Ontario College of Pharmacists
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PHARMACY CONNECTION

SUMMER 2018 • VOLUME 25 NUMBER 3
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THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

BUILDING BLOCKS OF QUALITY OUTCOMES

The power of data and knowledge in quality and safe pharmacy practice

IN THIS ISSUE:

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

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- 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

VISION
A trusted, collaborative leader that protects the public and drives quality and safe pharmacy care and improved patient outcomes.

MISSION
The Ontario College of Pharmacists regulates pharmacy practice to serve the interests, health and wellbeing of the public.

VALUES
ACCOUNTABILITY | INTEGRITY | TRANSPARENCY

STRATEGIC PRIORITIES
- Enhance system and patient outcomes through collaboration and optimization of current scope of practice
- Strengthen trust and confidence in the College's role and value as a patients-first regulator
- Enhance the College's capacity to address emerging opportunities and advance quality and safe pharmacy practice and regulatory excellence

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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Nancy Lum-Wilson,
R.Ph., B.Sc.Phm., MBA
CEO and Registrar

Dear Colleagues,

As pharmacy professionals, we all understand the value of evidence and data to support informed clinical decision making that has the patient's best interests in mind. As a regulator, the College must also rely on reliable information and data to guide our work, the decisions that we make, and the programs we develop and implement to promote quality and safe pharmacy practice in the public interest.

In my letter in the Winter 2018 edition of *Pharmacy Connection*, I point out the many initiatives underway at the College that have made access to data and quality indicators for pharmacy a top priority. Evidence and quality data are considered the building blocks of good health care, helping to improve knowledge and practice among health professionals and patients alike, inform good decision making and, ultimately, influence quality and safe care as well as positive patient outcomes.

As you all know, we're moving forward with a medication safety program and are making progress towards a province-wide roll out to all 4,300 of Ontario's community pharmacies later this year. Subsequently, we will begin the work in our hospital pharmacies. In this issue of *Pharmacy Connection* you'll learn about how the experiences of our ambassador pharmacies are helping to inform how best to support pharmacies and pharmacy professionals as they begin to implement the program in just a few months.

While a significant degree of attention has been paid to anonymous reporting of incidents and near misses through this program, one of the most important aspects of the program lies in what the pharmacy system will be able to do with aggregate data that we will, for the first time in Ontario, have access to. Reports generated through the program will help all of us better understand how many errors occur in community pharmacies in the province, why they happen and what we all can do to prevent them from recurring.

Our desire to make data-informed decisions and to better measure the quality and impact of pharmacy on patient outcomes continues to drive our work in other areas too. As you'll read later on, the College continues to work closely with Health Quality Ontario to establish pharmacy in the province's health quality agenda and recently invited several pharmacy stakeholders to participate in a roundtable to help us define a path forward to achieve this objective. The first step involves co-creating a set of standardized pharmacy quality indicators that will support our work – as a regulator and as pharmacy professionals – to better understand and measure the quality and impact of pharmacy on patient outcomes and health system performance.

Our focus on having information to support good decision making also extends to emerging matters such as cannabis. In October of this year, the *Cannabis Act*, which makes access to and use of recreational cannabis legal in Canada, will come into force. This is a significant milestone in the country's history; however, there is to-date limited information about the effects of cannabis on patient outcomes.

The College's Cannabis Strategy, endorsed by Council in June 2018, acknowledges the important role pharmacy professionals can and should play in supporting quality patient care for those who use cannabis, including building pharmacy professionals' knowledge to understand the effects of cannabis on a patient's overall health and well-being. The Strategy also acknowledges the need for better data and information about patient experiences with cannabis and how pharmacy professionals can help contribute to better knowledge in this rapidly evolving area.

When we don't have access to data or statistical information, it's important that we continue to build our understanding in other ways. In all of the strategies you'll read about in this issue of *Pharmacy Connection*, we have sought input from patients, the public, health system partners and pharmacy professionals to help shape our decisions and focus our work on what matters most: protecting patients. Combined with quality data, these are perspectives that we need and will continue to seek in everything we do as we work together to ensure the priorities of Canada's largest pharmacy regulator are always well-informed.

Best regards,

Nancy Lum-Wilson
CEO and Registrar
Ontario College of Pharmacists

JUNE 2018 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held on June 11th, 2018.

PATIENT REFLECTIONS AT COUNCIL

It is increasingly important for the College to hear and learn from the perspectives of patients and those with lived experiences and to involve them in how we operate as Canada's largest pharmacy regulator. As the College moves forward with identifying new ways to engage patients and the public in our work, the June 2018 Council meeting marked the start of a new format that will involve sharing a patient perspective at the beginning of every Council meeting to help ground the discussions and reinforce the importance of the public-protection mandate of the College.

At this meeting, Council was pleased to welcome Ms. Melissa Sheldrick, the mother of Andrew Sheldrick who passed away following a medication error in 2016, to share her perspective as a patient advocate. Ms. Sheldrick served as a member of our medication safety task force, which recommended what will ultimately become the largest Medication Safety Program of its kind in Canada, and has since championed patient safety and inspired positive change throughout the country.

COUNCIL APPROVES THE 2019 OPERATIONAL PLAN

In March 2018, Council participated in a facilitated planning session aimed at setting a new strategic framework to guide the work of the College over the next three years. Since then, College staff have worked on formalizing the framework and developing an operational plan for 2019 that aligns with the new strategic priorities identified by Council. The final 2019-2021 Strategic Framework and 2019 Operational Plan were presented to Council and can be found on the College's website. Each quarter, Council will receive a scorecard tracking the progress against the operational objectives identified in the operating plan.

CANNABIS STRATEGY AND POSITION STATEMENT

In September 2017, Council agreed to establish a task force to develop a cannabis strategy given the changing landscape in Ontario. The task force developed *A Cannabis Strategy for Pharmacy*, which was presented to Council at its June 2018 meeting, to support the ability of pharmacy professionals to respond to changes in the pharmacy practice environment related to the use of cannabis for medical purposes and the implications associated with the legalization of recreational cannabis. Council also considered a position statement regarding the dispensing of cannabis for medical purposes in pharmacies. Council agreed to an amended position statement, which is now posted on our website along with the Cannabis Strategy, FAQs and other supporting information.

CONSULTATIONS

Input from the public, pharmacy professionals and other stakeholders assists the College in the development of policies, guidelines and other documents and decisions that support our strategic priorities and the fulfillment of our mandate. At the June 2018 meeting, Council supported the College's recommendation to seek input on the following issues:

- **Supplemental Standards of Practice – Medication Safety Program**
  As the College proceeds to implement the Medication Safety Program, it is expected that the requirements of the program will be formalized through the adoption of a supplemental Standard of Practice, which will be brought forward for final approval in September.

- **Standards of Operation**
  The College is also consulting on Standards of Operation that serve to clarify the expectations of pharmacy operators to provide an environment that supports safe and effective practice, including participation in the Medication Safety Program.

- **Modernizing the Veterinarians Act**
  In Ontario, both licensed veterinarians and pharmacists may compound, dispense or sell drugs that are to be administered to animals. The College of Veterinarians of Ontario's (CVO) Council has recently approved recommendations for modernizing the *Veterinarians Act* to an authorized-acts model. Feedback is sought regarding changes being considered by CVO that will impact pharmacists, specifically that pharmacists would not be permitted to prescribe, adapt or administer any drug or substance to, or for, an animal. If you are a pharmacist involved in the practice of dispensing or compounding drugs to be administered to animals, the College would like to hear from you. The feedback is intended to be brought back to Council for information and provided to CVO to inform their work.

MODEL STANDARDS FOR PHARMACY COMPOUNDING OF NON-STERILE PREPARATIONS

Following Council's adoption of the Model Standards for Pharmacy Compounding of Non-Sterile Preparations in December 2017, the College initiated a stepwise implementation of the Standards, starting with an expectation for pharmacy professionals to familiarize themselves with the Standards and begin to identify their knowledge and practice gaps. Implementation will be guided by a national working group with representatives from provincial pharmacy regulatory authorities and pharmacy professionals. The working group will meet in September 2018 and use a risk-based approach to determine the first set of critical elements required for the next phase of implementation. High-risk activities, such as the handling of hazardous products will be prioritized and Council will be asked to consider and approve an implementation date based on the recommendations of this working group.

REGISTRATION PRACTICE – PACE AND COUNCIL RESOLUTIONS

In February 2014, Council accepted the pilot implementation of PACE (Practice Assessment of Competence at Entry) as a new model embedding principles of fairness and objectivity while allowing for assessment of candidate knowledge, skills and abilities. A comprehensive evaluation of PACE processes and outcomes, including stakeholder surveys and focus groups, was undertaken and confirmed that PACE was accomplishing its goals, specifically to (1) differentiate between those who are competent to practice and those who aren't and (2) reduce the amount of time required for the structured practical training requirement for those who are competent to practice.

At its June 2018 meeting, Council approved PACE as the structured practical training program requirement for pharmacist applicants. The development of PACE for pharmacy technicians will follow the implementation of changes to the experiential requirements for Canadian pharmacy technician programs, and will take effect in 2019.

Council then discussed and approved Council Resolutions that recognize Ontario entry-level PharmD graduates and Canadian Society of Hospital Pharmacists residents as meeting the structured practical training (PACE) requirements for registration purposes, through the completion of these programs.

OPTIMIZING PRACTICE STRATEGY – FUTURE OF PHARMACY

The Ontario Pharmacy Evidence Network (OPEN) is a team of multidisciplinary researchers who work together to evaluate the quality, outcomes and value of medication management services that pharmacists and other healthcare professionals provide. OPEN was commissioned by the College to prepare a paper aimed at providing the profession of pharmacy with critical insight and strategic direction to help envision the future of pharmacy.

Dr. Lisa Dolovich, who co-leads the OPEN program, presented to Council the themes emerging through this research. Ms. Susan James, Director, Quality, also presented to Council on how these themes will contribute to and enhance the College's own Optimizing Practice Strategy, which was developed to promote pharmacists and pharmacy technicians practicing to current scope. The paper is intended to be published with the objective of promoting discussion among pharmacy stakeholders regarding scope of pharmacy practice within the health care system in ways that make a difference in people's lives.

NEXT COUNCIL MEETINGS

To support planning for various College program activities, Council approved a meeting schedule for the next year as follows:

2018

- Monday, September 17 and Tuesday, September 18, 2018
- Monday, December 10, 2018

2019

- Monday, March 25, 2019
- Monday, June 17, 2019
- Monday, September 23 and Tuesday, September 24, 2019
- Monday, December 9, 2019

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. They are also live-tweeted. If you plan to attend, or for more information, please contact Ms. Ushma Rajdev, Council and Executive Liaison at council@ocpinfo.com.

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How Are You Preparing For the NEW STANDARDS FOR NON-STERILE COMPOUNDING?

In December 2017, College Council adopted the National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Non-Sterile Preparations. The standards are accompanied by a Guidance Document for Pharmacy Compounding of Non-Sterile Preparations.

The standards apply **to ALL pharmacies that are involved in any type of non-sterile compounding in any quantity (whether once in a while or every day).**

The College, in collaboration with other pharmacy regulators across the country, is currently working towards establishing an appropriate implementation timeline.

