Ontario College of Pharmacists
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PHARMACY CONNECTION

FALL 2019 • VOLUME 26 NUMBER 4
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THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

OPIOID STRATEGY: COLLABORATING TO SUPPORT QUALITY CARE

A Snapshot of Opioid Dispensing in Ontario **18**

Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas **22**

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COUNCIL MEMBERS

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

H Régis Vaillancourt
H Nadia Facca
K Mark Scanlon
K Tracey Phillips
L Billy Cheung (Vice President)
L James Morrison
L Siva Sivapalan
M Mike Hannalah
M Kyro Maseh
M Laura Weyland (President)
N Tom Kontio
N Karen Riley
N Leigh Smith
P Rachelle Rocha
T Connie Beck
TH Goran Petrovic

PM Kathy Al-Zand
PM David Breukelman
PM Tammy Cotie
PM Christine Henderson
PM Azeem Khan
PM Elnora Magboo
PM Sylvia Moustacalis
PM Dan Stapleton
PM Gene Szabo
U of T Lisa Dolovich
U of W David Edwards

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

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

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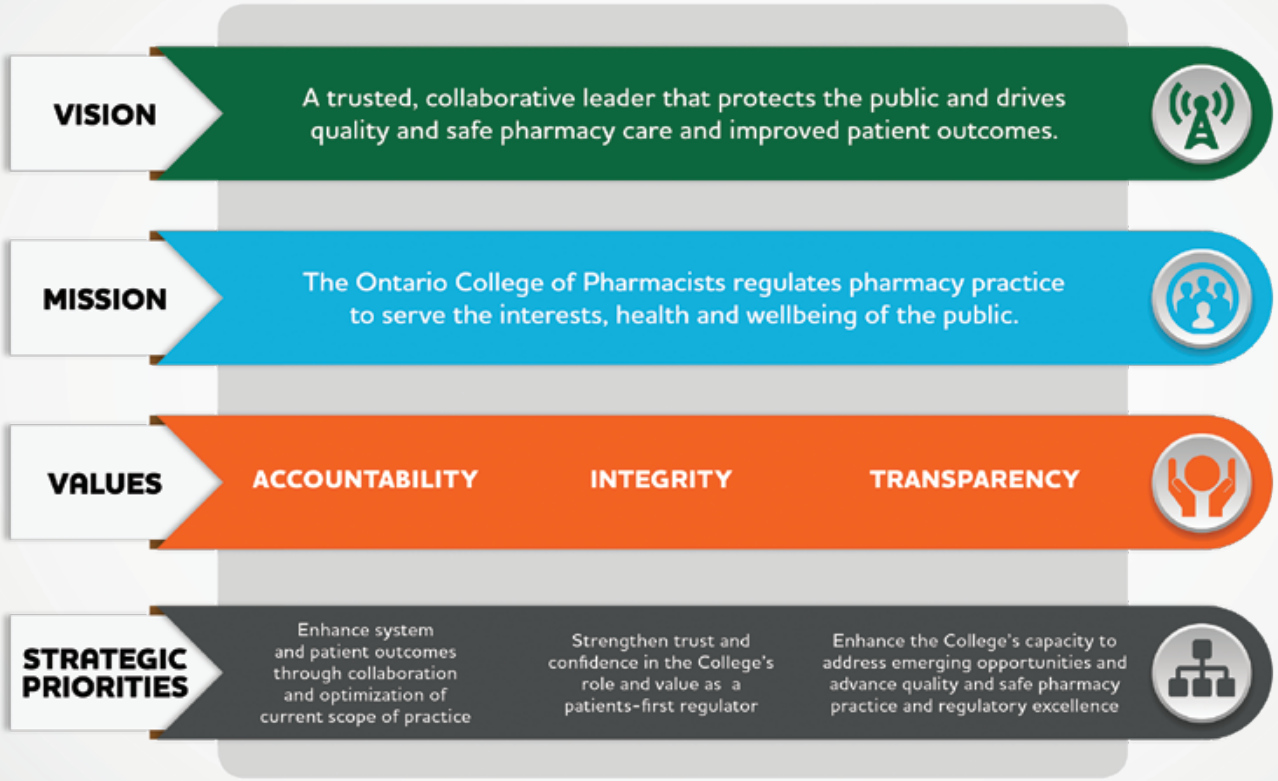
(2019-2021) OCP STRATEGIC FRAMEWORK



The objectives of *Pharmacy Connection* are to communicate information about College activities and policies as well as provincial and federal initiatives affecting the profession; to encourage dialogue and discuss issues of interest to pharmacists, pharmacy technicians and applicants; to promote interprofessional collaboration of registrants with other allied health care professionals; and to communicate our role to registrants 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 feedback by letter to the Editor. Letters considered for reprinting must include the author's name, address and telephone number. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.

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PHARMACY CONNECTION

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

Dear Colleagues,

It is an honour to serve as President for a second term, and I want to express my gratitude to the members of Council for their continued support as we move forward with the important work of enhancing and strengthening our approach to regulation in the public interest.

As 2019 draws to a close, we can be proud of how far we have come, from implementing the AIMS Program to launching the first set of quality indicators for pharmacy. It's also an opportunity to renew our commitment to better serve the public in the year ahead.

We can never forget that our role as a regulator is a privilege granted to our profession with the understanding that it will be used in service of the public. As a regulator, we are entrusted to protect and serve the public, and if we are to maintain that trust, we must continuously evaluate what we can do better to fulfill our mandate as societal expectations evolve and as the role of pharmacy in providing quality and safe care within a transforming healthcare landscape continues to expand.

Governance renewal is a critical component in strengthening the public's trust. By enhancing transparency and accountability in our decision making, we are joining a growing number of regulators who are modernizing their approaches to better serve the public, such as a competency-based selection of Council members and ensuring the right balance of public and professional members at the table. An update on this work is included in this issue of *Pharmacy Connection*.

We can also make better decisions by addressing cultural inequities. We have committed to cultivating Indigenous cultural competency among Council members, College staff and registrants, and to looking at ways that we can work collaboratively with Indigenous communities to address disparities in health care. You will hear more about the College's overall commitment to act and strategies to promote Indigenous cultural competency over the coming months. As a first step, every Council meeting will be introduced with a land acknowledgment to remind us of our role in the reconciliation process.

There are other opportunities for further teaching, coaching and collaboration. Earlier this year, the College released a data snapshot of opioid dispensing in Ontario to provide an overall look at dispensing patterns in community pharmacies as part of our commitment to our Opioid Strategy.

This is a resource that can help pharmacy professionals evaluate and enhance their own practice as medication experts. It also helps the College identify areas where we can work with registrants with a shared goal of preventing opioid-related harms, and to better understand the role of pharmacy in helping to reduce the human and societal impact associated with the opioid crisis in our communities. Additionally, the snapshot helps to emphasize that we, as pharmacy professionals, always need to look for opportunities to collaborate with prescribers and patients to deliver the best care.

There is an important development coming in 2020 that will also challenge us to consider what more we can do as pharmacy professionals to improve health outcomes: expanding scope of practice. Patients and our health care system can benefit from optimizing the knowledge and skills of pharmacists, while also ensuring the delivery of safe, high-quality care.

We heard from many registrants during the first phase of our work on scope of practice, who provided valuable input during the development of the draft regulatory amendments as well as the 60-day open public consultation. This feedback helped the College identify important themes and issues that will need to be addressed as scope expands. We will continue to engage pharmacy professionals and support them as they prepare for and adapt to these changes.

The first set of draft regulatory amendments related to expanded scope, which includes administering the flu vaccine to younger children and renewing prescriptions for up to a year, has been submitted to the provincial government for consideration. The College is now developing a new set of regulation changes to enable pharmacists to prescribe for minor ailments. Registrants will have an opportunity to provide their preliminary feedback in the very near future. Your expertise, experience and input is key to developing the regulatory amendments that enable these important practice changes while ensuring patient safety and the provision of high quality pharmacy care that the public can continue to trust.

There's much to do in 2020 – another busy year of working together to reach new milestones. We look forward to hearing from you as we move forward.

Sincerely,
Laura Weyland

SEPTEMBER 2019 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held on September 16th and 17th, 2019.

COUNCIL ELECTION 2019 – 2020 COUNCIL TERM

Following elections held in August, Council welcomed newly elected members Connie Beck in District T, Siva Sivapalan in District L and Mark Scanlon in District K. Re-elected to Council were Goran Petrovic in District TH, Billy Cheung and James Morrison in District L, and Tracey Phillips in District K. As well, Dr. Lisa Dolovich joined Council on July 1st as the interim Dean of the Leslie Dan Faculty of Pharmacy at the University of Toronto. We would like to thank all of the candidates who ran in the election for their interest and commitment to serving on Council.

Council re-elected Laura Weyland as President and Billy Cheung was elected as Vice President. Regis Vaillancourt will remain in the Past President position and the following members were elected to the Executive Committee: James Morrison, Kathy Al-Zand, David Breukelman and Sylvia Moustacalis.

The following Council members were elected as Committee Chairs:

- Executive – Laura Weyland
- Accreditation and Drug Preparation Premises – Regis Vaillancourt
- Discipline – Christine Henderson
- Finance and Audit – Dan Stapleton
- Fitness to Practice – James Morrison
- Inquiries, Complaints and Reports – Rachelle Rocha
- Patient Relations – Kathy Al-Zand
- Quality Assurance – Karen Riley
- Registration – Sylvia Moustacalis

A complete list of committee membership has been posted to the College website.

Report updated November 27, 2019

COUNCIL APPROVES CONCEPTS RELATED TO GOVERNANCE REFORM INTENTIONS

Following the approval of four governance renewal principles in December 2018, and associated intentions at the June 2019 meeting, Council deliberated on and approved the following governance-related matters (please refer to the September 16 and 17 Council meeting materials on the College website for additional details):

- ***Eligibility and competency-based selection of Council members***
  The Regulated Health Professions Act, 1991 (RHPA) sets out the authority for the College to establish by-laws respecting the qualification of candidates seeking election to Council. While the current by-law (5.9) sets out eligibility criteria, it does not address competence. To conform with governance best practices, and in addition to the changes agreed to by Council in June 2019 related to the representation of patient populations as opposed to registrant geography, Council approved the expanded eligibility criteria and desired competencies.

- ***Honoraria for elected Council members and non-Council committee members***
  It was decided that professional members of Council (Board) and committees will receive a taxable honorarium for time spent on College work and be reimbursed for incurred expenses. Time will be paid on a full-day or half-day basis and expenses will be reimbursed in accordance with common practice followed by other health colleges and public appointments. The daily honorarium was set at $260/day or $130 for less than three hours.

- ***Lay committee appointees including honorarium structure***
  In order to maintain the public voice on committees and to reduce the significant demand on the nine government-appointed public

members, the College committed to recruit and appoint lay members to committees as needed; government-appointed public members will be appointed to committees per statute requirements. Lay committee appointees will be selected using the same competency-based recruitment and screening process as professional non-Council committee appointments and will receive the same honorarium as professional committee appointees.

The new governance framework is grounded in adopting best practices and in building greater public trust in the role of the Council and the mandate of the College. The bylaws reflecting Council's decisions and approved intentions will be drafted and presented at the December 2019 meeting and, following stakeholder consultation, will become effective at the start of the 2020/21 Council year.

COUNCIL APPROVES COST-OF-LIVING FEE AMENDMENTS

In December 2018, Council approved a fee increase of 25% with one exception: annual registrant fee increases would be implemented over two years at a rate of 12.5% per year, effective 2019. This increase was implemented after several years of stable fees. Feedback from registrants regarding the rate of the increase was considered by Council, which reviewed the merits of implementing a modest annual cost-of-living increase tied to the consumer price index to prevent the need for future large increases. Council approved the drafting of bylaw amendments to implement annual cost-of-living fee increases (effective 2021) to be circulated for feedback along with other bylaw changes related to governance reform.

COUNCIL ADOPTS OPPORTUNITIES RELATED TO INDIGENOUS CULTURAL COMPETENCY

Following a review of the briefing note prepared by the Patient Relations Committee and subsequent discussion, Council unanimously approved the adoption of three opportunities to cultivate Indigenous cultural competency amongst Council, College staff and registrants:

- Develop a commitment to act. The College will identify ways to address cultural inequities to improve patient outcomes (reflecting the calls to action identified in the Truth and Reconciliation Commission of Canada's Calls to Action) and strive to build relationships with Indigenous communities and others focused on Indigenous health.

- Create a cultural sensitivity page on the College's website that would include resources and a training module on the inclusionary services that the College expects of registrants.

- Council meetings will begin with a land acknowledgement. Doing so will remind Council members, College staff and registrants that we all have a role in the reconciliation process and to consider this role within our work.

This initiative emerged from the College's growing awareness of the specific and devastating impacts of substance use on Indigenous patients and communities and the disparities in healthcare and health outcomes for Indigenous people compared to the non-Indigenous population. The College's approach to all three of these opportunities will reflect the importance of working in collaboration with Indigenous communities to improve pharmacy care and patient outcomes.

COLLEGE HONOURS MELISSA SHELDRICK FOR HER SIGNIFICANT CONTRIBUTIONS TO ADVANCING MEDICATION SAFETY, RELEASES FIRST EXPERT BULLETIN

At the September 17th Council meeting, on World Patient Safety Day, Council formally recognized patient safety advocate Melissa Sheldrick as an Honourary Member of the College for her work on the development of the Assurance and Improvement in Medication Safety (AIMS) Program and for her outstanding contributions to advancing medication safety in Ontario. In doing so, Council also celebrated Ms. Sheldrick's achievements as a patient safety advocate not just in this province but across the country and around the world.

Along with recognizing Ms. Sheldrick's significant role in promoting patient safety and guiding the development of the AIMS Program, the College also announced the release of the first independent expert bulletin that provides a preliminary analysis of medication incidents (errors that reach the patient) and near misses (errors that are intercepted before reaching the patient) reported anonymously by Ontario community pharmacies. The bulletin includes recommendations that provide important insights aimed at reducing the risk of medication safety events involving pharmacies.

From left to right; Laura Weyland, Anne Resnick, Melissa Sheldrich and Nancy Lum-Wilson.

Community pharmacies continue to be onboarded to the AIMS Program, which is expected to be fully rolled out to all 4,500+ community pharmacies across the province soon. Future priorities related to the implementation of the AIMS Program include the extension of the program to hospital pharmacies and the roll out of a pharmacy safety self-assessment (PSSA) tool to support ongoing quality improvement efforts.

COUNCIL RECEIVES UPDATE ON NARCOTICS MONITORING SYSTEM (NMS) DATA ANALYSIS RELEASE

Council was provided an update on the College's collaboration with the Ministry of Health related to the release of an aggregate data analysis from the provincial Narcotics Monitoring System (NMS) focused on opioid dispensing. The goal of releasing this data analysis is to provide information to help the College, its partners and pharmacy professionals to identify areas for further education and collaboration, educate pharmacy stakeholders (including the public) about dispensing patterns in the province, and highlight opportunities for pharmacy professionals to assess and enhance the quality and safety of their opioid-related practice.

