Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

FALL 2014 • VOLUME 21 NUMBER 4

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

TRANSPARENCY:
A Pillar of Good Governance

Ontario College of Pharmacists

Putting patients first since 1871

MISSION:

The Ontario College of Pharmacists regulates pharmacy to ensure that the public receives quality services and care.

VISION:

Lead the advancement of pharmacy to optimize health and wellness through patient-centred care.

VALUES:

Transparency - Accountability - Excellence

STRATEGIC DIRECTIONS:

1. Optimize the evolving scope of practice of our members for the purpose of achieving positive health outcomes.
2. Promote the use and integration of technology and innovation to improve the quality and safety of patient care, and to achieve operational efficiency.
3. Foster professional collaboration to achieve coordinated patient-centred care and promote health and wellness.
4. Build and enhance relationships with key stakeholders, including the public, the government, our members, and other health care professionals.
5. Apply continuous quality improvement and fiscal responsibility in the fulfilment of our mission.

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COUNCIL MEMBERS

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

H Christine Donaldson
H Regis Vaillancourt
K Esmail Merani (Vice President)
K Mark Scanlon (President)
L Jillian Grocholsky
L Michael Nashat
L Farid Wassef
M Fayez Kosa
M Don Organ
M Laura Weyland
N Bonnie Hauser
N Christopher Leung
N Ken Potvin
P Jon MacDonald
P Douglas Stewart
T Michelle Filo
TH Goran Petrovic

PM Kathy Al-Zand
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PM David Hoff
PM Javaid Khan
PM Lewis Lederman
PM Aladdin Mohaghegh
PM Shahid Rashdi
PM Joy Sommerfreund
U of T Heather Boon
U of W David Edwards

Statutory Committees

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

Standing Committees

- Communications
- Drug Preparation Premises
- Finance & Audit
- Professional Practice

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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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Mark F. Scanlon,
R.Ph., B.Sc.Phm.
President

> "... transparency is not something to be achieved but rather a foundational value that must be consciously considered and diligently applied to all the work that we do."

There's no denying that in recent years there has been a heightened focus on regulatory bodies — such as ours — to continuously demonstrate our understanding and commitment to our mandate of public protection. As the regulator for the profession of pharmacy in Ontario, it is our responsibility to maintain and enhance public confidence and ensure that Ontarians have access to the information they need to make informed decisions about their care.

The College's commitment to transparency (update article page 16) has been a key strategic priority for Council for many years. In 2012 — recognizing the foundational importance of considering transparency in the development of all College processes and decision-making — Council identified transparency, along with accountability and excellence, as a core value of the College and an integral part of our 2012-2015 strategic plan.

In doing so, we acknowledged that transparency is not something to be achieved but rather a foundational value that must be consciously considered and diligently applied to all the work that we do. In March 2015, Council will gather for our 2015-2018 strategic planning session. Understanding that transparency and accountability are pillars of good governance, Council will utilize this opportunity to solidify these concepts to ensure they continue to guide the work of the College.

As we look to 2015 the College is also focusing on a number of other key initiatives.

One of these is the development of the foundational components such as the regulations and inspection criteria necessary to support the College's anticipated authority – through the enactment of *Bill 21: Safeguarding Healthcare Integrity Act* – to inspect hospital pharmacies and other healthcare facilities throughout Ontario (update article page 28). This expansion of the College's oversight is important as it will help us ensure that all pharmacies in the province — both community and hospital —are meeting the standards of the day and are providing a safe, effective environment for pharmacy care.

Along the same lines, in early 2015 we will be formally piloting the new Practice Assessment model (update article page 27) which will allow us to expand our routine inspections — traditionally focused on assessing pharmacy operations and practice processes — to include an assessment of an individual practitioner's practice. In the new model, College practice advisors (formerly inspectors) will focus on identifying and understanding the processes that are in place to support patient assessment, decision-making, documentation and communication and education. The overriding objective, through coaching and sharing of best practices, will be to enhance practice standards and the delivery of patient outcomes.

Throughout the coming year the College will continue to reinforce the five Professional Responsibility Principles endorsed by Council this year, and will work with practitioners across the province to emphasize the importance of understanding these principles and applying them to every day practice. To further support these principles Council is implementing a task force to review and update the College's Code of Ethics so that it more appropriately reflects current practice and provides the necessary foundation to guide practitioners in the delivery of safe and ethical pharmacy care.

I look forward to working with Council over the coming year as we embrace the reality that we face today: although our challenges may be great, our opportunities may be even greater. Pc

SEPTEMBER 2014 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on September 15 and 16, 2014.

COUNCIL WELCOMES NEW COUNCIL MEMBERS AND ELECTS NEW PRESIDENT AND VICE-PRESIDENT

At the September meeting, Council welcomed newly elected members and newly appointed public members to the Council table. A full list of 2014-2015 Council members is available on the College website.

Mr. Mark Scanlon was elected College President and Mr. Esmail Merani was elected Vice-President for the 2014-2015 Council year. Elections were also held for Committee Chairs. Find a complete list of Committee Chairs and appointments on the College website.

2015 CAPITAL AND OPERATING BUDGET APPROVED

Council reviewed and approved the 2015 budget, which supports the strategic plan developed by Council in March 2012 and the Year Three Operational Plan presented to Council in June 2014.

There are no fee increases proposed for 2015 and the total reserves are expected to be around $8.6 million. The Finance and Audit Committee will undertake a global review of the fee structure and expense reporting after the strategic planning retreat in March 2015.

Council also approved the appointment of Clarke Henning LLP as auditors for 2014. The auditors were selected following an external review of the College's auditing and financial services.

BY-LAW NO. 3 – AMENDMENTS PERTAINING TO GOVERNANCE APPROVED AND FEEDBACK SOUGHT ON PROPOSED CHANGES TO THE PUBLIC REGISTER

Following approval of the Governance Manual at the June Council meeting and flowing from discussions at that time, a number of proposed changes to the by-laws were identified. A request was made at that meeting to seek a legal opinion pertaining to one of the provisions and upon receipt and review, Council approved, as presented, the proposed by-laws relating to governance.

Also discussed at the meeting were proposed amendments to by-laws relating to information posted on the Public Register. As previously reported, the College is working on a multi-staged initiative to determine how we can make more information available about decisions and processes. These proposed amendments are part of the first phase of the Transparency Project and the changes are related to the posting of findings of guilt and custody or release conditions. The proposed by-law provisions have been posted for a 60-day public consultation (deadline November 19, 2014). Feedback received will be considered at the next Council meeting.

Photos by DW Dorken

COUNCIL APPROVES PRACTICE POLICIES AND GUIDELINES

The policy regarding "Centralized Prescription Processing (Central Fill)", and guidelines respecting "Ending the Pharmacist-Patient Relationship" and "Record Retention, Disclosure and Disposal" were approved by Council.

CODE OF ETHICS – PROPOSED REVIEW

Council agreed to the establishment of a Task Force to review and update the current Code of Ethics. With the approval of the Professional Responsibility Principles (in March 2014), which articulate the expectations of the members' professional responsibilities in practice regardless of their role or practice setting, and the revised Professional Misconduct Regulations, which address the addition of pharmacy technicians as a new class of registrants, the expanded scope of practice, and in particular, the expectation that members will exercise professional judgment in choosing to deliver services, Council endorsed the decision to establish such a Task Force so that the Code of Ethics can be reviewed and updated so that it more appropriately addresses current practice.

The Task Force will be led by President Scanlon and over the next 12 months it is anticipated that the Task Force will meet regularly and report periodically to Council on the progress.

COUNCIL MEETING DATES 2014 - 2015 TERM

- Monday December 8, 2014
- Monday March 9 and Tuesday March 10, 2015
- Monday June 15, 2015
- Thursday September 17 and Friday September 18, 2015

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

MEMBERSHIP RENEWAL REMINDER

Online renewal starts in January with a deadline of March 10, 2015

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

Before you begin your online renewal you will need:

- Credit Card or Interac (Debit Card) if paying online
- User ID - This is your OCP number
- Password - If you have forgotten your password, click "Forgot your Password or User ID?" and a new password will be emailed to you

Once you're ready:

- Go to www.ocpinfo.com and click on ***"Login to my Account"***
- Enter your User ID (your OCP number) and your password
- Once you have successfully logged in, click on ***"Member Renewal"*** on the left hand side of the screen

Council for the Ontario College of Pharmacists elects President and Vice-President

Pictured here from left to right: Mark Scanlon (Council President), Marshall Moleschi (College CEO and Registrar) and Esmail Merani (Council Vice-President)

The Council of the Ontario College of Pharmacists (OCP) has elected Mark F. Scanlon, R.Ph. as President and Esmail Merani, R.Ph. as Vice-President for the 2014-2015 Council year. Each will serve a one-year term from September 2014 through to September 2015.

Scanlon, a third-generation pharmacist from the Peterborough area, is a graduate of the Faculty of Pharmacy at the University of Toronto. Carrying on in the same profession of his father and grandfather, Scanlon has over 25 years of experience as a community pharmacist in his hometown. He first served on College Council for a one-year term in 2002-2003 and then returned to Council in 2010. As a Council member, he has actively contributed to numerous committees including: Discipline, Registration, Fitness to Practise, Executive, Quality Assurance and Inquiries Complaints and Reports (ICRC).

"This is a time of innovation and exponential growth for the Ontario College of Pharmacists and for all Ontario pharmacists and pharmacy technicians," said Scanlon. "I feel privileged to have the opportunity to work with my fellow Council members as we continue to develop legislation in the area of hospital oversight, and provide greater transparency to support patient decision-making."

Merani, a community pharmacist from the Ottawa area, obtained a B.Pharm from Robert Gordon University in Scotland, UK in 1973 and a Pharm.D from Shenandoah University in Virginia, USA in 2008. He has been practicing pharmacy in Ontario for nearly 40 years. Merani joined College Council in 2010 and has served on various committees including: Accreditation, Finance and Audit, ICRC, Professional Practice, Executive and Registration.

"We are fortunate to have Mark and Esmail in these leadership roles as we continue to embark on new, exciting opportunities for pharmacy in Ontario," said College CEO and Registrar, Marshall Moleschi. "Mark and Esmail each bring a wealth of experience that will be extremely valuable as OCP continues to uphold its mandate of public protection and support members in understanding and embracing their commitment to the safe and ethical delivery of pharmacy services." Pc

MEMBERS OF COUNCIL

2014/2015

H Hospital

T Pharmacy Technician

TH Hospital Pharmacy Technician

PUBLIC MEMBERS

Kathy Al-Zand
Ottawa

Linda Bracken
Marmora

Babek Ebrahimzadeh
Woodbridge

David Hoff
Oakville

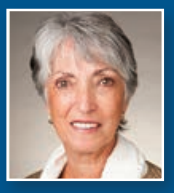
Javaid Khan
Markham

Lew Lederman
Ottawa

Aladdin Mohaghegh
Toronto

Sylvia Moustacalis
Toronto

Shahid Rashdi
Mississauga



Joy Sommerfreund
London

ELECTED MEMBERS

District **H**

Christine Donaldson
Windsor

Regis Vaillancourt
Ottawa

District **K**

Esmail Merani
VICE PRESIDENT
Carleton Place

Mark Scanlon
PRESIDENT
Peterborough

District **L**

Jillian Grocholsky
Fonthill

Michael Nashat
Brampton

Farid Wassef
Stouffville

District **M**

Fayez Kosa
Toronto

Don Organ
Toronto

Laura Weyland
Toronto

District **N**

Bonnie Hauser
Dunnville

Chris Leung
Windsor

Ken Potvin
Waterloo

District **P**

Jon MacDonald
Sault Ste. Marie

Douglas Stewart
Sudbury

District **T/ TH**

Michelle Filo (T)
Sudbury

Goran Petrovic (TH)
Kitchener

FACULTY OF PHARMACY

Heather Boon, Dean
Leslie Dan Faculty of Pharmacy
University of Toronto

David Edwards, Hallman Director
School of Pharmacy
University of Waterloo

OCP Council 2014/2015

Committee Appointments 2014/2015

EXECUTIVE

Elected Members:
Mark Scanlon - President & Chair
Esmail Merani - Vice President
Chris Leung - Past President
Regis Vaillancourt
Public Members:
David Hoff
Aladdin Mohaghegh
Joy Sommerfreund
Staff Resource: Marshall Moleschi

