Ontario College of Pharmacists
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PHARMACY CONNECTION

FALL 2018 • VOLUME 25 NUMBER 4
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THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

MOVING FORWARD

Medication Safety Program Rolls Out to All Community Pharmacies in Ontario 13

IN THIS ISSUE:

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COUNCIL MEMBERS

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

H Régis Vaillancourt
H Nadia Facca
K Esmail Merani
K Tracey Phillips
L Billy Cheung
L James Morrison
L Sony Poulose
M Mike Hannalah
M Kyro Maseh
M Laura Weyland (President)
N Tom Kontio
N Karen Riley
N Leigh Smith
P Rachelle Rocha
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TH Goran Petrovic

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PM Ravil Veli
PM Wes Vickers
U of T Christine Allen
U of W David Edwards

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

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

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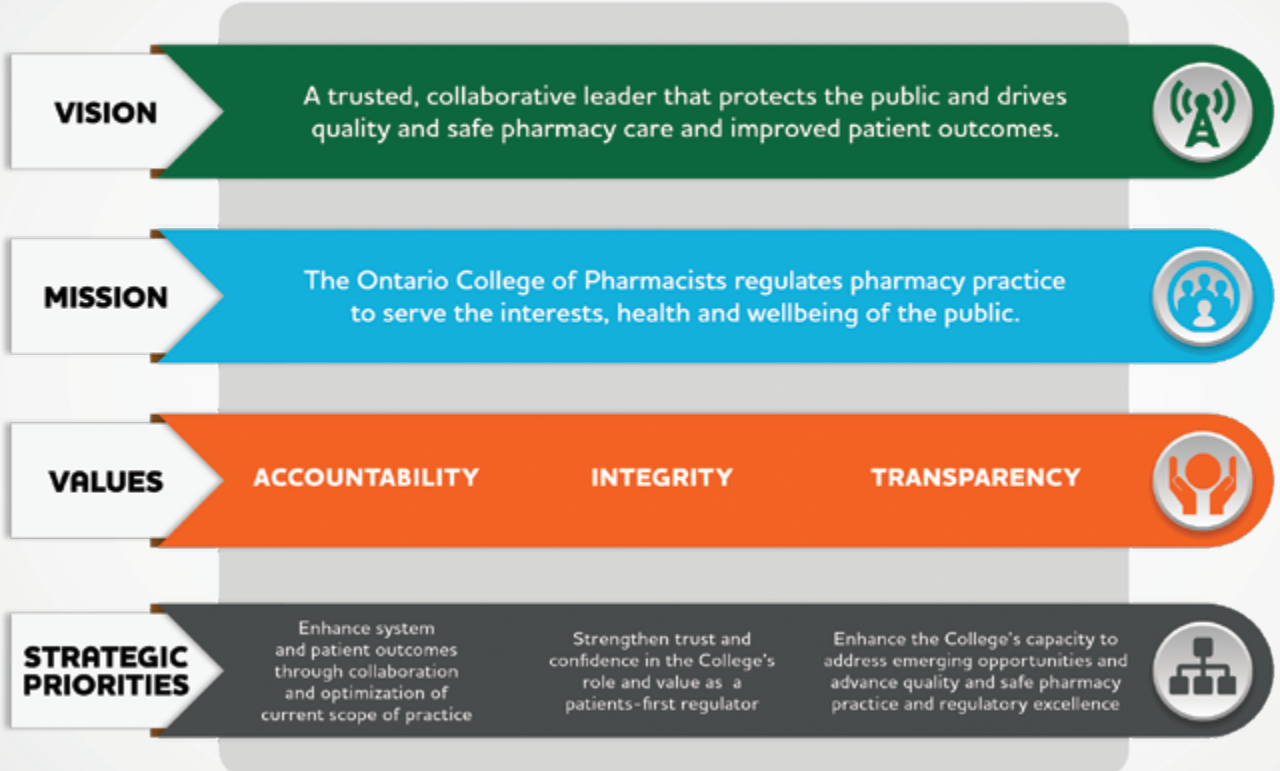
(2019-2021) OCP STRATEGIC FRAMEWORK



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

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

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

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PHARMACY CONNECTION

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CONTENTS

Laura Weyland,
R.Ph., B.Sc.Phm
President

Dear Colleagues,

In this, my first, letter as newly elected President of the Ontario College of Pharmacists, I'd like to start by expressing how much of an honour and privilege it is to serve on Council and to be involved with a regulator that has put patients first since the organization was founded nearly 150 years ago.

My time with the College in varying capacities since 2009 has been both professionally rewarding and personally gratifying. Serving in the public interest as a Council member, Committee member and now as President comes with a tremendous sense of responsibility as I truly believe in the public-protection mandate of the College and in the important role pharmacy professionals play in the lives of patients and the health of our communities. I am very much looking forward to the year ahead as the College takes on some important issues that will help further influence the quality and safety of pharmacy practice in the province in support of its new *Strategic Plan*.

No one will argue that patient safety is top of mind for everyone who works in healthcare, whether you work in a community or hospital pharmacy, or as a pharmacist or pharmacy technician. We all contribute to making our pharmacy system safer; it is a cornerstone of our professionalism and it is one that each of us must hold ourselves and each other accountable to.

As you all should know by now, the College's *Medication Safety Program* – known formally as the *Assurance and Improvement in Medication Safety (AIMS) Program* – is being rolled out to community pharmacies across the province. The milestone that we have now reached with such an incredibly important patient safety program would not have been possible without the insights provided by the public and pharmacy professionals and without the direct contributions of ambassador pharmacies which helped contribute to the development and refinement of the program leading up to the province wide roll out. Read more about the province-wide implementation of this mandatory medication safety program in this issue of *Pharmacy Connection*.

The privilege to care for the people of our community is one of, if not the top, reasons why pharmacists and pharmacy technicians chose to practice pharmacy and it is one of the traits that defines our professionalism. The *AIMS Program* is just one of the many examples of how the College relies on the perspectives, expertise and insights of those who provide care, and those who receive care, to improve the overall safety and confidence in pharmacy in the province.

> "I truly believe that pharmacy professionals have a lot to contribute to the College and the profession and that their diverse perspectives and experiences from all walks of life is a strength – one that we must continue to tap into in order to respond to society's evolving expectations of regulators and those entrusted to provide quality, safe and ethical healthcare to the people of Ontario."

For this reason, I strongly encourage you all to continue to seek and respond to opportunities to be involved with the College, to provide your constructive insights, expertise and perspectives on College or other broader professional activities and initiatives, and to be both an informed and engaged participant in pharmacy regulation in the province. This includes reading *eConnect* and *Pharmacy Connection*, visiting the website, providing input on consultations and participating in committees and ongoing engagement opportunities, from webinars and focus groups, to regional meetings (you'll hear more about the College's Spring 2019 regional meetings very soon).

I truly believe that pharmacy professionals have a lot to contribute to the College and the profession and that their diverse perspectives and experiences from all walks of life is a strength – one that we must continue to tap into in order to respond to society's evolving expectations of regulators and those entrusted to provide quality, safe and ethical healthcare to the people of Ontario.

Yours in health,

Laura Weyland

SEPTEMBER 2018 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held on September 17th and 18th, 2018.

COUNCIL ELECTIONS FOR 2018-2019 COUNCIL TERM

Following elections held earlier in August, Council welcomed newly elected member Mr. Tom Kontio (District N). Re-elected to Council were: Ms. Karen Riley (District N) and Ms. Leigh Smith (District N), Ms. Nadia Facca (District H) and Dr. Régis Vaillancourt (District H). Dr. Christine Allen, interim Dean, Leslie Dan Faculty of Pharmacy, University of Toronto, was appointed to serve on Council beginning July 1, 2018.

Each September, Council holds elections for the positions of President, Vice President, Executive and Committee Chairs. We are pleased to announce that Ms. Laura Weyland was elected College President and Mr. Doug Stewart was elected Vice-President. Other members elected to the Executive Committee were Mr. Billy Cheung (District L), and public members Ms. Kathy Al-Zand, Ms. Christine Henderson and Ms. Sylvia Moustacalis. (The past president position will be held by Dr. Régis Vaillancourt).

We are also pleased to announce the following Committee Chairs:

- Executive – Laura Weyland
- Accreditation and Drug Preparation Premises – Régis Vaillancourt
- Discipline – Christine Henderson
- Finance and Audit – Dan Stapleton
- Fitness to Practise – Karen Riley
- Inquiries, Complaints and Reports – Rachelle Rocha
- Patient Relations – Linda Bracken
- Quality Assurance – Tracey Phillips
- Registration – Ravil Veli

A complete list of Committee membership has been posted to the public website.

2019 CAPITAL AND OPERATING BUDGET AND AUDITOR APPOINTMENT

Council approved the College's operational budget for 2019, which includes new spending required to support the Strategic Plan developed by Council in March 2018. The College's 2019 budget proposes increases to fees in all categories of registrants and pharmacies. Fee increases to support the budget will take effect January 1, 2019; however, the required increase for registrant renewal fees will be phased-in over two years.

Below are the proposed changes:

Type	Adjusted Annual Fees $
Pharmacist	600 to 675 (2019) 675 to 750 (2020)
Pharmacy Technician	400 to 450 (2019) 450 to 500 (2020)
Community Pharmacy	940 to 1,175 (2019)
Hospital Pharmacy	3,500 to 4,375 (2019)
Registration Fee	300 to 375 (2019)

In establishing the fees, Council acknowledged that registrant fees have not been increased in nine years, due, in part, to the growth in registrants. Council also noted that had registrant fees increased annually by cost of living (2.5%), they would have surpassed the amount being proposed for 2019. Further, Council noted that fees in Ontario will remain the lowest across the country when compared to other pharmacy colleges and will also be at the lower end of other health profession fees in the province.

The decision to increase fees was made after much thought and analysis. The College has a duty to regulate pharmacy practice in the public interest and

to make sure that its programs and operations are fully funded in order to meet its responsibilities. It also has an obligation to use its resources wisely and to be a good fiscal steward in how it plans and delivers on its mandate year over year. This is a commitment that the College and its governing Council take very seriously, just as it does its public protection mandate.

Council approved the appointment of Tinkham & Associates LLP Chartered Accountants as Auditor for the College for the fiscal year 2018 and that services be taken to market in 2019.

BYLAW AMENDMENTS FOR CIRCULATION

Council approved bylaw amendments required to update the fee schedules, the public register and membership classes. There were also housekeeping bylaw amendments that had accumulated since the last review and revision in 2015 that have now been addressed. According to Section 94(2) of the Health Professions Procedural Code, these amendments will be circulated to registrants prior to final Council approval (December 2018).

For further details, and to participate in the consultation, please go to Consultations page of the website.

PRACTICE AND OPERATION STANDARDS APPROVED

Following open consultation and a review of feedback from the public, pharmacy professionals and other stakeholders, Council approved the supplemental Standard of Practice which provides guidance on the expectations of pharmacists and pharmacy technicians related to the College's Medication Safety Program. The College launched this important patient safety program to help reduce the risk of harm caused by medication errors and near misses by helping to identify medication incident trends and promoting continuous quality improvement in pharmacy practice through shared learning. This supplemental standard enhances the existing Model Standards of Practice outlined by the National Association of Pharmacy Regulatory Authorities.

Additionally, implementation of the Medication Safety Program will be reinforced in the pharmacy through the Standards of Operation, which were circulated concurrently, and were also approved by Council.

NEXT COUNCIL MEETING

Monday, December 10, 2018

Council meetings are open to the public and are held in the Council Chambers of the College at 483 Huron Street, Toronto, ON M5R 2R4. If you plan to attend, or for more information, please email council@ocpinfo.com. You can also follow along via Twitter during Council meetings.

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Ontario College of Pharmacists

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COUNCIL

2018/2019

2018/2019 Committee Appointments

Accreditation and Drug Preparation Premises

Council Members:
Regis Vaillancourt (Chair)
Elnora Magboo
Kyro Maseh
Joan A. Pajunen
Goran Petrovic
Rachelle Rocha
Joy Sommerfreund

Non-Council Members:
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Tracy Wiersema
Ali Zohouri

Staff Resource: Katryna Spadafore

Executive

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Regis Vaillancourt – Past President
Doug Stewart – Vice President
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Billy Cheung
Christine Henderson
Sylvia Moustacalis

Staff Resource: Nancy Lum-Wilson

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Esmail Merani
Doug Stewart
Regis Vaillancourt

Staff Resource: Connie Campbell

Fitness to Practise

Council Members:
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Kathy Al-Zand
James Morrison
Wes Vickers

Non-Council Members:
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Staff Resource:
Genevieve Plummer

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Council Members:
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Kathy Al-Zand
Azeem Khan
Kyro Maseh
Sylvia Moustacalis
Karen Riley

Non-Council Members:
Kshitij Mistry

Staff Resource: Todd Leach

Discipline

Council Members:
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Kathy Al-Zand
Linda Bracken
Nadia Facca
Azeem Khan
Tom Kontio
Sylvia Moustacalis
James Morrison
Ruth-Ann Plaxton
Sony Poulose
Karen Riley
Leigh Smith
Dan Stapleton
Doug Stewart
Ravil Veli
Wes Vickers

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Jennifer Antunes
Susan Blanchard
Fel dePadua
Dina Dichek
Jim Gay
Jillian Grocholsky
Jane Hilliard
Katherine Lee
Chris Leung
Beth Li
Doris Nessim
Don Organ
Jeannette Schindler
Connie Sellors
David Windross

Staff Resource: Anne Resnick

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Linda Bracken
Nadia Facca
Elnora Magboo
Joan A. Pajunen
Ruth-Ann Plaxton
Leigh Smith

Non-Council Members:
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Sarosh Tamboli
Mardi Teeple

Staff Resource: Susan James

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Council Members:
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Kathy Al-Zand
Christine Allen
Linda Bracken
Billy Cheung
Mike Hannalah
Azeem Khan
Tom Kontio
Elnora Magboo
James Morrison
Sylvia Moustacalis
Joan A. Pajunen
Goran Petrovic
Sony Poulose
Leigh Smith
Joy Sommerfreund
Dan Stapleton
Ravil Velii

Non-Council Members:
Elaine Akers
Sajjad Giby
Frank Hack
Bonnie Hauser
Wassim Houneini
Mary Joy
Rachel Koehler
Elizabeth Kozyra
Chris Leung
Jon MacDonald
Dean Miller
Vyom Panditpautra
Aska Patel
Chintan Patel
Saheed Rashid
Dan Stringer
Frank Tee
Tracy Wiersema

