Ontario College of Pharmacists
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PHARMACY CONNECTION

SUMMER 2015 • VOLUME 22 NUMBER 3

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

HOSPITAL PHARMACY ASSESSMENTS

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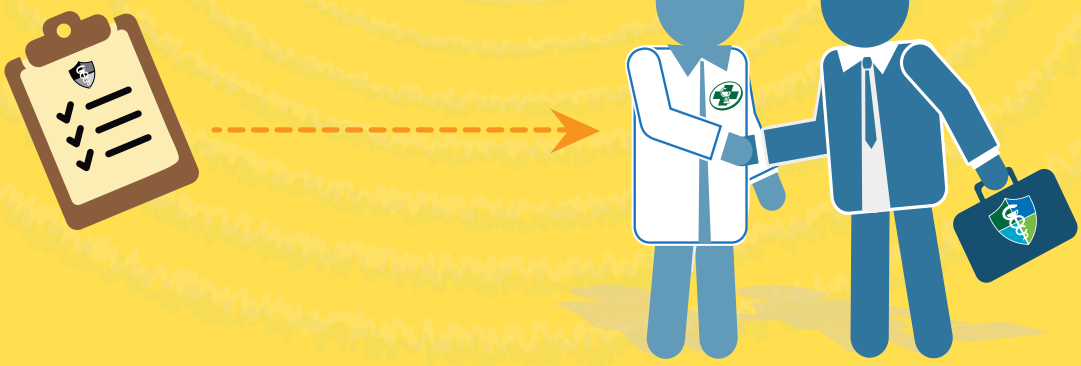

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COUNCIL MEMBERS

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

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U of T Heather Boon
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- Executive
- Accreditation
- Discipline
- Fitness to Practise
- Inquiries Complaints & Reports
- Patient Relations
- Quality Assurance
- Registration

Standing Committees
- Communications
- Drug Preparation Premises
- Elections
- Finance & Audit
- Professional Practice

Ontario College of Pharmacists
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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**

> "Clearly defining "what" we are working toward allows us to establish the more specific outcomes or key performance indicators . . ."

Although it's more than halfway through the calendar year, in many ways September marks the beginning of a new cycle for the College. It's the first Council meeting for our newly elected members and is also the time we refresh the chairs and membership of our various committees.

This year, September also marks the start of the College's new three-year Strategic Framework (2015 – 2018) (see page 5). The framework, which was created by Council, sets the high-level strategic priorities for the College and guides the work staff will focus on over the coming years.

At each Council meeting, I provide Council with an update on our progress as part of my Registrar's Report.

It is the process of creating and focusing on the Strategic Framework that holds the College accountable. The process helps to ensure that the work we do is aligned with the strategic priorities, with our mandate of serving and protecting the public interest, and with our values of transparency, accountability and excellence.

In operationalizing the strategic framework, staff developed specific outcomes or key performance indicators along with corresponding activities for each of the identified priorities.

To illustrate this, let's look at strategic priority number two – *Optimize Practice within Scope*. The first step in establishing an appropriate action plan to align with a significant yet lofty objective such as this, is to define the desired outcome. In other words, if we were effectively optimizing practice within scope, what would it look like? Perhaps something like this: *Patients receive quality healthcare services from pharmacy professionals*.

Clearly defining "what" we are working toward allows us to establish the more specific outcomes or key performance indicators, and ultimately identify the relevant activities or work that we must engage in, in order to achieve the desired outcome.

In this case, in order for patients to be receiving quality healthcare services from pharmacy professionals, pharmacists and pharmacy technicians must be consistently practicing to the minimum expectations set out in Standards of Practice and Code of Ethics. In order to achieve this, the College must make efforts to ensure that practice expectations are clear and broadly understood.

There are a number of initiatives currently underway that support this objective.

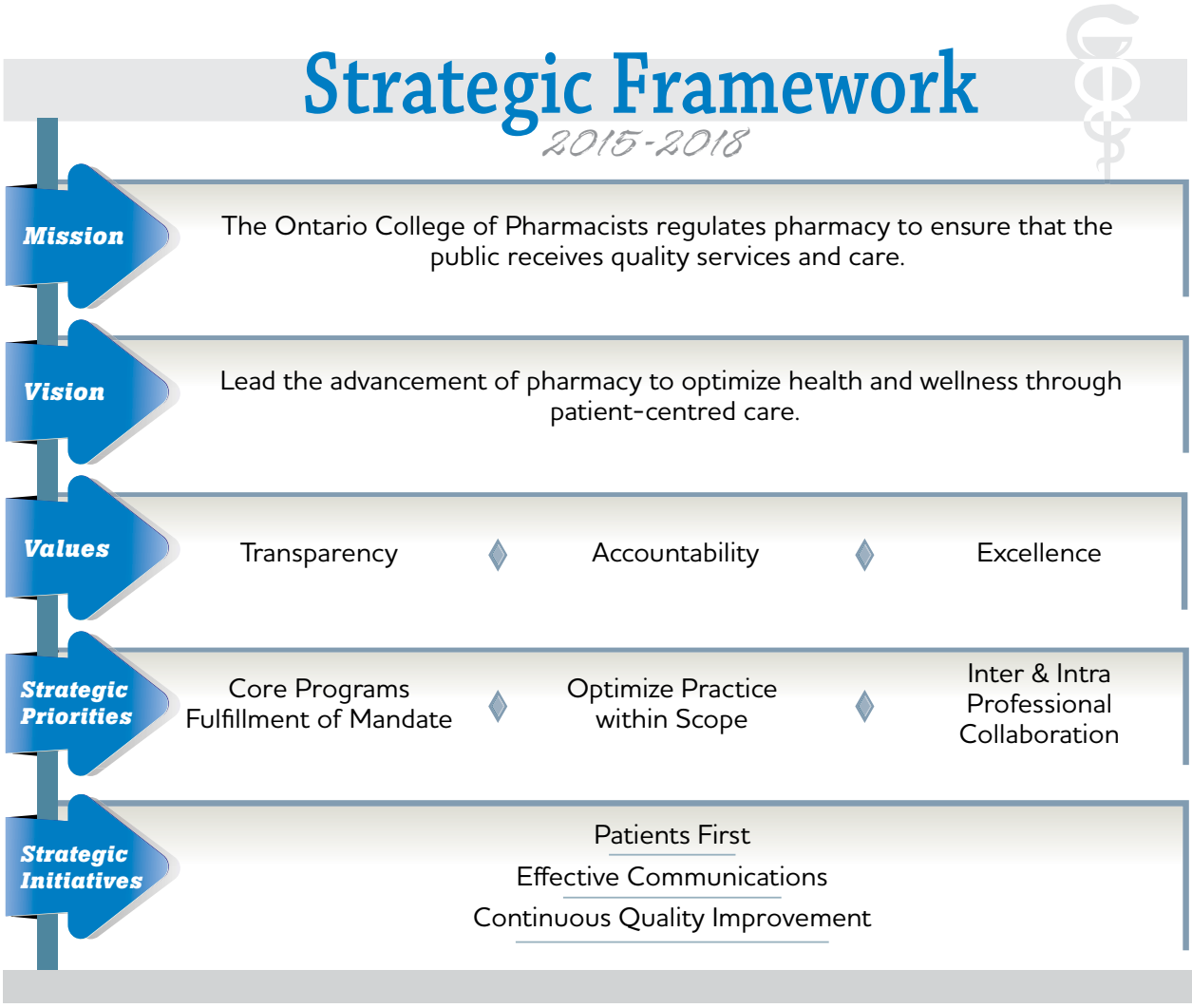
One example is the introduction of the new practice assessment, which focuses on providing guidance and educational support to help practitioners understand and adhere to the Standards of Practice and Standards of Operation. Adding the individual practitioner assessment alongside our ongoing pharmacy site visits allows our highly knowledgeable practice advisors to engage with practitioners within the context of their own practice setting. These visits are an excellent coaching and mentoring opportunity for a few thousand pharmacists and pharmacy technicians each year.

Another example is our initiative to update the College's Code of Ethics, which has not undergone a substantial review in 20 years (see page 15). Although expectations of ethical conduct remain the same, the draft Code is a more comprehensive document that outlines for pharmacists, pharmacy technicians and the public, the core ethical principles in healthcare that dictate a healthcare professional's ethical duty to patients and society.

It is these established strategic priorities and our well defined operational plan that are the keys to keeping the work of the College focused and aligned with our mandate and values.

Council endorsed the 2015-2018 Strategic Framework at their June 2015 meeting.

Council is responsible for the development of the Strategic Framework. The College uses the Framework to plan activities, focus human and financial resources and hold itself accountable.



JUNE 2015 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on June 15, 2015.

COUNCIL APPROVES PROPOSED AMENDMENTS TO THE DPRA REGULATIONS FOR SUBMISSION TO GOVERNMENT

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*, which only addresses community pharmacy practice, requires amendments.

The amended regulation adds provisions for hospital pharmacies and proposes an outcomes-based approach to the language, aiming to improve the relevance of the regulatory framework over time. By removing specific expectations from the regulation and moving these into standards, policies, guidelines and processes, the College will be able to respond to changes in practice and public expectations in a more timely manner.

At its meeting in March, Council approved that the proposed regulation be circulated for public and member feedback. In addition, College staff met with major stakeholders from the hospital and community pharmacy sectors, and the Ministry of Health and Long-Term Care.

There was support for the outcomes-based approach to the regulation, leaving specifics to supplemental documents such as standards, policies and guidelines that can be amended easily as practice evolves. Several stakeholders asked for clarification on how these supplemental documents would evolve over time — including the ability to provide feedback on new or changing expectations.

Recognizing these concerns, a *"Standard, Policy and Guideline Consultation Framework"* has been created to ensure a principle-based approach for stakeholder consultation. In addition, the supplemental documents — which capture the intent of what was removed from the regulation as a result of the revision — were created to confirm that the College's expectations will remain the same both pre and post proclamation. Following proclamation, as proposed changes are brought forward, the consultation process will be invoked to collect stakeholder feedback.

The next step in the process, given Council's approval of the proposed regulation at this meeting, is for the College to submit the proposed regulation to the Ministry of Health and Long-Term Care for their final consideration and ultimate proclamation. Until proclamation, which will likely take several months, the current DPRA regulation remains in effect.

Additionally, as already noted, with the exception of the new authority to license and inspect hospital pharmacies, the net result of the proposed DPRA regulation changes with the corresponding supplemental documents is that expectations of practice will not change when the proposed regulations are proclaimed and enacted into law.

Photos by DW Dorken

With respect to the pending authority for hospital pharmacy oversight, the College is currently conducting baseline assessments of all Ontario hospital pharmacies, which are expected to be complete by the end of 2015. By-law amendments incorporating hospital pharmacy oversight (fees and filing of information) will be drafted and brought forward to Council for approval for public consultation at the September meeting. Final approvals, reflective of feedback received, are expected in December, 2015.

Read more information about the DPRA initiative here.

POLICY ON FAX TRANSMISSION OF PRESCRIPTIONS REVISED

Council reviewed and approved revisions to the policy on Fax Transmission of Prescriptions which incorporates updates and clarifies various provisions related to facsimile transmission of prescriptions. The review of the Faxed Prescriptions Policy was prompted by a scheduled five year review as well as the need to align with the position statement on the Authenticity of Prescriptions using Unique Identifiers for Prescribers published in July 2013.

CODE OF ETHICS TASK FORCE — UPDATE

This Task Force was established in December 2014 with a mandate to review and update the current Code of Ethics so that it more appropriately addresses current practice and better enables pharmacists and pharmacy technicians to apply it in practice. Council heard a presentation from the project consultant, noting that the Task Force has now held a series of meetings to work through the initial draft documents and has held focus groups and working sessions with stakeholders to receive feedback.

Final draft documents will be brought to the September 2015 Council meeting for approval for posting for a 60-day public consultation. Following consideration of feedback received during the public consultation, the Task Force anticipates finalizing the Code of Ethics documents for approval by Council at its meeting in December 2015.

Read more about the Code of Ethics initiative here.

NEXT COUNCIL MEETINGS:

To support planning for various College and program activities, Council agreed to set a meeting schedule for the next two years. Future Council meetings will be held as follows:

2015
Thurs. Sept. 17 and Fri. Sept. 18
Mon. Dec. 7

2016
Tues. March 29
Mon. June 13
Mon. Sept. 19 and Tues. Sept. 20
Mon. Dec. 12

2017
Mon. March 20
Mon. June 12
Mon. Sept. 18 and Tues. Sept.19
Mon. Dec. 11

Council meetings are open to the public, and are held at the College: 483 Huron Street, Toronto, ON, M5R 2R4.

If you plan to attend, or for more information, please contact Ms. Ushma Rajdev, Council and Executive Liaison at urajdev@ocpinfo.com

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Council Election Results

OCP Council elections were completed on August 5, 2015.
The results are as follows:

DISTRICT H

The following candidates were acclaimed:

Christine Donaldson

Regis Vaillancourt

DISTRICT N

The following candidates were elected:

Gerry Cook

Chris Leung

Karen Riley

Hospital Pharmacies Benefit from Practice Advisor Visits

Baseline assessments preparing hospital pharmacies for new licensing and inspections by the College

By Stuart Foxman

As Director of Pharmacy at Bluewater Health, Andrea Wist, RPh, is proud of how the organization is ranked by Accreditation Canada. Bluewater, which operates hospital sites in Sarnia and rural Petrolia, earned an exemplary standing in 2015 for their safety and quality. Yet Wist realizes there are other even more effective ways to evaluate and confirm standards on the pharmacy side of hospital operations.

That's why Wist welcomed a visit earlier this year by practice advisors from the Ontario College of Pharmacists (OCP). Throughout 2015, the advisors are reaching all of Ontario's hospital pharmacies (about 260 sites) to perform baseline assessments. This is part of the College's preparation in advance of the enactment of legislation to grant OCP the authority to license and inspect pharmacies within public and private hospitals.

"I've been waiting for this," says Wist. "We aspire to excellence in safe medication practices. I want to adhere to standards so people get the right medication at the right time for the right therapy."

The *Safeguarding Health Care Integrity Act, 2014* will allow OCP to set and enforce licensing requirements for hospital pharmacies in the same way the College currently does for community pharmacies. The provisions around OCP's oversight will take effect

Pharmacist Andrea Wist (left) and Pharmacy Technician Norma Hansen (right)

> "We aspire to excellence in safe medication practices. I want to adhere to standards so people get the right medication at the right time for the right therapy."
>
> Pharmacist Andrea Wist

when the government approves amendments to the *Drug and Pharmacies Regulation Act*.

To get ready, OCP developed draft hospital pharmacy inspection criteria, and did pilot assessments in 2014 to ensure the criteria supported hospital practice. For this year's visits, OCP practice advisors spend one day per hospital site, working with pharmacy staff, others involved in the medication management system, and senior hospital executives. The focus is on touring the facility and discussing pharmacy processes and procedures, especially areas with the greatest risk for patient and public safety.

How have the site visits helped? "It's not about a number or a score. It's an opportunity for quality improvement, guided by legislation, professional standards and best practices," says Rene Thibault, RPh, Professional Practice Leader, Pharmacy at Providence Care in Kingston. "If you approach it with that understanding, the result will be improved medication management practices and exceptional patient care."

IMPACT OF ADVISORS FELT WIDELY

The hospital pharmacists who have undergone the assessments say the advisors provided value in highlighting ways to perform better, and also in verifying the effectiveness of current standards.