ACCREDITATION

Elected Members:
Bonnie Hauser
Michael Nashat
Michelle Filo
Regis Vaillancourt
Public Members:
David Hoff (Chair)
Joy Sommerfreund
NCCM:
Timothy Brady
Tracy Wiersema
Staff Resource: Tina Perlman

COMMUNICATIONS

Elected Members:
Fayez Kosa
Jon MacDonald
Goran Petrovic
Ken Potvin
Public Members:
Lew Lederman
Joy Sommerfreund (Chair)
NCCM:
Miranda Foster
Staff Resource: Lori DeCou

DISCIPLINE

Elected Members:
Jillian Grocholsky
Chris Leung
Don Organ
Ken Potvin
Mark Scanlon
Doug Stewart
Farid Wassef
Laura Weyland
Public Members:
Kathy Al-Zand
Linda Bracken
Bob Ebrahimzadeh (Chair)
Javaid Khan
Lew Lederman
Aladdin Mohaghegh
Sylvia Moustacalis
Shahid Rashdi
NCCM:
Lavinia Adam
Cheryl Bielicz
Erik Botines
Steve Clement
Dina Dichek
Jim Gay
Mike Hannalah
Helen Lovick
Doris Nessim
Akhil Pandit Pautra
Rachelle Rocha
Jeannette Schindler
Connie Sellors
Robert Spadorcia
David Windross
Staff Resource: Maryan Gemus

DRUG PREPARATION PREMISES

Same membership as Accreditation Committee
Staff Resource: Judy Chong

FINANCE & AUDIT

Elected Members:
Jon MacDonald
Esmail Merani
Doug Stewart
Public Members:
Linda Bracken
Javaid Khan (Chair)
Staff Resource: Connie Campbell

FITNESS TO PRACTISE

Elected Members:
Fayez Kosa
Regis Vaillancourt (Chair)
Public Members:
Linda Bracken
Shahid Rashdi
NCCM:
Barb DeAngelis
Staff Resource: Maryan Gemus

INQUIRIES, COMPLAINTS AND REPORTS (ICRC)

Elected Members:
Heather Boon
Christine Donaldson
Bonnie Hauser
Chris Leung
Michael Nashat
Don Organ
Goran Petrovic
Ken Potvin
Mark Scanlon
Doug Stewart
Farid Wassef
Laura Weyland (Chair)
Public Members:
Kathy Al-Zand
Linda Bracken
David Hoff
Javaid Khan
Aladdin Mohaghegh
Sylvia Moustacalis
Joy Sommerfreund
NCCM:
Elaine Akers
Kalyna Bezchlibnyk-Butler
Stephen Clement
Gerry Cook
Gurjit Husson
Eva Janecek-Rucker
Elizabeth Kozyra
Akhil Pandit Pautra
Hitesh Pandya
Saheed Rashid
Rachelle Rocha
Satinder Sanghera
Dan Stringer
Asif Tashfin
Tracy Wiersema
Staff Resource: Maryan Gemus

PATIENT RELATIONS

Elected Members:
Bonnie Hauser (Chair)
Jon MacDonald
Public Members:
Kathy Al-Zand
Javaid Khan
Sylvia Moustacalis
NCCM:
Gerry Cook
Staff Resource: Anne Resnick

PROFESSIONAL PRACTICE

Elected Members:
Christine Donaldson
Jillian Grocholsky
Esmail Merani
Michael Nashat (Chair)
Don Organ
Farid Wassef
Public Members:
David Hoff
Lew Lederman
NCCM:
Kathryn Djordjevic
Helen Lovick
Staff Resource: Tina Perlman

QUALITY ASSURANCE

Elected Members
Christine Donaldson
Michelle Filo
Jon MacDonald (Chair)
Michael Nashat
Public Members:
Aladdin Mohaghegh
Sylvia Moustacalis
Shahid Rashdi
NCCM:
Victor Naidoo
Zita Semeniuk
Irene Sing
Staff Resource: Sandra Winkelbauer

REGISTRATION

Elected Members:
Christine Donaldson (Chair)
Michelle Filo
Jillian Grocholsky
Public Members:
Kathy Al-Zand
Linda Bracken
Aladdin Mohaghegh
NCCM:
Deep Patel
Dean: David Edwards
Ontario Pharm Tech Program Rep: Sharon Lee
Staff Resource: Susan James

NCCM = Non-Council Committee Member

"Making Everyone Better"

Technicians talk about progress and embracing the role

By Stuart Foxman

Sarah-Lynn Dunlop, RPhT, loves practicing to her full scope – so that the pharmacists she works with can practice to theirs.

Dunlop is a pharmacy technician at Stuart Ellis IDA Pharmacy in Collingwood, and at Collingwood General & Marine Hospital. At the community pharmacy, she conducts the final check on prescriptions, especially blister packs, and takes verbal prescription orders over the phone. At the hospital, she reviews the technical accuracy of prescriptions (one technician checks another's work), and helps to manage the drug distribution system.

"Having professional and ethical standards pushes us and makes everyone better."

How does her role ultimately benefit patients? "It frees the pharmacist," says Dunlop. "In retail pharmacy for sure it allows the pharmacist to spend more time answering the patient's questions, and checking the therapeutic appropriateness."

Becoming a regulated healthcare professional was essential to Dunlop. "It validates what we do," she says. "Having professional and ethical standards pushes us and makes everyone better."

How are regulated pharmacy technicians making an impact and using their full scope? How can pharmacy colleagues understand and welcome what technicians bring to the pharmacy

team? Three technicians who registered at different points – spring 2011 (Dunlop), spring 2013 (Bonnie Dickson) and summer 2014 (Tracey Beaupre) – share their views.

ACCOUNTABILITY IS KEY

Dunlop never had a master plan to make pharmacy her field. At university, she studied psychology and health sciences, and got a part-time job in a pharmacy. After graduating she returned to her hometown of Wasaga Beach, unsure of her next academic or career move. So she began working at a compounding pharmacy in nearby Collingwood.

"I loved everything – the science behind it, collaborating with the pharmacists, and the actual compounding," says Dunlop. When did she know this would be her profession? "When I found out technicians would be regulated, that we'd have greater scope of practice," she says. "That's when I decided on technician as a career path."

Tracey Beaupre, RPhT, has enjoyed many rewarding opportunities throughout her career in pharmacy. She has been at Lennox and Addington County General Hospital in Napanee for just over 15 years. For the first 10, her name badge said "technician". When the College began to regulate technicians, her badge changed to "assistant". It was only in October that she was again able to wear the "technician" title proudly.

What has changed for Beaupre? "I am more accountable for my actions," she says. "I always felt responsible, but now I am legally."

As one of five technicians in the pharmacy (along with two pharmacists), Beaupre handles inventory management, drug distribution and order entry. "We're the frontline and see the orders first, and we bring any issues to the pharmacist," says Beaupre. "I take a best possible medication history from each patient and the physicians use this information to generate their medication orders. I have to make sure that I am very accurate and precise."

Beaupre adds that in a hospital the pharmacists already tend to focus on the clinical aspects and the technicians tend to focus on the technical aspects, so the regulation of pharmacy technicians has the opportunity to play a bigger role in the community pharmacy setting. Dunlop, who has experience in both settings, agrees. So does Bonnie Dickson, RPhT, who works at Boggio Pharmacy at Port Colborne and is casual on-call at the Welland County Hospital Pharmacy.

At the community pharmacy, Dickson works with three pharmacists, another technician and eight assistants. Since registering as a pharmacy technicians, her role

Pharmacy Technician Sarah-Lynn Dunlop

> "When I found out technicians would be regulated, that we'd have greater scope of practice... That's when I decided on technician as a career path."

Pharmacy Technician Tracey Beaupre

> "We're the frontline and see the orders first, and we bring any issues to the pharmacist."

at Boggio has evolved. Before, she spent much of her work day entering prescriptions into the computer system with another assistant. "Since registration, I've started checking blister packaging. We have a large clientele for that, about 340 a week. One of our pharmacists was just doing that. Now the other registered technician and I do it," says Dickson.

How do the pharmacists view the scope of technicians and the professional relationship with them? Dunlop, one of six technicians at her hospital but the only one at the community pharmacy, knows there has been a learning curve for some pharmacists.

She mentions one pharmacist at her community pharmacy who still does a technical check on Dunlop's work. "I'm liable for technical accuracy and she is for therapeutic accuracy," says Dunlop. Yet this pharmacist worries about being accountable for errors on the technical side. Dunlop has discussed the separation of responsibilities. But as she suggests, some pharmacists are searching for that comfort level about where their accountability stops and a technician's starts. "It's letting go of what you've done for years," says Dunlop.

Dickson says that some pharmacists simply don't fully realize what technicians can do. Having the support of her pharmacists has been critical to her ability to not just practice to her full scope but feel confident in doing so. "They knew they could rely on my knowledge and skill set," says Dickson. "Letting go is a lot easier when you know you can trust someone else to do the right thing."

EDUCATE THE TEAM

Why might some pharmacists not see the full potential of technicians? "Some pharmacists have embraced regulated technicians and have wanted them for a long time, and some don't see the value," says Dunlop. "They may think they have to pay us more, or maybe they haven't yet figured out a good workflow to use the technician and free themselves up."

What advice does she have for her fellow technicians who may not yet be practicing to their full scope? Check the College website for information on technician roles, and educate your team. (The College has a practice tool about pharmacy technicians; see http://www.ocpinfo.com/practice-education/practice-tools/collection/technicians/.)

Connect to other technicians too, says Dunlop, and learn how they're dealing with issues like the logistics of daily operations. Some pharmacists need help adopting the right structure to use the technician position most efficiently – and technicians can offer it. "You can't just say there's a problem, you need to propose a solution," says Dunlop.

Beaupre says that clarifying roles can help to remove barriers technicians might face in practicing to their full scope. She suggests fine-tuning your responsibilities and job description with your employer, but

> "Knowledge comes with experience. Continue to learn from people around you."

Pharmacy Technician Bonnie Dickson

recommends being patient when it comes to taking on new tasks. "Knowledge comes with experience. Continue to learn from people around you," says Dickson.

All three technicians say that educational opportunities, in many forms, are important to help them to grow professionally. Beaupre often attends conferences, and enjoys "Tech Talk" (from the pharmaceutical firm Teva) and the "Pharmacy Technician's Letter" (from the Therapeutic Research Center).

Dickson follows "Tech Talk" as well. She says that her time on the College's pharmacy technician working group, and as the first pharmacy technician appointed to serve as a member of Council, were instructive. "It made me appreciate the title even more," she says.

For her part, Dunlop recently began studying natural products and vitamins, and is pursuing her Masters in education. She is also the Program Coordinator/ Lead Faculty at CTS Canadian Career College in Barrie, shaping the education of future pharmacy technicians. It's another way that she hopes to support technicians in practicing to their full scope, for the benefit of patients first and foremost, and of the pharmacy. "I want to help drive the profession forward," she says.

DEFINING EACH ROLE

PHARMACIST

(cognitive functions)

Assesses the patient and authorizes that drug "X" is the appropriate medication to take. Counsels the patient on how to take the medication and monitor for best possible health outcomes.

PHARMACY TECHNICIAN

(technical functions)

Ensures that the bottle contains 100 tablets of drug "X" and that the information on the label (patient's name, prescriber, drug and directions) are correct, as per the prescription.

TRANSPARENCY

A Pillar of Good Governance

As the regulatory body for the profession of pharmacy in Ontario, the Ontario College of Pharmacists' (OCP) mandate — like all regulated healthcare professions under the *Regulated Health Professions Act* (RHPA) — is to protect the public by ensuring the safe and effective delivery of healthcare services. Maintaining public trust and confidence is critical to upholding this mandate, and transparency plays a key role.

Ensuring that Ontarians have access to information that is relevant, timely, useful and accurate – information that evokes public confidence and enhances their ability to make informed healthcare decisions – is the objective of transparency.

