Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SUMMER 2013 • VOLUME 20 NUMBER 3

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

In this issue:

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 number. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. U of T indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. U of W indicates the Hallman Director, School of Pharmacy, University of Waterloo.

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

Standing Committees
- Communications
- Finance
- 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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Marshall Moleschi,
R.Ph., B.Sc. (Pharm), MHA
Registrar

> "Maintaining public trust and confidence in the knowledge and skills of pharmacists and pharmacy technicians, and in the safe and effective delivery of drugs and services to Ontarians, is more important than ever."

Here at the College, fall marks the beginning of the next chapter as we conclude Council elections and welcome new faces in several districts (see page 8). Council will also appoint new committee members at their meeting in September. It's an exciting time and we are looking forward to the year ahead.

Council's work on a comprehensive governance manual and policies is nearing completion, and both Council and Committee members will greatly benefit from renewed clarity of their mandate and objectives as they continue to develop and guide the strategic direction for the College.

This leadership is essential as the work of the College evolves to address the increasing demands placed on us, as the regulatory body for the profession of pharmacy in Ontario, to uphold our legislative mandate to protect the public interest.

Maintaining public trust and confidence in the knowledge and skills of pharmacists and pharmacy technicians, and in the safe and effective delivery of drugs and services to Ontarians, is more important than ever. Recent events, in particular the discovery of the incident of under-dosing of chemotherapy drugs has helped to emphasize this point.

How we have and how we continue to respond to these challenges will go a long way, over the coming months and years, to shape and define our role as integral members of the healthcare team.

At this year's Ontario Pharmacists' Association (OPA) Conference, held in Toronto earlier this summer, I spoke about our need, as a profession, to demonstrate our value. I suggested that we must shift our focus from the "what", to the "how". Simply put, as our scope of practice continues to grow our focus must not be on the quantity of what we do, but rather the quality, ensuring that we are meeting the appropriate Standards of Practice in all that we do.

I emphasized the fact that we must be recognized and valued by our patients and other members of the healthcare team as medication experts who utilize our professional judgment to make decisions that benefit health outcomes. It's about doing the "right" thing in the "right" way by adding value to our patients and the healthcare system through the things we do.

The College needs to shift its focus as well. Routine pharmacy inspections and individual practitioner quality assurance evaluations will be better aligned to ensure that the College is appropriately assessing "how" things are being done in practice and supporting continuous improvement based on the Standards of Practice.

The world of healthcare is rapidly evolving and we must be moving as well . . . the status quo is not an option. Pc

FAREWELL & CONGRATULATIONS

Della Croteau retired from her position as Deputy Registrar of the Ontario College of Pharmacists at the end of June 2013. Della spent 20 years at the College – 13 as Deputy Registrar. She played an integral role in the development and implementation of many key initiatives including the Structured Practical Training, Quality Assurance and International Pharmacy Graduate programs, and most recently the expanded scope of practice regulation.

We wish Della all the best as she turns her attention to her many other passions – including her recent cycling trip from Toronto to Montreal. Congratulations Della!

The College is pleased to appoint Anne Resnick as our new Deputy Registrar. Anne has been with the College as Director of Professional Practice since 2005 and is well-prepared to move into her new role. Anne has a Bachelor of Science degree in Pharmacy from the University of Toronto, and prior to joining the College was a pharmacy owner and practicing community pharmacist for 26 years. Anne received her designation as a Certified Association Executive through the Canadian Society of Association Executives in 2009.

Congratulations Anne, and welcome to your new role at the College.

Anne Resnick, Deputy Registrar

Della Crouteau (centre) is pictured above at the start-line of her cycling trip from Toronto to Montreal this July. The trip, part of the *Friends for Life Bike Rally*, was in support of the Toronto People with AIDS Foundation. Anne Resnick, Deputy Registrar (left), and Susan James, Manager of Projects and Registration (right) wished Della good luck on her six-day journey.

JUNE 2013 COUNCIL MEETING

DRUG PREPARATION PREMISES (DPP) REGULATION UPDATE

Registrar Moleschi provided Council with a status report regarding Drug Preparation Premises. The regulation and enabling by-laws, which were unanimously approved by Council at the special meeting of Council held on May 10, 2013, when combined with the Ministry's regulation change to the *Public Hospitals Act* (PHA), will ensure that hospitals purchase drugs only from accredited, licensed or otherwise approved suppliers.

Council heard that the timelines and work plan for the various processes are on target. Members currently employed in these premises are identifying themselves to the College and draft standards for the inspection process are being compiled and are expected to be forwarded to stakeholders for consultation in the coming weeks. Inspections of Drug Preparation Premises are expected to commence in early August and to be completed prior to the implementation of the PHA regulation in mid-September.

REVISED OPERATING BY-LAW NO. 3 APPROVED FOR CONSULTATION

In September 2012, Council directed that a Special Committee of Council be appointed to conduct an overall review of the College's Operating By-law. Following extensive evaluation, the revised By-law No. 3 was provided to Council for discussion. Council noted that the review has resulted in clarification of language, intent and process and has eliminated redundant language where appropriate.

Since the proposed by-law includes amendments to sections regarding Professional Liability Insurance, the Register, and Pharmacy Transaction Fees, which are required to be circulated for consultation prior to being approved by Council, the proposed by-law is being circulated to members for feedback. Once the feedback has been collected from various stakeholder groups, it will be reported back to Council at the September meeting. More information can be found on the College website at www.ocpinfo.com.

PROFESSIONAL MISCONDUCT REGULATION APPROVED FOR CONSULTATION

Council approved for circulation a draft amended regulation to the *Pharmacy Act* to address professional misconduct. The College is proposing revision, addition and deletion of certain clauses of the Professional Misconduct Regulation at this time to address the addition of a new class of registrants, the expanded scope of practice, and the expectation that members will exercise professional judgement in choosing to deliver services and/or referring patients to another

Photos by DW Dorken

health professional as needed. The proposed regulation aligns with those of other health professions and takes into account current College policies and guidelines and the *Model Standards of Practice for Canadian Pharmacists*. The amendment follows the provision for proprietary misconduct under the *Drug and Pharmacies Regulation Act*.

Council will consider feedback at its September 2013 meeting at which time ratification of the regulation will be proposed and submission to government enabled. More information can be found on the College website at www.ocpinfo.com.

REVISED GUIDELINE ON MULTI MEDICATION COMPLIANCE AIDS APPROVED

Council approved a revised guideline (refer to page 17) on multi-medication compliance aids which updates a policy approved by Council several years ago and provides additional guidance to members who dispense medications in compliance packaging. The guideline focuses on areas where it is expected that a pharmacist will use professional judgment including: evaluating whether a medication is suitable for compliance packaging, choosing the packaging material, and taking into consideration best practices for drug administration when packaging medications together. It also addresses safety issues for both members and patients and provides a summary of the information to be shared between the pharmacist, patient, family member/caregiver and prescriber when choosing this dispensing option. Pc

NEXT COUNCIL MEETING:

September 9 & 10, 2013

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

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

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Council Elections Results

OCP Council elections were completed on August 7, 2013.
The results are as follows:

DISTRICT K


Esmail Merani


Mark Scanlon

DISTRICT L


Jillian Grocholsky


Michael Nashat


Farid Wassef

DISTRICT M

BY-ELECTION


Laura Weyland

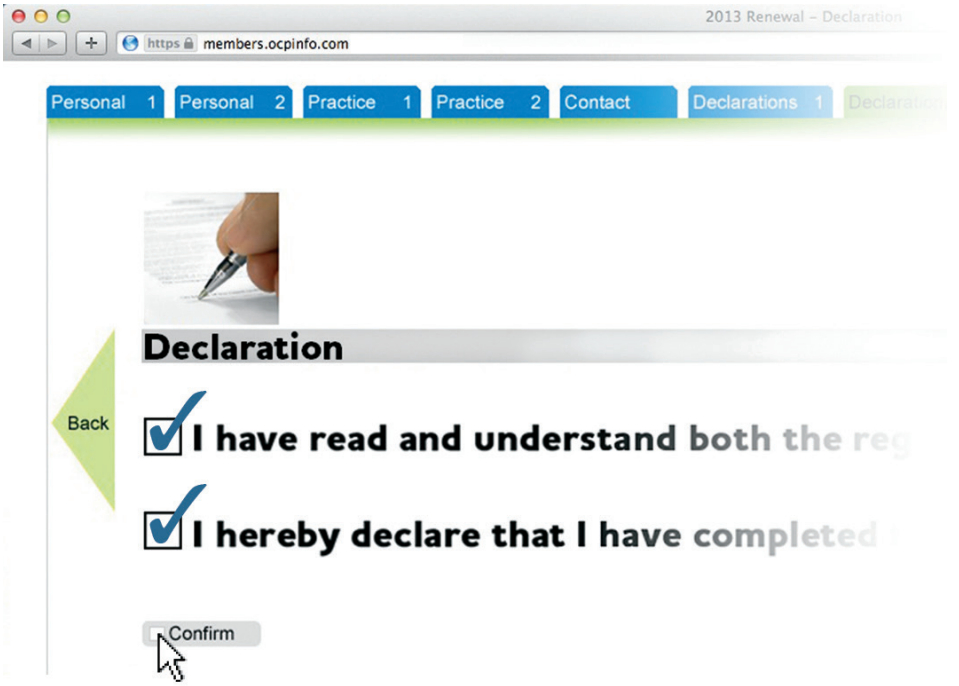
DISTRICT TH


Goran Petrovic

DISTRICT T


Tracy Wills
(acclamation)

College to Audit use of Self-Declaration



As part of the College's ongoing efforts to balance operational efficiency with effective accountability, it introduced self-declaration as a means for members to indicate their compliance with a number of legislative requirements. Examples include: self-declaration of Personal Professional Liability Insurance as part of a member's annual registration renewal, and self-declaration of the required education and first-aid training for injection authority.

Where self-declaration is utilized members are not required to submit evidence of their compliance to the specific requirement. Rather, the College's process includes a statement of self-declaration, which members acknowledge as part of completing the process. It is understood that the actual documentation would be made available to the College upon request. This process is consistent with other more familiar activities such as filing income taxes.

Although there are many advantages to self-declaration from the perspective of operational efficiency, there are also potential risks that must be appropriately managed. As the regulatory body for the profession of pharmacy in Ontario, the College has an obligation to ensure that this approach is providing the public assurance that practitioners are upholding their ethical and legal obligations to comply with all legislation and standards.

Over the coming months, in an effort to evaluate the effectiveness of self-declaration, the College will be conducting random audits of member compliance with their requirement to hold Personal Professional Liability Insurance as outlined in the College by-laws. Selected members will be notified directly by the College and asked to submit evidence of their mandatory insurance covering the full registration year.

Failure to comply with the College's request for this information or failure to provide appropriate evidence of valid insurance will result in suspension of the member's certificate registration until such time as the College is satisfied that the member is fully compliant. Additionally, should the audit suggest that a member has falsely made a self-declaration, they may be referred to the College's disciplinary process for an investigation into allegations of professional misconduct.

It is the hope and expectation of the College that the outcome of this audit – and others that will routinely follow – will support the further use of self-declaration as a viable mechanism for streamlining operational processes without compromising the public's trust.

MANDATORY REPORTING – A MEMBER'S ETHICAL OBLIGATIONS

The accompanying article on mandatory reporting sets out a member's obligations, as outlined in legislation, to make a report about him or herself or another member of a College in specific circumstances.
What happens if a member becomes aware of the behaviour of another member, or of a health professional registered to a different College, that may cause a concern for patient safety? Does the member have a mandatory obligation to address that concern?

Ethically speaking, if a member is concerned that a health care professional may be engaging in unsafe practice or unethical conduct, he or she must use professional judgment to determine whether the situation must be reported. The circumstances surrounding the situation should be thoughtfully considered before taking any action, balancing the interests of all parties. Patient safety is, as always, the paramount concern.