The data analysis is provided to the College by the Ministry of Health; it is in an aggregate format and does not identify any specific pharmacies or pharmacy professionals. The first NMS opioid dispensing snapshot report is anticipated to be publicly released later this fall.

OPERATING PLAN PRIORITIES FOR 2020

CEO and Registrar Nancy Lum-Wilson presented an overview of the Council-defined 2019-2021 strategic priorities as well as the milestones achieved to-date expressed through the Council Scorecard. She was later joined by College staff who presented highlights on the key initiatives and priorities for 2020 with a focus on risk-based regulation strategies and provided a high-level overview of the 2020 operational plan that will serve as the basis for the budget that will be submitted to Council for approval in December.

NEXT COUNCIL MEETING

The next scheduled meeting will be held Thursday November 21, 2019, which is the second of two special meetings of Council, needed to facilitate approval of regulations related to expanded scope of practice. The next regularly scheduled meeting of Council will be held on Monday, December 9, 2019.

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

Ontario College of Pharmacists

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COUNCIL

2019/2020

2019/2020 Committee Appointments

Accreditation and Drug Preparation Premises

Elected Members:
Regis Vaillancourt (Chair)
Goran Petrovic
Public Members:
Elnora Magboo
Gene Szabo
Non-Council Members:
Sameh Bolos
Nadia Filipetto
Chintan Patel
Tracy Wiersema
Ali Zohouri

Staff Resource: Katryna Spadafore

Discipline

Elected Members:
Connie Beck
Billy Cheung
Nadia Facca
Tom Kontio
Kyro Maseh
James Morrison
Karen Riley
Mark Scanlon
Siva Sivapalan
Leigh Smith
Laura Weyland
Public Members
Christine Henderson (Chair)
Kathy Al-Zand
David Breukelman
Tammy Cotie
Azeem Khan
Sylvia Moustacalis
Dan Stapleton
Non- Council Members:
Chris Aljawhiri
Jennifer Antunes
Ramy Banoob
Susan Blanchard
Dina Dichek
Jasmyn Gill
Simmar Grewal
Jillian Grocholsky
Saliman Joylan
Katherine Lee
Chris Leung
Beth Li
Sony Polouse
Jeannette Schindler
Connie Sellors
David Windross
Cathy Xu
Staff Resource: Anne Resnick

Executive

Elected Members:
Laura Weyland, (Chair)
Regis Vaillancourt
Billy Cheung
James Morrison
Public Members:
Kathy Al-Zand
Sylvia Moustacalis
David Breukelman
Staff Resource: Nancy Lum-Wilson

Finance and Audit

Elected Members:
Billy Cheung
Regis Vaillancourt
Tom Kontio
Public Members:
Dan Stapleton (Chair)
David Breukelman
Staff Resource: Connie Campbell

Fitness to Practise

Elected Members:
Karen Riley
James Morrison (Chair)
Public Members:
Kathy Al-Zand
Azeem Khan
Non-Council Members:
Dina Dichek
Adrian Leung
Fatema Salem
Jeannette Schindler
Staff Resource: Genevieve Plummer

Patient Relations

Elected Members:
Nadia Facca
Connie Beck
Public Members:
Kathy Al-Zand (Chair)
Azeem Khan
Sylvia Moustacalis
Non-Council Members:
Kshitij Mistry
Adam Silvertown
Staff Resource: Todd Leach

Quality Assurance

Elected Members:
Tracey Phillips
Karen Riley (Chair)
Leigh Smith
Public Members:
Christine Henderson
Elnora Magboo
Sylvia Moustacalis
Non-Council Members:
Shelley Dorazio
Eric Kam
Sarosh Tamboli
Mardi Teeple
Staff Resource: Susan James

Inquiries, Complaints and Reports (ICRC)

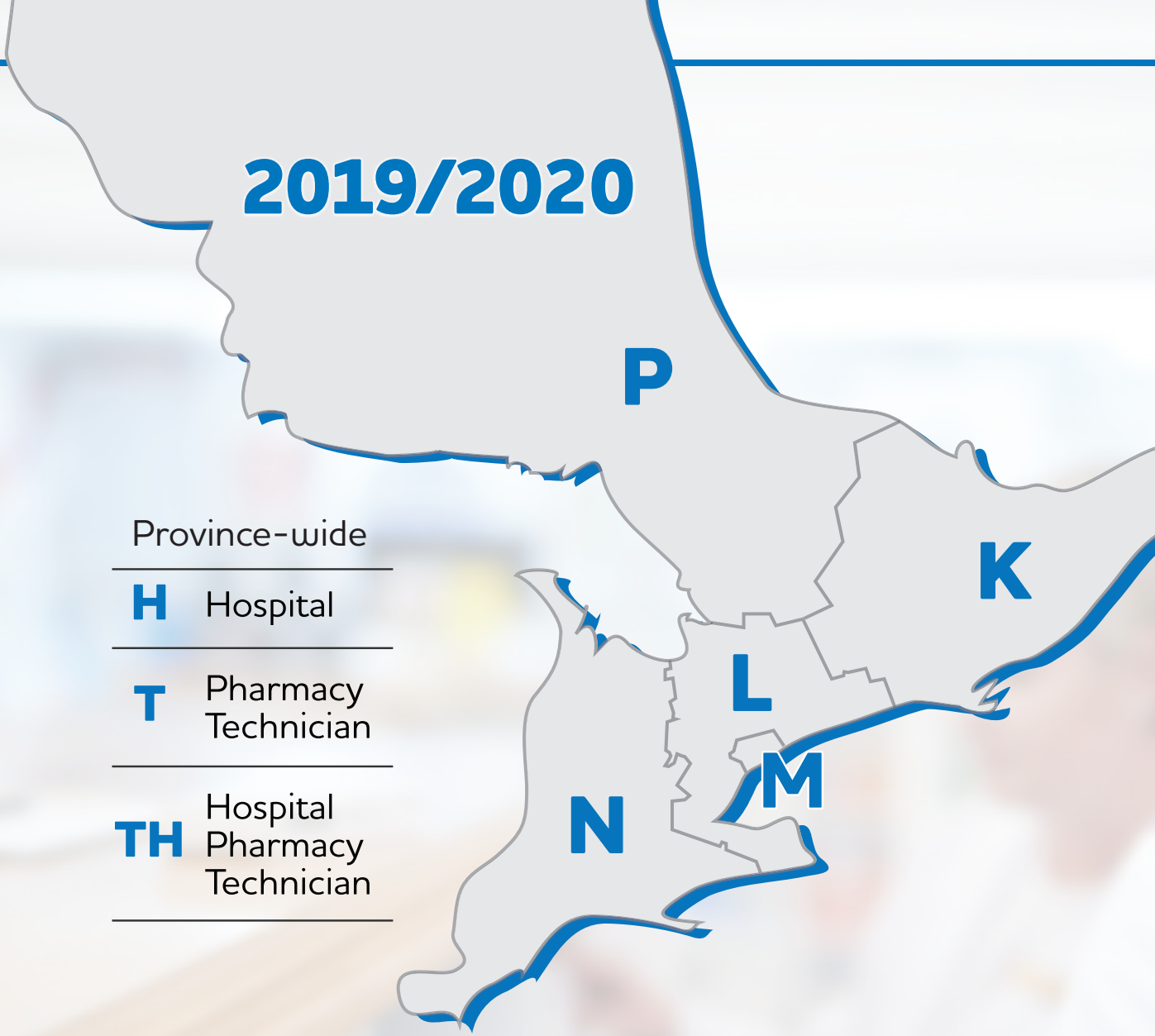
Elected Members:
Rachelle Rocha (Chair)
Connie Beck
Lisa Dolovich
Mike Hannalah
Tom Kontio
James Morrison
Goran Petrovic
Siva Sivapalan
Leigh Smith
Karen Riley
Public Members:
Kathy Al-Zand
David Breukelman
Tammy Cotie
Azeem Khan
Elnora Magboo
Sylvia Moustacalis
Dan Stapleton
Gene Szabo
Non-Council Members:
Elaine Akers
Sameh Bolos
Tanisha Campbell
Nadia Filippetto
Sajjad Giby
Frank Hack
Bonnie Hauser
Wassim Houneini
Mary Joy
Rachel Koehler
Elizabeth Kozyra
Chris Leung
Jon MacDonald
Kristen Madsen
Dean Miller
Vyom Panditpautra
Aska Patel
Chintan Patel
Meena Patel
Sony Poulose
Saheed Rashid
Dan Stringer
Frank Tee
Tracy Wiersema
Lisa-Kaye Williams
Amanda Vernooy
Ali Zohouri
Staff Resource: Katryna Spadafore

Registration

Elected Members:
Mike Hannalah
Mark Scanlon
Public Members:
Kathy Al-Zand
Christine Henderson
Sylvia Moustacalis (Chair)
Non-Council Members:
Tammy Cassin
Jane Hilliard
Edward Odumodu
Dean:
Dave Edwards
Ontario Pharm Tech Program Rep:
Angela Roach
Staff Resource: Sandra Winkelbauer

As of November 22, 2019

2019/2020



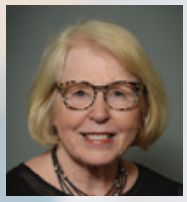
Province-wide

H Hospital

T Pharmacy Technician

TH Hospital Pharmacy Technician

PUBLIC MEMBERS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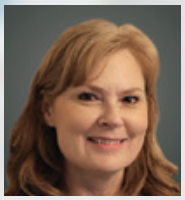
David Breukelman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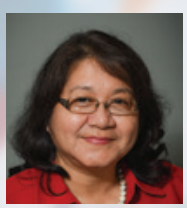
Christine Henderson


Azeem Khan


Elnora Magboo


Sylvia Moustacalis


Dan Stapleton


Gene Szabo

As of November 22, 2019

ELECTED MEMBERS

District **H**

Nadia Facca
London

Régis Vaillancourt
PAST PRESIDENT
Ottawa

District **K**

Tracey Phillips
Westport

Mark Scanlon
Peterborough

District **L**

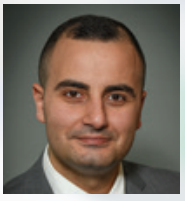
Billy Cheung
VICE-PRESIDENT
Markham

James Morrison
Burlington

Siva Sivapalan
Hamilton

District **M**

Mike Hannalah
Toronto



Kyro Maseh
Toronto

Laura Weyland
PRESIDENT
Toronto

District **N**

Tom Kontio
London

Karen Riley
Sarnia

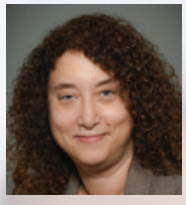
Leigh Smith
Cambridge

District **P**

Rachelle Rocha
Espanola

Vacant

Faculty of **PHARMACY**



Lisa Dolovich
Interim Dean
Faculty of Pharmacy
University of Toronto

David Edwards
Hallman Director
School of Pharmacy
University of Waterloo

District **T/TH**

Connie Beck (T)
Niagara Falls

Goran Petrovic (TH)
Kitchener

GOVERNANCE RENEWAL:

A Strengthened Focus on Public Trust

In December 2018, Council approved the decision to review the governance structure of the College. In the subsequent June 2019 and September 2019 meetings, Council considered and approved changes related to Council composition, competencies, and selection, as well as the composition of statutory committees. The required by-law amendments will be presented to Council in December 2019 before being circulated for public consultation.

REDUCTION IN COUNCIL SIZE

The total number of Council members will be reduced from 28 to the minimum of 20 as legislated in the *Pharmacy Act*. Best practices indicate that smaller boards are able to better engage in generative discussion and effective decision making.

Council will have twenty total members, including:

- nine elected members (two as pharmacy technicians),
- nine public members (appointed by the Lieutenant Governor in Council of Ontario), and
- two deans of the pharmacy schools (University of Toronto and University of Waterloo).

This composition will ensure that there is parity between professional and public members, ensuring the decisions at Council are made with a balance of perspectives.

COMPETENCY-BASED COUNCIL

To reflect the fact that pharmacy professionals elected to Council are not there to represent their voting constituents, Council decided to shift from the current geographical districts for the election of Council members to having positions on Council that reflect various patient populations, such as urban, rural, northern, and Indigenous. Candidates who wish to run for election will need to have demonstrated experience in serving the specified patient populations.

Candidates seeking election will be required to list their skills, knowledge and experience against the desired competencies approved by Council (see box). Competency-based selection ensures that Council has a diverse mix of knowledge, skills, experience and attributes to make evidence-informed decisions in the public interest. The College has previously put into place a competency-based method to guide the selection of non-Council committee members.

Approved Competencies for Council members

- Public interest/patient rights
- Working with diverse populations
- Board experience
- Governance/fiduciary
- Computer literacy
- Regulatory/legal expertise
- Strategic planning and thinking

In order to support the competency-based structure, Council also approved the development of a more robust and transparent qualification process to run for election, which would include screening of applications and an interview process with a screening committee prior to being confirmed as eligible to run for a seat.

In the absence of legislative change to separate Council from statutory committees (i.e. restrict Council members from serving on committees), there is a requirement that elected professional members serve on the Discipline Committee. Prospective candidates for Council are encouraged to have had prior service on College committees, such as having served as a non-Council committee member.

SEPARATION OF COUNCIL AND STATUTORY COMMITTEES

The mandates of Council and statutory committees are different. Council is focused on governing and setting policies, while statutory committees are charged with applying those policies and adjudicating matters. Additionally, these two roles may require distinct competencies and skills.

Council has agreed to appoint all elected professional members to the Discipline Committee as it is the only committee that requires elected members. Council also agreed to appoint all government-appointed public members to Discipline and seven of the nine members to ICRC (appointees serving on Accreditation are not permitted on Discipline). Two government-appointed public members will be appointed to all other statutory committees for which public members are mandatory under legislation.

In order to maintain the public voice on committees, as well as reduce the significant demand on the nine government-appointed public members as the College continues to advocate to increase the number of public appointments, the College will recruit and appoint lay members to committees as needed. Lay committee appointees will be selected using the same competency-based recruitment and screening process as professional non-Council committee appointments and will receive the same honorarium as professional committee members.

OTHER CHANGES

The terms of office for elected Council members will be reduced to a maximum of two consecutive three-year terms to ensure that new perspectives are regularly brought forward, while also respecting the necessary transition and succession planning.

Additionally, Council and committee members will begin to receive a taxable honorarium for time spent on College work in accordance with common practice followed by other health colleges and public members appointed to the Council by the Lieutenant Governor.

Changes have also been approved in regards to the titles of Council and Council members. Council will be called the Board of Directors (individual Council members will be called Directors) and the President and Vice President will be known as Chair and Vice Chair. These changes will help the public better understand the roles and responsibilities of Council. They also align with the College's move to refer to pharmacy professionals as "registrants" rather than "members," recognizing that the College does not represent members, but rather works in the public interest.

WHY GOVERNANCE RENEWAL?

Regulating the profession in the public interest is a privilege granted to Ontario's health regulatory colleges by the provincial government. With that privilege comes the responsibility to ensure the College does all it can to build and strengthen public confidence in its ability to deliver on its public-protection mandate. The College's Council felt it should be proactive in its efforts to evolve how it functions in order to continue to appropriately and effectively meet its fiduciary obligations.