Proactive preparation for the standards could include:

- ✔ Reviewing and becoming familiar with the standards and guidance.
- ✔ Conducting an assessment to identify gaps between the standards required in the pharmacy and your current practice, processes and compounding environment. The guidance document can be used to provide more details on how the standards can be achieved.
- ✔ Undertaking a risk assessment to identify the appropriate level of precautions required to minimize contamination of each compounding product and to provide adequate protection for personnel. Use *Diagram 1: Decision algorithm for risk assessment* found in the guidance document.
- ✔ Starting work to close those gaps. For example, pharmacies can begin by reviewing current policies and procedures, master formulations and Safety Data Sheets. Additionally, pharmacies could inventory all compounds that are prepared in the pharmacy and decide whether they will continue to produce them and, if so, what category the compound would fall into.
- ✔ Looking for resources (e.g. education) that are relevant to any gaps in knowledge or processes.

The standards are an important part of protecting patients. It is the responsibility of the Designated Manager, pharmacy manager and pharmacy professionals to ensure that they are up-to-date on these new standards and are moving towards achieving implementation.

To learn more and stay up-to-date, visit the Non-Sterile Compounding Key Initiative on the College's website.

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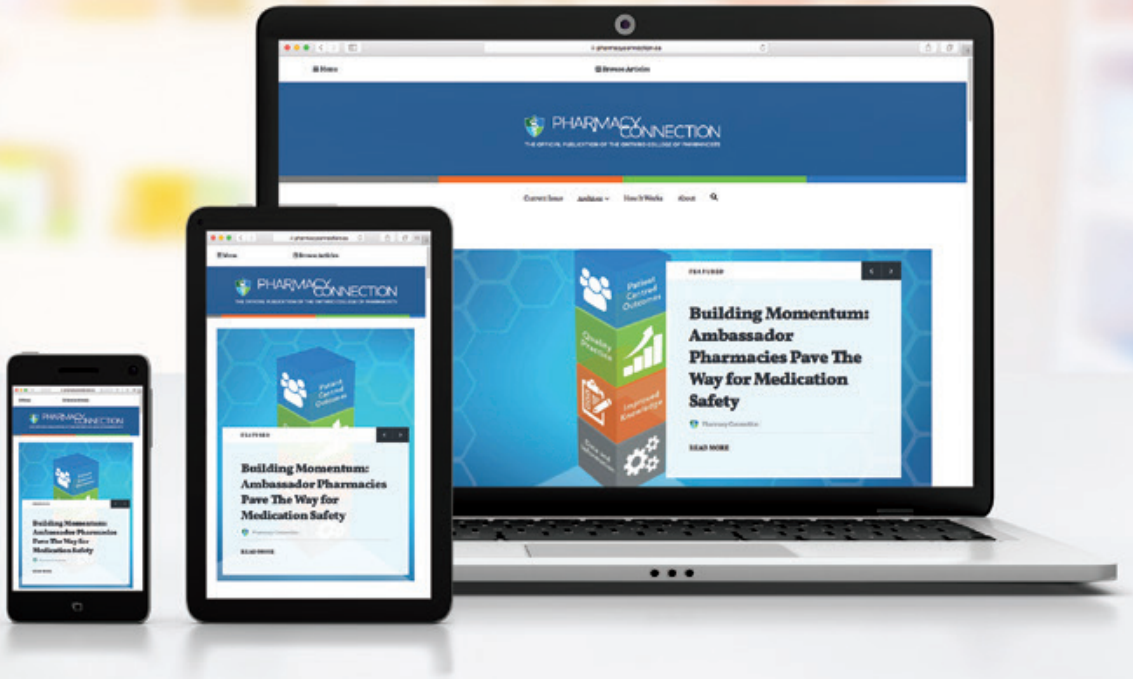
is the digital home of the College's quarterly magazine.



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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

CHANGES TO PROVINCIAL GOVERNMENT, OHIP+

On June 29, 2018, Ontarians formally welcomed The Honourable Doug Ford as the new Premier of Ontario following his election earlier in the month. Joining Premier Ford at the swearing in ceremony were the newly appointed members of his Executive Council, including the new Minister of Health and Long-Term Care, the Honourable Christine Elliott.

Shortly after her appointment, Minister Elliott announced changes to OHIP+. Children and youth who are not covered by private benefits will continue to receive their eligible prescriptions free. However, if a patient is covered by a private plan, that plan would be billed first, with the government covering all remaining eligible prescription costs.

MANDATORY WARNING STICKER AND HANDOUT WITH PRESCRIPTION OPIOIDS

To help ensure patients receive consistent, relevant information about the safe use of prescription opioids and their potential risks, Health Canada has announced that beginning in October 2018, warning stickers and patient information handouts will be mandatory when dispensing prescription opioids included in Part A of the List of Opioids for new prescriptions and subsequent refills.

FEDERAL GOVERNMENT URGES DRUG MAKERS TO END OPIOID MARKETING

On June 19, 2018, Federal Health Minister Ginette Petitpas Taylor asked pharmaceutical companies to suspend any opioid marketing and advertising-related activities while Health Canada develops appropriate policies around marketing opioids to the public. This was the same day the federal government released new data showing that nearly 4,000 Canadians died from opioid overdoses in 2017, a 34 percent increase from 2016.

The government has also announced its intent to create a compliance and enforcement team to monitor opioid manufacturers, enforce the rules against improper drug promotion and take action where necessary, including recommending criminal charges.

SEVERAL DRUGS CONTAINING VALSARTAN BEING RECALLED DUE TO CONTAMINATION WITH A POTENTIAL CARCINOGEN

Health Canada issued an advisory to inform the public that several drugs containing the ingredient valsartan are being recalled by their manufacturers. An impurity, N-nitrosodimethylamine (NDMA), was found in the valsartan used in these products. NDMA is a potential human carcinogen, which means that it could cause cancer with long-term exposure. Health Canada is encouraging patients to speak with their pharmacist to advise them if their medicine is being recalled.

PROPOSAL TO ADD TRAMADOL TO SCHEDULE I TO THE CONTROLLED DRUGS AND SUBSTANCES ACT AND THE SCHEDULE TO THE NARCOTIC CONTROL REGULATIONS

After a review of scientific evidence on the reports of "problematic use of tramadol and the rise in reported deaths" related to the drug, Health Canada announced its intent to reclassify the opioid painkiller tramadol as a Schedule I narcotic, which would place new restrictions on how it is prescribed as a way of reducing dependence and abuse.

NEARLY A QUARTER OF ONTARIO OPIOID PRESCRIPTIONS EXCEED GUIDELINES

As part of a study, researchers at the Institute for Clinical Evaluative Sciences and St. Michael's Hospital examined opioid prescriptions for more than 650,000 patients in Ontario and found nearly a quarter of first-time opioid prescriptions in the province from April 2015 to March 2016 surpassed recommended dose limits. The researchers discovered that the daily dose was more than 50 milligram morphine equivalents for 23.9 percent of initial opioid prescriptions in Ontario.

The study's findings highlight the importance of therapeutic checks to ensure patients' prescriptions (both new and refill) are appropriate for them and that pharmacists collaborate with prescribers when and where necessary. Pc

2019-2021 STRATEGIC PLAN

Trusted to Lead.
Inspired to Serve.
Driven to Protect.

In June 2018, College Council formally approved a new strategic plan that will guide the work of the College for the next three years. The development of the new strategic plan was guided by the College's public-protection mandate and informed through feedback received from a diverse range of stakeholders, including members and health system partners, government and the public.

As the College begins to put the strategic plan into motion, here are some of the initiatives and activities you'll begin to hear more about that will focus on advancing the three core strategic priorities identified by Council:

Strengthen trust and confidence in the College's role and value as a patients-first regulator.

This will include a greater emphasis on building public awareness of our role as a regulator, promoting greater transparency and continuing our efforts to benefit from the lived experiences and insights of patients in our work, programs and strategies.

Enhance the College's capacity to address emerging opportunities and advance quality and safe pharmacy practice and regulatory excellence.

This will include making sure we have the right capacity and structures in place to excel at our work and placing a greater emphasis on data and shared learnings to support quality improvement, effective evidence-informed decision making and better patient outcomes.

Enhance system and patient outcomes through collaboration and optimization of current scope of practice.

This will include implementing key strategies related to cannabis, medication safety, opioids and optimizing practice. It will also include establishing and spreading new partnerships and collaborations across the system to promote quality and safe pharmacy care.

Preparing pharmacy professionals to play an active, and appropriate, role in

THE RAPIDLY EVOLVING WORLD OF CANNABIS

When the Cannabis Act comes into force in October 2018, it will for the first time in Canada make access to and use of recreational cannabis legal. Yet while the country's pharmacy regulatory bodies have not yet received any indication that the framework for accessing cannabis for medical purposes will be re-evaluated, there remains a clear need to support pharmacy professionals who can and should play an important role in promoting quality and safe patient care among cannabis users.

How can pharmacy professionals support high quality patient care when there is no legal framework in place that permits distribution of cannabis for medical purposes in pharmacies? What role should pharmacy professionals play when evidence related to the impact of cannabis on patient health is at the moment limited? What should pharmacy professionals do to help prevent known harms associated with smoking, including cannabis?

ENHANCING KNOWLEDGE, PROTECTING PATIENTS: A CANNABIS STRATEGY FOR PHARMACY

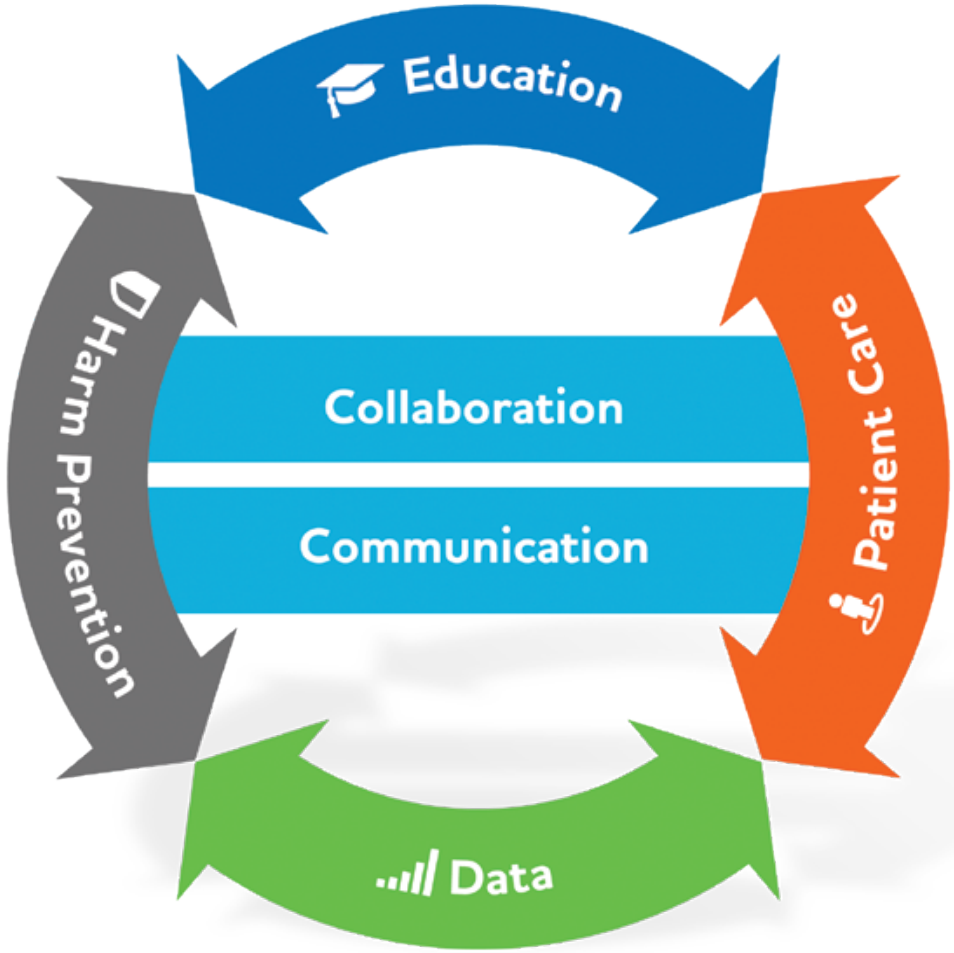
On June 11, 2018, the College's governing Council endorsed the publication of *A Cannabis Strategy for Pharmacy*. The Strategy, developed with the guidance of a multi-stakeholder task force, simultaneously focuses on relevant areas of practice and prepares the College and pharmacy professionals to address evolving cannabis-related issues, while considering how to best serve and protect patients and Ontarians. It also reflects the health and social factors that are related to the legalization of cannabis for recreational use and its continued access for medical purposes.

