with a free-text entry of the reason along with the staff's identifier (e.g. scanning of personal barcode). *[Automation/computerization]* Investigate purchasing differing age-specific formulations of the same vaccine from different manufacturers to help distinguish them (where applicable).[9] *[Simplification/standardization]* To prevent potential selection errors, affix auxiliary labels to the vaccines and/or storage areas to draw attention to the specific ages for these vaccines.[9] *[Reminders, checklists, double checks]* Separate/segregate the storage areas of pediatric and adult formulations of vaccines (e.g. use of baskets or bins).9 *[Rules & policies]* Prior to dispensing a vaccine, verify the patient's age by asking the date of birth (if the patient is available) and referencing the patient's health record, or immunization record, and verifying the indicated age range for the vaccine.[9] *[Rules & policies]* Make immunization schedules easily available to both clinicians/staff and patients/caregivers.[15] *[Education & Information]* Place easily accessible links to vaccine manufacturer monographs or a chart with vaccine brand names, age-specific formulations, and corresponding indicated ages at/near the order-entry computer as an accessible reference. *[Education & Information]*

TABLE 4: Theme Three – Wrong Time

Subtheme: Inappropriate Dosing Schedule Prescribed or Vaccine Dispensed too Early/Late

Incident Example	Possible Contributing Factors	Commentary
A patient's third dose of Twinrix® was given at the prescribed 6 months, but not after the necessary 5 months from the second dose. The error was discovered after the vaccine was administered by the physician. The pharmacist contacted the physician regarding the error, and the physician opted to test the patient to ensure adequate seroconversion.* *Note: The standard dosing schedule for Twinrix® is 3 doses given at 0, 1, and 6 months. Doses must never be given too early or too close together to ensure adequate seroconversion.	Unfamiliarity with the vaccine, particularly its dosing schedule.[9] Failure to check or verify the vaccination schedule and the patient's age, health record, or local immunization information system.[9]	If possible, link the immunization schedule to the pharmacy system and/or vaccination record.[9] *[Automation/computerization]* For frequently administered vaccines, establish standard, pre-printed order sets or protocols, which include: • Information regarding any required follow-up doses.[9] *[Simplification/standardization]* Build an alert into the vaccination record to remind staff to discuss prior immunizations with the patient or caregiver.9 *[Reminders, checklists, double checks]* Prior to prescribing or dispensing a vaccine, consult the manufacturer's dosing schedule (e.g. standard, rapid, or alternate schedule) to verify appropriateness with respect to patient's age. *[Rules & policies]* Prior to prescribing or dispensing a vaccine, verify the patient's current immunization status by checking the patient's health record, pharmacy profile, and vaccination record to avoid invalid doses administered too soon.9 *[Rules & policies]* Post up-to-date, easy-to-read immunization schedules for infants, children, teens, and adults that staff can quickly reference in clinical areas where vaccinations may be prescribed, dispensed, or administered (available from the Canadian Immunization Guide http://www.phac-aspc.gc.ca/publicat/cig-gci/p03-eng.php).[9] *[Education & Information]* Encourage patients, or their caregivers, to track their vaccination status using ISMP Canada's MyMedRec app or Immunize Canada's app to record and store vaccine information and to access vaccination schedules (https://itunes.apple.com/ca/app/mymedrec/id534377850?mt=8 http://www.immunize.ca/en/app.aspx). [Education & Information]

Subtheme: Expired Medication Dispensed/Administered

Incident Example	Possible Contributing Factors	Commentary
A pharmacy filled a prescription for Menjugate® that had been expired for over one month. The physician noticed the error prior to injecting the child. The mother contacted the pharmacy to request an exchange for a valid vaccine.	Unsafe storage conditions (e.g. expired vaccines).[9] Failure to check vaccine expiration date prior to dispensing or administering.	Implement barcode scanning at prescription preparation and configure pharmacy software to prompt user to enter expiration date of vaccine once scanned. *[Automation/computerization]* Use a standardized vaccination documentation form that includes a prompt to document vaccine expiry prior to the dispensing and administration of vaccine. *[Simplification/standardization]* Check for expired vaccines weekly and when vaccines are removed from stock. Rotate the stock based on the expiration date to prevent unnecessary waste by placing vaccines first to expire in the front.9 [9] *[Rules & policies]* If an expired vaccine has been administered in error, revaccination with a valid dose is advised.[9] *[Rules & policies]*

TABLE 5: Theme Four: Wrong Storage

Subtheme: Wrong Storage in Patient's Home		
Incident Example	**Possible Contributing Factors**	**Commentary**
A physician contacted the pharmacy stating that they would not administer the vaccination because Twinrix® was left unrefrigerated by the patient for over 7 hours. The patient claimed that the pharmacy failed to inform the patient's agent that the vaccine is to be refrigerated. The pharmacy only asked if the agent was going home immediately, but did not ask to place the product in the refrigerator.	Patient/Patient's agent not counseled/informed of the storage requirements for the vaccine.	Have the checking pharmacist place indicators/ reminders on prescription bag to remind dispensing staff to counsel regarding storage conditions (e.g. different coloured bag clips or stickers that indicate "fridge"). *[Reminders, checklists, double checks]* Place an auxiliary label directly onto the vaccine carton that brings attention to the storage conditions of the vaccine (e.g. "This medication must be stored in the refrigerator"). *[Reminders, checklists, double checks]* Have the pharmacy system print out a specific vaccine information sheet that includes storage conditions each time the vaccine is processed; this is to be dispensed along with vaccine. *[Rules & policies]* Where possible, inform patients to fill their vaccines on the day it is to be administered so as to avoid the need to take the vaccine home and store it in the fridge. *[Education & Information]*
Subtheme: Wrong Storage in Pharmacy		
Incident Example	**Possible Contributing Factors**	**Commentary**
A patient presented to the pharmacy to pick up their Twinrix® vaccine. The technician went to retrieve the receipt from the drawer and discovered that the vaccine had also been stored unrefrigerated with the receipt. A new vaccine was labelled and dispensed.	No system or protocol to ensure proper storage of vaccines that have been checked by the pharmacist	Use different coloured baskets for refrigerated and frozen items to alert checking pharmacist, pharmacy technician, and pharmacy staff to the appropriate storage conditions of the vaccine. *[Rules & policies]* Delegate the responsibility of storing the checked vaccine into the dedicated "dispensing" fridge to the checking pharmacist/pharmacy technician. *[Rules & policies]*

TABLE 6: Theme Five – Wrong Patient

Incident Example	Possible Contributing Factors	Commentary
A patient presented to the pharmacy to pick up their vaccine for Havrix®. The pharmacy dispensed the incorrect patient's vaccine. This vaccine was also Havrix® with the same patient first name but different last name. The error was discovered by the physician when the vaccine was brought in to be administered.	Failure to check or verify the vaccine and other prepared contents with corresponding patient or patient name.	Arrange to have refrigeration and freezer units large enough to store and organize checked prescriptions.[9] *[Simplification/ standardization]* Store checked vaccines in their own dedicated basket in the designated fridge according to last name (e.g. one basket each for last names A-F, G-N, O-Z). *[Simplification/standardization]* Highlight the patient's name on both the prescription receipt and label in order to draw attention to the patient's name after dispensing. *[Reminders, checklists, double checks]* At prescription pick-up, verify or double-check at least one other patient identifier (e.g. address), in addition to the patient's first and last name, prior to releasing the prescription. *[Reminders, checklists, double checks]*

TABLE 7: Theme Six – Wrong Documentation

Incident Example	Possible Contributing Factors	Commentary
A patient presented to the pharmacy with a prescription for Zostavax® to be administered by the pharmacist. It was discovered by the pharmacist shortly before the vaccine was to be administered that the patient had lymphoma.* *Note: The administration of Zostavax®, a live-attenuated vaccine, is contraindicated in patients with lymphoma.	Failure to check or verify the vaccination schedule and the patient's health record or local immunization information system.[9]	For frequently prescribed/administered vaccines, establish pre-printed standard order sets or protocols, which include: • Criteria for screening patients to determine the need for vaccination, indications, contraindications, and precautions.[9] *[Simplification/standardization]* To avoid omissions, duplicate vaccine doses, and administration of inappropriate or contraindicated vaccines: • Inquire about the patient's medical conditions at prescription drop-off. • Document any conditions into the pharmacy software's dedicated "Medical Conditions" section so that a drug-disease interaction check is performed when the vaccine is processed. • Check the patient's health record, pharmacy profile, and vaccination record (if applicable or available). *[Rules & policies]*

TABLE 8: Theme Seven – Wrong Manner/Route

Incident Example	Possible Contributing Factors	Commentary
A pharmacist was researching into Zostavax® for a patient and discovered that it is given subcutaneously. The pharmacist then remembered administering Zostavax® to a previous patient intramuscularly. Upon checking the documentation, the pharmacist did indeed administer the vaccine intramuscularly.	Unfamiliarity with the vaccine, particularly its protocol and route of administration.[9] Failure to check or verify the vaccine administration protocol.	For frequently administered vaccines, establish pre-printed standard order sets or protocols, which include: • Directions for administering the vaccine, including the route and any special procedures required to enhance safety.[9] *[Simplification/standardization]* Highlight the route of administration on vaccine carton labels by circling or using boldface type or colour to bring attention to the information as necessary.[9] *[Reminders, checklists, double checks]* Post a quick reference for clinicians to verify the route of administration for all vaccines. A chart is available from the Immunization Action Coalition (IAC) (http://www.immunize.org/catg.d/p3085.pdf).[9] *[Education & Information]* Place easily accessible links to vaccine manufacturer monographs, or a chart with multi-dose vaccine dosages, at/near administration area. *[Education & Information]*

CONCLUSION

Vaccinations are a vital component of preventive healthcare on both the individual and population level. Therefore, even relatively benign mistakes (e.g. administration of an expired vaccine) can expose individuals and communities to deadly infectious diseases. As healthcare professionals, it is our duty to protect the public by preventing immunization-related errors by exercising vaccine vigilance. This is especially true for pharmacists as our scope of practice expands and permits administration of an increasing number of vaccines in addition to our traditional dispensing role. Considering the complexity of the provincial immunization schedule, the abundance and variety of vaccines and their individual specifications, and the increasing responsibilities of pharmacists, vaccine vigilance on its own is not a sufficient mechanism to protect against vaccine-related errors.

This multi-incident analysis has provided the means to implement a system-based error prevention model intended to supplement vaccine vigilance exercised by the pharmacy team. It has highlighted the majority of vaccine-related errors in community pharmacy practice, and has facilitated the development of effective, yet practical, recommendations. Such recommendations vary greatly in their impact to current workflow, ranging from improvements that may be implemented immediately (e.g. staff/patient education and re-organization of vaccine storage area) to those that require time and resources (e.g. installation of barcode scanning devices). By utilizing both individual and system-based error prevention models, pharmacists can refine their contribution to immunization coverage in Canada.

ACKNOWLEDGEMENTS

The authors would like to acknowledge Roger Cheng, Project Lead, ISMP Canada, for his assistance in conducting the incident analysis of this report.

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

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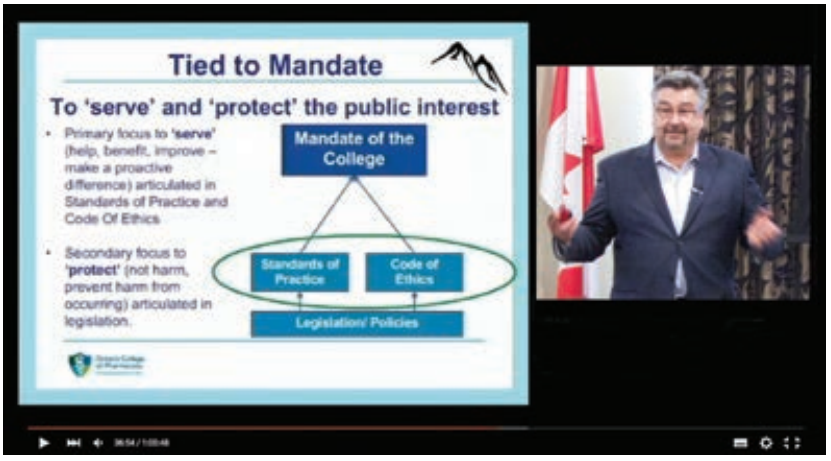
Shifting Focus to Enhance Patient Care

In a recent presentation entitled "Moving the Mountain", Registrar and CEO Marshall Moleschi introduced the idea that a shift in focus is required by both the College and practitioners in order to better support our mandate to serve and protect the public.



As Moleschi describes, historically both the College and practitioners have directed more of their attention on the *protect* aspect of this mandate. For the College, this has been an emphasis on ensuring practitioners adhere to the *rules* – legislation and policies. The focus has been on compliance to a checklist of operational standards, rather than an assessment of the application of these standards in practice.

For pharmacists and pharmacy technicians, the focus to protect has meant an emphasis on *doing no harm*. This means ensuring that the prescription is filled accurately with no known drug interactions or contraindications, and properly instructing the patient on how to take their medications. But, is it the most appropriate or effective medication therapy to help make the patient better?

Moleschi acknowledges that the importance of our responsibility to *protect* patients and the need for us to continue to be diligent in this area cannot be understated, but he challenges the profession by asking — what about our responsibility to *serve*? He's referring to that part of the mandate that calls on healthcare professionals to proactively apply their knowledge, skills and abilities to the individual needs of the patient to optimize their health outcomes.

In addressing this question, Moleschi points to the Standards of Practice and Code of Ethics – the foundational documents that outline the minimum expectations of practice and behaviour for pharmacists and pharmacy technicians. He explains, by better understanding and consistently meeting these expectations, we will ultimately move the profession forward and enhance the delivery of safe, effective and ethical care.

This particular segment of the presentation – Evolution: The Necessary Shifts in Focus – concludes by introducing the College's shift toward coaching and mentoring that supports practitioners' adherence to the Standards of Practice and Code of Ethics. Moleschi points to the new community pharmacy practice assessments and variety of practice tools and resources, including e-learning modules and videos, now accessible through the College website as evidence of this shift.