Moving forward with governance reform ultimately delivers on Council's belief that these

changes represent an important opportunity to demonstrate the profession's and the College's ongoing commitment to the public by reflecting the emerging best practices that are critical to modernizing health regulatory governance within a rapidly changing healthcare landscape.

A GROWING TREND

Several provincial health regulatory colleges have been reviewing trends and international best practices with respect to governance in professional regulation processes over the past several years.

In 2016, the College of Nurses of Ontario (CNO) developed its plan, Vision 2020, for governance reform and submitted it to the Ministry of Health for consideration of legislative changes. Other regulatory colleges, including ours, have supported and endorsed CNO's proposed framework and echoed the calls to review the governing legislation to allow for the implementation of governance best practices. The College of Physicians and Surgeons of Ontario (CPSO) also announced last year that they are considering various aspects of governance reform as well.

The Ontario Ministry of Health has maintained an interest in ensuring that regulatory frameworks strengthen the accountability of health regulatory colleges, and has recently confirmed its support for ensuring that health professions are overseen by a modern and effective regulatory framework.

In British Columbia the College of Dental Surgeons (CDSBC), upon the order of the government, underwent a review of its governance along with administrative and operational practices. The Cayton report (prepared by renowned regulatory accountability expert Dr. Harry Cayton) provided several recommendations on how to improve the governance structure at the CDSBC as well as proposed changes to the governing legislation.

NEXT STEPS

By-law amendments are necessary to operationalize the changes. The new College by-law has been drafted and will be presented to Council for consideration at the December 2019 Council meeting. After the meeting the amendments, along with supporting material, will be posted for consultation on the College's website for 60 days.

The results of the consultation and any necessary adjustments to the by-law will be provided to Council at the March 2020 meeting. The changes would be in effect for the start of 2020/21 Council year (i.e. the 2020 election and the composition of the new Council and committees in September 2020).

Council has also committed to working with the Advisory Group for Regulatory Excellence (AGRE) to develop options for legislative changes to support governance reform in Ontario's health regulatory colleges. This partnership allows the College to join other regulatory leaders to proactively work with government to support change, rather than having changes imposed on the sector.

By taking a leadership role and committing to governance reform, Council firmly believes that the College's mandate will be better served and that it will continue to be an effective governing body entrusted with an important responsibility in our society.

EXPANDED SCOPE OF PRACTICE: *Progress Update*

On May 30, 2019, the College was directed by the Minister of Health to submit draft regulations to the government by November 30, 2019 that would enable pharmacists, interns and registered pharmacy students to administer the flu vaccine to children as young as two years old, renew prescriptions in quantities of up to a year's supply and administer certain substances by injection and/or inhalation for purposes that are in addition to patient education and demonstration. The Minister also asked the College to work with Ministry staff to authorize point of care testing by pharmacists for certain chronic conditions.

REGULATION AMENDMENTS APPROVED FOR SUBMISSION TO GOVERNMENT

The proposed regulatory amendments to enable these changes, as well as point of care testing, were approved by Council during a special meeting on November 21, 2019 following a 60-day open public consultation. Prior to this consultation, the College engaged pharmacy professionals as well as various health system stakeholders to help guide its work in developing and drafting the amendments.

The proposed amendments would also enable pharmacy professionals to perform certain point of care tests when regulations under the *Laboratory and Specimen Collection Centre Licensing Act* are amended by the Ministry of Health. These changes will determine which tests can be performed.

In approving the regulatory amendments, Council also approved:

- the recommendation to replace existing drug lists for authorized substances that can be administered by injection and/or inhalation with drug categories, which has been adopted by other health regulators; and

- the recommendation that additional education in administering the flu vaccine to children aged two to five years old will be voluntary and left to the professional discretion of pharmacy professionals.

SUBMISSION TO GOVERNMENT

The proposed regulatory amendments have been submitted to the Minister of Health for consideration. The government must review and approve these changes and will determine when they will take effect. While the scope changes apply to all pharmacy professionals regardless of their practice environment, there is other legislation that supersedes the *Pharmacy Act*, such as the *Public Hospitals Act* that governs hospital practice.

NEXT STEPS

The feedback received during the open consultation identified a number of important priorities that are critical to ensuring that pharmacy professionals can take on these new responsibilities and optimize their practice, while continuing to provide quality and safe care.

The College is developing an implementation plan to support pharmacy professionals, in collaboration with registrants, stakeholders and other health system partners. This work may include updating policies and guidelines, developing strategies to address feedback that was raised through the consultation, and communicating additional education options.

CONSULTING ON MINOR AILMENTS – SUBMISSION TO GOVERNMENT DUE BY JUNE 2020

At the request of the Minister, the College is also moving forward with drafting a new set of proposed regulations that would allow pharmacists to prescribe for certain minor ailments, which must be submitted to the Minister of Health by June 30, 2020 for consideration. The College is committed to consulting broadly on minor ailments and recognizes that doing so is key to developing regulatory amendments that promote safe and quality pharmacy care.

As an initial step, the College has established a Minor Ailments Advisory Group (MAAG), comprising patient advisors as well as experts in pharmacy, medicine, public health, antimicrobial stewardship, and health systems research. The MAAG's role is to provide guidance and recommendations to the College for regulatory, policy, implementation and evaluation of pharmacist prescribing for minor ailments, with a view to improving health outcomes and health-system quality while ensuring patient safety.

Registrants will have an opportunity in the near future to provide initial feedback on prescribing for minor ailments, prior to a broader open public consultation on the draft regulatory amendments early next year. The College is also consulting with professional associations and will continue to collaborate with them as well as registrants as this work moves forward.

We look forward to hearing from pharmacy professionals on this important aspect of expanded scope of practice. Feedback received through all of these public and stakeholder consultation activities will be considered.

In the meantime, registrants are encouraged to watch for updates in e-Connect and on the OCP website for additional details on planned engagement opportunities.

KEY DATES

May 30, 2019: Minister of Health directs the College to develop draft regulations that would enable the expansion of scope in specific areas.

Aug. 22, 2019: Council approves the first set of draft regulatory amendments for open public consultation.

Aug. 26 – Oct. 26, 2019: The draft regulatory amendments are posted on the College website for open public consultation.

Nov. 21, 2019: Council approves the final regulatory amendments to be submitted to the Minister of Health.

Nov. 30, 2019: Deadline for the College to submit first set of draft regulations to expand scope of practice.

March 2020: Council to review and approve regulatory changes related to minor ailments for 60-day open public consultation.

June 30, 2020: Deadline for the College to submit a second set of draft regulations that would enable pharmacists to prescribe for minor ailments.

A Closer Look at OPIOID DISPENSING IN ONTARIO

As part of the College's continuing commitment to its Opioid Strategy, the College recently released the Opioid Dispensing in Ontario: 2018 Snapshot. The snapshot, which is available on our website, is intended to provide an overall look at opioid dispensing patterns in Ontario related to three areas of analysis that are considered high-risk dispensing practices. In publishing the snapshot, the College is seeking to better understand practice behaviours, with the primary goal of identifying areas for further teaching, coaching and collaborating with pharmacy professionals in preventing opioid-related harms.

The College also recognizes that there is growing public, patient and health system stakeholder interest in understanding the role of pharmacy in helping to reduce the human and societal impact associated with the opioid crisis in our communities. Publicly reporting this information can help guide quality pharmacy care and do so openly and transparently so that the entire health system can better understand these patterns and contribute as appropriate to quality improvement activities.

Of equal importance is providing pharmacy professionals with information to help them evaluate and enhance their own practice as medication experts. Pharmacy professionals are strongly encouraged to assess their own dispensing practices, using the provincial data provided and any other data they have access to (i.e. trends identified regionally, tracking in their organization) to look for opportunities to enhance the patient care they are providing. In the snapshot, the College has provided a number of key considerations for pharmacy professionals who are dispensing opioids.

A PICTURE OF OPIOID DISPENSING

The data analysis in the snapshot was provided by the Ministry of Health from the Narcotics Monitoring System (NMS). The Ministry is responsible for the management of the NMS and conducted the analysis before sharing the aggregate, de-identified data analysis with the College. The data analysis **did not identify specific pharmacies, pharmacy professionals or patients**.

The data analysis is focused on three areas of opioid dispensing:

- incidence of high-dose opioid prescriptions (i.e. new prescriptions for patients who did not receive an opioid in the previous six months);
- prevalence of high-dose opioid prescriptions; and
- opioid and benzodiazepine co-dispensing.

For the purposes of organizing the data and recognizing that there will be variations among regions, the data analysis is provided by Local Health Integration Network (LHIN)* as well as provincially.

It's important to note that the data analysis for a specific LHIN does not represent a benchmark or standard for pharmacy practice. Rather, the value of the data analysis is in providing a way to measure the impact of shifts in pharmacy practice over time and place and identify opportunities for improvement. The key considerations highlighted in the snapshot provide initial areas of focus for pharmacy professionals who are exploring where there is an opportunity to contribute to enhanced patient and system outcomes.

The College also recognizes that while this snapshot focuses on the opportunities for pharmacy professionals to enhance their practice, the dispensing of opioids also involves other healthcare professionals and various system factors. Accordingly, the College continues to look for opportunities for conversation and collaboration with the many organizations and healthcare professionals who are also committed to preventing patients from experiencing opioid-related harms. For more information on why the College released the opioid dispensing snapshot, please review the Frequently Asked Questions on the Opioid Dispensing in Ontario Snapshot on the OCP website.

Example table from the Opioid Dispensing in Ontario Snapshot

Opioid recipients co-dispensed benzodiazepines, by LHIN

LHIN name	2013	2014	2015	2016	2017	2018	Trends
Erie St. Clair	21.2%	20.7%	19.9%	19.7%	18.5%	20.0%	
South West	21.2%	20.6%	20.1%	19.8%	18.3%	17.8%	
Waterloo Wellington	20.3%	20.6%	20.1%	20.1%	18.9%	16.7%	
Hamilton Niagara Haldimand Brant	21.2%	20.7%	20.3%	19.5%	18.3%	21.6%	
Central West	20.4%	20.2%	20.5%	20.0%	18.7%	15.6%	
Mississauga Halton	20.3%	20.7%	20.5%	20.0%	18.4%	18.1%	
Toronto Central	21.4%	21.0%	20.3%	19.4%	17.8%	18.4%	
Central	20.9%	20.5%	20.1%	19.7%	18.8%	17.2%	
Central East	20.7%	20.7%	20.5%	19.7%	18.5%	18.0%	
South East	21.1%	21.0%	20.6%	19.5%	17.8%	18.0%	
Champlain	20.5%	20.4%	20.4%	20.0%	18.7%	16.6%	
North Simcoe Muskoka	20.4%	20.7%	20.6%	19.8%	18.6%	19.9%	
North East	20.7%	20.6%	20.3%	19.8%	18.5%	21.5%	
North West	21.2%	20.5%	20.3%	19.8%	18.2%	15.5%	
Ontario	**20.9%**	**20.6%**	**20.3%**	**19.7%**	**18.5%**	**18.4%**	

*Throughout the data analysis, the term LHIN is used to describe specific regions. At the time of the data analysis, Local Health Integration Networks were geographically based organizations that plan, integrate and fund local health care. However, future reporting formats are subject to change as the structure of the provincial health system transforms and evolves over time.

KEY CONSIDERATIONS FOR PHARMACY PROFESSIONALS

The snapshot provides an opportunity for pharmacy professionals to assess and evaluate their own opioid dispensing practice. The College has highlighted a few key considerations when doing so in both the snapshot and the one-page Resource for Pharmacy Professionals.

The considerations particularly focus on patient assessment and education. It is important to assess whether the prescribed opioid therapy is appropriate for the patient, including, but not limited to, their conditions, history, characteristics of their pain, possible treatment alternatives, possible risks to the patient and monitoring parameters, such as adverse effects. Complete documentation of this assessment should be readily accessible for continuity of care.

The snapshot chiefly focuses on high-dose opioid prescriptions since high doses of opioids, where a low dose may suffice, are associated with increased risk of adverse events including emergency department visits or hospitalizations, substance use disorder, and even overdose deaths.[1] Pharmacists should assess each opioid prescription to ensure that it is started at the lowest dosage necessary for that patient. This may involve collaboration with the prescriber and the suggestion of alternative medication and dosages.

One of the areas of data analysis is the co-dispensing of opioids and benzodiazepines, which despite numerous guidelines contraindicating concurrent use of opioids and benzodiazepines, are often co-prescribed.[2] Pharmacists are expected to assess situations within which opioid and benzodiazepines are co-prescribed, and examine the rationale for their concurrent use. Collaboration with patients and prescribers is critical to ensure potential adverse events, such as respiratory depression, are identified and prevented where possible.

Finally, it is important that appropriate education is provided to patients regarding their opioid prescription. For example, if the opioid prescribed is indicated for acute pain, patients should also be provided information on the characteristics of acute pain, including its self-limiting nature, and expected duration.

Conduct a full patient assessment and document your rationale.

Start new opioid prescriptions at the lowest effective dose.

Provide comprehensive information for patients using opioids for acute pain.

Use caution when co-dispensing opioids and benzodiazepines.

Learn more in the Opioid Dispensing Snapshot: Considerations for Pharmacy Professionals.

The College provides a number of resources to help pharmacy professionals identify and implement best practices with regards to dispensing opioid prescriptions, including:

- the Opioid Practice Tool;
- the Opioid Policy; and
- External Resources on Opioids.