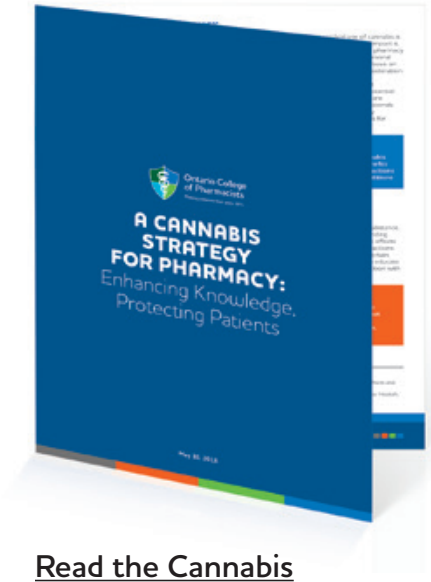
The College recognizes that there are opportunities for pharmacists, in their clinical roles as medication experts, to further promote quality and safety by taking into account cannabis use by patients such as through flagging drug interactions and providing relevant cannabis-related information.

Ultimately, patients and the public should expect pharmacy professionals to have sufficient knowledge about cannabis use to contribute to positive health outcomes and prevent harm. This expectation is set in the College's view that cannabis should be treated no differently than any other drug or substance on which pharmacists already provide advice.

STRATEGIC PRIORITIES

The Strategy consists of four priorities that together, through effective communication and collaboration, will support the College's mandate to serve and protect the public interest:





Read the Cannabis Strategy here

PHARMACY AND CANNABIS DISTRIBUTION: MAINTAINING A FOCUS ON PUBLIC PROTECTION

Throughout the creation of the Cannabis Strategy, the Cannabis Task Force recommended that the College develop a position statement that builds on the existing National Association of Pharmacy Regulatory Authorities (NAPRA) position and further defines an appropriate regulatory opinion on pharmacists' role in cannabis for medical purposes. Council approved the following position statement:

With the recognition that the dispensing of cannabis within pharmacy is currently not permitted within the existing legal framework, the Ontario College of Pharmacists would not oppose any federal or provincial legislation that would permit the dispensing of non-smoked forms of cannabis for medical use within pharmacies, would not oppose legal dispensing for medical use within pharmacies regardless of whether cannabis is approved as a drug by Health Canada or whether it receives an assigned Drug Identification Number provided that sufficient quality control measures are put in place by Health Canada, and opposes the distribution by pharmacies of any forms of cannabis for the exclusive use or purpose of smoking, and in accordance with any provincial legislation.

The College's position statement on the distribution of cannabis in pharmacies refers to cannabis for medical purposes only. The College continues to support NAPRA's position statement which opposes pharmacy practitioners being involved in the distribution of cannabis for non-medical purposes.

STRIKING THE RIGHT BALANCE: ADAPTING TO THE REALITIES OF INCREASED LEGAL ACCESS TO CANNABIS

The College recognizes that cannabis is an evolving matter and may update its position and Strategy as the legislative and regulatory framework in Canada and Ontario related to access and distribution of cannabis evolves and becomes more defined over time.

The College's position and Strategy strike an appropriate balance to make sure that the public is protected as society adapts to increased legal access to recreational cannabis and the emerging matter of cannabis for medical use. The position and Strategy also support professionals in playing an active and appropriate role as medication and clinical experts to provide patient-centred care and education so they can promote positive patient outcomes.

In the meantime, as always, the College expects all pharmacy professionals and pharmacies, including pharmacy owners, operators and designated managers, to act in accordance with established laws and regulations, standards of practice and the Code of Ethics.

ENHANCING KNOWLEDGE: COLLEGE PREPARES FOR MANDATORY CANNABIS EDUCATION FOR PHARMACISTS

In recognition of the important role education would be playing within the Strategy, in March 2018 the Task Force recommended that Council require all pharmacists to complete cannabis education in preparation for the anticipated practice changes due to the legalization of cannabis for recreational use. This recommendation was approved, allowing for work on the development of competencies and suggested learning objectives for cannabis education to move forward.

To prepare for this requirement, an advisory group was formed consisting of educators, community and hospital pharmacists and a patient advocate to provide input on defining competencies related to cannabis. Competencies and suggested learning objectives will be provided to the Canadian Council on Continuing Education in Pharmacy (CCCEP) and education providers later this fall. Approved programs will be identified through the CCCEP using their competency-mapped accreditation process. The College will communicate further details around this new requirement and the approved education programs and resources over the coming months. The deadline for completing an approved education program will be the 2020 license renewal.

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Similar, **BUT DIFFERENT**

Part Two: Human and Veterinary Patients

By: Heather Kidston, B.Sc, R.Ph, FSVHP

In the spring edition of Pharmacy Connection, some differences in veterinary and human marketed drugs were presented to raise awareness of the challenges they may present in a retail pharmacy setting. The purpose of this article is to present a few real-life pharmacy situations that highlight veterinary pharmacology and toxicology.

Consider how the following differences would affect drug dosing:

- Dogs cannot acetylate...what drugs would this affect?
- Cats cannot glucuronidate...what drugs would this affect?
- The GI transit time is 6-8 hours in dogs vs 20-30 hours in humans[1]
- The bioavailability of azithromycin is 97% in dogs, 37% in humans[2]
- The bioavailability of clonazepam is 33% in dogs, 90% in humans[2]

CASE ONE: LEVOTHYROXINE

JS presents a prescription for Synthroid 0.3mg BID for his dog, Ghost. The pharmacist is familiar with the veterinary prescribing short form "SID" instead of "OD" used for once daily dosing, and reads the prescription as Synthroid 0.3 mg SID. The CPS states that "few patients require doses greater than 0.2 mg/day." Using professional judgement and the information at hand, the Rx is dispensed as Synthroid 0.3 mg once daily.

Discussion:

Two veterinary pharmacy facts are presented in this case. The first is "SID" as the Rx abbreviation for once daily in veterinary medicine. Several reported dispensing errors involve SID and BID being confused.

The second is the high dosing of levothyroxine in dogs when comparing it to human dosing. This difference has also resulted in dispensing errors. The half-life of levothyroxine in canines is only 10 - 16 hours, compared to ~7 days in humans.[4] The CPS suggests an approximate initial adult dose of 1.7 µg/kg/day administered once daily. Canine levothyroxine dosing can range from 20 µg/kg/day to 20 µg/kg BID.[4] For context, based on average weight, that would be 200 µg for a beagle, 600 µg for a golden retriever, and 800 to 1000 µg for a great dane.

CASE TWO: XYLITOL

NL presents a prescription for mirtazapine OD 30 mg for her dog, Larry. When the pharmacist inquires, NL indicates that it has been prescribed as an appetite stimulant. The pharmacist knows that xylitol is toxic to dogs. Before proceeding to fill the prescription, the pharmacist ensures that xylitol is not an active ingredient in the generic brand of mirtazapine OD currently stocked.

Discussion:

Xylitol can be toxic to dogs in doses as low as 0.1 – 0.5 mg/kg.[3] For a 2 kg Chihuahua that works out to 200 mg – 1 g of xylitol. Often the quantity of xylitol is not stated on product labels. One of the higher xylitol containing products is "PUR" brand mints and gum, which contain about 1 gm of xylitol per piece. Watch for xylitol in dry mouth treatments, liquid dosage forms, nasal sprays, chewable tablets, nicotine gums or orally dissolving formulations. Avoidance of toxic non-medicinal ingredients such as xylitol, propylene glycol or benzyl alcohol is also a reason for a veterinarian to request a certain brand of a drug with "no substitution."

CASE THREE: OTC PAIN

SK approaches the pharmacist to ask about the best option for pain relief for her cat, Peaches, who got her paw caught in the patio door. She is considering acetaminophen, ibuprofen, ASA, or naproxen in the OTC pain relief section. Which of the following are correct?

A) SK can give Peaches ibuprofen infant drops (40 mg/mL) according to the dosing chart on the side of the box (based on Peaches' weight)

B) SK can give ibuprofen infant drops (40 mg/mL) but should call her veterinarian to check the dose in mg/kg, because it is different in every species

C) Although the ½ life of ASA in humans is 1.5-4 hours, in cats it ranges from 38-45 hours

D) Acetaminophen is contraindicated in cats at any dosage

E) Naproxen is highly toxic to dogs, cats, and ferrets

F) Since what is considered safe for humans is not always safe in cats, SK should consult her veterinarian before medicating Peaches.

Discussion:

C, D, E and F are all correct.

Naproxen, acetaminophen and ibuprofen are all toxic to cats.[3] ASA is rarely used in cats because of their impaired ability to metabolize the drug. If prescribed, it would require close monitoring and would be dosed q48-72h.

The reason "F" is correct, and what pharmacists likely do not know, is that the use of a human OTC in any other species is classified as extra label drug use. Veterinary oversight is expected if a drug is not Health Canada approved for use in the species being treated (ie an approved dose for cats on the package or insert material). Although you cannot prevent a client from purchasing an OTC for their pet, if asked, recommend that they consult their veterinarian.

CASE FOUR: ALLERGY MEDICATION

VF is purchasing a box of Benadryl Total. When asked if he has any questions about the medication, he explains that he is on his way home from his veterinarian, and was instructed to purchase it for his dog. He is surprised and thankful when the pharmacist intervenes to tell him that this product contains pseudoephedrine and acetaminophen in addition to diphenhydramine, which are both toxic to dogs.[3] The prescription from his veterinarian says "Benadryl tablets." VF had inadvertently chosen the wrong Benadryl product in the allergy section.

Discussion:

Pseudoephedrine is toxic to both dogs and cats. In dogs, 10-12 mg/kg can be lethal. Acetaminophen is toxic to cats, and although it can be used in dogs, doses above 100 mg/kg can be toxic.[3] This common OTC self-selection mistake can be especially dangerous to veterinary patients.

When providing care for animal patients, pharmacists must be aware that veterinary pharmacology does not always correlate with human pharmacology. This can make counselling challenging and could lead to contradictory recommendations and confusion. Awareness and communication are the keys to quality continuity of care for animal patients and their caregivers.

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BUILDING MOMENTUM:
Ambassador Pharmacies Pave The Way for Medication Safety

By Stuart Foxman

Late last year, the College identified about 100 community pharmacy ambassador sites to be the first to participate in OCP's new mandatory Medication Safety Program, providing beneficial feedback to inform the program's development. These sites have been working with the College and its program partner, Pharmapod, to train staff and onboard them to the incident recording platform and other program components and to provide the College with qualitative feedback as it prepares for a full province-wide roll out later this year.

At MacTavish Pharmacy in Dresden, Ontario, halfway between London and Windsor, pharmacist Randy Luckham knows the people who visit his pharmacy. That's what happens when you're in a community of about 2,700. Luckham bought the pharmacy 25 years ago, but it has been there for over 100 years. He feels like a custodian of a long tradition of care.