Mandatory Reporting

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

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

MANDATORY REPORTING: *REGULATED HEALTH PROFESSIONS ACT, 1991*

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

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

SUSPECTED SEXUAL ABUSE OF A PATIENT

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

TERMINATION OF EMPLOYMENT

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

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

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

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

GUILTY OF AN OFFENCE, PROFESSIONAL MISCONDUCT, OR MALPRACTICE

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

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

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

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

THE COLLEGE RESPONSE

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

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

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

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

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

MULTI-MEDICATION COMPLIANCE AIDS

14

...HELPFUL OR HARMFUL?

By Shelina Manji B.Sc., B.ScPhm., R.Ph.
Investigator

Multi-Medication compliance aids are useful tools that assist patients with adhering to their medication regimens. However, they can also be sources of multiple errors if the pharmacy does not have documented policies and procedures related to filling and checking these aids. It is the responsibility of the Designated Manager of a pharmacy to ensure that policies and procedures are in place and that they are understood and followed by all pharmacy staff.

The Model Standards of Practice expect a dispensing pharmacist to ensure that the correct product is selected, the correct quantity is dispensed, the packaging and labeling meets legal and professional requirements and that a final check of the prescription and the dispensed product is performed. While this is an expectation when any prescription is dispensed, it is even more critical when the medications are packaged into compliance aids, and especially when there is a change in the patient's medication regimen. Pharmacists need to take extra measures to ensure that compliance aids are error free as the patients who receive compliance aids rely on their pharmacists to help minimize the risk of medications being taken improperly.

THE COMPLAINT

The College received a complaint that had multiple issues identified, including dispensing errors that occurred in a compliance aid. This article will focus primarily on the dispensing errors.

A patient using a compliance aid was prescribed digoxin and diltiazem. During an admission to a hospital, these two medications were discontinued and metoprolol was prescribed instead. A copy of the Discharge Summary which documented the discontinuation of the two medications, and a prescription for metoprolol, was provided to the patient's agent who attended the patient's pharmacy and provided them to a staff pharmacist. The staff pharmacist verified with the agent all the medications the patient was taking and inactivated the two discontinued mediations in the pharmacy's computer system. The agent attended the pharmacy on a later date to pick up the patient's new compliance aid.

The patient was later readmitted to the hospital for issues related to her heart rate. When the medications contained in her compliance aid were reviewed, it was noted that it contained digoxin and diltiazem, the two discontinued medications,

as well as the newly prescribed metoprolol. The patient had ingested all three medications for four days. It was further noted that the label on the compliance aid did not list either digoxin or diltiazem as part of its contents.

THE MEMBER'S RESPONSE

The Designated Manager of the pharmacy, who was also the dispensing pharmacist ("the Member"), denied having received the Discharge Summary that the agent had provided to the staff pharmacist. The Member explained that the staff pharmacist did not inform the pharmacy assistants about the changes that were made to the patient's medications and that while he had informed her about the new prescription for metoprolol for the patient, he had failed to explain that both diltiazem and digoxin had been discontinued. The Member noted that the Discharge Summary was not included with the prescription that the staff pharmacist had provided to her. The staff pharmacist had also inactivated the prescriptions in the computer system but had not discontinued them. The Member explained that when a prescription is inactivated, it can be reactivated and dispensed. The Member further explained that a paper record listing all the medications a patient is receiving is used as a reference when a compliance aid is prepared. The staff pharmacist did not update this record or request that it be updated. Since the pharmacy staff was not aware that diltiazem and digoxin were discontinued, these medications were added to the compliance aid, as was the newly prescribed metoprolol. A new label was printed and attached to the compliance aid, however the Member failed to note that the label did not list diltiazem or digoxin.

The Member concluded that the following factors may have contributed to the incident:

- The reduction of staff at the pharmacy with a high turnover of pharmacy assistants.
- Lack of communication between pharmacists.
- Improper documentation.

The staff pharmacist explained that he had cancelled the discontinued medications in the pharmacy's computer system and had left all the documents on the counter so that the compliance aid could be filled on the following day.

As a result of this incident, various policies and procedures were initiated at the pharmacy.

CONCLUSION

The review of this case clearly identifies the importance of Designated Managers ensuring that pharmacy staff are aware of, and follow, the procedures governing the filling and checking of compliance aids, especially when a change has occurred in the patient's medication regimen. The procedures should include the following:

- Any changes to a patient's medication regimen should be completely and clearly documented in the pharmacy's computer system.
- The changes should be clearly communicated to all members of the staff that are involved in the dispensing and checking of compliance aids.
- Any documents that staff rely upon to fill and check compliance aids must also be updated to reflect these changes.
- All compliance aids should be thoroughly and completely checked.
- Any inconsistencies identified between the labels on a compliance aid, its contents and any other documents that staff rely upon to fill the compliance aid must be investigated and resolved prior to the release of the medication to the patient or to his or her agent.

Moreover, checking a compliance aid is not simply a mechanical activity. Pharmacists always have the responsibility to use their therapeutic knowledge to identify any drug related problems. This will also assist in the detection of any errors that may have occurred due to the incomplete documentation of changes in the patient's medication regimen.

Additional complaints received by the College reveal that in addition to the above procedures, a visual verification of the contents, as in any dispensing process, is also very important when checking compliance aids. A thorough and complete visual check prior to sealing of the compliance aid can be instrumental in identifying any errors that have occurred during the filling process. This type of check should not be replaced with the visual check that often occurs after a compliance aid has been sealed. While the latter can reveal problems that may have occurred during the sealing process, it is not however, a comprehensive check of the contents of the compliance aid.

Having the above processes in place will assist in ensuring that pharmacists continue to provide a very important service to patients without compromising patient safety.

A guideline related to the dispensing of multi-medication compliance aids including the labelling, documentation and record-keeping requirements is included in this issue and can also be reviewed on the College's website. Pc

Multi-Medication Compliance Aids

Title: Multi-Medication Compliance Aids

Approved: 1997; Updated 2013

Legislative References: *Drug Interchangeability and Dispensing Fee Act; Drug and Pharmacies Regulation Act.*

Additional References: National Association of Pharmacy Regulatory Authorities

College Contact: Professional Practice

INTRODUCTION

Multi-medication compliance aids offer a safe and effective approach to managing medication therapy by placing different medications in the same compartment, organized by dosing intervals. They are appropriate for patients who have difficulty remembering to take medications correctly, but who are otherwise deemed capable of self-administration or for those with complex drug regimes when other methods to improve compliance have been unsuccessful.[1] Some of the benefits of this approach to treatment include:

- Effective treatment of a condition requiring multiple medications through optimal dosing and incorporation of several medications (prescription and non-prescription) in one place;
- Better clarity and transparency of treatment through more effective communications between health professionals and patients; and
- Improved drug utilization while minimizing waste.

GUIDELINE

The decision to use a multi-medication compliance aid is made by the pharmacist in collaboration with the patient, family member/caregiver and prescriber where there is a clear benefit to the patient of using this approach. The pharmacist will only provide

compliance packaging to patients if he or she has the necessary knowledge and skills to provide this service. The pharmacy must have policies and procedures in place, and the appropriate physical space, equipment and trained staff to ensure the safe preparation of compliance packages.

Compliance packaging is available in various formats including single medication blister cards, multi-medication blister cards, hard packs, and strip packaging. The pharmacist will evaluate whether the medication is suitable for compliance packaging, including a consideration of any drug interactions and the impact of the packaging process itself on the medication.[2] The choice of packaging material will also be determined by the physical and chemical characteristics of each drug, and potential response to temperature fluctuations, light, moisture, and method of packaging. In addition, members must take into consideration best practices for drug administration when packaging a compliance aid. For example, medications that require administration on an empty stomach (e.g. bisphosphonates) should be packaged separately from other medications, and medications administered on an "as required" basis are generally unsuitable for packaging in a compliance aid since they may be mistakenly taken on a regular basis. If in doubt about the suitability of a drug for inclusion in a compliance pack, the member should contact the manufacturer.

Medications in compliance aids must be packaged as soon as possible after being removed from the stock bottle to minimize atmospheric exposure and protect the integrity of the medication. Sanitary procedures must be implemented to prevent staff from having direct contact with the drugs, for example by using gloves or tweezers, along with frequent hand washing. The pharmacy must have a protocol in place to check that the contents of the compliance package match the prescriber's order. If using optical scanner technology, the equipment should be tested and calibrated to ensure it is in proper working order. Once products are packaged, they are to be stored under the appropriate conditions until dispensed, i.e. packages containing temperature sensitive medications must be placed in the refrigerator in order to maintain the cold chain.

DISPENSING A MULTI-MEDICATION COMPLIANCE AID

The medications used in the compliance aid are to be dispensed for the entire prescribed quantity, unless otherwise indicated by the patient or prescriber.[3] The quantities of "PRN" medications are established in collaboration with the prescriber and patient and should be dispensed in a separate container. The patient or his or her agent must give written consent to dispense the patient's medication in a multi-medication compliance aid, including a note that the compliance aid may not be child resistant, if relevant. It is recommended that consent be reviewed on a yearly basis and updated as required.

The compliance aid is to be modified promptly when changes are made to the patient's drug therapy regimen. Medications which are returned to the pharmacy cannot be re-dispensed to another patient: however, the member may accept the return of medications for repackaging for the same patient where a change in therapy has occurred. If the member relies on his or her independent authority to renew or adapt a medication contained within the compliance aid, the member must notify the prescriber and update the consent and treatment plan, including the clinical rationale for the change as outlined in the College's Expanded Scope of Practice Orientation Manual.

LABELING

All container identification markings required by legislation apply to compliance packages.[4] Labeling includes the information that would appear if each drug had been dispensed in individual vials, in addition to a description of the shape, and colour of the tablet or capsule in a manner that meets the needs of the patient. The label indicates the dosing specifications for each medication, including day and time, with an emphasis on those medications that are taken at different frequencies, i.e. bisphosphonates. Each package is sequentially numbered where appropriate.

DOCUMENTATION AND RECORD-KEEPING

All details of the program will be documented, including disclosure of any charges and details of reimbursement. Documentation and

record-keeping will be completed according to the standards established in OCP Documentation and Record Retention, Disclosure, and Disposal guidelines. The pharmacy must have a process in place to record changes in dispensing to mitigate potential data errors when switching from regular to compliance dispensing. Documentation must also reflect any additional changes, including for example, switching the frequency of dispensing, administration, and dosage changes based on the patient's response to therapy. Where changes are initiated by the prescriber, a scanned electronic copy of the prescription is to be maintained in the pharmacy system. Changes may also be noted on the hard copy of the dispensing record and scanned back into the system. Pc

Following is a summary of the information that should be reviewed to support the initiation of a multi-medication compliance aid program (Appendix 1 at right)

REFERENCES

1. Brent National Health Service, Teaching Primary Care Trust, Policy for the Use of Medicine Compliance Aids

2. National Association of Pharmacy Regulatory Authorities (NARPA) Regulation Policy: Guidelines for Implementation of Oral Multiple Medication/Compliance Packaging Regulations. October 2008.

3. Drug Interchangeability and Dispensing Fee Act, Section 9.1.

4. Drug and Pharmacies Regulation Act, 1990, Section 156(3)

APPENDIX 1 - SUMMARY INFORMATION - MULTI-MEDICATION COMPLIANCE AID PROGRAM

The decision to use a multi-medication compliance aid is made by the pharmacist in collaboration with the patient, family member/caregiver and prescriber. The information to be shared between the parties in setting up this dispensing option includes, for example:

Patient/agent:

- Direction on ordering routines and prescription delivery/pick-up;
- Acknowledgement that prescriptions are being dispensed in non-child safe packaging, if relevant;
- Patient consent for pharmacist to access test results ordered by the physician related to prescribed drug therapy;
- Acknowledgement/outline of the pharmacy's "take back" program (to monitor compliance);
- Emergency contact numbers (family, caregiver, etc.);
- Approval/acknowledgement of the addition of non-prescription drugs into compliance aid; and
- Details on the issuance of receipts and other billing details, including information about third-party billing (if applicable).

Prescriber:

- The condition/rationale for dispensing medications in a compliance aid;
- Acknowledgement/direction for any reductions in quantities dispensed and
- The number of doses to provide for PRN drugs (e.g. analgesics, sleep aids, etc.), creams and liquids.