Staff Resource: Katryna Spadafore

Registration

Council Members:
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Linda Bracken
Mike Hannalah
Esmail Merani
Sylvia Moustacalis

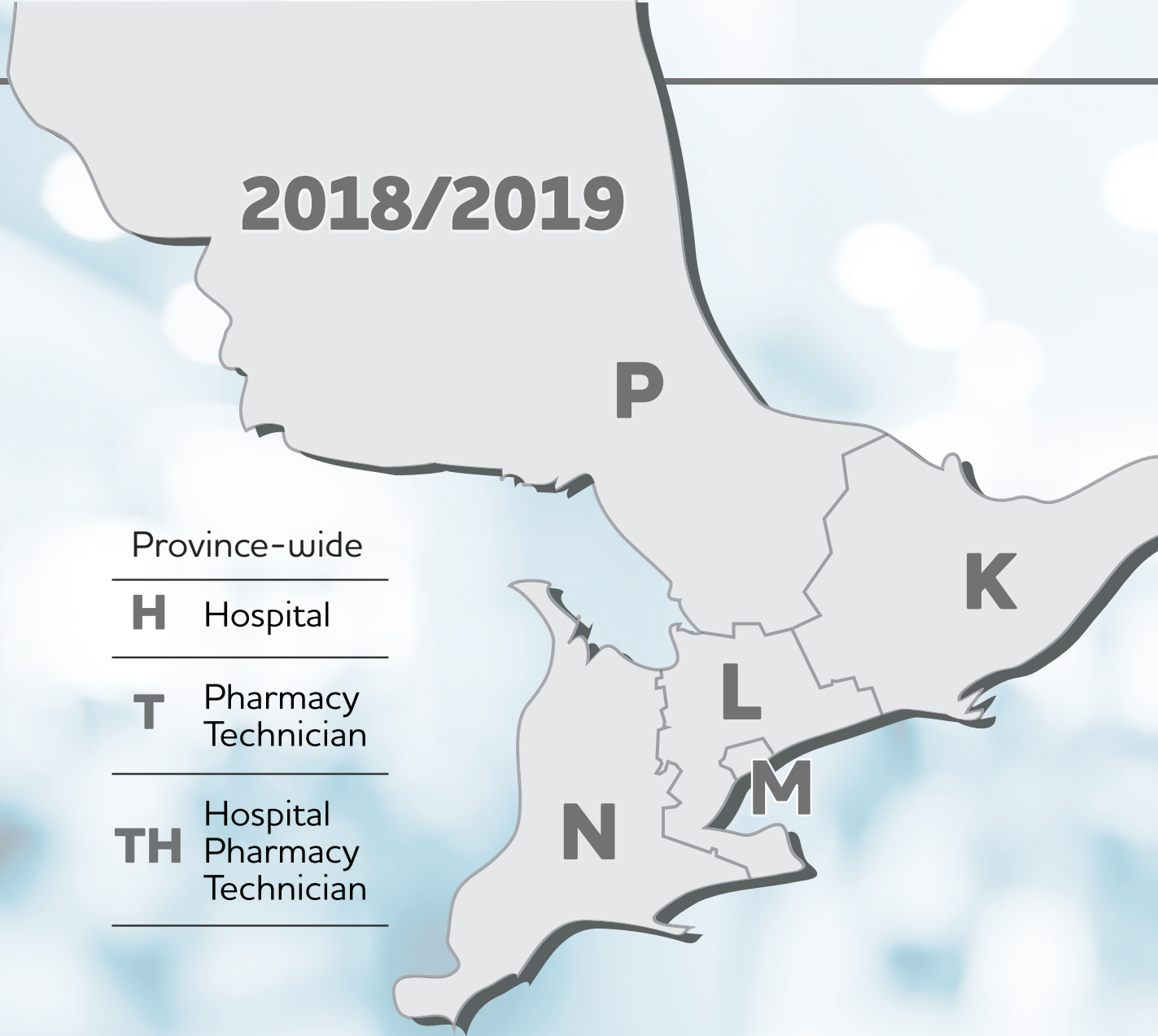
Non-Council Members:
Tammy Cassin
Edward Odumodu
Deep Patel

Dean:
Dave Edwards

Ontario Pharm Tech Program Rep:
Sharon Lee

Staff Resource: Sandra Winkelbauer

2018/2019



Province-wide

H	Hospital
T	Pharmacy Technician
TH	Hospital Pharmacy Technician

PUBLIC MEMBERS

Kathy Al-Zand
Ottawa

Linda Bracken
Marmora

Christine Henderson
Toronto

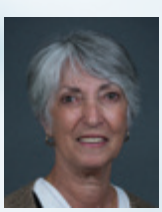
Azeem Khan

James MacLaggan
Bowmanville

Elnora Magboo
Brampton

Sylvia Moustacalis
Toronto

Joan A Pajunen
Kilworthy



Joy Sommerfreund

Dan Stapleton
Toronto

Ravil Veli
North Bay

Wes Vickers
LaSalle

ELECTED MEMBERS

District **H**

Nadia Facca
London

Régis Vaillancourt
PAST PRESIDENT
Ottawa

District **K**

Esmail Merani
Carleton Place

Tracey Phillips
Westport

District **L**

Billy Cheung
Markham

James Morrison
Burlington

Sony Poulose
Hamilton

District **M**

Mike Hannalah
Toronto

Kyro Maseh
Toronto

Laura Weyland
PRESIDENT
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District **N**

Tom Kontio
London

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Sarnia

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Espanola

Douglas Stewart
VICE-PRESIDENT
Sudbury

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University of Toronto

David Edwards
Hallman Director
School of Pharmacy
University of Waterloo

District **T/TH**

Ruth-Ann Plaxton (T)
Owen Sound

Goran Petrovic (TH)
Kitchener

This feature in *Pharmacy Connection* is a place to find information about news stories we're following. Here, you'll read summaries of recent stories relating to pharmacy in Ontario and Canada. For the latest updates, stay tuned to e-Connect and www.ocpinfo.com

IMPROVED VACCINE MATCH FOR THIS YEAR'S FLU STRAINS

Health officials believe they have created a vaccine that's more effective against the season's major flu strains than last year's shot.

The Canadian Sentinel Practitioner Surveillance Network, which researches the annual efficacy of the vaccine, found last year's shot was only 17 per cent effective in preventing respiratory illness from H3N2 (the dominant A strain of influenza) in the overall population. It was found to be only 10 per cent effective for adults aged 20 to 64. It was better at warding off respiratory illness caused by the dominant B strain of influenza; about 55 per cent effective.

According to the Public Health Agency of Canada's FluWatch, there were 64,403 lab-confirmed cases of influenza in Canada last season, mostly Influenza A/H3N2. There were 302 deaths directly attributed to influenza, including nine children.

HIGH RATES OF ANTIBIOTIC USE IN ONTARIO RAISE CONCERNS: STUDY

New research suggests Ontario is seeing a high rate of prescribed antibiotics, which could lead to an increase in drug-resistant infections.

In a study, Public Health Ontario examined the number of antibiotic prescriptions given across 14 health regions in the province from March, 2016 to February, 2017. The research team found that there were as many as 778 antibiotic prescriptions filled for every 1,000 residents in a region of southwest Ontario.

In total, patients in Ontario were prescribed more than 8.3 million antibiotic treatments during the 12-month study period.

CAMPAIGN TO CONNECT CANADIANS WITH DIGITAL HEALTH RECORDS

Canada Health Infoway has launched its "Access 2022" campaign, designed to encourage digital access to health information and e-services. A key goal of the campaign is to work towards a health system that is integrated, secure, innovative, and focused on improving health outcomes As a result of investments in digital health initiatives, Canada Health Infoway estimates that Canadians and the healthcare system have benefited from over $26 billion in cost savings and efficiencies since 2017.

ACCESS TO CANNABIS FOR MEDICAL PURPOSES REGULATIONS (ACMPR) TO REMAIN IN PLACE FOR AT LEAST FIVE MORE YEARS

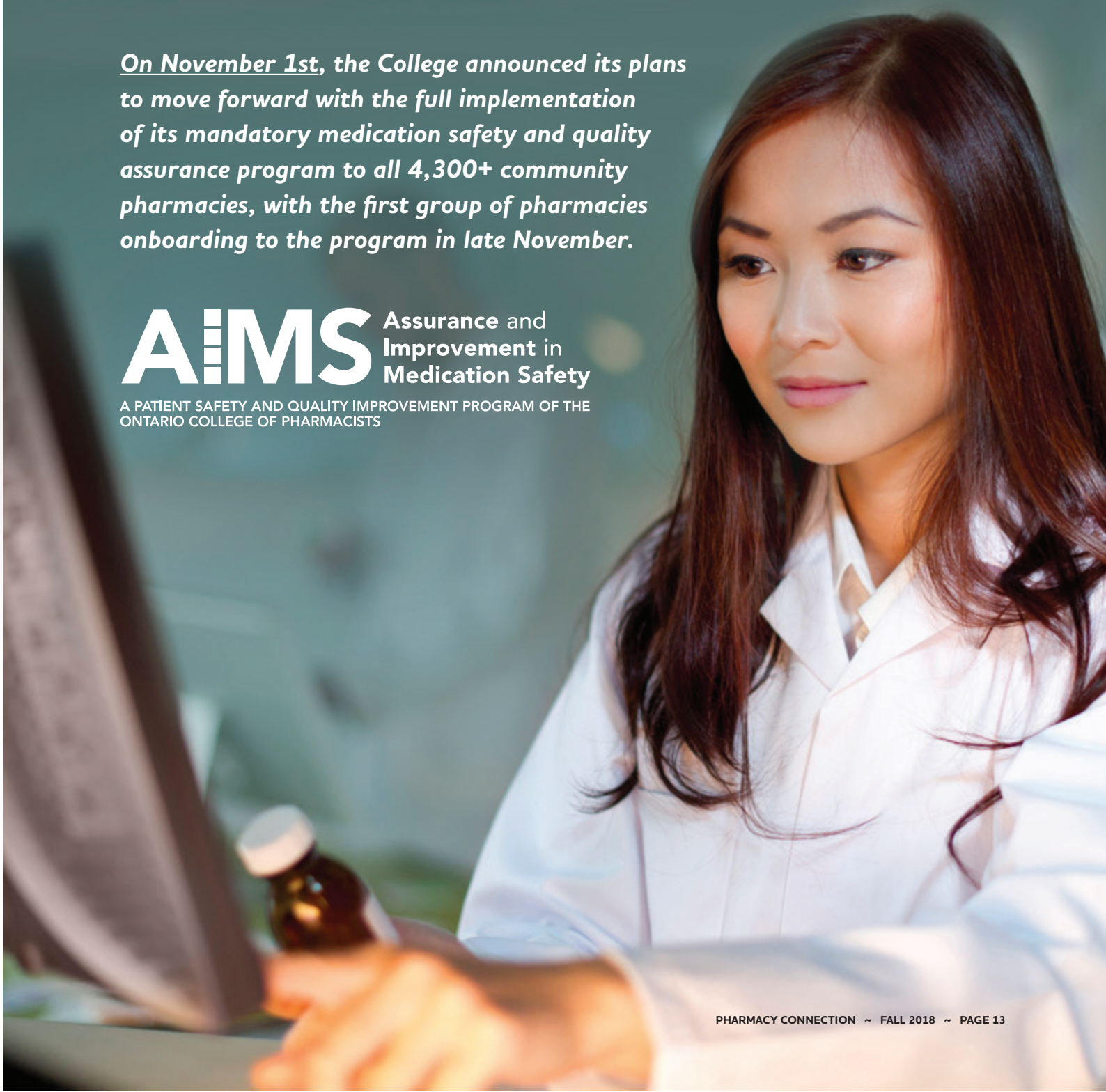
In September, Health Canada announced that Canada's existing medical marijuana system will remain in place for at least five years but will be reviewed at some point within that five year period. In a statement, Health Canada said that "measures under the *Cannabis Act* aim to facilitate research with the goal of improving our knowledge of the risks and benefits of cannabis" and that increased research "could lead to new drug submissions of cannabis-based products for market authorization as drugs."

MOVING FORWARD:
Medication Safety Program Rolls Out to All Community Pharmacies in Ontario

On November 1st, the College announced its plans to move forward with the full implementation of its mandatory medication safety and quality assurance program to all 4,300+ community pharmacies, with the first group of pharmacies onboarding to the program in late November.

AIMS **Assurance** and **Improvement** in **Medication Safety**

A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS



The province-wide roll out follows a nine-month preliminary phase in which the College worked with approximately 100 pharmacies, who tested and provided feedback on the program prior to full implementation. Once all community pharmacies have onboarded to the program by mid-2019, it will be the largest program of its kind in Canada.

Now known formally as ***AIMS (Assurance and Improvement in Medication Safety)***, the College's medication safety and quality assurance program supports continuous improvement and puts in place a mandatory consistent standard for medication safety for all pharmacies across the province. The goal of the program is to enhance patient safety and reduce the risk of patient harm caused by medication incidents in, or involving, pharmacies.

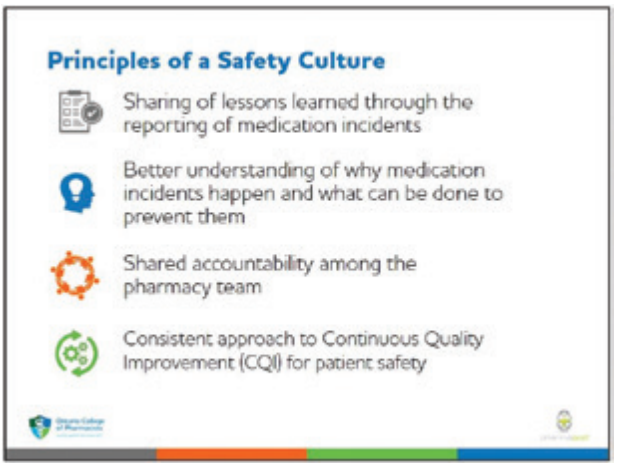
Through a better understanding of trends associated with recorded incidents including how and why they occur, the College, pharmacies and health system partners will be able to identify solutions and recommendations to prevent those incidents from recurring and to share these learnings province wide, and beyond.

"Moving forward with the full province-wide implementation of our medication safety program is an important milestone for patient safety, not just for the College, but for pharmacy and for the people of Ontario who rely on the safe high-quality care provided by pharmacy professionals every day," says Nancy Lum-Wilson, CEO and Registrar, Ontario College of Pharmacists.