For Luckham, only one mission matters. "We've always stressed a patients-first philosophy, with accuracy in the pharmacy," he says.

That's one reason why he jumped at the opportunity to be an ambassador for the College's new Medication Safety Program. Luckham's pharmacy was one of the ambassador sites that have had the opportunity to participate in the program before the College rolls it out to the province's 4,300+ community pharmacies.

The 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. Under the program, medication incidents will now be anonymously reported using a standardized process and tools, including Pharmapod's incident recording platform, with the aim of promoting a culture of continuous quality improvement within individual pharmacies.

The data gleaned from reported incidents across the province will be aggregated and used to identify overall areas of risk at a system level, to share learnings related to the causes of these incidents and subsequent preventative and quality improvement actions taken and to provide appropriate guidance to all pharmacy professionals.

"It gives us another tool for learning," says Luckham. "There's a big opportunity in information analysis. Individual pharmacies don't make that many errors. But when you add them together you can see patterns that we can all learn from."

PREPARING FOR THE ROLLOUT

Over the past several months the College has been working to ensure all of the program components are fully established by late 2018. At that time, the full roll out to all of Ontario's community pharmacies will begin, with onboarding to program components and Pharmapod's recording platform occurring in phases. Roll out of the program is expected to be completed by Spring 2019.

Luckham's pharmacy and the other pharmacy ambassadors are playing a critical role in the success of the program by testing the incident recording platform and implementing the other equally important components of the program. He sees this as a chance to both share experiences with the College and to get a head start on what he sees as a valuable patient safety program – one that ultimately will be the largest of its kind in the country once fully implemented.

"I think it is our responsibility to embrace change," Luckham says. "We can't just sit back if we can analyze patterns where we can improve our processes."

IDENTIFYING, LEARNING, SHARING AND IMPROVING: THE PRINCIPLES OF A JUST CULTURE

The Medication Safety Program is built upon the principles of a just culture, very similar to what exists in other parts of the health system. A just culture recognizes that mistakes will be made, but that they must be harnessed to improve the system as a whole. It helps promote open reporting of incidents, leading to opportunities to learn from them and to share those learnings with others to help prevent similar incidents from occurring across the system without fear of punishment for admitting a mistake.

While the program requires the anonymous reporting of medication incidents in Pharmapod's recording platform, the program is much more than incident reporting. From the data gleaned through anonymous reports comes better knowledge and understanding of why incidents happen and how they can be prevented and greater sharing of these learnings within and among individual teams and across the entire province. It will, for the first time in Ontario, allow all pharmacy professionals to benefit from system-level data to help make evidence-informed decisions and improvements and contribute to safer patient care and harm prevention. Pharmacies will have access to their data for learning and monitoring purposes; the College will receive aggregate and anonymized data only and will not receive data on any specific pharmacy through this program.

Brittany Bolton, a pharmacy technician at MacTavish Pharmacy, played an important role in her pharmacy's orientation to, and adoption of, the program as she was exposed to the "ins and outs" of the incident recording system while in the midst of her practical training. Luckham encouraged Bolton to help lead the implementation of the program at his pharmacy as he believes pharmacy technicians can contribute to quality improvement and patient safety and can, for example, suggest possible workflow process changes to reduce the chance of errors happening in the first place.

To Bolton, her experience with the program has reinforced that it is about improving and understanding why events happen so that they can be prevented from recurring. "It creates a sense of accountability and awareness, not a sense of blame," she says. "It's a system of learning."

"From the data gleaned through anonymous reports comes better knowledge and understanding of why incidents happen and how they can be prevented and greater sharing of these learnings within and among individual teams and across the entire province. It will, for the first time in Ontario, allow all pharmacy professionals to benefit from system-level data to help make evidence-informed decisions and improvements and contribute to safer patient care and harm prevention."

UNDERSTANDING THE DIFFERENCE BETWEEN INCIDENTS AND NEAR-MISSES

Medication incidents are defined as *any preventable events that may cause or lead to inappropriate medication use or patient harm*. That could include prescribing, order communication, product labelling/packaging/nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use. These are incidents in which an error has reached the patient's hands.

Near-misses are events that could have led to inappropriate medication use or patient harm, but did not reach the patient. These still offer insight into areas of risk, and possible weak spots among processes.

Even if a pharmacy rarely has an actual incident, it will still benefit from the aggregate data available through the program. Luckham stresses that the point is to learn not only from individual experiences, but from the collective pharmacy experience across the province.

He also doesn't consider there to be any real barriers in implementing the program. It can be easily

integrated into any pharmacy, and inputting incidents or near misses is neither complex nor a time burden, considering the program is key to preventing future errors that could potentially have tragic consequences.

Luckham says the fact that reporting is anonymous is also important to stress so that pharmacy professionals know that what is reported and shared through the program is not provided to the College for investigation or disciplinary purposes.

"Errors or near misses should lead to dialogue and corrective actions," he says. "The true purpose is patient care and preventing problems."

To Bolton, the mere presence of the program helps to keep medication safety top of mind and encourages pharmacy staff to have open and productive discussions about safety.

"It makes you stop and have the conversation, to consider why something has happened, even if it doesn't happen that often," says Bolton. "The idea is that it's there and you have to think about it, and then act on it."

WHAT CAN PHARMACIES DO TO PREPARE?

Familiarize yourself with the program requirements, including how it will help to improve patient safety and outcomes. PC

FOUR ESSENTIAL ELEMENTS OF THE MEDICATION SAFETY PROGRAM:

REPORT

Anonymous reporting of medication incidents and near misses by pharmacy professionals to Pharmapod, via an online platform, in order to populate an aggregate incident database to identify issues and trends to support patient safety improvements.

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 occurs, pharmacy professionals analyze the error 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 of appropriate details of a medication incident, including causal factors and actions taken as a result, to all staff. 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.

Safe Pharmacies Need PSYCHOLOGICAL SAFETY

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Given the complexity of the pharmacy workflow, medication incidents are an inevitable part of practice. In fact, it is estimated that as many as seven million medication incidents could occur in Canadian community pharmacies in a year.[1] Reporting, analyzing, and learning from medication incidents are key components of the College's Medication Safety Program or any other continuous quality improvement (CQI) program that aims to reduce the risk of future recurrences. Unfortunately, reporting and discussion of incidents in pharmacies is a responsibility that is often avoided, due to fear of potential retribution from both fellow colleagues and management.[1]

Overcoming these barriers is necessary to create an environment of psychological safety. Psychological safety refers to the phenomenon where members of a team are comfortable with taking interpersonal risks, such as reporting and discussing medication errors, without fear of negative consequences to self-image, status, or career.[2] In healthcare, where errors form the basis upon which improvements in processes are established, psychological safety sets the foundation in allowing both organizations as well as individual practitioners to learn from not only their own, but also from their colleagues' errors. The effects of psychological safety can be expressed across three different levels: individual, group, and organizational (**Table 1**).

Level	Description
Individual	Psychological safety at the individual level describes one's personally-defined perceptions of psychological safety in the workplace. This allows the employee to feel safe when taking interpersonal risks (i.e. sharing medication incidents) and promotes learning from their shortcomings.[3] A working environment where an individual feels psychologically safe elicits confidence, and therefore drives creativity, proactivity, and eagerness to share information with others. Driven by psychological safety, employees are more likely to proactively engage in sharing information with their peers, therefore forming a sense of trust among team members, and creating opportunity for generative discussion of improvements.
Group	Psychological safety at a group level is encompassed by team learning, continuing innovation, and improvements in performance; this is mainly driven by a climate of mutual trust and initiative, developed through task conflict and group collaboration. The resulting supportive network formed among team members allows for productive discussion and enhanced problem-solving skills.[3] Ultimately, psychological safety at the group level predisposes members to be able to learn from shortcomings and encountered incidents and allows the team to innovate and implement changes in existing processes to optimize outcomes in the future.
Organizational	Management practices that promote a sense of psychological safety within the organization facilitate knowledge exchange between peers and create an environment where the organization can perform more cohesively as a whole.[3] Building close relationships between employer and employee can guide individuals by means of mutual trust and respect, aiding the development of psychological safety, and promoting a culture of organizational learning. On an organizational level, psychological safety can be associated with failure-based learning, and the development of supportive networks within the company. Management that provides its employees with opportunity for autonomy, while maintaining organizational structure is fundamental in helping individuals understand that they have the flexibility to take interpersonal risks, and to feel subjectively safe when reporting medication incidents.

Table 1. *Effect of Psychological Safety at the Individual, Group, and Organizational Levels*

CREATING AN ENVIRONMENT OF PSYCHOLOGICAL SAFETY

Development of psychological safety within the workplace allows for understanding of organizational learning and promotes sharing of errors via upwards communication. This encourages staff to express concerns and share incidents not only among their peers, but also with executive staff members, resulting in potential for implementation of organization-wide changes and improvements.[3]

To develop a work culture that embraces psychological safety, factors that influence employees' subjective perception of the work environment must first be established. These include promotion of interpersonal relationships, management behaviours, and organizational practices that are present in the workplace. Cumulatively, these factors should aim to drive the continuous development of psychological safety and ensure that employees consistently feel comfortable with sharing any incidents that they encounter.

Interpersonal Relationships

Interpersonal relationships, and the social support and resources inherent within, promote psychological safety and contribute to team learning, performance, and innovation.[4] Growth of interpersonal relationships is essential in encouraging team collaboration, and the support of peers willing to provide constructive feedback is often a primary objective in helping employees establish a sense of belonging within a team. When relationships among the team are supportive and trusting, members are given the opportunity to manage interpersonal risks and proactively report incidents without fear of repercussions.[3]

Management Behaviours

Supportive and clarifying management processes are the most effective management styles in promoting psychological safety in the workplace.[3] Management characteristics such as inclusiveness, support, trustworthiness, openness, and behavioral integrity strongly influence employee perceptions of psychological safety, which in turn, fosters beneficial outcomes such as team learning behavior, team performance, engagement in quality improvement work, and reduction in errors amongst team members.[4]

Organizational Practices

Supportive organizational practices are positively related to employee work outcomes such as organizational commitment and job performance as they heighten perceptions of psychological safety.[4] The intimacy of a smaller, enclosed system effectively promotes open discussion and increased willingness of staff to express concerns and share incidents.[3]

PSYCHOLOGICAL SAFETY AND CONTINUOUS QUALITY IMPROVEMENT (CQI)

The recent implementation of the College's Medication Safety Program highlights the importance of psychological safety. The Medication Safety Program requires community pharmacies to conduct proactive reviews of existing work processes to identify areas of risk and retrospective reviews of medication incidents to help prevent recurrences in order to enhance medication safety. The incident reports generated will not only help individual pharmacies to develop quality improvement initiatives, but also allow aggregate analysis to inform the development of resources to address gaps in knowledge and skills, and support shared learning across Ontario.[5]

Psychological safety will be necessary to creating a culture where individuals are comfortable bringing forward medication incidents without fear of punitive outcomes. This aligns with the principles of a just culture upon which the College's Medication Safety Program is built.[5] Without psychological safety, pharmacy staff will be less likely to report errors, suggest new ideas, or seek assistance. Training of pharmacy staff, support from upper management, and frequent follow-up or monitoring from pharmacy regulatory authorities will be necessary to create this environment. By focusing on reducing barriers to achieving psychological safety, pharmacies can create a more open work environment and improve overall patient safety. Pc