As for the shift required by pharmacists and pharmacy technicians, Moleschi's message is simple – patients first. Reminding us that our focus must not be limited by "what can I do to prevent harm?" but rather, "what can I do to serve my patient and help make them better?"

It is by working collectively towards this common goal – a focus on optimizing patient health outcomes – that will result in "Moving the Mountain".

Find the video on OCP's YouTube channel: www.youtube.com/ocpinfo

Delivering pharmacy services is a complex, human process. Although technology is a helpful tool to assist in identifying red flag situations, mistakes can still occur. "Close-Up on Complaints" presents some of these errors so that practitioners can use them as learning opportunities.

Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

Dealing with Dispensing Errors: How Effective Communication Can Help

SUMMARY OF THE INCIDENT

The incident occurred when a mother visited her local pharmacy to pick up a prescription for her infant son. The infant had been prescribed an oral suspension of clavulin at a dose of 30mg/kg/day, twice per day for 14 days.

A pharmacy assistant dispensed the prescription to the child's mother without asking if she had questions or offering to have the pharmacist counsel her on how to properly give her son the medication. The mother left the pharmacy and went home to care for her sick child.

Once she returned home, the mother thought of some questions about the medication, and phoned over to the pharmacy. She asked the pharmacist if there would be enough of the solution to last for the full 14-day prescribed course. The pharmacist assured her that there would be more than enough solution — a 14-day course would only require 49mL of the 70mL bottle.

After hanging up the phone, the mother read the manufacturer's label on the bottle, which stated that the medication would only be stable for seven days —half the treatment period prescribed for her son.

She once again phoned the pharmacist to inquire, but the pharmacist refused to acknowledge his mistake. He instructed her to return to the pharmacy in seven days and he would give her another bottle of the medication to finish the second half of the treatment period.

When the mother arrived at the pharmacy seven days later, she was presented with the second bottle. The label directed that this bottle was also to be taken for 14-days — labeling that she felt was confusing and misleading. No further instructions clarifying these directions were provided by the pharmacist. The pharmacist also charged her for the cost of the second bottle — making her very upset since she thought she had already paid for the whole prescription. The pharmacist curtly told her that she would need to pay if she wanted the remainder of the medication. In her complaint to

Have a Complaint?

Anyone who is not satisfied with the care of services provided by a pharmacy, pharmacist, pharmacy technician, student or intern can file a formal complaint with the College. Complaints must be received in writing and include as much detail as possible. The College investigates all written complaints.

the College, the patient's mother stated that the pharmacist also refused to provide his full name when asked. She said that he would only wave to his name tag, which apparently only showed a short-form of his first name.

WHY DID THIS HAPPEN?

The pharmacist in this complaint made several mistakes.

Initially, he did not counsel the patient's mother on how to administer the medication when she first visited the pharmacy and did not appropriately explain the directions when dispensing the second bottle of medication. He also made a dispensing error by not checking the medication's expiry date and drug stability. As well, he failed to catch this mistake on more than one occasion, and provided the patient with false information about the medication by stating it would last the full 14 days. He also acted rudely and unprofessionally, and failed to communicate effectively with the patient by not explaining to her that she would have to pay for the second bottle.

The situation was likely worsened by his unprofessional and insensitive behaviour.

COMPLAINT OUTCOME

The College's Inquiries, Complaints & Reports Committee (ICRC) oversees investigations of each complaint the College receives. The Committee considers a practitioner's conduct, competence and capacity by assessing the facts of each case, reviewing submissions from both the complainant and the practitioner, and evaluating the available records and documents related to the case.

The Committee found that the pharmacist in this case acted unprofessionally, failed to counsel the patient, provided false information to the patient, failed to observe expiry/stability dates, demonstrated lack of care in labelling, refused to provide his name upon request and did not communicate effectively with the patient's caregiver.

The Committee ordered that the pharmacist appear in person to receive an oral caution, and that he complete remedial training — a specified continuing education or remediation program (SCERP) — on *Confronting Medication Incidents*.

LEARNING FOR PRACTITIONERS

This complaint is multi-faceted, and as such, there are several lessons for practitioners. Like many complaints the College receives, this incident could have been avoided (or at least de-escalated) if the pharmacist had been more diligent and used more effective communication techniques.

The first issue occurred when the pharmacist allowed the pharmacy assistant to release the medication without him first counseling the patient's mother on her child's prescription. Pharmacists must assess and educate patients on their prescriptions. If the pharmacist had properly assessed this patient, he would have noticed that he was dealing with an infant — a red flag population of vulnerable patients who require extra care and attention. For these patients, even small errors can cause significant problems.

As a regulated healthcare professional, pharmacists have an ethical responsibility to both help and not harm their patients. In this case, since he was apparently unfamiliar with the medication, the pharmacist should have ensured that this medication was both therapeutically appropriate and would not harm the infant. This requires taking extra time to review appropriate resources. If he had done this review, the pharmacist would have noticed the problem with the stability of the reconstituted medication.

The pharmacist had an additional opportunity to catch his mistake and properly counsel the patient's mother when she phoned with questions about her son's therapy. This time, the pharmacist provided incorrect information about the duration the initial bottle of medication could be used for. When the patient's mother identified the issue with the medication's stability, the pharmacist said he did not have another bottle of the medication in stock to reference. However, he should have consulted an alternate resource to confirm the required information and ensure the infant received the intended benefit of the medication.

When the patient's mother came to pick-up the second bottle of medication for the remaining seven days, it was labelled for a 14-day course. The pharmacist had processed this bottle of medication as a repeat — and in many pharmacies the label can not be altered on repeats. However, he could have provided handwritten instructions on the label or clearly explained to the patient why it was labelled for 14 days when the remaining duration of therapy was seven days. He should have also explained that the second bottle was

not included in the initial charge and the second charge was only for the cost of the medication.

If a problem is identified, it is always best to de-escalate the situation by apologizing to the patient, empathizing with how they are feeling, and explaining options that could help fix the problem. Using this approach would have helped the pharmacist when discussing the error in stability, the issue with labelling and additional cost of the second bottle of medication. Once a dispensing error was discovered, the pharmacist also should have reviewed the pharmacy's dispensing error protocol, discussed the issue with the designated manager, and made a plan to avoid similar incidents in the future.

Ensuring you provide proper counselling is important. But ensuring that the patient understands it and feels informed is even more important. Some good techniques for communicating with patients include:

- Watching the patient's non-verbal cues to ensure they understand
- Providing rationale and explanations for your decisions or business processes
- Asking the patient to repeat the information you've just provided
- Using open-ended questions and listen to the patient's responses
- Following-up with a phone call if you're not sure the patient understood everything

Acting professionally is essential for all regulated healthcare professionals. Patients trust that, as a healthcare professional, you will use your knowledge, skills and abilities to make decisions that enhance their health and well-being.

ORAL CAUTIONS

An oral caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. Oral cautions require the practitioner to meet with the ICRC in person for a face-to-face discussion about their practice and the changes they will make that will help avoid a similar incident from occurring in the future. It is not an opportunity for the practitioner to further argue their position, provide additional documentation, or attempt to change the ICRC's view with respect to their final decision. For all complaints filed after April 1, 2015, we post a summary of the oral caution and its date on the "Find a Pharmacy or Pharmacist" section of our website.

REMEDIAL TRAINING (SCERPS)

A SCERP is ordered when a serious care or conduct concern requiring a pharmacist or pharmacy technician to upgrade his or her skills has been identified. The ICRC orders SCERPs when they believe that remediation is necessary. For all complaints filed after April 1, 2015, we post a summary of the required program and its date on the "Find a Pharmacy or Pharmacy Professional" section of our website.

PRACTICE TIP!

As a members of a self-regulated profession, pharmacists must be able to rationalize the clinical decisions that they make, to their peers and to any person or organization which may be affected by their actions, including individual patients, the public, their employers, and other healthcare professionals.
http://www.ocpinfo.com/library/practice-related/download/Professional%20Judgment.pdf

Follow @OCPinfo on Twitter and get a helpful practice tip each week. #OCPPracticeTip

FREE RESOURCES FOR METHADONE AND BUPRENORPHINE/NALOXONE PHARMACIST-PROVIDERS

The Ministry of Health and Long-Term Care (MOHLTC) provides funding for opioid substitution therapy drug information and professional development through the Ontario Pharmacists Association (OPA). These offerings are designed to support pharmacist-providers of methadone and buprenorphine/naloxone therapies and are ***completely free of charge.***

Opioid Substitution Therapies Drug Information Line
Get free access to drug information experts who can answer questions about methadone and buprenorphine/naloxone in the treatment of addiction and pain. For health care providers only.
1-888-519-6069
Monday – Friday: 9 a.m. - 5 p.m.

Opioid Substitution Therapies Discussion Forum
The forum allows practitioners to share best practices, discuss practice questions and interact with other pharmacists and physicians who prescribe or dispense methadone and buprenorphine/naloxone for opioid addiction. Free registration at methadoneforum.opatoday.com.

Methadone and Buprenorphine/Naloxone Toolkit
The toolkit helps pharmacists support patients on opioid substitution therapies, provides a general overview on addictions management principles, addresses initiating a methadone and buprenorphine/naloxone program in the pharmacy, and much more. The two-part toolkit is available for download at www.opatoday.com under the Resources/Tools and Forms section.

Interested in learning more about opioid dependence treatment? Need to update your methadone training? OPA's free Methadone and Buprenorphine/Naloxone professional development programs may be of interest to you!

Methadone, Buprenorphine, and the Community Live Program
This one-day program focuses on destigmatizing methadone maintenance treatment and addresses the effect of methadone clinics and programs on the community. A session on pain management also explores situations in which patients on methadone or buprenorphine maintenance treatment may require analgesics and what options they may have. This program qualifies as an approved training course for methadone dispensing pharmacists as part of the training update that is required at minimum every five year. For full details visit https://www.opatoday.com/224085

Online modules
The online modules cover a variety of topics including the policies guiding methadone dispensing in Ontario, addiction management principles, methadone use in chronic pain management, and treatment in patients with comorbid health problems. The Methadone and Buprenorphine/Naloxone Online Modules are acceptable for meeting the required training update for methadone dispensing pharmacists. For full details visit https://www.opatoday.com/224062

"Preventing Methadone Dispensing Errors and Handling Difficult Dispensing Questions" Webinar
Webinars to support pharmacists who have an interest in opioid substitution therapy will be scheduled throughout the year. For full details visit https://www.opatoday.com/224098

Student Dinner and Learn Sessions
These on-campus sessions are designed to support pharmacy students, as well as students in other health disciplines, in building knowledge in addiction and opioid use. Registration for 2016 sessions to open soon.

College Piloting New Assessment for Competence at Entry-to-Practice

The College is piloting a new approach to assessing applicants' readiness for practice. Practice Assessment of Competence at Entry (PACE), currently being piloted with pharmacists, is designed to meet the structured practical training registration requirement outlined in legislation.

Given that graduates of the entry-level PharmD program at the universities of Toronto and Waterloo meet this requirement within their programs, the College has been working closely with key stakeholders on the development and validation of PACE for candidates requiring assessment outside these programs. The goal has been to ensure a consistent approach for assessing if readiness for practice exists, for both domestic and international pharmacy graduates.

Following evaluation and approval, it is anticipated that PACE would replace the College's current Structured Practical Training (SPT) program as the entry-to-practice requirement for all applicants.

BACKGROUND

One of the College's fundamental responsibilities as a regulator for the profession of pharmacy is to ensure that those entering the profession have the knowledge, skills and abilities (competencies) necessary to safely and ethically practice pharmacy.

Therefore, a requirement for registration is that applicants have successfully completed a structured practical training program. The intent of this requirement is to allow those seeking entrance into the profession to demonstrate their competence for entry-to-practice.

In keeping with our commitment to continuous quality improvement, the College conducted a formal evaluation of the current SPT program. Although the evaluation found that the program was effective in preparing applicants for independent practice, it identified that the "one-size fits all" approach does not reflect the differing levels of education, practice experience and cultural competence of applicants.

Furthermore, the evaluation raised important considerations for the College relating to our mandate as a regulator and our role in the development and delivery of *training* programs versus *assessment* programs. The outcome is the introduction and pilot of PACE, as the replacement for the current SPT program.

OVERVIEW OF PACE

PACE focuses on the assessment of a candidate's ability to demonstrate entry-to-practice competencies in a practice setting, with further development being self-directed by the candidate, if required.

Candidates engage in practice under the supervision of a College trained and appointed assessor. Through direct observation of the candidate over a specified period of time, the assessor — using a validated assessment tool — rates the candidate's ability to demonstrate their adherence to identified entry-to-practice competencies outlined in the PACE Assessment Criteria. The completed assessment is then forwarded to the College where a standardized scoring rubric is applied to determine if the candidate has successfully demonstrated their competence at entry-to-practice or if additional development is required.

If additional development is required, candidates will receive a performance profile which identifies the gaps in their competence. They will be invited to work with College staff to create an action plan to guide their development in the identified areas. The implementation of this plan, however, will be self-directed by the candidate.

The candidate is responsible for identifying an appropriate practice site and pharmacist to supervise and support the implementation of their plan. The expectation is that candidates will engage in development until all of the goals of the plan have been fulfilled, for a minimum of four weeks before re-attempting PACE. The candidate will continue to go through this process until competence has been demonstrated.