Pharmacist: This section should outline what the patient can expect from the pharmacist:

- Pick-up and delivery times;
- Child proof or not;
- Destruction of drugs and retention of personal health information;
- Quality assurance procedures, use of gloves, checking of meds, review of program;
- MedsCheck evaluations, how many or how often;
- Consultation with physicians/prescribers;
- Any reports that pharmacist could provide (if applicable).

PRACTICE TIPS

The College produces fact sheets to remind practitioners about certain aspects of practice. Topics are chosen based on questions that the College receives most frequently. The two fact sheets that follow are about out-of-province prescriptions and prescription transfers – subjects that are appropriate and well-timed given that travel season is upon us.

FACT SHEET

Out-of-Province Prescriptions

Published: August 2013

Legislative References: *Drug and Pharmacies Regulation Act (1990), s. 1 and s. 158*

Additional References: n/a

College Contact: Professional Practice (pharmacypractice@ocpinfo.com)

Drug and Pharmacies Regulation Act (DPRA)

Interpretation

s. 1. (1) "prescriber" means a person who is authorized under the laws of a province or territory of Canada to give a prescription within the scope of his or her practice of a health discipline; ("personne autorisée à prescrire des médicaments")

s.158. A pharmacist may dispense a drug pursuant to a prescription authorized by a prescriber licensed to practise in a province or territory of Canada other than Ontario if, in the professional judgment of the pharmacist, the patient requires the drug. 2007

The definition of "prescriber" in the DPRA reflects the enactment of an expanded scope of practice across multiple professions in Ontario and jurisdictions across Canada.

1. Members of the College can now accept a prescription written by any prescriber licenced in a province or territory of Canada. The decision to dispense the prescription is the responsibility of the pharmacist based on his or her professional judgement.
2. Members can accept a written, verbal or faxed prescription, including refills, if any. There are no restrictions regarding accepting new narcotic, controlled drug, benzodiazepine and other target substances prescription orders, provided members use professional judgement and practice due diligence in verifying authenticity.
3. The intent of the legislation is to ensure continuity of care for those persons coming into Ontario from another province, or residing in Ontario with a prescriber in another province, where there is a direct patient-prescriber relationship. The member has the authority to refuse to fill a prescription based on the patient's circumstances, and the application of his or her professional judgement.
4. Out-of-province transfers of prescriptions are discussed in the fact sheet on "Prescription Transfers", section titled "Requirements for the Receiving Pharmacy" PC

FACT SHEET

Prescription Transfers

Published: August 2013

Legislative References: *Drug and Pharmacies Regulation Act, O Reg. 58/11 s.43*

Additional References: *Food and Drug Regulations, s. C.01.041.1 – C.01.041.4; Narcotic Control Regulations (NCR), s. 31, 32; Benzodiazepines and Other Targeted Substances Regulations, s.54*

College Contact: Professional Practice (pharmacypractice@ocpinfo.com)

Background:

The Regulations to Ontario's *Drug and Pharmacies Regulation Act* (DPRA) enacted in March 2011 align the provincial regulations with the Federal Food and Drugs Act Regulations and provide greater detail and clarity regarding prescription transfers.

Prescription Transfers:

1. Transfers occur between "pharmacies" with members responsible for the transfer.
   - Pharmacy technicians, in accordance with federal regulations, cannot transfer prescriptions at this time. However, the necessary amendment to the *Food and Drug Regulations* was published on June 19, 2013 with an implementation date of December 19, 2013. Therefore, effective as of the implementation date, pharmacy technicians will be allowed to transfer prescriptions.

2. Section 43: A prescription "shall" be transferred from a pharmacy upon the request of the patient or a person acting on behalf of the patient.
   - Where refills exist, a pharmacy must transfer a prescription when requested
   - "a person acting on behalf of the patient" includes a member acting on behalf of the patient
   - The consent to transfer is implied and there is no need for a pharmacy to contact the patient to verify the transfer when the request comes from a member acting on behalf of a patient
   - Regulations to the DPRA refer to transferring a specific prescription and not a patient's record or file.

Requirements for the Transferring Pharmacy:

1. Name and address of the patient for whom the drug was prescribed
2. Name and strength (if applicable) of the drug prescribed
3. Directions for use as prescribed
4. Name and address of the prescriber
5. Identity of the manufacturer of the drug product most recently dispensed.
6. Identification number of the prescription, i.e. prescription number
7. Total quantity of the drug remaining to be dispensed
8. Date the drug was first dispensed under the prescription and the date of the last refill
   - The date issued by the prescriber is not required **except** for benzodiazepines and other targeted substances (Benzodiazepines and Other Targeted Substances Regulations)
9. Quantity most recently dispensed, if different from the quantity prescribed

Records Required by the Transferring Pharmacy

1. Date of the transfer
2. Identity of the pharmacy to which the prescription was transferred
3. Name of the member responsible for the transfer
4. If the prescription is transferred verbally, the name of the member who received the transfer.

Requirements for the Receiving Pharmacy

1. The person receiving the transfer must ensure the

transfer was made from a pharmacy licenced in a province or territory of Canada, i.e. can only receive a transfer from an accredited Canadian pharmacy.

2. The required information provided by the transferring pharmacy has been recorded

3. For verbal transfers, the record is signed by a member

All the above requirements for both pharmacies are required in order to transfer the authority to dispense the prescription in the receiving pharmacy.

Limitations to the Transfer of Prescriptions

Under the regulations, conditions exist where a transfer is not permitted:

1. Prescriptions cannot be transferred if the total quantity of the drug authorized has been dispensed, i.e. no refills remain or no quantity left to transfer
   - A copy[1] of the prescription can be provided to the other pharmacy who can then contact the physician for a new authorization or the member may use their expanded scope to authorize the prescription provided they have enough information
   - A copy is not an authorization to fill

2. Narcotic and Controlled Drugs cannot be transferred[2]

3. Benzodiazepine and targeted substances can only be transferred once.[3] Once transferred they can no longer be transferred any further.

Misconceptions and Best Practices

1. Where a patient brings in a prescription for multiple drugs on a single sheet, members are under the misconception that they can photocopy the prescription, fill one or two items and give the prescription with the remaining drugs ordered, back to the patient to fill elsewhere.
   - This is not an acceptable practice. A photo-copy does not provide a true authorization to fill the prescription as it is only a copy.

2. It is not necessary to call the patient to get consent to transfer a prescription. Transfers are legislated and the consent is implied (PHIPA). Delaying a transfer for this reason interferes with continuity of care.

3. Some pharmacies may charge for a transfer; withholding a transfer unless the patient pays a required fee first is not in the patient's best interest. If a pharmacy wishes to charge for a transfer, this charge is between the pharmacy and patient. Pharmacies may invoice the patient but in no way should this prevent the transfer. Members charging for professional services should review the policy regarding Fees for Professional Pharmacy Services http://www.ocpinfo.com/Client/ocp/OCPHome.nsf/web/Fees+for+Professional+Pharmacy+Services

4. Transfers should be done in a timely manner. If circumstances arise that result in a delay, as a professional courtesy, the member should inform the pharmacy awaiting the transfer.

REFERENCES

1. Drug and Pharmacies Regulation Act, s.157

2. Narcotic Control Regulations, s. 31, 32

3. Benzodiazepines and Other Targeted Substances Regulations, s. 54

There are a number of other fact sheets available on the College's website. Visit www.ocpinfo.com and search for fact sheets. Topics include:

- Expiry dates on prescription labels
- Identifying forgeries and fraudulent prescriptions
- Internet pharmacies
- Key requirements for methadone dispensing
- Narcotic purchases
- Narcotic purchase records
- Narcotic reconciliation and security
- Narcotic prescription part-fills
- Narcotic reporting of forgeries and losses
- Out-of-province prescriptions
- Physician prescribing status
- Prescription transfers

July 3, 2013

Re: Potential Eye Health Risks associated with Non-Corrective (Cosmetic) Contact Lenses

To All Ontario Pharmacy Designated Managers,

On behalf of the Ontario College of Pharmacists and the College of Optometrists of Ontario we ask for your assistance with an important issue regarding the sale of non-corrective (cosmetic) contact lenses in retail pharmacies throughout Ontario.

While a prescription is not required to purchase these products and they are not restricted from sale in pharmacies, there is a variety of eye health risks associated with improper use and care of this product. The potential for harm always exists when placing a contact lens onto the cornea. Individuals, who have not had a thorough ocular health assessment and the appropriate testing to determine whether they are suitable candidates for healthy contact wear, run significant eye health risks. Instruction on care, cleaning, insertion and removal of contact lenses are also integral to successful and safe contact lens wear.

The increased evidence of risk of harm, which has included a number of documented cases where individuals suffered permanent vision loss after purchasing and wearing cosmetic lenses without receiving professional evaluation or instruction on handling and usage, prompted a recent (December 2012) reclassification of this product to a Class II Medical Device in the Federal Food and Drug Act.

In light of the potential risk of harm to the public and in support of the reclassification, which positions this product more in line with pharmacies provision of other health care aids and devices, the College recommends that pharmacies who currently, or intend to, sell non-corrective (cosmetic) contact lenses:

- Ensure the provision of information and education to patients regarding the appropriate use of this product, including the potential risks

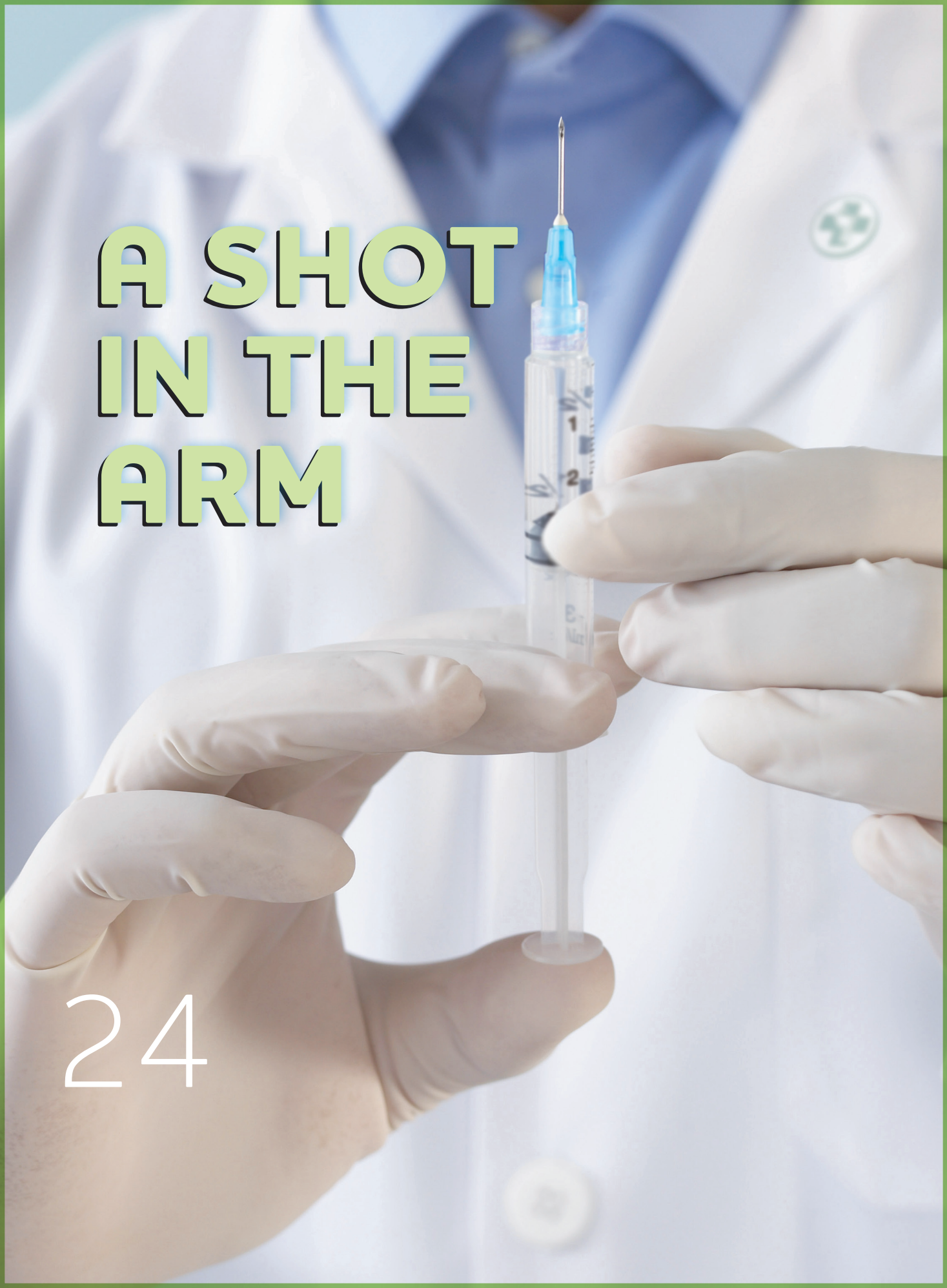
In meeting this recommendation consideration should be given to appropriate placement of the product in the pharmacy, ensuring that access to and oversight by a pharmacist is readily available.