"This is the first structured program in Ontario specific to pharmacy that will lead to an improved understanding of the number, type, frequency, impact and cause of medication incidents," she adds. "It establishes a standardized approach and expectations related to quality improvement and will help identify trends that will lead to system-wide recommendations to reduce the risk of medication incidents across the province."

The power of data and continuous quality improvement in incident prevention

There has always been an expectation that pharmacies are engaging in continuous quality improvement. The AIMS Program brings structure and clarity around the College's expectations regarding the handling of medication incidents, including near misses, and how lessons learned from such incidents can be used to improve the safety and quality of pharmacy care.



A sample slide from the AIMS Program e-training module explaining the significance of a just culture, one of the program's foundational principles.

Once fully onboarded to the AIMS Program, pharmacy professionals will be required to begin anonymously recording medication incidents and near misses via the third party incident-recording platform managed by the College's program partner, Pharmapod. Utilizing both a preventative approach through proactive reviews of work processes to identify areas of risk and retrospective reviews of specific medication incidents, the program enables pharmacists and pharmacy technicians to learn from medication incidents and better understand why they happen and how they can be prevented.

This is a critical component of the AIMS Program as it will lead to the collection and analysis of medication incident data to support improvements at the pharmacy level. Ultimately, through data sent to the College in an aggregate, non-identifiable form, data will be used to identify trends and areas of risk and provide appropriate guidance to pharmacy professionals across the province.

"There is always a patient at the end of every prescription. As part of a patient's healthcare team, pharmacy professionals have one of the most important roles to play when it comes to patient safety and reducing the risk of preventable harm caused by medication errors," says Melissa Sheldrick, a valued member of the Medication Safety Task Force, patient safety advocate and mother of Andrew Sheldrick, who tragically passed away following a medication error. "I am pleased that the College is now moving into this final phase and that it acted quickly yet thoughtfully to develop and implement a program in Ontario that will contribute to safer pharmacy care."

What pharmacies can expect as they onboard

Community pharmacies will be onboarded to the program over the next six to eight months, with the first of several groups of pharmacies commencing their onboarding in late November; the remaining groups are expected to be onboarded between January and May of 2019. Designated Managers (DMs) will receive advance notification prior to the planned onboarding of their pharmacies to allow for team planning and preparation and will be provided additional information and instructions on how to prepare for this process.

> "Moving forward with the full province-wide implementation of our medication safety program is an important milestone for patient safety, not just for the College, but for pharmacy and for the people of Ontario who rely on the safe high-quality care provided by pharmacy professionals every day,"

Pharmacies can expect to receive ongoing support, guidance and regular information from the College and Pharmapod throughout the entire onboarding process. Training resources will be available through the platform via short web-based modules. Where possible, pharmacies that belong to the same chains will have the same roll-out date to allow for an opportunity to consolidate efforts.

Resources for Pharmacies and Professionals

In addition to the tools and resources that pharmacies will have access to as they onboard to the program, the College has also published a number of other resources. Visit the AIMS Program section of the website under Regulations and Standards where you will find a number of resources including:

- FAQs for pharmacies (related to onboarding and other program/operational details) and general FAQs for both the public and pharmacy professionals
- Information regarding the Supplemental Standard of Practice and Standards of Operation
- Links to previous *Pharmacy Connection* articles, including the last issue which featured the experience of Ambassador sites as they onboarded to the program
- Ongoing updates from the College
- Background information about the program and our medication safety journey

More information and resources will be added to the website, including additional updates to the FAQs as pharmacies onboard to the program, so it is important that you check back often.

At this time, implementation of the AIMS Program is focused on community pharmacies. Hospitals already have well-established mechanisms related to incident reporting and quality improvement, and should for now continue to engage and participate in incident recording and CQI initiatives.

Please read the information under the Foundations of Safety article in this issue of Pharmacy Connection that confirms the expectations of pharmacy professionals and DMs of both hospital and community pharmacies regarding medication safety and continuous quality improvement.

Questions?

Questions regarding the AIMS Program can be directed to medicationsafety@ocpinfo.com.

Quality Indicators FOR PHARMACY

How do we define quality in pharmacy? How do we measure pharmacy's impact on patient outcomes? And how do we all – the regulator, pharmacy professionals, government and other stakeholders – monitor pharmacy's impact on health system performance, make evidence-informed improvements and demonstrate the value of our collective work to patients?

This past year, the College and Health Quality Ontario (HQO), the provincial advisor on health care quality, came together to set the stage for the development of a set of standardized and system-focused indicators for pharmacy. Establishing these indicators will help answer important questions related to the quality of pharmacy practice and its impact on patient outcomes and the overall quality of our health system in the province.

As first shared with you in the Summer 2018 issue of *Pharmacy Connection*, the College is collaborating with Health Quality Ontario (HQO) to establish a set of quality indicators for pharmacy that will ultimately promote a **culture of quality improvement** within the profession of pharmacy and improve **public transparency** about the impact of pharmacy on patient outcomes.

Pharmacy professionals, like other healthcare professionals, play an active part in providing quality and safe care to patients while contributing to solutions to address common quality challenges experienced throughout our health system. Safe transitions of care, the opioid crisis, medication-related adverse events and antimicrobial resistance are just a few examples where pharmacy can play an increasingly valuable role in our health system, while continuing to contribute directly to a patient's health goals. However, at this time there is no way to measure pharmacy's impact on these issues.

The College is the regulating body for the profession of pharmacy in Ontario. As part of its duty to serve and protect the public, it is important to understand the quality of pharmacy care in Ontario, and its impact on the health system.

Developing system-focused pharmacy indicators will not only help establish pharmacy within the province's quality health care agenda, it will promote a better understanding of the performance and impact of pharmacy on patient outcomes and on broader health system quality priorities and challenges. The adoption of a common set of indicators will lead to better data on which to make evidence-informed decisions to guide improvements in areas such as clinical practice, care models or standards and to help identify solutions that ultimately promote high-quality and safe patient care for all Ontarians.

BUILDING MOMENTUM THROUGH COLLABORATION

In June 2018, the College and HQO co-hosted a roundtable that brought together stakeholders from pharmacy, academia, health system and government agencies and patient advocates to develop a synopsis document to determine how to proceed and what areas to focus on as the indicators are developed. Following the roundtable session, the College and HQO established an expert panel to achieve consensus on a preliminary set of indicators. The panel met in early November and will continue to deliberate until the final set of indicators is selected. Patients and the pharmacy sector will remain involved in patient and sector engagement sessions to provide feedback to the panel.

The first pharmacy sector engagement session took place as an interactive webinar earlier in November where 50 participants heard about the indicator initiative and the progress to date. The College benefited greatly from the exercise which generated a positive dialogue among participants who had a number of questions about the initiative, its impact on them as professionals and how it differs from other indicator work being conducted by other organizations but for very different purposes.

Following this exercise the College is working on publishing a comprehensive FAQ resource that will be posted on the website. Until then, *Pharmacy Connection* has published a sampling of those FAQs here.

Q – Why are these indicators only focused on community pharmacy?

A – There has already been a lot of work done to establish indicators in hospital pharmacy, including the successful efforts of the Canadian Society for Hospital Pharmacists. The expert panel is familiar with this work and the College will align with this work wherever possible. However, for now, the primary gap is in community pharmacy and this will be the main focus of the indicators work.

Q – How do the College's quality indicators differ from other indicators, such as those being established by insurance providers?

A – The quality indicators for pharmacy that the College is developing are not intended to be used for quality assurance or to determine reimbursement. They are solely intended to provide the public and pharmacy sector with information about the overall quality of pharmacy care and to support the sector in gaining a better understanding of pharmacy's impact on patient outcomes. The College acknowledges that there are other indicators in development by other organizations. While it intends to learn from other such initiatives, it has no intention of overloading the sector with too many indicators and would explore potential alignment opportunities only if it aligns with the College's goals.

Q - What will the indicators be used for? Will information be shared with the public? Will the public see how my pharmacy's indicator performance compares to others?

A - The quality indicators will be used for quality improvement within the sector, improving broader public transparency about the impact of pharmacy practice and establishing pharmacy within the **broader health system**. Pharmacist and pharmacy-specific data will **not** be shared publicly. Only aggregate provincial/regional level data will be made public.

Q – Will the quality indicators be used to assess individual pharmacists?

A – This initiative is not about tracking the performance of individual pharmacists or for quality assurance or reimbursement. The initial function of these indicators is to leverage public reporting at a system level while striving for continuous quality improvement. Once the system level indicators are identified, efforts will be made to work with pharmacy practice to determine which measures, data, and supports can be shared with pharmacies to support quality improvement efforts.

Q - How will the indicators get chosen?

A - Roundtable participants selected indicator themes based on measurement areas where pharmacy can have an impact and where reporting on quality of pharmacy care can be done in a way that is important to patients and providers. The indicator measurement areas identified included:

- Patient/caregiver experience & outcomes
- Provider (i.e Pharmacy professional) experience
- Appropriateness of dispensed medications
- Medication-related hospital visits
- Transitions of care

The expert panel will continue to deliberate and use feedback from sector and patient engagement sessions to shortlist a set of quality indicators for pharmacy within the measurement areas identified above.

PATIENTS AND PHARMACY WILL BENEFIT FROM DEVELOPMENT OF QUALITY INDICATORS

by Nancy Lum-Wilson, CEO and Registrar

I've often commented that we can't improve what we can't measure. Many of the initiatives you will have seen or heard about coming from the College over the past two years focus on data and measurement to inform our decision making. And for good reason: because it's the only way to quantify the impact of pharmaceutical care and it's the right thing to do for patients.

As health professionals, we're all committed to providing high quality patient care and to looking at ways that we can improve what we do, and how we do it, to make sure patients receive the best, safest care possible. As a regulator, we are driven by the desire to be responsive to societal expectations, to be a collaborative and influential contributor to quality and safe patient care in the province, and to use data and information to guide our decisions and improve upon our own work to satisfy our fiduciary responsibilities.

When we first initiated our work on the development of quality indicators for pharmacy with Health Quality Ontario back in the fall of 2017, we did so with the understanding that this was, in many ways, new territory not just for us as a regulator but also for pharmacy. But we felt it was more important than ever that we take the lead and work collaboratively with pharmacy professionals and our broader health system partners to move forward with this exciting work that will undoubtedly help shape and strengthen the quality of pharmacy care in the province for the future.

The roundtable exercise we held last summer was a validation that pharmacy, the health system and regulatory stakeholders see tremendous value in the development of quality indicators for pharmacy. It will equip us – including the public – with the information we all need to understand our work better, and what we can do to continually improve.

While we understand that a number of companies such as Green Shield are developing their own set of indicators for reimbursement, the motivation of the College to develop a common set of outcome indicators for pharmacy is entirely different. To be clear, this initiative is about improving patient and health system outcomes. It is about establishing a way for all of us – as a system and as a sector – to measure the impact of pharmacy care on patient outcomes and using this knowledge to improve the care that we provide. For example, we can use measures to understand the impact of pharmacist involvement in transitions of care, or in reducing medication incidents on emergency room usage, or even on reducing the devastation from the opioid crisis that Ontario currently finds itself in.

That is truly an important goal for us as a regulator, and indeed for all of you. And it is one that we are proud to lead together with our health system partners and the 20,000 pharmacy professionals who care for patients every day in Ontario.

As we move this work forward, we will be implementing even more opportunities to engage and involve pharmacy professionals on this initiative. Please be sure to follow the latest news from the College. If you have any questions in the meantime, feel free to email the Policy team directly at pharmacypractice@ocpinfo.com.

Sincerely,
Nancy

ENHANCING KNOWLEDGE, PROTECTING PATIENTS

An Update On Cannabis Education

The *Cannabis Act* came into effect October 17, 2018, signalling legalized access to cannabis for recreational use across Canada. With the legalization of cannabis for recreational use comes the potential for more open use among the public and pharmacy patients.

As medication experts, pharmacists are in a unique position to support quality and effective patient care for those who are using cannabis, for recreational or medical purposes, along with other medications that they may be taking. Recognizing the important role pharmacy professionals play in safe medication practices, and in consideration of the legalization of recreational cannabis, in March 2018 the College's Cannabis Task Force recommended that Council require all pharmacists to complete cannabis education to support and promote quality and safe patient care for cannabis users.

The Task Force's recommendation was approved, allowing for work on the identification of competencies and suggested learning objectives for cannabis education to move forward.

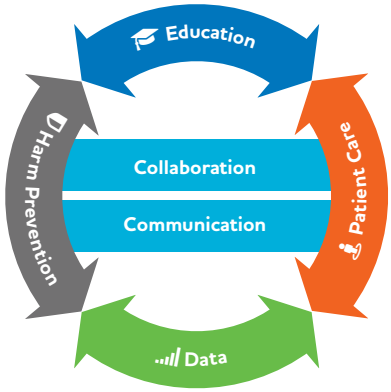
Through the guidance of the Cannabis Education Advisory Group consisting of pharmacy educators on cannabis, practicing community and hospital pharmacists and a patient advocate, this work is now complete and the College is now working with the Canadian Council on Continuing Education in Pharmacy (CCCEP) to identify cannabis education programs that address the competencies identified by the Advisory Group. Once accredited by CCCEP as mapped to the outlined competencies, these programs will be listed on the OCP website. The College anticipates education programs will begin to be accredited and approved in early 2019.

CANNABIS STRATEGY AND POSITION STATEMENT

In anticipation of the *Cannabis Act*, Council approved the Cannabis Strategy for Pharmacy on June 17, 2018. The Strategy focuses on relevant areas of practice and prepares the College and pharmacy professionals to address evolving cannabis-related issues. Consistent with the position of the National Association of Pharmacy Regulatory Authorities (NAPRA) related to cannabis and pharmacy, it protects patients and Ontarians congruent with the College's mandate and within the current legal framework for accessing cannabis.

Along with the Strategy, Council also endorsed a formal position statement on the distribution of cannabis for medical purposes within pharmacy. The College continues to support NAPRA's position statement which opposes pharmacy practitioners being involved in the distribution of cannabis for non-medical purposes.