PACE – STEP BY STEP PROCESS

PACE is made up of four parts:

1. Orientation

- The candidate is provided with an orientation to the practice site to ensure sufficient understanding of the workflow and processes to support engagement in practice
- Orientation lasts approximately 35 hours (one week) but may be extended up to 70 hours upon request

2. Assessment

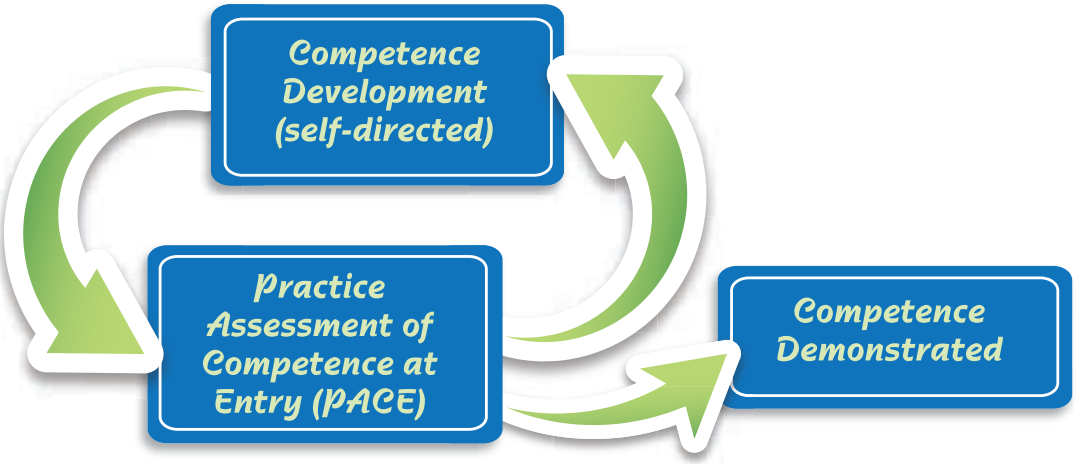
- The candidate engages in the scope of practice of the profession to demonstrate competence. The assessment is conducted over 70 hours (spanning up to three weeks)
- The assessment is standardized through a rubric that is used by an assessor to rate the competencies to be assessed in a fair and objective manner

3. Outcome

- The candidate receives the outcome of the assessment (within one week):
  - Competence demonstrated; or
  - Competence development (self-directed) required

4. Feedback & Plan Development (only for candidates requiring development)

- Candidates will receive a profile of their performance (within one week)
- Candidates to create an action plan to address gaps in their practice
  - College staff available to provide support in the development of the plan



The graphic above illustrates the high-level PACE process.

ROLE OF THE ASSESSOR

The success of PACE relies significantly on the quality and dedication of a large number of volunteer assessors appointed by the College. As practicing pharmacists themselves, assessors are leaders within the profession who are committed to the mandate of serving and protecting the public, and have a strong desire to uphold the standards of the profession.

Assessor Criteria - Overview:

- Experienced community or hospital pharmacist registered and practicing in Ontario, or other Canadian jurisdiction with similar scope of practice, for at least two years providing patient-centred care
- Have an understanding of and commitment to pharmacy regulation, Standards of Practice and the Code of Ethics
- Have a strong sense of professional responsibility demonstrated by a commitment to continuing professional development
- Experienced in fostering collaborative relationships with excellent verbal, written and listening skills
- Currently practicing a minimum of 25 hours per week in a community or hospital pharmacy in Ontario that supports a diverse patient population and is engaged in the delivery of a wide-range of pharmacy services
- Willing to participate as a PACE assessor a minimum of three times per year, which requires direct supervision of candidates for 70 hours over a three week period for each assessment

APPLYING TO BECOME AN ASSESSOR

Pharmacists can apply, at any time, to the College for consideration as a PACE assessor by completing the application form. The application will be reviewed by the College and successful applicants will be notified of their appointment as a PACE assessor. Assessors will be required to successfully complete assessor training and must continue to meet the criteria outlined in the initial application.

For more information about PACE, please contact regprograms@ocpinfo.com.

PRACTICE TIP!

Clearly understanding pharmacy technicians' scope of practice and standards of practice is a key step in identifying the best way to integrate these valuable members of the healthcare team into your pharmacy practice.
http://www.ocpinfo.com/library/practice-related/download/Legal%20Authority%20Scopes.pdf

APPLY TO BECOME A COLLEGE ASSESSOR *TODAY!*

Rewarding new opportunity to give back and help shape the future of the pharmacy profession.

The College is currently piloting a new structured practical training requirement for pharmacists - Practice Assessment of Competence at Entry (PACE) - and we need your help!

A vital step in the College's registration process is to ensure that potential new pharmacists are competent to deliver patient-centred care in a dynamic and diverse practice setting. Who better than an engaged and experienced pharmacist could assist in making this determination?

If you are currently working in a busy community or hospital pharmacy, are experienced in fostering collaborative relationships, and have a strong desire to uphold the standards of the profession, this volunteer opportunity may be a perfect fit for you.

As a PACE assessor you'll be recognized at our annual professional development event and given priority consideration for future assessor roles with the College!

LEARN MORE
AND APPLY TODAY!

http://www.ocpinfo.com/about/key-initiatives/pace/

THANK YOU, PRECEPTORS & EVALUATORS!

Pharmacists and pharmacy technicians consistently demonstrate commitment to their students, interns and pharmacy technician applicants – and to the profession – by fulfilling their roles as preceptors in the SPT Program. 2015 was no exception. The tremendous dedication our preceptors put forward in supporting future colleagues is the backbone of the program and is pivotal to its success. Thank you, preceptors.

AJAX

Garcha, Patrick . . . . . Shoppers Drug Mart
Ghassemi, Amir . . . . . Costco Pharmacy
Jaffry, Haider . . . . . Costco Pharmacy

ALEXANDRIA

Lauzon, Helene . . . . . Pharmacie Jean Coutu Pharmacy

ALLISTON

Shah, Ketan . . . . . Loblaw Pharmacy

ALMONTE

James, Diane . . . . . Rexall Pharma Plus

AMHERSTBURG

Demitroff, Danielle . . . . . Emrose Medical Pharmacy

ANCASTER

MacKinnon, Jesse . . . . . Costco Pharmacy

AURORA

Azemodeh Ardlan, Elaheh . . . . . Wellington Pharmacy
Bielawski, Edmund . . . . . Summit Veterinary Pharmacy Inc
Cheung, Tsz . . . . . Enhanced Care Pharmacy
Ho, Joseph . . . . . Remedy's Rx
Onizuka, David . . . . . Shoppers Drug Mart
Shenouda, John . . . . . Hollandview Pharmacy
Yong, Pei . . . . . Summit Veterinary Pharmacy Inc

BARRIE

Au, Kai-Wing . . . . . A & W Pharmacy
Bomenhalli Krishne, Gowda . . . . . Pharma Plus
Francis, Karim . . . . . Shoppers Drug Mart
Hogarth, Shirley . . . . . Pharma Plus
Huynh, Anna . . . . . Shoppers Drug Mart
Ignacio, Cynthia . . . . . Rexall Pharma Plus
Kamel, Magdy . . . . . PureHealth Pharmacy
Lalji, Nimet . . . . . Express Aid Pharmacy
Leung, Janet Pui Sea . . . . . Rexall Pharma Plus
Malik, Sajjad . . . . . Kempenfelt Pharmacy
Mankarious, Maged . . . . . Shoppers Drug Mart
Momberg, Margaret . . . . . Sobeys Pharmacy
Ogundipe, Boluwaji . . . . . Costco Pharmacy
Rajan, Shamin . . . . . Shoppers Drug Mart
Tang Wing, Kevin . . . . . Wal-Mart Pharmacy
Tse, Lisa . . . . . Drugstore Pharmacy
Van, Siumy . . . . . Dunlop Pharmacy

BEAMSVILLE

El-Sarraf, Walei-el-din . . . . . Rexall
Menon, Seema . . . . . Rexall

BELLEVILLE

McConnell, Sherry . . . . . Quinte Health Care
Parker, Nicole . . . . . Quinte Health Care
Patel, Ankur . . . . . Rexall
Vieira, Leanne . . . . . Quinte Health Care

BOLTON

Awad, Medhat . . . . . Total Health Pharmacy
Ebele, Charles . . . . . Shoppers Drug Mart
Gobran, Nabil . . . . . Total Health Pharmacy
Siow, Yin . . . . . Shoppers Drug Mart

BOWMANVILLE

Rice, Patricia . . . . . Bowmanville Clinic Pharmacy Limited
Zhao, Nan . . . . . Loblaw Pharmacy

BRACEBRIDGE

MacKnight, Earl ..... Wal-Mart Pharmacy

BRADFORD

Perrotta, Enrico ..... Rexall

BRAMPTON

Arora, Monika ..... BramQueen Pharmacy
Azer, Maria ..... Logos Pharmacy
Aziz, Ehab ..... Spring Valley Pharmacy
Chauhan, Kalpesh ..... Shoppers Drug Mart
Chauhan, Tejal ..... Castlemore Remedy's RX Pharmacy
Darji, Dharmegn ..... Pharma Plus
Desai, Jigisha ..... Pharma 7 Care
Dhillon, Manveer ..... Pharmasave Bramcity Pharmacy
D'Souza, Sandra ..... Shoppers Drug Mart
Gautam, Rakesh ..... West Brampton Pharmacy
Ghattas, Salwa ..... Cornerstone Pharmacy
Hanna, Rania ..... Shoppers Drug Mart
Hernane, James ..... Shoppers Drug Mart
Jain, Naresh ..... Nathan Pharmacy
Jurkuvenas, Rita ..... Torbram Pharmacy
Kantawala, Beena ..... Fogal Pharmacy Limited
Kaushik, Ram ..... Rexall
Khachh, Sharanjit ..... Shoppers Drug Mart
Kondoor, Sunitha ..... Shoppers Drug Mart
Lall, Gurpreet ..... Dusk IDA Pharmacy
MacPherson, Patricia ..... Shoppers Drug Mart
Mahmood, Saima ..... Shoppers Drug Mart
Moustafa, Hossam ..... Wal-Mart Pharmacy
Nguyen, Ellie ..... Shoppers Drug Mart
Oliveiro, Christopher ..... Springdale Pharmacy
Parikh, Nishant ..... Kensington Pharmacy
Patel, Nisha ..... Brameast Pharmacy
Patel, Sangeeta ..... Charolais Pharmacy
Qureshi, Muneera ..... Brampton Medical Plex Pharmacy
Rattia, Gurpreet ..... Castle Oaks Pharmacy
Riar, Nina ..... Bramalea BestCare Pharmacy
Rizarri, Ethel ..... Shoppers Drug Mart
Rizvi, Kehkashan ..... Rexall
Saad, Neven ..... Greencross Drugs
Salama, Heba ..... Shoppers Drug Mart
Salem, Fatema ..... Wal-Mart Pharmacy
Satija, Lalit ..... Nanak Pharmacy
Sayani, Nadeem ..... Connaught Place Pharmacy
Shah, Dushyant ..... Mayfield Pharmacare
Sharma, Shamah ..... Pharma Plus
Sidhu, Ranjodh ..... Wal-Mart Pharmacy
Singh, Parvinder ..... Bramcentre Pharmacy
Singh, Sandip ..... Shoppers Drug Mart
Srivastava, Shuchita ..... Drugstore Pharmacy
Suliman, Fady ..... Cornerstone Pharmacy
Varghese, Zacheriah ..... Drugstore Pharmacy
Virk, Harsimran ..... Sandalwood Care Pharmacy
Yousef, Joseph ..... Sandalwood Medical Pharmacy

BRANTFORD

Asad, Irene ..... Brantford Medical Pharmacy
Bauer, Rosmarie ..... The Brantford General Hospital
Bove, Bruno ..... Shoppers Drug Mart
Detweiler, Nancy ..... Smith Drugs & Apothecary Ltd.
Flexman, Stephen ..... iPharm
Mabiling, Jennifer ..... Medisystem Pharmacy
Morgan, John ..... Brantford Life Care Pharmacy
Salama, Fady ..... Guardian Discount Pharmacy
Thapar, Atul ..... Wincare Drug Mart

BROCKVILLE

Campbell, Anna ..... Brockville General Hospital

BROOKLIN

Huynh, Tony ..... Shoppers Drug Mart

BURLINGTON

Abdulla, Ban Tahir ..... Shoppers Drug Mart
Abu-Halimeh, Najat ..... Jasmin Pharmacy
Al-Alawi, Khadija ..... Halton Family Pharmacy
Bertrand, Robin ..... Costco Pharmacy
Chou, Sing ..... Loblaw Pharmacy
Cousins, Marilyn ..... Classic Care Pharmacy
Desai, Manisha ..... Smartmeds Pharmacy
Desouza, Ashley ..... Smartmeds Pharmacy
El Kabbani, Mayada ..... Aldershot Village Pharmacy
George, Sarah ..... Shoppers Drug Mart
Georges, Nabil ..... Aldershot Guardian Pharmacy
Jain, Shaleen ..... Rexall
Kanni, Paranjothy ..... Mountainside Pharmacy
Killeny, Raief ..... Total Health Pharmacy
Kot, Remon ..... Shoppers Drug Mart
Lopes, Renata ..... Costco Pharmacy
Moloughney, Adora ..... Classic Care Pharmacy
Patel, Samir ..... Morelli's Pharmacy
Pinkus, David ..... Shoppers Drug Mart
Roberts, Kerry ..... Brant Arts Disp - Laboratory Ltd
Salama, Heba ..... Shoppers Drug Mart
Stojanovic-Kojic, Jelena ..... Pharma Plus
Yasseen, Baseer ..... Shoppers Drug Mart

CALEDONIA

Shirodker, Anish ..... Shoppers Drug Mart

CAMBRIDGE

Acharya, Vishal ..... Shoppers Drug Mart
Amr, Mona ..... Langs Medical Pharmacy
Samaan, Nabil ..... St. Michael Medical Pharmacy
Smith, Juanita ..... Shoppers Drug Mart

CARP

White, Ryan ..... West Carleton Drug Mart

CHATHAM

Collodel, Michael ..... Rexall
Crow, Christina ..... Chatham Kent Health Alliance
Deroo, Gary ..... Chatham-Kent Health Alliance - Chatham General Hospital
Kay, Nancy ..... Chatham-Kent Health Alliance - Chatham Chatham General Hospital

CHESLEY

Hastings, Kirstin ..... Rexall

COBOURG

Lee, Eun-Ho ..... York Super Pharmacy Limited

CORNWALL

Froats, Jessica ..... Cornwall Community Hospital - McConnell Site
Guindon, Darlene ..... Medical Arts Pharmacy
Hamed, Eslam ..... Shoppers Drug Mart