Although it has always been understood that transparency is a pillar of good governance and therefore something that must be considered in all work that is done, in recent years the College has engaged in a number of specific initiatives designed, in part, to identify opportunities to enhance

transparency and ensure we are responsibly meeting the public's evolving expectations.

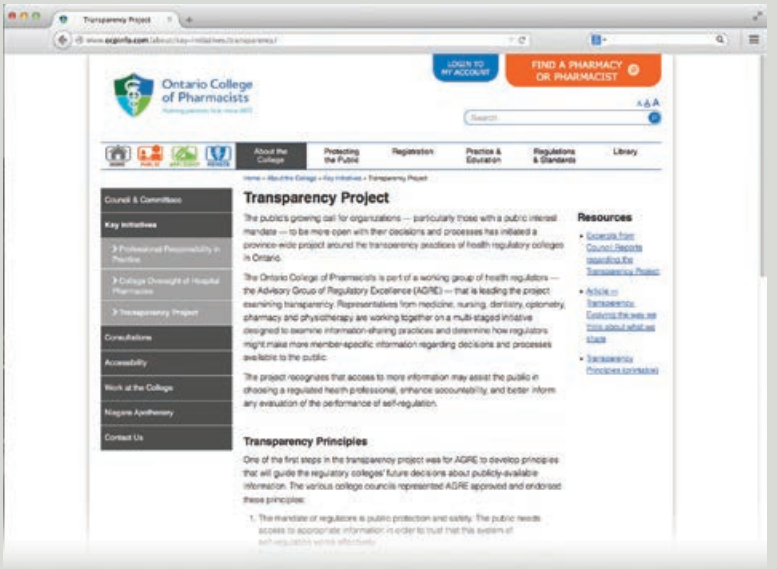
An overview of a few of these initiatives is provided here with more detail available on the College website under Key Initiatives – Transparency.

AGRE — TRANSPARENCY PROJECT:

In 2012, the College – as a member of the Advisory Group of Regulatory Excellence (AGRE) – began work on a collaborative project focused exclusively on examining transparency. Along with representatives from medicine, nursing, dentistry, optometry and physiotherapy the College is working collaboratively on a multi-staged initiative designed to examine information-sharing practices and determine how regulators might make more member-specific information regarding decisions and processes available to the public.

Committed to a principled and consistent approach amongst regulatory health colleges, AGRE developed transparency principles (see right) — endorsed by each of the AGRE college councils — to provide a framework for decision-making. The principles were used to guide the development of a recommended two-phased approach (approved by OCP Council at their June 2014 meeting) for the implementation of changes for the disclosure of specific information regarding decisions and processes to the public.

Phase one focuses primarily on enhancing the consistency and clarity of existing information found on the public register, including notices of discipline committee hearings, criminal findings and bail conditions. The necessary amendments to



TRANSPARENCY PRINCIPLES

1. The mandate of regulators is public protection and safety. The public needs access to appropriate information in order to trust that this system of self-regulation works effectively.

2. Providing more information to the public has benefits, including improved patient choice and increased accountability for regulators.

3. Any information provided should enhance the public's ability to make decisions or hold the regulator accountable. This information needs to be relevant, credible and accurate.

4. In order for information to be helpful to the public, it must:
   - be timely, easy to find and understand.
   - include context and explanation.

5. Certain regulatory processes intended to improve competence may lead to better outcomes for the public if they happen confidentially.

6. Transparency discussions should balance the principles of public protection and accountability, with fairness and privacy.

7. The greater the potential risk to the public, the more important transparency becomes.

8. Information available from Colleges about members and processes should be similar.

> "A more open and transparent approach to the public consultation process."

College by-laws were approved by Council at the September 2014 meeting and subsequently posted for public consultation, which concluded on November 19. The final by-laws – which will consider the feedback received – will be brought to Council for approval at the December 2014 meeting. Once the by-laws are approved the appropriate changes will be made to the public register.

Phase two recommendations focus on the provision of information relating to outcomes of the College's Inquiries, Complaints and Reports Committee (ICRC), including oral cautions and education orders called SCERPs (specified continuing education and remediation programs). The necessary amendments to College by-laws will be brought to the December 2014 Council meeting for approval. They will be posted for public consultation with the expectation that final by-laws – reflective of consultation feedback – be brought forward for approval at the March 2015 Council meeting.

COLLEGE WEBSITE:

In 2012 the College – with the understanding that transparency is an equal blend of disclosure and accessibility – undertook a comprehensive website re-design to enhance visitors' ability to easily access and understand the information that research had identified as the most important for them.

The new website (www.ocpinfo.com), launched in January 2014, created a tailored experience for each of the identified user groups – public, applicants and members – providing easier access to clear, concise and relevant information.

Among the new features was a more open and transparent approach to the public consultation process for new or proposed amendments to regulations, by-laws or policies. All comments are now posted as they are received on the consultation page of the website ensuring all points of view are publicly shared.

Although the new website has significantly enhanced transparency, the College recognizes that ongoing evaluation, research and enhancements of both content and navigation are necessary to keep pace with the evolving needs of users.

PUBLIC REGISTER:

Building on the principles that guided the website re-design – "user-identified" and "task-driven" – the College is now engaged in an initiative to enhance the public register. At the core of the re-design will be revisions to better assist the public with completing basic tasks – such as easily accessing information about pharmacies in their neighbourhood and the practitioners who work there. The new public register is expected to launch in the summer of 2015.

Meanwhile, using the transparency principles as a guide, the College will continue to identify and implement measures to enhance transparency and ensure the public has access to the information that they need – regarding pharmacists, pharmacy technicians, pharmacies and the regulatory process – in order to make informed choices about their healthcare.

More e-Learning modules for Jurisprudence

The College is continuing to develop online learning tools that provide support for learning and understanding jurisprudence.

The e-Learning modules are intended to support:

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

The modules are self-directed and review key topics of legislation but are not intended as stand-alone courses or substitutes for reading the legislation and OCP practice policies and guidelines.

The College currently offers four e-Learning modules covering:

- *Drug and Pharmacies Regulation Act (DPRA)*
- *Controlled Drugs and Substances Act (CDSA) and Narcotics Safety and Awareness Act (NSAA)*
- *Ontario Drug Benefit Act (ODBA)*
- *Drug Interchangeability and Dispensing Fee Act (DIDFA)*

To access the e-Learning modules go to www.ocpinfo.com/registration/training-exams/jp-exam and click on "Resources".

Centralized Prescription Processing (Central Fill)

The former Policy on the Use of Central Fill was recently updated to clarify the roles and responsibilities of pharmacies participating in a central fill agreement.

Approved by Council in September 2014, the new Centralized Prescription Processing policy provides direction to members in the development of transparent and auditable policies and procedures that protect the health, safety and well-being of patients. The revised policy also clarifies that drugs listed in the *Controlled Drugs and Substances Act* (CDSA) are not permitted to be processed by centralized prescription processing.[1]

It's important to remember that when entering into a central fill agreement with a patient, practitioners must ensure that consent is received from the patient or the patient's agent, the process remains transparent, and that policies and procedures are developed with patient safety in mind.

Regardless of where the cognitive or technical aspects of dispensing occur, practitioners are required to meet the Standards of Practice, provide patient-focused care, and exercise all of their professional responsibilities. Pc

1. Health Canada has stated that pursuant to subsection 45(1)(b) of the Narcotic Control Regulations and subsection G.03.014(b) of Part G of the Food and Drug Regulations the sale/provision of narcotics or controlled substances from one pharmacy to another is allowed only in emergency situations. Section 55(1)(b)(ii) of the Benzodiazepines and Other Targeted Substances Regulations also states that one pharmacist can sell/provide to another pharmacist if it is required because of a delay or shortfall in an order for the targeted substance placed with a licensed dealer. Pursuant to paragraph 24(2)(b) of the Narcotic Control Regulations, paragraph G.02.024(1)(b) of the Part G of the Food and Drug Regulations an subparagraph 15(2)(c)(ii) of the Benzodiazepines and Other Targeted Substances a licensed dealer may sell or provide a narcotic, a controlled drug or a targeted substance to a pharmacist (please note that a licensed dealer is referring to a controlled substance license). Should a pharmacy become a licensed dealer, the pharmacy as a licensed dealer will be able to sell or provide narcotics, controlled drugs and targeted substances to another pharmacist on the reception of a written order and provided all the requirements of the relevant regulations are met. Please note that depending on the activities the pharmacy wishes to perform, an establishment license may also be required.

CENTRALIZED PRESCRIPTION PROCESSING (CENTRAL FILL)

POLICY: Centralized Prescription Processing (Central Fill)

Approved: September 2005; **Revised:** September 2014

Legislative References: *Drug and Pharmacies Regulation Act, The Controlled Drugs and Substances Act, Benzodiazepines and Other Targeted Substances Regulations, Narcotic Control Regulations*

Additional References: Model Standards of Practice for Pharmacists, Model Standards of Practice for Pharmacy Technicians, Documentation Guidelines, Record Retention, Disclosure, and Disposal Guidelines.

College Contact: Professional Practice

INTRODUCTION

Centralized prescription processing (central fill) refers to a service one pharmacy provides to another where the central fill pharmacy processes a request from an originating pharmacy to prepare a drug order. Medications packaged by a central fill pharmacy are dispensed by the originating pharmacy pursuant to a prescription. Each participating pharmacy is required to be accredited by the Ontario College of Pharmacists.

DEFINITIONS

Originating pharmacy

The originating pharmacy is defined as the patient contact pharmacy accredited by the Ontario College of Pharmacists that uses a central fill pharmacy to prepare and package prescription orders for the purposes of dispensing and provision of patient care by the originating pharmacy.

Central fill pharmacy

The central fill pharmacy is defined as a pharmacy accredited by the Ontario College of Pharmacists acting as an agent of the originating pharmacy to prepare and package prescription orders on the originating pharmacy's direction.

POLICY

Members are obligated to protect the health, safety and well-being of patients. There must be transparent and auditable policies and procedures when using a central fill process to support patient safety.

Responsibilities of Both Pharmacies

1. Pharmacists, pharmacy technicians, pharmacy managers and owners are required to:
   a) Maintain the Standards of Practice and comply with the Code of Ethics and all federal and provincial legislative requirements.
   b) Ensure the security of all data transmission to protect the privacy, confidentiality and integrity of patient information.
   c) Ensure accurate labelling that is compliant with legislative requirements.
   d) Ensure accurate record keeping that is compliant with legislative requirements and the Record Retention, Disclosure, and Disposal Guideline.
   e) Maintain a mechanism for tracking the prescription drug order through the stages of the drug preparation and patient care process, including documentation of the member responsible.
   f) Maintain a continuous quality assurance program with the participation of both pharmacies. At a minimum the program must monitor the quality and integrity of the process to ensure patient safety and confidentiality, maintain and support patient care, and resolve identified problems.
2. The prescription or auxiliary label must clearly show that the medication was prepared and packaged by a central fill pharmacy and not by the originating pharmacy including the date of preparation and packaging and the transaction/prescription number used for cross referencing at the central fill pharmacy.
3. The central fill pharmacy must have the same ownership as the originating pharmacy or a legally binding contract with the originating pharmacy. Documentation will include the services to be provided and the roles, responsibilities and accountabilities of each party in fulfilling the terms of the contract.
   3.1 If the two pharmacies have common ownership, this agreement may take the form of a corporate policy.
   3.2 The agreement will be signed by the owner and designated manager of both the central fill and originating pharmacy.

3.3 A new agreement will be signed within 7 days upon change of ownership or designated manager.
3.4 The agreement will be available to the Ontario College of Pharmacists upon request.

4. The owner/designated manager must provide notice of the provision or utilization of central fill services to the Ontario College of Pharmacists within 7 days upon entering into an agreement.