> "I was surprised at how well-versed the advisors were in our policies. They knew everything..."
>
> Pharmacy Technician Norma Hansen

Thibault calls the practice advisors highly supportive in providing guidance. Some ideas were so easy to implement that she could do them immediately. For example, at the Providence Care pharmacy all the injections had been stored together. The advisors suggested that the pharmacy separate the long-acting depot injections.

"That was a five-minute fix, yet our medication safety practices were improved just by having the advisor look at our shelves," says Thibault.

Norma Hansen, RPhT, a Senior Pharmacy Technician at Bluewater Health, says she and Wist were impressed by the scope of the assessment. Before the site visit, they and a staff pharmacist went over more than 400 self-assessment questions, touching on everything from handoffs between shifts, to policies on care and maintenance of automated dispensing units, to sterile compounding.

During the assessment, Hansen was impressed by the extreme thoroughness of the practice advisors. They looked at the refrigerators where drugs were stored to check on temperatures, they took down bottles to look at expiry dates, they reviewed the narcotic transaction process –from doctor's orders to the pharmacy to nursing and administration at the patient's bedside – and they talked to nurses as well.

"I was surprised at how well-versed the advisors were in our policies. They knew everything," says Hansen.

She notes too that the advisor process enhances and compliments other types of reviews, like those of Accreditation Canada. Regarding medication management standards, "OCP was much more detailed," Hansen says.

"My focus has always been on raising the level of practice in any way possible. Having OCP come in has raised awareness of what's required," adds Ryan Itterman,

> "Having the assessment was a good way to force us to reflect and look at everything in greater detail."
>
> Pharmacist Ryan Itterman

> **"The assessement empowered us to reach out to the rest of the organization and make this a priority for the overall safety of patients and staff."**
>
> Pharmacist Rene Thibault

RPh, Regional Director, Pharmacy Services at Huron Perth Healthcare Alliance and Alexandra Marine and General Hospital.

Following the assessment, Itterman and his team developed an action plan, with over 100 short-term and long-term items.

"A lot of them are reviewing what's in place, or updates to procedures. For many of the items, a member of our team was already aware, but the assessment was a good way to force us to reflect and look at everything in greater detail. You have to validate; you can't just trust that a procedure is in place."

A FOUNDATION FOR COLLABORATION

The assessments were valued beyond their ability to encourage improvements or provide validation. To understand the full importance of the visits, hospital pharmacists say that it's important to consider the environment in which they operate.

Thibault has worked at Providence for three years, and in hospital pharmacies for 32. She suggests that in meeting and enhancing standards, hospital pharmacies face different considerations than their community counterparts.

Pharmacy procedures and medication management practices impact many other departments and programs within the hospital. So improvements can not always be self-contained, says Thibault. Some need to be addressed as organizational initiatives and require group efforts. That's one reason why she welcomed the practice advisors; in a way, their efforts could help support collaboration in key areas.

"It required us to critically examine every one of our pharmacy procedures, policies and processes," says Thibault, "and also our relationships with other disciplines in the hospital as they apply to medication management."

For example, a broad initiative like hazardous medication procedures affects areas ranging from nursing to housekeeping, far beyond the pharmacy. Oversight of the procedures falls under yet another area, occupational health and safety.

"The assessment empowered us to reach out to the rest of the organization and make this a priority for the overall safety of patients and staff," says Thibault.

She says the advisors were beneficial in both reinforcing existing standards and defining new ones. "We want to elevate our practice, so it's important to understand what processes to put in place," says Thibault. "Emerging standards can be a valuable planning tool,

i.e. what resources do we need, how should we rethink pharmacy processes, and who do we need to work with."

Thibault points to a new hospital site that will combine the current two sites in 2017. "When we move, we'll have a new drug distribution system. The OCP assessment criteria provides the framework to guide our policy and procedure development, and to support and maybe even influence decisions we're making."

Itterman, likewise, sees the value of the practice assessment as his hospital looks at a possible new facility to make sterile IV preparations. "That's a longer-term plan," he says, "but the assessment validated that this is an area we need to look at, and provided guidance on the standards."

Any future role by OCP in licensing and inspecting hospital pharmacies is important from a compliance standpoint. But the weight of OCP's processes could pay greater dividends.

As Wist says, after the assessments she felt greater authority over the policies and procedures she sets in her hospital. She also knew, from their reaction, that the hospital leaders respected the pharmacy for meeting high standards. More than that, says Wist, "We're recognized even more seriously by the organization as an area that needs support to adhere to these standards."

UPDATE ON DPRA CHANGES

UPDATE: AMENDMENTS TO THE *DRUG & PHARMACIES REGULATION ACT* AWAITING MINISTRY APPROVAL

The College will soon have the authority to license and inspect pharmacies within public and private hospitals, and eventually within other institutional pharmacy locations as well. As a result, the *Drug and Pharmacies Regulation Act* (DPRA) required updating.

Proposed changes to the DPRA include adding provisions for hospital pharmacies and making a shift to an outcomes-based approach. The overall goal is to move specific expectations from the regulation into standards, policies, guidelines or processes. This will help the regulation to stay current with changes in practice for a longer period of time.

The proposed changes to the regulation were circulated for public consultation from March 10 to May 10, 2015. College staff also collected feedback from stakeholders in the hospital and community pharmacy environments, and from the Ministry of Health and Long-term Care. Overall, there was great support for the proposed changes and for the new outcomes-based approach — which were approved by Council at their June 2015 meeting. The proposed revisions are currently being considered by government and are expected to be proclaimed in late 2015/early 2016.

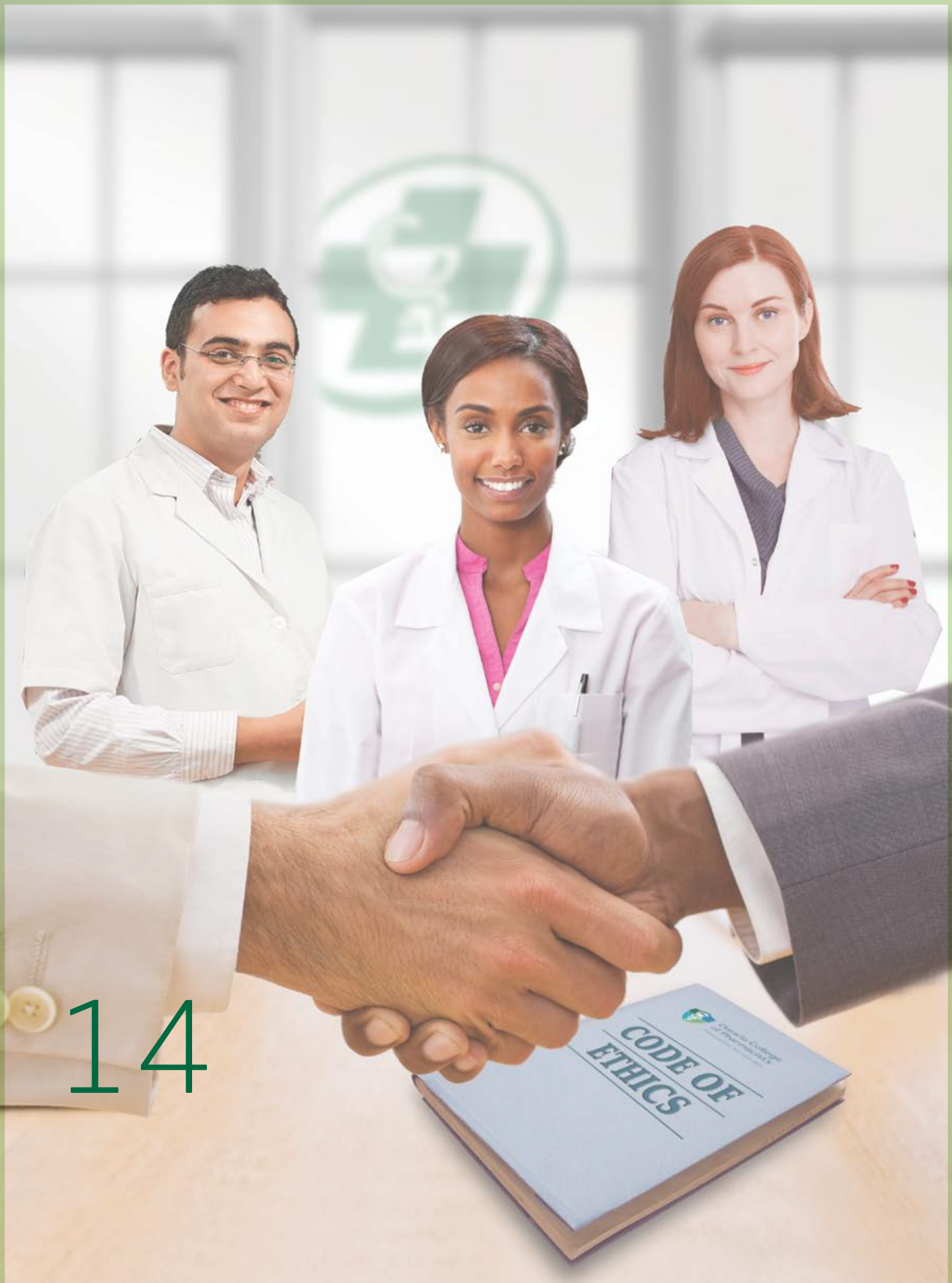
Upon enactment, practice expectations will not change. The most significant change will be in where the details for expectations are located. The new outcomes-based approach will see specific details moved from the regulation into standards, policies, guidelines or processes.

Over time, the College will work to update these supplementary documents to keep up with changes in practice. To aid in this process, a "Standard, Policy and Guideline Consultation Framework" was developed to help direct the consultation process and ensure all stakeholders have the opportunity to provide feedback where appropriate. The Framework outlines several principles that will be applied to help the College to decide if consultation is required.

These principles generally relate to the effect the new or revised standard, policy or guideline could have on public safety, practice, operations or inter-professional collaboration

Presently, the current DPRA regulations are still in effect.

For more information about the changes to the DPRA and OCP's future oversight of hospital pharmacies, please visit the Key Initiatives page on the OCP website.


CODE OF
ETHICS

REVISING OUR CODE OF ETHICS . . . WHY NOW?

Part 2 of 4

In the last issue of *Pharmacy Connection* (Spring 2015) we published the first in a series of four articles about the initiative to revise our Code of Ethics.

Part One – What's Ethics Got to Do With It? – provided an introduction and overview on the role and purpose of a Code of Ethics. The article was a reminder that the objective of a profession's Code of Ethics is to outline the unique obligations and behavioural and conduct expectations that come with being a health-care professional.

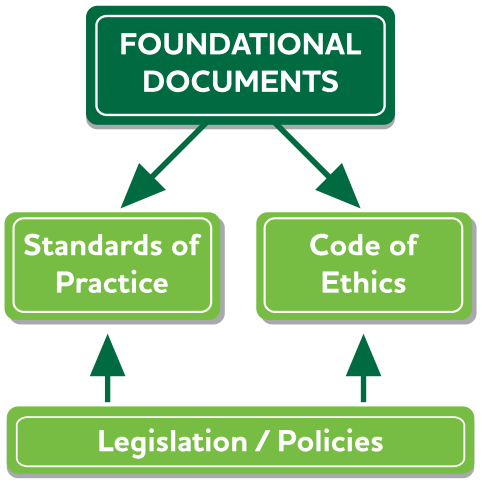
At the core of this obligation is the commitment to put the best interests of your patient first and foremost. The established ethical principles of healthcare: beneficence, non-maleficence, respect for persons/justice and accountability (fidelity) were defined and reinforced as *the* principles – not your own – that must guide and inform every decision you make as a healthcare professional.

The Code of Ethics – along with Standards of Practice, relevant legislation, policies and guidelines – are the foundational documents of all healthcare professions and collectively express the what, how and why of practice. Additionally, the requirements outlined in this profession's Standards of Practice and Code of Ethics communicate the *minimum* expectations of practice (diagram 1) that must be consistently met in order to deliver safe, effective and ethical care.

Ensuring that you clearly understand and are effectively practising to these expectations is a fundamental responsibility and strategic priority for the College.

DIAGRAM 1

Standards of Practice and Code of Ethics communicate the minimum expectations of practice for all pharmacists and pharmacy technicians, regardless of practice setting.



EVOLVING EXPECTATIONS

The last substantial update to the College's Code of Ethics happened 20 years ago – a lot has changed since then!

The growing pressures of an overstretched health-care system, combined with an aging population have resulted in evolving expectations from government and the public, for all healthcare professionals. With an objective of *Putting Patients First* – in part through providing better access to the *right* care, by the *right* person at the *right* time – government has supported a number of enhancements to the scopes of practice of many professions – including pharmacy.

Expanded authority in the areas of prescribing, renewing and adapting prescriptions, and administering a drug by injection or inhalation – with more on the horizon – have enhanced a pharmacist's role and responsibility as a decision-maker. This has shifted the focus from the more technical aspects of dispensing medications to the delivery of clinical services.

As the pharmacist's role as a clinician increases, so too does their responsibility to ensure decisions are guided

by the ethical principles of healthcare. Ultimately, decisions must support the overriding commitment to put the best interests of patients first.

This shift in practice is evident in both hospital and community settings and has been supported in part by the introduction of a brand new healthcare professional – the pharmacy technician. Nearly 3,500 pharmacy technicians are currently registered with the College and working throughout Ontario. These integral members of the pharmacy team are not only independently responsible and accountable for their own scope of practice but are also held to the same ethical standards as pharmacists.

MAINTAINING PUBLIC TRUST

There have been a number of other factors and incidents that have influenced society's confidence in the ability for healthcare professionals and regulators to effectively maintain the public's trust. As explained in Part One of our Code of Ethics series, all healthcare professionals have entered into a social contract with society. In exchange for society granting the profession the autonomy to govern itself, and the privileges and status that come with being a healthcare professional, pharmacists and pharmacy technicians – like all healthcare professionals – must continuously demonstrate their commitment to putting the needs of their patient above their own personal or business interests. This concept of being a fiduciary of the public trust is a critical point, and in fact is the foundation on which a profession's Code of Ethics is built.

COMMITMENT TO ACCOUNTABILITY AND TRANSPARENCY

These changes that have happened over the past few decades are not unique to Ontario, or even Canada. As patient expectations evolve and trust erodes there is more and more pressure on healthcare professionals to demonstrate their understanding and commitment to delivering ethical care. The net effect has been a heightened focus – by both government and the College – on our mandates to serve and protect the public interest through our longstanding commitments to accountability and transparency.

To more effectively hold pharmacists and pharmacy technicians accountable for their professional conduct, the College must ensure that expectations are clearly understood and applied by all

HELPFUL DEFINITIONS

Fiduciary

Given the inherent power imbalance in the professional/patient relationship healthcare professionals are required under the social contract to act for and on behalf of the patient/society in order to retain public trust and confidence.

Principle of Beneficence

The ethical principle of beneficence refers to the healthcare professional's obligation to actively and positively serve and benefit the patient and society.

Principle of Non-Maleficence

The ethical principle of non-maleficence refers to the healthcare professional's obligation to protect their patients and society from harm.

Principle of Respect for Persons/Justice

The ethical principle of respect for persons/justice refers to the healthcare professional's obligation to respect and honour the intrinsic worth and dignity of every patient as a human being, and to treat all patients fairly and equitably.