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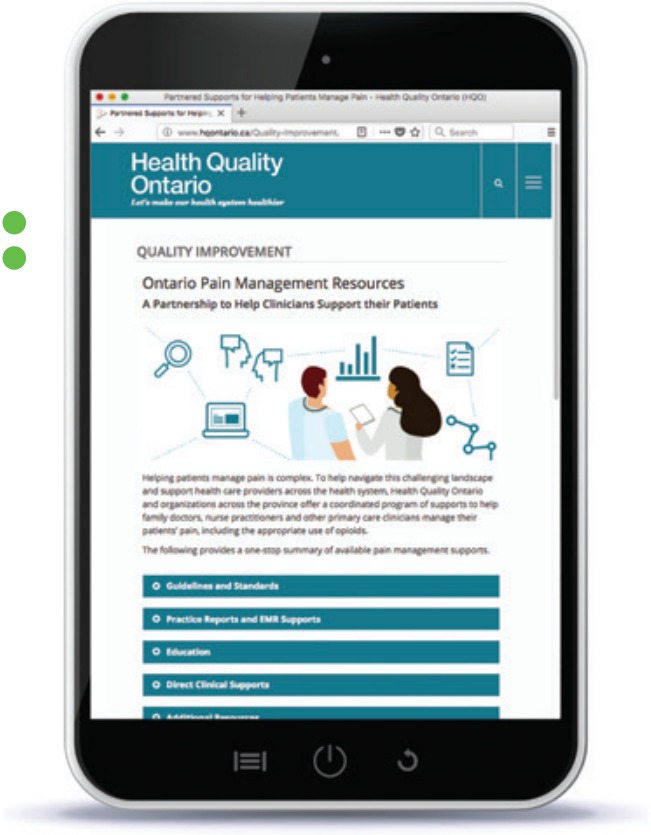
Collaboration with Purpose:

Developing Opioid Resources for Pharmacy Professionals



The College continues to move forward with implementing initiatives and activities to advance its Opioid Strategy. The Strategy's objectives are aimed at establishing goals to advance opioid-related education for pharmacy professionals, improve harm reduction strategies and delivery of opioid dependence treatment, prevent overdose and addiction by supporting evidence-based and appropriate dispensing practices, and strengthen oversight of the provision of narcotics and controlled drugs to patients and the security of drug distribution.

In recent months, the College has engaged pharmacy professionals and health system stakeholders in response to the opioid crisis affecting our communities. This work has included:

- Establishing and collaborating with an external working group comprised of pharmacy professionals and other key healthcare stakeholders with expertise in addiction, pain and other specialties. This group provides advice and works with the College to identify tools and resources to support Opioid Strategy-related initiatives.

- Participating on various health system working groups, including the provincial Opioid Emergency Task Force and the Health Quality Ontario Partnered Efforts Table. The Partnered Efforts Table was created to develop a coordinated and integrated approach to support clinicians in the areas of opioid prescribing and pain management and recently released the "Ontario Pain Management Resources", a one-stop summary of available pain management supports.

- Collaborating with Health Canada and the Office of Controlled Substances to work toward a common goal of responding to the opioid crisis through the prevention and management of loss and theft of controlled substances, particularly narcotics.

- Pulling together tools and resources on morphine equivalent dosing and tapering. These tools have been reviewed by the external working group and posted on the College's website.

TOOLS AND RESOURCES RELATED TO MORPHINE EQUIVALENT DOSING AND TAPERING SUPPORTED BY THE COLLEGE'S EXTERNAL OPIOID WORKING GROUP

Opioid Manager
www.opioidmanager.com
Opioid Manager is a point of care tool for healthcare professionals to support them in prescribing and managing opioid use in patients with chronic non-cancer pain. The tools are based on the 2017 Canadian Guidelines for Opioids for Chronic Non-Cancer Pain and are available in a PDF format, an iOS app and in many EMR platforms. The sections

include: important considerations for opioid therapy trials, starting an opioid therapy trial, maintenance and monitoring, switching opioids, including a morphine equivalent table, and tapering opioids.

MAGICapp – 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
https://app.magicapp.org/app#/guideline/2178
MAGICapp is an app version of the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, including recommendations, evidence summaries and consultation decision aids for practice.

Centres for Disease Control and Prevention (CDC) Opioid Guideline Mobile App
https://www.cdc.gov/drugoverdose/prescribing/app.html
This opioid guideline app is published by the Centers for Disease Control and Prevention in the United States. It reflects the CDC's Guidelines for Prescribing Opioids for Chronic Pain and includes a morphine milligram equivalent calculator. Available for both android and iOS.

Management of Chronic Non-Cancer Pain Tool
https://thewellhealth.ca/cncp
This tool is designed to assist healthcare professionals in developing and implementing a management plan for adult patients living with chronic non-cancer pain.

Opioids and Chronic Non-Cancer Pain – What Can Pharmacists Do to Better Address Both "Pain" & "Addiction/Diversion" Concerns
www.rxfiles.ca/rxfiles/uploads/documents/Pain-Opioids-Pharmacists-QandA.pdf
A document that provides considerations for pharmacists when interacting with patients who are using opioids. It suggests conversation prompts and actions to be taken when assessing the prescription and counselling patients.

Ontario Pain Management Resources
http://www.hqontario.ca/Quality-Improvement/Guides-Tools-and-Practice-Reports/Primary-Care/Partnered-Supports-for-Helping-Patients-Manage-Pain
Visit this one-stop spot for guidelines on appropriate opioid use, CME-accredited webinars on chronic pain and direct links to medical mentors who can answer your care questions.

Opioid Tapering Template
www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf
This template provides a format for a tapering schedule and includes general approach considerations to tapering off opioids related to chronic non-cancer pain.

OPEN – Deprescribing Algorithm for Benzodiazepines
www.open-pharmacy-research.ca/evidence-based-deprescribing-algorithm-for-benzodiazepines/
There are two tools available for healthcare professionals: a benzodiazepine deprescribing algorithm and a benzodiazepine deprescribing information pamphlet.

Choosing Wisely – Drowsy Without Feeling Lousy
https://choosingwiselycanada.org/perspective/toolkit-benzos-primary-care/
A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in primary care, including resources related to achieving consensus on indications, risks and benefits, engaging patients in shared decision making, deprescribing and alternatives.

MAKING DECISIONS **IN THE BEST INTEREST** *OF THE PATIENT*

In this four part series, the College will focus on the four domains of the community pharmacist practice assessment, highlighting trends that we are seeing in practice. Part two of this series focuses on decision making. Review Part one on patient assessments in the spring 2018 edition of Pharmacy Connection.

NOT ALL DECISIONS FEEL LIKE DECISIONS

Pharmacists, as important members of a patient's healthcare team, are always making decisions. These decisions, such as ones made in the context of renewals or adaptations, are evident in a pharmacist's everyday practice.

Decisions are made during the patient assessment, in the process of filling the prescription, in creating documentation and in counselling the patient. They are also made when determining whether follow-up and/or monitoring is appropriate, such as to engage more frequently with a patient that has chronic health issues or to conduct a more regular evaluation of the effectiveness of a drug therapy.

Think about the many decisions made throughout a day's practice, such as determining when the following may be required:

- Pharmacist intervention (e.g. adaptation, alternate therapy)
- Additional patient assessment
- Informed consent
- Consideration of additional therapeutic options
- Management of drug interactions
- Patient education or communication
- Collaboration with a prescriber or healthcare professional
- Follow-up and monitoring
- Additional research or information gathering

Whether the decisions are related to a complex medication management question or a simple operational matter such as adapting workflow assignments for a day, the decisions that pharmacists – and indeed all pharmacy professionals – make can have a dramatic impact on patient outcomes.

USING PROPER JUDGMENT

As healthcare professionals, pharmacists must use proper judgment when making decisions, taking into account the patient's best interest, their own knowledge and expertise and whether the decision is reasonable and acceptable. Regardless of the decision, the rationale and actions taken (or not taken) should be documented.

Decisions that are made in practice should be considered appropriate for the individual patient and the circumstances. Decisions about appropriateness may be based on a number of factors, such as a pharmacist's clinical knowledge, data gathered from resources, and information collected through the patient assessment process. There should be a clinical rationale to dispense or sell any drug therapy – the focus of the pharmacist should not just be on achieving technical accurateness or completeness.

When issues with a patient's prescription or therapy is identified, it's important to document any decisions made as a result. It's also important to remember that a decision to do nothing is still a decision.

Additionally, pharmacists have the autonomy to make decisions and to collaborate when necessary.

For example, if a pharmacist identifies a serious drug interaction and then sends a fax to the prescribing physician who confirms the prescription, the pharmacist now needs to make a decision about how to proceed (e.g. putting in place additional monitoring, providing more patient education, researching additional options, suggesting alternatives, refusing to fill). It is not acceptable in this situation for the pharmacist to say that they have no decisions to make because the "doctor said so."

It is imperative that when collaborating with prescribers or other healthcare professionals, pharmacists should put thought into how they are communicating and how they decide what to include in their communication. Is the information provided complete? Is it clear? Has the pharmacist made a recommendation that reflects their skills and knowledge?

It is the College's expectation that pharmacists are making decisions that optimize patient outcomes, that they are implementing those decisions and that they are monitoring the outcome of them to ensure they continue to be the best option for the patient.

AN EXAMPLE PATIENT SCENARIO

In the *Pharmacy Connection* Spring article, "The Importance of Patient Assessment," a patient scenario was shared of a 59-year-old male who had been filling his prescriptions at the pharmacy for about one year. His patient profile showed that he has Type 2 Diabetes, dyslipidemia, osteoarthritis and is a smoker. He was currently on Atorvastatin 10mg once daily, Metformin 1000mg twice daily, Gliclazide MR 30mg daily and Venlafaxine 150mg once daily and was looking to pick up his new refills.

In looking at this patient case, what decisions may be made during the course of the interaction?

Consider the following:

- What do you need to know to make an appropriate decision regarding whether and how to fill this prescription?
- Do you need to speak with the patient to gather enough information?
- What questions do you need to ask the patient?
- Do you need to adjust the therapy?
- Do you need to make a recommendation to the prescriber or otherwise communicate or collaborate with them?

- Do you need to advise the patient on any related health issues (e.g. smoking cessation)?
- Do you need to put in place monitoring of the patient?
- Is there an opportunity for a more comprehensive medication review?
- What needs to be documented and what needs to be followed-up on?
- What needs to be communicated to the patient and is any additional education needed?

All of the above considerations represent actions that could be explored further and each one individually will result in a decision. Even the order in which these actions are triaged is a decision. In this case, all of these smaller decisions will add up to a larger one, which is deciding the appropriate action to take regarding this patient and their prescription.

In the previous article, the Chat, Check, Chart IESU (indicated, effective, safe and patient use) model was referenced in the context of patient assessment. However, it is also relevant for decision making actions, especially since patient assessment and decision making are intertwined. During a patient assessment, you are asking yourself questions such as whether you have enough information or if you are making assumptions about effectiveness and indication.

Asking these questions then requires you to make decisions about how to proceed, such as deciding to confirm the prescription or gather more information (for example through patient dialogue). Ultimately, your ethical obligations to do no harm and to benefit the patient mean that if you believe that there is a more appropriate medication therapy to optimize a patient's health outcome, you need to take appropriate action.

RESOURCES RELATED TO DECISION MAKING

- Practice Assessment Criteria for Pharmacists – Decision Making
- Framework for Ethical Decision Making
- Code of Ethics Video Practice Example: Applying Professional Judgment
- Decision Making Practice Tool

HERE'S WHAT THIS SCENARIO COULD LOOK LIKE IN PRACTICE

You've determined that is it necessary for you to speak with the patient to gather more information before deciding whether the prescription as written is appropriate (a decision).