NEXT STEPS

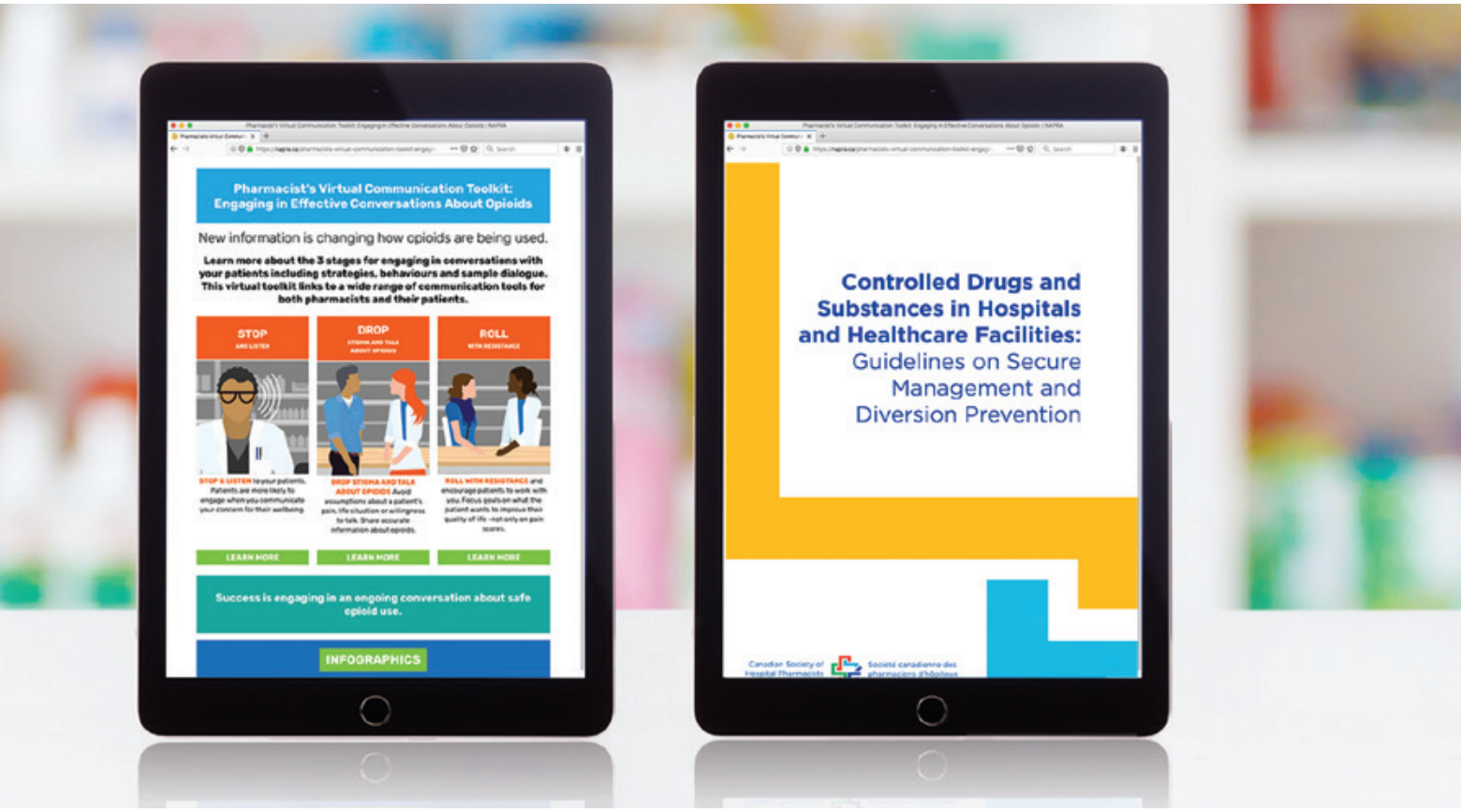
Ultimately, the goal of the snapshot is to identify opportunities, through greater awareness of patterns made possible through analyzed data, to influence quality improvement and safe pharmacy practice and enhance system and patient outcomes.

The College anticipates that it will provide updated data for the most recent year on an annual basis. Over time, the data analysis will provide an overview of the impact of the various activities and strategies being undertaken by pharmacy, and the larger healthcare system, on opioid dispensing. It is anticipated that greater awareness of the data and opioid dispensing trends by pharmacy professionals will lead to improved practice and better patient health outcomes.

The College will also continue to look for opportunities to provide learnings and resources for pharmacy professionals that reflect the findings/needs identified through the data analysis. Feedback from pharmacy professionals, stakeholders and patients will also be taken into account when looking at future reporting opportunities.

[1] https://www.sciencedirect.com/science/article/pii/S0197457218302015
[2] https://www.sciencedirect.com/science/article/pii/S0197457218302015

NEW EXTERNAL **OPIOID-RELATED** *RESOURCES*



PHARMACIST'S VIRTUAL COMMUNICATION TOOLKIT: ENGAGING IN EFFECTIVE CONVERSATIONS ABOUT OPIOIDS

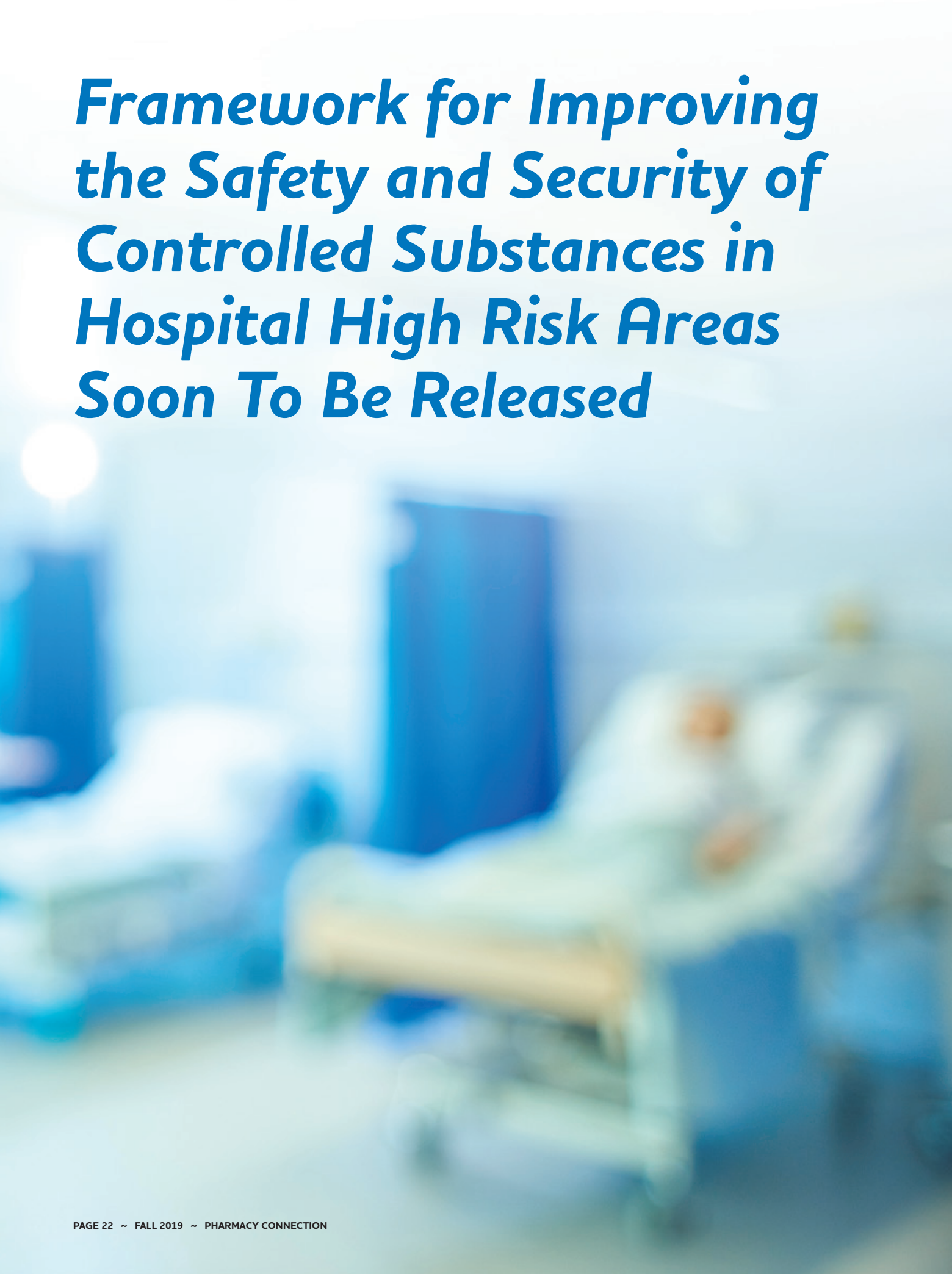
This interactive pharmacist's toolkit from NAPRA focuses on having potentially difficult conversations with patients regarding opioids. It provides specific strategies and sample dialogue related to the three stages for engaging in conversations: Stop and Listen, Drop the Stigma and Talk About Opioids, and Roll with Resistance. It also provides a list of other resources for pharmacy professionals and patients.

CONTROLLED DRUGS AND SUBSTANCES IN HOSPITALS AND HEALTHCARE FACILITIES: GUIDELINES ON SECURE MANAGEMENT AND DIVERSION PREVENTION

The guidelines on secure management and diversion prevention developed by the Canadian Society of Hospital Pharmacists, are useful resources for staff at Canadian healthcare facilities, including pharmacy professionals. Advice and guidance are provided on developing a system that prevents, detects and responds to diversion of controlled substances. There are also suggestions for continuously improving such a system once it has been established.

The guidelines address inventory management, preparation, dispensing and distribution, prescribing, administration to the patient, waste and disposal, identifying diversion and investigating diversion.

Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas Soon To Be Released



A new framework aimed at reducing the risk of diversion within hospitals has been established through the collaborative efforts of several health system and pharmacy stakeholders. As the sponsor of the Partnered Table to Improve the Safety and Security of Controlled Substances in Hospital High Risk Areas, the College is pleased to work with its partners to share the framework and contribute to system-wide responsibility aimed at reducing the harms associated with the misuse and abuse of Controlled Substances in our communities.

The *Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas* contains a number of recommendations to enable healthcare system stakeholders to proactively identify and prevent the diversion of Controlled Substances in hospitals.

The recommendations recognize that the diversion of Controlled Substances can have a substantial impact on patients, staff and organizations. Identifying gaps in awareness, policies, procedures and capacity that increase avenues for diversion and acting to bridge these gaps is vital to preventing diversion in hospitals.

The recommendations in the framework are intended to focus on system level solutions and act as guidance for health system leaders and organizations. The recommendations address identifying diversion, shared accountability and responsibility, a culture of safety, collaboration, transitions of care, and knowledge translation/sharing across the health system.

In addition to its development through a partnered table, the framework was also reviewed by other healthcare system stakeholders to ensure it is applicable and relevant.

The framework will be released in the coming weeks.

A JOINT EFFORT

The Partnered Table to Improve the Safety and Security of Controlled Substances in Hospital High Risk Areas is a collaborative group of healthcare providers, hospital leadership, regulators and other subject matter experts established to take action to improve the safety and security of Controlled Substances in high risk areas of hospitals.

In late 2018, the College invited organizations that have made significant contributions to health care and medication management in Ontario to participate in a collaborative partnership to address the safety and security of Controlled Substances in hospital. The group was established in early 2019 as an initiative of the College's Opioid Strategy.

The organizations involved in developing the framework are: the Ontario Hospital Association, Thunder Bay Regional Health Sciences, the Canadian Anesthesiologists Society, Accreditation Canada, Hamilton Health Sciences, the Ontario Ministry of Health, University Health Network, Health Quality Ontario, Canadian Society of Hospital Pharmacists, Alexandra Hospital Ingersoll and Tillsonburg District Memorial Hospital, William Osler Health System, Institute for Safe Medication Practices Canada, St. Joseph's Hospital, Hamilton and the College. A patient was also part of the group.

As a partnered table, its role is to review and consider available evidence and identify areas for improvement in relation to the diversion of Controlled Substances in order to establish recommendations, methods to promote a culture of safety, and ways to measure and monitor the impact of the recommendations. Each partner organization has also committed to taking action to enhance the security of Controlled Substances and minimize the risk of diversion.

APPLYING THE FRAMEWORK

The framework is meant to be a tool for hospitals to use as part of their overall work to enhance the management of Controlled Substances in their high risk areas and contribute to patient and staff well-being. Effective implementation of the recommendations will require collaboration across the hospital setting in order to identify any gaps and implement any necessary changes to policies, procedures, reporting, or training.

Hospitals can also consider establishing key performance indicators (KPIs) to evaluate their progress on improving the safety and security of Controlled Substances. Such indicators may include, but are not limited to, the number of Health Canada loss and theft reports, the number of confirmed diversions and the results of physical security and process audits on a regular basis to track the impact of their diversion prevention and mitigation strategies. The Partnered Table will also be exploring how to measure the framework's recommendations and monitor impact on how hospitals are addressing the risks of diversion.

Once the framework is published, pharmacists and pharmacy technicians working in hospitals are encouraged to become familiar with the recommendations, identify any gaps that might exist in their practice setting, and bring the framework to the attention of pharmacy and hospital leadership. It will be important to look for opportunities for collaboration with other healthcare professionals to identify where there is a role for pharmacy professionals to adjust, enhance or share practices around Controlled Substances. College hospital operations advisors will also share and discuss the framework with hospitals as part of their regular assessments.

Look for the release of the framework in the coming weeks in e-Connect.

Ontario College of Pharmacists

Putting patients first since 1871

MEMBERSHIP RENEWAL REMINDER

RENEWAL PROCESS OPENS IN LATE JANUARY

NOTE: No form will be mailed to you, however email reminders will be sent. If you fail to pay your fees by March 10, a penalty will apply.

Requirement for Part A Pharmacists to Complete an Approved Cannabis Course

- During the 2020 renewal process Part A pharmacists must declare that they have completed a College-approved cannabis course. The deadline to declare is March 10, 2020 (when annual renewal ends).
- Details of these courses are found on the Continuing Education for Pharmacists page of the College website (under Cannabis).

Before you begin your renewal you will need:

- Credit Card
- User ID: This is your OCP number
- Password: If you have forgotten your password, click "**Forgot your password**"

Once you're ready:

- Go to www.ocpinfo.com and click on "**Login**" and then click on "**My Account**"
- Enter your User ID (your OCP number) and your password
- Once you have successfully logged in, click on "**Annual Renewal**"

Health Professional Corporation Renewals

A reminder that all Pharmacy Health Professional Corporation owners must complete this year's annual renewal on or before March 10, 2020. The renewal application can be found online under the Practice & Education section of the OCP website.

Pharmacy Accreditation Renewals

Pharmacy accreditation renewals will be available online the last week of March and must be completed on or before May 10, 2020. Pharmacy owners should watch for future notifications alerting them to when the renewal application becomes available.

AIMS Assurance and Improvement in Medication Safety

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

Expert Recommendations and Important Reminders

The Assurance and Improvement in Medication Safety (AIMS) Program has reached a significant milestone, with the majority of community pharmacies in Ontario now able to access the online platform – administered by Pharmapod – to anonymously record all medication incidents and near misses as part of the College's mandatory medication safety program.

Collecting this information is an important step in preventing errors that can lead to patient harm, as well as strengthening the public's trust in pharmacy professionals. By moving towards a more standardized, accurate and complete tracking of medication events, pharmacies are contributing valuable information that will help staff improve safety by applying and sharing the lessons learned from medication incidents and near misses.

BUILDING A SAFETY CULTURE AT THE PHARMACY

Medication incidents can and do happen, but they are also preventable. A key component to preventing medication events is building a safety culture within pharmacies. This can be done by:

- encouraging colleagues in the pharmacy to record medication incidents and near misses without fear of blame;
- discussing what happened as a team and what can be learned from these events; and
- identifying any improvements that could be made to prevent them in the future, and implementing them.

These are important steps that, when put into common practice, promote patient safety and support continuous quality improvement. Onboarded pharmacies can access their own individual data as well as aggregate provincial data through the AIMS Pharmapod platform to facilitate these discussions and learn from medication events.

REVIEW THE EXPERT RECOMMENDATIONS TO PROMOTE PATIENT SAFETY

An important resource for pharmacy teams is the first expert bulletin that was released, along with a supplementary data snapshot, on World Patient Safety Day in September.

This Taking AIMS Bulletin provided a preliminary analysis of medication event data collected by onboarded community pharmacies from Feb. 1, 2018 to May 31, 2019. It established a solid foundation from which to further develop and provide information and recommendations for pharmacy and other health system professionals to enhance patient safety and reduce the risk of medication incidents and near misses.