Principle of Accountability (Fidelity)

The ethical principle of accountability (fidelity) refers to the healthcare professional's fiduciary duty to be a responsible and faithful custodian of the public trust.

practitioners.. In addition, these expectations must be transparent to the public, and any concerns regarding the ethical conduct of a pharmacy professional be noted on the College's website so patients can make informed decisions about their healthcare.

REVISED CODE REFLECTS BEST PRACTICE

It is for all of these reasons that the College is revising our Code of Ethics. The project began when Council appointed a task force, who with guidance from an ethicist, reviewed and compared Codes of Ethics from pharmacy regulatory colleges across Canada, the United States, Australia and Great Britain. They also reviewed ethical conduct standards for physicians and nurses in Ontario.. Particular attention was given to codes that had been revised in the last five years or so, and were considered to be best practice. In particular, these included: the College of Pharmacists of British Columbia, the Alberta College of Pharmacists, and the General Pharmaceutical Council (the regulator for pharmacists and pharmacy technicians in England, Scotland and Wales.)

The most striking similarity of these codes is that they are all comprehensive with substantive content that describes expectations and provides guidance for understanding and applying to practice. They also include some form of context that outlines the role and purpose of the code, reference ethical principles and define who the code is applicable to. These codes also reflect the understanding that a profession's Code of Ethics, Standards of Practice and legislation – although companion documents that should not be read or applied in isolation of the other(s) – will contain duplication as some requirements are both ethical and legal.

A SYSTEMATIC APPROACH TO DEVELOPMENT

An initial draft of the Code was developed using these sample codes as guides, and drawing on the feedback gathered from staff regarding current practice issues. This draft was modified using feedback gathered through informal focus groups with key stakeholders from a variety of practice settings and perspectives. These groups included practising community and hospital pharmacists and pharmacy technicians, corporate pharmacy managers, academic program leaders and pharmacy organization representatives.

Through this systematic approach to development, the task force created a proposed draft of the Code of Ethics which will be brought forward to Council at their September meeting for approval for public consultation. The draft Code – which is for pharmacists, pharmacy technicians and the public – is a comprehensive document that outlines the core ethical principles in healthcare that dictate a healthcare professional's ethical duty to patients and society. The document supports these principles with standards that indicate how a pharmacy professional is expected to fulfill his or her ethical responsibilities. In addition to the Code, the task force has drafted a Declaration of Commitment which is meant to be signed by individual practitioners to confirm their understanding and commitment to their Code of Ethics.

Expectations outlined in the proposed draft of the Code of Ethics are unchanged and align with those in the current Code and Professional Responsibility Principles, Standards of Practice and all relevant legislation, policies and guidelines – they are simply more explicit in the new draft..

WE WANT TO HEAR FROM YOU

After Council's anticipated approval of the proposed draft of the Code of Ethics at their September Council meeting, the document will be posted on the website for public consultation. This is an important step in the development of any proposed change to legislation, policy or foundational document such as the Code. The details of the consultation, including the deadline for submissions, will be communicated on the website, in e-Connect and through all social media channels following the Council meeting.

The consultation process is completely transparent with feedback welcomed from pharmacists and pharmacy technicians, and anyone who may have an interest, including corporations, institutions, associations and members of the public. All feedback received is posted on the website in accordance with posting guidelines.

Following the consultation period, the task force will consider all feedback received as they finalize the College's new Code of Ethics. The new Code is expected to be presented to Council at their December 2015 meeting for approval.

Once the final Code has been approved, a comprehensive communications and education plan will support current and new practitioners as they understand and apply the Code in practice.

Stay tuned for more updates about the Code of Ethics project. Pc

Revised Policy on Fax Transmission of Prescriptions

INTRODUCTION

We regularly monitor all practice policies and guidelines to ensure they accurately reflect current practice and provide practitioners with the proper guidance and support.

The Policy on Fax Transmission of Prescriptions was recently updated to clarify expectations when verifying the authenticity of a prescription received by fax.

The revised policy states that practitioners should:
- *Assess the prescription as a whole instead of focusing solely on the prescriber's signature or fax letterhead*
- *Maintain the confidentiality and integrity of personal health information when sending and receiving prescriptions by fax*
- *Consider where the prescription is transmitted from to ensure it came from a machine authorized by the prescriber*

The revised policy also clarifies that fax transmissions can be accepted from a practitioner registered to practice in any Canadian province.

POLICY ON FAX TRANSMISSION OF PRESCRIPTIONS

POLICY: Policy on Fax Transmission of Prescriptions

Approved: March 2007; **Revised:** June 2015

Legislative References: *Personal Health Information Act, Drug and Pharmacies Regulation Act*

Additional References: Authenticity of Prescriptions using Unique Identifiers for Prescribers

College Contact: Pharmacy Practice

DEFINITIONS

- Facsimile Transmission — a prescription received by facsimile transmission ("fax") means transmission of the exact visual image of a document by way of electronic equipment[1]

POLICY

Considerations When Receiving a Prescription by Fax

Authenticity

A member must evaluate the prescription as a whole when determining whether to dispense a prescription. When assessing a prescription the member must consider the content of the prescription and its appropriateness given the patient's condition and prescription history, as well as who transmitted the prescription, and the location from which a prescription was transmitted. If, upon assessing the prescription as a whole, a member is unsure of a prescription's authenticity, it is the responsibility of the member to confirm the prescription with the prescriber prior to dispensing the medication.

Prescribers and Drugs

All prescriptions, including those written for narcotic, controlled drugs, and targeted substances may be accepted by fax. Additionally, a fax transmission can be accepted from a practitioner registered to practice in any province or territory of Canada. Regular e-mail (i.e. not a secure web mail portal) is not considered

equivalent to receiving a prescription by fax and is not a secure medium for prescription transmission, therefore legislation does not permit prescriptions to be transmitted through e-mail.[2]

For any prescription received by fax members must ensure the following:

1. All prescription authorizations transmitted by fax, must originate with the prescriber and be sent directly from a device authorized by the prescriber. Pharmacists are reminded that fax-header information can be manipulated and should be verified where appropriate by checking the number against a known fax number for the prescriber.
2. If a prescription written by a prescriber is faxed to the pharmacy by a patient or a patient's agent, the original prescription must be obtained before the medication is dispensed.
3. The process of receiving faxed transmissions must maintain patient confidentiality. Fax equipment must be located within a secure area where the transmission is received and handled only by pharmacy staff, to protect the confidentiality of patient information.[3]
4. If any document containing personal health information is received in error, the pharmacy should notify the sender that the fax was received in error and destroy the information in a secure manner.[4]
5. Patient choice must be protected; that is the patient must determine the pharmacy where the prescription is to be filled.
6. The pharmacy has policies and procedures for the regular maintenance and cleaning of fax machines to ensure optimal transmission of medication-related information.[5] PC

REFERENCES

1. National Association of Pharmacy Regulatory Authorities. Fax Prescription Model Policy. Retrieved on August 29, 2014 from http://napra.ca/pages/Practice_Resources/fax_prescription_model_policy.aspx
2. Information and Privacy Commissioner Ontario. Privacy Protection Principles for Electronic Mail Systems (1994). Retrieved at http://www.ipc.on.ca/images/Resources/email-e.pdf
3. Cavoukian, A. Information and Privacy Commissioner Ontario. Guidelines on Facsimile Transmission Security. Retrieved on September 16, 2014 from http://www.ipc.on.ca/images/Resources/fax-gd-e.pdf
4. Cavoukian, A. Information and Privacy Commissioner Ontario. Guidance on Facsimile Transmission Security. Retrieved on September 16, 2014 from http://www.ipc.on.ca/images/Resources/fax-gd-e.pdf
5. Institute for Safe Medication Practices Canada. ISMP Canada Safety Bulletin ALERT: Medication Mix-up with a Faxed Prescription. Retrieved from http://ismp-canada.org/download/safetyBulletins/2012/ISMPCSB2012-06_Alert-MedMixupwithFaxedPrescription.pdf on October 14, 2014.

Ministry of Children and Youth Services

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Ontario

June 11, 2015

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

Dear Mr. Marshall Moleschi,

On September 9, 2013, a Coroner's Inquest into the 2002 death of a young child who had involvement with the child protection system in Ontario began. In February 2014, the Inquest jury provided its verdict and recommendations to the Ontario government. Of the 103 recommendations, four focus on the duty to report child abuse and neglect as set out in the Child and Family Services Act (CFSA). The Inquest jury also recommended that the Ministry of Children and Youth Services further promote public and professional awareness to ensure suspected child abuse and neglect are consistently reported across the province.

In an effort to increase professional awareness and knowledge with respect to the "duty to report", I'd like to request that the Ontario College of Pharmacists share the following information with your respective college members.

> *The Child and Family Services Act (CFSA) recognizes that the public, including professionals who work with children, must promptly report any suspicions that a child is or may be in need of protection directly to a children's aid society. This is referred to as one's "duty to report".*
>
> *The CFSA states that people working closely with children have a special awareness of the signs of child abuse or neglect, and a particular responsibility to report their suspicions. Under the Act, persons who perform professional or official duties with respect to children include:*
> - *Health care professionals, including physicians, nurses, dentists, pharmacists and psychologists;*
> - *Teachers and school principals;*
> - *Social workers and family counsellors;*
> - *Religious leaders, including priests, rabbis and members of the clergy;*

- *Operators or employees of child care centres;*
- *Youth and recreation workers (not volunteers);*
- *Peace officers and coroners;*
- *Child and youth service providers and employees of these service providers; and*
- *Any other person who performs professional or official duties with respect to a child.*

Professionals should never hesitate to report suspected child abuse or neglect. It is their legal duty to make a report to a children's aid society where they have reasonable grounds to suspect that a child is or may be in need of protection. Any professional or official who fails to report a suspicion of child abuse or neglect is liable upon conviction to a fine of up to $1,000, if this information is obtained in the course of their professional or official duties. The CFSA specifies that a person who acts in accordance with the duty to report is protected from civil actions, unless the person acts maliciously or without reasonable grounds for the suspicion.

For contact and other information of all Ontario's children's aid societies, please visit the Ontario Association of Children's Aid Societies' website at: www.oacas.org. You can also locate a children's aid society in the local telephone listings or, where available, by dialing 411.

For more information, please visit:
http://www.children.gov.on.ca/htdocs/English/topics/childrensaid/reportingabuse/in dex.aspx.

The "Reporting Child Abuse and Neglect: It's Your Duty" brochure is a useful resource and can be located on the Ministry's website or through Publications Ontario free of charge. The brochure can be found at the following link: http://www.children.gov.on.ca/htdocs/English/documents/topics/childrensaid/Repor tingchildabuseandneglect.pdf.

Should you have any questions, please feel free to contact Jill Dubrick, Manager of the Prevention and Protection Services Unit, Child Welfare Secretariat, Ministry of Children and Youth Services at Jill.M.Dubrick@ontario.ca or 416-326-0273.

Sincerely,

Aryeh Gitterman
Assistant Deputy Minister

MANDATORY REPORTING — ETHICAL OBLIGATIONS FOR HEALTHCARE PROFESSIONALS

This article was originally published in the Summer 2013 issue of *Pharmacy Connection*.

It is provided again as a reminder about the ethical obligations of all healthcare professionals to report themselves or other professionals in certain situations.

Mandatory Reporting

Health professionals have the privilege of providing essential care to patients to help them when they are sick and support them when they are well. All members of the Ontario College of Pharmacists are obliged through their code of ethics to act in the best interest of the patient, and to practice in accordance with ethical principles and standards of practice. When a member doesn't meet the standards of the profession, the College must take steps to protect the public.

This article provides an overview of mandatory reporting obligations for health professionals and how the College responds when a report is received. All regulated health professionals are required to provide information to a health professional College in specific circumstances, this ensures that a College is alerted to members who may not be practising safely and permits the College to take action to protect the public. Stemming from legal, professional and ethical requirements, mandatory reporting is triggered, for example, by the alleged sexual abuse of a patient, or when any restriction is placed on a member's practice, or when a member's employment is terminated due to the member's professional misconduct, incompetence or incapacity. Pharmacists, registered pharmacy students, interns and pharmacy technicians are all members of OCP and share these obligations.

MANDATORY REPORTING:
REGULATED HEALTH PROFESSIONS ACT, 1991

The mandatory reporting framework is established through the *Regulated Health Professions Act* (RHPA), the *Pharmacy Act* and the *Health Professions Procedural Code* (Schedule 2 of the RHPA). *Regulation 681/93 under the Pharmacy Act* outlines what is considered to be professional misconduct, while the Code lists the circumstances in which a member is required to file a report. With respect to pharmacy, these obligations, depending on the context, fall on the member, the employer/Designated Manager of a pharmacy, or a facility operator, if relevant (facilities include, but are not limited to, acute care hospitals or long-term care homes).

It should be stated at the outset that a report does not constitute a finding of sexual abuse, professional misconduct, incompetence, or incapacity against the member who is the subject of the report. Those findings can only be made by the Discipline Committee or the Fitness to Practise Committee which make findings on the basis of the evidence submitted at a hearing.

SUSPECTED SEXUAL ABUSE OF A PATIENT

According to the Code a member is required to file a report if he or she has reasonable grounds, obtained in the course of practice, to believe that a member of any college regulated under the RHPA has sexually abused a patient. In the Code, sexual abuse is defined as intercourse or other forms of sexual relations between the member and the patient, including touching, behaviour, or remarks of a sexual nature. The report is to be filed with the Registrar of the College of the member who is the subject of the report including the name of the person making the report, the name of the member who is the subject of the report, an explanation of the sexual abuse, and with the consent of the patient or their agent, the name of the patient who may have been sexually abused. If no consent is given, the patient can remain anonymous but the report must still be made.

TERMINATION OF EMPLOYMENT

The owner of a pharmacy, or Designated Manager, is required to report to the College the facts of terminating the employment of a member terminated for reasons of professional misconduct, incompetence or incapacity. This obligation relates strictly to professional reasons rather than employment-related reasons. Employment-related reasons generally refer to issues such as lateness or personal incompatibility and don't compromise patient safety or violate standards of practice. The obligation to report continues even if the member who is the subject of the proposed report resigns his or her position, or voluntarily relinquishes his or her privileges.

The acts that constitute professional misconduct for members of the Ontario College of Pharmacists are listed in *Regulation 681/93 under the Pharmacy Act* including, for example, contravening a term, condition or limitation imposed on the member's certificate of registration or failing to maintain a standard of practice of the profession. The standards of practice for pharmacists outline the expected standards of expertise in medications and medication use, collaboration, safety and quality, and professionalism and ethics that pharmacists, registered pharmacy students and interns are expected to meet. Similar standards of practice for pharmacy technicians are also in place. In addition to an allegation of failing to meet the standards of practice, professional misconduct may also include dispensing without authorization, insurance or other fraud, working while impaired, abusive conduct, or otherwise engaging in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The obligation to report is also triggered when a member is terminated from employment due to incompetence or incapacity. Allegations of incompetence may relate to a member who, in his or her practice, displays a general lack of knowledge, skill or judgment, or a disregard for the welfare of his or her patients. Termination

on the grounds that a member is incapacitated may be precipitated by the impact of a member's physical or mental health disorder on his or her ability to practise safely. Incapacity may also stem from untreated or uncontrolled emotional or psychiatric disorders or substance abuse. Reporting is also required when the privileges of a member are revoked, suspended or restricted, or a partnership of a member with a health profession corporation is dissolved for the reasons stated above.