Thank you in advance for your cooperation.

Sincerely,

Marshall Moleschi, R.Ph., B.Sc. (Pharm), MHA
Registrar
Ontario College of Pharmacists

Paula Garshowitz, OD
Registrar
College of Optometrists of Ontario



A SHOT IN THE ARM

THREE-FOLD INCREASE IN PHARMACY PARTICIPATION INCREASES ACCESS TO FLU SHOTS

By Stuart Foxman

The reach of the province's flu shot program promises to increase this year, with a surge in pharmacies taking part.

After pharmacists gained the right to administer the publicly-funded vaccine, about 620 pharmacies participated in Ontario's Universal Influenza Immunization Program (UIIP) for 2012-2013. With more than 1,900 pharmacies applying to be part of the program for 2013-2014, health officials are excited about the potential impact.

"When you improve access and convenience, you enable more people to have the flu shot, particularly those who make a spontaneous decision to get it," says Dr. Arlene King, Chief Medical Officer of Health of Ontario.

The setting for a flu shot matters. In an Ipsos survey for the Ministry of Health and Long-Term Care (MOHLTC), the public named "accessibility" as the most important factor to increase their likelihood of getting the flu shot. Most Ontarians live within walking distance or a short drive to a pharmacy. That proximity, combined with longer (and weekend) hours, makes a pharmacy a handy setting to be immunized.

Last year, pharmacies delivered over 250,000 doses of vaccine under the UIIP. In all, almost 4.3 million doses were distributed, for an uptake rate in Ontario of just over 31%. That's about the same rate as two years earlier.

For now, the involvement of pharmacists has shifted how the pie is sliced in delivery sources of the vaccine. In 2010-2011, doctors gave 80% of shots and health units 12%. Last year, those numbers were down

to 76% and 9%, as pharmacies/pharmacists were responsible for 8% of shots in the province.

A shift like this – even without an overall increase in shots – can have a positive impact on the health system, as doctors can free up more time for other duties. Now, three times as many pharmacies will participate in the UIIP.

Yet there is evidence, too, that allowing pharmacists to give flu shots may well increase coverage.

The MOHLTC notes that in B.C., Alberta and New Brunswick, pharmacists have received broad authority to administer injections. In 2011, all three provinces had higher flu immunization rates than Ontario: 52% in B.C., 41% in Alberta, and 38% in New Brunswick.

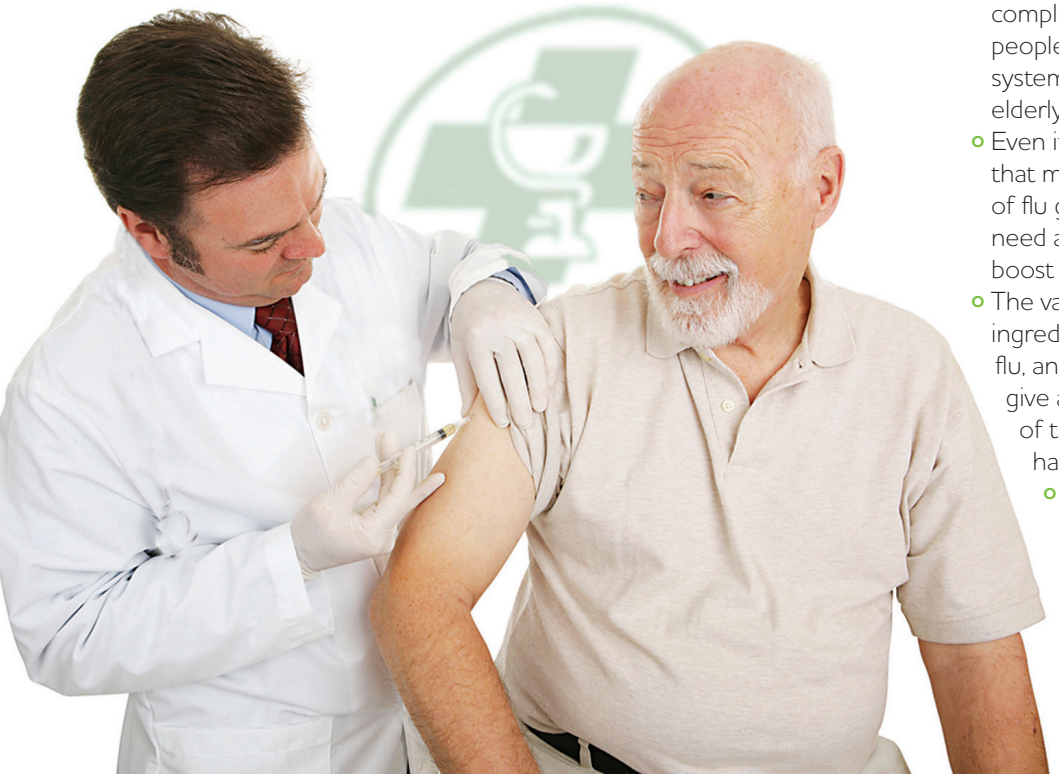
There are program differences across jurisdictions, and many factors can influence whether people get flu shots, such as health promotion messages. So it's unclear how much the higher coverage rates can be directly attributed to pharmacist participation in the provincial influenza immunization programs.

However, speaking specifically about the B.C. vaccination rate, Dr. King said "The data does seem to demonstrate an increase in the number of flu shots administered when there's an expanded scope of practice for pharmacists."

The experience in other jurisdictions bolsters the case. The Canadian Pharmacists Association reports that U.S. states where pharmacists can administer flu vaccines have significantly more citizens immunized than states where pharmacists lack that authority. The Association called the boost in vaccination rates "a step towards improved public health".

Here in Ontario, the MOHLTC says pharmacies can also play a key role in dispelling some of the myths around flu shots. The Ipsos survey revealed that among people who did not get the flu shot, the main reasons why included a perceived lack of susceptibility, questions about the effectiveness of the shot, and concerns about side effects.

Last year, pharmacies delivered over 250,000 doses of vaccine under the UIIP.



AS THE MOHLTC NOTES:

- Flu strains can change every year. Anyone is susceptible. Getting immunized is important for everyone – especially people who have a greater risk of developing complications from the flu, i.e. people with weakened immune systems, young children, the elderly, and pregnant women.
- Even if you had a vaccine before, that may not help given the type of flu going around this year. You need a flu shot every year to boost your natural protection.
- The vaccine doesn't contain any ingredients that would cause the flu, and therefore the shot can't give anybody the flu. The risk of the vaccine causing serious harm is also very small.
- The seasonal flu shot is typically 70-90% effective in preventing the flu in healthy children and adults, when the vaccine is a good match to the influenza types circulating that flu season. Pc

Recommendations for Prevention of Narcotic Medication Errors

By Andreea Pirvulescu

Andreea Pirvulescu is a fourth year pharmacy student at the Leslie Dan Faculty of Pharmacy at the University of Toronto. Andreea worked as a student at the Ontario College of Pharmacists during the summer of 2013.

The Patient Safety Review Committee (PSRC) assists the Office of the Chief Coroner (OCC) in Ontario with the investigation, review and development of recommendations toward the prevention of healthcare-related deaths where systems-based errors appear to be a major factor. The Committee also assists coroners with improving the investigation of deaths within or arising from the healthcare system where system-based errors appear to have occurred.

A relatively recent case concerned a dispensing error of hydromorphone that resulted in an overdose of the drug in a palliative care patient. The OCC brought the case forward in a report to the Ontario College of Pharmacists. Consequently, the PSRC has made recommendations in order to address issues related to narcotic medication errors.

EDITOR'S NOTE

Below is a summary of the case and recommendations for pharmacists and pharmacy technicians to help with preventing similar errors in the future.

CASE

Date of Death:
October 1, 2011

Age:
82 years

Patient Overview:
Patient had been a resident of a long-term care facility since June 16, 2011. His past medical history was significant for oxygen-dependent chronic obstructive pulmonary disease, sleep apnea, coronary artery disease, hyper-cholesterolaemia, hypertension, cardiac defibrillatory insertion, trans-urethral resection of the prostate, diabetes and peripheral vascular disease with a left above-knee amputation. He was bed and wheelchair-bound.

July 2011

Patient was admitted to the hospital for a fall that resulted in a fractured right lower tibia and fibula and subsequent osteomyelitis requiring a course of intravenous (IV) cloxa-cillin therapy.

August 31, 2011

Patient was admitted to hospital due to failure to thrive. In the hospital, he was being managed for his multiple medical problems, including debridement of his right leg ulceration and management of an associated wound infection, hypokalemia, hypotension, and an episode of gross hematuria.

September 13, 2011

Patient was stepped down to alternate level of care (ALC) status.

September 22, 2011

With general overall deterioration and loss of appetite the patient was deemed palliative.

Hydromorphone 2 mg/mL | Hydromorphone 2 mg/mL | Hydromorphone 10 mg/mL

September 29, 2011

~1900 HOURS

The patient was transferred to the palliative care unit and continued on a number of medications for treatment of the aforementioned conditions. New palliative care medications were prescribed as per the physician's dictated note:

> *In addition, in case of pain, I added a low dose of opioid in the form of Dilaudid 0.2 to .4 mg subcu if needed for pain, Midazolam 1 to 2 mg subcu if needed for anxiety, and Haldol 0.5 to 1 mg subcu if needed for nausea or agitation.*

~1930 HOURS

One tablet of 650 mg acetaminophen was given.

~2330 HOURS

One subcutaneous injection of 1 mg haloperidol was administered.

October 1, 2011

~0320 HOURS

One subcutaneous injection of 1 mg haloperidol was administered along with one 0.4 mg subcutaneous injection of hydromorphone.

~1116 HOURS

The Registered Practical Nurse (RPN) noted that all morning medications were held since the patient refused and was drowsy, lethargic, confused, and hypotensive. When awakened, he was agitated. The Registered Nurse (RN) and doctor were notified. An order to hold bisoprolol was written and the plan was for close observation.

~1900 HOURS

Hydromorphone 0.4mg was documented as given. Subsequently, the Coroner found that a 4mg subcutaneous dose was inadvertently administered. The dose had been drawn from a vial containing a 10mg/mL concentration, which resulted in a ten-fold error.

~1930 HOURS

Death was pronounced. The file did not include documentation as to why this dose was administered or when and how the error was discovered.

~2300 HOURS

A late entry was written by an RPN in the progress notes that stated the patient was anxious and yelling. The RN gave haloperidol without effect. The patient continued to call out, but denied pain. The RPN gave another dose of haloperidol without effect. The patient was confused and calling out continued. The patient was restless and not comfortable, and subsequently hydromorphone was given with good effect.

DISCUSSION

The incident was identified as a drug dosing error by the hospital and was investigated internally. Based on the available information, possible contributing factors included the availability of high concentration hydromorphone in unit stock, a failed independent double-check process, and knowledge gaps. The ten-fold dosing error may have been more readily recognized if the nurse was using a lower (2mg/mL) concentration of hydromorphone since the volume calculated for administration (4mg would equal 2mL) would be larger than a usual subcutaneous injection. There was no documentation of an independent double-check in this file although the hospital states that there is an existing policy in place. A comment on the Medication Administration Record (MAR) stated "use 10mg concentration"; however, there was no information included on how to obtain a 0.4mg dose from a 10 mL vial. It appeared that it was not evident to the nurse that the prescribed dose could not be

obtained from that specific product unless further dilution was carried out. A 0.4 mg dose would equal a volume of 0.04mL of the undiluted product.