All pharmacy professionals are encouraged to review the Taking AIMS expert bulletin (see following pages for print copy) and evaluate how the recommendations may be applied in your practice to help prevent medication incidents and near misses.

IMPORTANT REMINDERS

As pharmacy professionals become familiar with the program and platform, it's important to keep the following in mind:

- Pharmacy professionals should onboard to the platform **as soon as possible** once receiving the invitation from Pharmapod (the College's vendor for the platform).
- All users of the AIMS Pharmapod platform **must** complete the web-based training program that is available through the platform. These mandatory training modules are quick and cover both the use of the platform for recording incidents and near misses and for continuous quality improvement (CQI), and provide guidance on how to implement CQI processes within your pharmacy.
- It is important that when entering an incident or near miss in the platform, the user chooses the best possible option for "Incident Type" (what happened) and "Contributing Factors" (why it happened) from the dropdown menu. Avoid using "other" as much as possible as it makes it more difficult to track incident trends.
- Near misses provide important learnings for pharmacies and pharmacy professionals. Review the *Pharmacy Connection* article *Exercise Professional Judgment When Deciding to Record a Near Miss* to understand when near misses should be recorded.

The College recognizes the efforts of the thousands of community pharmacies and pharmacy professionals who have embraced the AIMS Program and a safety culture that thrives on shared learnings, accountability and a commitment to continuous quality improvement.

The College is also working collaboratively with our hospital partners to explore how AIMS can be implemented in hospital pharmacies using existing systems for medication incident reporting.

You can learn more about AIMS and access AIMS Program Resources, a supplementary data snapshot, and FAQs on the College website.

Taking AIMS

THE AIMS RESPONSE TEAM BULLETIN FOR THE PHARMACY PROFESSION IN ONTARIO

This bulletin is possible because of the important work of all pharmacy team members who have adopted the AIMS Pharmapod platform as part of the Assurance and Improvement in Medication Safety Program (AIMS). This bulletin aims to improve the safety of all patients who Ontario pharmacy team members have the honour of serving.

Key Insights

- 4,132 patient safety related events (incidents and near misses) have been recorded on the Pharmapod system as part of the AIMS program
- One in ten incidents involved the incorrect patient

Introduction

Pharmacists and pharmacy team members across Ontario report the details of any patient safety related events that occur in their pharmacies using the AIMS Pharmapod Platform. The system has been rolled out as part of the Ontario College of Pharmacists (OCP) AIMS Program. Each recorded incident or near miss is anonymized and aggregated into reports which are accessed and analyzed by members of the AIMS 'Response Team'.

This bulletin provides an overview of the AIMS Program roll-out to date and summarizes some key insights identified by the Response Team along with recommendations for pharmacy practice. Further updates will be issued on a regular basis, providing timely insights from the data and actions to drive improvements. Each bulletin will focus on a concise number of insights and actions for pharmacy teams to focus on. We commend all pharmacy teams who have demonstrated their dedication to improving patient safety through their engagement with Continuous Quality Improvement (CQI) by recording and learning from events through the AIMS Pharmapod Platform.

How to Use this Bulletin in your Pharmacy

CQI is about taking action and measuring the improvements made. This bulletin is intended to be used as a working document. An 'action summary page' is included at the end of the bulletin to allow you to action the Response Team's recommendations. We recommend that you print this page and complete the actions to drive improvements in your pharmacy. Share the bulletin and actions with the pharmacy team as part of your next patient safety meeting and file in a suitable location. In doing so, you will be able to track and demonstrate system improvements you have made over time. It is important that a pharmacy team member is selected as being accountable for each action and that they are completed against agreed upon time-lines.

About the Response Team

The Response Team consists of pharmacy professionals and patient safety domain experts and is chaired by Lisa Dolovich. The team analyzes the aggregate, anonymized provincial medication event data in Ontario to identify areas of risk and opportunities to improve patient safety. This report highlights their notable findings from the data collected thus far (incidents and near misses) from community pharmacies who have been reporting to the AIMS Program.

Taking AIMS
The AIMS Response Team Bulletin For The Pharmacy Profession In Ontario

Data Insights - What the Data Says[1]

This bulletin provides some key insights identified by the Response Team from the data in the AIMS Pharmapod system to date. The Team looks at the data using a systems approach. A systems approach recognizes that errors will happen, even in the best organizations, and so recommendations or resources for practice are focused on those that can increase learning and improve system processes in pharmacy practice. As the system roll-out progresses and incident recording increases, so will the amount of data available for analysis.

Number of Recorded Events

As of May 31, 2019, 4,132 events (1,801 incidents and 2,331 near misses) had been recorded on the AIMS Pharmapod Platform. The level of reporting to date is really encouraging and provides a great start to building the AIMS incident data from which insights and learning can be taken and shared.

Recommendations and Resources for Practice Change

Designated Manager

- ☐ Is your pharmacy team actively logging patient safety related events on AIMS Pharmapod Platform?
- ☐ Are team members commended when they record incidents and near misses?
- ☐ Have you discussed with your team about how they can keep up the great work and make incident reporting fit better into regular workflow?
- ☐ Have all your pharmacy team members completed the AIMS e-training available through the AIMS Pharmapod Platform? Is this incorporated into your orientation process for all new team members?
- ☐ Is your pharmacy meeting the requirements of the AIMS program as set out in the OCP's Supplemental Standard of Practice (sSOP)?[2]
- ☐ Have you reminded all team members about the importance of recording near misses?[3] These can also identify opportunities to create safer work processes.

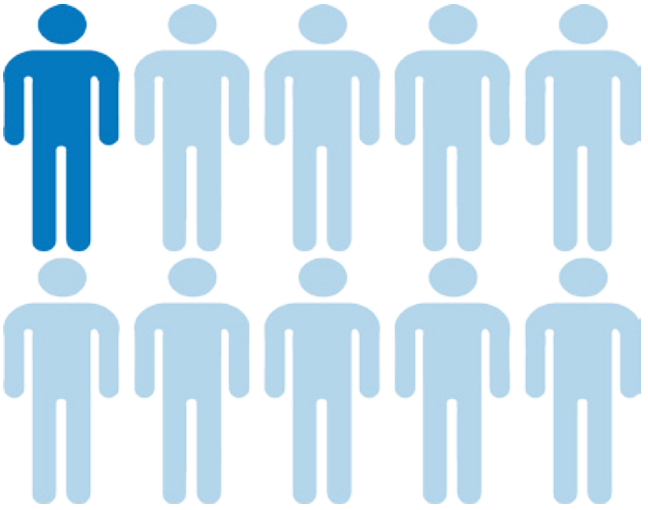
Pharmacy Team Members

- ☐ Have you completed the AIMS e-training available through the AIMS Pharmapod Platform?
- ☐ Are you clear on what needs to be recorded on the AIMS Pharmapod Platform, including when near misses should be recorded?
- ☐ Have you any ideas about how recording on the system could fit better into your pharmacy's regular workflow? Have you shared these ideas with your manager?

1. Date range: 1 Feb 2018 - 31 May 2019
2. http://www.ocpinfo.com/library/other/download/supplemental-standard-of-practice-med-safety-program
3. A near miss is an event that could have led to inappropriate medication use or patient harm but that was intercepted before reaching the patient.

Taking AIMS
The AIMS Response Team Bulletin For The Pharmacy Profession In Ontario

Incidents Involving the Wrong Patient



1 in 10 incidents involved the wrong patient

Recommendations and Resources for Practice Change

Designated Manager

- ☐ Observe how pharmacy team members collect and update patient information at each encounter (e.g. contact information). Are there opportunities to strengthen work processes? If so, discuss these opportunities with your team.
- ☐ Do two pharmacy team members check patient name and address information as part of the dispensing process to ensure the prescription is entered against the correct patient?
- ☐ Get together with your pharmacy team to address the following questions:
  - ☐ What independent check system is in place in your pharmacy to double check patient identifiers?
  - ☐ How well is your workflow system to double check patient identifiers working in your pharmacy?

Pharmacy Team Members

- ☐ Are two identifiers routinely used both when accepting prescription orders for entry and when releasing to the patient? (e.g. first and last name, date of birth and address)
- ☐ Are pharmacists asking patients questions to determine why they are receiving their medication? This will highlight if they are not expecting a medication for that purpose or indication.

Coming Soon: An Opportunity To Share Your Story

We want to hear from you. In future bulletins, we will include de-identified case studies sharing experiences from pharmacy teams across Ontario about how they have reflected on and reviewed their practice as a result of these bulletins and have made changes to improve patient safety. If you would like to share your story, contact aims.responseteam@pharmapodhq.com.

Print this page and complete actions to drive improvements in your pharmacy. Share with the pharmacy team as part of your next patient safety meeting and file in a suitable location.

Actions for Designated Manager:	Actioned By	Date
☐ Is your pharmacy team actively logging patient-safety related events on AIMS Pharmapod Platform?		
☐ Are team members commended when they record incidents and near misses?		
☐ Have you discussed with your team about how they can keep up the great work and make incident reporting fit better into regular workflow?		
☐ Have all your pharmacy team members completed the AIMS e-training available through the AIMS Pharmapod Platform? Is this incorporated into your orientation process for all new team members?		
☐ Is your pharmacy meeting the requirements of the AIMS program as set out in the OCP's Supplemental Standard of Practice (sSOP)?[1]		
☐ Have you reminded all team members about the importance of recording near misses? These can identify opportunities to create safer work processes.		
☐ Observe how pharmacy team members collect and update patient information at each encounter (e.g. contact information). Are there opportunities to strengthen work processes? If so, discuss these opportunities with your team.		
☐ Do two pharmacy team members check patient name and address information as part of the dispensing process to ensure the prescription is entered against the correct patient?		
☐ Get together with your pharmacy team to address the following questions:		
☐ What independent check system is in place in your pharmacy to double check patient identifiers?		
☐ How well is your workflow system to double check patient identifiers working in your pharmacy?		
Actions for Pharmacy Team Members:		
☐ Have you completed the AIMS e-training available through the AIMS Pharmapod Platform?		
☐ Are you clear on what needs to be recorded on the AIMS Pharmapod Platform, including when near misses should be recorded?		
☐ Have you any ideas about how reporting on the system could fit better into your pharmacy's regular workflow? Have you shared these ideas with your manager?		
☐ Are two identifiers routinely used both when accepting prescription orders for entry and when releasing to the patient? (e.g. first and last name, date of birth and address)		
☐ Are pharmacists asking patients questions to determine why they are receiving their medication? This will highlight if they are not expecting a medication for that purpose or indication.		

1. http://www.ocpinfo.com/library/other/download/supplemental-standard-of-practice-med-safety-program

Taking AIMS
The AIMS Response Team Bulletin For The Pharmacy Profession In Ontario

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pharmapod

AIMS Assurance and Improvement in Medication Safety
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

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Preparing for Phase 2 of the NON-STERILE COMPOUNDING STANDARDS

DEADLINES FOR IMPLEMENTATION

Phase 1 Assessing Risks and Gaps: January 1, 2020

Phase 2 Training and Quality Assurance: July 1, 2020

Phase 3 Equipment and Facilities: January 1, 2021

As your pharmacy finishes assessing risks and gaps as part of Phase 1, it's time to look ahead to the Phase 2 requirements on personnel training and quality assurance

THE STANDARDS APPLY TO YOUR PRACTICE FOR PATIENT AND PERSONNEL SAFETY

The *NAPRA Model Standards for Pharmacy Compounding of Non-Sterile Preparations* **apply to every pharmacy and pharmacy professional engaged in compounding**. If you are unclear whether you are engaged in compounding, read the *Pharmacy Connection* article Compounding: Are You Doing It?. Even if your pharmacy is engaged in very simple compounds, such as 50:50 creams, the standards will still apply.

The standards are accompanied by a Guidance Document for Pharmacy Compounding of Non-Sterile Preparations which provides pharmacists and technicians who compound non-sterile preparations with the details necessary to evaluate their practice, develop service-related procedures, and implement appropriate quality controls for the protection of both patients and compounding personnel.

The standards have been developed to support the safety and quality of pharmacy care in the province. Meeting and adhering to these standards is an important way of protecting patients and preventing harmful incidents. The standards are also an important way to protect pharmacists, pharmacy technicians and others involved in compounding from the potential harmful effects of these drugs and substances.

PHASE 1: ASSESSING RISKS AND GAPS – COMPLETION DATE OF JANUARY 1, 2020

The expectation of the College is that by January 1, 2020 all pharmacies engaged in non-sterile compounding **will have completed** a risk assessment for ALL preparations compounded by the pharmacy.

Phase 1 requires a risk assessment to be completed for each preparation compounded by the pharmacy. The Designated Manager (DM), pharmacy department head and/or the non-sterile compounding supervisor (the pharmacy professional assigned to oversee all compounding-related activities) is responsible for ensuring risk assessments are performed.

For examples of how community and hospital pharmacies undertook this task, read the Pharmacy Connection articles *Implementing the Non-Sterile Compounding Standards: The Community Pharmacy Experience* and *Consider These Steps While Preparing for the First Phase of Non-Sterile Compounding Compliance: The Hamilton Health Sciences Experience*. College Operations Advisors will be reviewing your risk assessment activities during operational assessments in 2020 (do not send the risk assessment to the College).

After completing risk assessments and determining the level of requirements for each preparation the pharmacy compounds (or intends to compound), a gap analysis can be performed. This involves evaluating the pharmacy's current practices in comparison to the minimum standards in each area. The College has produced a Non-Sterile Compounding – Self Assessment Criteria document that can be used for this process. This document is intended to support your self-assessment process and should not be submitted to the College. College Operations Advisors will review your self-assessment documentation with you during operational assessments.

The knowledge and skills of compounding personnel must be assessed for gaps. The potential need for training is not limited to the compounding processes or technique; personnel must also be educated on policies and procedures related to attire, personal protective equipment, cleaning, maintenance, conduct and behaviour.

The nature and extent of the gaps identified will be a good indicator of the magnitude of changes the pharmacy needs to make in order to fully achieve and maintain the standards.

Where change is needed, it is important to be cognizant that pharmacy personnel will require sufficient time and training to modify their usual routines and adapt to the Standards.

The Designated Manager, pharmacy department head and/or compounding supervisor should develop a plan of action to address gaps with this in mind. As you move towards full compliance, it may be appropriate to put into place an intermediary risk mitigation strategy that addresses safety, while providing continuity of care for patients.

For more details on Phase 1, read the *Pharmacy Connection* articles *Timelines Announced for Non-Sterile Compounding Standards* and *Non-Sterile Compounding FAQs*. The deadline for completing Phase 1 is **January 1, 2020**.

PHASE 2: TRAINING AND QUALITY ASSURANCE – COMPLETION DATE OF JULY 1, 2020

Phase 2 must focus on addressing the gaps identified in Phase 1 between current practice and the standards, specifically training and policies and procedures that need to be in place. The College has highlighted some of the key considerations to start with, including their corresponding references to the Guidance Document for Pharmacy Compounding of Non-Sterile Preparations (GPCNP), when preparing for full implementation.