DEEP RIVER

Crossman, Leanne ..... Rexall Pharma Plus

DON MILLS

Salehmohamed, Shelina ..... Shoppers Drug Mart

DOWNSVIEW

Ismail, Fatima ..... Nor-Arm Pharmacy
Joseph, Josee ..... Jane Centre Pharmacy

Kherani, Alym . . . . . Shoppers Drug Mart
Mostaan, Mahsa . . . . . Shoppers Drug Mart

DUNDAS

Shukla, Kusum . . . . . Shoppers Drug Mart

EAST GWILLIMBURY

Ayoub, Diana . . . . . Costco Pharmacy
Hanna, Christine . . . . . Costco Pharmacy
Osuntoyinbo, Adeyinka . . . . . Costco Pharmacy
Saifi, Parinaz . . . . . Costco Pharmacy

ETOBICOKE

Abd El Said, Mary . . . . . Sherway Pharmasave
Chan, Christopher . . . . . Shoppers Drug Mart
Hassan, Farhana . . . . . Woodbine Pharmacy Pharmachoice
Nisevic, Nada . . . . . Trust Care LTC Services
Roy, Meghna . . . . . Shoppers Drug Mart
Soor, Anmol . . . . . Shoppers Drug Mart
Sourial, Ramy . . . . . Sav-On Drug Mart
Stewart, Ian . . . . . Shoppers Drug Mart
Sundaramoorthy, Ragavan . . . . . Shoppers Drug Mart
Thomas, Mathew . . . . . Albion Martingrove Pharmacy
Vaidya, Parth . . . . . Shoppers Simply Pharmacy
Wajid, Abdul . . . . . Loblaw Pharmacy
Youn, Jie-Young . . . . . Shoppers Drug Mart
Zaytoon, Nancy . . . . . Kipling Pharmacy
Zlydennyy, Vyacheslav . . . . . Markland Wood Pharmacy Limited

EXETER

Cook, Gerald . . . . . Huron Apothecary Ltd
Marchioni, Daniel . . . . . Exeter Guardian Pharmacy

FERGUS

Oosterveld, Jennifer . . . . . Groves Memorial Community Hospital
Sarma, Vijay . . . . . Centre Wellington Remedy's Rx

FORT ERIE

Longval, Gerard . . . . . Garrison Square Remedy's RX

FORT FRANCES

Nielson, Kevin . . . . . Shoppers Drug Mart

GANANOQUE

Patel, Krunalkumar . . . . . Shoppers Drug Mart
Tang, Jean . . . . . Pharmasave
Zhou, Mark . . . . . Shoppers Drug Mart

GARSON

Jussila, Tammi . . . . . Nickel Centre Pharmacy

GEORGETOWN

Bouls, Peter . . . . . Alpha Care Pharmacy

GERALDTON

Sutherland, Debra . . . . . Rexall

GLOUCESTER

Bhatti, Sarah . . . . . Medical Pharmacy
Crotty, Kelly . . . . . Medical Pharmacy
Ntoko Ntoko, Daniel . . . . . Wal-Mart Pharmacy

GODERICH

De Jager, John . . . . . De Jager Town Square I.D.A. Pharmacy Ltd.
Fielding, Mary . . . . . Loblaw Pharmacy

GRAND BEND

Bannerman, James . . . . . Grand Bend Pharmacy

GRAVENHURST

De Peralta, Clarissa . . . . . Shoppers Drug Mart
Howell, Angela . . . . . Shoppers Drug Mart

GRIMSBY

Costa, Despina . . . . . Shoppers Drug Mart

GUELPH

Chan, Kenneth . . . . . University Square Pharmacy
Cimino, Judith . . . . . Shoppers Drug Mart
Edmonds, Kristen . . . . . Prime Care Pharmacy Arboretum
Galias, Maria . . . . . Woodlawn Pharmacy
Howard, Theresa . . . . . Guelph General Hospital
Hulbert, Avril-Anne . . . . . Wal-Mart Pharmacy
Husain, Diary . . . . . Costco Pharmacy

HAGERSVILLE

Gandhi, Vinod . . . . . Cavanagh IDA Pharmacy

HALIBURTON

Mansfield, Aimee . . . . . Shoppers Drug Mart

HAMILTON

Al Balas, Mosab . . . . . Shoppers Drug Mart
Anderson-Muwonge, Alecia . . . . Shoppers Drug Mart
Aziz, Tamer . . . . . Upper James Clinic Pharmacy
Choi, Hoi . . . . . St. Joseph's Hospital
Clarke, Nicole . . . . . Hamilton Health Sciences Corp
Closs, Jordan . . . . . McMaster University Medical Centre
Davis, Denise . . . . . St. Joseph's Hospital
Edillo, Ansberta . . . . . St. Joseph's Hospital Outpatient Pharmacy
Elsaigh, Amru . . . . . Pharma Plus
Ghayur, Muhammad . . . . . Shoppers Drug Mart
Houneini, Wassim . . . . . Shoppers Drug Mart
Ishfaq, Muhammad . . . . . Shoppers Drug Mart
Jorge, Margaret . . . . . Charlton Medical Pharmacy
Khalil, Hany . . . . . Hamilton Community Pharmacy
Labib, Maged . . . . . West End Pharmacy
LaPalme, Monique . . . . . Juravinski Hospital
Lavji, Shemin . . . . . Remedy's Rx Healthcare Plus Pharmacy
Lu, Susie . . . . . Juravinski Hospital
Makhova, Daria . . . . . Hamilton Health Sciences Corp
McGinley, Teresa . . . . . Hamilton Health Sciences Corp
Nagra, Bhupinder . . . . . Shoppers Drug Mart
Nasim, Umair . . . . . HD Pharmacy
Panesar, Tajinder . . . . . Shoppers Drug Mart
Parihar, Kavita . . . . . Hamilton Health Sciences Corp
Rana, Ayesha . . . . . Shoppers Drug Mart
Roic, Durdica . . . . . Rexall
Ross, Ivan . . . . . McMaster University Medical Centre
Sadik, Henaa . . . . . Shoppers Drug Mart
Safi, Rami . . . . . Shoppers Drug Mart
Sefain, Ehab . . . . . King Medical Pharmacy
Sekharan, Santhosh . . . . . Rexall
Seliskar, Brigit-Ann . . . . . McMaster Drugstore
Shabbir, Iftikhar . . . . . Rexall
Sheth, Ashish . . . . . Nebo Medical Pharmacy Inc.
Syed, Khalid . . . . . Shoppers Drug Mart
Tawfilis, Hani . . . . . Danmar Pharmacy
Thapar, Atul . . . . . Shoppers Drug Mart
Wighardt, Zoltan . . . . . First Place Pharmacy
Yau, Edwin . . . . . Rexall Pharma Plus
Zaki, Ashraf . . . . . Queenston Pharmacy

HANMER

Balaz, Gregory . . . . . Valley Plaza Pharmacy Pharmasave

HANOVER

Scarborough, Michele . . . . . Hanover And District Hospital

HAWKESBURY
El-Maddah, Nanees ..... Loblaw Pharmacy
Levesque, Marie- Claude ..... Shoppers Drug Mart
Taheri, Kamran ..... Pharmacie Jean Coutu Pharmacy

HENSALL
Haddad, Mammdouh ..... Hensall Pharmacy

HUNTSVILLE
Murdy, Dana ..... Shoppers Drug Mart

INGERSOLL
Austin, Benjamin ..... Pharmasave
Nicholson, Victoria ..... Remedy'sRx
Sawler, Christopher ..... Shoppers Drug Mart

INNISFIL
Khalkhali, Elham ..... Sobeys Pharmacy

IROQUOIS FALLS
Bertrand, Brian ..... Family Care Pharmacy

KANATA
Gana, Shohdy ..... Shoppers Drug Mart
MacDonald, Russell ..... Shoppers Drug Mart
Pappin, Janet ..... Kanata Pharmasave

KEMPTVILLE
Yari Pour, Sepideh ..... Loblaw Pharmacy

KESWICK
Dhiman, Samanta ..... Rexall

KINCARDINE
Luk, David ..... Rexall Pharma Plus

KING CITY
Meghjee, Haiderali ..... King City Pharmacy
Parsa, Parastoo ..... Shoppers Drug Mart

KINGSTON
Babcock, Pennie ..... Ontario Regional Pharmacy
Doyle, Adam ..... Shoppers Drug Mart
Fetar, Hossam ..... St. Mary's of the Lake Hospital
Ford, Scott ..... Shoppers Drug Mart
Graham, David ..... Graham's Pharmacy
Kerr, Suzanne ..... Drugsmart Pharmacy
Koob, Ronald ..... Kingston General Hospital
Patel, Hitesh ..... Gardiners Pharmasave
Schell, Maria ..... Shoppers Drug Mart
Sekhon, Charanjeev ..... Shoppers Drug Mart
Slack, Andrea ..... Shoppers Drug Mart

KITCHENER
Abbas, Zohaib ..... Shoppers Drug Mart
Abdel Sayed, Ehab ..... The Tannery Pharmasave
Abdel Shahid, Mina ..... Queens Pharmacy
Brar, Gurinder ..... Fairway Lackner Pharmacy (PHARMASAVE)
Bunston, Grant ..... St. Mary's General Hospital
Halim, Nader ..... Shoppers Drug Mart
Ibrahim, Mona ..... Aim Medical Pharmacy
Leamen, Lisa ..... Shoppers Drug Mart
Mayring, Ljiljana ..... Pharma Plus
Naidoo, Abilashen ..... Shoppers Drug Mart
Saad, Maged ..... Shoppers Drug Mart
Saad, Mervat ..... Main Drug Mart
Salsali, Hanan ..... Rexall
Serjani, Klarida ..... Shoppers Drug Mart

LAKEFIELD
Fazzari, Daniel ..... Lakefield IDA Pharmacy
O'Brien, Andrew ..... Lakefield IDA Pharmacy

LAKESHORE
Cheikh, Ghada ..... Sobeys Pharmacy

LASALLE
Adebayo, Adeniyi ..... Loblaw Pharmacy
Gaudet, Heather ..... Shoppers Simply Pharmacy
Modestino, Roberto ..... Rexall

LEAMINGTON
Lahoud, Elaine ..... Shoppers Drug Mart
Palmer, Jennifer ..... Leamington District Memorial Hospital

LINDSAY
Allen, Sheri ..... Ross Memorial Hospital
Cheng, Edgar ..... Pharma Plus
Noorbakhsh, Mahvash ..... Shoppers Drug Mart

LISTOWEL
Soehner, Catherine ..... Shoppers Drug Mart
Vanderspiegel, Christine ..... The Listowel Memorial Hospital

LONDON
Alghouti, Shadi ..... Pharmasave - Adelaide North Pharmacy
Barghi, Ardalan ..... Shoppers Drug Mart
Baskette, John ..... London Health Sciences Centre
Bosta, Milad ..... Pond Mills Medical Pharmacy
Brown, Tracy ..... Shoppers Drug Mart
Butnari, Christina ..... Prescription Centre
Cheng, Yue ..... Pharma Plus
Cimino, Gino ..... Ealing Pharmacy Limited
Coulter, Scott ..... Coulter's Pharmacy & Home Health Care
Cunningham, Maria ..... London Health Sciences Centre
Dacosta, Jaclyn ..... London Health Sciences Centre
Delamere, Mark ..... Oxford Medical Pharmacy
Dini, Olamarie ..... Dini IDA Pharmacy
El-Sabbahi, Assmaa ..... Medisystem Pharmacy
Gaikwad, Ajit ..... Carling Heights Pharmacy
Garrick, Cynthia ..... Prescription Centre
Gawlik, Christine ..... London Health Sciences Centre
Geoffrey, Belinda ..... London Health Sciences Centre
Gingerich, Sarah ..... London Health Sciences Centre
Kolendowski, Kimberly ..... London Health Sciences Centre
Kommineni, Suresh ..... Rexall
Kutz, Daniel ..... Rexall Pharma Plus
Ledger, David ..... Wortley Village Pharmasave
Linton, Bradley ..... London Health Sciences Centre
Mukherjee, Suranjana ..... Costco Pharmacy
Nassori, Siamak ..... Costco Pharmacy
Norris, Faith ..... London Health Sciences Centre
Patel, Pragneshbhai ..... Pharma Plus
Patel, Vikas ..... Rexall I.D.A Medsana Pharmacy
Pretorius, Elizabeth ..... Shoppers Simply Pharmacy
Ragheb, Karim ..... London Care Pharmacy
Sensabaugh-Parker, Sabrina ..... London Health Sciences Centre
Shanghavi, Puja ..... Rexall Specialty
Shatara, Raied ..... Costco Pharmacy
Smith, Katie ..... London Health Sciences Centre
Taylor, Grant ..... Shoppers Drug Mart
Tomita, Trina ..... Shoppers Drug Mart
Van Ness, Dawn ..... London Health Sciences Centre
Watson, Rachel ..... Shoppers Drug Mart
Woo, Stephen ..... Shoppers Drug Mart
Wright, Betty ..... Pharma Plus
Yausie, Amanda ..... London Health Sciences Centre
Zimmer, James ..... Yurek Specialties Limited

MAPLE

Chauhan, Jason ..... Shoppers Drug Mart
Dalimonte, Jack ..... Shoppers Drug Mart

MARKHAM

Bekhit, Peter ..... Main Drug Mart
Foroozannasab, Neda ..... Bayshore Specialty Rx
Isaac, Kuruvilla ..... Fenton Discount Pharmacy
Khan, Mohamed ..... Shoppers Drug Mart
Leekha, Kamna ..... Shoppers Drug Mart
Noronha, Wayne ..... Costco Pharmacy
Pashang, Faranak ..... Costco Pharmacy
Pham, Amanda ..... Bayshore Specialty Rx
Tse, Calvin ..... SKL Guardian Drugs
Vali, Parvaneh ..... World Pharmacy
Wong, Michelle ..... Shoppers Drug Mart
Woo, Willie ..... The Chemist Pharmacy
Yuen, Ann ..... Markham Stouffville Hospital
Zaidi, Syed Muhammad ..... Costco Pharmacy
Zaki, Salwa ..... Focus Drug Mart