RECOMMENDATIONS

To the Ontario Hospital Association (OHA), Ontario College of Pharmacists (OCP); Ontario Branch of Canadian Society of Hospital Pharmacists (CSHP); Ontario Long-Term Care Association (OLTCA); Ontario Association of Long-Term Care Physicians:

1. Consider pharmacy preparation of small doses of hydromorphone in the absence of a commercially available product.
2. Provide a readily available standard dilution chart for usual doses of HYDROmorphone using the standard concentration available (usually 2mg/mL).
3. Consider the use of morphine as the drug of first choice in patients with low opioid needs and no contraindications.
4. Review prescribing practices related to the use of dangerous abbreviations and dose designations. Refer to Institute of Safe Medication Practices (ISMP) Canada's Do Not Use list available at: http://www.ismp-canada.org/download/ISMPCanadaListOf-DangerousAbbreviations.pdf
5. Review prescribing practices related to range dosing.
6. Consider implementing standardized palliative care admission orders.
7. For palliative care areas in which higher concentration preparations of hydromorphone may be necessary, mechanisms must be in place to maintain a physical separation from lower-concentration preparations, and ideally to limit access to these preparations to prevent inadvertent administration.
8. Consider using ISMP Canada's HYDROmorphone knowledge assessment survey as a tool for education. It is available at http://www.ismp-canada.org/education/webinars/20120209_Hydromorphone/Answers.pdf
9. Periodic checks/audits should be conducted to ensure compliance with existing policies, such as independent double-checks.

ADDITIONAL COMMENTS

Opioid analgesics rank among the drugs most frequently associated with adverse drug events. Some of the causes for adverse events related to opioid use are associated with:

- Lack of knowledge regarding potency differences and conversion factors among various opioids.
- Improper prescribing and administration of multiple opioids and modalities of opioid administration (i.e. oral, parenteral, and transdermal patches).
- Inadequate monitoring of patients on opioids.[1]

Characteristics of patients who are at higher risk for over sedation and respiratory depression include:

- Sleep apnea or sleep disorder
- Snoring
- Older age (risk is 2.8 times higher for individuals aged 61-70, 5.4 times higher for age 71-80, 8.7 times higher for those over age 80)
- No recent opioid use
- Post-surgery, especially if surgery involved the upper abdominal or thoracic area
- Increased opioid dose requirement or opioid habituation
- Longer length of time receiving general anesthesia during surgery
- Receiving other sedating drugs, such as benzodiazepines, antihistamines, diphenhydramine, sedatives, or other central nervous system depressants
- Pre-existing pulmonary or cardiac disease or dysfunction or major organ failure
- Thoracic or other surgical incisions that may impair breathing
- Smoker

According to the Joint Commission's Sentinel Event Database from 2004 to 2011, of the opioid-related adverse drug events (including deaths) that occurred in hospitals, 47% were wrong dose medication errors, 29% were related to improper monitoring of the patient, and 11% were related to other factors including excessive dosing, medication interactions and adverse drug reactions. These reports underscore the need for the judicious and safe prescribing and administration of opioids, and the need for appropriate monitoring of patients.[2] PC

REFERENCES

1. The Joint Commission Sentinel Event Alert - Safe Use of Opioids in Hospitals - Issue 59, August 8, 2012
2. Hagle ME, et al: Respiratory depression in adult patients with intravenous patient-controlled analgesia. *Orthopaedic Nursing*, 2004;23(1):18-27

FOCUS ON ERROR PREVENTION

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

DISPENSING AN INTERCHANGEABLE PRODUCT

When presented with a prescription for a specific brand name product, pharmacists often dispense an interchangeable product listed in the *Ontario Drug Benefit Formulary*. However, it must be noted that interchangeability in Ontario is legislated in the *Drug Interchangeability and Dispensing Fee Act* (DIDFA). Not all products are interchangeable. Regardless of whether two products have the same active ingredients in the same dose or concentration, they are only interchangeable if they are defined as such under DIDFA. The inappropriate interchanging of two products can impact patient outcome.

CASE:

Rx
Citrodan® (magnesium citrate)
Sig: 10mL po bid
Mitte: one bottle
Repeat 3 times

The above prescription was hand written by a nephrologist and faxed into a local community pharmacy. The prescription was for a four year old child who requires a low carbohydrate diet to reduce seizures. The specific brand of magnesium citrate (Citrodan®) was prescribed because it is sugar free.

The pharmacy assistant entering the prescription into the computer was not familiar with the product Citrodan®. In addition, Citrodan® was not listed as a product in the pharmacy computer. Since the doctor also wrote magnesium citrate, the assistant searched for magnesium citrate in the computer system and found Citro Mag®. She therefore assumed that the two products were interchangeable. However, though both products contain the exact same amount of active ingredient (anhydrous magnesium citrate 15g per 300ml), their inactive ingredients differ. Citrodan® is sugar free (contains sodium saccharin) while Citro Mag® contains sorbitol.

The pharmacist checking the prescription was also unfamiliar with the product Citrodan® and also assumed that it was interchangeable with Citro Mag®. Citro Mag® was therefore dispensed.

After the child had received Citro Mag® for approximately six weeks, the mother reported an increase in seizure frequency and suggested that the sorbitol content of Citro Mag® likely played a role. The mother was understandably upset. The pharmacist sincerely apologized to the mother and dispensed the brand Citrodan® as prescribed.

POSSIBLE CONTRIBUTING FACTORS:

- Both the pharmacist and pharmacy assistant were unfamiliar with Citrodan®. Therefore, they were unaware that the product was sugar free.
- Citrodan® was not listed as a product in the pharmacy computer. Hence, limited information regarding Citrodan® was available to the pharmacy staff.
- Though the patient's file included a note stating "patient is on a no-carb diet", pharmacy team members did not fully understand the implications of the note.
- Both the pharmacist and pharmacy assistant assumed that Citrodan® was interchangeable with Citro Mag®. They felt that if the physician intended to have the brand Citrodan® dispensed, he would have added a note such as "no-sub" to the prescription.

RECOMMENDATIONS:

- Educate all pharmacy team members regarding the needs of unique patient populations. All team members must understand the implications of "low carbohydrate diets" or "ketogenic diets".
- Use extra care when dispensing medication to these patients. Read all patient notes carefully.
- When adding notes to patient profiles, ensure that it can be clearly understood by all pharmacy team members.
- Ensure that there is clear, effective communication when counseling these patients or their agents.
- Encourage the patient and/or their agent to ask questions. Patients can play a key role in error prevention.
- Speak with your software provider to ensure that all patient notes are clearly visible to the dispensing pharmacist when the prescription is being checked.
- All pharmacy team members must understand the criteria for interchangeability. Pc

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

RELEASING PERSONAL HEALTH INFORMATION PROTECTING PATIENT CONFIDENTIALITY AND SUPPORTING CARE

The following article on releasing personal health information sets out to assist members to understand the rules governing sharing a patient's information in selected circumstances. The article clarifies what falls within the definition of health information custodian; identifies when it is OK to automatically share information with other health providers involved in a patient's care; and provides additional examples of disclosures in specific circumstances.

Along the way, the piece asks, and answers, some of the questions that may come up in community pharmacy practice. Members are moving forward in providing care under the expanded scope of practice, and in collaboration with other health professionals in the interprofessional delivery of care. Understanding and applying the framework in which personal health information is released and protected is an essential tool in that process.

Releasing Personal Health Information

All regulated health professionals are legally and ethically obligated to protect the confidentiality of a patient's personal health information. This article will provide an overview of what a member should consider in determining whether he or she has the authority to release a patient's personal health information in selected circumstances. According to the rules established in 2004 under the *Personal Health Information Protection Act* (PHIPA), personal health information may only be disclosed by health information custodians if the individual consents, or if PHIPA specifically permits the disclosure without consent. Under the Act, health information custodians are both organizations (hospitals, long term care homes, pharmacies, etc.) and persons (health care practitioners).[1] As health information custodians, members of the Ontario College of Pharmacists, including pharmacists, registered pharmacy students, interns and pharmacy technicians, have a responsibility to collect, disclose and dispose of personal health information according to the rules established in PHIPA, and to ensure that information is protected against theft, loss, and unauthorized use or disclosure.

In general, according to the Act, personal health information cannot be shared without the express consent of the person to whom it relates; however, personal health information can be shared without express consent when it is shared between health information custodians who are providing health care to the same individual.[2] In this situation, the health providers are entitled to assume an individual's implied consent to disclose personal health information for the purpose of providing health care.[3] A pharmacist and all other regulated health professionals providing care to the same patient are within the circle of care and can therefore exchange information quickly and efficiently to facilitate treatment. As an illustration of how this 'circle of care' works, the *Information and Privacy Commissioner* provided the following examples:

> *"pharmacists are permitted to advise specialists about drug interactions; specialists are permitted to send reports to referring physicians; and Community Care Access Centres are permitted to provide test results to referring physicians to facilitate treatment of an individual"* unless the person to whom the information relates explicitly states otherwise.[4]

There are additional circumstances where personal health information can be shared without the express consent of an individual. The following are examples that illustrate when such disclosure is permitted:

DISCLOSURES PERMITTED

1. For the purpose of determining eligibility of the person to receive health care and related goods,

services or benefits (PHIPA [s.39(1)(a)])

Where a pharmacist is disclosing personal health information to a third party who is being asked to provide payment for medication or related goods or services.[5]

2. To a person who compiles or maintains a registry of personal health information for purposes of facilitating or improving the provision of health care (PHIPA [s.39(1)(c)])

   The *Narcotics Safety and Awareness Act, 2010* permits the Ontario Ministry of Health and Long-Term Care to collect, use and disclose information, including personal information and personal health information that relates to the prescribing and dispensing of prescription narcotics and other monitored drugs. The legislation requires prescribers, dispensers and pharmacy operators to disclose information related to prescriptions to the Minister or executive officer.

3. To another College for the purpose of administration or enforcement of the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act, 1991*, or an Act named in Schedule 1 of that Act (PHIPA [s.43(1)(b)])

But what about occasions when a request for information is not an administrative matter, such as when a police officer requests information about a patient; or, when a parent requests information about a minor child who has requested smoking cessation therapy or the morning after pill? Should a member release information to the policeman, or disclose information to a child's parent?

DISCLOSURES IN SPECIFIC CIRCUMSTANCES

Disclosure to Police

What happens in the course of litigation, or when a law enforcement agent requests information in the course of carrying out an investigation?

> A health information custodian is not free to disclose personal health information about an individual without the express consent of the individual, or incapable individual's substitute decision maker, or as required or permitted by law, for example, pursuant to a warrant or court order (PHIPPA [s.43(1)]).

Information may only be disclosed when the health professional is presented with a warrant, court order, production order, or under authority established in legislation, for example, the *Coroners Act*. Should a warrant or court order be produced, care must be taken to ensure that only the information outlined in the document is released. For example, a summons may require a member to attend a court at a particular time and to take a specific patient record. In this case the summons does not authorize the member to discuss the patient's care with, or show the record to, anyone in advance of the court appearance.

When information is disclosed, the member is required to document any details related to the disclosure in the patient record, including an officer's name and badge number along with a photocopy of the warrant, court order, production order, or other authority relied upon to release the information.

Disclosure to a parent

Ontario does not specify an age of consent, whether with respect to treatment or related to the release of personal health information. This means that any person may consent to receive a medical treatment, regardless of age, if he or she is able to understand the information about the treatment, including possible risks and benefits. In terms of pharmacy, medical treatment includes receiving prescriptions for medications and products such as contraceptives and smoking cessation aids. Permission from a parent is not required for a minor child if the pharmacist believes the patient understands the information provided and is able to give an informed consent.

A young person also has the right to make his or her own decisions about the collection, use or disclosure of personal health information. If a child under the age of 16 has given his or her own consent under the *Health Care Consent Act* to treatment, or participated in counselling under the *Child and Family Services Act*, any decisions related to releasing information are the child's to make. If there is a conflict between a parent and the capable child who is under 16, the decision of the child overrides that of the parent.[6]

What about the responsibilities of the pharmacist where the cardholder of a prescription drug plan wants to know the details of drug usage by a family member covered under the plan? Would the family member who is not the cardholder need to give permission or sign a consent form for the release of their own personal health information?