Training and skills

- Refer to the checklist regarding responsibilities for pharmacy personnel (regulated and non-regulated) and delineate these responsibilities. Note the responsibilities for non-hazardous and hazardous non-sterile compounding (GPCNP 5.2.1 and 5.2.1.1).
- Complete the skills assessment checklist (Checklist 1) and determine the skills training program required to address gaps and maintain quality practice. Appropriately train all personnel involved in non-sterile compounding and document completion.
- Assess the skills required for cleaning personnel and provide appropriate training (GPCNP 5.2.2).

Policies and procedures

- Review policies and procedures and identify gaps based on the findings from Phase 1. Develop and update policies and procedures as necessary.
- Ensure your policies and procedures address proper hygiene for personnel (GPCNP Template 1, 6.5).
- Complete policies and procedures for Standards 9.3, 9.4, and 9.5 (if compounding hazardous preparations).
- Complete master formulation records, including all necessary information to compound a non-sterile preparation (GPCNP 6.2, Template 2).

Quality assurance

- Develop policies and procedures for components of quality assurance program (GPCNP 7.6).
- Implement quality assurance processes for personnel (GPCNP 7.3), and adherence to policies and procedures. (GPCNP 7.4).
- Quality assurance components related to facilities, equipment, personnel metrics, final compounded non-sterile preparations and documentation (GPCNP 7.2, 7.5) can be finalized in Phase 3.

PHASE 3: EQUIPMENT AND FACILITIES – COMPLETION DATE OF JANUARY 1, 2021

Work for Phase 3 should happen in tandem with Phase 2, as the improvements needed may require additional time and resources. Note that SPCNP is a reference to the Model Standards for Pharmacy Compounding of Non-Sterile Preparations and GPCNP is a reference to the Guidance Document for Pharmacy Compounding of Non-Sterile Preparations document.

- Ensure that hoods are certified every six months, hazardous material is stored appropriately, and cleaning and decontamination equipment and supplies are in place for hazardous compounding (SPCNP 9.2, GPCNP 9.3, 9.6.1).
- Ensure that your facility and equipment meet the requirements for lighting, heating, ventilation and air conditioning systems, water supply, work surfaces, furniture, walls, and flooring (SPCNP 9.1).
- Establish protocols and schedules for cleaning facilities and equipment to maintain the quality and integrity of the final preparations (GPCNP 5.4.1.6).
- Ensure routine maintenance of the facility and all equipment including the cleaning of specialized equipment. This must be documented in the general maintenance log (GPCNP 5.4.2.1).
- Finalize your quality assurance program and ensure that it addresses: facility, equipment, personnel metrics, final compounded non-sterile preparations, and documentation (GPCNP 7).
- For facilities that compound hazardous preparations, ensure that proper deactivation, decontamination, and cleaning procedures are addressed (GPCNP 9.3).
- Ensure that an environmental monitoring plan is in place (GPCNP 9.6.3).

KEY RESOURCES TO ASSIST IN IMPLEMENTING THE STANDARDS

- Model Standards for Pharmacy Compounding of Non-Sterile Preparations (NAPRA)
  - Guidance Document for Pharmacy Compounding of Non-Sterile Preparations
  - Printable and Fillable Forms related to skills assessment, training, policies and procedures, quality assurance programs and master formulation record
- Non-Sterile Compounding Key Initiative (OCP website)
  - Non-Sterile Compounding Standards - Self-Assessment Criteria
- Pharmacy Connection articles
  - Frequently Asked Questions on Non-Sterile Compounding Implementation
  - Implementing the Non-Sterile Compounding Standards: A Closer Look at Personal Protective Equipment
  - Implementing the Non-Sterile Compounding Standards: The Community Pharmacy Experience
  - Consider These Steps While Preparing for the First Phase of Non-Sterile Compounding Compliance: The Hamilton Health Sciences Experience
  - Timelines Announced for Non-Sterile Compounding Standards
  - Compounding: Are You Doing It?
- Alberta College of Pharmacy resources *note that Alberta has different implementation deadlines
  - Non-Sterile Compounding Essentials
  - Master formulation record vs compounding record

WHEN SHOULD YOU REPORT INFORMATION?

As regulated healthcare professionals, and under the *Regulated Health Professions Act*, pharmacists, pharmacy technicians, employers and facility operators have obligations to report certain information to the College. These obligations are in place to protect patients and contribute to safe and effective pharmacy care.

Employers (e.g. pharmacy owner, DM) must file a report with the College if a registrant's employment is terminated, they are suspended or other privileges are revoked for reasons of professional misconduct, incompetence or incapacity. This obligation remains even if the registrant resigned or relinquished any privileges prior to the employer having done so. Reporting is not required for employment-related reasons (e.g. issues such as lateness or personal incompatibility) that don't compromise patient safety or contravene standards of practice.

Facility operators must file a report with the College if they suspect a registrant has sexually abused a patient or if they suspect the registrant is incompetent or incapacitated. All pharmacists and pharmacy technicians must file a report with the College if they suspect another registrant has sexually abused a patient.

Additionally, pharmacists and pharmacy technicians must self-report certain information to the College **within 30 days** of being charged with an offence, being found guilty of an offence, having a finding of professional negligence or malpractice, having a finding of professional misconduct, incompetence or incapacity, or being the subject of a current investigation or proceeding for professional misconduct, incompetence or incapacity.

HOW TO REPORT INFORMATION TO THE COLLEGE

Mandatory Reports

Please visit the College's webpage on Mandatory Reporting.

Employers, facility operators, pharmacists and pharmacy technicians should use the Mandatory Reporting Form available on the College website. The form can be emailed, faxed or mailed. Please provide as much information as possible.

The College cannot assist employers, facility operators, or registrants in determining their legal obligation to make a mandatory report. If you are in doubt whether a mandatory report is required, you may wish to submit one and allow the College to assess the information contained within the report to determine if further action is required.

No action can be taken against a person for filing a mandatory report in good faith.

YOUR ETHICAL OBLIGATIONS

In addition to mandatory reporting obligations under legislation, pharmacists and pharmacy technicians also have obligations under the Code of Ethics. Under 2.18 "Members raise concerns to the appropriate authority if they reasonably believe human resources, policies, procedures, working conditions or the actions, professional performance or health of others may compromise patient care or public safety."

As described in this Close Up On Complaints article, pharmacists and pharmacy technicians need to ensure that they inform an appropriate person with oversight of pharmacy operations (e.g. pharmacy manager, Designated Manager, district manager) if they do not have the support required to practice to the Standards of Practice or if they reasonably believe human resources, policies, procedures, working conditions or the actions, professional performance or health of others may compromise patient care or public safety.

However, failure to submit a mandatory report when it is required could result in a fine (up to $25,000 for an individual or up to $50,000 for a corporation).

Self Reports

Please visit the College's webpage on Self-Reporting. Registrants should use the Self-Reporting Form to make a report. Please note that the College cannot provide legal advice about a pharmacy professional's obligation to make a self-report.

Other information

Information which doesn't fall under the category of a mandatory report or self-report can also be provided to the College. The best way to provide information is via email at concerns@ocpinfo.com. Information can also be provided by phone at 1-800-220-1921. The College will assess your concern and take appropriate action. You may be contacted and asked to provide additional information. Please note that during the course of any College investigation, your identity may become known to the pharmacy professional being investigated.

SHOULD YOU REPORT?

Scenario #1

You are the Designated Manager of a community pharmacy. You have discovered that a pharmacist working at your pharmacy is struggling to show up on time for her shift. Upon discussion, the pharmacist admits that she is struggling with an addiction to alcohol that has affected her work. You agree to place the pharmacist on leave from your pharmacy until she has sought appropriate help and support. Should you report this information to the College?

Yes. If an employer revokes a registrant's privileges in any way due to incapacity, even if it is believed that registrant is no longer practicing, this must be reported to the College within 30 days through the College's Mandatory Reporting Form. More information about incapacity is available on the College's website.

Scenario #2

You are a pharmacy technician. While out in your community, you witnessed a pharmacist co-worker engaged in a public display of affection with an individual who you know is a patient of the pharmacy. Upon preparing the patient's next prescription for pick up later that week, you review the patient's file and note that the pharmacist very recently signed off on this patient's prescription, including documenting that patient counselling was provided. You suspect that the pharmacist and the patient may be engaged in a sexual relationship. Should you report this information to the College?

Yes. A pharmacist or pharmacy technician must file a report with the College if they suspect another registrant has sexually abused a patient through the College's Mandatory Reporting Form. Per the College's Guideline on Preventing Sexual Abuse and Harassment, a registrant must not become sexually involved with his or her patient.

Scenario #3

You are a pharmacist in a community pharmacy. You have reason to believe that the Designated Manager is engaged in unethical behavior, including offering monetary incentives for patients to stay at the pharmacy. Should you report this information to the College?

Yes. Under the Code of Ethics, registrants should report professional incompetence or unethical behaviour by colleagues or other healthcare professionals to the appropriate regulatory authority. Reports can be made to concerns@ocpinfo.com.

Scenario #4

You are the manager of a hospital pharmacy and have recently discovered that one of the pharmacy technicians working on your team has improperly accessed and shared patient health information. The decision is made to terminate his employment. Should you report this information to the College?

Yes. If an employer terminates a registrant's employment due to professional misconduct, this must be reported to the College through the College's Mandatory Reporting Form.

A SHARED RESPONSIBILITY

It's important to note that reporting information to the College does not necessarily mean that any action will be taken against the pharmacy professional. It only means that the College has an opportunity to review the information and assess whether further investigation is required.

Everyone, including pharmacists, pharmacy technicians, managers and owners, has an obligation to protect patients and promote the quality and safety of pharmacy care. Reporting relevant information to the College is an important part of these responsibilities.

FREQUENTLY ASKED QUESTIONS

from Pharmacy Practice

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

RELEASING INFORMATION ABOUT A DECEASED PATIENT

Q Can we give the details of a deceased patient's profile to family members, including medical history and medical expenses for tax purposes?

A Pharmacies and pharmacy professionals in Ontario have responsibilities to safeguard the personal health information of their patients as health information custodians under the *Personal Health Information Protection Act* (PHIPA). One of the additional resources on the OCP website is called **Quick Links to the Office of the Information and Privacy Commissioner of Ontario (IPC)**. These resources have been selected to assist registrants in understanding their obligations under PHIPA, such as the Fact Sheet #15 – Obtaining Personal Health Information About a Deceased Relative. Additional information can be found on the IPC website.

RECORD KEEPING

Q Our community pharmacy has original prescriptions and hard copies dating back to before we started scanning. How long do we need to keep these?

A Please refer to the Guideline – Record Retention, Disclosure, and Disposal and the Fact Sheet – Record Keeping and Scanning Requirements.

Regulations under the *Drug and Pharmacies Regulation Act* (DPRA) require pharmacies to make

NEW ASSISTANCE PROGRAM FOR REGISTRANTS EXPERIENCING MENTAL HEALTH OR SUBSTANCE USE CONCERNS

Since 2004, the College has offered an assistance program offering intervention, assessment, and monitoring to its registrants experiencing work/life stress, concerns about their mental health or substance use problems.

As of July 5, 2019, Lifemark Health Group provides case management and monitoring services for registrants on behalf of the College. Under the Ontario Pharmacy Health Program (OPHP) administered by Lifemark, the primary objective is to ensure that registrants receive appropriate treatment and monitoring services and remain in stable recovery thereby allowing them to practise safely when they return to the practice environment.

The program is available to all registrants of the College. Registrants can access the program directly and anonymously. Access can also be facilitated on behalf of the registrant by the College.

Note: The program was previously administered on behalf of the College as the Ontario Pharmacy Support Program by the Centre for Addiction and Mental Health (CAMH). CAMH no longer provides this service. Those currently participating in the CAMH program have been notified of the transition to Lifemark and the College is working closely with both Lifemark and CAMH to ensure an effective and seamless transition to the new program.

and retain a scanned copy of all original prescriptions. All prescription records in the pharmacy's possession, scanned or in hardcopy form, are subject to the retention period of a *minimum* 10 years after the last date of service provided to the patient.

Since records cannot be destroyed until at least 10 years after the patient has ceased to use a pharmacy's services (notwithstanding the provision for children under 18 years of age), the date of when a record can be destroyed cannot be pre-determined. If the patient continues to use the services of the pharmacy, the patient record would need to be retained on file for an indefinite period of time (i.e. forever).

Also, the patient record must be maintained as a whole, therefore dispensing records (hard copies) and prescriptions (originals or scanned originals) cannot be singled out for destruction. The decision to destroy paper based records after they have been scanned is at the discretion of the Designated Manager who should evaluate the backup processes in place to safeguard records for the required timeframe.

BEST POSSIBLE MEDICATION HISTORY AND PHARMACY TECHNICIANS

Q Does a pharmacy technician have the scope of practice to perform a Best Possible Medication History (BPMH) when a patient is admitted to – or discharged from – hospital?

A The *Pharmacy Act* and Ontario Regulation 202/94 – General define *Scope of Practice and Authorized Acts* for all pharmacy professionals.

The steps involved in conducting a BPMH, such as gathering patient records from various sources and identifying discrepancies, are not necessarily governed by legislation. However, the regulation does set out Terms, Conditions and Limitations on a pharmacy technician's certificate of registration, and pharmacy technicians cannot provide information or education relating to drug use which requires therapeutic knowledge, clinical analysis or assessment (s18.4).

Pharmacy technicians responsible for performing a BPMH must have the appropriate knowledge, skills and training to meet the Standards of Practice for Pharmacy Technicians outlined in #9-#12. When collaborating to provide patient care, technicians are expected to document their decisions and actions in the patient's health record, including the relevant health and drug information they've obtained and their interpretation of this information.

The Pharmacy Manager/Administrator should establish policies and procedures for conducting medication reconciliations, outlining the respective roles for pharmacy technicians and pharmacists. OCP resources to consult include the Hospital Assessment Criteria, Standards of Operation, and the Pharmacy Technician Practice Assessment Criteria. External resources are also available from organizations such as the Canadian Society of Hospital Pharmacists (CSHP), ISMP Canada, the Canadian Patient Safety Institute (CPSI), etc. Collaborating with peers at other hospitals to share operational advice and best practices is also encouraged.