MASSEY

Preuss, Heather ..... Janeway PharmaChoice

MEAFORD

Davies, Christopher ..... Muxlow Pharmacy Limited

MIDHURST

Lougheed, Jenna ..... Midhurst Pharmacy

MIDLAND

Gignac, Danielle ..... Wal-Mart Pharmacy
Mallows, Vaughan ..... Georgian Bay General Hospital
Moore, Eunice ..... Georgian Bay General Hospital
Tang, Wai-On ..... Shoppers Drug Mart
Tolmie, Michael ..... Shoppers Drug Mart

MILTON

Atia, Yehia ..... Zak's Pharmacy
Fikry, Nesreen ..... Total Health Pharmacy
Jeon, Hee ..... Rexall
Johal, Puneet ..... Halton Healthcare Services
Makar, Rania ..... Milton Square Pharmacy
Philips, Hany ..... St. George Pharmacy

MISSISSAUGA

Abd El Malak, Jakleen ..... Lisgar Pharmacy
Abou Assy, Mohamed ..... SDM Specialty Health Services
Ahmad, Jauher ..... Shoppers Drug Mart
Ahmad, Navid ..... Battleford Pharmacy Inc
Ahmad, Sarah ..... Medisystem
Ahmed, Nadeem ..... Total Health Pharmacy
Andipara, Bhargav ..... Medisystem
Ang, Mark ..... Baxter Pharmacy Services
Awad, Mina ..... City Care Pharmacy
Aziz, Ehab ..... Marcos Pharmacy
Aziz, Farid ..... Shoppers Drug Mart
Azziz, Safaa ..... Costco Pharmacy
Bahnam, Mais ..... Guardian Matheson Pharmacy
Bath, Jagdeep ..... The Credit Valley Hospital
Benegal, Suraj ..... City Centre Remedy's Rx
Berbecel, Manuela ..... Costco Pharmacy
Berry, Marianne ..... The Credit Valley Hospital
Bhatti, Khalid ..... Total Health Pharmacy
Chan, Pui Kar ..... Shoppers Drug Mart
Cheng, Lucy ..... Shoppers Drug Mart
Dias, Angelo ..... Derry Village IDA
Elsabakhawi, Mohamed ..... Shoppers Drug Mart
Esguerra, Monaliza ..... Shoppers Drug Mart
Gergis, Adel ..... Glenderry Pharmacy
Gingras, Marie ..... The Credit Valley Hospital
Gupta, Chakshu ..... Costco Pharmacy
Haj-Bakri, Mohamad ..... Hiway 10 Pharmacy
Hanna, Rita ..... Shoppers Drug Mart
Hussain, Khurram ..... Shoppers Drug Mart
Jaferi, Zehra ..... Rexall
Khaled, Luay ..... Target Pharmacy
Khan, Asra ..... The Trillium Health Centre
Khan, Munawar ..... Costco Pharmacy
Kim, Mee Sun ..... Medisystem
Kithoray, Gurdeep ..... Shoppers Drug Mart
Lam, Sun Fu ..... Wal-Mart Pharmacy
Lamonica, Vincenzo ..... Shoppers Simply Pharmacy
Latchman, Sharmila ..... Medisystem
Le, Wayne ..... Shoppers Drug Mart
Lekhi, Ameesh ..... Shoppers Drug Mart
Loh, Katherine ..... SDM Specialty Health Services
Luong, Duy ..... Shoppers Drug Mart
Maghera, Jagjit ..... Shoppers Drug Mart
Mah-Allum, Yee-ping ..... Costco Pharmacy
Mahrous, Tamer ..... Eglinton Churchill Medical Pharmacy
Makar, Nancy ..... Erin Centre Pharmacy
Mikhaeil, Sameh ..... Van Mills IDA Pharmacy
Morgan, Nabil ..... Shoppers Drug Mart
Moy, Debra ..... Credit Valley Hospital
Muhammad, Sajjad ..... The Trillium Health Centre
Paggos, Marios ..... Shoppers Drug Mart
Patel, Jai ..... Unicare Pharmacy of Mississauga
Philemon, Amal ..... Eglinton Churchill Medical Pharmacy
Rambaksh, Zarin ..... Shoppers Drug Mart
Saad, Adel ..... Thomas Pharmacy
Saad, Morcos ..... Parkside Pharmacy
Sachania, Ramniklal ..... Heritage Hills Pharmacy
Samonis, Ruta ..... Guru Nanak Dev Pharmacentre
Sarma, Vijay ..... Target Pharmacy
Sarofiem, John ..... Main Drug Mart
Shafqat, Qaisar ..... Battleford Pharmacy Inc
Shah, Amit ..... Floradale Medical Pharmacy
Shin, Sandra ..... Marketplace Pharmacy
Sidrak, Sameh ..... King Medical Arts Pharmacy
Singh, Bharpur ..... The Credit Valley Hospital
Skakavac, Olivera ..... Hooper's Pharmacy
Stoch, Malgorzata ..... Shoppers Drug Mart
Suthar, Pareshkumar ..... Floradale Medical Pharmacy
Tatlonghari, Rom ..... The Credit Valley Hospital
The, Nikita ..... Shoppers Drug Mart
Towadros, Adel ..... Courtesy Pharmacy
Tran, Michelle ..... Shoppers Drug Mart
Ur Rehman, Najeeb ..... Shoppers Drug Mart
Uy-gallardo, Janeth ..... Medical Pharmacy
Yuan, William ..... Medisystem
Zaidi, Syed ..... Greenfield Pharmacy

MITCHELL

Appleby, William ..... Walthers IDA Pharmacy

MOOSONEE

Sarma, Vijay ..... Northern Pharmacy

MORRISBURG

Lane, Scott ..... Seaway Valley Pharmachoice Morrisburg

MOUNT FOREST

Patel, Rajendrakumar ..... Loblaw Pharmacy

NAPANEE

Guirguis, Mina ..... Napanee Richmond Medical Pharmacy

NEPEAN

Ghadianlou, Leila . . . . . Rexall
Guest, Michael . . . . . Medisystem Pharmacy
Long, Alana . . . . . Queensway-Carleton Hospital

NEW LISKEARD

Alexander, Bruce . . . . . Findlay's Drug Store

NEWMARKET

Bashta, John . . . . . Skycare Pharmacy
Fernandez, Samantha . . . . . Southlake Regional Health Centre
Gasic, Dragana . . . . . Shoppers Drug Mart
Khalil, Shehab . . . . . Newmarket Pharmacy

NIAGARA FALLS

Ibrahim, Medhat . . . . . Queen Street Pharmacy
Isak, Mina . . . . . Golden Care Pharmacy
Rezkalla, Ihab . . . . . Valley Way Pharmacy
Saati, George . . . . . Pharmachoice

NIAGARA ON THE LAKE

Lee, David . . . . . Shoppers Drug Mart

NORTH BAY

Abdelghany, Mohamed . . . . . North Bay Regional Health Centre
Latimer, Sarah . . . . . Kalvin Brown Pharmasave
Prior, Veronica . . . . . North Bay Regional Health Centre
Pygott, Christopher . . . . . North Bay Guardian Pharmacy
Simpson, Pamela . . . . . Pharmasave
Woolsey, Matthew . . . . . North Bay Regional Health Centre

NORTH YORK

Atia, Yehia . . . . . Finch-Weston Medical Pharmacy
Filippetto, Nadia . . . . . Shoppers Drug Mart
Fincur, Slavica . . . . . York Downs Pharmacy
Ghali, Carole . . . . . Victoria Terrace Pharmacy
Hanna, Kiroloss . . . . . Main Drug Mart
Henein, Emad . . . . . Concourse Pharmacy
Johnston, Karen . . . . . Sunnybrook St. John's Rehab
Kupchak, Taras . . . . . Shoppers Drug Mart
Kwok, Monica . . . . . Loblaw Pharmacy
Law, Faye . . . . . Shoppers Drug Mart
Lin, Yong . . . . . Shoppers Drug Mart
Liu, Yueming . . . . . North York General Hospital
Rajan, Shamin . . . . . Shoppers Drug Mart
Rajan, Vinit . . . . . Shoppers Drug Mart
Rezaei, Soheila . . . . . Ariana Pharmacy
Salgado- Corpuz, Mary . . . . . North York General Hospital
Soroka, Yevgeniya . . . . . Shoppers Drug Mart
Szto, Wanda . . . . . Loblaw Pharmacy
Tadros, Sylvia . . . . . Shoppers Drug Mart
Widmer, Evan . . . . . Wilson - Allen Pharmacy
Yuen, Jia-Wei . . . . . Shoppers Drug Mart

OAKVILLE

Ali, Ahmed . . . . . Target Pharmacy
De Rango, Fabio . . . . . Shoppers Drug Mart
De Rango, Marie . . . . . Shoppers Drug Mart
Eskandar, Tamer . . . . . Advanced Care Specialty Pharmacy Inc.
Gouda, Michael . . . . . Shoppers Drug Mart
Hanna, Magdy Yashoue Rizkalla . Oakville Town Centre Pharmacy
Iskandar, Nermin . . . . . Cims Pharmacy
Janmohamed, Alim . . . . . Pharma Sense
Jones, Andrea . . . . . Halton Healthcare Services
Kumar, Victor . . . . . Shoppers Drug Mart
Nashat, Robert . . . . . Leon Pharmacy
Pabla, Sandeep . . . . . Shoppers Drug Mart
Pemas, Meagan . . . . . Halton Healthcare Services
Saghir, Rania . . . . . Shoppers Drug Mart
Sandhu, Kanwardip . . . . . Shoppers Drug Mart
Sourial, Emad . . . . . Oak Park Community Pharmacy
Tieman-Sengupta, Barbara . . . . . Shoppers Drug Mart
Tieu, Kim Ghet . . . . . Halton Healthcare Services
Yassa, Silvana . . . . . Royal Oak Pharmacy

ORANGEVILLE

Cuddy, Amanda . . . . . Rexall Pharma Plus
Gandhi, Ajay . . . . . Fifth Avenue Pharmacy

ORILLIA

Ali, Rukhsana . . . . . Loblaw Pharmacy
Chung, Christina . . . . . Shoppers Drug Mart
Mankarious, Maged . . . . . Shoppers Drug Mart
Mitrovski, Biserka . . . . . Loblaw Pharmacy
Santiago, Renz . . . . . Fittons Pharmacy

ORLEANS

Khalil, Raafat . . . . . St. Mary Health Center Pharmacy
Rossignol, Luc . . . . . Pharmacie Jean Coutu Pharmacy
Thabet, Essame . . . . . Shoppers Drug Mart

OSHAWA

Bakhoum, Meena . . . . . Eastview Pharmacy
Jejna, Marsha . . . . . Loblaw Pharmacy
Liu, Yang . . . . . Costco Pharmacy
Mikhaiel, Mona . . . . . PharmaChoice
Murphy, George . . . . . Costco Pharmacy
Uwadiae, Lewis . . . . . Scotts Drug Mart
Younis, Marwah . . . . . Seamless Care Pharmacy

OTTAWA

Abdalla, Amira . . . . . Shoppers Drug Mart
Abdalla, Mohamed . . . . . Shoppers Drug Mart
Abdel Sayed, Nassef . . . . . Shoppers Drug Mart
Al Taslaq, Ashraf . . . . . Greenbank Hunt Club Pharmacy
Alvarez, Tatiana . . . . . Shoppers Drug Mart
Badawy, Tamer . . . . . First Care Pharmacy
Bedard, Mario . . . . . The Ottawa Hospital
Botros, Ragi . . . . . St. Laurent Pharmacy IDA
Cecillon, David . . . . . University Of Ottawa Heart Institute
Corman, Celine . . . . . The Ottawa Hospital
Cummings, Nancy . . . . . Classic Care Pharmacy
Darwish, Mohamed . . . . . Shoppers Drug Mart
Desjardins, Veronik . . . . . Montfort Hospital
Egunjobi, Omolade . . . . . Rexall Pharma Plus
Guirguis, Bassem . . . . . Medical Arts Dispensary of Ottawa (2003) Ltd.
Hanna, Andrew . . . . . Shoppers Drug Mart
Hassan, Zaineb . . . . . Rexall
Hayes, Carolyn . . . . . Classic Care Pharmacy
Ibrahim, Najlaa . . . . . Shoppers Drug Mart
Jean, Melina . . . . . Bruyere Continuing Care
Kuo, Alexander . . . . . The Ottawa Hospital
Lamarche, Marie-Pierre . . . . . Canadian Forces Health Services Centre Ottawa
Lamer, Angela . . . . . Bruyere Continuing Care
Lamont, Kimberley . . . . . Ottawa Hospital
MacInnis, Jacqueline . . . . . KidCare Pharmacy - Pharmacie Pediatrique
MacKenzie, Jane . . . . . The Ottawa Hospital
McLintock, Deanne . . . . . Canadian Forces Health Services Centre Ottawa
Mulley, Jennifer . . . . . Shoppers Drug Mart
Osman, Ahmed . . . . . Shoppers Drug Mart
Peters, Adam . . . . . Children's Hospital of Eastern Ontario
Pour-Ghorban, Mandana . . . . . Costco Pharmacy
Rambout, Lisa . . . . . The Ottawa Hospital
Rizk, Adel . . . . . Shoppers Drug Mart
Spencer, Jennifer . . . . . The Ottawa Hospital
Sweeney, Sylvia Shiou Wen . . . . . Shoppers Drug Mart
Swetnam, Jennifer . . . . . Shoppers Drug Mart
Tonon, Matthew . . . . . New Edinburgh Pharmacy

Tripsa, Narcisa . . . . . Shoppers Drug Mart
Truong, My-Hanh . . . . . Montfort Hospital
Watson, Michael . . . . . Watson's Pharmacy and Compounding Centre
Wilson, Loretta . . . . . Montfort Hospital