5. Drugs listed in the *Controlled Drugs and Substances Act* (CDSA) and regulations (i.e. narcotics, controlled drugs, and benzodiazepines and other targeted substances) cannot be processed by centralized prescription processing.[1]

6. It is important for both the central fill and originating pharmacy to document policies and procedures. Items to consider may include the following:
   - How patient confidentiality and the privacy of personal health information will be maintained according to the requirements of provincial and/or federal privacy legislation;
   - The mechanism for auditing each step in the drug preparation and patient care process, including how the individual responsible for each step in the process is identified;
   - The procedures to ensure that all pharmacies involved in dispensing the prescription order will be identified on the prescription or auxiliary label;
   - How the central fill pharmacy will process the records of requests received from the originating pharmacy and maintain them for the purposes of filing and record keeping. All records will be maintained for a minimum of ten years at the central fill pharmacy;
   - The process to establish effective two-way communication between pharmacies on pertinent patient or prescription information.

Responsibility of the Originating Pharmacy

1. Receiving the prescription from the patient or the patient's agent and providing the medication and other pharmacy services to the patient or the patient's agent.
2. Providing patient care and ensuring the best patient outcomes.
3. Maintaining all documentation relating to the prescription and patient and accountability for the prescription authority.
4. Ensuring the overall processing of prescriptions as required by the DPRA and meeting the terms of the agreement with the central fill pharmacy including but not limited to prescription order entry and filing and storing of all documentation relating to the prescription and the patient for a minimum of ten years as per record keeping requirements.
5. Ensuring there is a method of identifying which prescriptions were transmitted to the central fill pharmacy for processing.
6. Meeting the Standards of Practice for members on all prescriptions including but not limited to collecting and documenting all relevant patient information, performing the patient assessment, reviewing all prescriptions for appropriateness, identifying and resolving drug therapy problems, providing all patient education and information and performing monitoring and follow-up. All interactions with the patient, the patient's agent and health care professionals are the responsibility of the originating pharmacy.
7. Ensuring that the patient or the patient's agent has provided informed consent to the fact that the prescription will be processed by a central fill pharmacy and that there will be transfer of personal health information. This consent is documented and current and maintained by the originating pharmacy.

Responsibility of the Central Fill Pharmacy

1. Ensuring the preparation of prescriptions as required by the DPRA and meeting the terms of the agreement with the originating pharmacy including but not limited to the accuracy of labelling, packaging, processing and record keeping of the drug product preparation.
2. Maintaining all records associated with the processing of prescriptions for a minimum of ten years as per record keeping requirements.
3. Ensuring the safety and integrity of the drug product until received by the originating pharmacy. There must be an established process in place that gives assurance to the originating pharmacy of this integrity.

1. Health Canada has stated that pursuant to subsection 45(1)(b) of the Narcotic Control Regulations and subsection G.03.014(b) of Part G of the Food and Drug Regulations the sale/provision of narcotics or controlled substances from one pharmacy to another is allowed only in emergency situations. Section 55(1)(b)(ii) of the Benzodiazepines and Other Targeted Substances Regulations also states that one pharmacist can sell/provide to another pharmacist if it is required because of a delay or shortfall in an order for the targeted substance placed with a licensed dealer. Pursuant to paragraph 24(2)(b) of the Narcotic Control Regulations, paragraph G.02.024(1)(b) of the Part G of the Food and Drug Regulations an subparagraph 15(2)(c)(ii) of the Benzodiazepines and Other Targeted Substances a licensed dealer may sell or provide a narcotic, a controlled drug or a targeted substance to a pharmacist (please note that a licensed dealer is referring to a controlled substance license). Should a pharmacy become a licensed dealer, the pharmacy as a licensed dealer will be able to sell or provide narcotics, controlled drugs and targeted substances to another pharmacist on the reception of a written order and provided all the requirements of the relevant regulations are met. Please note that depending on the activities the pharmacy wishes to perform, an establishment license may also be required.

Example of Centralized Prescription Processing

The patient brings their prescription in Pharmacy A

Pharmacy A (registered technician or pharmacist) collects and documents the relevant patient information for the pharmacist's review of the therapeutic appropriateness.

Prior to using centralized prescription processing, Pharmacy A (registered technician or pharmacist) must receive consent from the patient or the patient's agent authorizing the transfer of personal health information to the central fill pharmacy.

Pharmacy A (pharmacist) can also adapt or renew the prescription and should identify any drug related problems.

Pharmacy A (pharmacist) is required to communicate with the prescriber when renewing a prescription and, if appropriate, when making an adaptation.

If drug related problems are identified Pharmacy A (pharmacist) should also communicate with any other relevant healthcare professionals.

Pharmacy B (registered technician or pharmacist) packages and prepares the medication and checks the final product for technical accuracy (for example is it the right drug and the right quantity as per the original prescription)

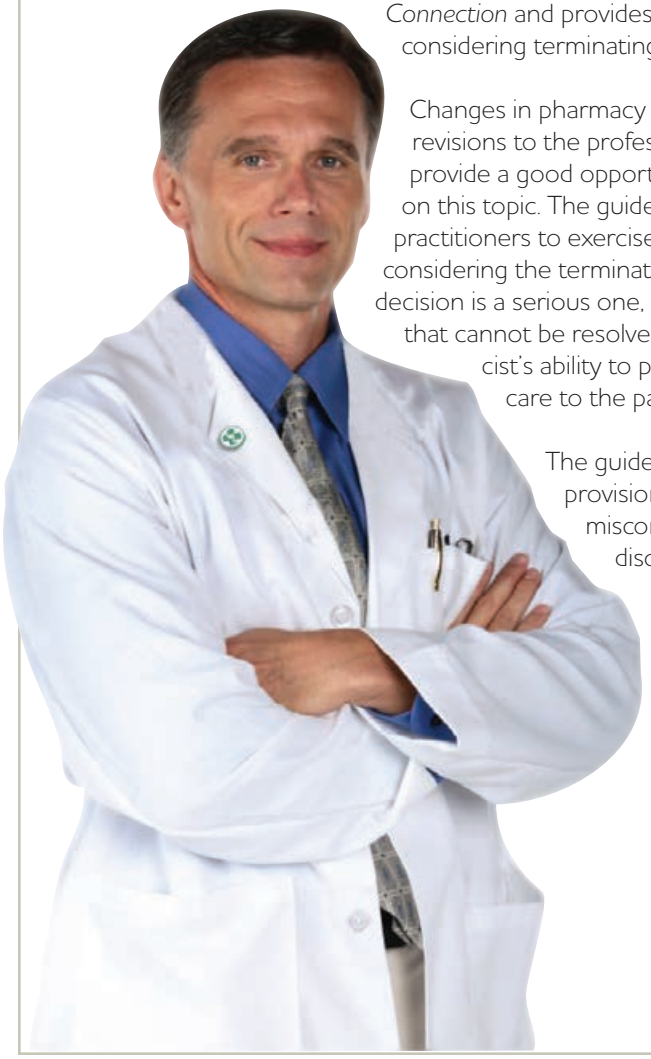
Once the prescription goes back to Pharmacy A the pharmacist communicates with the patient and/or the patient's agent regarding the medication, answers questions and monitors and conducts necessary follow-ups.

The patient leaves Pharmacy A with the appropriate medication

* Pharmacy A may choose to provide interactions/services at different points than depicted in the diagram, and fewer or additional interactions/services as appropriate. The diagram illustrates the flow of a prescription in a centralized filling process as well as where cognitive and technical aspects of dispensing occur.

Ending the Pharmacist-Patient Relationship Guideline

At their September 2014 meeting, Council approved a new guideline about Ending the Pharmacist-Patient Relationship. This guideline comes as a follow-up to an article published in a 1999 edition of *Pharmacy Connection* and provides advice to members who are considering terminating a relationship with a patient.



Changes in pharmacy practice and the currently proposed revisions to the professional misconduct regulations provide a good opportunity to deliver advice to members on this topic. The guideline emphasizes the need for practitioners to exercise their professional judgment when considering the termination of a patient relationship. This decision is a serious one, most often taken because of issues that cannot be resolved, and which impact on the pharmacist's ability to provide appropriate pharmaceutical care to the patient.

The guideline is meant to supplement the provisions of the proposed professional misconduct regulations with respect to discontinuing professional services.

ENDING THE PHARMACIST-PATIENT RELATIONSHIP

GUIDELINE: Ending the Pharmacist-Patient Relationship

Approved: 2014

Legislative References: *Pharmacy Act, 1991: Ontario Regulation 681/93*

Additional References: Drug and Pharmacies Regulation Act, General; O Reg 58/11, Part X: Recordkeeping; Personal Health Information Protection Act, 2004, SO 2004, c 3, Sch A.; s.12(1)

College Contact: Professional Practice

INTRODUCTION

A member's practice is performed within the context of legislation, regulation, the Code of Ethics and Standards of Practice. All decisions affecting the care and treatment of patients are taken within the context of this legal and ethical framework. Pharmacists have the authority to exercise professional and clinical judgment, including the choice to terminate a pharmacist/patient relationship where warranted. Patients are entitled to dignity and respect when interacting with health professionals. The decision to terminate a pharmacist/patient relationship is a serious one, most often taken because a therapeutic relationship has been compromised and/or there are issues that cannot be resolved and which impact on the ability to provide appropriate pharmaceutical care to the patient.

The following guidance will assist the pharmacist when, in his or her professional judgment, it is in the patient's best interest to terminate the pharmacist/patient relationship. This guidance does not apply in circumstances where the patient's care moves to another pharmacy/pharmacist in a planned transfer of services, or when the patient initiates the termination/transfer of prescriptions. The decision to terminate the pharmacist/patient relationship is not the same as declining to provide products or services for moral or ethical reasons.[1]

GUIDELINE

The pharmacist will consider the patient's condition and availability of alternative services when making the decision to terminate the pharmacist/patient relationship.[1] The patient relationship cannot be terminated without good reason, proper notice, and an opportunity given to the patient to obtain another pharmacist's/pharmacy's services before discontinuation.[2] The pharmacist must ensure that the decision to terminate care does not infringe a prohibited ground within the meaning of the Ontario Human Rights Code.[3]

Where several pharmacists work together, it may be appropriate to plan in advance how terminations will be executed, and whether another member is available to provide patient care.

1. Communicate the decision

Depending on the reason for the termination, the member will communicate the decision to terminate service in writing, unless the patient has no fixed address or the pharmacy does not have a current address on file. When communicating the decision in person, it is important to maintain acoustical privacy while ensuring that both the patient and staff members are safe.

The patient should be clear about the availability of refills or other professional services until he or she is able to obtain services from another pharmacist. Based on an evaluation of the patient's condition, determine whether to notify his/her prescriber(s) of the change in pharmacy or rely on the patient to do so.

2. Provide a reasonable amount of time for the patient to find a new pharmacist

The amount of time provided for the patient to find a new pharmacist will be reflective of the condition of the patient, his or her special needs and availability of services in the local community. Advise the patient of measures that will assist the transition including record transfers and providing information directly to the next provider, as required. If no refills remain on file, provide

the patient with a patient profile report/medication history for his/her information.

3. Document

Document the decision and rationale for the termination according to the Documentation Guidelines and retain a copy of the patient's letter. A summary of the type of information that could be included in the patient's letter is attached (Appendix 1).

4. Advise staff members

Let the appropriate staff members know of the decision to terminate the patient relationship and the period in which services will continue to be provided, if any. PC

1. Ontario College of Pharmacists. Refusal to Fill for Moral or Religious Reasons: Position Statement on Refusal to Fill for Moral or Religious Reasons. March 2001.

2. O Reg 681/93 (revised) section 8

3. Ibid.

4. The Ontario Human Rights Code, R.S.O. 1990, c. H 19.

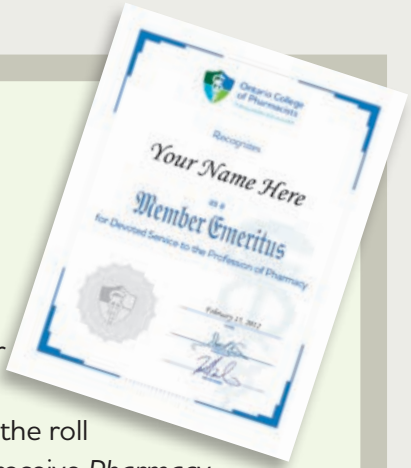
APPENDIX 1

Summary Information – Letter of Termination

A written communication to the patient regarding a termination of the pharmacist/patient relationship contains the patient's name, the pharmacist's name and the name of the pharmacy; and additional information including, for example:

- Affirmation and rationale for the decision to terminate the relationship and date chosen as the last day of care;
- Direction to the patient to obtain services at another pharmacy and offer to transfer prescriptions;
- Confirmation that prescriber(s) will be informed of the decision in the event that verbal prescriptions are received, if relevant, and/or a recommendation that the patient inform his/her prescriber(s) directly;
- Acknowledge attachment of patient profile/medication history (if applicable); and
- Any other information considered relevant.