It is important to emphasize that the College's regulatory approach focuses on patient safety as society adapts to the new realities associated with legal cannabis use. However, it is not the College's role to advocate for distribution of cannabis for any purpose within pharmacies and continues to remind all pharmacies and pharmacy professionals of the legal frameworks currently in place related to how cannabis for recreational or for medical purposes can be legally distributed. We believe that our position and our Strategy recognizes that Ontario pharmacy professionals should play a role in how people use cannabis in the context of their health care experience, regardless of where it is distributed.



ADDITIONAL RESOURCES FOR PHARMACY PROFESSIONALS

Interested in understanding why the College developed a Cannabis Strategy, the work of the Task Force and what role pharmacy professionals can play? The College has posted the Strategy, background materials and additional resources such as an FAQ on the public website under Key Initiatives.

FOUNDATIONS OF SAFETY:

Supplemental Standard of Practice and Standards of Operation help pharmacies promote a constructive, collaborative and open patient safety culture

Last September, College Council approved the supplemental Standard of Practice (sSOP) to provide clearer expectations surrounding medication safety to pharmacy professionals as the College moved forward with the implementation of the AIMS (Assurance and Improvement in Medication Safety) Program in Ontario. Specifically, the sSOP builds on the NAPRA Model Standards of Practice related to safety and quality and provides additional detail for professionals, including the Designated Manager (DM), on what is expected of Ontario pharmacy professionals under the AIMS Program.

A SAFETY WORK CULTURE

Pharmacy owners and DMs are required to create a safety culture that is conducive to all components of the AIMS Program and supports shared accountability. A safety culture enables staff to engage in open, honest discussions about medication incidents and near misses. It also permits staff to identify the causal factors of incidents and share lessons learned with an emphasis on preventing errors from recurring and supporting meaningful and sustainable change at the pharmacy level and, eventually, across the health system.

Mandatory Requirements of Medication Safety

Pharmacy professionals must meet all of the following requirements of the mandatory AIMS Program; pharmacies (i.e. DMs and owners) must enable and support pharmacy professionals in meeting these requirements:

REPORT: Anonymous recording of all medication incidents and near misses by pharmacy professionals to a specified independent, objective third-party organization to support quality improvement within the pharmacy, and for population of an aggregate incident database to facilitate anonymous reporting that will identify issues and incident trends to support shared learnings.

DOCUMENT: Pharmacy professionals document appropriate details of medication incidents and near misses in a timely manner to support accuracy. Continuous quality improvement (CQI) plans and outcomes of staff communications and quality improvements implemented are also documented.

ANALYZE: When a medication incident or near miss occurs, pharmacy professionals analyze the incident in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident. Pharmacies must complete a Pharmacy Safety Self-Assessment (PSSA), which will be available as part of the Pharmapod reporting platform to facilitate use, within the first year of the implementation of the program, then at least once every two to three years, but it may be done more frequently depending on any significant changes in the pharmacy. Pharmacy management should also take the opportunity to analyze aggregate pharmacy data regularly to help inform the development of quality improvement initiatives.

SHARE LEARNINGS: There should be prompt communication to all staff of appropriate details of a medication incident or near miss, including causal factors and actions taken as a result.

The development and monitoring of CQI plans and outcomes should be supported. Pharmacies should have regular CQI communication with pharmacy staff to educate all pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete a PSSA, and develop and monitor quality improvement plans.

Continuous Quality Improvement in Pharmacy – A Foundational Element of the Supplemental Standard of Practice

One of the goals of the AIMS Program is to improve patient safety through the identification of medication incident trends and workflow issues leading to medication incidents, in order to support continuous quality improvement (CQI) in pharmacy practice. CQI involves an ongoing and systematic examination of an organization's work processes to identify and address the root causes of quality issues and implement corresponding changes.

Effective CQI programs focus on the implementation of quality improvements resulting from both proactive review of work processes to identify areas of risk, and retrospective review of specific medication incidents. The objective of CQI is to ensure that all pharmacy professionals learn from medication incidents, and review and enhance their policies and procedures to reduce the chances of recurrence, thereby improving patient safety.

To achieve safer care for patients, CQI must focus on both system improvements as well as the tasks that individual practitioners perform. CQI principles support shared accountability and holds pharmacy owners and managers accountable for creating a work culture that supports staff engagement in CQI activities and holds pharmacy professionals accountable for the quality of their choices. To enable a culture that supports learning and accountability over blame and punishment, individuals must be comfortable to discuss medication incidents without fear of punitive outcomes.

A critical element in safe medication practices is the sharing of lessons learned from medication incidents through recording of medication incidents and near misses, to support sustainable changes in practice.

Standards of Operation – Enabling Safe Pharmacy Practice

At its September meeting, College Council also approved new Standards of Operation.

The purpose of the Standards of Operation is to facilitate the creation of the optimal environment for the safe and effective practice of pharmacy and enable the supplemental Standard of Practice (sSOP) to be met. The Standards of Operation also reflect changes in minimum library requirements that allow pharmacy professionals to determine what additional references and resources are required to support their practice.

Learn more about the Standards of Operation on the College's website under Regulations and Standards.

What this means for pharmacy professionals and DMs

- ✔ DMs in both community and hospital pharmacies are responsible for cultivating and fostering a safety culture grounded in continuous quality improvement and shared learning and for promoting open and honest discussions about incidents. They are expected to become familiar with the requirements under the sSOP and Standards of Operation and educate staff in their pharmacies.
- ✔ DMs in community pharmacies should also ensure that staff complete the required training through web-based modules as their pharmacies are onboarded to the AIMS Program and Pharmapod's recording platform.
- ✔ All pharmacists and pharmacy technicians should make sure that they understand their obligations under the sSOP and actively participate in facilitating the integration of the four medication safety program and quality improvement requirements in the pharmacy.

Questions?

Have questions about the AIMS Program or how the Supplemental Standard of Practice or Standards of Operation apply to you? Email us at medicationsafety@ocpinfo.com or visit the AIMS Section of the College's website under Regulations and Standards.

STERILE COMPOUNDING STANDARDS IN EFFECT JANUARY 1, 2019

The January 1, 2019 deadline for the implementation of the Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations and the Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations is quickly approaching.

As previously shared in *Pharmacy Connection*, **full compliance** on **all elements** of the standards is expected by January 1, 2019. Please take the time to review the College's Sterile Compounding Key Initiative and Frequently Asked Questions to ensure your pharmacy is prepared.

If a pharmacy needs additional time to ensure compliance with the standards, it is the College's expectation that those pharmacies will prioritize their work to ensure that they comply *with all critical elements of the standards by January 1, 2019 and submit a detailed action plan with risk-mitigation strategies to the College that outlines the steps the pharmacy will take, with timelines, towards full compliance.*

As the College completes its visits to all pharmacies that engage in sterile compounding, it is evident that there has been a tremendous degree of hard work put in by pharmacies throughout the province as they prepared for the implementation of these important patient-safety standards. For those pharmacies that have submitted action plans, it is important that this work continues and that risk mitigation strategies are in place until a pharmacy's full compliance with the standards is achieved.

It is also important that the College continues to provide support and guidance to pharmacies to help them achieve full compliance. Practice advisors will continue to provide assistance and support for pharmacies with action plans following the implementation deadline and the College will continue to provide information and resources to pharmacies to support their ongoing efforts in meeting the standards.

In the meantime, the College has posted Frequently Asked Questions on our website. Be sure to check them out.

Questions in the online FAQs include:

- What is required for January 1, 2019?
- What happens if our pharmacy is not able to meet the critical elements by January 1, 2019?
- What are the next steps for organizations that are not fully compliant with the NAPRA Model Standards for Pharmacy Compounding of Sterile Preparations by January 1, 2019 but have met the critical elements?
- Who can be a sterile Compounding Supervisor (CS) and what are they responsible for?
- Where can I find a "third party evaluator" to evaluate the sterile compounding supervisor?
- Do you have any suggestions or recommendations to aid us in requests regarding potential capital projects required to meet standards by January 1, 2019?
- Are there opportunities for regional models?
- Whom should I contact about specific questions that I have about operational procedures and polices?
- What are the College's expectations for Beyond-Use-Dating (BUD)?
- What training and certification programs are recommended?
- What is required when organizations/pharmacies respond to assessment report action plans?
- How do I submit and respond to an action plan?
- What are the requirements for environmental testing?
- Does our hospital need to be concerned about the sterile implementation guidelines if there is no pharmacy on site?

College Introduces **Practice Assessments for Pharmacy Technicians**

Practice assessments for pharmacy technicians in community and hospital practice settings follow the successful roll out of practice assessments for community pharmacists.

Beginning in January 2019, the College will expand its practice assessment program – an important part of the College's quality assurance activities – to pharmacy technicians providing patient care in both hospital and community practice settings.

Practice assessments are designed to help pharmacy professionals identify areas for improvement in their practice so that they can develop, maintain, and enrich their skills and knowledge to support better patient health outcomes. As with community pharmacist practice assessments that are already part of the College's quality assurance process, practice advisors will apply a collaborative approach to assessment visits with pharmacy technicians, using coaching and feedback to support the identification and implementation of opportunities to optimize their practice.

Routine practice assessments are scheduled every four to six years. During the assessments, practice advisors provide feedback outlining areas of practice where pharmacy technicians are doing well and meeting standards as well as where there may be potential for improvement. They probe the thinking behind certain decisions, offer recommendations, and share helpful educational resources.

The results of a practice assessment are confidential and are not shared with employers, owners, colleagues or any College committee, other than the Quality Assurance Committee. As with community pharmacist assessments, if a pharmacy technician does not meet the standards indicated on their first

assessment, he/she is given the opportunity to spend time with a quality assurance coach (peer practitioner) before being reassessed by another practice advisor.

AREAS OF FOCUS DURING A PHARMACY TECHNICIAN PRACTICE ASSESSMENT

During a pharmacy technician practice assessment, practice advisors will focus on four key areas: **patient care, collaboration and decision-making, documentation, and communication and education**. Each focus area has specific performance indicators which describe the minimum practice requirements for pharmacy technicians.

More information about these four key areas and how technicians can prepare for an assessment will be posted to the College's website in January 2019.

2018 PILOT PROGRAM AND FEEDBACK RECEIVED

The full roll out of the practice assessment program for pharmacy technicians follows a preliminary phase that was implemented in the Fall of 2018 which helped the College make final adjustments to the program that will ultimately reach all 4,000+ practicing pharmacy technicians in the province. Pharmacy technicians who were part of the preliminary phase told the College that they found the assessments helpful in validating the work they are doing and in recognizing areas for improvement and ongoing professional growth.

The roll out of the pharmacy technician assessment program also follows the successful implementation of community pharmacist assessments in place since 2016. Pharmacists who have undergone practice assessments have responded positively to the coaching approach and have shared that the assessments provided an opportunity for self-reflection and are instrumental in providing valuable practice insights.

NEXT STEPS

Pharmacy technicians will be notified by the College in advance of an assessment. Practice assessments for pharmacists who practice in hospital and other care settings are expected to be implemented in 2020. Stay tuned for additional information about pharmacy technician practice assessments in eConnect, on our website and in future issues of *Pharmacy Connection*.

All pharmacy professionals providing patient care must identify a place of practice upon renewal of their registration with the College. This is key in ensuring the requirement to undergo a practice assessment every four to six years is met. Upon renewal, you will be required to specify a place of practice where you provide patient care for your practice assessment.

PRACTICE ASSESSMENTS FOR PHARMACISTS AND PHARMACY TECHNICIANS IN ALL PRACTICE SETTINGS – TIMELINE

Pharmacist practice assessments in community	Implemented in 2016
Pharmacy technician practice assessments in community	Commencing January 2019
Pharmacy technician practice assessments in hospital	Commencing January 2019
Pharmacist practice assessments in hospitals & other settings	Planned for 2020

DOCUMENTATION: *Essential To A Patient's Continuity Of Care*

In this four-part series, the College focuses on each domain of the community pharmacist practice assessment, highlighting trends that are being seen in practice. Part Three focuses on documentation. Review: Part One (Patient Assessments) in the Spring 2018 edition and Part Two (Decision Making) in the Summer 2018 edition.

STANDARD OF PRACTICE

Documentation is a fundamental cornerstone of a pharmacy professional's responsibilities and is a standard of practice. Appropriate documentation has four important characteristics: it is factual, it is complete, it is current (timely) and it is organized.

Patient documentation has significantly evolved beyond the use of a check mark to indicate that a patient or their agent was counselled. Information obtained from thorough patient assessments and the rationale behind thoughtful, patient-focused decisions has short-lived benefits if it is not recorded and accessible to pharmacy team members and other health care professionals for continuity of patient care. Thus, the adage "If it wasn't documented, it wasn't done" is highly relevant to pharmacy practice.

Today, pharmacy professionals are not only expected to gather the information needed to assess

the patient and the prescription, they must also keep a reliable and easily-retrieved record of this information. Documentation of what is clinically relevant is vital to continuity of patient care. While changes to a patient's health or characteristics are likely to be noted, things that have **not** changed may also be of significance.

SUCCINCT APPROACH

Documentation on the patient record doesn't require noting entire conversations with patients or their agents. It's about using professional judgement to identify key pieces of information necessary to support decision making. A good documentation practice suggested by practice advisors is to anticipate and record what a colleague would need to know about a patient's existing condition at a future time in order to continue where you left off. For example, if you addressed a concern, explain your course of action and the rationale behind it.

Effective documentation should incorporate pertinent patient information and relevant data acquired from prescribers and other healthcare providers. In turn, it will optimize decision-making, help avoid errors, reduce duplication of services and demonstrate one's thought process. Documentation includes any written or electronically-generated information about a patient that describes the care or services provided. It should include evidence of the objective and/or subjective data used for clinical decision making.

CONSISTENCY

Designated managers are encouraged to emphasize consistency in documentation approaches within a pharmacy by establishing operational processes for documenting on the patient record. The practice of writing notes on a slip of paper or notebook where it can be forgotten or misplaced is discouraged by practice advisors who stress the importance of directly recording information into the patient record.

PATIENT SCENARIO

The past two issues of the practice assessment series featured the following patient scenario to reinforce learning: A 59-year-old male has been filling his prescriptions at the pharmacy for about one year. His patient profile shows that he has Type 2 Diabetes, dyslipidemia, osteoarthritis and is a smoker. He fills his medications mostly on time, doesn't say much when picking up his medications and you haven't noticed any changes on his prescriptions profile. He's currently on Atorvastatin 10mg once daily, Metformin 1000mg twice daily, Gliclazide MR 30mg daily and Venlafaxine 150mg once daily and was looking to pick

OCP'S DOCUMENTATION GUIDELINES

A member uses professional judgment in determining the extent of documentation and information that should be contained in the patient record. Members should avoid extraneous information and only document what is clinically relevant. The meaning of any entry into a patient record should be clear to a health care professional reading the record. The level of detail will vary depending on each situation, including when necessary:

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

up his new refills.