STAYING ALERT TO FRAUDULENT PRESCRIPTIONS

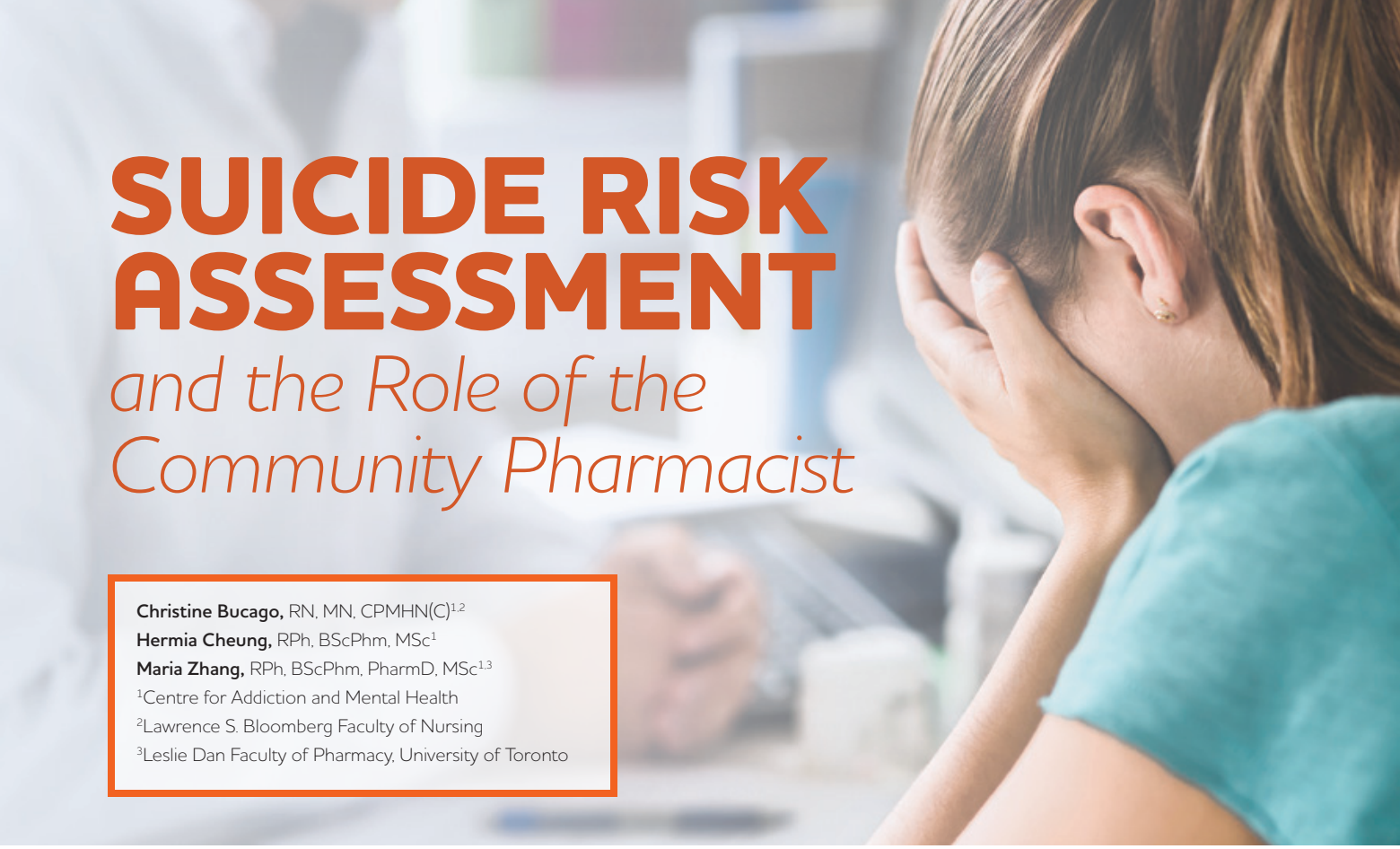
In June and September 2019, the College shared an alert in e-Connect from the Ontario Provincial Police regarding a specific ongoing fraud occurring at pharmacies involving false oxycocet prescriptions. Specifically in this case:

Police have been advised that a particular amount of oxycocet has been used in a series of frauds across Ontario.

The prescription is for 120 oxycocet pills. Suspects are using the agent system to pick up the prescription for a parent, relative, or neighbour. The patient will present the identification of the person as a facsimile as either a picture on a phone or a copy of the health card or accepted Identification.

The College is pleased to let registrants know that as a result of increased awareness of this fraud, numerous individuals were arrested and charged. Registrants should continue to be vigilant and report any fraudulent prescriptions to the police.

To assist registrants in identifying and handling fraudulent prescriptions, the College provides two fact sheets on our website, Forgery: Management and Reporting of Fraudulent Prescriptions and Forgery: Tips for Identifying Fraudulent Prescriptions.



SUICIDE RISK ASSESSMENT

and the Role of the Community Pharmacist

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Suicide is a major public health concern worldwide. In Canada, approximately 4,000 people die by suicide every year and approximately 90% of these individuals lived with a mental health problem or illness[1]. Every suicide is a tragedy that has lasting impacts on the families, friends, classmates, coworkers, and communities left behind.

Suicide is a complex issue involving biological, psychological, social, cultural, spiritual, economic and environmental factors. Depending on how these factors interact, a person experiencing suicidal thoughts may be encouraged or discouraged from seeking help. The stigma related to suicide also plays a role in this decision.

Hope exists despite these complexities, and all members in a person's health care team, including pharmacists, can play a key role in the identification and management of suicide risk. Pharmacists are uniquely positioned to assess risk and implement interventions to support a person's safety across the care continuum. This article will focus on two main roles for pharmacists: assessing suicide risk, and connecting individuals experiencing thoughts of suicide to resources.

WHAT IS A SUICIDE RISK ASSESSMENT?

According to the American Psychiatric Association, "the goal of a suicide risk assessment is to identify factors that may increase or decrease a patient's level of suicide risk, to estimate an overall level of risk, and to develop a care plan that addresses their safety and modifiable contributors to suicide risk"[2].

Research has demonstrated that asking about suicide does not generally increase chances that an individual will attempt suicide[3–5]. In fact, acknowledging and talking about suicide may reduce suicidal ideation and lead to improvements in mental health in treatment seeking populations[3].

When assessing suicide risk, a pharmacist can observe for possible warning signs, and then ask specific questions to better understand a person's risk factors and protective factors (Table 1 and Figure 1). While it may not be feasible to complete a full suicide risk assessment, especially in a community pharmacy setting, pharmacists are well-placed to critically assess, and undertake a more specific suicide inquiry if needed. For example, during the course of a usual interaction with patients, you may already be aware of some warning signs and risk factors that put them at higher risk of suicide.

Table 1: Examples of warning signs, risk factors and protective factors

Warning signs	Risk factors	Protective factors
Indicators that someone may be at immediate risk of suicide. • Talking about dying, or feelings of purposelessness, hopelessness or intense anxiety • Increased substance use • Seeking out a means to end one's life (e.g., purchasing large quantities of medications)	Modifiable or non-modifiable characteristics of a person or their environment that increase the likelihood they will die by suicide • Unemployment or financial difficulties • Previous suicide attempt • Family history	Factors that may mitigate the risk of suicide • Strong connections to family or support network • Identification of future goals • Effective care for addictions, mental health and/or physical disorders

Figure 1: 3 Steps to helping someone thinking about suicide[6,7]

Ask: "Are you thinking about suicide?"

Listen: If the person says "yes", give them time and space to discuss their thoughts and feelings.

Get Help: Stay with them and/or contact others that can be relied on to stay with them. Crisis lines are available 24/7 across Ontario and Canada. They are a good place to start and can provide direct support to the individual expressing thoughts of self-harm, and/or to the pharmacy team to discuss options. Patients may need to be accompanied to emergency departments by emergency medical services, if their life may be in immediate danger (i.e., they have a plan and intend to end their life soon).

As with all clinical interventions, your assessment of suicide risk and related actions should be documented. This is also valuable in communicating to other health care providers (e.g., paramedics, emergency department team, patient's primary care provider). See Figure 2.

Figure 2: Sample scenario and corresponding documentation:

"Patient presented to pharmacy around 10:30pm on Saturday, November 24, wishing to purchase a large quantity of acetaminophen tablets. She appeared tearful and upon questioning, voiced an intent to consume the entire bottle in order to die by suicide. I reviewed her medication profile which indicated that she was non-adherent to her antidepressant medications. Risk factors were assessed (history of depression, medication non-adherence) as well as protective factors (sister, nieces and nephews). Notably, she has not attempted suicide previously. Patient was open to calling her sister who met her at the pharmacy. Sister will spend the night with her and escort her to her physician's office in the morning. Sister agreed to call me tomorrow with an update.

This note has also been shared with the patient's family physician."

Signed: Pharmacist's Name, RPh

November 24, 2019

PRACTICAL TIPS

- Have conversations about sensitive topics in a private space.
- Don't be afraid to ask questions if you notice warning signs. Remember, talking about suicide will not increase the chances that the individual will attempt suicide.
- For patients on medications with links to suicidal ideation (e.g. antidepressants, isotretinoin, varenicline etc.), consider enlisting the help of family members to keep an eye on any behavioural changes.
- Pay special attention to patients buying unusually large quantities of medications or who demonstrate poor adherence to medications used to treat psychiatric conditions.
- Keep a list of who or where to call for help in the pharmacy (see Resources).
- Be transparent and involve the patient as much as possible with the intervention. For example, let them know that you'd like to call the crisis line for additional support, and then call them together so that the patient is aware of what you're saying. Even in situations where patients may refuse help, you can still inform others of what's happening[6].
- Document your interactions and keep other members of the health care team informed in a timely manner.
- Consider getting trained in Mental Health First Aid and/or obtain a free Psychological First Aid Guide from the Canadian Red Cross.

RESOURCES

- 9-1-1
- Provincial services:
  - Find your local crisis line and mobile crisis team via: https://www.connexontario.ca/
  - Distress and Crisis Ontario: http://www.dcontario.org/
- Specialty services:
  - Kids Help Phone: 1-800-668-6868 or www.kidshelpphone.ca
  - Trans Lifeline (Operators within Canada and United States): 1-877-330-6366; more information available at https://www.translifeline.org/hotline
  - Hope for Wellness Help Line (counselling and crisis intervention for all Indigenous Canadians): 1-855-242-3310 and www.hopeforwellness.ca
  - Indian Residential Schools Crisis Line: 1-866-925-4419
- Federal services:
  - Canada Suicide Prevention Service: 1-833-456-4566 [24/7]
  - Canadian Association for Suicide Prevention to find a crisis support centre near you: https://www.suicideprevention.ca/need-help
- Stories of how individuals experiencing suicidal thoughts find resilience: https://www.cbc.ca/listen/live-radio/1-45-ontario-today/clip/15550961-suicide-making-your-way-back-from-a-dark-place

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FLU SEASON IS HERE

According to the Ministry of Health, influenza causes about 12,200 hospitalizations and 3,500 deaths in Canada each year. The flu shot is proven to reduce the number of doctor visits, hospitalizations and deaths related to the flu. Therefore, it is particularly important for high risk groups, including patients 65 years or older, women who are pregnant, children and infants and those with medical conditions. to receive the flu vaccine.

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

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

FluMist® will not be available in Canada for 2019/2020 influenza season.

The College's Administering Injections Practice Tool contains important information on training and registration requirements. The Ministry of Health has also provided specific information and FAQs regarding the UIIP.

Pharmacists play an important role in supporting patient well-being and promoting healthier communities. This includes educating patients on current evidence-based immunization practices. Encourage patients to review the Ministry's resources on the Flu and Flu Vaccine Safety.

Medication Incidents Associated with Patients with Renal Impairment: A MULTI-INCIDENT ANALYSIS

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INTRODUCTION

The kidneys are one of the main organs responsible for eliminating drugs from the body. Decreased renal function may lead to reduced drug clearance and a subsequent increase in plasma drug concentration. If dosing adjustments are not made based on a patient's renal function, increased exposure to the medication may put the patient at risk of side effects, serious harm, or death.[1]

As our population ages and requires an increasing number of medications, situations of inappropriate medication use in patients with reduced renal function may become more frequent.[2] Renal impairment, regardless of the cause, introduces further complexity and opportunity for errors within the medication-use process. The likelihood of medication incidents involving this population is particularly high in communities when healthcare practitioners have limited access to patient medical records and lab values. Despite these challenges, pharmacists are responsible for providing safe and effective care to patients. Acknowledging the limitations of our current health care system will help us implement feasible improvements in the medication-use process.

To protect patients with renal impairment, many medications must be dose-adjusted according to the patient's renal function. A list of common medications requiring dose adjustment or avoidance in renal impairment is presented in **Table 1**. The objective of this multi-incident analysis is to examine medication incidents involving patients with renal impairment within the community pharmacy setting. Common themes and potential contributing factors are provided as well as recommendations to improve the care of these patients (**Tables 2-5**).

Table 1. Examples of Top 100 prescribed drugs that must be considered for dose adjustment or avoidance in renal impairment[3,4]

• Gabapentin	• Duloxetine
• Pregabalin	• Escitalopram
• Ciprofloxacin	• Venlafaxine
• Valacyclovir	• Alendronate
• Gliclazide	• Risedronate
• Glyburide	• Rosuvastatin
• Metformin	• Spironolactone

Disclaimer: *This list is not comprehensive of all medications requiring dose adjustment in renal impairment. Refer to the Ontario Renal Network and other resources as appropriate to confirm dose adjustments or contraindications in renal impairment.*

METHODS

A total of 172 incident reports were extracted from the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) program database from June 2014 to May 2019. The CPhIR program aggregates medication incident data from different provinces, including incident reports from jurisdictions where pharmacists have access to patient lab values.* A collection of broad renal-associated search terms including but not limited to: "GFR", "dialysis", "kidney" and "renal" were used to capture incidents involving patients with renal impairment. Thirty-eight incidents were excluded, as they did not involve the target patient population. A total of 134 incidents met the inclusion criteria and were evaluated in this qualitative incident analysis. Two independent analysts conducted a multi-incident analysis of the data, identifying common

themes, subthemes, contributing factors, and recommendations to improve patient safety.

Of note, 86 of the 134 incidents analyzed were classified by reporters as "near misses" that were caught before reaching the patient. Therefore, many of the following incident examples should be interpreted as demonstrating best practices by pharmacy professionals, rather than errors that should be avoided. Where applicable, we will differentiate mitigating factors or best pharmacy practices in preventing medication harm from potential contributing factors to medication incidents in **Tables 2 to 4** below.