OWEN SOUND

Browne, Christopher . . . . . Rexall Pharma Plus
Vacheresse, Marc . . . . . Grey Bruce Health Services

PALMERSTON

Plagenz, Nicole . . . . . North Wellington Health Care - Palmerston District Hospital

PARIS

Hawkins, Natalie . . . . . Northville Pharmacy

PEMBROKE

Keon, Lynn . . . . . Pembroke Regional Hospital Inc
Ouimet, Kelli . . . . . Mulvihill Drug Mart
Rey-McIntyre, Andrew . . . . . Shoppers Drug Mart

PENETANGUISHENE

Moore, Sean . . . . . Village Square Pharmacy

PERTH

Shah, Avish . . . . . Shoppers Drug Mart

PETERBOROUGH

Azubuike, Madukwe . . . . . Loblaw Pharmacy
Gillis, Allison . . . . . CATP/DrugSmart Pharmacy
Harp, Joanne . . . . . Shoppers Drug Mart
Lovick, Stephen . . . . . Medical Centre Pharmacy
Lycett, Tracy . . . . . Medical Pharmacy
Naik, Pradeep . . . . . Peterborough Hospital Pharmacy
Plassery, Biju . . . . . Rexall
Recoco, Russelle . . . . . Westmount Pharmacy

PETROLIA

McDonald, Anna . . . . . Lambton Pharmacy

PICKERING

Hanna, Adel . . . . . Glendale Pharmacy
Roodbaraki, Poorang . . . . . Shoppers Drug Mart

PORT HOPE

Khan, Sumera . . . . . Loblaw Pharmacy

REXDALE

Labib, Ihab . . . . . Humber Green Pharmacy

RICHMOND HILL

Abu El Khire, Anis . . . . . Health Link Pharmacy
Andrade, Anna . . . . . Mackenzie Richmond Hill Hospital
Avetissov, Vera . . . . . Shoppers Drug Mart
Avinashi, Gunjan . . . . . Shoppers Drug Mart
Colella, Giuseppe . . . . . Shoppers Drug Mart
Francis, Marianna . . . . . Public Health Pharmacy
Jiang, Hui . . . . . Medical Pharmacy
Kang, Mun . . . . . Mackenzie Richmond Hill Hospital
Leong, Shaun . . . . . Costco Pharmacy
Li, Kwan Ting . . . . . Shoppers Drug Mart
Loduca, Richardo . . . . . Shoppers Drug Mart
Lorestani, Shohreh . . . . . Shoppers Simply Pharmacy
Mandlsohn, Mark . . . . . Shoppers Drug Mart
Mekhail, Sylvia . . . . . Total Health Pharmacy
Morgan, Faddy . . . . . PharmAssist
Mosallam, Tamer . . . . . Pars Medical Pharmacy
Rahman, Md Khalilur . . . . . Yonge Medical Centre Pharmacy
Riad, Mirette . . . . . Leslie & Major Mac. I.D.A. Pharmacy
Siwani, Shani-Abbas . . . . . Uptown Apothecary
Yan, Andrew . . . . . Medical Pharmacy

RIDGEWAY

Edwards, Donald . . . . . Boggio & Edwards Ridgeway IDA Pharmacy

ROCKLAND

Brousseau, Natasha . . . . . Raymond Arseneau Pharmacien
Corbeil, Josee . . . . . Pharmacie Jean Coutu Pharmacy

RUSSELL

Cecillon, Cindy . . . . . Downtown Pharmacy

SAINT-JEAN-SUR-RICHELIEU

Miron, Jason . . . . . National Defence

SARNIA

Baxter, John . . . . . Hogan Pharmacy
Cane, Jocelyn . . . . . Rexall
Hanna, Jessica . . . . . Centrepoint IDA Pharmacy
Kelch, Richard . . . . . Northgate Pharmacy
Laporte, Marcel . . . . . BMC Pharmacy

SAULT STE MARIE

Coccimiglio, Maria . . . . . Sault Area Hospital
Coccimiglio, Stefanie . . . . . Market Mall Pharmacy
Di Renzo, Paolo . . . . . Pharmacy
Forsyth, Gavin . . . . . Sault Area Hospital
Gauthier, Christy . . . . . Shoppers Drug Mart
Kniahnicki, Carissa . . . . . Rexall Pharma Plus
Longo, Aurelio . . . . . Ideal IDA Drugmart
O'Laney, Marlene . . . . . Rexall
Patterson, Paula . . . . . Loblaw Pharmacy
Policicchio, Matthew . . . . . Wal-Mart Pharmacy
Ross, Susannah . . . . . Shoppers Drug Mart
Saleeb, Adel . . . . . Central Drug Mart
Santa Maria, Angelo . . . . . Wellington Square Drug Mart

SCARBOROUGH

Abbaskhani-Davanlou, Golmehr Fairlane Drug Mart
Abdullah, Ahmad . . . . . Shoppers Drug Mart
Amro, Moe . . . . . Shoppers Drug Mart
Au, Karen . . . . . Shoppers Drug Mart
Baig, Asad . . . . . Shoppers Drug Mart
Balachandran, Jayashree . . . . . Costco Pharmacy
Balani, Meenakshi . . . . . Shoppers Drug Mart
Barua, Kanan . . . . . Kanan's Guardian Pharmacy
Benegal, Kiran . . . . . Shoppers Drug Mart
Bhanji, Zahir . . . . . Remedy's Global Drug Mart Pharmacy
Cau, Chieng . . . . . Shoppers Drug Mart
Cerovic-Radusinovic, Aleksandra . . Shoppers Drug Mart
Chau, Elizabeth . . . . . Drugstore Pharmacy
Dhirani, Akil . . . . . Village Square Pharmacy
Farag, Mamdouh . . . . . Danforth Pharmacy
Garabet, Nayre . . . . . Costco Pharmacy
Gawtrey, Aulona . . . . . Cliffside Pharmacy
Ip, Jerry . . . . . Shoppers Drug Mart
Iskander, Maged . . . . . Woburn Medical Pharmacy
Li, Brian . . . . . Village Square Pharmacy
Li, Wing . . . . . National Pharmacy
Lugtu, Mildred . . . . . Rexall
Meysami, Farnoush . . . . . Total-Care Pharmacy
Mwanza, Leaggy . . . . . Shoppers Drug Mart
Patel, Nayan . . . . . Pharmasave
Patel, Rajvi . . . . . Rexall Pharma Plus
Patel, Sagufta . . . . . Noble IDA Pharmacy
Rascu, Maria . . . . . Shoppers Drug Mart
Shtein, Viktoria . . . . . Shoppers Drug Mart

So, Amy. . . . . A & W Pharmacy
Wong, Victor. . . . . Shoppers Drug Mart
Woo, Ka Kei. . . . . Shoppers Drug Mart
Yamasaki, Mei-Fe. . . . . Pharmasave
Yehya, Ali . . . . . Quints Medical Pharmacy
Yuen, Dian . . . . . Shoppers Drug Mart

SIMCOE

De Fields, Pamela . . . . . Shoppers Drug Mart
Stephens, Mark . . . . . Roulston's Pharmacy

SMOOTH ROCK FALLS

Stewart, Lisa . . . . . Smooth Rock Falls Pharmacy Ltd

ST. CATHARINES

Ahmed, Adnan . . . . . Shoppers Drug Mart
Coholan, Janice . . . . . Shoppers Drug Mart
Desai, Siraj . . . . . Sobeys Pharmacy
Elnazir, Linda . . . . . Niagara Health System
Gamotin, Belinda . . . . . Costco Pharmacy
Hanuschuk, Michael . . . . . Shoppers Drug Mart
Hindi, Eyad . . . . . Montebello Medical Pharmacy
Kooter, Rosmarie . . . . . Shoppers Drug Mart
Longval, Gerard . . . . . Niagara Street Remedy Rx
Panneerselvam, Singaravelu. . . . . Niagara-Welland Pharmacy
Roushdy, Bassem. . . . . Shoppers Drug Mart

ST. CLAIR BEACH

Gbadamosi, Mojisola. . . . . Loblaw Pharmacy

ST. THOMAS

Bond, Stephen . . . . . Yurek Pharmacy Limited
Campbell, Sandra. . . . . St. Thomas-Elgin General Hosptl
Fletcher, Kathryn. . . . . St. Thomas-Elgin General Hosptl
Hache, Richard. . . . . St. Thomas-Elgin General Hosptl

STAYNER

Thompson, Glenn . . . . . Rexall

STITTSVILLE

Ramzi-Safaee, Fatemeh. . . . . Loblaw Pharmacy

STONEY CREEK

Carvalho, Lisa . . . . . Loblaw Pharmacy

STRATFORD

Adair, Kristy . . . . . Sinclair Pharmacy
Roulston, Paul. . . . . Shoppers Drug Mart

STRATHROY

Clark, Kathleen. . . . . Strathroy Middlesex General Hospital

STREETSVILLE

Shalvardjian, Berge . . . . . Robinson's IDA Pharmacy

STURGEON FALLS

Steel, Karen. . . . . Loblaw Pharmacy

SUDBURY

Brereton, Delia. . . . . Choose Healthy Now
Brisebois, Frances . . . . . Health Sciences North - Ramsey Lake Health Centre
Chappell, Adam. . . . . Health Sciences North - Ramsey Lake Health Centre
Filo, Michelle . . . . . Health Sciences North - Ramsey Lake Health Centre
Hopkins, Maryanne. . . . . Health Sciences North - Horizon Sante-Nord
Krawczuk, Nykolas. . . . . Shoppers Drug Mart
Matthews, Kristen . . . . . Health Sciences North - Ramsey Lake Health Centre
Paquette, Jean-Robert . . . . . Health Care Pharmacy
Ranger, Luisa. . . . . Shoppers Drug Mart
Wong, Vicky . . . . . Plaza 69 - Shoppers Drug Mart

THORNHILL

Botros, Dimiana . . . . . Pharma Plus
Chan, Brent. . . . . Shoppers Drug Mart
Mandel, Sandra. . . . . Shoppers Drug Mart
Maurice, Bichoy . . . . . Main Drug Mart
Modabber, Minoo . . . . . Pharmacy 7
Mourid, Amany. . . . . St. Mary Pharmacy
Prodensky, Tal. . . . . FreshCo Pharmacy
Shterenberg, Khristina. . . . . North-Med Pharmacy

THUNDER BAY

Kantymir-Paquette, Jessica . . . . Thunder Bay Regional Health Sciences Centre
Prokopowich, Garry . . . . . St. Joseph's Hospital

TILLSONBURG

Kelly, Megan . . . . . Shoppers Drug Mart
Schafer, Linda . . . . . Coward Pharmacy Ltd

TIMMINS

Larocque, Lee-Anne. . . . . Timmins And District Hospital

TORONTO

Abdel Maseh, Nagib . . . . . Pharmasave
Ahamad, Asim. . . . . St. Michael's Hospital
Anati, Costinela . . . . . Baycrest Centre for Geriatric Care
Antunes, Jennifer . . . . . Sunnybrook Health Sciences Centre
Antwi-Boasiako, Lynn . . . . . Orton Park Pharmacy
Askarian-Monavvari, Roya . . . . . Roya Boutique Pharmacy
Azim, Sheikh Muhammed . . . . . Shoppers Drug Mart
Aziz, Nabil. . . . . The Medicine Shoppe
Bacher, Marilyn. . . . . Ambulatory Patient Pharmacy
Bae, Jieun . . . . . Shoppers Drug Mart
Balac, Mirjana . . . . . Toronto Rehab. Institute
Bennett, Glenda. . . . . St. Joseph's Health Centre
Besharati, Ramin . . . . . Welcome Guardian Drugs
Beven, Brian . . . . . The Hospital For Sick Children
Bharaj, Rupinder . . . . . Wal-Mart Pharmacy
Boshara, Wafaa. . . . . Bay College Drug Mart
Bregu, Esmeralda. . . . . Shoppers Drug Mart
Brittain, Cherry . . . . . Shoppers Drug Mart
Brun, Rita. . . . . Toronto East General Hospital
Chan, Christopher. . . . . Shoppers Drug Mart
Chan, David . . . . . Moss Park Pharmacy Ltd.
Chaudhry, Komal . . . . . Loblaw Pharmacy
Chen, Yan. . . . . Shoppers Drug Mart
Chow, Lei Lei Lily. . . . . Sunnybrook Health Sciences Centre
Da Silva Moniz, Odette . . . . . The Toronto Western Hospital
Dang, Edward . . . . . Shoppers Drug Mart
Davies, Peter. . . . . St. Michael's Hospital
Delawala, Soebmohmed . . . . . Shoppers Drug Mart
Dev, Shruti. . . . . Toronto East Pharmasave
Dhaliwall, Jatinderjit . . . . . Shoppers Drug Mart
Dhalla Sunderji, Tazeem. . . . . Shoppers Drug Mart
Elias, Basem. . . . . Islington IDA Pharmacy
Ellis, Julian . . . . . Canadian Compounding Pharmacy
Fanous, Mena . . . . . The Village Pharmacy
Farrahi, Sepideh . . . . . Shoppers Drug Mart
Farrand, Jeffrey . . . . . Shoppers Drug Mart
Francis, Baher. . . . . Allcures Pharmacy
Gandevia, Hemamalini . . . . . Loblaw Pharmacy
Gergis, Alaa . . . . . Albion Finch Pharmacy
Ghobrial, Sali. . . . . St. Gabriel Medical Pharmacy
Giraudi, Alexander. . . . . Omni Pharmacy
Girgis Boktor, Amir . . . . . College Medical Pharmacy
Gould, Kelly . . . . . Shoppers Drug Mart
Hanna, Wissam. . . . . Canes Community Pharmacy
Hansra, Manjit. . . . . Shoppers Drug Mart
Harilall, Amit . . . . . Toronto East Pharmasave
Hirmina, Peter . . . . . Demarco Pharmacy