You ask the patient whether he has been experiencing any side effects and what his latest blood work looks like, keeping in mind that the patient may not know what side effects he should be monitoring for (ask specifically about common side effects like dizziness). The patient says that his blood sugar numbers have been a little high lately and the medication doesn't seem to be helping. He also says he has a doctor's appointment in a couple of weeks. You decide to make a recommendation to the prescriber to alter the dosage (a decision) and engage in more proactive monitoring (a decision).

You see there is a note on the patient's profile to check back in with him on how his attempt to quit smoking is going (a decision made by the previous pharmacist involved in this patient's care). The patient says that he is having difficulty quitting "cold turkey." You talk to him about his options for smoking cessation (a decision).

Ultimately, you decide to fill the prescription as written with patient-directed monitoring until his next appointment. You obtain the patient's informed consent to initiate smoking cessation therapy. You discuss with the patient that it is important for him to discuss his blood sugar issues with his physician at the next appointment and that you have made a recommendation to the physician to adjust the dose. You provide appropriate guidance on the smoking cessation therapy and ask the patient to check back in with you next month. You make a note on the patient record to follow up with both the physician and the patient.

CONCLUSION

As a pharmacist, you are frequently making decisions in every aspect of patient care you provide. Making appropriate decisions is not just a component of your scope of practice; it is fundamental to putting the patient's interest and wellbeing first.

NEW STERILE COMPOUNDING FAQs

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 discussed, full compliance on all elements of the standards is expected by January 1, 2019. If a pharmacy has expressed to the College that it needs additional time to ensure compliance with the standards, then the expectation is that all critical elements of the standards will be fully met by January 1, 2019 and that the pharmacy will have in place an action plan towards full compliance. Read more on the Sterile Compounding Key Initiative.

To assist pharmacies and pharmacy professionals in preparing for the standards, the College has posted new Frequently Asked Questions on our website.

Questions 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?

Please take the time to review the College's Sterile Compounding Key Initiative and Frequently Asked Questions to ensure your pharmacy is prepared well in advance of the deadline.

QUALITY ASSURANCE:

Environmental Monitoring, Gloved Fingertip and Media Fill Testing

The Hamilton Health Sciences Experience

by Gwen Liu, R.Ph, B.Sc.Phm, PharmD, ACPR

The National Association of Pharmacy Regulatory Authorities (NAPRA) standards highlight the importance of a quality assurance program when performing sterile compounding tasks. The intent of such a program is to generate information demonstrating that the compounding pharmacy's personnel, facilities and equipment (i.e. hoods) attain and maintain the conditions required for contamination-free compounding of sterile preparations. A key component of the quality assurance program is environmental verification of the parameters required by facilities according to the NAPRA standards.

In addition to temperature, humidity and pressure differential monitoring, pharmacies are now required to test for viable, non-viable air and surface sampling in controlled areas of the cleanrooms and the primary engineering control (hood) to ensure they fall within NAPRA requirements for ISO air classification and number of colony forming units.

Several years ago at Hamilton Health Sciences (HHS), the Pharmacy department began the creation of an environmental monitoring program to test for air and surface particle counts, as well as conducted gloved fingertip and media fill testing to meet the new NAPRA standards. The following is a step-by-step description of considerations into how HHS implemented their program.

VIABLE, NON-VIABLE AIR AND SURFACE SAMPLING

Step 1: Obtain organizational support

Having the support of upper management is important before setting up an environmental monitoring program. Many hospital cleanroom facilities may not be NAPRA compliant and need renovation. The organization must be cognizant that once testing begins, their current cleanroom facilities may yield particle count levels beyond acceptable range, otherwise known as particle count excusions.

Step 2: Set up a working group with key stakeholders

The working group should include representation from pharmacy operations, facilities, occupational health/health and safety, housekeeping, microbiology and infection control. Educating the group on the NAPRA requirements for cleanroom facilities is vital to ensure everyone is clear and aware of the expectations. Deciding whether to in-source or outsource to a third party vendor is the next decision. Most hospitals will likely outsource since most organizations will not have in-house expertise. Assessment of third party certifier competency should include a discussion of their knowledge of the required cleanroom standards; the type of equipment being used to test; and the testing parameters that certifiers must follow. This information is listed in the NAPRA standards.

Step 3: Design a policy and a sampling plan

The first step is to obtain a floorplan of the cleanroom facility area. The designated certifier, together with review from the working group should identify areas in the cleanroom to be tested. Typical areas targeted for non-viable and viable air sampling are inside the hoods and certain areas in the cleanroom and anteroom (i.e. centre of the room and doorways). Counters, inside hoods, and high touch areas are some areas to consider for surface sampling. As well, all air and surface viable samples must be identified to the genus level. There are specific accreditation standards that labs are required to meet in order to demonstrate that they have the expertise to process environmental samples. It is important to be mindful that speciating samples and the total number of samples taken can have a significant impact on the budget.

Step 4: Design an action plan to address excursions
The different members of the working group will be critical in addressing excursions discovered once monitoring is in place. The initial testing will yield some expected and possibly unexpected results. Developing an action plan to manage excursions in each area will be helpful when such results are obtained. A hood shutdown will have a strong impact on daily operations. Thus, discussing the action plan for an excursion finding in the hood and identifying the parameters as to when the hood would be required to be shut down is important.

Step 5: Identify equipment required
Purchase of equipment and testing materials (i.e. agar plates), will not be required if the testing is outsourced to a third party certifier. Some sites may consider purchasing a particle count tester if additional, more frequent testing is desired.

Step 6: Implement testing
Testing should be performed in dynamic conditions when staff are in the room performing their daily activities in the cleanroom. The certifier must follow the same procedures that sterile compounding staff must follow for donning/doffing personal protective equipment and hand hygiene. They should also wipe down all equipment with sterile 70% isopropyl alcohol before bringing it into the cleanroom space. After surface sampling, a designated person to wipe the residue from the agar plates should be identified.

Step 7: Review results and address excursions
As each testing session occurs, patterns may emerge that may prompt review of regular procedures (i.e. cleaning). Facilities/engineering staff will be helpful in addressing ventilation issues (i.e. pressure differential, airflow, hood performance). Housekeeping and infection control will assist in addressing and recommending cleaning practices (i.e. focused cleaning in particular areas, cleaning agents). Viable air and surface results may also guide decisions surrounding cleaning procedures in the cleanroom facilities. Remember to document actions completed when addressing excursions.

GLOVED FINGERTIP AND MEDIA FILL TESTING

Step 1: Set Up a working group
Consulting the hospital's microbiologist and lab department is beneficial when embarking on development of testing protocols. Their expertise in microbiology and lab standards and procedures is valuable to the process. At HHS, the regional microbiology lab agreed to process the gloved fingertip agar plates for the pharmacy. Media fill testing is completed and incubated in the pharmacy department/lab depending on the site.

Step 2: Develop a policy and procedure for testing and a failed result action plan
Developing a policy outlining the details of the gloved fingertip and media fill testing is important. The policy shall include purpose, frequency of testing, detailed step-by-step testing procedure, incubation temperatures and duration, actionable levels and plan. The media fill test procedure should be reflective of the most challenging sterile compounding procedures and ideally completed at the end of a shift/day. Designing a detailed action plan to address positive results is important before starting so that there is a clear plan to address positive results and to educate staff on the process of handling a positive result.

Step 3: Identify equipment required
In most instances, an incubator will be required. If purchase of an incubator is required, the hospital's microbiology lab may have some insight and recommendation into reputable vendors. Ideally, the location of the incubator should be in a separate area away from medication storage, food and drink. Daily documentation of incubator temperatures is a requirement. As well, the lab may have existing contracts with vendors they can recommend that can supply agar plates and tryptic soy broth media. The use of agar paddles sold by certain vendors are not recommended since the agar is too thin compared to the thickness of the agar in plates.

Step 4: Educate sterile compounding staff on new testing requirements
Educating sterile compounding staff on the new testing procedures and the rationale behind testing can help alleviate anxiety around these new testing requirements.

Step 5: Implement testing
Scheduling testing for each sterile compounding staff member will require coordination of arrival of testing materials and scheduling time in the staff's shift. Depending on the resources and number of staff required for testing, scheduling the testing in a focused time frame may be easier or staggering the testing throughout the year may make more sense.

CONCLUSION

At HHS, developing and implementing an environmental monitoring program has been an informative and enlightening experience. It has highlighted the importance of having standard operating procedures for cleaning, donning/doffing of personal protective equipment, hand hygiene, and proper aseptic technique, as well as proper facility layout and ventilation design in order to maintain a state of control in a cleanroom facility. Following the steps outlined above will help your institution develop and implement an environmental monitoring quality assurance program for your cleanroom that will help meet the NAPRA standards.

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.

PRIVACY

Q I received a summons from another regulatory body requesting patient identifying information for an investigation. Is there any requirement on my part to obtain patient consent to release this confidential information?

Q A police officer has requested information regarding a patient currently under investigation for fentanyl diversion and patch tampering. Can I provide this information?

A Please refer to the Fact Sheet -- Releasing Personal Health Information, which describes a few of the more common disclosures permitted by health information custodians, which pharmacists are, under the *Personal Health Information Protection Act* (PHIPA). You can also to refer to the legislation directly for complete details or contact the Information and Privacy Commissioner of Ontario.

Regarding requests from health regulatory colleges in Ontario, all colleges – including OCP – must follow the same Health Professions Procedural Code (set out in the *Regulated Health Professions Act*). Colleges also establish Rules of Procedure, as any hearings in Ontario must meet the standard for procedural fairness mandated by the *Statutory Powers Procedure Act*. You could reach out to the investigator directly regarding questions about their rules of procedure.

Specific to fentanyl, please refer to the Patch-For-Patch Fentanyl Return Program: Fact Sheet. Regulation 305/16 under the Safeguarding Our Communities Act (Patch for Patch Return Policy) has specific provisions for dispensers providing information to law enforcement. Please refer to section 4(3) under 'Contingency Plan' in the regulations.

CLOSING A PHARMACY

Q I am closing my pharmacy and need to transfer patient files. However, I am uncertain of the rules pertaining to narcotics and controlled substances; would patients be required to get a brand new prescription for all narcotic and controlled medication, or is there a system in place for moving these items, recognizing that there are no "transfers" of narcotic and controlled substances, except benzodiazepines?

A When closing a pharmacy, the patient files and prescription records are "transferred" or relocated to the receiving Designated Manager (DM)/owner, and the prescriptions will then belong to the receiving pharmacy. Exactly "how" the records are entered or merged into the receiving pharmacy's software system is sorted out by the DMs and the vendor(s). Ideally, it should be seamless to the patient.

This "transfer of records" process is not the same as a prescription transfer (as permitted by the *Drug and Pharmacies Regulation Act*) from one accredited pharmacy to another at the patient's request, where transfer of narcotics and controlled prescriptions is prohibited by federal regulations.

Pharmacies and pharmacy professionals participating in the closure of a pharmacy should review the College's Closing a Pharmacy webpage. Additionally, the College's Guideline on Record Retention, Disclosure and Disposal can provide additional information on the management of patient records.

Pharmacy Practice often receives questions about Ministry of Health and Long Term Care programs that are not administered by the College, for example, MedsCheck, Pharmaceutical Opinion Program, Smoking Cessation, the Universal Influenza Immunization Program, and the Narcotic Monitoring System. For Quick Links to the Ministry of Health and Long-Term Care Ontario Public Drug Programs, please see Quick Links to Ontario Public Drug Programs, MOHLTC. The following Frequently Asked Questions illustrate scenarios when it is necessary to contact an external resource.

I'm a pharmacist practicing in Ontario. Is there a course I need to take to perform a Diabetes MedsCheck? Also, can my pharmacy student do a MedsCheck and sign the forms on his own?