GUILTY OF AN OFFENCE, PROFESSIONAL MISCONDUCT, OR MALPRACTICE

A member is required to self-report a finding of guilt of an offence relevant to the member's suitability to practise, or a finding of professional negligence or malpractice. This obligation stands whether the finding is made in the member's current profession and jurisdiction, or in another regulated health profession in which a member holds a certificate, or a jurisdiction other than Ontario. While a report of an offence cannot contain any information that violates a publication ban, if any, the report must contain the name of the member filing the report, the nature of, and a description of the offence, the date the member was found guilty, the name and location of the court, and the status of any appeal initiated with respect to the finding of guilt. The member is also required to file a report if there is a change in status of the finding of guilt as a result of an appeal. All reports must be made as soon as is reasonable after the finding.

OTHER MANDATORY REPORTING OBLIGATIONS: *CHILD AND FAMILY SERVICES ACT*

All members of the public, including any health professional providing services to a child, must promptly report to a children's aid society any suspicions that a child is, or may be in need of protection. In the context of the Act, the duty to report includes physical, sexual, and emotional abuse, neglect, and risk of harm.[1] The person making a report does not need to have evidence or proof of the need for protection, he or she may rely on reasonable grounds, the information that an average person would rely on, to decide to make a report. In this circumstance a report is required even when the information is otherwise confidential or privileged. The person making the report cannot rely on someone else to do so as it is an offence if he or she does not report a suspicion that was obtained in the course of his or her professional practice.

All mandatory reports must be made in writing and addressed to the Registrar of the College of the member who is the subject of the report. In the case of sexual abuse, the report must be made within 30 days; however, if there is concern that the member will continue to sexually abuse the patient, or other patients, the report must be made immediately. This stipulation on the timing of the report is the same in the case of suspected incompetence or incapacity which may expose a patient to harm or injury, where there is a need for intervention. In all other scenarios, a member is required to report as soon as is reasonably practical in the circumstances. A summary of reporting obligations and the timing of reports is provided in the Appendix at right.

THE COLLEGE RESPONSE

Once a report is received, the information will be reviewed by the Registrar to determine the next steps, including appointing an investigator and initiating a formal investigation. If determined as necessary, the investigator appointment would be placed before a panel of the Inquiries, Complaints and Reports Committee (ICRC) for a approval of the investigator appointment. The investigator will notify the member of his or her appointment, conduct an investigation and a report of the investigation will be reviewed by the ICRC for review and disposition. Dispositions can range from "take no action" to, in the most serious circumstances, a referral of allegations of professional misconduct and or incompetence by the member to the Discipline Committee. In these instances, a hearing into the allegations is held before a panel of the Discipline Committee and a decision is rendered by the panel.

Typically, the College will deal with all the information received in a confidential manner and information is only shared with the public if it results in disciplinary proceedings. Complainants are protected from any action or other proceeding when a complaint is made and/or a report is filed in good faith.

1 Ontario. Reporting Child Abuse and Neglect: It's Your Duty: Your responsibilities under the Child and Family Services Act. Retrieved at: http://www.children.gov.on.ca/htdocs/english/documents/topics/childrensaid/Reportingchildabuseandneglect.pdf

What Behaviour or Action Triggers a Mandatory Report?	Legal Authority	Threshold of Proof	Report Author/ Report Recipient
Suspected Sexual Abuse of a Patient Sexual relations, touching, behaviour or remarks of a sexual nature between a regulated health professional and a patient/ client (name of health professional must be known).	*RHPA* *The Code*:* *s1(3)(a)-(c).*	Reasonable grounds obtained: • In the course of practice; or • In the operation of a facility	Member or Facility Operator Registrar of the College of the member who is the subject of the report.
Timing of the Report • Filed in writing within 30 days after the obligation to report arises. • If there are reasonable grounds to believe that the member will continually to abuse the patient, or other patients, and there is an urgent need for intervention, the report must be filed immediately.			
Reporting by Employers, etc. Termination of employment, revocation or restriction on a member's privileges, or dissolution of a partnership, health profession corporation, or association with a member for reasons of professional misconduct, incompetence or incapacity.	*RHPA* *The Code:* *s 85.5(1) and (2)*	Termination of the member's employment or privileges.	Employer, Designated Manager or any person, who employs or offers privileges to the member or associated in a partnership or otherwise for the purpose of offering health services Registrar
Timing of the Report • Filed in writing with the Registrar within 30 days after the termination, revocation, suspension, imposition or dissolution. • In the case of alleged incompetence or incapacity, if there are reasonable grounds to believe that the member will expose a patient to harm or injury, and there is an urgent need for intervention, the report must be filed immediately.			
Reporting by Members re: Offences A finding of guilt of an offence OR an additional report if there is a change in status of the finding of guilt as a result of an appeal.	*RHPA* *The Code:* *s 85.6.1(1)*	Finding of guilt	Member Registrar
Timing of the Report • Filed in writing with the Registrar as soon as is practicable after the member receives notice of the finding of guilt or a notice of a change in the status of the finding of guilt made against the member as the result of an appeal.			
Reporting by Members re: Professional Negligence and Malpractice A finding of professional negligence or malpractice OR an additional report if there is a change in status of the finding as a result of an appeal	*RHPA* *The Code:* *s 85.6.2(1)*	Finding of negligence or malpractice	Member Registrar
Timing of the Report • Filed in writing with the Registrar as soon as is practicable after the member receives notice of the finding of professional negligence or malpractice or a notice of a change in the status of the finding as the result of an appeal.			
Contents of a Report: Depending on the Subject of the Report All Reports: The name of the person filing the report; the name of the member who is the subject of the report Sexual Abuse: An explanation of the alleged sexual abuse; the name of the patient (with consent) Incompetence or Incapacity: An explanation of the incompetence or incapacity. An Offense: The nature of, and a description of the offence; the date the member was found guilty; the name and location of the court that found the member guilty of the offence; and, the status of any appeal. Professional Negligence and Malpractice: The nature of, and a description of the finding; the date of the finding made against the member; the name and location of the court that made the finding; and, the status of any appeal.			
Reporting Child Abuse and Neglect Any suspicions that a child is or may be in need of protection as a result of physical, sexual and emotional abuse, neglect, and risk of harm	*Child and Family Services Act s.72*	Reasonable grounds to suspect that a child under 16 is or may be in need of protection	Any person, including a person performing professional or official duties with respect to children Directly to a Children's Aid Society
Timing and Contents of a Report • A report is made promptly, including the information on which the suspicion is based (i.e. physical harm, risk of physical harm, sexual molestation or exploitation, etc.). Any professional who fails to make a report is liable, on conviction, to a fine of up to $1,000.			

* Regulated Health Professions Act, 1991: The Health Professions Procedural Code – "The Code"

KEEPING CURRENT WITH DRUG SCHEDULE CHANGES

The College often receives inquiries from members seeking advice with respect to the conditions for sale of specific drug products (e.g., Schedule I, II, III or Unscheduled). This article will help clarify the roles of both Health Canada and NAPRA in drug scheduling.

FEDERAL ROLE

Health Canada determines whether or not a drug requires a prescription. Once Health Canada classifies a drug as requiring a prescription for sale, then it requires a prescription for sale in all of Canada. The drug is placed on the Prescription Drug List[1] maintained by Health Canada. This list has replaced Schedule F to the *Food and Drug Regulations* and was created to make the process simpler and more efficient.

The Prescription Drug List is a list of medicinal ingredients that when found in a drug, require a prescription. However, it does not include medicinal ingredients that when found in a drug, require a prescription if those ingredients are listed in *Controlled Drugs and Substances Act* (CDSA) Schedules. (Ingredients listed in the CDSA Schedules include narcotics, controlled drugs, restricted drugs, benzodiazepines, targeted substances, precursors, industrial hemp and marihuana for medical purposes.) Prior to the adoption of the Prescription Drug List, a regulatory amendment was needed to give a drug prescription status by adding it to Schedule F, or to switch its status from prescription to nonprescription by removing it from Schedule F.[2]

Although regulatory amendments are no longer required, Health Canada does employ a defined process whereby medical ingredients are removed or added to the Prescription Drug List. The process as described by Health Canada includes[3]:

- Health Canada evaluates data from a drug submission/product license application to assess the safety, quality and efficacy of a medicinal ingredient and whether it should be available by prescription only.
- Health Canada scientific staff make a recommendation to the existing Health Canada committee of scientific

PRESCRIPTION DRUG LIST – examples of recent changes:
http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/notice-avis-eng.php

DRUG	DATE OF NOTICE	EFFECTIVE DATE
Levonorgestrel	2015-05-29	2015-05-29
Naproxen	2015-03-26	2015-03-26
Mometasone furoate monohydrate (Nasonex)	2015-02-12	2015-08-12
Traimcinolone acetonide (Nasacort)	2015-01-14	2015-01-14
Hydrocortisone	2014-12-24	2014-12-25
Lovastatin	2014-12-05	2014-12-05

experts to add or remove a medicinal ingredient from the Prescription Drug List.

- Following endorsement by the Committee, the following steps occur (in this order):
  - o Notice of Consultation posted to the Health Canada website regarding the Department's intent to add or remove a medicinal ingredient from the Prescription Drug List and the rationale for the proposed addition or removal
  - o 75 day consultation
  - o Health Canada evaluates the comments received during the consultation
  - o Notice of Intent to Amend the Prescription Drug List posted to Health Canada website
  - o Notice of Amendment to the Prescription Drug List posted to Health Canada website six months from the date of the posting of the Notice of Intent to Amend. This informs the public that the ingredient has been added and provides the rationale regarding the addition.
- Note: If the drug is new to the Canadian market, a Notice of Amendment is posted to the Health Canada website, informing the public of the ingredient that has been added to the Prescription Drug List and the Department's rationale regarding the addition. There is no consultation period.

Additional information on this process is available on the Health Canada website - http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/pdl_qa_fin_ord-eng.php.

Notices of changes to the Prescription Drug List, including amendments and consultations are posted on the Health Canada Website - http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/notice-avis-eng.php. Additionally, individuals can subscribe to the Health Canada Prescription Drug List Really Simple Syndication (RSS) feed - http://www.hc-sc.gc.ca/dhp-mps/prodpharma/feeds-fils/index-eng.php.

PROVINCIAL AND NAPRA ROLES

If a drug has been given non-prescription status by Health Canada, it is up to the provinces and territories to determine the appropriate conditions of sale for that drug. Ontario has adopted the National Association of Pharmacy Regulatory Authorities (NAPRA) National Drug Schedules (NDS)[4] and thus amendments made to the National Drug Schedules are effective immediately. The NAPRA Supplemental Standards of Practice[5] guide pharmacists in the level of professional intervention and advice necessary for the safe and effective use of drugs by consumers, according to each Schedule.[6]

When Health Canada approves a switch from prescription to non-prescription status (i.e., removal from Prescription Drug List), the National Drug Scheduling Advisory Committee (NDSAC) formed by NAPRA, will evaluate the change and update the National Drug Schedules. This evaluation only occurs if a submission by a manufacturer to have the drug reviewed by the *National Drug Scheduling Advisory Committee* (NDSAC) has been received. If a submission is made, the NDSAC reviews the submission and makes a recommendation for scheduling. The recommendation of the NDSAC is posted to the NAPRA website approximately 7 days after the meeting. This triggers the start of a 30-day consultation period during which comments on the interim recommendation of the NDSAC are received by NAPRA. After the 30-day consultation period, the NAPRA Executive Committee makes a final recommendation for scheduling. If Health Canada has already changed the Prescription Drug List, then the National Drug Schedules (NDS) will be changed immediately according to the final recommendation. If the Prescription Drug List has not yet been changed (i.e. it is during the 6 month waiting period), then the

OUTLINE OF THE SCHEDULES [6]

Schedule I drugs require a prescription for sale and are provided to the public by the pharmacist following the diagnosis and professional intervention of a practitioner. The sale is controlled in a regulated environment as defined by provincial pharmacy legislation.

Schedule II drugs, while less strictly regulated, do require professional intervention from the pharmacist at the point of sale and possibly referral to a practitioner. While a prescription is not required, the drugs are available only from the pharmacist and must be retained within an area of the pharmacy where there is no public access and no opportunity for patient self-selection.

Schedule III drugs may present risks to certain populations in self-selection. Although available without a prescription, these drugs are to be sold from the self-selection area of the pharmacy which is operated under the direct supervision of the pharmacist, subject to any local professional discretionary requirements which may increase the degree of control. Such an environment is accessible to the patient and clearly identified as the "professional services area" of the pharmacy. The pharmacist is available, accessible and approachable to assist the patient in making an appropriate self-medication selection.

Unscheduled drugs can be sold without professional supervision. Adequate information is available for the patient to make a safe and effective choice and labeling is deemed sufficient to ensure the appropriate use of the drug. These drugs are not included in Schedules I, II or III and may be sold from any retail outlet.

change to the NDS will not occur until Health Canada has updated the Prescription Drug List (after the 6 month waiting period). It is important to note that if no submission to NAPRA is received, the policy for drugs not reviewed will apply and the drug will remain in Schedule I.[7]

To receive updates on NDSAC activities and changes to the NDS, individuals can subscribe to the Drug Scheduling External Liaison Group (DSELG) - http://napra.ca/pages/Schedules/Overview.aspx?id=2396.

Members are reminded that the National Drug Scheduling Advisory Committee does not review drugs that have been given prescription status by Health Canada. These drugs are all automatically considered to be in Schedule I of the National Drug Schedules (NDS). Many of these are listed in the NDS for clarity, but since there is no automated link between Health Canada's databases and the NAPRA National Drug Schedules, it is possible that some drugs that have been classified as requiring a prescription by Health Canada are not captured in the NDS.

Additionally, member can verify the Prescription Drug List and the schedules to the *Controlled Drugs and Substances Act* and its regulations, or Health Canada's Drug Product Database[8], to find out if a drug requires a prescription at the federal level. If the drug has been classified as non-prescription by Health Canada, members are encouraged to utilize the NAPRA National Drug Schedules to determine the current conditions of sale for that drug. However, as drugs are subject to schedule changes, it is important for members to be familiar with the process directing such changes, resources to keep current, and how schedule changes may affect their practice. PC

REFERENCES

1 Available at: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/pdl_list_fin_ord-eng.php
2 Health Canada – Prescription Drug List FAQ. Retrieved at: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/pdl_qa_fin_ord-eng.php
3 Health Canada – Prescription Drug List FAQ. Retrieved at: http://www.hc-sc.gc.ca/dhp-mps/prodpharma/pdl-ord/pdl_qa_fin_ord-eng.php
4 Available at: http://napra.ca/pages/Schedules/Search.aspx
5 Available at: http://napra.ca/Content_Files/Files/SupplementalStandardsofPracticellandIII-June2005.pdf
6 National Association of Pharmacy Regulatory Authorities (NAPRA) – Outline of Schedules. Retrieved at: http://napra.ca/Content_Files/Files/Schedules-Outline.pdf
7 NAPRA - Policy for Drugs Not Reviewed. Available at: http://napra.ca/pages/Schedules/Overview.aspx?id=1965
8 Available at: http://webprod5.hc-sc.gc.ca/dpd-bdpp/index-eng.jsp

For a quick guide on how to look up something in the NAPRA schedules, watch OCP's e-Learning Module on the Food and Drugs Act (Chapter 7).

CONTINUING TRANSPARENCY:

Improving Access to Information

Find information simply

Over the last few years, the College has been enhancing transparency and ensuring Ontarians have more access to the information they need to make informed healthcare decisions.