Members Emeritus



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

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

UPDATE

New Pharmacy Inspection Process

Earlier this year, the College announced the addition of a new quality assurance measure that will help ensure Ontario's pharmacists and pharmacy technicians are providing safe, ethical and effective pharmacy care to patients. The new measure comes in the form of a change to how the College will conduct routine pharmacy inspections.

The new inspection model — known as the Practice Assessment — will expand the College's traditional approach of focusing on pharmacy operations and practice processes, to include an observation of an individual practitioner's performance in their practice site.

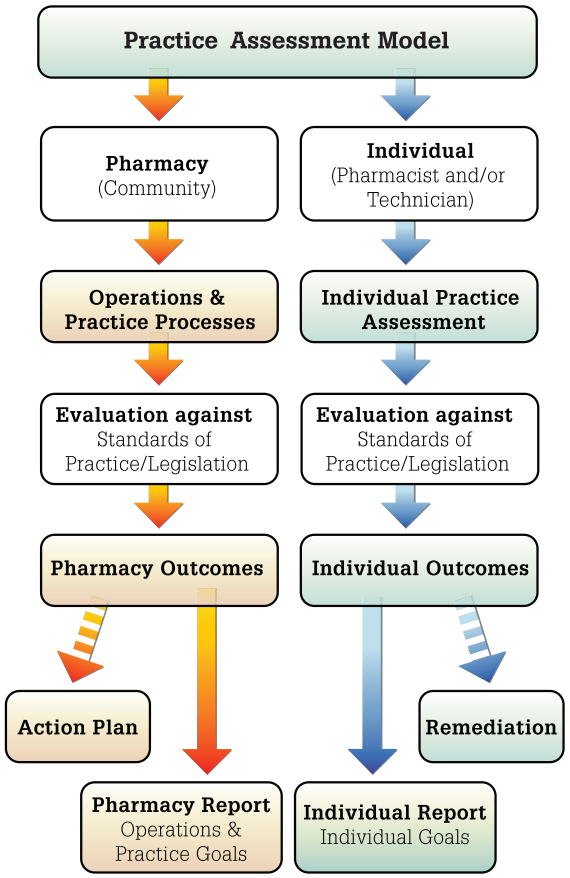
By assessing individual practitioners, the College will be able to better evaluate, coach and mentor pharmacists and pharmacy technicians to adhere to their professional responsibilities and Standards of Practice.

The Practice Assessment does not replace any part of the College's formal Quality Assurance Program such as the Peer Review, but does offer a chance for more practitioners to be involved in a quality assurance activity throughout their career. While the Peer Review uses standardized patient interviews with sample cases in a controlled environment, the new practice assessment reviews the practitioner's actual practice.

Practice advisors (formerly inspectors) will visit the pharmacy and evaluate the process for new prescriptions, refills, adaptations/prescribing and medication reviews. This will allow the practice advisor to assess the practitioner(s) in the following areas:

1. Patient assessment
2. Decision making
3. Documentation
4. Communication and education

Practice advisors will focus on identifying the processes that are in place that shape and support the practitioner's clinical decision-making, but will not assess the specific clinical decision.



The shift supports the role of pharmacists as medication experts and clinical decision-makers and is consistent with other primary healthcare practitioners such as doctors and nurses. A number of other provincial pharmacy regulators across the country have already implemented similar models or are in the process of moving to a more practice-focused assessment or inspection.

The College anticipates that the new Practice Assessments – that will begin with pilots in early 2015 – will increase adherence to practice standards, support practitioners as they practice to their full scope and ultimately assist in the delivery of greater health outcomes for patients.

College to inspect hospital pharmacies

On July 22, 2014 the government of Ontario reintroduced legislation that, if passed, will give the Ontario College of Pharmacists the authority to license and inspect hospital pharmacies throughout Ontario.

These changes will allow the College to conduct regular inspections of hospital pharmacies to ensure they meet practice standards and legislation — consistent with the College's current oversight of community pharmacies and drug preparation premises (DPPs).

The proposed *Safeguarding Health Care Integrity Act* (Bill 21) provides the College with the authority to license and inspect pharmacies within public and private hospitals, in the same manner it currently licenses and inspects community pharmacies. It also provides the College with the ability to:

- Enforce licensing requirements with regard to hospital pharmacies
- Make regulations to establish the requirements and standards for licensing, operation and inspection of hospital pharmacies
- Extend the College's oversight to other institutional pharmacy locations in the future, as appropriate

The College is currently working on regulations to support the *Safeguarding Health Care Integrity Act* (Bill 21), which outline the specifics for the inspection of hospital pharmacies. The draft regulations will be circulated for stakeholder consultation and then approved by College Council before submission to government.

As another step toward preparing for the expanded authority to inspect hospital pharmacies, the College has drafted an initial version of the hospital pharmacy inspection criteria. The criteria was developed with input from practicing hospital pharmacists and pharmacy technicians and will be used in pilot inspections over the coming months. It is divided into three main categories:

1. Standards currently mandated by legislation
2. Emerging standards
3. Organizational/collaborative standards.

The pilot inspections — which have already begun — allow the College to gather feedback and continue to evolve the criteria to fit hospital practice.

The College's hospital practice advisors are planning to visit all of Ontario's hospital pharmacy sites by the end of 2015. The first visit will be a baseline assessment and will take approximately one day. A pre-assessment package will be sent to the hospital pharmacy ahead of the visit and some materials must be completed and returned to the College prior to the assessment. College practice advisors will spend the day working with pharmacy staff members, those involved in the medication management system, and the senior team discussing pharmacy processes and procedures, and touring the facility. Should any problems in the pharmacy or medication management system be identified, the practice advisor will work with the team to mentor and coach them on how to rectify the problems as soon as possible.

BACKGROUND

In response to the 2013 incident of alleged chemotherapy under-dosing in four Ontario hospitals and one in New Brunswick, the government commissioned Dr. Jake Thiessen to do an independent review and produce a report — a Review of the Oncology Under-dosing Incident — which was released to the public by the Minister of Health and Long-Term Care on August 7, 2013.

The report included 12 recommendations — subsequently endorsed by government — intended to prevent future chemotherapy incidents and mitigate identifiable risks. Five of Dr. Thiessen's recommendations look to the College and/or the National Association of Pharmacy Regulatory Authorities (NAPRA) for leadership in implementation.

Dr. Thiessen's recommendation number 12 suggested that the College license all pharmacies operating within Ontario's clinics or hospitals. In response, the government introduced draft legislation that provides the College with the authority to license and inspect hospital pharmacies throughout Ontario.

The draft legislation — *Bill 117: Enhancing Patient Care and Pharmacy Safety Act* — was initially introduced in October 2013 but did not pass before the dissolution of the legislature in the spring of 2014. The legislation was reintroduced without changes in July 2014 as part of the proposed *Safeguarding Health Care Integrity Act* (Bill 21).

ONTARIO'S PHYSICIAN ASSISTANTS

AN UPDATE

30

ANY CONTROLLED ACT ASSIGNED TO THE PHYSICIAN ASSISTANT MUST BE DELEGATED BY THE PHYSICIAN EITHER THROUGH A DIRECT ORDER (VERBAL OR WRITTEN) OR THROUGH THE USE OF A MEDICAL DIRECTIVE.

In 2006, the Ministry of Health and Long-Term Care announced a demonstration project to evaluate the role of Physician Assistants (PAs) in the provincial healthcare system. Since the launch of the PA demonstration project, PAs have been successfully integrated into interprofessional teams within specialized hospital services (internal medicine, orthopedics, surgery, etc.), community health centres, ambulatory, diabetes and long-term care settings, and more recently family health teams (FHTs) and emergency departments. There are currently approximately 250 PAs working within these practice settings across Ontario.[1]

HISTORY AND EDUCATION

PAs have practiced in the United States since the 1960s and with almost 90,000 practicing members, they have established their role as a safe and effective part of the U.S. healthcare system.[2] Similar to the U.S., the Canadian PA is rooted in the Canadian Forces as a class of clinicians introduced to provide medical care to the men and women of the Canadian Forces both at home and abroad. However, it wasn't until the 1990s that the concept of the PA within Canada's civilian healthcare system began to take shape.

Today, in addition to training under the Canadian Forces Health Services Program, three Canadian Universities offer degree programs in Physician Assistant Studies; McMaster University (Hamilton), University of Manitoba and the University of Toronto.

REGULATION AND SCOPE OF PRACTICE

Despite PA practice advances in Ontario, an application (January 2012) by the Canadian Association of Physician Assistants (CAPA) to the Health Professions Regulatory Advisory Council (HPRAC) for regulation of the Physician Assistant profession in Ontario was not approved. This decision was centred on HPRAC's assessment that public safety and quality of care are sufficiently upheld through the delegation model under the supervision of a licensed physician. Therefore, PAs remain unregulated under the *Regulated Health Professions Act* (RHPA), and, as such, do not have the independent authority to preform controlled acts.

Without the independent authority to perform controlled acts, the care a PA provides under the supervision and delegated authority of a registered physician; which must take place within the physician-patient relationship. The specific duties of a PA will vary according to individual PA competencies, the physician's area of practice, and the work the physician chooses to assign, but may include:

- Conducting patient interviews and taking medical histories
- Performing physical examinations
- Counseling on preventative healthcare
- Performing certain controlled acts delegated by the physician (including prescribing)

DELEGATION

Any controlled act assigned to the PA must be delegated by the physician either through a direct order (verbal or written) or through the use of a medical directive. When a physician delegates to a PA, they must do so in accordance with the College of Physicians and Surgeons of Ontario (CPSO) policy on Delegation of Controlled Acts: http://www.cpso.on.ca/policies-publications/policy/delegation-of-controlled-acts.

Although PAs are not authorized to independently prescribe medication, a PA acting under the authority of a physician may evaluate patients and prescribe medication as established by his or her delegated authority. Ultimately, the supervising physician remains responsible for the quality of care that the PA provides to patients.

FAQS

How do I know that a PA has been given authority to prescribe pursuant to physician delegation?

A prescription generated by a PA pursuant to delegation (direct order or medical directive) should include:

- Reference to the fact that the prescription was generated via delegated authority
- Name and contact information of authorizing physician
- Name, designation, signature, and contact information of the PA issuing the prescription

See the example of a prescription generated under a medical directive on page 33.

A consistent format including all of the above information allows the pharmacy team to identify prescriptions that have been authorized through delegation. Pharmacists and pharmacy technicians are encouraged to collaborate with PAs practicing in their communities to establish best practices with respect to PA generated prescriptions.

Can PAs prescribe narcotics and other controlled substances under delegation?

No, Health Canada, responsible for administering the *Controlled Drugs and Substances Act* (CDSA) does not permit medical directives to be used to implement orders for prescriptions for narcotics, controlled drugs, and benzodiazepine/other targeted substances.

Who should I contact for clarification/confirmation of PA prescriptions?

If there are questions about the prescription, the pharmacist should contact the PA directly. If the questions cannot be resolved, the physician should be contacted for further clarification.

Who is recorded as the "prescriber" on the pharmacy generated label and dispensing record?

The physician is recorded as the prescriber for the purposes of a pharmacy's prescription records. All communication with both the PA and physician should be documented within the patient record.

Where can I find more information?