During his latest visit to the pharmacy, the pharmacist on duty followed up on a note from a colleague to check in with his progress on quitting smoking. The decision was made to initiate smoking cessation treatment, as well as to continue self-monitoring his daily blood glucose levels. In response to the pharmacist's recommendation to adjust the dose of his diabetes medication, a reply from the doctor on file indicates that the patient was overdue for his bloodwork (A1C and cholesterol lab tests) and changes would be considered pending the results.

NEW PRESCRIPTION

The patient has returned to the pharmacy after his doctor's visit and presents a new prescription. Upon reviewing his profile, you verify that the dose of his atorvastatin has been increased and the others remained unchanged. The patient explains that the doctor was mostly concerned about his "bad" cholesterol and only wanted to make one medication change at a time, with a follow-up appointment in four weeks. He has also brought a copy of the lab results, which you review and offer to include in his patient profile.

When you commend his decision to quit smoking, the patient admits that, after setting a quit date, he was still struggling to go more than a day or two without any nicotine. However, he says the effort continues to get easier and he is proud of his progress even though he couldn't quit "cold-turkey." To keep him motivated and compliant, you decide to quickly review his cardiovascular disease (CVD) risk, asking for his blood pressure as measured at the doctor's visit to emphasize his ability to control some of his "modifiable" risk factors.

The Chat, Check, Chart **DAP** model used by the pharmacy team guides the format of your documentation on the patient's profile:

Data – What information did you gather and check? (Lab test results, new dose of atorvastatin, patients reported BP, smoking status, date of next visit)

Assessment – What is your assessment of the patient and therapy? (Increase in dose is clinically appropriate based on patient's risk factors for CVD and lab results)

Plan – What steps did you/will you take? (Patient to monitor for side effects of atorvastatin, what to do if myalgia occurs)

After ensuring the key points from today's visit are entered into the pharmacy's software system, you save the record which correlates to your name and is timestamped. The pharmacy assistant performs the administrative task of scanning in the lab results, following the procedure established for naming documents to ensure easy identification and retrieval in the future.

CONCLUSIONS:

As a pharmacy professional, you play an essential role in the circle of patient care. Effective documentation maintains the standards of the profession and contributes to optimized health outcomes.

RESOURCES RELATED TO PHARMACY DOCUMENTATION

- Chat, Check, and Chart – This resource provided by the Alberta College of Pharmacists is focused on getting patient information, evaluating the appropriateness of therapy and documentation.
- The Four R's of Documentation – Reliable, Retrievable and Useable, Robust and Retained – is another highly effective way to ensure successful patient recordkeeping procedures.
- Documentation Guidelines
- Documentation Practice Tool
- Pharmacy Practice Assessment Criteria - Documentation
- Documenting Pharmacy Interventions in a Busy Dispensary – Produced by the Canadian Pharmacists Association, webinar material focuses on reasons for/benefits of documentation.

Presentations to **PHARMACY STUDENTS** *at the University of Toronto*

Nancy Lum-Wilson, CEO and Registrar of the Ontario College of Pharmacists, attended the Leslie Dan Faculty of Pharmacy Undergraduate Student Awards Ceremony at the University of Toronto on September 24. As a bursary and scholarship program donor, the College supports the education and development of the next generation of pharmacy professionals.

Jenna-Rose Melanson, a student at the Leslie Dan Faculty of Pharmacy and winner of the War Memorial Scholarship, is joined by Sandra Bjelajac Mejia, Interim Director, Professional Programs Professor, University of Toronto (left) and Nancy Lum Wilson, Registrar and CEO, Ontario College of Pharmacists, who presented the certificate to Jenna-Rose. The certificate is awarded to the student accepted into the program with the highest admission index.

Communication IS KEY TO MEDICATION SAFETY

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As patient cases become more complex, it is inevitable that more healthcare professionals will be involved in their circle of care (1). These healthcare professionals may include family physicians, specialists, nurses, and pharmacists. As such, it is crucial that all healthcare providers in the circle of care effectively communicate with their "team mates," have a clear understanding of the care plan, and collaborate to provide optimal patient-centered care (1). However, in reality, healthcare providers may be unaware of their "team mates" involvement and this may contribute to minimal inter-professional communication, and a lack of complete awareness surrounding details of the patient's intended care plan. This is particularly challenging in outpatient/ambulatory care and community pharmacy settings where healthcare professionals may be distributed in different geographical regions. Communication gaps between patients and among different healthcare providers can have negative impacts on patient care and, more importantly, on patient outcome and safety (1-3).

The Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPhIR) program (http://www.cphir.ca) was used to generate a list of medication incidents (anonymously reported by community pharmacies) that were associated with moderate to severe patient harm from 2009 to 2017. A total of 134 medication incidents were included for a qualitative multi-incident analysis conducted by two ISMP Canada medication safety analysts. Themes, sub-themes, and contributing factors of the medication incidents were identified, and recommendations were derived to address safety gaps in patient care (Table 1).

From the 134 medication incidents that were identified, 78 involved communication gaps of which three main themes were identified: (1) Gaps in written communication; (2) Gaps in verbal communication; and 3) Lack of communication. We further derived sub-themes from these main themes: (a) Gaps in communication between healthcare providers; and (b) Gaps in communication between

healthcare providers and patient. Selected examples of medication incidents that involved various degrees of communication gaps are provided in Table 1 and Figure 1.

We identified the following common contributing factors of medication incidents that involved communication gaps (**Table 1**): (1) lack of a standardized information gathering process or technique; (2) hectic work environment with time constraints; (3) ambiguous prescription instructions; (4) look-alike/sound-alike drug names; and (5) confirmation bias.

Communication Gaps	Incident Example	Contributing Factors
Written Communication Gap	Refer to Figure 1	Refer to Figure 1
Verbal Communication Gap	Patient has prescriptions for Warfarin 1 mg and Warfarin 5 mg on file at the pharmacy. Patient called and asked for a refill for Warfarin but no strength was indicated. Pharmacy assistant refilled for Warfarin 5 mg. Patient took Warfarin 5 mg, as opposed to Warfarin 1 mg, which he had intended to refill. Patient's INR was not controlled.	• Look-alike/sound alike drug names (in this case, same medication, but different strength) • Hectic work environment with time restraints • Confirmation bias • Lack of a standardized information gathering process or technique
Lack of Communication	Patient has an allergy to Amoxicillin. Neither patient nor pharmacy team discussed allergies during prescription drop-off. Patient picked up Amoxicillin prescription and declined counselling. Patient took medication and experienced an anaphylactic reaction.	• Hectic work environment with time restraints • Lack of a standardized information gathering process or technique

Table 1. *Communication Gaps in Pharmacy Practice*

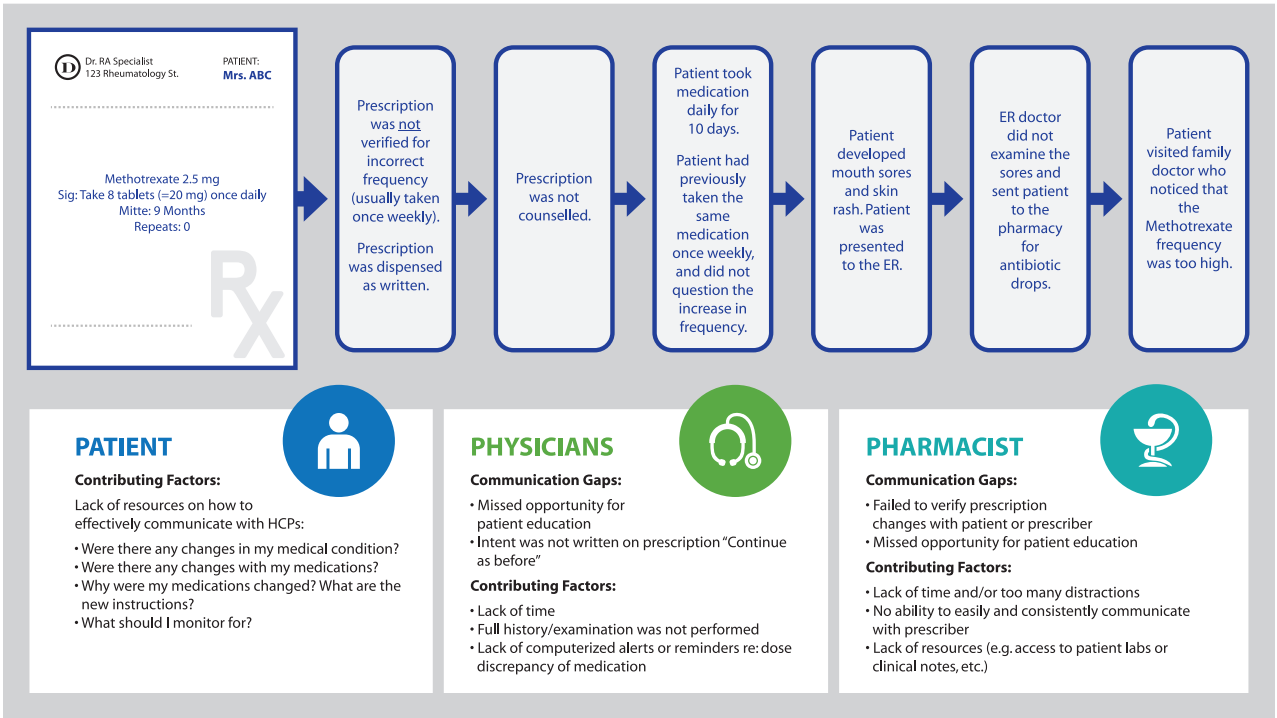

Figure 1. *An example of a medication incident that involved communication gaps: (a) Gaps in communication between healthcare providers; and (b) Gaps in communication between healthcare providers and patient.*

COLLABORATION BETWEEN PATIENTS AND HEALTHCARE PROVIDERS

An essential competency for healthcare professionals is effective communication skills (4, 5). In order to address communication gaps, patients and their healthcare providers need to recognize the challenges and effectively communicate amongst themselves.

Healthcare professionals must develop an information gathering process that is standardized, efficient, and comprehensive. In addition, they must engage in open dialogue with their patients as it is important to build a strong rapport with them (4). Decreasing the interaction or time with patients may negatively affect the ability for patients and healthcare professionals to build a trusting relationship and, more importantly, it may impact patient/medication safety.

Technology has enabled instantaneous communication with anyone, anywhere, at any time. However, as people communicate more frequently, the form of content becomes increasingly superficial and ineffective (6, 7). This trend is apparent in the digital world but it is also influencing interpersonal communication skills (6, 7). Moreover, some patients may be pre-occupied with their mobile devices when picking up prescriptions. This may distract them from receiving and understanding critical patient counselling points in their medication therapy management and compromise the overall quality of care and patient safety.

Information Gaps

Lack of information is usually a two-fold problem: (1) pharmacists may not have enough information to safely dispense a medication; and/or (2) patients are not knowledgeable or not fully informed about their medical condition(s) and intended care plan; and they are not aware of the questions they should ask about their medications, etc.

Patients are the common denominator that connects all members of the circle of care. As such, patients should be seeking necessary information from their healthcare providers, such as changes in their medication(s), the nature/rationale of medication therapy adjustments, and what actions or monitoring parameters are required on their part as patients (8-10). Although patients may expect that all healthcare providers in their circle of care are communicating with each other regarding their care plan, unfortunately, this may not always be the case (1, 3, 11). Information exchange among healthcare practitioners is often perceived to be incomplete (11). Furthermore, it is also possible that some healthcare providers, depending on their practice settings, do not have access to critical information (e.g. lab values and diagnostic test results) that is required to support decision-making for optimal patient care (12). A common example is that community pharmacists often play broken telephone – trying to piece information together from various resources: prescriptions or medication records, patient profile, and contacting the prescriber, if necessary, etc. in order to safely dispense a medication within time constraints (12). This practice is not only time-consuming but may also put patients at risk of medication harm, especially if wrong assumptions or confirmation bias are made during the medication-use process.

Educating Patients

Healthcare practitioners need to educate their patients on what to ask and document during each patient encounter. This begins with a clear communication strategy. The American College of Clinical Pharmacy suggests using simple non-medical language, limiting the amount of content, using visual aids, increasing patient participation, and emphasizing key counselling points as techniques for clear communication (13). Furthermore, there are several Canadian resources that can support patients with effective communication. This includes HealthLinkBC's printable patient reference sheets (available from https://www.healthlinkbc.ca/health-topics/hw226888), a resource that encourages patients to ask important questions during different medical appointments (for example, new ailment diagnosis and follow-up appointments) (9).

Before the patient leaves the clinic, healthcare practitioners should ensure their patients have a basic comprehension of their care plan. Counselling techniques such as "show and tell" and "teach back" can help healthcare professionals gauge patient's understanding (2). In addition, the Institute for Safe Medication Practices Canada (ISMP Canada), the Canadian Patient Safety Institute, Patients for Patient Safety Canada, the Canadian Pharmacists Association, and the Canadian Society for Hospital Pharmacists have collaborated and developed the "5 Questions to Ask About Your Medications" (available from https://www.ismp-canada.org/medrec/5questions.htm) to help patients initiate a dialogue with their healthcare providers about their medications. Effective and efficient communication becomes second nature when both parties come prepared for the encounter.

Educate your team

A community pharmacy team often consists of pharmacists, technicians, and assistants. Very often, technicians and assistants have the first

interaction with patients via an in-person encounter or a phone conversation. Therefore, all members of the pharmacy team should be educated and informed on the importance of communication and comprehensive information gathering techniques. This would optimize work flow and improve patient safety.

Use technology

Current communication techniques, such as fax and telephone, are inefficient and may overload the workflow or practice setting with paper. In the near future, the healthcare system will require better tools or strategy to facilitate seamless communication among healthcare professionals and help prioritize tasks with respect to the increasing demands of patient-centered care. A fully functional e-health system where healthcare providers have ready access to a patient's complete medical and medication records will become the gold standard. Meanwhile, healthcare practitioners should better utilize and demand more from their point-of-care clinical decision support applications that may allow or support safety features, such as reminders for updating patient medication lists and alerts for dose discrepancy (e.g. dose too high, or dose too low). These are some examples of how current technology may help healthcare providers deliver safe and effective patient care.