We're continuing down the path toward greater transparency by making some significant changes to the public register — also known as the "Find a Pharmacy or Pharmacist" on www.ocpinfo.com. With an anticipated launch by the end of 2015, the enhanced register will allow anyone to easily find information about the people and places this College oversees.

While the College has always disclosed information about pharmacists, pharmacy technicians and pharmacies, this new tool will make accessing and understanding that information easier, with simpler navigation and straightforward language. Additionally, as a result of by-laws passed earlier this year, we're adding *more* information, such as the outcome of some complaint investigations, federal or provincial criminal charges or findings of guilt, and full notices of hearing for discipline cases. Details about what's new can be found on our Key Initiative — Commitment to Transparency webpage.

FOCUS ON THE PUBLIC

The College's mandate is to serve and protect the public. As such, the new "Find a Pharmacy or Pharmacist" is being re-designed with a single audience in mind — the public.

The focus is on making things easy-to-find, simple-to-understand and uncomplicated. Terminology that is specific to the profession of pharmacy is being minimized and regulatory processes will have supporting information to provide context and explanations wherever possible.

NEW SEARCH OPTIONS

One of the most useful features on the new register will be the many search options available to users. Basic search fields will allow for simple searches of people (pharmacists, pharmacy technicians, students and interns) or places (community pharmacies, hospital pharmacies, drug preparation premises and remote dispensing locations) by name, type or location. Advanced search fields will allow for more in-depth searches using options such as practice status, registration or accreditation number, gender, discipline history and more.

SIMPLE PROFILES

Each person and place the College oversees will have their own profile with lots of detailed information. People profiles include information such as name, type, status, location, registration number, training history, gender, and any concerns the College has about the person. Place profiles include information such as name, type, status, location, contact information, accreditation number, staff members, assessment information, and any concerns the College has about the place. For specific details about the information that is disclosed on the register please see College By-Law No. 3.

Stay tuned for more information!

New Continuing Education Tool is Home to a Wealth of Valuable Information

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CE FOR PHARMACISTS IS ORGANIZED IN THE FOLLOWING CATEGORIES:

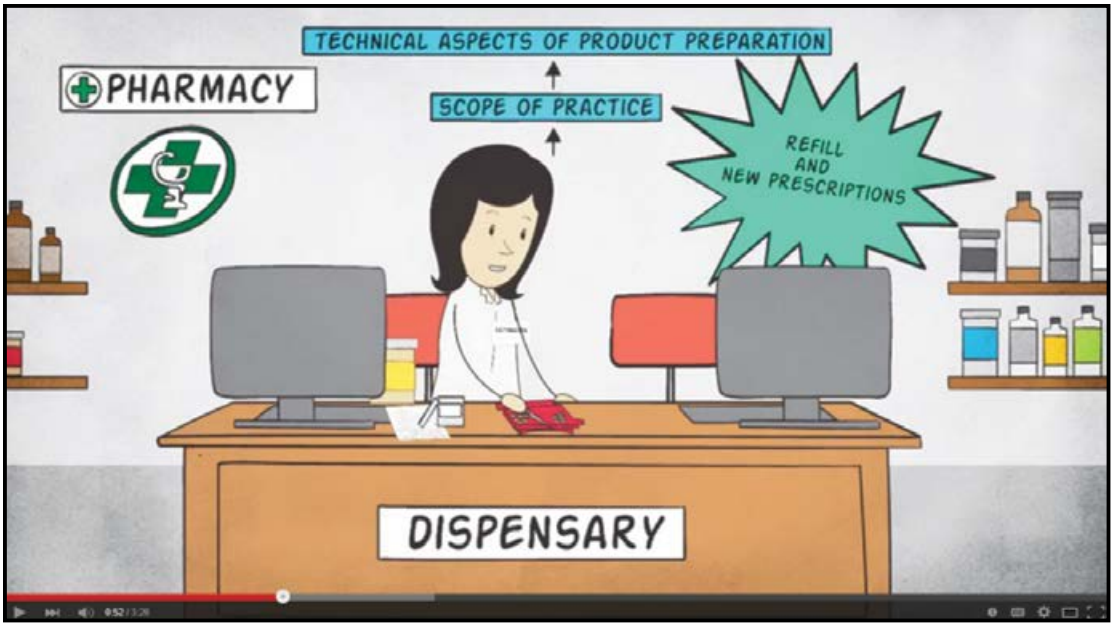
- Cancer therapy
- Cardiovascular disorders
- Diabetes and endocrine disorders
- Ethical, legal and professional
- Fluid and electrolyte disorders
- Gastrointestinal disorders
- Genitourinary disorders
- Geriatrics
- Healthcare system
- Hematology
- Immunization and injections
- Infectious diseases
- Musculoskeletal disorders
- Neurological disorders
- Nutritional supplements and alternative therapies
- Patient issues
- Professional skills
- Psychiatric disorders
- Respiratory disorders
- Skin disorders
- Women's health

CE FOR PHARMACY TECHNICIANS IS ORGANIZED IN THE FOLLOWING CATEGORIES:

- Communication and education
- Drug and product distribution
- Ethical, legal and professional
- Immunization and injections
- Patient care
- Practice setting
- Quality and safety

Please note that the College will no longer print listings of upcoming CE activities in *Pharmacy Connection*.

NEW VIDEO DEMONSTRATES THE IMPORTANT ROLE PHARMACY TECHNICIANS PLAY IN COMMUNITY PRACTICE



Are you familiar with how the responsibilities of a pharmacy technician differ from those of a pharmacy assistant and pharmacist?

Are you aware of the many benefits that come with fully integrating pharmacy technicians into community practice?

This new video helps answer these questions and illustrates how technicians — when working to their full scope — can be instrumental in helping pharmacists shift their time from dispensing medications to delivering clinical services.

The College is committed to creating resources for members, like this one, that help improve practice and support enhanced health outcomes for patients.

The video will be used as a training tool by OCP's community practice advisors when they visit pharmacies, and will be easily accessible on the College's website and YouTube channel.

To watch the video, visit our YouTube channel at www.youtube.com/ocpinfo.

Methotrexate Medication Incidents in the Community

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

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Project Lead, ISMP Canada

INTRODUCTION

Methotrexate is a folate antagonist used in oncologic and non-oncologic situations alike.[1,9] Most commonly associated with its use as a chemotherapeutic agent, low-dose methotrexate may also be prescribed for conditions such as psoriasis, asthma and rheumatoid arthritis. The different indications in turn require varying dosing schedules, facilitating error in all steps of the medication-use process.[9] As its mechanism of action is targeted towards the interference of DNA synthesis, replication and repair, the side effect profile of methotrexate is also significant. Toxicities may include immunosuppression, blood dyscrasias, renal dysfunction, and stomatitis.[1] Due to the heightened risk of errors associated with methotrexate, the agent is listed as a high-alert medication in the *ISMP List of High Alert Medications in Acute Care Settings*.[4]

It is essential for healthcare practitioners and patients to recognize the potential safety risks posed by the use of methotrexate. The rationale of this multi-incident analysis is to therefore examine medication incidents within the community as related to methotrexate use. Voluntarily reported through ISMP Canada's Community Pharmacy Incident Reporting (CPhIR) Program (https://www.cphir.ca), a multi-incident analysis was conducted to identify common themes and subthemes. An overview of the findings is provided, along with potential contributing factors and system-based solutions.

MULTI-INCIDENT ANALYSIS OF METHOTREXATE MEDICATION INCIDENTS

Reports of medication incidents involving "Methotrexate" or "MTX" or "Metoject" were extracted from the CPhIR program between April 2010 and August 2014. Of the 161 incidents retrieved, 137 met inclusion criteria and were included in the qualitative, multi-incident analysis. All medication incidents were independently reviewed by two ISMP Canada analysts.

The majority of incidents resulted in no error (i.e. near misses), with two resulting in mild harm (i.e. symptoms were mild, temporary and short-term, with no treatment or minor treatment required). As illustrated in Tables 1 to 4, the medication incidents were categorized into three themes, with each theme categorized into further sub-themes. Note that incident examples were limited by the descriptions provided by the reporters in the "Incident Description" field.

TABLE 1 – Themes and Subthemes of the Methotrexate Multi-Incident Analysis

THEMES	SUBTHEMES
Associated Medications	Drug Interactions
	Look-alike/Sound-alike Drug Names
	Concomitant Drugs
Dosing Complexities	Calculation Error
	Frequency Error
	Parenteral Route
	Multi-Medication Compliance Aids
Medication-Use Process	Prescribing
	Order Entry
	Preparation/Dispensing

TABLE 2 – Theme One – Associated Medications

SUBTHEME: Drug Interactions

Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient, currently on methotrexate, was prescribed amoxicillin for an infection. The drug interaction was caught by the pharmacist, and the antibiotic was changed to cefprozil.	Lack of knowledge of clinically relevant drug interactions (Table 5 provides an overview of medications that may potentially increase methotrexate toxicity)	To prevent alert fatigue, pharmacies should utilize an updated drug interaction (DI) detection system, focusing on clinically significant interactions. Education of pharmacy staff of potential drug interactions should be implemented. This strategy does not necessarily require the memorization of all possible interactions, but to remind the team to be cognizant when dealing with the high-alert drug.

SUBTHEME: Look-alike/Sound-alike Drug Names

Incident Examples	*Potential Contributing Factors*	*Commentary*
A prescription for methotrexate was entered on the computer as methotrimeprazine. The error was found when the pharmacist called the doctor to clarify the dose.	Close proximity of storage Confirmation bias* *Definition: selective thinking, i.e. seeing what one wants to see, instead of what is actually there	Possible computerized solutions may include computerized alerts for look-alike/sound-alike drugs when entering prescriptions, as well as a bar-coding system when preparing prescriptions. Independent double checks (IDCs) may mitigate the risk of potential error. (Note: bar-coding systems are a computerized method of IDC.)

SUBTHEME: Concomitant Drugs

Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient was prescribed both folic acid and methotrexate tablets. When the pharmacist was checking the prepared prescriptions, it was realized that the labels were switched.	Concurrently prescribed drugs* *Note: Folic acid and methotrexate are commonly prescribed together to decrease the toxic effects of methotrexate. An example would be their concurrent use in rheumatoid arthritis.[2] *Note: Medications may be used in combination with methotrexate in certain conditions. An example would be the use of both hydroxychloroquine and methotrexate in moderate-severe cases of rheumatoid arthritis.[2]	In the scenario where multiple medications are being dispensed simultaneously, independent double checks may mitigate the risk of potential error of mixing up the prescription labels.

TABLE 3 – Theme Two – Dosing Complexities

Subtheme: Calculation Error

Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient received a prescription for methotrexate injection, with instructions to inject 25 mg weekly. The prepared prescription instructed the patient to inject 2 mL weekly, when the strength of the dispensed product was actually 25 mg/mL. *A patient received a prescription for methotrexate 10 mg once weekly, dispensed as 2.5 mg strength tablets. The weekly dose calculated was ten of the 2.5 mg strength tablets, instead of four.*	Multiple strengths and formulations available Uncommon dosage schedules* Reliance on mental calculations Confirmation bias *Note: Methotrexate may be indicated for a number of different conditions, each of them requiring different dosage schedules. The complexity increases with the availability of both injectable and oral options, each with varying strengths.[3,9] All factors may increase the risk of error in calculating the desired dose and/or quantity.	Use of handwritten calculations should be actively practiced. Independent double checks may also mitigate the risk of error, such as with verifying initial calculations. Pharmacy staff should be educated and familiarized with the different strengths and formulations available (i.e. those commonly stocked in the pharmacy).

Subtheme: Frequency Error

Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient received a new prescription for methotrexate, to be taken as a once weekly dose. Although the patient received written instructions from her doctor and counseling from the pharmacist, there was a gap in communication and the patient instead took her weekly dose spread out over the course of the week. The error was found when the patient asked the pharmacist for clarification. *A prescription for methotrexate 2.5 mg tablets instructed the patient to take 5 tablets once weekly. The prescription was entered as 5 tablets once daily.*	Lack of standardized prescribing templates Uncommon dosage schedules* Practitioner/patient miscommunication Confirmation bias *Note: The dosing frequency changes between indications. For example, oral methotrexate may be taken as a once weekly dose for rheumatoid arthritis, or as a daily dose for a pre-defined amount of time in certain cancers[1,2]	Pre-defined order sets, where the indication for methotrexate is clearly defined, may standardize the prescribing process.[5] Independent double checks may also mitigate the risk of potential error. Patient education and follow-up is essential to confirm understanding and appropriate use of the medication.[9]

Subtheme: Parenteral Route

Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient requested a refill of her methotrexate injection. The pharmacist noticed the refill was several days late, and it was realized that the patient was re-using vials intended for single-use.	Multiple strengths and formulations available Practitioner/patient miscommunication	To prevent potential dispensing errors, segregation of single- and multi-use vials may also be implemented. Patient education and follow-up is essential to confirm understanding and appropriate use of the medication.

Subtheme: Parenteral Route		
Incident Examples	*Potential Contributing Factors*	*Commentary*
A set of blister packages were prepared for a patient. The methotrexate tablets, intended as a once weekly dose, were dispensed as once daily dosing. The error was found after the patient had taken two extra doses. *A prescription for methotrexate was written as 3 tablets once weekly every Sunday. In the blister packages, 1 tablet each was instead placed in the supper slot of Monday, Wednesday and Friday. Novasen and Vitamin B12 were also to be placed in those slots, causing confusion.*	Lack of cross-referencing between packages Multiple medications within bubbles Uncommon dosage schedules Confirmation bias *Note: Multi-medication compliance aids present with additional complexities independent of the handling of methotrexate.[10]	A separate area of the pharmacy should be dedicated to preparing packages, where environmental distractions are minimal. Highlighting high-alert drugs (i.e. methotrexate) on compliance labels may aid in alerting both the practitioner and patient. Independent double checks may also mitigate the risk of potential error.[10]

TABLE 4 – Theme Three – Medication-Use Process

Subtheme: Prescribing		
Incident Examples	*Potential Contributing Factors*	*Commentary*
An MD erroneously wrote a prescription for methotrexate 25 mg weekly, when the patient usually takes methotrexate 10 mg weekly.	Reliance on hand-written prescriptions Lack of safeguards following therapy alterations	A systematic method of cross-referencing and documenting patient information may reduce the risk of over-dosing or under-dosing. Computerized examples include e-prescribing and automatic alerts following therapy alterations. Patient communication is essential to confirm acknowledgement and understanding of dose changes.

Subtheme: Order Entry		
Incident Examples	*Potential Contributing Factors*	*Commentary*
A patient was prescribed an increase of their usual methotrexate dose. The change was not made when the previous prescription was copied.	Multiple strengths and formulations available Misreading/confusion between numbers Copying prescriptions Confirmation bias	The copy functionality is available in all pharmacy software systems to enhance pharmacy workflow. In order to prevent confirmation bias, policies may be considered within the pharmacy to limit the process of copying from previous prescriptions (where applicable). The inputted prescription information should be verified against the original prescriber-generated prescription order.[7] Educate pharmacy staff regarding the different strengths and formulations available (i.e. those commonly stocked in the pharmacy).

Subtheme: Preparation/Dispensing		
Incident Examples	*Potential Contributing Factors*	*Commentary*
A methotrexate prescription was dispensed to a patient who had the same last name as the intended patient. The error was found when the patient went to take their dose, and did not recognize the pill as their own.	Multiple prescriptions per patient Lack of patient verification Confirmation bias	Independent double checks may mitigate the risk of potential error. One example would be patient communication to confirm patient identity and understanding.