Canadian Association of Physician Assistants: http://capa-acam.ca

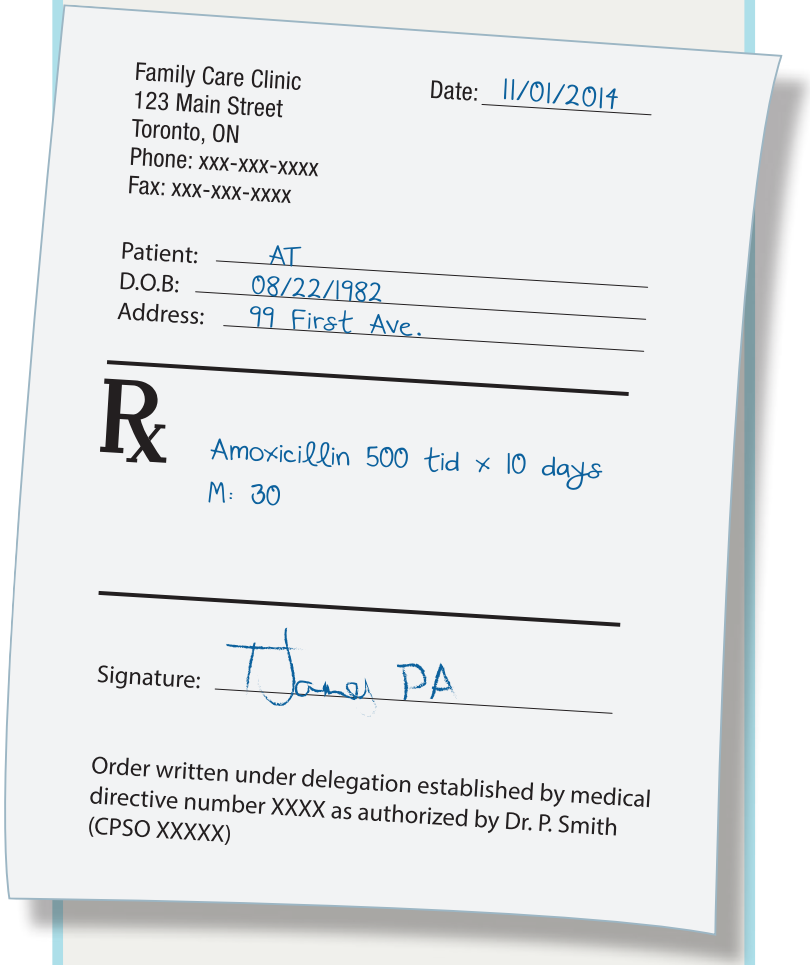
Canadian Medical Association (CMA) – Physician Assistant Toolkit: https://www.cma.ca/Assets/assets-library/document/en/advocacy/PA-Toolkit-e.pdf

Ontario's Physician Assistant Initiative (Health Force Ontario): http://www.healthforceontario.ca/en/M4/Ontario%27s_Physician_Assistant_Initiative

OCP Practice Tools - Interprofessional Collaboration & Teamwork: http://www.ocpinfo.com/practice-education/practice-tools/collection/ipc-team/

1. http://capa-acam.ca/about-pas/pa-fact-sheet/
2. http://capa-acam.ca/about-pas/history/

EXAMPLE OF A PA ISSUED PRESCRIPTION WRITTEN UNDER DELEGATED AUTHORITY AND PURSUANT TO AN ESTABLISHED MEDICAL DIRECTIVE.


Family Care Clinic
123 Main Street
Toronto, ON
Phone: xxx-xxx-xxxx
Fax: xxx-xxx-xxxx

Date: 11/01/2014

Patient: AT
D.O.B: 08/22/1982
Address: 99 First Ave.

Rx

Amoxicillin 500 tid x 10 days
M: 30

Signature: T James PA

Order written under delegation established by medical directive number XXXX as authorized by Dr. P. Smith (CPSO XXXXX)

OCP practice consultants often receive questions from members seeking guidance with respect to other healthcare professionals' scope of practice (nurses, optometrists, naturopathic doctors, etc.). OCP practice consultants cannot provide details related to another practitioners' legal authority. As such, members are encouraged to discuss their questions/concerns with the practitioner directly and (or) contact the appropriate regulatory body for guidance (e.g. College of Nurses of Ontario for nurse practitioner (NP) related questions). Links to Ontario's health regulatory colleges can be found on the Federation of Health Regulatory Colleges of Ontario (FHRCO) website: http://www.regulatedhealthprofessions.on.ca

PROFESSIONAL RESPONSIBILITY #5

"Members must be diligent in identifying and responding to red flag situations that present in practice."

Drug tapering is a great example of a red flag situation!

Medication Incidents Involving Drug Tapering in Community Pharmacy:

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

Amanda Chen, BSc, BScPhm, ACPR, PharmD Candidate
Leslie Dan Faculty of Pharmacy, University of Toronto
Analyst, ISMP Canada

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Research Assistant, ISMP Canada

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Project Manager, ISMP Canada

INTRODUCTION

Prescriptions involving a drug tapering process are often complex in nature, involving multiple, sequential doses of medication(s), extensive directions of use, and complex mathematical calculations.[1-3] In addition, the lack of standardized tapering guidelines may explain the fact that in practice, a wide variety of unique tapering regimens are prescribed that do not follow a homogenous, consensus-based pattern. As a result, pharmacists may find it challenging to assess the appropriateness of the prescription, with respect to its efficacy, safety and tolerability for the particular patient.[1-3] All of these considerations illustrate the inherent vulnerability of drug tapering to errors that may occur at any stage of the medication-use process, including prescribing, order entry, dispensing, administration, and/or patient monitoring. As such, further investigation of incident reports may be beneficial to help elucidate a better understanding and appreciation of potential contributing factors that are associated with drug-tapering incidents.

TABLE 1 – THEMES AND SUBTHEMES

THEME	SUBTHEME
Lack of standardized tapering guidelines	○ Prescribing error ○ Miscommunication
Inadequate patient counseling	○ Cross-taper ○ Multi-medication compliance aids
Operational limitations	○ Labeling restrictions ○ Billing restrictions
Complexity of prescription	○ Calculation error ○ Transcribing error ○ Wrong selection of prescription to be filled ○ Prescription preparation error

Drug tapering is defined as the gradual discontinuation or reduction of a therapeutic dose of a particular drug over a period of time. Conversely, drug titration refers to the incremental increase in drug dosage to a level that provides a desired therapeutic effect. In practice, these terms are sometimes used interchangeably to signify gradual dosage change - up or down - to achieve the targeted goal of either discontinuation of therapy, lowered maintenance dose, or optimal therapeutic effect. For this analysis, incidents involving drug tapering as well as drug titration are included, as both are associated with similar challenges and risks for medication errors.

The Community Pharmacy Incident Reporting (CPhIR) Program (available at http://www.cphir.ca) is designed for community pharmacies to report near misses or medication incidents to ISMP Canada for further analysis and dissemination of shared learning from incidents.[4] CPhIR has allowed collection of invaluable information to help identify system-based vulnerable areas in order to prevent medication incidents.[4] This article provides an overview of a multi-incident analysis of drug tapering-related incidents reported to the CPhIR program.

MULTI-INCIDENT ANALYSIS OF DRUG-TAPERING INCIDENTS IN COMMUNITY PHARMACY PRACTICE

Reports of medication incidents involving "taper," "titrate," "wean," "escalate, "de-escalate," "increasing dose," or "decreasing dose" were extracted from the CPhIR Program from 2010 to 2014. In total, 122 incidents met the criteria and were included in this qualitative, multi-incident analysis. The majority of the incidents involved corticosteroid therapy (e.g., prednisone, dexamethasone, budesonide), but antidepressants (e.g., SSRIs, SNRIs, TCAs), pain medications (e.g., opioids, methadone), and anti-epileptics (e.g., gabapentin, pregabalin) were also commonly reported.

The 122 medication incidents were independently reviewed by two ISMP Canada Analysts. The incidents were analyzed and categorized into four major themes, all of which are potential contributing factors for drug-tapering incidents in community pharmacy practice: (1) lack of standardized tapering guidelines, (2) inadequate patient counseling, (3) operational limitations, and (4) complexity of prescription. The four major themes were further divided into subthemes, as shown in Table 1. Tables 2 to 5 provide further details and incident examples for each subtheme. (Note: The "Incident Examples" provided in Tables 2 to 5 were limited by what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.)

TABLE 2 – THEME #1 LACK OF STANDARDIZED TAPERING GUIDELINES

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY
Prescribing error	The physician wrote a high dose prednisone prescription that lasted over 14 days, but did not prescribe a tapering regimen thereafter. The prednisone prescription had a quantity of 30 days, but the tapering schedule only lasted for 17 days. The pharmacy technician filled the prescription assuming it was for the full 30 days, but later discovered that the prescription was intended to last only 17 days – 13 extra tablets were then given to the patient.	Standardized, pre-printed order forms for drug tapering prescriptions should be considered in order to encourage complete and accurate communication of information between physician, pharmacist, and patient.
Miscommunication (i.e. amongst healthcare professionals)	The patient brought in a computer generated prescription for prednisone, with the first line of directions stating 'take 6 tabs by mouth for 5 days.' The next line stated 'will wean after seven days' with no additional directions or total quantity given. The patient was not sure about the directions of use either.	

TABLE 3 – THEME #2 INADEQUATE PATIENT COUNSELING

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY
Cross-taper	Patient brought in a new prescription for venlafaxine 150 mg daily, which was to be switched with his old prescription, sertraline 75 mg daily. However, cross-tapering directions were not specified on the prescription, and the patient was unclear on the directions of use as well. The physician was called to obtain these instructions.	Providing patients with a tapering schedule tool (i.e. personalized calendar or booklet) for their reference, may be beneficial to clarify confusing and extensive directions of use. This should be done in conjunction with adequate face-to-face counseling and appropriate follow-up.
Multi-medication compliance aids	The patient's prescriptions were being blister packed for the first time. Because her prednisone prescription was being tapered, it was not included in the blister pack, but in a separate vial instead. Several days later, the patient called the pharmacy to say that she just noticed the additional prednisone vial in the prescription bag and that she missed her doses for the past couple of days. She thought that all of her medications would have been included in the blister pack.	

TABLE 4 – THEME #3 OPERATIONAL LIMITATIONS

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY
Labeling restrictions	The wrong sig (directions of use) was entered during order entry because the original instructions were too long for the space provided. The technician tried to shorten it, but important parts of the instruction were being left out. The prescription label was corrected before reaching the patient.	A helpful feature of the order entry queue would be an "extended labeling" function, where directions longer than the standard spacing restrictions would automatically populate into this new interface. The full directions would then be entered, printed, and affixed to the prescription vial.
Billing restrictions	The prescription was for budesonide 9 mg daily x 6 weeks, followed by 3 mg taper every 2 weeks, for a total duration of 10 weeks. Unfortunately, the patient's drug plan only allowed a month's supply (i.e., 35 days) per prescription fill, so the full supply was not able to be dispensed in one transaction, which added much confusion during prescription order entry. This resulted in a transcribing error on the second part of the prescription, which was logged.	A helpful feature of the order entry queue would be an interface for "chained" or "linked" prescriptions, where the total drug tapering schedule is entered sequentially with start and stop dates automatically populating as directions, durations, and quantities are entered. Another benefit of this feature is that it only allows prescriptions to be filled in sequential order (i.e., prescription in the middle of the chain cannot be selected to be filled), which is also helpful in addressing the following Theme #4 (Complexity of Prescription) – Subtheme #3 (Wrong Selection of Prescription to be Filled) – see Table 5.