> This circumstance would constitute disclosure of personal health information by a health information custodian to a non-health information custodian, which can **only** be done on the basis of express consent. Accordingly it would be required to seek

consent from the other family member or members who are covered under the cardholder's health plan. If the information the cardholder is seeking relates to his or her child under 16, it would be appropriate for the pharmacist to determine whether the child has the capacity to consent to the release of his or her own personal health information. If the child is capable and disagrees with the release, the child's decision prevails.[7]

Under any circumstance when disclosing personal health information, a member is encouraged to keep copies of relevant agreements or court orders in the patient's record. Documentation of a patient's consent to disclose personal health information ought also to be kept. A printable form to document patient consent is available; it can be completed and scanned back into a record as required: http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/consent/consent_disclose_form.pdf

REFUSAL TO DISCLOSE

Refusing disclosure to a patient

A patient may be refused access to their own information in a number of situations, including in those circumstances where the health information custodian believes that access:

- Would result in a risk of serious harm to the treatment or recovery of the patient, or a risk of serious bodily harm to someone else;
- Would interfere with an inspection or investigation under a statute, i.e. the Coroners Act and the matter is ongoing; or
- Would reveal the identification of a person who provided health information to the member explicitly or implicitly in confidence and in circumstances in which it was appropriate that the person's name be kept confidential. [8]

CONVERSATIONS WITH, OR ABOUT, PATIENTS

There are several instances where a member needs to ask questions and/or discuss personal health matters with a patient, another health care professional, and/or pharmacy staff. While not within the formal context of releasing personal health information, it is essential that precautions are taken to protect a patient's information. Pharmacies are required to have a separate and distinct patient consultation area where a pharmacist can engage a patient in dialogue about medications.[9] Members and pharmacy staff should be careful about discussing patient matters on the telephone, within hearing distance of others.

When it is necessary to leave a voice message for a patient on an answering machine, or with a third party, members are advised to exercise caution regarding the content of the message. While it is acceptable for messages to contain the name and contact information of the member or the pharmacy, messages should not contain any personal health information related to a patient, such as details of the patient's medical condition, medications or other personal health matters. It should be noted that while social media are great tools to market health promotional materials, research medical information, and for patients to seek out communities, they are not appropriate for sharing personal health information between health care providers and patients. Regardless of the communication medium that is used, health care professionals remain subject to the same rules governing the security and privacy of patient information. [10]

In 2011, the Council of the Ontario College of Pharmacists approved a guideline in 2011 on *Record Retention, Disclosure and Disposal* which includes principles for working with personal health information. This is a useful a resource for members in determining their obligations under the legislation. If in doubt about the authority to release personal health information in circumstances beyond the routine delivery of care, it is recommended to err on the side of caution and seek advice or clarification using trusted resources, such as the ones that have been referenced in this article. Pc

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BULLETIN BOARD

INTERIM DEAN AT THE LESLIE DAN FACULTY OF PHARMACY

Dr. Heather Boon was appointed Interim Dean of the Leslie Dan Faculty of Pharmacy at the University of Toronto on July 1, 2013.

Dr. Boon is a graduate of the Faculty's Bachelor of Science in Pharmacy Program, has a PhD from the University of Toronto, and completed a Post-doctoral Fellowship at Centre for Studies in Family Medicine at Western University. A licensed pharmacist, Professor, and active member of the Faculty since 2001, Dr. Boon has built strong relationships with undergraduate and graduate students, cultivated a reputation as a leading expert in Canada on Complementary, Alternative and Integrative Medicine, and published over 120 scholarly publications.

Dr. Boon will remain Interim Dean until June 30, 2014 or until the appointment of a new Dean, whichever comes first.

For more information about Dr. Boon visit www.pharmacy.utoronto.ca

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

CALL FOR METHADONE DISPENSERS WHO PLAN TO ATTEND THE CAMH COURSE: ADVANCED ISSUES IN OPIOID DEPENDENCE TREATMENT

In planning for CAMH's annual Advanced Issues in Opioid Dependence Treatment workshop, which will be held in Toronto on November 16, 2013 from 8:00am to 1:00pm, organizers would like to hear from you about challenges in treatment with methadone and buprenorphine, that you would like to discuss at the workshop. In particular, if you have challenging cases that relate to one of the topics to be covered in the course:

- Pregnancy and opioid use
- Acute pain management
- Drug interactions
- Poly-substance use
- Concurrent disorders

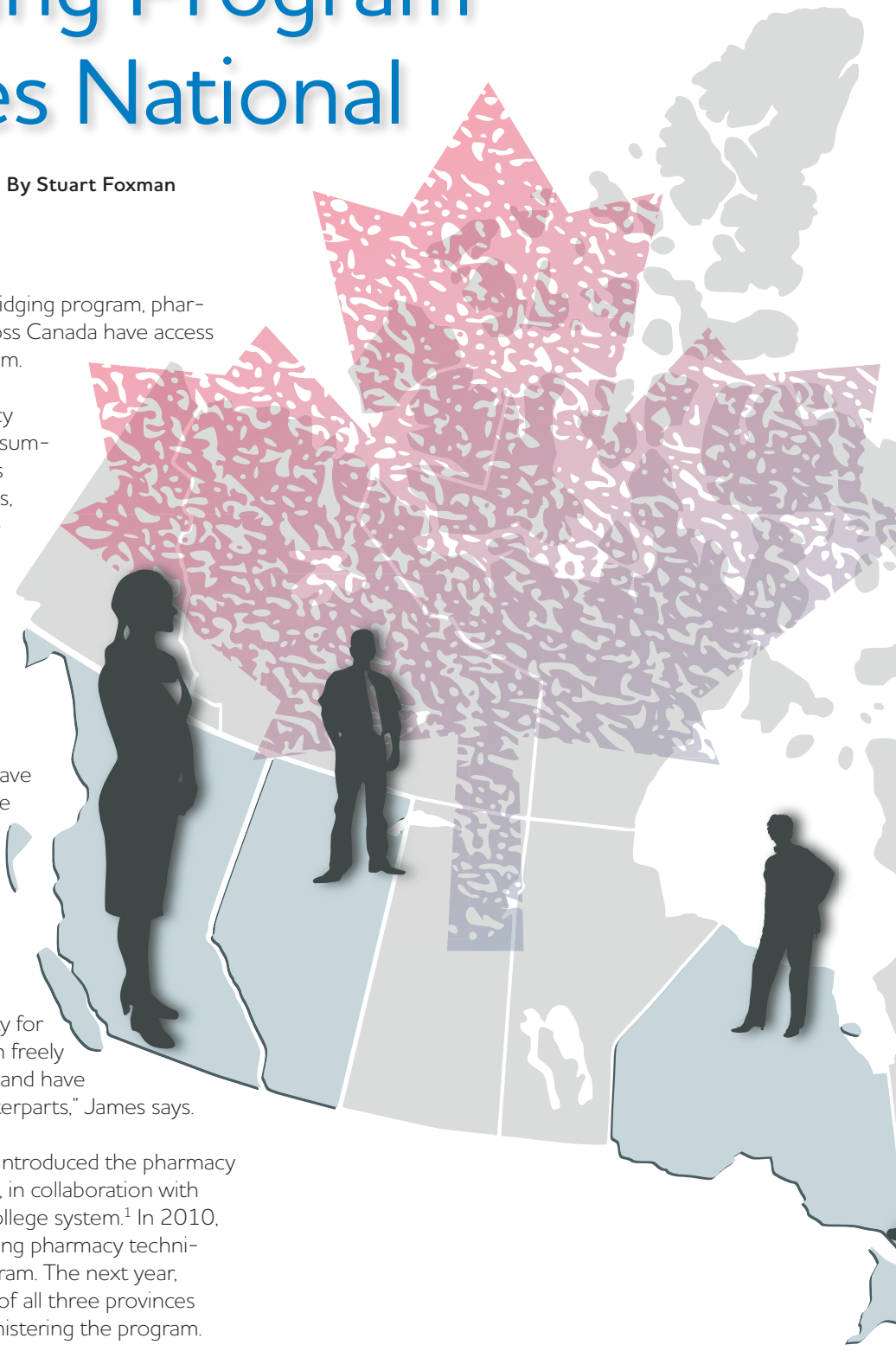
To register for the workshop (deadline September 18, 2013) please visit: http://www.camh.ca/en/education/about/AZCourses/Pages/advance-dodt_odt.aspx

To submit case studies, please visit: http://survey.CAMHX.ca/survey/AdvancedIssues2013.aspx

The College hosted an information booth (Jasmine Graham, OCP Communications Specialist pictured here) at the Ontario Pharmacists' Association's (OPA) annual convention held at the Metro Toronto Convention Centre June 20 – 22. With over 600 delegates in attendance (pharmacists, pharmacy technicians and an assortment of industry representatives) in addition to appearances by the Minister of Health, Deb Matthews and Premier, Kathleen Wynne. It was an important event for the College, as the regulatory body, to have a presence at the event. The agenda included a session led by College Registrar Marshall Moleschi entitled Demonstrating Value: Shifting Focus from the 'What' to the 'How'. Some of the key messages from this presentation are captured in the Registrar's Message (page 4) in this issue of Pharmacy Connection.

For Pharmacy Technicians, Bridging Program Goes National

By Stuart Foxman



With the launch of a new national bridging program, pharmacy technicians in Ontario and across Canada have access to a consistent and updated curriculum.

The National Association of Pharmacy Regulatory Authorities (NAPRA) is assuming responsibility for the program this fall. For anyone in the midst of studies, the changeover will be seamless. The courses are based on Ontario's existing program, and the NAPRA program will accept all previous credits. Technicians will simply complete any remaining courses within the new program.

By moving the program under the NAPRA umbrella, all regulators can have confidence in the skills and knowledge that emerge from bridging. "We want to be assured that everyone has the same level of training," says Susan James, Manager of Projects and Registration, Ontario College of Pharmacists.

The change also eases labour mobility for pharmacy technicians. "Individuals can freely move from one province to another, and have the same qualifications as their counterparts," James says.

The Ontario College of Pharmacists introduced the pharmacy technician bridging program in 2008, in collaboration with the marketing alliance of Ontario's college system.[1] In 2010, when Alberta and B.C. began regulating pharmacy technicians, they adapted the Ontario program. The next year, the pharmacy regulatory authorities of all three provinces assumed joint responsibility for administering the program.

Ontario pharmacy technicians ***must complete*** all four of the bridging program courses ***by January 1, 2015***

Why create a national program? When additional provinces began moving towards regulating pharmacy technicians, not all had the same resources to develop their own bridging courses. Rather than re-create a whole set of provincial programs, it made more sense to take an already successful program and adjust it for national delivery and sharing.

In 2012, NAPRA secured funding from the federal government to revise the existing bridging programs.[2] The year-long project drew on a curriculum advisor, subject matter experts, representatives from pharmacy technician education programs across Canada, and input from the provincial/territorial pharmacy regulatory authorities.

"This was an opportunity to do a full review, to update and refresh the program," says James, who served as a project manager for the development.

The consultations ensured that the program incorporates educational content that's relevant nationally, and remains current. Across the country, the practice of pharmacy technicians is fairly consistent. However, every jurisdiction also has its own distinct aspects. James explains that the program focuses on the common components in provincial legislation. Where certain topics are unique to the jurisdiction, the program provides outlines and directs participants to self-study.

The national curriculum still includes four courses of about 35 hours each: Professional Practice, Pharmacology for Pharmacy, Product Preparation, and Management of Drug Distribution. Professional Practice is mandatory for all. Pharmacy technicians also have the option to complete a challenge exam, which could demonstrate they have sufficient knowledge to avoid taking any or all of the other three courses.

The curriculum is available either in-class or online. James suspects that with a decline in registrations at this point, some institutions may lack the volume of students to make in-class offerings viable. She says that was likely to happen regardless of whether the bridging program became national. The upside of online classes is the flexibility, says James, as well as the chance to learn and share with technicians from across Canada.