TABLE 5 – Medications That May Increase Methotrexate Toxicity[8]

NSAIDs	Antibiotics	Other
Salicylates	Trimethoprim/Sulfamethoxazole	Barbiturates
Naproxen	Sulfonamides	Colchicine
Ibuprofen	Penicillins	Dipyridamole
Indomethacin	Minocycline	Ethanol
Phenylbutazone	Ciprofloxacin	Phenytoin
		Sulfonylureas
		Furosemide
		Thiazide-diuretics

CONCLUSION

While methotrexate is an effective drug for a number of conditions, the potential repercussions to patient safety are significant should an error occur. This risk is further compounded by the agent's unique characteristics that may increase the probability of error occurrence. These include the complexity of methotrexate dosing, as well as the prescribing of potentially associated medications. As a high-alert drug, caution must therefore be exercised when dealing with the agent in all stages of the medication-use process.[4,9]

System-based strategies may aid in reducing the risk of potential patient harm, and should be actively implemented in the workplace. This multi-incident analysis has demonstrated the key areas to which improvements can be made possible. These include the standardization of prescribing practices (i.e. pre-defined order sets), the implementation of safeguards in the community pharmacy (i.e. independent double checks) and a culture of patient-centered care (i.e. patient education and follow-up).

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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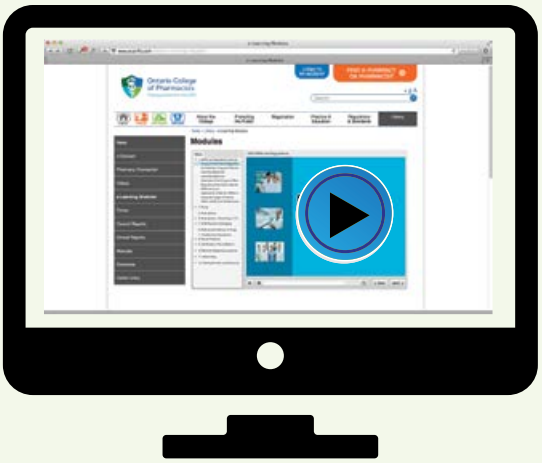
More Jurisprudence e-Learning Modules Published

To date, the College has produced six e-learning modules that provide support for learning and understanding jurisprudence.



These self-directed learning modules review key topics of legislation and are intended to support a variety of individuals, including:

- Candidates who are preparing to write the College's entry-to-practice Jurisprudence Exam
- Students who are learning the legislation
- Practitioners who may be interested in updating their jurisprudence knowledge
- Practitioners who are looking for a continuing education opportunity

These educational learning tools are not meant as stand-alone courses or substitutes for reading the legislation and OCP practice policies and guidelines.

There are now six modules covering:

- *Drug and Pharmacies Regulation Act* (DPRA)
- *Controlled Drugs and Substances Act* (CDSA) and *Narcotics Safety and Awareness Act* (NSAA)
- *Ontario Drug Benefit Act* (ODBA)
- *Drug Interchangeability and Dispensing Fee Act* (DIDFA)
- *Regulated Health Professionals Act* (RHPA) and *Pharmacy Act* — **NEW!**
- *Food and Drugs Act* (FDA) Module — **NEW!**

To access the e-Learning modules, visit the e-Learning Modules page in our Library of www.ocpinfo.com

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CLOSE-UP ON COMPLAINTS

Several years ago, "Close-Up on Complaints" was a regularly featured article in *Pharmacy Connection*. It appeared in every issue and involved an analysis of a complaint that the College had investigated.

We've recently decided to bring back this regular feature as another learning resource for members.

Delivering pharmacy services is a complex, human process. Even with the assistance of technology, mistakes can still occur. "Close-Up on Complaints" will take a look at some of these errors, and use them as learning opportunities for all practitioners.

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.

Systematic Dispensing Error

An Error In Processing Batch Medications

SUMMARY OF THE INCIDENT

An elderly patient living in a retirement home was prescribed prednisone 20mg daily by her family physician in January 2014. The medication was to be administered once a day for seven days, for a chest infection. The prescription also included two refills, to be used with discretion if the patient was still not feeling well. The retirement home sent the prescription to the pharmacy where the patient's medications were usually dispensed. The patient then received the prednisone 20mg daily, along with her other medications, in her weekly compliance strip.[1]

Over the next few months, the patient experienced panic attacks, anxiety, aggression, insomnia, loss of appetite, and breathing problems. Four months after the original prescription was supplied — due to the patient's ongoing symptoms— the patient's daughter suspected that the patient was potentially suffering from another chest infection, and requested that one of the prednisone refills be provided. It was then discovered that the patient was still on prednisone 20mg daily as the pharmacy had failed to stop the medication after the original prescribed duration of seven days, and had continued to dispense it with the other medications in the patient's weekly compliance strip.

This complaint was originally filed by the patient's daughter. After filing the initial complaint, the daughter informed the College that the patient had since suffered a broken hip. The daughter also stated that she was informed by the patient's physician that the prednisone may have been a contributing factor to the broken hip, as prednisone does affect a person's bones.

WHY DID THIS HAPPEN?

When the pharmacy first received the prescription for prednisone 20mg daily it was set to be dispensed in the weekly compliance strip with the rest of the patient's medications. No stop date was entered into the pharmacy's computer software and the prescription continued to be dispensed in the weekly batch for approximately four months. At the time of dispensing each week, the pharmacy did not consistently have a process in place to ensure that the batch was reviewed therapeutically prior to release.

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.

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 this error was caused by a lack of appropriate processes and procedures in the pharmacy, and not by the behaviour of a single pharmacist or pharmacy technician. In all pharmacies, the Designated Manager (DM) is responsible for ensuring that the necessary and appropriate systems are in place to prevent errors. As such, the DM in this complaint was found to be responsible for not having the appropriate systems in place at the pharmacy at the time of the incident to prevent the error from occurring. The Committee ordered that the DM appear in person to receive a caution, and that he complete a specified continuing education or remediation program (SCERP) on medication system safety.

LEARNING FOR PRACTITIONERS

Taking time to review and reflect on this complaint provides a number of learning opportunities for practitioners. For example, it's clear that appropriate systems, procedures, processes and training are essential in avoiding medication incidents like this one.

The DM is responsible for ensuring that the medication processing systems are used correctly by the pharmacy staff to minimize errors, protect the public and enable practitioners to meet the Standards of Practice. DMs must ensure that all staff in the pharmacy understand and follow the procedures for processing new prescriptions, refilling batched and non-batched prescriptions, and obtaining authorizations for prescription refills. In this case, the prednisone 20mg daily was not only entered incorrectly when it was first processed — it was missing the stop date — but there was also no consistent process in place to ensure that the patient's profile was reviewed prior to releasing the prescription.

This incident is a "red flag" situation; it is the professional responsibility of *all* practitioners to be diligent in identifying and responding to red flags that present in practice. This error went undiscovered for approximately four months, indicating that there was likely no formal documented process to check the prescriptions in the batch — a red flag. There should be a clear process for ensuring accuracy and appropriateness (both therapeutic and technical) for all batch prescriptions prior to dispensing. Ultimately, processes should be in place to ensure that ongoing refills are reviewed for therapeutic appropriateness – a measure which may have identified the error in question earlier.

This pharmacy, like many others, works with a high number of patients who are elderly, fragile and vulnerable. While these checks and processes should be in place in all pharmacies, those working with a high number of fragile patients must take extra caution and care. The same can be said for pharmacies with a high volume of prescriptions — extra care and attention should be given to the safeguards and structure of systems to avoid incidents. Pc

REFERENCE

1. Medications for patients in retirement or long-term care homes are often dispensed in weekly batches in multi-dose compliance "strips", similar to in a hospital setting.

CAUTIONS

A caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. 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 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 Pharmacist" section of our website.

DISCIPLINE DECISIONS

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Member: Martin Keeping, R.Ph. (OCP #93378)

At a hearing on April 24, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Keeping with respect to the following:

- that the Member failed to maintain pharmacy records relating to his practice in accordance with legislative requirements;
- that the Member dispensed drugs and/or products for which prescriptions are legislatively required without an authorized prescriber's authorization;
- that the Member sold drugs and/or products in the absence of a prescription authorized by a prescriber in contravention of C.01.041 of the Food and Drug Regulations;
- that the Member backdated documentation on hardcopies; and
- that the Member falsified prescribers' authorizations.

In particular, the Panel found that he

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

The Panel imposed an Order which included as follows:

1. A reprimand

2. That the Registrar impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully with an unconditional pass, at his own expense and within 12 months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals.

3. That the Registrar impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully, at his own expense and within 12 months of the date of this Order, the Ontario College of Pharmacists' Jurisprudence Exam.

4. That the Registrar suspend the Member's Certificate of Registration for a period of two months, with one month of the suspension to be remitted on condition that the Member complete the remedial training as specified above.

5. That the Member's practice will be monitored by the College for a period of two years from the date the Order is imposed by means of inspections by a representative of the College at such times as the College may determine. The monitoring inspections may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. The Member shall cooperate fully with the College during the inspections, and, further, shall pay to the College in respect of such monitoring the amount of $600.00 per inspection, such amount to be paid immediately after each inspection, with

the total number of inspections not to exceed three in any 12 month period.

6. Costs to the College in the amount of $1,500.00.

In its reprimand, the Panel indicated that the Member engaged in conduct that was disgraceful, dishonorable and unprofessional. It pointed out that the Member failed to meet his obligation to adhere to the standards of the profession and in so doing let down the public and the profession. The Panel explained that this conduct can harm patient care can cause the public to lose confidence in the profession. The Panel affirmed that pharmacists must practise to a very high standard.

Member: Svetlana Tracey, R.Ph. (OCP#607716)

At a hearing on May 5, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Tracey with respect to the following incidents:

- That, while employed as a pharmacist at the Drugstore Pharmacy in Brockville, Ontario, she misappropriated from the Pharmacy narcotics and other controlled and prescription drugs that had not been prescribed for her in or about December 2013-March 2014.

In particular, the Panel found that she

- failed to maintain a standard of practice of the profession;
- dispensed or sold drugs for an improper purpose;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 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 C.01.041 and/or G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, as amended; section 4 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended; section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended; and/or section 51 of the Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000-217, as amended;
- 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 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 shall complete successfully, at her own expense and within twelve (12) months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass;
   b) that the Member shall be prohibited, for a period of sixty (60) months from the date of this Order, from acting as a Designated Manager or narcotic signer at any pharmacy;
   c) for a period of twelve (12) months from the date the Member returns to active practice as a pharmacist in Ontario:
      i. the Member shall notify the College in writing of any employment in a pharmacy, which notification shall include the name and address of the employer and the date on which the Member began or is to begin employment, within seven (7) days of commencing such employment, and
      ii. the Member shall only work for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of the pharmacy to the College, within seven (7) days of the Member commencing employment at the pharmacy, that the Designated Manager received and reviewed a copy of the panel's decision and reasons in this matter before the Member commenced employment.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of five (5) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training exercises set out in subparagraph 2(a) above, as specified.

4. Costs to the College in the amount of $2,500.00.

In its reprimand, the Panel explained that integrity, trust, and professional conduct are core to the practise of pharmacy. The Panel pointed out that the practise of pharmacy is a privilege that carries significant obligations. The Panel agreed that the Member's conduct was disgraceful, dishonourable, and unprofessional. The Panel expressed its expectation that the Member will not be before a panel of the Discipline Committee again.

Member: Zbigniew Wasilewski, R.Ph. (OCP#73784)

At a hearing on May 8, 2015, a Panel of the Discipline Committee made findings of proprietary misconduct against Mr. Wasilewski, as Director of Wasilewski Drugs Ltd., c.o.b. as Dixie Village Pharmacy, and/or as Designated Manager of Dixie Village Pharmacy in Mississauga, Ontario, and that Wasilewski Drugs Ltd. as holder of Certificate of Accreditation #34100 for Dixie Village Pharmacy in Mississauga, that he committed an act or acts of proprietary misconduct, in about 2009-2014, with respect to the following incidents:

- purchased narcotics and other controlled drugs without authorization, and without keeping records as required;
- sold drugs and natural health products not approved for sale in Canada and not labelled as required;
- sold prescription drugs without a prescription or other authorization, and without keeping records as required;
- sold narcotics and other prescription/Schedule I drugs without keeping records as required;
- sold narcotics and other controlled drugs without a prescription or other authorization, and without keeping records as required;
- failed to record prescription information in relation to the sale of narcotics and other controlled drugs.

In particular, the Panel found that Mr. Wasilewski

- failed to keep records required to be kept by the pharmacy respecting the patients and the practice of the pharmacy;
- contravened the Drug and Pharmacies Regulation Act or the regulations made under the Act, and in particular, sections 155, 156 and/or 160 of the Drug and Pharmacies Regulation Act, and/or sections 40, 54 and/or 55 of O.Reg. 58/11;
- contravened any law of Canada or Ontario or any municipal by-law with respect to the distribution, purchase, sale or dispensing of any drugs or product in a pharmacy, and in particular
  - section 9 of the Food and Drugs Act, R.S.C., 1985, c. F-27, as amended; sections C.01.003 and/or G.01.003 of the Food and Drug Regulations, C.R.C., c.870, as amended; and/or sections 4 and/or 86 of the Natural Health Products Regulations, S.O.R./2003-196, as amended;
  - section C.01.041 of the Food and Drugs Regulations, C.R.C., c.870, as amended;
  - sections G.01.006, G.02.001, G.03.001, G.03.002, G.03.004, G.03.007, G.03.008, G.03.009 and/or G.03.010 of the Food and Drugs Regulations, C.R.C., c.870, as amended;
  - sections 4 and/or 5 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, and/or sections 8, 30, 31, 38, 39 and/or 40 of the Narcotic Control Regulations, C.R.C. c.1041, as amended; and/or
  - section 11 of the Narcotics Safety and Awareness Act, 2010, S.O., c.22, as amended; and
- engaged in conduct or performed an act relevant to the business of a pharmacy that would reasonably be regarded by members as disgraceful or dishonourable.

And in particular that Wasilewski Drugs Ltd:

- failed to keep records required to be kept by the pharmacy respecting the patients and the practice of the pharmacy;
- contravened the Drug and Pharmacies Regulation Act and regulations thereunder, and in particular, sections 155, 156 and/or 160 of the Act and/or sections 40, 54 and/or 55 of O.Reg. 58/11;
- contravened a law of Canada or Ontario or any municipal by-law with respect to the distribution, purchase, sale or dispensing of any drugs or product in a pharmacy, and in particular
  - section 9 of the Food and Drugs Act, R.S.C., 1985, c. F-27, as amended; sections C.01.003 and/or G.01.003 of the Food and Drug Regulations, C.R.C., c.870, as amended; and/or sections 4 and/or 86 of the Natural Health Products Regulations, S.O.R./2003-196, as amended;
  - section C.01.041 of the Food and Drugs Regulations, C.R.C., c.870, as amended;
  - sections G.01.006, G.02.001, G.03.001, G.03.002, G.03.004, G.03.007, G.03.008, G.03.009 and/or G.03.010 of the Food and Drugs Regulations, C.R.C., c.870, as amended;

  - sections 4 and/or 5 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, and/or sections 8, 30, 31, 38, 39 and/or 40 of the Narcotic Control Regulations, C.R.C. c.1041, as amended; and/or
  - section 11 of the Narcotics Safety and Awareness Act, 2010, S.O., c.22, as amended; and
- engaged in conduct or performed an act relevant to the business of a pharmacy that would reasonably be regarded by members as disgraceful or dishonourable.