Ho, Hsin-Ying ... Medisystem Pharmacy
Ho, Rayburn ... Shoppers Drug Mart
Hsu, Joseph ... Hooper's Pharmacy
Huynh, Linh ... Centre for Addiction & Mental Health - Queen Street Site
Ilagan, Kristoffer ... Transplant Outpatient Pharmacy
Ip, Robert Siu Lin ... Shoppers Drug Mart
Ishani, Rumina ... Remedy's Rx Eglinton Bayview Compounding Pharmacy
Jaffer, Akeel ... Shoppers Drug Mart
Jani, Jiten ... St. Joseph's Health Centre
Javaid, Suhail ... Shoppers Drug Mart
Johari, Mahtab ... Rexall
John, Annabel ... The Hospital For Sick Children
Kakani, Padma ... Shoppers Drug Mart
Kaliy, Olesya ... Shoppers Drug Mart
Kam, Sarah ... Shoppers Drug Mart
Kim, Clarissa ... St. Joseph's Health Centre
Kim, Susan ... Shoppers Drug Mart
Kishida, Makiko ... Charles Pharmacy
Knight, Robyn ... Rexall
Kolta, Samer ... Northview Pharmacy
Kong, Josephine ... Costco Pharmacy
Koutroubis, Demitrios ... Rexall Pharma Plus
Kua, Benson ... Pharma-Cita
Kue, Kin ... CAMH Pharmacy
Lacsamana, Jason ... Sunnybrook Health Sciences Centre
Lee, Jung-Ok ... Rexall
Lee, Soo-Ling ... St. Joseph's Health Centre
Leung, Michael ... Sunnybrook Health Sciences Centre
Li, Wilson ... Shoppers Drug Mart
Liu, Cheng-Cha ... Shoppers Drug Mart
Liu, Ying ... The Toronto General Hospital
Lopez Palacios, Marisol ... Nova Pharmacy
Lu, Ngoc ... Sunnybrook Health Sciences Centre
Lytwyn-Nobili, Elizabeth ... Shoppers Drug Mart
Mahajan, Puneet ... Mid-Eg Pharmacy Inc.
Mall, Angela ... Prescription Care Centre
Manshouri, Ali ... Shoppers Drug Mart
Mansoubi, Abdoulnaser ... Shoppers Drug Mart
Marchesano, Romina ... Sunnybrook Health Sciences Centre
Marinkovic, Miodrag ... Shoppers Drug Mart
Marsden, Carla ... The Hospital For Sick Children
Mehawed, Merry ... Northcliffe Pharmacy
Messih, Hany ... Action Pharmacy
Metyas, Jerry ... Lakefront Medical Pharmacy
Mikhaeil, Sami ... Sam's I.D.A. Pharmacy
Mikhail, Maher ... Dufferin Drug Mart
Mohamed, Ibrahim ... Shoppers Drug Mart
Molnar, Judy ... The Hospital For Sick Children
Nahidi, Maral ... Shoppers Drug Mart
Nasralla, Amin ... Westmore Pharmacy
Nathoo, Falzana ... St. Michael's Hospital
Nekkalapu, Sree ... Regency Pharmacy
Nenadovich, Maria ... Shoppers Drug Mart
Nencheva, Nadya ... Mount Sinai Hospital
Nhan, Jonathan ... Shoppers Drug Mart
Panakkal, Silvie ... Sunnybrook Health Sciences Centre
Panebianco, Gina ... CAMH Pharmacy
Papastergiou, John ... Shoppers Drug Mart
Patel, Rushikumar ... St. Michael's Hospital
Perry, Amanda ... Shoppers Drug Mart
Petten, Jeffrey ... Prescription Care Centre
Phan, Be ... Princess Margaret Hospital Outpatient Pharmacy
Phillips, George ... Shoppers Drug Mart
Pileggi, Giuseppe ... Shoppers Drug Mart
Rajora, Jay ... Peoples Choice Remedy's Rx
Rando, Lucy ... Mimico Pharmacy
Reiner, Brigitte ... Kassel's Pharmacy Limited
Remtulla, Nadeem ... Shoppers Drug Mart
Riss, Vera ... The Hospital For Sick Children
Rodrigues, Hilary ... Runnymede Healthcare Centre
Rofaiel, Lillian ... White's Pharmacy
Rofaiel, Sarah ... Main Drug Mart
Rowntree, Candice ... Shoppers Drug Mart
Rubbani, Ghulam ... Shoppers Drug Mart
Ruschin, Henry ... Centre for Addiction & Mental Health - College Street Site
Saiy, Niloofar ... Shoppers Drug Mart
Savage, Mark ... CATP
Scott, Heather ... Regional Cancer Centre/Odette Cancer Centre Pharmacy
Seto, Tak-Wo ... The Hospital For Sick Children
Shafagh-Motlagh, Nima ... Shoppers Drug Mart
Shah, Arpan ... Haber's Compounding Pharmacy
Shah, Kaushil ... Bloor-Dundas Pharmacy
Siddiqui, Mansur ... Wal-Mart Pharmacy
Siha, Christine ... Dalecliff Medical Pharmacy
Singh, Priya ... The Toronto Western Hospital
Soltys, Irene ... The Toronto Western Hospital
Sourial, Safwat ... Shoppers Drug Mart
St Pierre Jr, Barry ... Shoppers Drug Mart
Stamadianos, Angelo ... Metro Drugs
Strybosch, Lynn ... Shoppers Simply Pharmacy
Tadros, Mina ... Sam's I.D.A. Pharmacy
Tailor, Jayesh ... Shoppers Drug Mart
Tan, Kenny ... Shoppers Drug Mart
Terzaghi, Maria ... Shoppers Drug Mart
Thomas, Koshy ... St. Michael's Hospital
Tran, Chan ... Shoppers Drug Mart
Twfic, Mina ... Bathurst-Bloor IDA Drug Mart
Vidotto, Stephanie ... Sunnybrook Health Sciences Centre
Walton, James ... Shoppers Drug Mart
Wan, Tom ... Shoppers Drug Mart
Wasef, Botros ... Main Drug Mart
Weber, Brittany ... Princess Margaret Hospital Outpatient Pharmacy
Weyland, Laura ... Shoppers Drug Mart
William, Ossama ... Main Drug Mart
Wong, Wing ... Toronto Manning Drug Mart
Xu, Heng ... Pharma Plus
Yacob, Souzan ... College Centre Pharmacy II
Yeganegi, Kamal ... Willowdale Pharmacy
Yip, Paul ... Rexall
Youhanna, Peter ... Liberty Market Pharmacy
Zannella, Stefano ... Regional Cancer Centre/Odette Cancer Centre Pharmacy
Zervas, John ... Shoppers Simply Pharmacy

TOTTENHAM

Hilliard-Ridd, Ellen ... Tottenham Medical Pharmacy

TRENTON

Chuen, William ... Trenton Pharmacy

UNIONVILLE

Xu, Li ... Unionville Guardian Pharmacy

VAL CARON

Bignucolo, Robert ... Val Est Pharmacy
Jolicoeur, Caroline ... Val Est Pharmacy

VANIER

Fisher, Steven ... Vanier Pharmacy

VAUGHAN

Di Michele, Salvatore ... Forum Drug Mart
Kahlon, Shaminder ... Shoppers Drug Mart
Metyas, John ... Jane Medical Pharmacy
Moldovan, Manuela ... Drugstore Pharmacy
Sabzvari, Ali ... Shoppers Drug Mart

Sharma, Rajiv. . . . . Summeridge Guardian Pharmacy
Tenenbaum, Shirley. . . . . Shoppers Drug Mart

WALKERTON

Currie, Rosanne . . . . . Pellow Pharmasave

WASAGA BEACH

Mankarios, George . . . . . Wasaga Beach IDA Pharmacy

WATERFORD

Sloot, Robert . . . . . Pharma Plus

WATERLOO

Abdel Sayed, Ehab. . . . . Central Pharmasave Pharmacy
Anand, Veneta . . . . . Shoppers Drug Mart
De Sousa, Dragana . . . . . Shoppers Drug Mart
Patel, Kiran. . . . . Student Health Pharmacy

WELLAND

Badasu, Rejoice . . . . . Wal-Mart Pharmacy
Ibrahim, Mina . . . . . Shoppers Drug Mart
Morcous, Micheil . . . . . Shoppers Drug Mart
Severin, Shawn. . . . . Loblaw Pharmacy

WESTON

Hassan, Farhana. . . . . Shoppers Drug Mart

WHITBY

Elnazir, Nancy . . . . . Total Health Pharmacy
Farooq, Muhammad . . . . . Shoppers Drug Mart
Robinson, Janet . . . . . Pringle Creek Pharmasave
Rule, Colin . . . . . Shoppers Drug Mart

WINCHESTER

Gazarin, Mohamed . . . . . Winchester District Memorial Hospital
Leclair, Joanne . . . . . Winchester District Memorial Hospital

WINDSOR

Alam, Intekhab . . . . . Shoppers Drug Mart
Amlin, April . . . . . Shoppers Drug Mart
Braccio, Elisa . . . . . Shoppers Drug Mart
Corra, Ashley. . . . . Windsor Regional Hospital
D'angelo, Rocco . . . . . Royal Windsor Pharmacy
Daoud, George. . . . . Medical Centre Pharmacy
Dawood, John . . . . . Windsor River Pharmacy
Di Pietro, Sebastiano . . . . . Shoppers Drug Mart
Drouillard, Kellie-Ann. . . . . Windsor Regional Hospital - Metropolitan Campus
Duronio, Antoinette . . . . . Windsor Regional Hospital - Metropolitan Campus
Fazekas, Effie. . . . . Hotel Dieu Grace Health Care
Field, Dawnmarie . . . . . We Care Pharmacy
Francis, Nathalee . . . . . Shoppers Drug Mart
Gao, Ran. . . . . Shoppers Drug Mart
George, Alfred . . . . . Central Mall Drug Mart
Groulx, Janet . . . . . Shoppers Drug Mart
Hancrar, Nancy. . . . . Remedy'sRx
Hijazi, Amal . . . . . Windsor Clinical Pharmacy
Houle, Karrie. . . . . Costco Pharmacy
Kummer, Theodore . . . . . Shoppers Drug Mart
Leung, Hoi Man . . . . . Shoppers Drug Mart
Mannarino, Giuseppina . . . . . Fontainebleu Pharmacy
Marentette, David . . . . . Sure Health Pharmacy
McQueen, Joey . . . . . Windsor Regional Hospital - Metropolitan Campus
Nardone, Alessandro . . . . . Shoppers Drug Mart
Rublik, Angel . . . . . Windsor Regional Hospital
Stanczak, Yolanda . . . . . Rexall
Vella, Francesco . . . . . Olde Walkerville Pharmacy
Yee, Richard. . . . . Yee Pharmacy Limited

WINGHAM

Morrison, Sandra . . . . . Wingham And District Hospital

WOODBRIDGE

Ali, Helen . . . . . Shoppers Drug Mart
Atia, Yehia. . . . . Weston-Rutherford Medical Pharmacy
Daoud, Fiby . . . . . Costco Pharmacy
Levine, Lisa . . . . . Panacea Pharmacy
Mazza, Caterina . . . . . Rexall Pharma Plus
Mendolia-Moriana, Franca . . . . . Langstaff Pharmacy
Pandit Pautra, Akhil. . . . . Costco Pharmacy
Raphael, Mona . . . . . Henderson's Woodbridge Medical Pharmacy
Shetty, Prajna . . . . . Shoppers Drug Mart
Valela, Anna . . . . . Rexall Pharma Plus
Wong, Terence . . . . . Shoppers Drug Mart

WOODSTOCK

Andrecyk, Stacey . . . . . Shoppers Drug Mart
Patel, Jayantkumar . . . . . Huron Street Dispensary Pharmasave
Payne, Catherine . . . . . Woodstock General Hospital
Wong, Hiu . . . . . Huron Street Dispensary Pharmasave

PRACTICE TIP!

Wondering how much you need to document? Ask yourself "Would a relief pharmacist know everything they would need to know to cover where I left off?" If the answer is no, you need to take more notes.
http://www.ocpinfo.com/practice-education/practice-tools/fact-sheets/record-keeping/

Follow @OCPinfo on Twitter and get a helpful practice tip each week.
#OCPPracticeTip

White Coat Ceremonies at University of Toronto and University of Waterloo

The University of Toronto and University of Waterloo recently hosted ceremonies to formally mark the beginning of incoming pharmacy students' professional journey. During the ceremonies, students make their commitment to ethics and integrity and are formally welcomed into the professional community.

As usual, College Registrar & CEO, Marshall Moleschi, attended both ceremonies. This year, given the recent passing of the profession's new Code of Ethics in December 2015, both schools updated their ceremonies and incorporated foundational elements from the new Code.

Photo by Neil Trotter, Studio 66.

ABOVE: The University of Waterloo's Pharmacy Class of 2019.

BELOW: Leslie Dan joins incoming students at the University of Toronto's White Coat Ceremony.

Photo by Horst Herget, Horst Herget Photography.

Photo by Neil Trotter, Studio 66.

LEFT: College Registrar Marshall Moleschi reminds incoming students about their new professional obligations at the University of Waterloo's White Coat Ceremony.

BELOW: Incoming students at the University of Toronto (left) and University of Waterloo (right) participate in their program's White Coat Ceremony.

Photo by Horst Herget, Horst Herget Photography.

Photo by Neil Trotter, Studio 66.

OCP's Social Media Journey

2009
Launched Twitter and YouTube

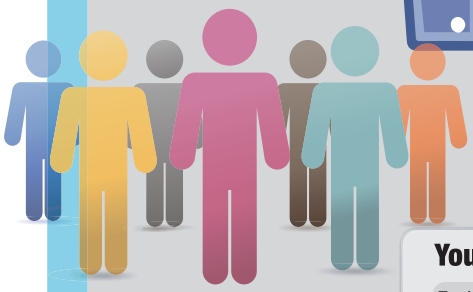
2015
Launched Facebook and LinkedIn

How are we doing?