Registration for the in-class and online courses is available via www.napra.ca. In Ontario, pharmacy technicians must complete all four of the bridging program courses by January 1, 2015. James says that it usually takes a minimum of one year to complete the program, so anyone who hasn't yet started should do so by this fall. If people take more than one course at a time, they could accelerate their completion.

Each province is on a different timeline in moving toward regulating pharmacy technicians. While Ontario is nearing the end of the bridging program phase, some provinces haven't even started yet. So the offerings on the NAPRA website will be available for a number of years.

As part of developing a national program, the federal government provided funds to support the translation of program material into French. "That's something we weren't able to do previously," says James. The French program delivery may not happen immediately, but should be available by the new year. Pc

1. Funded by the Government of Ontario, Ministry of Health and Long-term Care

2. Funded by the Inter-Provincial Labour Mobility Initiative

Methadone Medication Incidents

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

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INTRODUCTION

Methadone, a synthetic opioid, has been successfully used to manage opioid addiction and chronic pain. In Ontario, the methadone maintenance treatment (MMT) program represents the cornerstone approach to manage opioid addiction.[1] Although the benefits and effectiveness of MMT are well-documented in the literature,[2,3] safety of methadone in the medication-use process (such as prescribing and dispensing) continues to be a challenge to health care practitioners.

The literature contains many references about methadone-related medication incidents.[4,5] In 2003, an Institute of Safe Medication Practices Canada (ISMP Canada) Safety Bulletin described medication incidents involving methadone that led to patient harm, along with recommendations for system enhancements.[6] In a community setting, methadone medication incidents can occur during any stage of the medication-use process, including prescribing, order entry, dispensing, administration and/or monitoring. Incident reporting can be used to gain a better understanding of contributing factors or potential causes leading to methadone-related incidents.

The Community Pharmacy Incident Reporting (CPhIR) Program (available at http://www.cphir.ca) is designed for community pharmacies to report near misses or medication incidents to ISMP Canada for further analysis and dissemination of shared learning from incidents.[7] CPhIR has allowed collection of invaluable information to help identify system-based vulnerable areas in order to prevent medication incidents.[7] This article provides an overview of a multi-incident analysis of methadone-related incidents reported to the CPhIR program.

MULTI-INCIDENT ANALYSIS OF METHADONE MEDICATION INCIDENTS IN COMMUNITY PHARMACY PRACTICE

Reports of medication incidents involving "Methadone" and/or "Metadol" were extracted from the CPhIR Program from 2010 to 2012. In total, 72 incidents met inclusion criteria and were included in this qualitative, multi-incident analysis. The majority of the incidents were related to oral methadone used for opioid addiction, that is, the methadone maintenance treatment (MMT) program.

The 72 medication incidents were independently reviewed by two ISMP Canada Analysts. The incidents were analyzed and categorized into two major themes: (1) characteristics unique to methadone and (2) medication-use process. The two major themes were further divided into subthemes, as shown in Table 1 and Table 2, respectively. (Note: The "Incident Examples" provided in Tables 1 and 2 were limited by what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.)

WHY IS METHADONE A PROBLEM?

As seen in Table 1, methadone exhibits unique properties compared to other opioids that are inherently prone to medication incidents. In terms of pharmacokinetics, methadone has variable absorption and metabolism.[6,9,10] Methadone's half-life can range from 8 to 59 hours.[6,9,10] The half-life varies depending on past opioid use. Opioid-tolerant patients can experience a methadone half-life of approximately 24 hours.[6,9,10] However, methadone half-life in opioid naïve

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TABLE 1. THEME 1 – MEDICATION INCIDENTS WITH CHARACTERISTICS UNIQUE TO METHADONE

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY	SAFETY RECOMMENDATIONS
Compounding	*A pharmacist was filling a methadone prescription with environmental distractions (e.g. noise, interruptions from staff members, and multiple prescriptions being processed at the same time). The pharmacist prepared a methadone dose by measuring 8 mL instead of 0.8 mL. The patient was given the witnessed dose and left the pharmacy. The pharmacist contacted the patient after the mistake was discovered. The patient was instructed to go to the emergency room if changes in cognition or breathing were noticed. The pharmacist monitored the patient by phone for 4 hours.*	Prescribers are encouraged to write all orders in milligrams (mg), instead of milliliters (mL). Pharmacies that commit to dispensing methadone need to implement a linear work-flow that allows for sufficient time and space to safely prepare oral doses. All methadone orders and preparations should be independently double checked and reviewed before the patient receives the dose.	To reduce the incidence of expressing wrong doses on prescriptions, prescribers should never use a zero by itself after a decimal point (i.e. use "X mg").[8] Also, prescribers should always use a zero before a decimal point (i.e. use "0.X mg").[8]
Confirmation Bias	*Patient is on decreasing [or tapering] dose of methadone. [Pharmacist assumed the patient's methadone dose was the same as the previous encounter.] The pharmacist made up a dose of methadone based on the previous dose. [This led to the patient receiving a higher than anticipated methadone dose.] [However,] both the patient and prescriber are fine with decreasing the dose for the next scheduled dose.*	Patients on methadone maintenance treatment (MMT) often require frequent dose adjustments. The highly individualized dose of methadone means MMT needs to be continually re-assessed with the patient and dosing requirements needs to be communicated between all healthcare professionals within the circle of care. In preparing any prescriptions, especially with methadone, healthcare professionals must be prepared to prevent preconceived notions (or confirmation bias) from interfering daily practice.	To avoid incidents related to confirmation bias, independent double checks should be performed for each prescription during the order entry and dispensing process.[6]

TABLE 2. THEME 2 – MEDICATION INCIDENTS RELATED TO MEDICATION-USE PROCESS

SUBTHEME	INCIDENT EXAMPLE	COMMENTARY	SAFETY RECOMMENDATIONS[6]
Prescribing	*Physician wrote 3 different strengths for one patient. [It was] unclear as to what the actual strength was [for the patient].*	If prescriber intentions are not clearly communicated with pharmacists, confusion can arise about the correct dose to prepare for patients. Safe and effective delivery of methadone maintenance treatment (MMT) involves a well-informed multi-disciplinary team.	To encourage accurate communication of intended therapeutic interventions, prescribers should consider using standardized pre-printed order forms for methadone.
Order Entry	*Student looked at a previous prescription when preparing maintenance methadone. Prepared as previous dose of 112 mg, current dose is 116 mg. Error discovered when pharmacist was labeling for dispensing. When we looked at patient's drug file, the previous dose had not been discontinued.*	Methadone calculations need to be independently double checked in order to reduce order entry errors. The process of copying from previous prescriptions should be restricted or eliminated to prevent confirmation bias. Inactive methadone orders should be hidden or deactivated from patient profiles. This minimizes, or potentially eliminates, confirmation bias.	These medication-uses processes are directly related to daily pharmacy activities. Pharmacies should be encouraged to adopt a workflow that allows independent double checks to verify proper order entry, dispensing, and administration.
Dispensing	*[Pharmacy] should have [filled] 3 bottles [for the patient]. Only one [bottle was] put through. Patient [was] allowed different [number] of bottles on various days [prior to discovering incident].* *[Note: The incident reporter did not describe the exact order entry and/or dispensing process that led to this patient having different number of carries on different days.]*	Methadone dispensing represents a complex process that requires a safe environment to ensure proper preparation. Hence, methadone dispensing should be separated from regular workflow. Pharmacies should avoid the practice of pre-pouring doses, except for take-home doses or "carries", in order to reduce unnecessary bottles being stored in the fridge, which may lead to giving the wrong dose to the wrong patient.	
Administration	*[The] pharmacist poured orange juice in [the] cup [without methadone]. Patient was dispensed 100 ml of orange juice only. [The] pharmacist noticed within 5 minutes after [the patient] left and called the methadone clinic immediately. Methadone nurse said he would call [the patient] and if he could not get [a hold of the patient] by phone, [he] would go and get [the patient] at his apartment. [The methadone nurse] tried and could not contact [the patient]. [The patient] showed up the next day and was told that he had no methadone the day before. [The patient] did not notice any symptoms.*	Methadone stock solutions are usually clear solutions. Pharmacy staff preparing oral methadone doses cannot estimate appropriate concentration by physical appearance. Oral methadone doses should be verified independently by at least two pharmacy staff members to ensure accuracy of dose preparation. Prior to administering a methadone dose, pharmacy staff must check when the last dose was received by the patient. If a dose has not been taken by the patient for 3 consecutive days, the patient may lose tolerance to the usual methadone dose; contact the prescriber for a dose adjustment in order to prevent a potential overdose.[6,9]	

patients can be as high as 55 hours.[6,9,10] Methadone's long half-life means that there will be a delayed peak analgesic effect and presentation of respiratory depression may be slower compared to other opioids.[6,9,10] Therefore, in order to optimize therapeutic outcomes, methadone use requires a highly individualized approach by healthcare professionals.

WHY IS A PATIENT-FOCUSED MULTI-DISCIPLINARY APPROACH AN INTEGRAL PART OF SAFE METHADONE USE?

As seen in Table 2, preventing methadone-related medication incidents requires a strong relationship between the prescriber, the pharmacist, and the patient. Since 1996, the College of Physicians and Surgeons of Ontario (CPSO) has administered Ontario's MMT program on behalf of the Ministry of Health and Long-Term Care.[11] As of July 2012, approximately 360 physicians in Ontario were prescribing methadone to approximately 38,025 patients in the MMT program.[11] Interprofessional collaboration and regular communication between physicians and pharmacists are key to patient care and safe methadone use.[12] The *2011 CPSO MMT Program Standards and Clinical Guidelines* emphasize that in order to facilitate collaborative communication, 3-way treatment agreements between the physician-patient-pharmacist are encouraged.[12] Similarly, the *Ontario College of Pharmacists (OCP) Methadone Maintenance Treatment and Dispensing Policy* (available at http://www.ocpinfo.com), which provides guidance to OCP members who dispense methadone for the treatment of opioid dependence in Ontario pharmacies, supports the principle that the ideal model for MMT is one which allows the 3-way integration of patient, pharmacist, and physician within the community to ensure availability and accessibility of MMT for patients requiring such care. Patients are often the liaison between prescribers and pharmacists. If possible, patients should be included in the discussions to facilitate communication of methadone dose changes or therapy adjustments.

CONCLUSION

Methadone-related medication incidents continue to cause undesired patient outcomes in community pharmacy practice. Learning from medication incidents is a fundamental step to medication system improvement. The results of this multi-incident analysis are intended to educate health care professionals about the vulnerabilities within our healthcare system.

ACKNOWLEDGMENT

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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. Pc

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DISCIPLINE DECISIONS

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Member: Amanpreet Phull

At a hearing on May 2, 2013, a Panel of the Discipline Committee found Mr. Phull guilty of professional misconduct. The allegations of professional misconduct against Mr. Phull included falsifying prescriptions, falsifying pharmacy records, dispensing drugs for an improper purpose, submitting accounts and charges for services that he knew were false or misleading, amongst other allegations.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
- that he complete successfully, at his own expense, within 12 months of the date of the Order, the ProBE course and any related evaluations offered by the Centre for Personalized Education for Physicians as well as CPS II Module 5 (Advanced Professional Practice & Pharmacy Management) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
- for a period of three years from the date of the expiry of the period of suspension indicated below, that he shall:
  - o be prohibited from acting as a Designated Manager;
  - o be prohibited from having any direct or indirect proprietary interest in a pharmacy as a sole proprietor, partner, or director or shareholder in a corporation that owns a pharmacy; and
  - o be prohibited from having narcotic signing authority for any pharmacy;
- that he continue his current course of therapy with Dr. Julian Gojer (or such course of therapy as may be recommended by Dr. Gojer) for one (1) year from the date of the Order or until such period of time as may be recommended by Dr. Gojer, whichever is shorter
- for a period of two years from the date of the expiry of the period of suspension indicated below, that he shall only work for an employer who confirms to the College in writing that the employer has been provided with a copy of:
  - o the two Notices of Hearing in this matter;
  - o the Order;
  - o the Panel's reasons for decision in this matter, if available;
- A suspension of eighteen months, with three months of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of $15,000.