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose specified terms, conditions or limitations on Mr. Wasilewski's Certificate of Registration, and in particular, that Mr. Wasilewski complete successfully the following courses, programs, and instruction, including any evaluations, at his own expense and within 12 months of the date of this Order:
   a) the College's Jurisprudence e-learning module and examination; and
   b) the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass.

3. Directing the Registrar to impose additional specified terms, conditions or limitations on Mr. Wasilewski's Certificate of Registration restricting Mr. Wasilewski from being the Designated Manager or narcotics signer at any pharmacy for a period of two years from the date of this Order.

4. Directing the Registrar to suspend Mr. Wasilewski's Certificate of Registration for a period of seven (7) months, with two (2) months of the suspension to be remitted on condition that Mr. Wasilewski complete the courses, programs and instruction set out in paragraph 2 above as specified.

5. Directing Mr. Wasilewski and Wasilewski Drugs Ltd., jointly and severally, to pay a fine in the amount of $70,000 to the Minister of Finance.

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

In its reprimand, the Panel expressed disappointment that the Member, who is a senior member of the profession, was before them. It indicated that the Member's conduct showed a pattern that was contrary to the rules and regulations, and was dangerous and irresponsible. The Panel suggested that the Member's actions brought discredit to the profession and harmed the public interest.

Member: Harvey Organ (OCP#37311)

At a hearing on May 11, 2015 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Organ as a pharmacist, Designated Manager of Kohler's Drug Store in Hamilton, Ontario, and/or director or shareholder of Kohler's Drug Store Ltd. and/or 1508767 Ont. Inc. The Panel found that Mr. Organ committed professional misconduct in relation to CanadaRx, PetPharm and/or Kohler's Drug Store being operated as an internet pharmacy business in or about 2009-2013, with respect to the following activities:

- operating a pharmacy for which a certificate of accreditation had not been issued by the College;
- using the protected designations "drug" or "drugs" in connection with a retail business that was not an accredited pharmacy;
- selling prescription drugs by retail to customers in the U.S. without prescriptions or other authorization recognized by law in Ontario;
- operating a pharmacy internet site in contravention of the Policy for Ontario Pharmacies Operating Internet Sites issued by the College in June 2001 and/or the Policy for Prescriptions - Out of Country issued by the College in January/February 2003; and/or
- failing to comply with his Undertaking & Acknowledgement to the College dated September 28, 2007 with respect to removing from Ontario the entire CanadaRx export business for the sale of prescription drugs in the absence of prescriptions recognized as valid in Ontario and not returning the CanadaRx or any similar export business to Ontario in the future.

In particular, the Panel found that Mr. Organ:

- failed to maintain a standard of practice of the profession;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 139, 147, 155 and/or 156 of the Drug and Pharmacies

Regulation Act , R.S.O. 1990, c. H.4, as amended, and/or sections 4, 40 and/or 43 of O.Reg. 58/11, as amended;
- contravened, while engaged in the practice of pharmacy, any 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 C.01.041 and/or C.01.042 of the Food and Drug Regulations, C.R.C., c. 870, as amended;
- knowingly permitted the premises in which a pharmacy is located to be used for unlawful purposes;
- permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to the sale of drugs by a corporation of which he was a director;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand;

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

3. Costs to the College in the amount of $15,000.00.

In its reprimand, the Panel reported that it found the Member's conduct to be shameful, as well as disgraceful, dishonorable, and unprofessional. It opined that the severity of the Order was appropriate and that the Member has proven to be ungovernable. The Panel indicated that the Member showed a lack of respect for the profession and complete disregard for the lack of public safety.

Member: Ashraf Bebawey (OCP #213897)

At a hearing on May 28, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Bebawey, while a director and shareholder of the corporation that owned Rowntree Gate Drug Mart, with respect to the following incidents:

- That between about May 31, 2010 and April 10, 2011, he introduced into active inventory, and/or permitted to be introduced into active inventory, and/or permitted to be sold in the Pharmacy, drugs not approved for sale in Canada, namely, counterfeit Viagra.

In particular, the Panel found that he:

- failed to maintain a standard of practice of the profession;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts, namely, s. 150 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4;
- contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, namely, s. 9 of the Food and Drugs Act, R.S.C. 1985, c. F-27, and C.01.003, C.01.004, C.01.005, and C.08.002 of the Food and Drug Regulations made under that Act;
- knowingly permitted the premises in which a pharmacy was located to be used for unlawful purposes;
- 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 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, or provide evidence satisfactory to the College that he has completed this course and any related evaluations within the 12 months prior to the date of this Order;
   b. that the Member shall be prohibited from acting as a Designated Manager in any pharmacy until the date the College is notified that the

Member has successfully completed with an unconditional pass the course and evaluation set out in paragraph 2(a) above;

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 4 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in subparagraph 2(a) above.

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

In its reprimand, the Panel noted that integrity, trust, and professional conduct are at the core of the practise of Pharmacy. The Panel pointed out that the practise of pharmacy is a privilege that carries with it significant obligations to the public, the profession, and to oneself. The Panel expressed its view that the Member's conduct was totally unacceptable to his fellow pharmacists and to the public.

Member: Marilyn Adamo (OCP #203872)

At a hearing on June 2, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Adamo with respect to the following:

- That she dispensed and/or allowed the pharmacy to dispense narcotics and/or controlled drugs to her spouse in breach of an undertaking entered into on January 7, 2013, from on or about February 1, 2013 to on or about December 31, 2013.
- That she failed to keep records as required of narcotic prescriptions, from on or about May 1, 2011 to on or about December 31, 2011, contrary to s. 40 of the Narcotic Control Regulations, C.R.C., c. 1041, as amended.

In particular, the Discipline Committee found that she

- failed to maintain a standard of practice of the profession;
- failed to keep records as required respecting her patients;
- contravened, while engaged in the practice of pharmacy, 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 s. 40 of the Narcotic Control Regulations, C.R.C., c. 1041, as amended;
- 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.

At the same hearing, the Panel also made findings of proprietary misconduct against Lifestyle Pharmacy and Candy Bar IDA and Ms. Adamo, as the sole director and shareholder of 2250556 Ontario Inc., the corporation that owns Lifestyle Pharmacy and Candy Bar IDA and the holder of Certificate of Accreditation #302189, with respect to the following:

- That they failed to take all reasonable steps that were necessary to protect narcotics, controlled drugs and targeted substances on the premises of the pharmacy or under their control against loss or theft or to take steps necessary to ensure their security, including failure to count and reconcile narcotics, controlled drugs and targeted substances at least every six months from on or about February 18, 2013 to on or about January 29, 2014;
- That they dispensed and/or allowing the pharmacy to dispense narcotics and/or controlled drugs to Ms. Adamo's spouse in breach of an undertaking entered into on January 7, 2013, from on or about December 1, 2013 to on or about January 28, 2014.

In particular, the Panel found that they

- contravened a law of Canada or Ontario or any municipal by-law with respect to the distribution, purchase, sale or dispensing of any drugs or product in a pharmacy, and in particular s. 43 of the Narcotic Control Regulations, C.R.C., c. 1041, as amended, under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, and/or s. G.03.012 of the Food and Drug Regulations, C.R.C., c. 870, as amended, to the Food and Drugs Act, R.S.C. 1985, c. F-27, as amended, and/or s. 7(1)(a) of the Benzodiazapines and Other Targeted Substances Regulations, S.O.R./2000-271 under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended;
- engaged in conduct or performed an act relevant to the business of a pharmacy that would reasonably be regarded by members as disgraceful or dishonourable.

The Panel imposed an Order which included as follows:

1. A reprimand

2. An Order directing the Registrar to suspend the Member's certificate of registration for a period of four (4) months, one (1) month of which shall be remitted if the Member complies with subparagraphs (c)(i) and (ii) of this Order by June 6, 2016.

3. an Order directing the Registrar to impose the following terms, conditions and limitations on the Member's certificate of registration:

   (i) the Member is to successfully complete the Professional Problem Based Ethics (ProBE) Program offered by the Center for Personalized Education for Physicians, with an unconditional pass, at the Member's own expense;

   (ii) the Member shall, at her own expense, attend at least two (2) mentoring sessions with a practice mentor selected by the College's Manager of Investigations and Resolutions ("Mentor") at the Mentor's primary place of practice, following the Member's own return to the practice of pharmacy.
   Prior to the mentoring sessions, the Member must provide the Mentor with the following:
      (a) a copy of both Notices of Hearing dated July 16, 2014 and August 5, 2014;
      (b) a copy of the Agreed Statement of Facts dated June 2, 2015;
      (c) a copy of the Joint submission on Order dated June 2, 2015;
      (d) a copy of the Discipline Committee's Decision and Reasons, when available; and
      (e) a copy of the Order of the Discipline Committee, when available.
   The Member's sessions with the Mentor shall address:
      (A) the Member's conduct as described in the Agreed Statement of Facts;
      (B) proper record keeping of narcotics, controlled drugs and targeted substances; and,
      (C) protection, including counting and reconciliation, of a pharmacy's inventory of narcotics, controlled drugs and targeted substances.
   At the conclusion of the mentoring sessions, the Member must provide a written direction to the Mentor to forward his or her report to the Registrar within thirty (30) days from the date of the last mentoring session. The Member's written direction to the Mentor shall specify that the Mentor's Report ("Report") shall:
      (i) confirm the dates of all sessions attended by the Member;
      (ii) confirm that the topics identified in subparagraphs (c)(ii)(A), (B) and (C) were covered with the Member; and,
      (iii) include an assessment as to whether the Member has the requisite skills and knowledge to complete regular counts and reconciliations of narcotics, controlled drugs and targeted substances inventory on her own.

   (iii) the Member shall not:
      (1) act as a Designated Manager in any pharmacy; or,
      (2) practise independently in the community;
      until the terms, conditions and limitations at paragraph (c)(i) and (ii) above are removed, as provided for in subparagraph (c)(vi) below;

   (iv) neither the Member nor the Pharmacy shall dispense narcotics, controlled drugs or targeted substances to the Member herself or her family members, including the Member's spouse;

   (v) the Member's practice is to be monitored by way of a maximum of four (4) unannounced inspections by a representative of the College during a twenty-four (24) month period commencing on July 6, 2016, at the Member's expense. The Member shall fully cooperate with these inspections and shall reimburse the College $600 for each inspection, to be paid immediately after each inspection. These monitoring inspections are in addition to any routine inspections conducted by the College pursuant to s. 148 of the Drug and Pharmacies Regulation Act, R.S.O. 1990 c. H.4, as amended;

   (vi) the terms, conditions and limitations referred to in subparagraphs (i), (ii) and (iii):
      (1) are in addition to, and apply irrespective of any other Order made by this Committee or any other Committee of the College; and,

(2) shall be removed when the Registrar receives both satisfactory confirmation of the Member's successful completion of the ProBE Program and a satisfactory Report confirming that the Member has the requisite skills and knowledge to complete regular counts and reconciliations of narcotics, controlled drugs and targeted substances inventory on her own.

(vii) The term, condition and limitation referred to in subparagraph (v) shall be automatically removed on July 6, 2018;

4. an Order requiring the Member to pay the College's costs fixed in the amount of $5,000.

The Panel reprimanded the Member as follows:

The province of Ontario is one of the few remaining jurisdictions where we have the privilege of being self regulated, and thus with this comes significant obligations to the public, the profession and to oneself. Through the Member's conduct, she failed in her obligations to adhere to the standards of practice.

It is necessary for the Panel to impress upon the Member the seriousness of her misconduct. The Panel also notes that she has acknowledged her professional and proprietary misconduct.

The Panel wished to make clear to the Member that, although the Order imposed is appropriate in relation to the findings, a more significant Order will likely be imposed by another Discipline panel in the event that she is ever found to have engaged in further professional misconduct.

Moving forward, it is the Panel's expectation that the remediation imposed by this Order as well as the consequences the Member has already incurred will be sufficient motivation to modify her behaviour and professional practise. And as such they do not expect to see her before another Discipline Panel of the College.

Member: Brian Hemens (OCP #603517)

At a hearing on June 17, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Hemens with respect to the following incidents:

- He was found guilty of knowingly using a forged prescription as though it were genuine, contrary to the Criminal Code, section 368(1)(a), on September 10, 2013; and
- He forged a prescription for 1,080 oxycodone 10mg IR tablets, altered patient records to support the forged prescription, and/or attempted to obtain narcotics for himself without a valid prescription in or about March 20-22, 2012.

In particular, the Panel found that he:

- was found guilty of an offence that is relevant to his suitability to practice;
- 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; and
- 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:
   - that the Member complete successfully with an unconditional pass, at his own expense and within 12 months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals;
   - that the Member remain in Part B of the College registry until other specified proceedings have been concluded;

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of six (6) months, with one(1) month of the suspension to be remitted on condition that the Member complete the remedial training as specified above; and

4.Costs to the College in the amount of $7,500.

In its reprimand, the Panel related that the Member, through his conduct, failed in his obligations to

uphold the standards of the practice and threatened the public confidence in the profession. The Panel pointed out that the Member's actions drew in other individuals. The Panel indicated that compliance with standards of practice and protection of the public is of paramount concern. The Panel expressed its expectation that the remediation imposed by this Order and the consequences already incurred will be sufficient motivation to modify the Member's behaviour and professional practise.

Member: Robert Button, R.Ph. (OCP #212276)

At a hearing on July 13, 2015 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Robert Button with respect to the following incidents:

- That he dispensed narcotics and other prescription drugs misappropriated from the Pharmacy, including morphine, Oxycontin, Tramadol, clonidine, clonazepam and/or temazepam, to patients and other persons, including H.K. (H.T.), T.M., E.S. and/or T.S., without authorization or record, in or about 2010-2012.

In particular, the Panel found that he

- failed to maintain a standard of practice of the profession
- failed to keep records as required respecting his patients
- contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and/or 156 of the Drug and Pharmacies Regulation Act , R.S.O. 1990, c. H-4, as amended
- contravened, while engaged in the practice of pharmacy, 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 4 and/or 5 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, sections 31, 37, 38 and/or 40 of the Narcotic Control Regulations, C.R.C., c.1041, as amended, sections 51, 52 and/or 53 of the Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000-271, and/or section 11 of the Narcotic Safety and Awareness Act, 2010, S.O. 2010 C.22
- knowingly permitted the premises in which a pharmacy was located to be used for unlawful purposes
- 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 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 shall complete successfully, at his own expense and within twelve (12) months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass;
   b) that the Member shall be prohibited, for a period of thirty six (36) months from the date of this Order, from having a proprietary interest in any pharmacy, or from acting as Designated Manager or narcotic signer at any pharmacy;
   c) for a period of thirty six (36) months from the date of this Order:
      i. the Member shall notify the College in writing of any employment in a pharmacy, which notification shall include the name and address of the employer and the date on which the Member began or is to begin employment, within seven (7) days of commencing such employment, and
      ii. the Member shall only work for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of the pharmacy to the College, within seven (7) days of the Member commencing employment at the pharmacy, that the Designated Manager received and reviewed a copy of the panel's decision and reasons in this matter before the Member commenced employment.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of seven months with two months of the suspension to be remitted on condition that the Member complete the remedial training exercises set out in subparagraph 2(a) above, as specified. The suspension shall commence on July 13, 2015 and run without interruption until December 13, 2015,

inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training exercises as specified in paragraph 2(a) above, the suspension shall continue from July 13, 2016 to September 13, 2016, inclusive.