TABLE 5 – THEME #4 COMPLEXITY OF PRESCRIPTION

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY
Calculation error	Prescription for lamotrigine involved a gradual dose titration up before reaching steady maintenance dose. The wrong total quantity was calculated – 448 tablets were given, but should have been 280 tablets.	Independent double checks should be performed for each prescription during the order entry and dispensing process.[6] More specifically, rules and policies in the dispensary should be implemented to increase awareness and conscientiousness during the prescription preparation process. For example, calculations should be documented by both the order entry staff as well as the independent double-checker to enhance accuracy.
Transcribing error (e.g., typo, wrong dose, wrong formulation, wrong frequency, wrong addition/exclusion of refills)	The patient was prescribed a tapering dose of prednisone and given the correct number of tablets to complete it. He noticed 2 refills on the vial, so he called the pharmacy for the repeat prescription. As he was leaving with the medication, he asked if he should start with taking 8 tablets again and wean down. The pharmacist looked up the original prescription and noted that there were no refills prescribed. The pharmacist took back the medication and explained that he had completed his therapy.	
Wrong selection of prescription to be filled	The prescription was written for an increasing dose titration for galantamine. On June 28th, the 8 mg strength was filled, while the 16 mg was logged for July, and the 24 mg was logged for August. When the patient came in for a refill in July, the 24 mg prescription was filled in error, skipping the 16 mg dose. The patient felt unwell after taking 1 dose, and returned to pharmacy.	
Prescription preparation error	Prescription was written for 'prednisone 50 mg daily x 5 days, then taper by 5 mg every 3rd day until discontinued.' Prescription was filled as prednisone 50 mg – take 10 tablets once daily for 5 days, then taper by 1 tablet (5 mg) every 3rd day until discontinued. Prescription should have been filled with Prednisone 5 mg tablets, not 50 mg tablets. The error was picked up when the pharmacist was checking the prescription.	

THE IMPORTANCE OF DRUG TAPERING

Drug tapering can be a very long and arduous process fraught with confusion, miscommunication and medication errors, as demonstrated in the incident examples from Tables 2-5. But there are specific scenarios that warrant its use. First, drug tapering is important to help prevent adverse drug withdrawal reactions that would otherwise be very difficult and challenging for patients to withstand.[5] Second, the gradual and sequential reduction in dose allows for early detection of return of condition/symptom(s) being treated.[5] These symptoms can be mitigated immediately with a consequent increase in dose, followed by close monitoring. Both of these beneficial effects of drug tapering ultimately help to increase patient tolerability and overall comfort, which is one of the key goals to pharmaceutical care and patient-centred care.

CONCLUSION

Errors associated with drug tapering regimens occur on all levels of patient care that involve physicians, pharmacists, patients, and caregivers alike. Learning from medication incidents is an imperative step in improving medication-use systems. Future development of a general framework for drug tapering (e.g. aggressive or conservative regimens) may be helpful for prescribers in clarifying safe

and effective drug tapering methods. The objective of this multi-incident analysis was to identify potential systems-based contributing factors and areas of vulnerability towards medication incidents involving drug tapering. It is hoped that these insights can pave way for future developments in quality improvement initiatives at the local, provincial and national levels.

ACKNOWLEDGEMENT

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

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

1. Suttner J, White Lovett A, Vernachio K. Best practices in tapering methods in patients undergoing opioid therapy. Advances in Pharmacology and Pharmacy 2013; 1(2):42-57.
2. American College of Rheumatology Ad Hoc Working Group on Steroid-Sparing Criteria in Lupus. Criteria for steroid-sparing ability of interventions in systemic lupus erythematosus. Consensus meeting summary. Arthritis and Rheumatism 2004; 50(11):3427-3431.
3. Alberta Provincial CNS Tumor Team. Clinical Practice Guidelines: the use of dexamethasone in patients with high grade gliomas. Re: dexamethasone tapering. Alberta Health Services, 2013; 5-6.
4. Ho C, Hung P, Lee G, Kadija M. Community pharmacy incident reporting: a new tool for community pharmacies in Canada. Healthc Q 2010; 13:16-24.
5. Reeve E, Shakib S, Hendrix I, et al. Review of deprescribing processes and development of an evidence based, patient-centered deprescribing process. Br J Clin Pharmacol 2014; doi: 10.1111/bcp.12386. [Epub ahead of print]
6. ISMP Canada. Lowering the risk of medication errors: Independent double checks. ISMP Canada Safety Bulletin 2005; 5(1):1-2.

BULLETIN BOARD

RUBBING ALCOHOL COMPOUND ALERT

The Alberta College of Pharmacists has recently received a number of reports of individuals being admitted to emergency departments with alcohol toxicity, having consumed rubbing alcohol compound and isopropyl alcohol purchased from pharmacies.

Ontario pharmacists should watch for customers purchasing frequent or large amounts of rubbing alcohol compound and isopropyl alcohol. Pharmacies that notice a high number of customers in their community displaying these behaviours may wish to store these products behind the counter and avoid promoting these products in sale flyers and advertisements. All pharmacies should ensure that alcohol products are stored in an area where sales can be monitored.

NAPRA'S PHARMACISTS' GATEWAY CANADA

On August 20, 2014 the National Association of Pharmacy Regulatory Authorities (NAPRA) launched its Pharmacists' Gateway Canada — a new, national approach to facilitate the pharmacist licensure process for applicants who graduated with a pharmacy degree not accredited by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP).

The new registration portal is now the first point of contact for internationally educated pharmacist applicants, including graduates from an American-accredited pharmacy degree program. The Gateway is meant to eliminate duplication and create a fair, consistent approach to registration in all Canadian provinces.

All internationally educated pharmacist applicants who wish to be licensed to practise pharmacy in Ontario will follow the new procedure within the Gateway.

The Gateway provides a website with key information online and through telephone support, and features two self-assessment tools that assist internationally educated pharmacist applicants in making informed decisions before starting the process to become licensed as a pharmacist in Canada.

The Gateway is a simple, transparent and safe way to facilitate licensure for internationally educated pharmacist applicants wishing to live and work in Canada.

A SUMMER STUDENT'S EXPERIENCE AT OCP

Chia Hui Chung, B.Sc., PharmD Candidate (2016)
University of Toronto Leslie Dan Faculty of Pharmacy

WHAT KIND OF PROJECT(S) DID YOU COMPLETE FOR THE COLLEGE THIS SUMMER?

By collaborating with five different departments within the College, I was able to work on a wide range of projects that allowed me to apply my therapeutic knowledge, hone my research skills and gain exposure to pharmacy legislation. This year, I was given the unique experience to work alongside the Hospital and Other Healthcare Facilities Committee as a result of the introduction of legislation that would permit the College to inspect and license hospital pharmacies. With this committee, I helped to develop the OCP Hospital Inspection Form and an assessment guide to evaluate inspection criteria for hospitals. Being given the opportunity to speak with hospital pharmacy staff from all across Ontario has opened my eyes to the multitude of ways in which hospital pharmacies can operate.

WHAT WAS YOUR FAVOURITE PART ABOUT WORKING AT THE COLLEGE?

My favourite part was being able to attend a number of committee meetings, which helped me understand how each committee serves to protect the public. By attending both an Accreditation and an Investigations, Complaints and Reports Committee meeting, I was able to observe how systematic decision-making processes were used to ensure that each case was being reviewed in an objective and fair manner. In addition, attending the Professional Practice Committee meeting made me appreciate the high level of research and groundwork that is performed by staff to develop policies and guidelines. I was fortunate to attend the June Council meeting as well, which allowed me to gain insight as to how Council makes decisions that ensure the public's safety.

WHAT WAS THE MOST IMPORTANT THING YOU LEARNED THIS SUMMER?

The most important thing I learned this summer is that, in addition to its core mandate of public protection, the College is truly committed to empowering its members as healthcare practitioners. With the introduction of five Professional Responsibility Principles, the College encourages its members to reaffirm their own abilities to be proactive in deciding the best course of action for their patients. I learned that these guiding principles are meant to encourage members to make the clinical decisions that are necessary to enhance patient outcomes. I believe that becoming familiar with these principles will ultimately shape my future practice for the better and I look forward to sharing them among my peers.

HOW DO YOU THINK YOUR SUMMER EXPERIENCE WILL HELP YOU IN YOUR STUDIES?

I believe that my summer experience will help me in all aspects of my studies. For instance, having collaborated with the Registration Committee to construct a research report on language proficiency policies from start to finish has allowed me to smoothly transition my focus towards conducting pharmacy-based research within the faculty this upcoming year. Moreover, becoming familiar with the standards of practice and practice tools for expanded scope has prepared me to take on courses which focus on optimizing the pharmacist's scope of practice in providing effective patient care. Overall, my experience at the College greatly complements my studies since I realize that having a firm grasp of both the therapeutics as well as the legislation that governs our practice is critical for the safe and effective delivery of pharmacy services.

DISCIPLINE DECISIONS

40

Member: Esam Danial

At a hearing on October 14, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Danial in that he communicated abusively, threatened assault and/or committed assault in relation to an adult male patient, D.M., who provoked the Member, on or about June 17, 2013.

In particular, the Panel found that Mr. Danial:

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

The Panel imposed an Order which included the following:

1. A reprimand;
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully with an unconditional pass, at his own expense and within 12 months of the date of the Order, the ProBE Program on Professional/ Problem Based Ethics for Healthcare Professionals;
3. A suspension of one (1) month, with the entire suspension to be remitted on condition that the Member completes the remedial training;
4. Costs to the College in the amount of $ 2,500.

In its reprimand to the Member, the Panel acknowledged the Member's admissions and reminded the Member that, as a pharmacist, he had agreed to a certain set of standards. The Panel further reminded the Member that members of the public, especially his patients, hold the Member in high regard, and, as such, pharmacists are expected to conduct themselves in a manner that is professional and maintains public confidence at all times. The Panel stated its hope that the Member has had a chance to reflect on his conduct and is truly sorry for his behaviour. Pc

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

CALL FOR PRECEPTORS

Are you looking for a way to recapture the excitement of practicing pharmacy and give back to the profession? Consider becoming a preceptor for the Structured Practical Training (SPT) Program in 2015 and attend an Orientation Workshop.

The SPT Preceptor Orientation Workshops are designed to provide pharmacists & pharmacy technicians* with the necessary skills to become preceptors for registered pharmacy students, interns and pharmacy technician applicants. If you wish to attend a workshop, please complete the SPT Preceptor Workshop Application form.

2015 WORKSHOPS

DATE	CITY	WORKSHOP TYPE
Wednesday January 7th	Toronto	Orientation
Thursday February 12th	Toronto	Orientation
Thursday March 12th	London	Orientation
Tuesday March 24th	Toronto	Orientation
Wednesday April 15th	Ottawa	Orientation
Wednesday April 22nd	Toronto	Orientation
Tuesday May 12th	Toronto	Orientation
Wednesday May 27th	Burlington	Orientation
Thursday June 11th	Toronto	Orientation
Wednesday July 22nd	Toronto	Orientation

Please visit the SPT section of the College's website for more information.
http://www.ocpinfo.com/registration/training-exams/spt/preceptor-info/

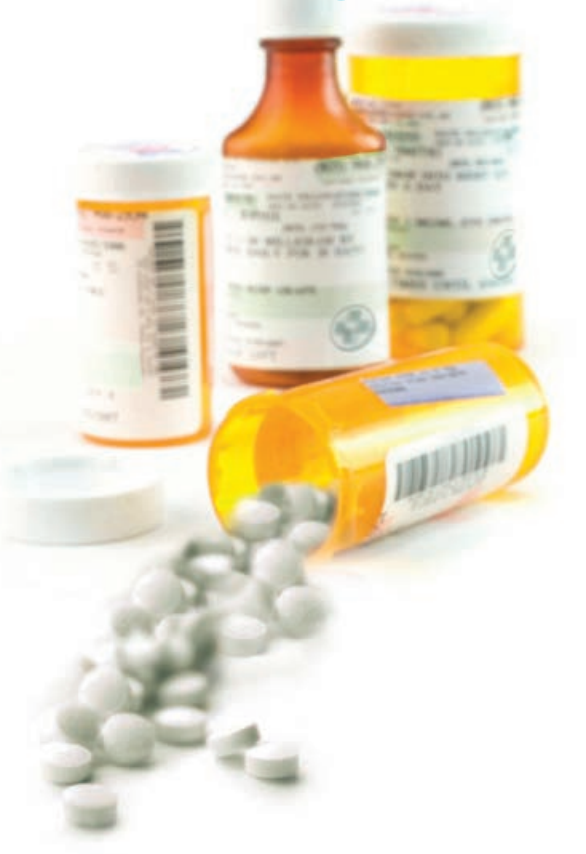
Dates for workshops in the second half of 2015 will be posted at a later date.