OVERCOMING BARRIERS AND OPTIMIZING COMMUNICATION TECHNIQUES

Poor communication degrades the quality of patient care. Barriers to effective communication include logistical factors, such as healthcare providers being unaware of other healthcare providers within a patient's circle of care and relying on ineffective means of communication for information transfer/exchange (e.g. fax and telephone). Leveraging current technology and informatics could combat such challenges. Optimizing communication techniques (e.g. computerized physician order entry (CPOE) or electronic pre-printed prescription orders), standardizing information-gathering strategies (e.g. adopting a consistent process to conduct a Best Possible Medication History (BPMH) (available from https://www.ismp-canada.org/download/MedRec/SHN_medcard_09_EN.pdf)), and facilitating effective workflow should be ongoing safety initiatives in any healthcare setting. Ultimately, everyone who is involved in a patient's care (including the patient) should be responsible for effective and efficient communication. Failing this responsibility often translates to delays in patient care and/or risks to patient health and safety.

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College Implementing CRIMINAL BACKGROUND CHECKS FOR APPLICANTS

*The Ontario College of Pharmacists is introducing criminal background checks as an additional registration requirement for all **new** registrants.*

The policy, which will take effect during the second quarter of 2019, will be implemented in conjunction with existing registration requirements. It supports the College's due diligence in assessing an applicant's eligibility for final registration.

Pharmacists and pharmacy technicians already registered with the College will not be required to submit background checks. However, pharmacy students, interns, and technician applicants already registered/pre-registered with the College will be required to do so when they proceed to the next level of registration.

The new policy reflects the College's mandate to regulate pharmacy practice in Ontario to serve and protect the public.

In September 2016, Council approved the recommendation by the Registration Committee to implement criminal background checks as an additional requirement for registration in any class with the College.

Medical Assistance in Dying: REPORTING REQUIREMENTS AND GUIDANCE DOCUMENT

Health Canada's new federal reporting requirements for medical assistance in dying (MAiD) came into effect on November 1, 2018. Pharmacists who have dispensed a substance in connection with the provision of MAiD are now required to report to Health Canada within 30 days after the day of dispensing.

Information that must be reported in all cases consist of:

- The patient's date of birth, health insurance number, and province or territory of issuance
- Your name, province or territory of practice, registration number, mailing address and e-mail
- Name and licence or registration number for the practitioner who prescribed or obtained the substance
- The date that the substance was dispensed and where it was dispensed (hospital or community pharmacy)

Please review the detailed information on the Health Canada website. On this site you can find a printable PDF checklist of the information (outlined here) that pharmacists are required to report.

The College's MAiD guidance document has now been updated to reflect the changes to the new federal reporting requirements. *Please review this updated guidance document*, which is intended to assist pharmacy professionals to comply with legal obligations and professional expectations with respect to MAiD as outlined in federal and provincial legislation, the Standards of Practice, Code of Ethics and College policies and guidelines.

You can learn more about MAiD on the Ontario Ministry of Health and Long-Term Care website. The site provides a breakdown of Ontario's hybrid approach to the new federal reporting requirements and includes links to tools and resources to aid clinicians in fulfilling their reporting obligations.

Coroner's Inquest into the

DEATH OF A HEMODIALYSIS PATIENT ON METHOTREXATE

CASE SUMMARY

A 48-year-old male who was being treated for end stage renal disease died as a result of sepsis, subsequent to pancylopenia caused by Methotrexate (MTX) prescribed for treatment of sarcoidosis. Contributing causes of death were determined to be E. coli septicemia due to bone marrow hypoplasia due to MTX toxicity due to end stage renal disease due to polycystic kidney disease.

The patient was admitted to hospital with neutropenia and thrombocytopenia. The following day he became hypotensive with a CBC showing a WBC of 0.1 and he had a low-grade fever (37.8C). He was admitted to the ICU the next day and treated with vancomycin, piperacillin/tazobactam. He developed decreased cardiac output and received a pacemaker. He died later the same day.

The coroner's investigation into the patient's death identified system-based errors as a main factor in this case This led to a Patient Safety Review Committee review which recommended actions pharmacists can take in preventing similar future deaths. The Committee's recommendations to several institutions are highlighted following the review of the case.

CASE HISTORY

The patient was on hemodialysis for renal failure (end stage renal disease) as a result of his polycystic kidney disease (PCKD). He also had a history of hypertension and coronary artery disease for which a stent was inserted in 2013. That same year, he was diagnosed with sarcoidosis. In January, 2015, one of the patient's kidneys was removed and he was subsequently treated by Respirologist A for shortness of breath (a symptom of sarcoidosis) which improved after a course of prednisone.

SUMMARY OF EVENTS LEADING TO HOSPITAL ADMITTANCE

May 4: The patient saw Respirologist B who started him on MTX. He took the first dose of 10mg that day and his wife had the prescription placed in his dialysis file.

May 11: The patient took 15mg of MTX. A nephrologist noticed the patient appeared to have oral thrush and ordered nystatin. At this time, his complete blood count (CBC) was relatively normal. It is not known if the prescriber, the renal pharmacist or the community pharmacist considered that there could be a relationship between these symptoms and MTX toxicity.

May 14: A nephrologist contacted Respirologist B regarding MTX being contraindicated in renal disease. The patient was instructed to stop the MTX and started on azathioprine.

May 15: The patient was started on fluconazole for oral ulcers.

May 18: The patient developed diarrhea and a CBC revealed a white blood count (WBC) of 0.2, indicating neutropenia and thrombocytopenia.

DISCUSSION

It is not uncommon for medications that may be contraindicated or require dosage adjustment to be prescribed for patients with renal disease. In this case, the pancytopenia caused by the use of MTX in a dialysis patient was not an unexpected outcome.

The adverse outcome of this case serves as an important reminder of the pharmacist's ethical responsibility to prevent harm to patients, and to practice within the limits of their knowledge and skills. To ensure the patient's

PATIENT SAFETY CONCERNS

Patient safety issues identified by the Patient Safety Review Committee were:

- The prescribing of MTX without consultation with the treating nephrologist;
- An opportunity to stop the administration of MTX was missed when the prescription was reviewed in the dialysis unit;
- Uncertainty as to whether a community pharmacist would have likely identified the contraindication of renal dialysis for MTX.

safety and positive health outcomes, placing trust in the care provided by colleagues and other healthcare professionals must be balanced with critical evaluation. Ultimately, pharmacists are accountable for their actions, including failure to take appropriate action when necessary.

The Standards of Practice expect pharmacists to gather the information necessary to assess every prescription for therapeutic appropriateness prior to dispensing. The patient should be given sufficient information regarding the potential risks and the most frequent and serious side effects associated with the prescribed therapy. When a potential risk is identified, the pharmacist must evaluate and choose the best option(s) to manage it. Finally, the Designated Manager of the pharmacy must provide access to the references required to support pharmacists in meeting their professional and ethical obligations to the patient.

This case highlights the essential role of pharmacists in supporting patient safety, as the medication experts in the patient's circle of care.

RECOMMENDATIONS:

The Coroner's committee made the following recommendations to the College of Physicians and Surgeons, Ontario Hospital Association, Ontario Renal Network, Ontario Local Health Integration Networks (dialysis units) and College of Nurses Ontario as a result of their review of this case:

1. Medications ordered for dialysis patients by a physician who is not a nephrologist should be checked for appropriateness with a nephrologist, unless the physician is thoroughly knowledgeable of their effects in a dialysis patient. It is noted that the appropriateness of medication, and medication doses, can be quite different in dialysis patients.

2. A standardized process should be in place to ensure that new medications not ordered by a nephrologist should be reviewed with a renal pharmacist or nephrologist immediately by nursing staff, unless the nurse knows from previous experience that the use of the medications or the dose is appropriate.

3. Patients should be instructed to notify the dialysis unit when started on a new medication.

4. All immunosuppressive prescriptions for patients with renal disease, including dialysis, should be reviewed with a nephrologist before the patient receives the first dose.

The Coroner's committee made the following recommendations to the Ontario College of Pharmacists and Ontario Pharmacists Association as a result of their review of this case:

1. Pharmacists should be reminded of the importance of obtaining information from patients about chronic medical conditions and entering this information into pharmacy information systems in a way that supports drug-disease interaction checking.

2. Pharmacists should consider the patient's general medical condition/fragility in decisions about whether to communicate drug interaction alerts with intermediate or low significance with prescribers.

ADDITIONAL LEARNING:

If unfamiliar with a particular medication, review appropriate resources to ensure the medication being dispensed won't harm the patient AND is therapeutically appropriate. See: http://www.ocpinfo.com/library/practice-related/download/PharmacistAssessmentCriteria_PatientAssessment.pdf

"Close-Up on Complaints" explores incidents reported to the College that have occurred in the provision of patient care and which present learning opportunities. Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

Effective Communication ***Benefits Staff*** *and* ***Patients***

SUMMARY OF THE INCIDENT
This incident involves two staff from the same pharmacy – the designated manager (DM) and a pharmacist.

A woman (patient), her husband and son made an evening visit to a community pharmacy and requested flu shots. When the patient was told by pharmacy staff that flu shots were no longer being administered for the day, she challenged the decision, insisting the hours for flu shots should be posted to avoid patients being turned away.

At this point, the pharmacist agreed to administer the flu shot to the patient and her family that evening. The patient claimed that the pharmacist, when agreeing to administer the vaccine, complained about a busy work load, saying that she didn't get paid extra for administering injections.

The patient reported that, within hours of receiving the vaccine, she experienced pain in her shoulder and arm. She eventually contacted her doctor because she was unable to move her arm and was losing sleep. The patient subsequently reported the issue to the pharmacist-on-duty at the same pharmacy (not the pharmacist who had administered the shot). She also submitted a formal complaint to Public Health Ontario, noting her significant pain required medication and visits to a physiotherapist, a doctor and a specialist.

The patient subsequently filed two complaints with the College. One complaint was related to the DM's handling of the patient's concerns and the other related to the pharmacist's administration of the flu shot and her alleged verbal objections as she did so.

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

Complaint against the member who administered the flu shot
Regarding the patient's post-injection pain, the panel observed there was no proof to indicate that the administration of the vaccine by the pharmacist was the direct cause of her discomfort. However, the panel indicated that the pharmacist should have advised the patient of the potential side effects of influenza vaccinations, including the possibility of an injection injury, which could have related to the issues the patient experienced. The DM of the pharmacy reported, based on available documentation, she could not determine if the patient's sore arm was due to the administration of the vaccine.

Both parties offered divergent accounts of the pharmacist's conversation with the patient and her family and there was

no evidence to determine if the pharmacist behaved inappropriately. However, the panel pointed out that, while the content of the interaction cannot be determined, the patient was left with the unfortunate impression that the pharmacist was being inconvenienced by providing the vaccine.

Complaint against the DM regarding the management of the patient's concerns:
In the matter of unposted flu shot hours, the panel ruled that the DM is responsible for ensuring that staff are aware of the operational details of the pharmacy. While most pharmacies have increased patient volumes during the flu season, appropriate management and professional practice should help prevent confusion and ensure that staff are able to manage with increased patient volumes.

The panel noted that the DM indicated that she did not notify the pharmacist of the vaccine administration concern raised by the patient. This further emphasized that the DM should have communicated the patient's concern to the administering pharmacist, apologized to the patient and determined how to better address such situations in the future. The DM, the panel noted, is ultimately responsible for the standards of practice in the pharmacy.

WHY DID THIS HAPPEN?

While the posting of flu shot hours is not a requirement, the lack of direction surrounding the administration of flu shots created confusion for staff who were unable to determine if the pharmacy could accommodate the patient and her family's request. This subsequently impacted the patient's overall experience at the pharmacy.

The pharmacist who administered the shot pointed out that the patient likely first spoke with another member of pharmacy staff who was under the incorrect assumption that the vaccine would only be administered by another pharmacist who had since left for the day. The administering pharmacist further pointed out that she would never have turned the complainant and her family away had she been the first to encounter them at the pharmacy.

The patient's discomfort following receipt of the flu shot could have been better addressed by both the DM and the pharmacist. The pharmacist did not adequately communicate possible side effects of the vaccine injection and the DM did not adequately address the expressed concerns with both the patient and the administering pharmacist prior to the complaint being made.

LEARNINGS FOR PHARMACY PROFESSIONALS

The Standards of Practice state that pharmacists must demonstrate effective communication, including the use of effective verbal, non-verbal, listening and written communications. The DM should have empathically addressed the issues presented by the patient and extended an apology. As a pharmacist, the DM should have recognized a general Standard of Practice that required her to promptly disclose incidents and potentially unsafe practices to those affected in accordance with legal and professional requirements.

Model Standards of Practice also dictate that pharmacists who manage a pharmacy must also develop policies and standard operating procedures that support staff's ability to continuously improve the safety and quality of patient care provided.

Pharmacists must also demonstrate professionalism and apply ethical principles in their daily work. The DM would have better served the patient and her staff had she accepted responsibility for actions taken and decisions made, and maintained the patient's best interest as the core of all activities.

When administering the influenza vaccine, the pharmacist should have advised her patients of potential side effects.

Additionally, pharmacists are required to use evidence from relevant sources to inform their activities, critically evaluate medication and related information and adhere to current laws, regulations and policies applicable to pharmacy practice. By complying with the Standard pertaining to effective communication skills, the pharmacist would have conveyed flu injection information to patients while also maintaining the patient's best interest as the core of all activities.

RELATED RESOURCES

- Reporting Adverse Reactions to Vaccines and Medications, *Pharmacy Connection*, Summer 2017 issue
- Fact sheet: Adverse Event Following Immunization Reporting for Health Providers, Public Health Ontario
- Model Standards of Practice for Pharmacists
- Guideline - Administering a Substance by Injection or Inhalation

FREQUENTLY ASKED QUESTIONS

from Pharmacy Practice

Note that these answers were current at date of publication and are meant as guidance for pharmacy professionals. The College cannot tell a member what course of action to take, provide legal advice or opinions, or make any decisions for a member.

TRANSFER

Q When transferring a logged prescription to another pharmacy, is it a legal requirement to provide the receiving pharmacy a copy of the original prescription along with all of the information included in the fax?

A Providing a copy of the original with the transfer would be considered a best practice in the interest of patient safety. Unlike a refill, the logged prescription has never been dispensed and has not gone through the same complete checking process. This is the same reason members within their own practice site should be retrieving or viewing the original hardcopy before a logged prescription is dispensed.