4. Costs to the College in the amount of $3,500.00.

In its reprimand, the Panel pointed out that regardless of intent, there remain professional boundaries that simply cannot be crossed. The Panel related that the practice of medicine and pharmacy remain distinct, each with their own expertise and purpose. The Panel expressed its trust that the member has learned from the experience and will use this learning to better his practise.

Member: Mustafa Salem (OCP #604014)

At a hearing on July 14, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Mustafa Salem with respect to the following incident:

- That, on or about November 30, 2013, while working as a pharmacist at the Shoppers Drug Mart in Alliston, Ontario ("Pharmacy"), he misappropriated from the Pharmacy one or more controlled and/or prescription drugs.

In particular, the Panel found that he

- failed to maintain a standard of practice of the profession;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 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 C.01.041 and/or G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, as amended; section 4 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended; section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended; and/or section 51 of the Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000- 217, as amended;
- 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 as disgraceful, dishonourable or unprofessional.

(Note: Mr. Salem resigned his membership with the College on December 9, 2013.)

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose the following terms, conditions or limitation on Mr. Salem's Certificate of Registration if he successfully applies for registration with the College:
   a) Mr. Salem must complete successfully, with an unconditional pass, at his own expense and within 12 months of obtaining a Certificate of Registration, the ProBE Program on Ethics for Healthcare Professionals;
   b) Mr. Salem must complete successfully pass, at his own expense and within 24 months of obtaining a Certificate of Registration, the ProBE Plus Program on Ethics for Healthcare Professionals;
   c) Mr. Salem shall be prohibited for a period of five years from acting as a designated manager of any pharmacy;
   d) For a period of 12 months from the date Mr. Salem returns to active practice as a pharmacist in Ontario:
      i. he shall notify the College in writing of any employment in a pharmacy, which notification shall include the name and address of the employer and the date on which he began or is to begin employment, within seven days of commencing such employment, and
      ii. he shall only work for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of the pharmacy to the College, within seven days of him commencing employment at the pharmacy, that the Designated Manager received and reviewed a copy of the panel's decision and reasons in this matter before Mr. Salem commenced employment.

3. The Registrar to suspend Mr. Salem's Certificate of Registration for a period of five months, with one month of the suspension to be suspended on condition that the Member complete the

remedial training as specified in paragraphs 2(a) and 2(b), above. The suspension shall commence immediately on the date that Mr. Salem successfully applies for registration with the College and shall run without interruption for four months. If Mr. Salem is required to serve the one month remitted portion of the suspension because he fails to complete the remedial training as specified in paragraphs 2(a) and 2(b), the suspension shall continue for one month from the date the College is notified that Mr. Salem has not completed the remedial training specified in paragraphs 2(a) and 2(b).

4. Costs to the College in the amount of $2,500.00.

In its reprimand, the Panel observed that integrity and trust are paramount to the profession of pharmacy. The Panel expressed its disappointment in Mr. Salem's conduct. The Panel pointed out that pharmacy is a self-regulated profession and the practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession and to oneself. The Panel indicated its expectation that the remediation imposed in the Order will assist to modify Mr. Salem's behaviour and future professional practise.

Member: Essam Siha, R.Ph. (OCP #603717)

At a hearing on July 20, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Siha with respect to the following incidents:

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

In particular, the Panel found that:

- he failed to maintain a standard of practice of the profession;
- records relating to his practice were falsified;
- he submitted accounts or charges for services that he knew or reasonably ought to have known were false or misleading;
- he 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 Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder;
- he engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand

2. A suspension of 6 months with 1 month to be remitted provided the member completes the remediation set out below. The suspension is to commence n August 4, 2015, and continue until January 4, 2016, inclusive. If the remitted portion of the suspension is required because the Member fails to complete the remediation set out below, the balance of the suspension shall commence on July 20, 2016, and continue until August 20, 2016.

3. Directing the Registrar to impose terms, conditions or limitations on the Member's certificate of registration as follows:
   a. the Member must successfully complete with an unconditional pass, at his own expense and within 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 years from the date the Order is imposed, the Member shall be prohibited from:
      i. acting as a Designated Manager in any pharmacy; and
      ii. receiving any remuneration for his work as a pharmacist other than remuneration based on hourly or weekly rates only, or remuneration in respect of earnings by way of bonus or dividend as a result of holding an ownership interest in a pharmacy corporation;
   c. for a period of three 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

employer(s) within fourteen days of commencing employment in a pharmacy;

d. for a period of three years from the date the Order is imposed, the Member shall provide his employer with a copy of the Discipline Committee Panel's decision in this matter and its Order;
e. for a period of three 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 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

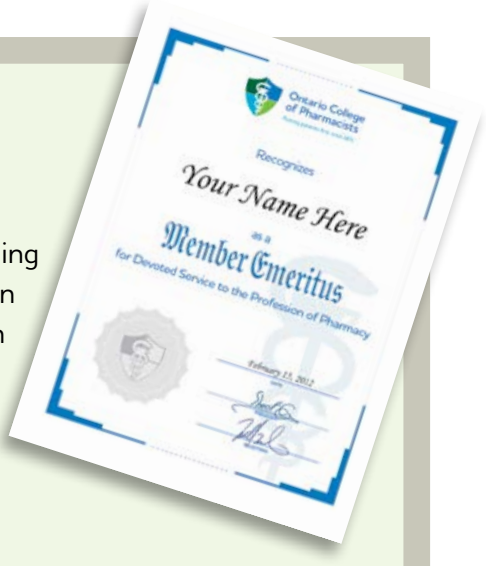
4. Costs to the College in the amount of $7000.

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy. The Panel related that it was necessary to impress upon the Member the seriousness of his misconduct and expressed its disappointment. The Panel pointed out that the practice of Pharmacy is a privilege that carries significant obligations to the public, the profession, and oneself. The Panel suggested that the Member's actions eroded trust and cast a shadow over his own integrity. The Panel expressed its hope that this hearing gave the opportunity to pause for reflection. PC

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

Members Emeritus

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



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

The College of Naturopaths of Ontario

August 24, 2015

Naturopathic Doctors Gain Prescribing Authority

On July 1, 2015, the *Naturopathy Act, 2007* was proclaimed, meaning naturopathic doctors (NDs) have come under the umbrella of the *Regulated Health Professions Act, 1991* and can now prescribe certain drugs.

NDs are now governed by the new College of Naturopaths of Ontario, and are authorized to prescribe, dispense, compound and sell a drug. NDs have a prescriber code, and ND prescriptions for eligible drugs are covered by the Ontario Drug Benefit Program.

The 23 drugs that NDs can prescribe can be found on Table 3 of the General Regulation or in the Professional Practice section of our website.

ND are responsible for knowing what they're authorized to prescribe. For the most part, the drugs on the list are natural health products that have been restricted by the federal government. The list was developed after extensive public consultations. It includes limitations such as dosage amounts, route of administration or the form of the drug that may be used (e.g. topical or suppository but not oral form).

Like all health care professionals, NDs are not automatically authorized to perform a new controlled act – they must first demonstrate their knowledge, skill and judgment to do so. To prescribe drugs safely and competently, all naturopaths must meet the Standard of Practice for Prescribing, which includes a Prescribing and Therapeutics course and exam. The training ensures NDs understand: 1) evidence-based therapeutic prescribing; 2) interactions between pharmaceuticals and natural substances; and 3) how to appropriately prescribe and use specific substances/medications to treat a variety of common conditions.

Any pharmacist who wants to learn about the scope of NDs, including their prescribing rights, can check our website or contact practice.advisor@collegeofnaturopaths.on.ca.

We want to acknowledge the Ontario College of Pharmacists for their guidance as we developed our rules around prescribing. The practice advisors from our two colleges have also been working collaboratively, with the mutual goal of ensuring the safety of patients.

Andrew Parr, CAE
Registrar & CEO

150 John St., 10th Floor, Toronto, ON M5V 3E3

FOCUS ON ERROR PREVENTION

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

VISUAL, HEARING OR COGNITIVE IMPAIRMENT MEDICATIONS

Many patients exhibit varying degrees of visual, hearing or cognitive impairment, and may therefore require specialized care to ensure the appropriate use of medications. CNIB estimates that approximately half a million Canadians are living with significant vision loss that impacts their quality of life[1]. In a recent survey, 5% of Canadians aged fifteen years and older reported having a hearing limitation[2]. Pharmacists must there be cognizant of the unique limitations and needs of these patients when providing pharmaceutical care.

CASE:

A twenty-seven year old patient with severe visual impairment has been taking Levetiracetam for epilepsy for an extended period of time. The initial dose prescribed was 1000mg in the morning and 1500mg at bedtime. The tablets are available in both the 500mg and 750mg strengths. The patient was therefore given the 500mg tablets and advised to take two tablets in the morning and three tablets at bedtime.

Her physician later increased the dose to 1500mg in the morning and 1500mg at bedtime. The 500mg strength tablets were again dispensed and the patient advised to take three tablets in the morning and three tablets at bedtime.

Following a visit to her physician, the patient was given a new prescription stating 1500mg to be taken in the morning and 1500mg at bedtime. The prescription was taken to her usual pharmacy for dispensing. On this occasion, the pharmacy assistant selected the 750mg strength tablets in an effort to reduce the number of tablets taken by the patient. The instructions on the prescription vial therefore indicated that the patient should take two tablets in the morning and two tablets at bedtime. The pharmacist checked the prescription and dispensed the 750mg tablets. No documentation was made regarding the change in tablet strength.

The patient later returned to pick up the medication. No counselling took place. It is believed that the patient indicated that she has been taking the medication for an extended period of time and did not require any additional information. However, no documentation was made.

Not being aware of the change in tablet strength, the patient continued to take three tablets twice daily. That is, a daily dose of 4500mg instead of the 3000mg prescribed daily dose.

After completing the dispensed tablets early, the patient requested a refill of the Levetiracetam tablets. Though the refill request was early, the pharmacist did not question the patient regarding the reason.

At some point, the patient's parents with whom she resides, noticed the change in tablets and contacted the pharmacy to discuss the issue.

Though the patient did not suffer any adverse effects, the patient and her parents were unhappy that the change was made without discussing the issue with either the patient or her parents.

POSSIBLE CONTRIBUTING FACTORS:

- The change in tablet strength was made by the pharmacy assistant without highlighting the change and the need to inform the patient.
- The pharmacist either did not notice the change in strength or did not take steps to ensure that the patient was made aware of the change.
- The visual impairment of the patient likely contributed to her inability to notice the change in the labelled instructions and the change in appearance of the new strength.
- The pharmacist did not inquire and/or document the reason for an early medication refill.

RECOMMENDATIONS:

- Always document changes in drug therapy and the reasons for making the change.
- Establish standards to ensure that all changes to a patients' medication regimen be discussed with the patient or caregiver. Document that the communication took place.
- Ensure patient counselling takes place or document why it did not occur.
- Always attempt to establish the reason for early or late refills. Document your findings. Pc

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.

REFERENCES

1. Fast Facts about Vision Loss. Available at: http://www.cnib.ca/en/about/media/vision-loss/pages/default.aspx (Accessed August 9th, 2015).
2. Facts on Hearing Limitations. Available at: http://www.statcan.gc.ca/pub/89-628-x/2009012/fs-fi/fs-fi-eng.htm (Accessed August 9th, 2015).

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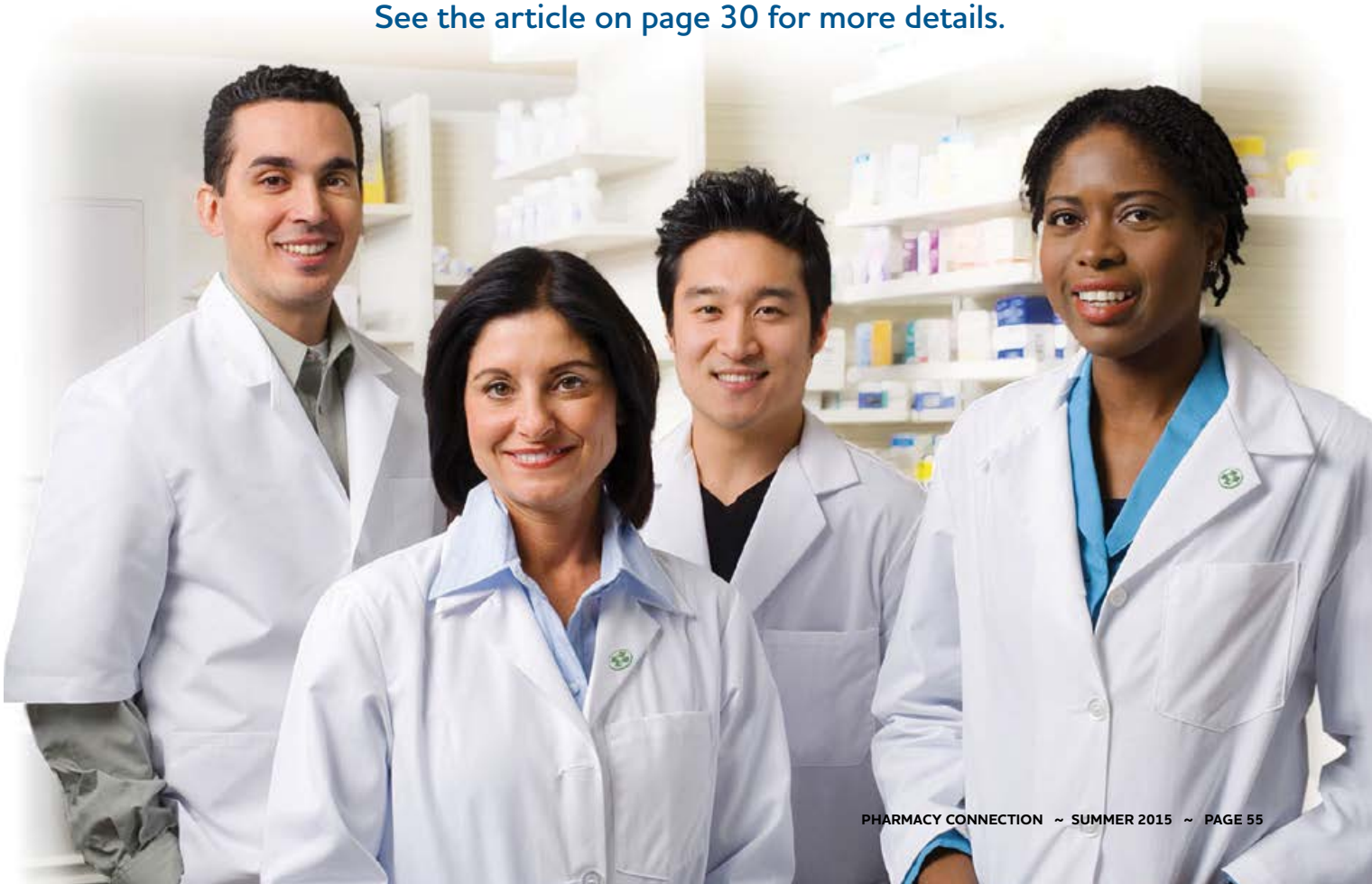
See the article on page 30 for more details.



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