Member: Ehab Dimitry

At a hearing on May 15, 2013, a Panel of the Discipline Committee found Mr. Dimitry guilty of professional misconduct. The allegations of professional misconduct against Mr. Dimitry related to dispensing and/or selling a drug, operating a pharmacy, using the title "pharmacist", and holding himself out as a person who was qualified to practise in Ontario as a pharmacist, all while his Certificate of Registration was suspended.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, requiring the Member to provide proof to the College that he has successfully completed, at his own expense and within 12 months of the date of this Order becoming final, remedial training as follows:
  - (a) the Member shall successfully complete the ProBE Program on Ethics for Healthcare Professionals; and
  - (b) the Member shall participate in a session with an expert who is acceptable to the College to discuss ethics, governance and self-regulation. Prior to the session, the expert shall be provided with a copy of the Reasons for Decision in this

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

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matter and the Member shall review published materials to be identified by the expert;
- A suspension of two months, with one month of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of $2,500.

Member: Ahmed Al-Tamimi

At a motion on May 24, 2013, a Panel of the Discipline Committee considered allegations of professional misconduct against Mr. Al-Tamimi which involved falsifying records, signing or issuing documents that he knew contained false and misleading statements, and submitting accounts or charges for services that he knew were false and misleading, all with respect to claims made to the Ministry of Health and Long-Term Care.

In resolution of the matter, Mr. Al-Tamimi entered into an Undertaking, Agreement and Acknowledgment with the College whereby he resigned permanently as a member of the College, irrevocably surrendered his Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario.

Accordingly, the parties made a joint submission to the Discipline Committee to issue an Order for a stay of the allegations of professional misconduct against Mr. Al-Tamimi. On the basis of the Undertaking, Agreement and Acknowledgment Mr. Al-Tamimi entered into with the College, the Discipline Committee accepted the joint submission of the parties and issued an Order staying the allegations of professional misconduct against Mr. Al-Tamimi.

Member: Lou Ann Blahey

At a hearing on June 14, 2013, a Panel of the Discipline Committee found Ms. Blahey guilty of professional misconduct insofar as she

- dispensed a Schedule 1 and/or Schedule F drugs, controlled drugs, narcotics, and/or targeted substances without a prescription and/or proper authorization;
- recorded authorizations for prescriptions and/or refills of prescriptions where no such authorization was given, and/or altering one or more written prescriptions without proper authorization; and
- submitted false claims to third-party payors including Ontario Blue Cross and ESI.

The Panel imposed a penalty which included
- A reprimand;
- That the Registrar impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular, that the Member complete successfully, at her own expense, within 12 months of the date of the Panel's order, the ProBE Program – Professional/Problem Based Ethics, offered by the Centre for Personalized Education for Physicians, or an equivalent program acceptable to the College;
- A suspension of four months, with two months of the suspension to be remitted on condition that the Member completes the remedial training;
- Costs to the College in the amount of $5,000.

Member: Maheshkumar Patel

At a hearing on June 27, 2013, a Panel of the Discipline Committee found Mr. Patel guilty of professional misconduct in that he misappropriated narcotics and/or other drugs from a pharmacy on or about 10 occasions in or about June-November 2011.

Neither Mr. Patel nor any representative of him attended the hearing.

The Discipline Committee made a penalty order directing the Registrar to revoke Mr. Patel's Certificate of Registration, effective June 27, 2013.

Member: Mohamed Hanif

At a motion held on December 12, 2012, the Attorney General of Ontario ("AG") sought reconsideration of a previous decision of the Discipline Committee ("2012 Decision") respecting Mr. Mohamed Hanif (*see Ontario College of Pharmacists v. Hanif, 2012 ONCPDC 9* (CanLII)). In the 2012 Decision, Mr. Hanif was found guilty of sexual abuse of a patient and the mandatory revocation of his Certificate of Registration was suspended pending the outcome of his application to the Ontario Superior Court of Justice challenging the mandatory revocation provisions of the *Health Professions Procedural Code ("Code")*.

Specifically, the AG was seeking reconsideration of the original panel's order ("Penalty Order") as set out in paragraph 82 of its written reasons dated July 4, 2012, and an order setting aside point 3 of the Penalty Order.

A preliminary motion was heard on November 26, 2012 respecting the issues of standing of the AG and the jurisdiction of a panel of the Discipline Committee to hear a motion of reconsideration of the 2012 Decision. The panel of the Discipline Committee determined that the AG had standing and that the panel had jurisdiction to hear the AG's reconsideration motion.

In response to the AG's reconsideration motion, Mr. Hanif brought a cross-motion arguing that, in the event the panel found that the Discipline Committee lacked the jurisdiction to suspend the revocation of the Member's Certificate of Registration, the entire matter must be set aside, not merely point three of the Penalty Order. Mr. Hanif's cross-motion was also heard on December 12, 2012.

For reasons articulated in a decision dated July 10, 2013, the panel of the Discipline Committee which heard both the AG's reconsideration motion and Mr. Hanif's cross-motion, dismissed the AG's motion, and in that regard, did not make a determination regarding the Member's cross-motion. The panel noted that while the parties agreed in submissions as to the gravity of cases involving sexual abuse, the dispute centred around whether the mandatory penalty to be imposed in cases of sexual abuse can be suspended by a panel of the Discipline Committee. The panel ultimately determined that panels of the Discipline Committee have the jurisdiction and statutory authority under subsection 51(4) of the Code to suspend an order made pursuant to subsection 51(2) of the *Code* in matters involving sexual abuse.

Member: Sherif Abdel-Messih

At a hearing on July 29, 2013, a Panel of the Discipline Committee found Mr. Abdel-Messih guilty of professional misconduct in that

- hardcopies were not signed by the dispensing pharmacist;
- patient counselling and other information were not documented;
- he signed hardcopies and completed other documentation after the date of dispensing, when he had not dispensed the drugs or provided the counselling;
- authorizations were not attached to hardcopies;
- on July 18, 2012, he failed to ensure that a pharmacist was physically present in Main Drug Mart;
- on one or more occasions during the period 2005 – November 5, 2009, pharmacy assistant S.S. provided counselling to a patient known as "D.L." regarding her medications; and
- on or about July 18, 2012, pharmacy assistant S.S.:
  (i) provided counselling regarding Tylenol #1; and/or
  (ii) sold Tylenol #1 to a customer.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar impose the following terms, conditions and limitations on the Member's Certificate of Registration:
  - The Member must successfully complete, at his own expense, and within 12 months of the date of the Order, the ProBE course and any related evaluations offered by the Centre for Personalized Education for Physicians; and
  - The Member is prohibited from acting as a Designated Manager for any pharmacy so long as the Member is a member on part A of the College's register;
- A suspension of three months, with two months of the suspension to be remitted on condition that the Member completes the remedial training;
- Costs to the College in the amount of $3,500. Pc

CONTINUING EDUCATION (CE)

This CE list is provided as a courtesy to members and is by no means exhaustive. Inclusion of a CE on this list does not imply endorsement by the Ontario College of Pharmacists. 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

September 7, October 27, or November 10, 2013 (Toronto)
September 8, 2013 (Barrie)
September 15, 2013 (Thunder Bay)
September 29, 2013 (London)
October 6, 2013 (Windsor)
October 19, 2013 (Richmond Hill)
Flu Season and Pharmacy Services – An Injections Refresher Workshop
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

September 27–October 27, 2013 (Toronto)
October 23–November 23, 2013 (Toronto)
October 30–November 30, 2013 (Nova Scotia)
Opioid Dependence Treatment Core Course
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/odtcore_odt.aspx

September 12, 2013 (Toronto)
Multi-Incident Analysis Workshop – Analyzing medication incidents one group at a time
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

September 18 or November 20, 2013 (Toronto)
BPMH Training for Pharmacy Technicians
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

September 21, 2013 (Toronto)
Supporting Nutrition and Diet Management in the Pharmacy Certificate Program
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

September 21-22, 2013 or December 7-8, 2013 (Toronto)
September 28-29, 2013 (Windsor)
October 5-6, 2013 (Woodbridge)
October 19-20, 2013 (Ottawa)
October 26-27, 2013(London)
November 9-10, 2013 (Markham)
November 16-17, 2013 (Kingston)
November 23-24, 2013 (Niagara Falls)
Go Beyond the Counter: A Communications and Pharmacy Operations Workshop
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

September 23, 2013 (Toronto)
Infectious Diseases/Critical Care Conference
University of Toronto
Contact: http://www.pharmacy.utoronto.ca/cpd/id

September 26, 2013 (Toronto)
Root Cause Analysis (RCA) Workshop for Pharmacists
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

September 27, 2013 (Toronto)
Failure Mode and Effects Analysis (FMEA)
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

September 28, 2013 (Toronto)
9th Annual Infectious Diseases/Critical Care Pharmacotherapy Conference on "Contemporary Issues in the Management of Infections"
University of Toronto
Contact: http://www.pharmacy.utoronto.ca/cpd/id

October 5-6, 2013 (Toronto)
Nutrition for Docs (CSOM)
Canadian Society for Orthomolecular Medicine
Contact: https://www.csom.ca/nutrition-for-docs/

October 6, 2013 (Toronto)
Addictions Medicine Certificate Program (Toronto)
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

October 19, 2013 (London)
Contraceptives in Women's Health
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

October 20, 2013 (London)
New and Expectant Mothers
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

November 1-2, 2013 (Toronto)
Infectious Disease Management
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

November 16, 2013 (Toronto)
Advanced Issues in Opioid Dependence Treatment
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/default.aspx

November 16–17, 2013 (Toronto)
Pain and Palliative Care
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

November 22–23, 2013 (Toronto)
TEACH Specialty Course Integrated Chronic Disease Prevention: Addressing the Risks
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/default.aspx

December 6-8, 2013 (Toronto)
Psychiatric Patient Care Program – Level 1
Ontario Pharmacists Association
Contact: http://members.opatoday.com/live-courses

Multiple dates and locations – contact course providers
Immunizations and Injections training courses
Ontario Pharmacists Association http://www.opatoday.com/
Pear Health http://www.pearhealthcare.com/training-injection-training.php
RxBriefcase, CPS and PHAC
http://www.advancingpractice.com/
University of Toronto http://www.pharmacy.utoronto.ca/cpd

ON-LINE/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)
On-line courses with live workshops in subjects including mental health, safe and effective use of opioids, opioid dependence treatment core course (with additional elective courses), motivational interviewing, interactions between psychiatric medications and substances of abuse.
Contact: http://www.camh.ca/en/education/

Canadian Pharmacists Association (CPA)
Home Study Online accredited education programs including the ADAPT Patient Skills Development certificate program, Diabetes Strategy for Pharmacists, Micronutrients, QUIT: Quit Using & Inhaling Tobacco and Respiratory care
http://www.pharmacists.ca/index.cfm/education-practice-resources/

Canadian Society of Hospital Pharmacists (CSHP)
Online education programs accredited by CCCEP
www.cshp.ca

Canadian Healthcare Network
On-line CE Lessons
www.canadianhealthcarenetwork.ca

Communimed
A Practical Guide to Successful Therapeutic Drug Monitoring and Management (TDM & M) in Community Pharmacy: Focus on Levothyroxine
www.tdm-levothyroxine.ca

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

Ontario Pharmacists Association (OPA)
Complimentary online programs in therapeutic areas including Cough & Cold, Physical Assessment for Pharmacists, Methadone, Practical Management of Cough and Cold, Smoking Cessation, Ulcerative Colitis and Vitamin D in Osteoporosis.
http://www.opatoday.com/index.php/education/
Contact: onlinelearning@opatoday.com

RxBriefcase
On-line CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).
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.*

ADDITIONAL CE COORDINATORS NEEDED:

For members interested in expanding their network and giving back to the profession, OCP is looking for regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 11 (Markham 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 at www.ocpinfo.com. To apply, please submit your resume to ckuhn@ocpinfo.com.

The Niagara Apothecary

The Apothecary is open from Mother's Day to Labour Day, daily from 11 a.m. to 6 p.m.; Labour Day to Thanksgiving, weekends only. Retired pharmacists are available to provide information and answer questions about this heritage building.

Admission is free; donations welcome.

Visit us before Thanksgiving!

For more information visit the Apothecary's website at:

www.niagaraapothecary.ca

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