The *Code of Ethics* also expects that when a patient moves from one healthcare provider to another, the relevant information is provided to the receiving healthcare provider, to ensure safe and effective transition of care.

OUT OF PROVINCE

Q I have a question regarding a prescription from a Naturopathic Doctor from British Columbia. The prescription is for a medication that Naturopathic Doctors in Ontario cannot prescribe. Can I dispense it?

A The College does not maintain information on the scope of practice of practitioners other than pharmacy professionals in Ontario. Questions about the scope of practice and prescribing authority of another health professional should be directed to their regulatory body. Collaboration with the practitioner is also encouraged, as self-regulated health professionals should be aware of – and practicing within – their legal scope of authority and the policies and guidelines of their College. This topic was covered in the *Summer 2017 Pharmacy Connection* article *Prescriptions from Other Healthcare Professionals*, p 37.

The Fact Sheet -- Out of Province Prescriptions explains that dispensers may accept a prescription written by a prescriber licensed in any province or territory of Canada. *The Drug and Pharmacies Regulation Act* (DPRA) defines "Prescriber" as "a person who is authorized under the laws of a province or territory of Canada to give a prescription within the scope of his or her practice of a health discipline". An out-of-province prescriber is registered and regulated by their province's (or territory's) health disciplinary college. Therefore, the regulations and corresponding scope of practice of the same health discipline in Ontario cannot be applied to an out-of-province practitioner. Similarly, a pharmacist licensed in another province whose scope includes prescribing authority (for example, to initiate treatment for minor ailments or to renew a prescription) is considered a prescriber for the purposes of the Act.

CREDENTIAL

Q Can someone who completed their PharmD use this credential and title while practicing within the province? Are there any restrictions on how it is used?

A Having a degree in pharmacy is one of several requirements needed for a certificate of registration, in order to practice as a licensed pharmacist in Ontario. It does not, in itself, confer the right to practice pharmacy. Should an individual wish to make reference to their educational credentials, this information should be presented in a manner that is not ambiguous, confusing, or misleading to the public. OCP has not established any additional policy or guideline restricting how a degree or credential may be used, however, it must be evident whether an individual is licensed by the College and able to practice pharmacy, or not.

Pharmacy graduates who possess a PharmD (Doctor of Pharmacy) degree should be aware that use of the title "Doctor" (or an equivalent abbreviation, such as Dr.) is restricted by the *Regulated Health Professions Act*, Section 33. A pharmacist cannot use this title in the course of providing, or offering to provide, health care to an individual. The regulated health professionals who may use this title in practice are defined in the Act. Pharmacists should be mindful when referring to their PharmD degree of the potential for misinterpretation by a patient that the individual is, for instance, a Medical Doctor (MD).

Once registered with the College as a pharmacist, they are permitted to use the title of "Pharmacist" or an equivalent abbreviation, such as the designation "RPh" (approved by Council in 2003). Section 10 of the *Pharmacy Act* also restricts the use of the titles "Apothecary" and "Pharmaceutical Chemist" to registered pharmacist members of the College. Similarly, "Pharmacy Technician" (and its abbreviation RPhT) became a restricted title under the *Pharmacy Act* in December 2010. All other titles – such as Certified Pharmacy Technician (in use prior to 2008) – must no longer be used. This does not prevent someone from indicating their past achievement of passing the College's certification exam, such as on a résumé, however the title of "Pharmacy Technician" cannot be used in practice unless they are registered as members of the College.

Flu Season IS HERE

Data released by Public Health Ontario indicates that more than 14,000 cases of influenza (flu) were reported throughout Ontario in 2016-17. The flu shot is proven to reduce the number of doctor visits, hospitalizations and deaths related to the flu.[1] Therefore, it is particularly important for high risk groups, including patients 65 years or older, women who are pregnant, children and infants and those with medical conditions, to receive the flu vaccine.[2]

To administer the flu vaccine to patients five years and older, pharmacists, pharmacy students and interns must:

- Be in a pharmacy participating in Ontario's Universal Influenza Immunization Program (UIIP),
- have completed an OCP-approved injection training course and registered their training with the College, and
- hold a valid certification in the required level of CPR and First Aid

Pharmacists participating in the UIIP are also authorized to administer the FluMist® vaccine to patients aged 5 to 17. Patients outside this age range can receive the publicly-funded FluMist® vaccine from their family physician.

The College's Administering Injections Practice Tool contains important information on training and registration requirements. Pharmacists can also refresh their practice knowledge by referring to their UIIP agreement and FAQs from the Ministry of Health and Long-Term Care which administers the program.

EDUCATING PATIENTS

Pharmacists play an important role in supporting patient well-being and facilitating a healthier community. This includes educating patients on current evidence-based immunization practices.

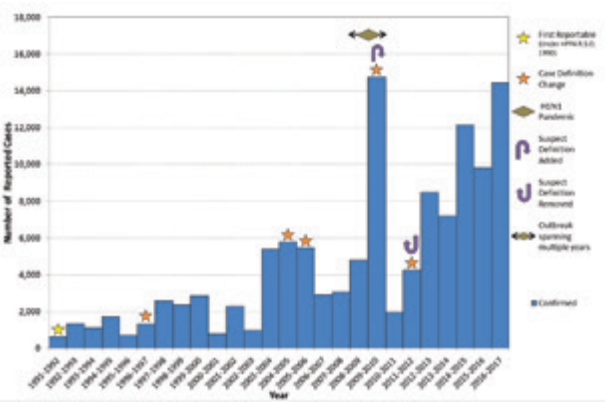
Encourage patients to review the Ministry's resources on the Flu and Flu Vaccine Safety. Common questions and answers on the flu shot are available on the Get The Facts About the Flu Shot factsheet.

DID YOU KNOW?

Of the approximate 15,500 Part A pharmacists currently licensed with the College, 65% are trained and registered to administer injections.

INFLUENZA

Figure 20. Number of reported cases of laboratory-confirmed influenza by season, Ontario, 1991/1992 – 2016/2017. Pharmacists have had the authority to administer flu vaccines since October 2012.



3. Data Source: MOHLTC, iPHIS database, extracted by Public Health Ontario on: [2013/03/07] for 1991-2004 data; [2017/05/16] for 2005-2016 data; [2010/09/09] for pH1N1 counts for the 2009-2010 season; [2009/09/03] for pH1N1 counts for the 2008-2009 season; [2011/08/10] for seasonal influenza counts for the 2008-2009 and 2009-2010 seasons.

OVERVIEW

- Unlike other reportable diseases, surveillance for influenza is conducted by season which occurs from September 1st to August 31st for the relevant year(s) (instead of the calendar year).[18]

- An epidemiologic link was added to the case definition in 2005. However, from 2012, the epidemiologic link was only applicable to institutional outbreaks.[4]

- A global pandemic of influenza A(H1N1) occurred in 2009, with the first wave of pandemic influenza beginning in the spring, 2009 and the second was in the fall of 2009 with extension of cases into 2010, with minimal seasonal influenza activity during the 2009-2010 influenza season.[41]

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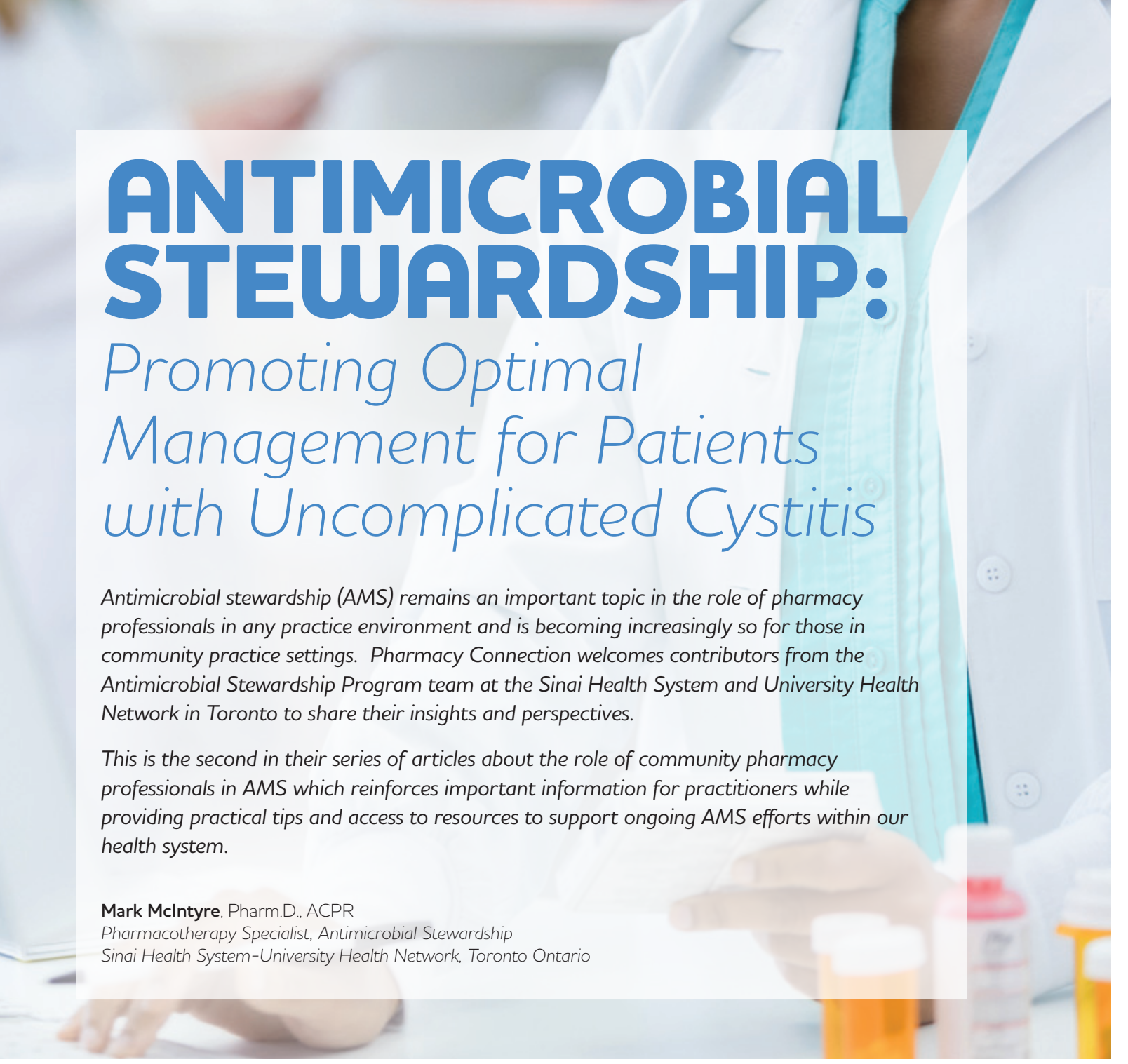

ANTIMICROBIAL STEWARDSHIP:

Promoting Optimal Management for Patients with Uncomplicated Cystitis

Antimicrobial stewardship (AMS) remains an important topic in the role of pharmacy professionals in any practice environment and is becoming increasingly so for those in community practice settings. Pharmacy Connection welcomes contributors from the Antimicrobial Stewardship Program team at the Sinai Health System and University Health Network in Toronto to share their insights and perspectives.

This is the second in their series of articles about the role of community pharmacy professionals in AMS which reinforces important information for practitioners while providing practical tips and access to resources to support ongoing AMS efforts within our health system.

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In this issue of *Pharmacy Connection*, we discuss uncomplicated cystitis beginning with a quick take of this infection:

- Uncomplicated cystitis is a commonly encountered infection in community pharmacy practice.
- Pharmacists should focus on the choice of antimicrobial agent and duration of therapy when assessing patients with uncomplicated cystitis to promote optimal antimicrobial stewardship principles and patient outcomes.

ASSESSMENT OF UNCOMPLICATED CYSTITIS

Urinary tract infection (UTI) is an exceptionally common reason for infection-related primary care visits[1]. More than half of women will experience a UTI in their lifetime with an 11% annual incidence.[2,3] Urinary tract infection is defined by anatomic site and complexity. In this review, we focus on lower urinary tract disease, namely cystitis (infection of the bladder) in the uncomplicated patient population.

SYMPTOMS OF CYSTITIS

1) Acute dysuria (pain while urinating)
2) New urinary urgency
3) New urinary frequency
4) Suprapubic pain (pain in the lower abdomen)

SIGNS OF CYSTITIS

1) Hematuria (blood in the urine)
2) Urine Turbidity (cloudy urine)
3) Leukocyte esterase positive urine (indicating presence of white blood cells in the urine, seen on urine dipstick testing)
4) Nitrites present in the urine (indicating gram negative bacteria in the urine and reflecting the ability of some bacteria to reduce nitrates to nitrites, seen on urine dipstick testing)

The initial assessment of urinary tract infection is based on presenting symptoms and signs,, (performing a urinary dipstick assessment if available), and exclusion of other infections/ complicating factors[4] No single symptom or sign is diagnostic and patient history and clinical judgement are key to diagnosing cystitis. Urine culturing is not recommended for first episode uncomplicated cystitis but should be considered for recurrent/ worsening disease.[4] If cultures are sent, keep in mind that turnaround times for results will likely be equal to or longer than the anticipated treatment duration. If the culture is positive for bacteria (bacteriuria) but the patient is asymptomatic (termed asymptomatic bacteriuria), no further treatment is warranted.

Uncomplicated UTI:

1) Non-pregnant adult females (without any complicated criteria below)

Complicated UTI

1) Urologic or neurologic abnormality
2) Upper tract or systemic disease
3) Immunocompromised patients
4) Catheter use
5) Males

MANAGEMENT OF UNCOMPLICATED CYSTITIS

Many cases of uncomplicated cystitis self-resolve.[5] Despite this, symptoms can be significant and concern exists for progression to the upper urinary tract or systemic infection.[6] A balanced approach to education and waiting, culturing and empiric therapy is essential. No one approach (waiting, immediate treatment, etc.) will work for all patients and shared decision making with patients is vital.