To arrange a workshop in your community, please ask your CE Coordinator to contact Vicky Clayton-Jones: 416-962-4861 • 1-800-220-1921 x 2297 • regprograms@ocpinfo.com

**Pharmacy technicians can only be preceptors for pharmacy technician applicants.*

FOCUS ON ERROR PREVENTION

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



TENFOLD MEDICATION ERRORS

Tenfold therapeutic dosing errors are often seen in practice. These errors can occur at the prescribing or dispensing stage. Common causes of tenfold dosing errors include:

1. Failure to place a leading zero before a decimal point. For example, .5mg is misinterpreted as 5mg. The dose should be written as 0.5mg.
2. Incorrect use of a trailing zero after a decimal point. As a result, 5.0mg can be misinterpreted as 50mg if the decimal point is missed or misplaced. The strength should be written as 5mg.
3. Calculation errors.
4. The availability of drugs with tenfold strength differences.

CASE:

A physician prescribed prednisone for an eighty-one year old patient with the directions to take 15mg once daily for 4 weeks, then 10mg once daily for 4 weeks, then 5mg once daily for 4 weeks.

The patient took the prescription to her regular pharmacy and gave it to a pharmacy assistant for processing. While entering the prescription into the computer, the pharmacy assistant selected prednisone from a list of drugs. In error, the pharmacy assistant selected prednisone 50mg instead of 5mg. Prednisone 50mg was therefore prepared and given to the pharmacist for checking. Upon checking the prescription, the pharmacist did not detect the tenfold dispensing error. The incorrect dose was therefore dispensed to the patient.

Minimal patient counseling took place because the patient had taken prednisone 5mg previously. The patient therefore began taking three prednisone 50mg each day. She later reported that she "began to feel terrible and could not sleep". She therefore decided to stop taking the medication after a few days. It was only a few months later on a future visit to her pharmacy that she reported the incident to the pharmacist. An investigation was made and the tenfold dispensing error was discovered.

POSSIBLE CONTRIBUTING FACTORS:

- Prednisone is available in tenfold strength differences, 5mg and 50mg.
- When reviewing the list of prednisone tablets available in the pharmacy computer system, the 50mg tablet first appears on the list and is immediately followed by the 5mg tablet even though the 5mg strength is used most often. The sequential listing of both strengths with a tenfold difference, and the listing of the higher strength

first likely contributed to the selection of the wrong strength.
- The pharmacist failed to detect both the computer entry error and the high dose of prednisone being dispensed.
- The patient's medication history was not consulted to identify any changes in therapy.
- The patient either did not detect the change in appearance of the 50mg versus 5mg tablet or was not alarmed by the change.

RECOMMENDATIONS:

- Be aware of the potential for error when dispensing drugs with tenfold strength differences. Other pairs include warfarin 1mg versus 10mg, terazosin 1mg versus 10mg and morphine 5mg versus 50mg.
- Contact your software vendor to discuss and possibly change the logic used to sort various drug strengths. Suggest leaving a gap between the two strengths to prevent an incorrect selection.
- Whenever possible, have a second pharmacy assistant read the original prescription to detect any computer entry errors before the medication is prepared for checking by the pharmacist.
- Always consult the patient's medication history to identify changes in drug therapy and to detect prescribing and dispensing errors.
- When checking prescriptions for accuracy, always consider the appropriateness of the drug, dose and dosage form.
- Many prescribing and dispensing errors can and have been detected at the time of patient counselling. Educate all pharmacy staff regarding the importance of patient counselling on new prescriptions even if the patient had taken the medication previously.
- Encourage patients to ask questions if something seems different or incorrect. Patients can play a key role in medication error prevention. Pc

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.

CONTINUING EDUCATION (CE)

This list of continuing education activities is provided as a courtesy to members. The Ontario College of Pharmacists does not necessarily endorse the CE activities on this list.
For information on local live CE events in your area you may wish to contact your Regional CE coordinator (list available on the OCP website).

Visit www.ocpinfo.com for an up-to-date list of Continuing Education.

LIVE EVENTS AND CONFERENCES

November 28, 2014 (Toronto, ON)
Drugs: Oversight, Safety and Supply
Ontario Hospital Association
Contact: http://www.oha.com/Education/Conferences/Pages/Conferences.aspx

December 2-4, 2014 (Ottawa, ON)
2014 Canadian Immunization Conference
Canadian Public Health Association
Contact: http://cic-cci.ca/en

December 4, 2014 (Toronto, ON)
Mental Health: Building Capacity and Inspiring Innovation
Ontario Hospital Association
Contact: http://www.oha.com/Education/Conferences/Pages/Conferences.aspx

January 16, 2015 (Toronto, ON)
Cancer Services in Ontario: Providing the Best Possible Care
Ontario Hospital Association
Contact http://www.oha.com/Education/Pages/EventDirectory.aspx

January 17 – April 26, 2015 (Toronto, ON) (Multiple Dates)
Introductory Psychopharmacology for Clinicians
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/psychopharmacology.html

January 19 – 21, 2015 (Toronto, ON) (Multiple Dates)
Advanced Cardiology Pharmacy Practice Part I, Part II and Part III
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/cardiology.html

January 28, 2015 (Toronto, ON)
Closing the Loop on Medication Incident Reporting: The Importance of Safety Culture
The Institute for Safe Medication Practices
Contact: http://www.ismp-canada.org/education/

January 29, 2015 (Toronto, ON)
Multi-Incident Analysis Workshop: Analyzing medication incidents one group at a time
The Institute for Safe Medication Practices
Contact: http://www.ismp-canada.org/education/

January 30, 2015 (Toronto, ON)
Outbreaks: Preparedness and Control
Ontario Hospital Association
Contact: http://www.oha.com/Education/Conferences/Pages/Conferences.aspx

January 31-February 4, 2015 (Toronto, ON)
Professional Practice Conference
Canadian Society of Hospital Pharmacists
Contact: http://www.cshp.ca/events/ppc/2014/index_e.asp

February 6-7, 2015 (Ottawa, ON)
BORN Ontario Conference 2015
Born Ontario
Contact: http://bornontarioconference.ca/

February 23, 2015 (Ottawa, ON)
Diabetes Educator Graduate Certificate Program
The Michener Institute
Contact: http://michener.ca/ce_course/diabetes-educator-graduate-certificate-program-2/

March 20-22, 2015 (Ottawa, ON)
International Meeting on Indigenous Child Health
Canadian Paediatric Society
Contact: http://www.cps.ca/en/imich

March 28, 2015 (Toronto, ON)
Education Program for Immunization Competencies
Canadian Paediatric Society
Contact: http://www.cps.ca/en/epic-pfci

April 25, 2015 (Ottawa, ON)
Mise a Jour 2015 – 32th Annual Conference
The Ottawa Hospital
Contact: http://rxinfo.ca

May 6 – 9, 2015 (Toronto, ON)
Primary Care Today – 13th Annual Conference
University of Toronto
Contact: http://www.mycmeupdates.ca/pct/home.html

May 21 - 22, 2015 (Toronto, ON)
Canadian Association for Ambulatory Care (CAAC) Conference
Canadian Association of Ambulatory Care
Contact: http://www.canadianambulatorycare.com/

November 25 - 27, 2015 (Toronto, ON)
Thrombosis Management
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/thrombosis.html

Multiple dates and locations – contact course providers
Immunizations and Injections training courses:
Ontario Pharmacists Association: https://www.opatoday.com/223957
RxBriefcase, CPS and PHAC http://www.advancingpractice.com/p-68-immunization-competencies-education-program.aspx
Pear Health http://www.pearhealthcare.com/training-injection-training.php
University of Toronto: http://cpd.pharmacy.utoronto.ca/programs/injections.html
Dalhousie University: http://www.dal.ca/faculty/healthprofessions/cpe/programs/live-programs/immunization-andinjectionadministrationtrainingprogram.html

ONLINE LEARNING/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)
Online courses with live workshops in subjects including: TEACH: Certificate Program In Intensive Tobacco Cessation Counselling, Core Course: A Comprehensive Course on Smoking Cessation , ADAT, Basic Pharmacology in Mental Health and Substance Use, Buprenorphine-Assisted Treatment of Opioid Dependence, Concurrent Disorders Core, Concurrent Disorders in Primary Care, Fundamentals of Addiction, Fundamentals of Mental Health, Interactions Between Psychiatric Medications and Drugs of Abuse, , Medications and Drugs of Abuse Interactions in ODT, Motivational Interviewing, Opioid Dependence Treatment, Safe and Effective Use of Opioids for Chronic Non-cancer Pain, Youth, Drugs and Mental Health, Case Studies: Examining Substance Use in Older Adults.
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/default.aspx

Canadian Pharmacists Association (CPhA)
Home Study Online accredited education programs including: ADAPT Patient Care Skills Development. Lab Tests, Medication Review Services, QUIT:

Smoking Cessation Program, CANRISK: Diabetes Risk Questionnaire in Your Community Pharmacy.
Contact: http://www.pharmacists.ca/index.cfm/education-practice-resources/professional-development/

Canadian Society of Hospital Pharmacists (CSHP)
Online education programs, including Medication Reconciliation, Minimizing the Risk of Contamination in the Oncology Pharmacy Setting and Immunization Competencies Education Program (ICEP).
Contact: http://www.cshp.ca/programs/onlineeducation/index_e.asp

Canadian Healthcare Network
Online CE Lessons for pharmacists and pharmacy technicians.
Contact : http://www.canadianhealthcarenetwork.ca/

Continuous Professional Development – University of Toronto, Leslie Dan Faculty of Pharmacy:
Infectious Diseases Online Video Lectures and Slides, Influenza DVD
Contact: http://cpd.pharmacy.utoronto.ca/

Complimentary from OCP and University of Toronto, Leslie Dan Faculty of Pharmacy:
Collaborative Care: Conflict In Inter-Professional Collaboration; Pain: Chronic Non-Cancer Pain; Pharmacists Role: Who Do We Think We Are? The '10 Minute Patient Interview' webcast; Physical Assessment for Pharmacists; There is no "I" in "Team".
Contact: http://www.ocpinfo.com/practice-education/continuing-education/listings/pharmacists/

Ontario Pharmacists Association (OPA)
Online courses with live workshops in subjects including; Methadone Education Program, Principles of Oncology Treatments and Pharmaceutical Care, Serving Travel Medicine Needs in the Pharmacy, Infant Care and Nutrition, Natural Health Products, Infectious Disease – Foundations for Pharmacy, Implementing Smoking Cessation Services in the Pharmacy, Heart healthy diets; Food bioactives for protection against cardiovascular disease risk, Implementing a successful clinic day, Panel discussion: Independent billing numbers, From Pink eye to athlete's foot: Pharmacists' role in common ailments, Medical directives, Marketing your pharmacy services, Optimizing the pharmacy technician's role in pharmacy practice, Maximizing the value of the pharmaceutical Opinion Program, Multi-Session Package.

Complimentary online courses include: Why the Common Cold and Flu Matter: A Look at Prevention, Ontario Drug Benefit blood glucose test strip reimbursement policy: Support tools for pharmacists, Managing menopause and it's Associated Disorders.
Contact: http://www.opatoday.com/professional/online-learning

rxBriefcase
Online CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).
Contact : http://www.rxbriefcase.com/

Ontario is fortunate to have a dedicated team of regional CE Coordinators, who volunteer their time and effort to facilitate CE events around the province.

OCP extends its sincere appreciation and thanks *to each and every member of these teams for their commitment and dedication in giving back to the profession.*

Interested in expanding your network and giving back to the profession?

OCP is looking for additional regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 17 (Brantford area), 25 (Sault Ste. Marie area), 27 (Timmins area).
A complete list of CE coordinators and regions by town/city is available on our website.

To apply, submit your resume to ckuhn@ocpinfo.com

REMINDER:

ONLINE MEMBERSHIP RENEWAL BEGINS IN JANUARY 2015

WATCH FOR MORE INFORMATION ON DEADLINES AND ENSURE WE HAVE YOUR UPDATED EMAIL ADDRESS AS MEMBERSHIP RENEWAL IS OFFERED ONLINE

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Putting patients first since 1871