From a scope of practice perspective, a pharmacist may conduct a comprehensive medication review for a patient according to the Standards of Practice.

Establishing the MedsCheck program eligibility criteria for patients and pharmacists falls under the mandate of the Ministry of Health and Long Term Care (MOHLTC). Information related to billing, such as submitting a claim for reimbursement and the required paperwork, can be found in the materials available on the MOHLTC website, such as the Professional Pharmacy Services Guidebook, and the Ontario Pharmacists Association's MedsCheck FAQ. Additional questions can be directed to the ODB HelpDesk or Medscheck.Moh@ontario.ca.

For example, the MOHLTC may require the pharmacist to meet certain education requirements to be eligible to receive reimbursement for providing a MOHLTC professional service program.

As pharmacists are self-regulated professionals, the College cannot interpret the Guidebook on behalf of a member and/or determine whether or not the Ministry's criteria have been met.

I have a question regarding the Smoking Cessation Program. Are pharmacists required to take a smoking cessation training program or special course? If so, which specific programs will qualify?

As explained in the Guideline, "Initiating , Adapting and Renewing Prescriptions," pharmacists have the independent authority to initiate treatment for smoking cessation with buproprion or varenicline under O. Reg 202/94 of the *Pharmacy Act*.

The regulations do not require a pharmacist to complete specific training prior to initiating treatment for smoking cessation. Similarly, OCP does not require or endorse a particular program you may wish to take. As with any patient care scenario, pharmacists are relied upon to practice within the limits of their competence, and to obtain the knowledge and skills necessary to carry out their professional duties.

However, you may be required to complete a certification course for the purposes of obtaining reimbursement for providing a specific smoking cessation service offered through a patient's third-party insurer or the MOHLTC.

"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.

CONSIDERING ALL RELEVANT CIRCUMSTANCES IN DECISION MAKING

SUMMARY OF THE INCIDENT

A patient visited his community pharmacy to pick up his prescription refills for lorazepam and risperidone as requested a few days earlier. While the risperidone was ready, the pharmacist refused to dispense the lorazepam because the patient still had two days (doses) remaining of his current prescription.

The pharmacist explained that she would only dispense the lorazepam before the patient was out of the medication if she contacted the physician to authorize an "early release." As this incident occurred on a Sunday, the physician was not available, and this was not communicated to the patient before he arrived to pick up the refills. She asked the patient to come back to the pharmacy in two days, once the physician approved the early release.

The patient expressed concern about running out of his medication and felt that this was an unnecessary inconvenience due to his busy work schedule which prevented him from being able to make frequent pharmacy visits. The patient's view was that he should have been given some leeway related to his refill given that it was a difference of two days and that he was not aware of his doctor placing any limits on when he could refill his prescriptions. The patient also indicated that he felt lied to and that the pharmacist communicated and acted in a demeaning, unprofessional manner toward him.

WHY DID THIS HAPPEN?

The pharmacist believed that it was important not to release the lorazepam – a targeted substance – before the day it was due, unless the physician provided authorization for early release. The pharmacist's rationale, as explained to the patient, did not seem to take into account any other factors; the patient felt as if his needs were not being met. This case illustrates the importance of putting patients at the centre of the decision making process and of considering all of the information and circumstances at hand before exercising professional judgement.

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, and evaluating the available records and documents related to the case.

The pharmacist had the ability to exercise her professional judgement as to whether to release the medication to the patient after reviewing all the information available to her. In this case, there was no interval on the patient's prescription and the panel observed that the pharmacist did not take this into consideration. Furthermore, the patient's profile did not show a history or pattern of misuse, noncompliance, or early refills.

With regards to the pharmacist acting in a demeaning and unprofessional manner, both parties offered divergent accounts of what took place and there was no evidence to definitively determine if the pharmacist behaved inappropriately. The panel noted that human communication is both verbal and non-verbal and is affected by such things as context, tone, word choice and body language. As such, pharmacy professionals should keep all of these factors in mind when communicating with patients.

In light of the above reasons, the panel issued the member Advice/ Recommendations.

ADVICE/ RECOMMENDATIONS

Advice/recommendations allow an opportunity for pharmacy professionals to improve conduct or care.

Advice/recommendations are issued as a remedial measure for matters which are not serious in nature and are considered to pose low risk of harm to the public.

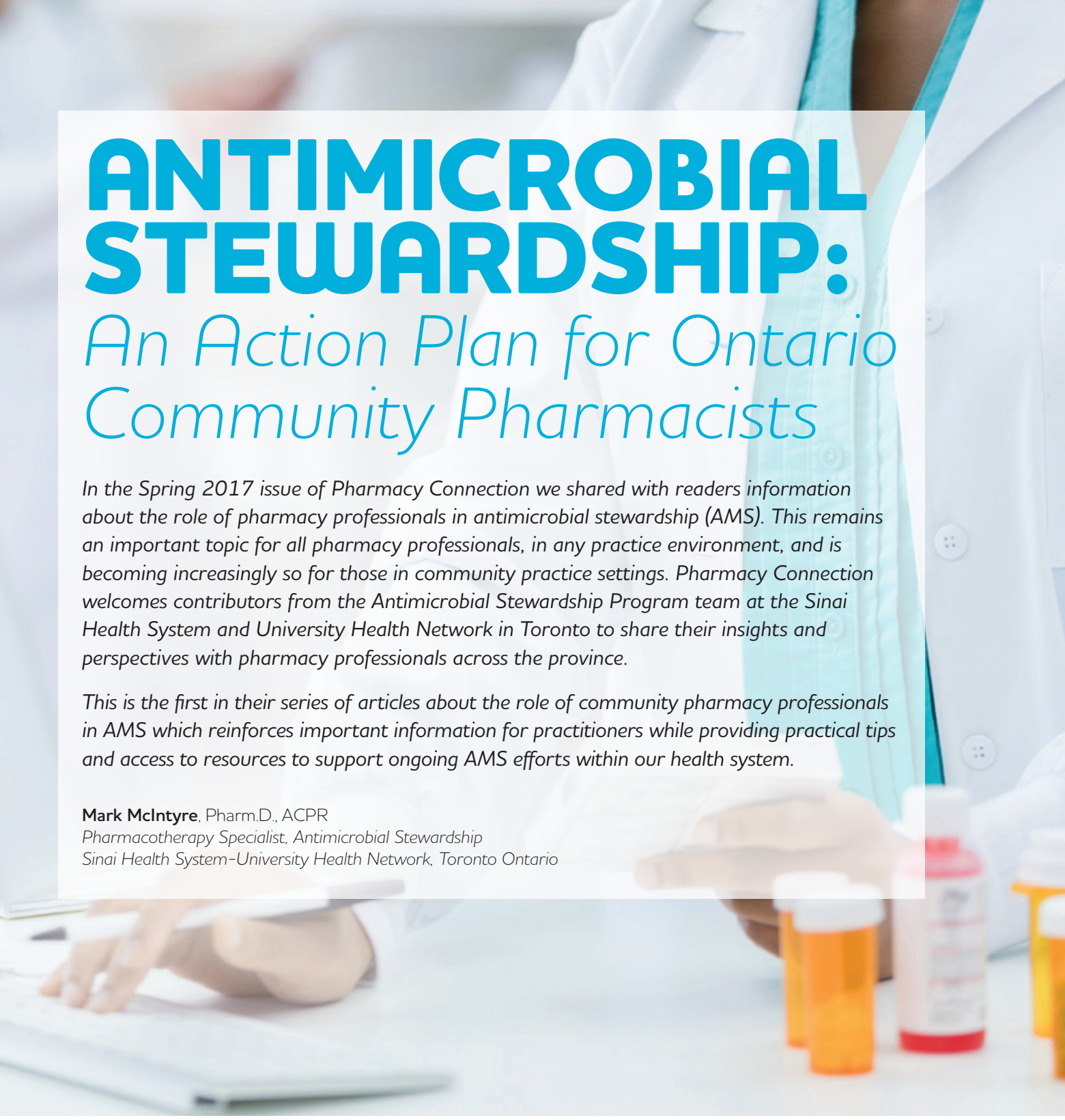
LEARNINGS FOR PHARMACY PROFESSIONALS

The Standards of Practice state that pharmacists must use evidence from relevant sources to inform their activities and critically evaluate medication and related information.

The pharmacist in this case should have thoroughly considered and evaluated all the information at her disposal, including the content of the patient's prescription, his history, his underlying medical condition(s), the rationale for his request, and the amount of his medication remaining. In delivering high quality patient care, pharmacy professionals must properly assess the entirety of each situation as it arises. When making difficult decisions, pharmacists are encouraged to engage in discussion, consultation and deliberation with their peers when they feel it may be helpful to do so.

The Standards also outline circumstances where a pharmacist may refuse to dispense a prescription, such as when there is a risk to the patient, but that the patient's best interests should be at the core of all activities. Regardless of the decision made, pharmacy professionals are responsible for their actions and should effectively communicate the rationale for their decision(s) to the patient as well as document them.

In addition, as a Standard of Practice, pharmacists must demonstrate professionalism and empathy, and apply the principles of the Code of Ethics when providing patient care. Although there was no evidence that the pharmacist in this case acted in an unprofessional manner, pharmacy professionals are reminded of their obligations to treat patients fairly and with dignity, respect, and compassion.



ANTIMICROBIAL STEWARDSHIP: *An Action Plan for Ontario Community Pharmacists*

In the Spring 2017 issue of Pharmacy Connection we shared with readers information about the role of pharmacy professionals in antimicrobial stewardship (AMS). This remains an important topic for all 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 with pharmacy professionals across the province.

This is the first 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.

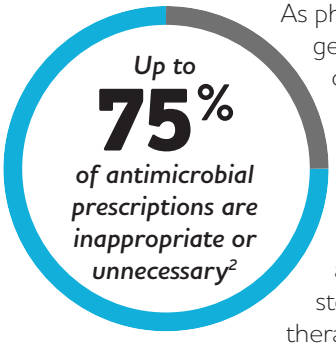
Mark McIntyre, Pharm.D., ACPR
Pharmacotherapy Specialist, Antimicrobial Stewardship
Sinai Health System-University Health Network, Toronto Ontario

92%
of human antimicrobial use is in the community[1]

How many prescriptions for antimicrobials do you encounter every day? In Canada, we fill more than 22 million prescriptions for antimicrobials each year.[1] In Ontario, this equates to an annual average of more than one antimicrobial prescription for every two people.

Antimicrobials are a lifesaving component of medical care. Without effective antimicrobial therapy, many minor infections turn serious or deadly and many routine procedures such as joint replacement and chemotherapy become nearly impossible to achieve optimum patient outcomes.

With antimicrobial use, however, comes the inevitable risk of antimicrobial resistance (AMR). AMR is a growing threat to modern healthcare and is compounded by inappropriate or unnecessary prescribing of antimicrobial agents.[3,4]



As pharmacists, we have a duty to get the right patient the right drug at the right dose via the right route at the right time. Antimicrobial stewardship (AMS) takes this central tenet of pharmacy practice and applies it to antimicrobial agents. Remember that stewardship aims to get optimal therapy for each patient and to preserve antibiotics for everyone. Pharmacists encounter nearly every dose of antimicrobial therapy prior to the patient receiving the medication, making pharmacists – as clinicians and medication experts – antimicrobial stewards.

This and subsequent submissions to *Pharmacy Connection* will focus on stewardship for pharmacists in community practice, specifically syndromes that drive the majority of adult antimicrobial prescribing in community practice – uncomplicated cystitis, sinusitis, pharyngitis and bronchitis. The goal of our submissions is to highlight the importance of effective infectious disease assessment and to ensure optimal antimicrobial use for the discussed conditions. In this issue, we review general strategies to incorporate AMS into your current practice.