Place in therapy	Antimicrobial	Dose	Rate of *E. Coli* Resistance	Dosage adjustments in renal dysfunction
1st line	Nitrofurantoin macrocrystals	100mg PO BID x 5 days	~3%	Should not be used in CrCl<40ml/min
2nd line	Trimethoprim-Sulfamethoxazole (TMP-SMX)	160mg/800mg PO BID x 3 days	~20%	Requires dosage adjustment in significant renal dysfunction
3rd line	Ciprofloxacin Note: higher risk for ADR and *C.difficile*	250-500mg PO BID x 3 days	~15%	Requires dosage adjustment in significant renal dysfunction
4th line	Amoxicillin/ Clavulanate Note: broad spectrum, B-lactams require longer therapy	875mg/125mg PO BID x 5-7 days	~10%	Requires dosage adjustments in significant renal dysfunction

When treating with antimicrobial therapy, the following drugs and dosages are recommended based on resistance patterns in Ontario and assuming normal renal function.

While fosfomycin has activity against most urinary pathogens, a recent study found it inferior to nitrofurantoin[7]. However, fosfomycin may be an alternative to the above in those with organisms resistant to more common antimicrobial agents.

If cultures are available prior to starting treatment, targeting the choice of drug to the sensitivity pattern of the organism should be done with the goal of using the narrowest appropriate therapy.

STEWARDSHIP OPPORTUNITIES FOR THE COMMUNITY PHARMACIST

Despite the clinical frequency of cystitis and the widespread availability of practice guidelines[4,8], management frequently does not adhere to guidelines. More than half of antimicrobial prescriptions for UTI are for a non-first line antibiotic choice or for a duration longer than recommended.[9-11] Unnecessary antimicrobial treatment can place patients at risk for adverse events (ADRs) and *C.difficile* infection. Additionally, antimicrobial usage will increase the likelihood for antimicrobial resistance and treatment failure.[12,13]

Generally, these interventions should not preclude the provision of antimicrobial therapy to patients but can prompt an initial discussion and follow-up with the prescriber and then patient for modification after dispensing. If therapy does change, encourage patients to return the unused antibiotic supply to the pharmacy.

Though intervening with antimicrobials may seem difficult at first, there are many opportunities to make a difference in your daily practice. We encourage you to be the best stewardship pharmacist you can be and keep antibiotics working for everyone. More information and resources are available at our website: www.antimicrobialstewardship.com.

Examples of proactive strategies to address cystitis management in community pharmacy practice

Prescriber:

- *Academic detailing on local resistance rates and optimal treatment for cystitis*
- *Feedback antibiotic prescription data (if available)*
- *Reinforce avoidance of antibiotics for asymptomatic bacteriuria (ASB)*

Patient:

- *Educate on preventative measures for patients at risk of recurrent cystitis*
- *Increase fluid intake to >1.5L/day (if appropriate)[13]*
- *Encourage optimal hygiene practices and consider[14]*
  - *Post-coital voiding*
  - *Avoidance of spermicides*

Examples of reactive strategies to address cystitis management in community pharmacy practice

Patients, prior to visit to prescriber:

- *Assessment of symptoms and referral to appropriate level of care*
  - *Consider providing a list of the patients recent antibiotics, if available, for presentation to the prescriber*

Patient and Prescriber, after visit to prescriber:

- *Confirm indication for antimicrobial prescription (cystitis versus pyelonephritis/ other)*
- *Review the antimicrobial order for appropriateness*
  - *Choice of antibiotic (for condition, allergy history and renal function)*
  - *Duration of therapy*
- *Intervene as appropriate with prescriber*
- *Follow up with the patient in 48-72 hours to establish efficacy and safety of the prescribed medication*

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Public Health Ontario — Partners for Health | Santé publique Ontario — Partenaires pour la santé

NEW RESOURCES *for Antimicrobial Stewardship in Long-Term Care Homes*

Public Health Ontario (PHO) is pleased to announce that it has developed a series of resources to address the overuse of antibiotics in long-term care homes (LTCHs).

Up to half of antibiotic prescriptions in long-term care may not be necessary. The overuse of antibiotics in LTCHs can lead to harm for residents, such as C. difficile, side effects and antibiotic resistance.

The new PHO resources will be bundled under two topics and posted online:

1. Shorter is Smarter: For most infections treated in LTCHs (such as urinary tract infection, pneumonia, skin and soft tissue infection), shorter courses are equally effective as longer courses and have lower risk of harm. PHO has developed an infographic on why Shorter is Smarter, a one-page fact sheet containing duration recommendations and three evidence briefs that support the fact sheet recommendations.
2. Antimicrobial Stewardship Essentials: Antimicrobial Stewardship Essentials is a primer that aims to help LTCHs that are interested in developing an antimicrobial stewardship program (ASP). Also available is a checklist to provide ideas and practical examples to improve antibiotic use in LTCHs.

PHO is committed to supporting improved antibiotic use in Ontario LTCHs. Contact us at asp@oahpp.ca if you have any additional feedback.

Diverse Assignments BENEFIT OCP SUMMER STUDENT

Stephanie Woo is a McMaster University undergraduate student in Honours Molecular Biology and Genetics (2020).

1. How would you describe your experience at the College this summer?

My experience at the College proved to be eye-opening and extremely valuable. Prior to this, I had limited knowledge about the role of the College, how self-regulatory bodies function, and the importance of the pharmacy profession on improving health outcomes. However, throughout the summer, I was given the incredible opportunity to work with many different College departments which allowed me to paint a better picture of how each unique department works together to ensure public safety and the importance of the College's role as a whole. Many of the projects that I was given were focused on areas that I haven't had much exposure to throughout my studies. This experience provided me with a great opportunity to not only learn more about the subject matter, but also to apply it to my work.

2. What was the most interesting project you worked on?

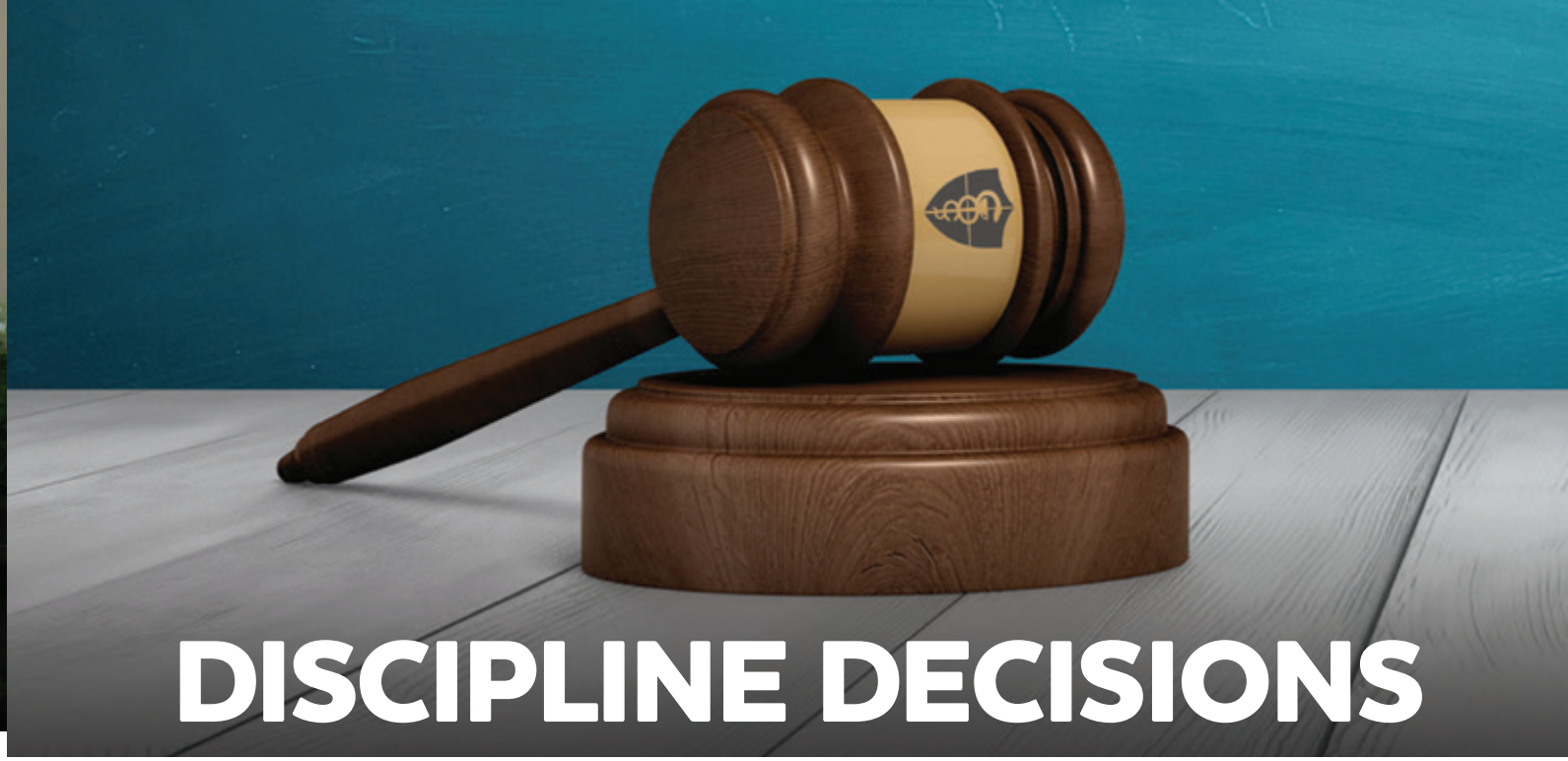
This summer, I wrote the literature review and backgrounder that focused on the diversion of opioids for the roundtable examining controlled substances security and safety in high risk hospital areas. I developed a better understanding of diversion, the opioid crisis and the urgent nature of this matter. It was absolutely fascinating learning about this issue which made me eager to dive into the project even more. Soon after I finished the literature review, I was ecstatic when I was also given the opportunity to draft the backgrounder for the Partners Table. Writing the backgrounder was definitely not the same type of writing that I do in school. It required a completely different style of writing and a subjective approach which made this project challenging but extremely interesting and informative. This is definitely one of the topics that I will continue to monitor after my time at the College.

3. What was your favourite part about working at the College?

I thoroughly enjoyed the diversity of the projects that I was given. Each assignment was completely different and unique from the previous one. This really allowed me to learn more about the different aspects of the College and to also explore my own interests and capabilities. I also enjoyed having the opportunity to attend meetings, a disciplinary hearing, and shadow a practice advisor. Lastly, everyone I met and worked with was extremely friendly and eager to help me learn and really get the most out of my experience at the College - which made my time here that much better.

4. How do you think your experience this summer will help you with your future career?

My current goal for the future is to actually pursue a career in dentistry. As there is also a self-regulating body for this profession, I know that I will be able to apply what I learned this summer to my future career. My experience here at the College has provided me valuable insight into all the hard work that is involved with regulating a healthcare profession while also stressing the best interest of the public. Learning about the College's emphasis on best practices and the optimization of scope has sparked a realization and a sense of comfort in me knowing there are ongoing efforts to improve and optimize our healthcare system. These will be guiding principles to keep in mind when I become a healthcare provider.



DISCIPLINE DECISIONS

The College has moved Discipline Decisions online to pharmacyconnection.ca.

These easy-to-access decisions facilitate greater accessibility among pharmacy professionals, stakeholders and members of the public and allow us to share decisions more widely via e-connect, our website and social media. As always, pharmacy professionals are encouraged to view these decisions as opportunities to examine and enhance their own practice. Decisions also remain available to view on the public register and CanLii.

LIST OF FALL 2018 DECISIONS:

Shady Mawad (OCP #218593)

Joshua Ramsammy (OCP #613037)

Dawn Romeo (OCP #502404)

Carol Sieler (OCP #93785)

Shabuddin Syed (OCP #614650)

Medhat Abdelmalak (OCP #209168)

Pharmacist X

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.

FOCUS ON ERROR PREVENTION

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

Don't ignore computerized drug utilization warnings due to the large number of clinically insignificant warnings provided. Alert fatigue can result in therapeutic oversights.

Pharmacists must be aware of the potential for therapeutic duplication when assessing the appropriateness of drug therapy.

The risk of therapeutic duplication increases as the population ages and when patients are seeing multiple healthcare providers and who subsequently may have their prescriptions filled at more than one pharmacy. Patients transitioning from one patient care setting to another are also at risk of therapeutic duplication.

The following case highlights the potential for patient harm when a doctor changes from one medication to another within the same therapeutic class, and the patient is dispensed both medications.

CASE:
A 70-year-old patient had been taking Sandoz Valsartan for an extended period of time.

With Health Canada's recent recall of specific lots of Valsartan, the patient's Sandoz Valsartan became unavailable. Upon hearing news of the recall, the patient decided to discontinue taking the Valsartan and contacted her pharmacist for guidance. The pharmacist made the decision to contact the patient's physician and sent a fax indicating that Valsartan was unavailable and asking that an alternative medication be prescribed.

The following day, the patient contacted the pharmacy for follow up as they were concerned about not taking their blood pressure medication. However, the physician had not yet responded to the pharmacist request. On this occasion, the pharmacist made the decision to switch the patient to another brand of Valsartan (Diovan®) which was not recalled and therefore available. Diovan® was therefore prepared and dispensed correctly.

The following day, the patient's physician faxed a new prescription to the pharmacy for Olmesartan for the patient. The Olmesartan was prepared and checked by the pharmacist. Unfortunately, the pharmacist did not identify the therapeutic duplication. The patient was therefore called to pick up the medication.

During patient counselling, the pharmacist checked the patient's profile to review her medication history. It was then that the duplication was discovered.

The Olmesartan prescription was therefore cancelled and the patient advised to continue with the Valsartan as previously taken. The prescriber was advised of the cancellation of Olmesartan.

POSSIBLE CONTRIBUTING FACTORS:

- Delay in response by the patient's physician.
- Following the decision to dispense Diovan® to the patient, the pharmacist failed to inform the patient's physician that the change in medication was no longer needed.
- When dispensing Olmesartan, the pharmacist failed to check the patient profile to confirm therapeutic appropriateness.
- The dispensing pharmacist failed to notice and/or act on the Drug Utilization Review warnings provided by the computer system. One factor may be the large number of clinically insignificant warnings provided. These or false alarms can lead to alert fatigue, resulting in the ignoring of warnings.

RECOMMENDATIONS:

- Always use the patient's medication profile to perform a therapeutic check when dispensing any new or refill medication.
- When requesting a change in drug therapy, assist the prescriber by making a couple suggestions.
- Computer software vendors should ensure that significant warnings stand out and can be easily seen and interpreted by health care providers. When appropriate, a pharmacist override should be required before the prescription can be processed.
- Always contact the prescriber for clarification when multiple medications from the same therapeutic class are prescribed.

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

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