Fan growth & interactions since 2015 launch*:

End of Jul 2015:	End of Aug 2015:	End of Oct 2015:
338 likes	649 likes	2,136 likes
114 interactions	368 interactions	2,701 interactions

An average of **596** new Facebook fans per month*



YouTube videos & views since 2009 launch:

End of Aug 2011:	End of Aug 2013:	End of Aug 2015:
7 videos	15 videos	37 videos
381 views	15,609 views	50,965 views

Since launching Twitter in 2009:

650+ interactions per month

43 new followers per month

Since launching LinkedIn in 2015:

60+ interactions per month

36 new followers per month

*Since the College launched its Facebook page, we ran a paid advertising campaign. "Interactions" refer to comments, likes, clicks, and shares/retweets. Any one of these actions count as an interaction. Averages were calculated over the three month period between August and October 2015.

DISCIPLINE DECISIONS

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Member: Ovietobore (Felix) Ayigbe (OCP #204476)

At a hearing on November 18, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ayigbe with respect to the following:

- That he submitted false claims to the Ontario Drug Benefit Program totalling approximately $44,000 for drugs and other health products that were not actually dispensed to patients, in or about March-October 2010;
- That he submitted false claims to insurers other than the Ontario Drug Benefit Program totalling approximately $18,000 for drugs and other health products that were not actually dispensed to patients, in or about March-October 2010;
- That he created false records of dispensing and/or billing transactions in relation to the false claims submitted to the Ontario Drug Benefit Program and/or other insurers in relation to the false claims described above; and/or
- That he provided false information and documentation to the Ministry of Health and Long-Term Care regarding drug purchases for Sunshine Pharmacy from Main Drug Mart in the course of the Ministry's audit, in or about November-December 2010.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession;
- Falsified a record relating to his practice;

- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement;
- Submitted an account or charge for services that he knew was false or misleading;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, the Ontario Drug Benefit Act, sections 5, 6 and/or 15(1);
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand

2. Requiring the Registrar to revoke the Member's certificate of registration

3. Costs to the College in the amount of $5,000

In its reprimand, the Panel described the Member's conduct as disgraceful, dishonourable, and unprofessional. The Panel expressed its view that the Member betrayed the people of Ontario and is a thief. The Panel suggested that the people of Ontario and the profession are well served by the revocation of the Member's certificate of registration.

Member: Elizabeth Toth (OCP #204196)

At a hearing on November 25, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Toth with respect to the following:

- That she submitted accounts or charges for services that she knew were false or misleading to

the Ontario Drug Benefit program for one or more drugs and/or products; and/or
- That she falsified pharmacy records relating to her practice in relation to claims made to the Ontario Drug Benefit program for one or more drugs and/or products.

In particular, the Panel found that she:

- Failed to maintain a standard of practice of the profession;
- Falsified records relating to her practice;
- Submitted accounts or charges for services that she knew to be false or misleading;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular sections 5 and 15(1)(b) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder;
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regarding to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

i. A reprimand

ii. An Order directing the Registrar to suspend the Member's certificate of registration for a period of eight months, with one month of the suspension to be remitted on condition that the Member complete the remedial training specified in paragraph (iii)(A) below;

iii. an Order directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:
(A) the Member must successfully complete with an unconditional pass, at her own expense and within twelve (12) months of the date the Order is imposed, the ProBE Program on professional / problem-based ethics for health care professionals offered by the Centre for Personalized Education for Physicians;
(B) for a period of three (3) years from the date the Order is imposed, the Member shall be prohibited from:
(1) having any proprietary interest in a pharmacy of any kind;
(2) acting as a Designated Manager in any pharmacy; and,
(3) receiving any remuneration for her work as a pharmacist other than remuneration based on hourly or weekly rates only;
(C) for a period of three (3) years from the date the Order is imposed, the Member shall be required to notify the College in writing of the name(s), address(es) and telephone number(s) of all pharmacy employer(s) ("employers") within fourteen (14) days of commencing employment in a pharmacy;
(D) for a period of three (3) years from the date the Order is imposed, the Member shall provide her employer with a copy of the Discipline Committee Panel's decision in this matter and its Order; and
(E) for a period of three (3) years from the date the Order is imposed, the Member shall only engage in the practice of pharmacy for an employer who agrees to write to the College within fourteen (14) days of the Member's commencing employment, confirming that it has received a copy of the required documents identified above, and confirming the nature of the Member's remuneration

iv. Costs to the College in the amount of $7,000.

In its reprimand, the Panel observed that integrity and trust are paramount to the profession, as pharmacists provide care to the public and in return are held in high regard. The Panel expressed its disappointment with the Member's failure to maintain a standard of practice with respect to falsifying records and submitting false claims. The Panel related its expectation that the Member will learn from this process and work to regain the trust that was diminished through her actions.

Member: Sherif Samwaiel (OCP #218729)

At a hearing on December 1, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Samwaiel with respect to allegations of professional misconduct set out in two notices of hearing.

With respect to the allegations set out in the first notice of hearing, the Panel found that

Mr. Samwaiel, while engaged in the practice of pharmacy as director, shareholder, Designated

Manager and/or dispensing pharmacist at Total Health Pharmacy, Bloor Street location and Sheppard Avenue East location, in Toronto, Ontario, committed professional misconduct in that he

- falsified pharmacy records relating to his practice in connection with:
  - o claims made for various drugs in 2008-2010;
  - o various invoices purporting to be from Canadian Pharmaceutical Supply in 2009-2010;
  - o the Statement of Accounts payable at November 30, 2010 for [Individual 1]

- signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement in connection with claims made for various drugs in 2008-2010

In particular, the Panel found that he

- failed to maintain a standard of practice of the profession;
- falsified a record relating to his practice;
- signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement;
- submitted an account or charge for services that he knew was false or misleading;
- contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended;
- contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, sections 5, 6 and 15(1) of the Ontario Drug Benefits Act, R.S.O. 1990, c O.10, and section 25 of Regulation 201/96 under the Ontario Drug Benefits Act;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

With respect to the allegations set out in the second notice of hearing, the Panel found that

Mr. Samwaiel, while engaged in the practice of pharmacy as director, shareholder, Designated Manager and/or dispensing pharmacist at Northcliffe Pharmacy in Toronto, Ontario, committed professional misconduct in that he

- falsified pharmacy records relating to his practice in connection with one or more claims made for drugs and other products in 2010 and 2011;
- signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement in connection with one or more claims made for drugs and other products in 2010 and 2011;
- submitted an account or charge for services that he knew was false or misleading in connection with one or more claims made for drugs and other products in 2010 and 2011;
- failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping, documentation, and billing the Ontario Drug Benefit Program; and/or
- failed to actively and effectively participate in the day-to-day management of the pharmacy, including, but not limited to drug procurement and inventory management, record keeping and documentation, and billing.

In particular, the Panel found that he

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

The Panel imposed an Order which included as follows:

1. A reprimand.

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   (a) The Member must successfully complete with an unconditional pass, at his own expense and within twelve (12) months of the date the Order is imposed, the ProBE program on Professional Problem-Based Ethics for Health Care Professionals offered by the Centre for Personalized Education for Physicians;
   (b) The Member shall be prohibited from having any proprietary interest in a pharmacy of any kind and/or receiving remuneration for his work as a pharmacist other than remuneration based on hourly or weekly rates only, provided that this term, condition and limitation may be removed by an Order of a panel of the Discipline Committee upon application by the Member, such application not to be made sooner than five (5) years from the date the Order is imposed;
   (c) For a period of five (5) years from the date the Order is imposed, the Member shall be required to notify the College in writing of the names, addresses, and telephone numbers of all employers within fourteen (14) days of commencing employment in a pharmacy;
   (d) For a period of five (5) years from the date the Order is imposed, the Member shall provide his pharmacy employer with a copy of the Discipline Committee Panel's decision in this matter and its Order;
   (e) For a period of five (5) years from the date the Order is imposed, the Member shall only engage in the practice of pharmacy for an employer who agrees to write to the College within fourteen (14) days of the Member's commencing employment, confirming that it has received a copy of the required documents identified above, and confirming the nature of the Member's remuneration.
   (f) For a period of five (5) years from the date the Order is imposed, the Member shall not work at nor be employed by any pharmacy in which a family member has a proprietary interest.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of twenty four (24) months with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in subparagraph 2(a) above. The suspension shall commence on December 1, 2015 and shall continue until October 31, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraph 2(a) above, the balance of the suspension shall commence on November 1, 2017, and continue until November 30, 2017, inclusive.

4. That the Member pay a fine in the amount of $35,000.00, payable within twelve (12) months from the date of this Order.

5. Costs to the College in the amount of $20,000.

In its reprimand, the Panel observed that the Member stole from the people of Ontario, betrayed his profession, and undercut the public's confidence in it. The Panel noted that the Member's actions exemplified disgraceful, dishonorable and unprofessional conduct. The Panel related that the Member brought shame to himself and his family and indicated that it did not wish to see the Member before the Discipline Committee again.

Member: Gopi Menon (OCP #202656)

At a hearing on December 15, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Menon with respect to the following incidents:

- That he sexually harassed colleague and patient [Colleague 1] in or about April 2012 by:

a) inappropriately removing a pen from a pocket of [Colleague 1]'s clothes near her breasts; and/or
b) inappropriately commenting on and/or touching [Colleague 1]'s hair;

- That he sexually harassed colleague and patient [Colleague 2] in or about April 2012 by:

a) inappropriately commenting on and/or touching [Colleague 2]'s hair

In particular, the Panel found that he:

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

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   a) that the Member complete successfully with an unconditional pass, at his own expense, within 12 months of the date of this Order, the ProBE course and any related evaluations offered by the Centre for Personalized Education for Physicians
   b) that the Member successfully complete, within 12 months of the date that he successfully completes the ProBE course identified above in paragraph 2(a), a course with Gail E. Siskind Consulting Services, or another professional ethics consultant acceptable to the College, to be designed by the consultant, with the purpose of addressing the professional misconduct issues raised in this case; the following terms shall apply to the course:
      i. the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 3;
      ii. the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
      iii. the Member shall provide to the consultant his evaluation from the ProBE course, and any essay he completed as part of that course, and discuss with the consultant the issues arising from that course;
      iv. the Member shall be responsible for the cost of the course;
      v. the consultant shall agree to confirm to the College once the Member has completed the course to the satisfaction of the consultant

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 1 month, which period of suspension shall be remitted upon the Member successfully completing the remedial training as specified in subparagraphs 2(a) and 2(b) above. If the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraphs 2(a) and 2(b) above, the suspension shall commence on December 16, 2017, and continue until January 15, 2018, inclusive.

4. Costs to the College in the amount of $5,000

In its reprimand, the Panel noted that members of the public and the profession hold pharmacists in high regard, and as a pharmacist the Member has a moral obligation to conduct himself in a manner that is professional and maintains pubic confidence. The Panel indicated that pharmacists are expected to demonstrate personal and professional integrity and to maintain professional boundaries at all times, and that these boundaries are based on trust, respect, and the appropriate use of power. The Panel expressed its expectation that the remediation ordered will served as an opportunity to remediate the member's practice and that he will not appear before a panel of the Discipline Committee again.

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

Graduated cylinders are not reliable for accurately measuring methadone doses. Learn what specifications the device measuring methadone needs to meet.
http://www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2/

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FOCUS ON ERROR PREVENTION

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

NEW DRUG THERAPY

Patients with chronic medical conditions are often taking multiple medications. With increasing age and progression of their medical condition, patients may receive new drug therapies. It is therefore critical that steps be taken to prevent the dispensing of drugs that the patients should no longer be taking.

CASE:

A sixty-six year old diabetic patient has been taking metformin for an extended period of time.

During a recent visit to his physician, the patient was asked to discontinue metformin and was given a new prescription for Jentadueto® (linagliptin/metformin hydrochloride 2.5 mg/500 mg) to be taken twice daily. The prescription was taken to the patient's regular pharmacy for processing. The patient received the correct medication and was counselled appropriately.

Approximately one month later, the patient called the pharmacy and asked a pharmacy assistant to "renew his diabetic medication." The pharmacy assistant reviewed his medication profile and saw both Jentadueto® and metformin. However, the pharmacy assistant was not aware that Jentadeuto® was a "diabetic medication" and therefore assumed that the patient was asking for a refill of metformin.

Metformin was therefore prepared for checking by the pharmacist. The computer's Drug Utilization Review (DUR) indicated a potential duplication of therapy with metformin and Jentadueto®. The DUR also indicated that the patient was "late" in refilling the metformin. Both notations were missed by the pharmacist. Hence, metformin was dispensed and placed in a sealed bag for pick up.

When picking up the medication later in the day, the patient indicated that he had been taking the medication and did not require counselling. The patient therefore took the metformin and left the pharmacy. Upon arriving home, the patient opened the bag and identified the error. He was very upset that he was given a medication that he should no longer be taking.

POSSIBLE CONTRIBUTING FACTORS:

- When ordering his medication, the patient did not specify the name of the drug and the pharmacy assistant did not take the time to confirm.
- The pharmacy assistant was unfamiliar with the drug Jentadeuto®.
- On receiving the new prescription for Jentadeuto®, the pharmacy staff failed to deactivate the metformin prescription which should no longer be dispensed due to the change in therapy.
- When dispensing the metformin, the pharmacist failed to read and act upon the DUR notes.

RECOMMENDATIONS:

- Remind staff to always confirm the name of the medication the patient is requesting when processing refills.
- Whenever a new medication is added to the pharmacy inventory, all staff should be educated about the product.
- Consider placing information regarding newly marketed products in an appropriately labelled binder to be reviewed by all staff on a regular basis.
- If there is a change in a patient's drug therapy or dosage, establish a system to deactivate or discontinue all previously dispensed medications which should no longer be dispensed. Add a notation to the patient's profile to link these deactivated prescriptions to the new prescription.
- Remind all pharmacy staff to carefully review and act upon all DUR notes. If necessary, contact your software vendor to ensure the information is prominently displayed and easy to read.

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

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

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