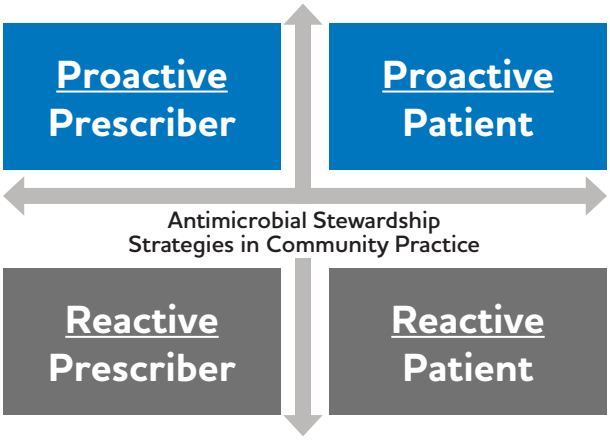
ANTIMICROBIAL STEWARDSHIP INTERVENTIONS IN COMMUNITY PHARMACY PRACTICE

Many antimicrobial stewardship interventions are already widespread in practice.[5,6] From administration of influenza vaccine, to counselling on the expected duration of viral illness-related symptoms, we are reducing the human antimicrobial footprint every day. However, we can do more.

Through the Antimicrobial Stewardship Program at Sinai-UHN, we classify AMS interventions as proactive or reactive. Proactive interventions are those that occur in the absence of an ill patient presenting to your pharmacy counter. These interventions are targeted at prescribers or patients and serve to either prevent the need for antimicrobials or optimize use if they are prescribed. Many of these interventions take training and time to pull together but serve to facilitate a collegial relationship with your prescribers and extensive collaboration may be well worth the effort.

Interventions occurring at the time of an encounter with an ill patient are termed reactive. In the busy reality of daily practice, these types of interventions are likely to represent the majority of stewardship actions. Be it recommending self-care measures for bronchitis or optimizing antimicrobial duration for a urinary tract infection, many opportunities are well within the reach of pharmacists in the community.

The exact mix of strategies employed in your pharmacy will depend on various factors including workflow, experience and prescriber relationships. Whichever mix of strategies you choose, the goal of all interventions is to facilitate valuable, lasting behavior change and improve patient outcomes.



Examples of Proactive AMS Interventions

Prescriber:

- *Academic detailing on decision aids/optimal treatment for specified syndromes*
- *Promoting dated watchful waiting prescriptions*
- *Shared speaking engagements with clinicians (schools, community groups)*

Patient:

- *Vaccination clinics*
- *Cold and flu education days*
- *Engagement posters supporting reasonable antimicrobial use*

Examples of Reactive AMS Interventions

Patients without prescriptions for antimicrobials

- *Assessment and counselling on self-management of viral/self-limited conditions*
- *Counselling on expectation of symptom duration and when to seek further care*
- *Education on viral vs. bacterial infections*
- *Pharmacist follow-up for symptom resolution*

Patients with prescriptions for antimicrobials

- *Confirming indication with patient or agent (optimally at drop-off)*
- *Counselling on expectation of antimicrobial benefits and risks*
- *Adaptation and/or follow-up with prescriber for questions regarding duration, of or indication for, antimicrobial therapy*

Where to start? Pharmacists should know the indication for every antimicrobials they dispense.[7] Though not always available, this information can transform the pharmacist's understanding of antimicrobial therapy as well as his/her ability to plan and apply stewardship interventions successfully.

As stated in NAPRA's Model Standards Of Practice for Canadian pharmacists, "...each new prescription should be reviewed to ensure that it is the most appropriate for the specific patient."[8] Fundamental to appropriateness is knowledge of why the medication is prescribed. Engaging pharmacy technician colleagues and ensuring optimized pharmacy workflow to gather indication information, as an example, may prove an impactful and practical way to start or expand stewardship activities in your pharmacy.

Knowledge is only part of the intervention. Communication to prescribers and patients about reactive stewardship interventions can be challenging. Time pressure to get patients antibiotics and difficulties discussing patient care issues with prescribers are barriers to successful interventions. To facilitate better communication with patients and prescribers, examples of scripting for patient interactions and fax templates for prescribers will be provided in subsequent submissions to *Pharmacy Connection*.

In the meantime, see the links to some practical web-based resources below to help support effective antimicrobial stewardship in your community pharmacy. Keep antibiotics working; we can't do it without you!

LINKS:

http://www.antimicrobialstewardship.com/

https://choosingwiselycanada.org/campaign/antibiotics/

https://www.canada.ca/en/public-health/services/antibiotic-antimicrobial-resistance/antibiotic-resistance-awareness-materials.html

https://www.pharmacists.ca/advocacy/antimicrobial-resistance/

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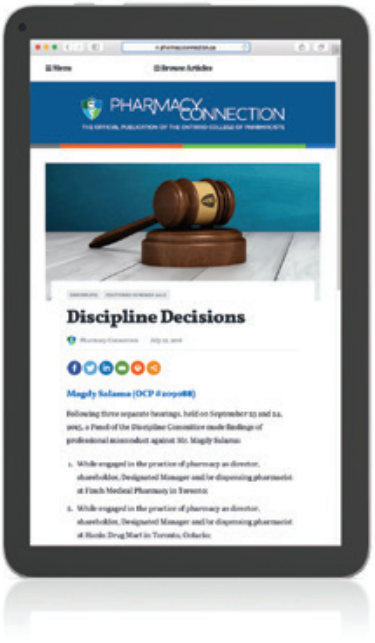
DISCIPLINE DECISIONS

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 SUMMER 2018 DECISIONS:

Magdy Salama (OCP #209088)

John Alma (OCP #17752)

Mustafa Salem (OCP #604014)

Sara Etemad-Rad (OCP #603101)

Nataliya Ivasiv (OCP #220077)

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.

QUALITY ROUNDTABLE: *PHARMACY INDICATORS 2018*

Developing the principles for system-focused 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, government, pharmacy professionals 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.

The first step? Listening and learning.

DIVERSITY OF INSIGHTS KEY TO SUCCESS

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.

With the goal of closing this gap, the College and HQO recently brought together a group of key stakeholders to achieve consensus on a set of principles that will guide the development of standardized and system-focused pharmacy quality indicators.







The Quality Roundtable: Pharmacy Indicators session held in June 2018 at the University of Toronto included patients, providers (including pharmacists), experts in data and informatics, and stakeholders from the Ministry of Health and Long-Term Care, Local Health Integration Networks, insurance providers, associations and academia. The diversity of insights was important as it provided an opportunity for participants to consider the perspectives of pharmacy professionals and patients and to learn from the experiences of other parts of the health care system where indicators are already firmly established.

Facilitated by Dr. Adalsteinn Brown, the Dean of the Dalla Lana School of Public Health and the Dalla Lana Chair of Public Health Policy at the University of Toronto, session participants discussed areas they considered important to measure from the patient, provider and system perspectives. Some of these included indicator measurement areas related to patient experiences and outcomes, provider experiences, appropriateness of medications dispensed, medication related incidents and hospital visits, and transitions of care.

In addition to identifying indicator measurement areas, session participants also discussed principles to consider when moving forward with a quality-based approach to reporting. These included ensuring an adequate focus on high-quality data access and infrastructure support, analysis and sharing of indicator data, developing capacity for quality improvement in pharmacy practice and open sharing of system-wide indicators.

So why is this important to pharmacy and pharmacy professionals, and why now?

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.

WHAT'S NEXT

The *Roundtable* was the first of several steps in the journey to establishing standardized pharmacy indicators. A synopsis document, which summarizes the discussion and takeaway messages from the *Roundtable*, is expected to be published and posted on the College website in September 2018.

A synopsis will support the College's ongoing work with HQO and an expert panel and will eventually lead to the development of a formal set of province-wide quality pharmacy indicators that will be shared for open consultation with members and the general public.

Until then, members are encouraged to stay tuned for further updates in *Pharmacy Connection* and to watch for the publication of the *Roundtable* synopsis report on the College's website.

FOCUS ON
ERROR PREVENTION

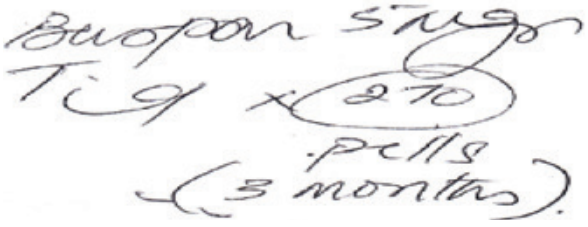
By Ian Stewart R.Ph, B.Sc.Phm.

Failure to accurately process information is a human factor which often results in the occurrence of medication errors. Confirmation bias is often a contributing factor.

Confirmation bias is the tendency of people to look for and interpret information in a way that confirms their beliefs or hypotheses and to ignore or not look for information which is contradictory. We therefore tend to 'see' what is in our memory or what we believe to be true.

The similarity of drug names together with confirmation bias can lead to a medication error as the following case demonstrates.

CASE:



The above prescription was presented to a pharmacy assistant at a community pharmacy. The prescription was interpreted and entered as Buscopan® tablets with the instructions to "take half a tablet three times daily." The Buscopan® tablets were therefore prepared and given to the pharmacist for checking.

Upon checking the prescription, the pharmacist identified that the physician prescribed Buspar® and not Buscopan®. The change was therefore made and the patient received the correct medication.

POSSIBLE CONTRIBUTING FACTORS:

- Buspar® and Buscopan® can look similar when written.
- The pharmacy assistant was unfamiliar with the drug Buspar® and therefore did not consider it as a possibility. On the other hand, Buscopan® was often dispensed. As a result, the pharmacy assistant likely "saw" what was familiar.
- The patient's medication history was not consulted by the pharmacy assistant entering the prescription to identify any similarity or changes in drug therapy.

RECOMMENDATIONS:

- Be aware of the potential for confirmation bias when dispensing drugs with similar names. Educate all pharmacy staff about problematic drug pairs that may be misinterpreted.

Below is an abbreviated list of problematic drug pairs. A more comprehensive list can be accessed at: http://www.ismp.org/tools/confuseddrugnames.pdf.

Folic Acid	Folinic Acid
Metoprolol	Misoprostol
Divalproex sodium	Valproic Acid
Tanacet®	Tramacet®
Hydralazine	Hydroxyzine
Dimenhydrinate	Diphenhydramine
Fluocinonide	Fluocinolone
Tobrex®	Tobradex®
Pantoprazole mag	Pantoprazole sodium
Lasix®	Losec ®
Ceftin®	Cefzil®
Dicetel®	Diclectin®

- The patient's medication history should be consulted to identify changes in drug therapy or potential prescribing errors.

- When counselling the patient, ask open ended questions including, "What did the doctor tell you this medication is for?" Also, "What did he/she tell you to expect from this medication?"

- When dispensing a specific drug, consider all aspects of the prescription for appropriateness. Factors to be considered include the patient parameters, medication history, indication for use, the dose, dosing interval, duration of therapy, etc.

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.

REMINDER:

ARE YOU KEEPING THE COLLEGE INFORMED OF YOUR PLACE OF PRACTICE?

Keeping the College informed of your place of practice isn't just important, it's a requirement under section 12.1.3 of College By-Law No. 4.

We require pharmacy professionals to abide by this By-Law and notify the College of any change in practice location within 30 days. Keeping this information up-to-date is imperative for a variety of reasons, including making sure the College has accurate registrant records.

By keeping the College informed of your place of practice, we're also able to carry out key quality assurance activities to ensure that you're equipped with the knowledge you need to provide patients with safe and appropriate care.

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