**Note: While incident examples included in this article are not specific to Ontario, we believe that the shared learning and experiences from these near misses and medication incidents are still beneficial to pharmacy professionals in Ontario.*

RESULTS

Table 2. Main Theme 1 – Recognition of Renal Impairment

Subtheme 1 – Checking/Availability of Lab Values		
Incident Examples	**Contributing Factors**	**Commentary**
• Physician gave Nitrofurantoin to a patient without checking their CrCl, which was very low. Patient's renal function was checked by the pharmacist when filling prescriptions and medication was changed to something more appropriate.	• Lab values unavailable to healthcare practitioners • Lab values available to practitioners, but not checked	• Healthcare providers should always check or obtain lab values whenever high-alert medications are ordered/dispensed for patients with renal impairment.
Subtheme 2 – Patient-Related Factors		
Incident Examples	**Mitigating Factors / Best Practice in Preventing Medication Harm**	**Commentary**
• Physician gave patient Metoclopramide 10 mg QID. Based on a conversation with the patient, we discovered their renal function has been decreased, therefore patient requires a dosage reduction. Contacted the physician and explained the situation. Physician stated to decrease the dose to 5 mg QID. • A prescription was phoned in from the physician for Amoxicillin/Clavulanic acid 875 mg twice daily. Pharmacy knew the patient has renal function issues, so they called the kidney clinic. Patient had a CrCl of 16 mL/min, which means dose should be reduced to 250 to 500 mg twice daily. Pharmacy faxed physician and had dose changed.	• Medical conditions discussed during patient counselling • Practitioner familiarity with patient • Recognizing patients with increased risk of having renal impairment • Interprofessional collaboration within the circle of care	• The familiarity that comes with longstanding patient-provider relationships can draw attention to inappropriate medication prescribing. This includes medications, which have not been dose-adjusted being prescribed to patients with renal impairment.
Subtheme 3 – Drug-Related Factors		
Incident Examples	**Mitigating Factors / Best Practice in Preventing Medication Harm**	**Commentary**
• Prescription was written for Trimethoprim-Sulfamethoxazole DS once daily PO x 7 days. Prescription was filled as Trimethoprim-Sulfamethoxazole DS 800/160 mg - take one tablet by mouth twice daily for 7 days, dispense 14 tablets. Pharmacist caught error when checking prescription. Trimethoprim-Sulfamethoxazole DS is normally dispensed BID, but due to the patient's poor renal function, the physician decided to give DS dosing once daily as opposed to single strength dosing BID. • Physician wanted to prescribe Rivaroxaban for a patient but had not ordered a renal panel. We phoned the physician about checking patient's kidney function first. Renal panel came back and the dose had to be adjusted from 20 mg daily to 15 mg daily.	• Pharmacist's recognition of atypical medication dosing • Pharmacist's recognition of high-alert medications in renal impairment	• Pharmacists, as medication therapy experts, play a key role in recognizing atypical medication dosing and high-alert medications.
Subtheme 4 – Documentation and Computerization		
Incident Examples	**Mitigating Factors / Best Practice in Preventing Medication Harm**	**Commentary**
• Pharmacy had patient's medical conditions documented in patient profile; we knew patient had severe kidney dysfunction and should not be on that dose for that duration. We called physician and discovered that the wrong dose had been ordered; dose was ordered for 3 months instead of 3 days. • The computer system picked up an interaction with Levofloxacin and the patient's medical condition, renal failure.	• Documentation of patient's renal status • Presence of computer alerts/prompts regarding patient's renal status	• Computer system alerts can prompt providers to recognize potentially inappropriate drug therapy (e.g. drug-disease interaction alerts, dosage warnings).

Table 3. Main Theme 2 – Additional Safeguards for Patients With Renal Impairment

Subtheme 1 – Additional Renal-Specific Care Providers		
Incident Examples	**Mitigating Factors / Best Practice in Preventing Medication Harm**	**Commentary**
• A prescription for the patient was written for one tablet twice a day. The patient requires blister packs and previously had received one tablet twice a day on non-dialysis days: Tuesday, Thursday and Saturday. However, the dose was changed to one tablet twice a day everyday. The patient went to the dialysis unit at the hospital and the pharmacist noticed that Candesartan was missing on dialysis days. The hospital pharmacist contacted the community pharmacy and corrections were made.	• Disease specific knowledge and experience • Presence of an independent double check	• Patients being monitored by specialized care providers (e.g. renal pharmacists and nephrologists) have an additional safeguard against the inappropriate use of highly specialized medications. The use of medication reconciliation processes is recommended to detect and resolve potential medication incidents.
Subtheme 2 – Additional Education Provided to Renal Patients		
Incident Examples	**Mitigating Factors / Best Practice in Preventing Medication Harm**	**Commentary**
• Patient was counselled by both the physician and pharmacist to take only one tablet BID due to their decreased kidney function. Upon opening the prescription bag at home, the patient discovered the label said take one tablet QID and the quantity was double what it should have been. Patient contacted pharmacy at once.	• Care providers communicate dosing changes/rationale to patient • Patient knowledge of drug therapy/disease state	• Communication of drug dosing changes/ rationale to the patient and providers within the circle of care is highly recommended. • Patients with renal impairment often receive additional education regarding their medication therapy and disease state. These discussions empower patients to detect near misses or medication errors and act as an independent double check of their medication therapies.

Table 4. Main Theme 3 – Additional Risk Introduced by Renal Impairment

Subtheme 1 – Dialysis		
Incident Examples	**Contributing Factors**	**Commentary**
• Metoprolol was supposed to be placed in blister packaging except for the dialysis days. Medication was placed in the wrong slot in compliance packaging. Pharmacist noticed mistake when checking packages and mistake was corrected. • Prescription was misinterpreted - Cephalexin 500 mg PO daily (give after dialysis on Tuesday / Thursday / Saturday) x 2 weeks. Medication was filled as "dispense 6 tablets for the 3 days of the week indicated x 2 weeks". Patient phoned back and explained that the medication is supposed to be taken every day for 14 days (i.e. after dialysis on the indicated days of the week, so that the medication would not be dialyzed and removed from the patient).	• Ambiguity of prescriptions/lack of indicated changes in therapy • Lack of independent double checks	• Dialysis introduces several additional risks to patient, one of which is potential medication incidents due to scheduling complexities.
Subtheme 2 – Drug Therapy Changes Relating to Renal Function		
Incident Examples	**Contributing Factors**	**Commentary**
• After packaging, the clinical check found that the dosing frequency of Valacyclovir to be inappropriate for the patient's renal function. The order was re-processed and counted, but the original label was not changed and still reflected the incorrect dosing frequency.	• Lack of appropriate follow-up to drug therapy changes	• Drug therapy changes related to patient's renal function should always be documented and followed up properly throughout the medication-use process.

DISCUSSION

Access to patient diagnostic test results (e.g. lab values) should be accessible to all healthcare professionals where access to these results would improve the quality of care they provide to the patient. This includes pharmacists who require access to indicators of patient renal function to evaluate the appropriateness of medication therapy and to recommend suitable alternatives if necessary. Furthermore, healthcare practitioners are encouraged to remind patients to share with them if they have any changes to their medical conditions or medications and if they have any recent blood work done. A resource that pharmacists can share and recommend patients to use is the 5 Questions to Ask About Your Medications handout where patients can learn about common questions that they should ask their healthcare providers regarding their medications at each encounter.

Table 5. Summary of Recommendations

For Pharmacists	For Prescribers
• Ask patients about changes to their medical/medication history at every visit. Document changes prominently in the patient profile • Recognize populations at high risk for renal impairment, for example, the elderly, patients under the care of renal specialists (e.g., nephrologists, renal clinics) and patients with hypertension and/or diabetes • Lab values, if available, should be consulted when prescribing and evaluating medication therapy • Practitioners should recognize and exercise caution with high-alert medications in renal impairment (**Table 1**) • When prescribing, recommending, or evaluating medication therapy, consider the potential for drug-disease interactions	
• Atypical medication dosing may signify that a patient has renal impairment. Unfamiliar medication dosing should be investigated to discover the rationale • If there is uncertainty surrounding a patient's degree of renal impairment, contact the patient or prescriber as appropriate to confirm renal status • Utilize pharmacist's expanded scope of practice (as permitted by provincial legislation) to adapt prescriptions as appropriate, including for patients with renal impairment • Implement a checklist of measures to take when adapting drug therapy (e.g. change SIG, adjust quantity, inform prescriber, inform patient, document changes, etc.) • Consider implementing an independent double check system for medications prescribed to patients receiving dialysis • Discuss patient medical conditions during counselling (for both prescription and non-prescription medications)	• Regularly monitor patients' renal function and communicate relevant changes to the patient and the patient's care team • Include relevant lab values (e.g. CrCl, INR, A1C, etc.) on prescriptions to allow pharmacists to independently assess the appropriateness of drug therapy • Clearly indicate changes in therapy and supporting rationale on prescriptions

CONCLUSION

This multi-incident analysis has highlighted several reasons that patients with renal impairment may be prone to medication incidents. These patients are cared for by multiple providers and they work closely with their healthcare team. Collaboration is needed within this circle of care to prevent errors and provide the best possible care.

ACKNOWLEDGEMENTS

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. The CPhIR Program contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS). A primary objective of CMIRPS is to analyze medication incident reports and develop recommendations for enhancing medication safety across all healthcare settings.

AIMS PROGRAM REMINDER

Please be reminded that as part of the AIMS program, pharmacy professionals must report medication incidents and near misses in the AIMS Pharmapod platform, as well as document the details of the medication incidents, analyze them to identify causal factors and share the learnings with their team in a timely manner.

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

SUMMARY OF THE INCIDENT

A patient visited her community pharmacy to pick up her prescription which had been dropped off a few days prior. The medication was for inducing an abortion. During her visit, the pharmacist expressed concerns about the dose of the medication and the possible effects on a fetus and gave the patient the impression that he could not ethically fill the prescription. Following a conversation with the prescriber, the pharmacist agreed to fill the prescription but required the patient to sign a waiver before dispensing. The patient reported that throughout the interaction she felt judged by the pharmacist and the incident caused her distress.

WHY DID THIS HAPPEN?

This incident occurred because the pharmacist did not practice within the ethical standards of the profession.

While the pharmacist said he consulted a number of resources to find more information on the medication dose, he waited until the patient arrived at the pharmacy to contact the prescriber to ask about the higher dose, and only did so after the patient requested it. In his conversation with the patient, he focused his concern on the potential side effects of the medication on the fetus and not on the woman who was actually his patient, resulting in her feeling judged and disrespected.

Finally, the pharmacist placed his own views and concerns above those of the patient by requiring her to sign a waiver absolving him of all responsibility for negative outcomes associated with the medication use.

COMPLAINT OUTCOME

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

In this case, the panel had significant concerns with three aspects of the pharmacist's practice: his actions regarding the dosage, his professionalism and his use of a waiver. In regards to how the pharmacist approached the medication dosage, the panel noted that the pharmacist failed to promptly investigate and resolve any concerns he had about the dose, even though he had days between the prescription being dropped off and the patient returning to the pharmacy. While the pharmacist offered to contact the prescriber on the patient's behalf during their conversation, the panel noted that that is not a task which should be extended as a favour to the patient; rather it is one of his responsibilities as a pharmacist.

The panel noted that the patient indicated she felt judged during the encounter and reported that the pharmacist was disrespectful and abrasive. The pharmacist made references to concerns about the fetus, but did not seem to express concerns about the patient, who should be the primary concern. The panel noted that the pharmacist had a number of days to make himself comfortable with dispensing this medication and had an obligation to refer the patient elsewhere as soon as possible if felt he could not dispense it.

Finally, the panel found that the use of a waiver in order to dispense the medication was inappropriate. The content of the waiver, which was created by the pharmacist himself, focused on the risks of the medication and stated that no responsibility for negative outcomes from its use lies with the pharmacist or the pharmacy, but did not express any concern with patient safety. The panel noted that the pharmacist's primary concern seemed to have been protecting himself from liability and that having the patient sign the waiver in the pharmacy could be considered duress as she may have felt that it was the only way to get her time-sensitive medication.

Due to the seriousness of the issue, and the pharmacist's demonstration that the best interest of the patient was not his primary concern, the panel

issued an oral caution and required the pharmacist to complete a course on ethics.

LEARNINGS FOR PHARMACY PROFESSIONALS

All pharmacy professionals must comply with the ethical principles and standards outlined in the Code of Ethics. The Code requires that pharmacy professionals ensure that their primary focus at all times is the well-being and best interests of the patient. This means that pharmacists and pharmacy technicians should not put their personal interests above those of their patients.

A fundamental component of the Code is that pharmacy professionals recognize and respect the vulnerability of patients and treat them with sensitivity, caring, consideration and respect. In this case, the pharmacist should have recognized that the patient may have been feeling quite vulnerable and, as a result, ensured that he expressed compassion, not judgment.

If a pharmacy professional declines to provide a product or service due to a conscientious objection, they must meet the expectations as outlined in Standard 2.13 of the Code and in the College's guideline on Professional Obligations When Declining to Provide a Pharmacy Product or Service Due to Conscience or Religion. These obligations include making an effective referral in a timely manner and ensuring that it is done in a sensitive and respectful manner that does not impose any personal moral judgments or directly convey their conscientious objection to the patient.

Pharmacy professionals must take appropriate action to prevent medication discrepancies and errors. If a pharmacist has a concern about the dosing of a medication, it is the responsibility of that pharmacist to seek clarity on the prescriber's instructions. This is not an obligation that should be presented as a service or favour to the patient. Clarifications with the prescriber should be done in a timely manner, especially where there may be significant time constraints on the administration of the medication.

Under both the Code and the standards of the profession, pharmacy professionals must accept responsibility for their actions and decisions. The panel noted that, outside of truly exceptional circumstances, there is no place in the practice of pharmacy for patients to sign waivers. The more appropriate place for a note about the pharmacist's concerns would have been the patient's profile, where the pharmacist could have provided details about his conversation with the patient. Pharmacy professionals must have due regard for the best interests of the patient at all times – a waiver, especially one that does not focus on the patient's own health and safety, can imply that the pharmacist's liability is more important than the patient's well-being.

Ultimately, the Code of Ethics requires all pharmacy professionals to be guided by the foundational principles of healthcare: serving and protecting the best interests of patients, being diligent in doing no harm, understanding that all persons are worthy of respect, compassion and consideration, and keeping the public trust by acting in the patient's best interest and not their own.

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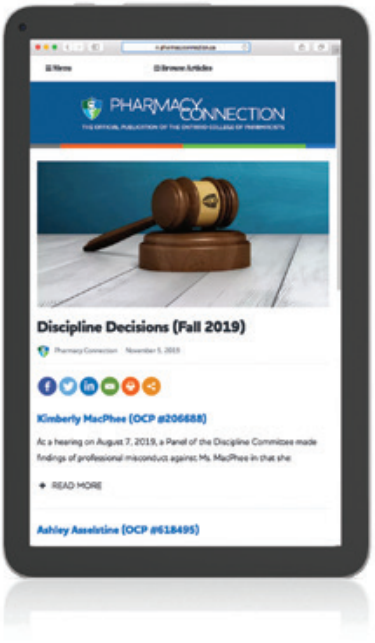
1. Get tips and advice on how to maximize your pharmacy experience (patients) and get practice resources to help you provide better patient care (pharmacy professionals)
2. Stay informed on key projects the College is involved in that directly impact you
3. Learn about our new open consultations as soon as they're posted
4. Stay up-to-date with the latest pharmacy regulatory news and updates
5. Get important reminders of key dates and events
6. Be the first to know when we develop a new helpful tool or resource, such as a video or an infographic
7. Get access to helpful resources we have curated and share on our social media channels from other organizations

DISCIPLINE DECISIONS

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

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



LIST OF FALL 2019 DECISIONS:

Kimberly MacPhee (OCP #206688)

Ashley Asselstine (OCP #618495)

Mounir Atia (OCP #202892)

Luigi Di Pierdomenico (OCP #604718)

Stephen Shier (OCP #79936)

John-Paul Federico (OCP #218925)

Sameh Ghobrial (OCP #617587)

Ragaie Khalil (OCP #205504)

The full text of these decisions is available at www.canlii.org.
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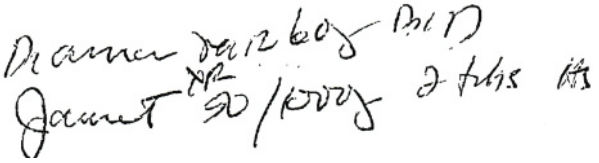
FOCUS ON ERROR PREVENTION

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

Pharmaceutical manufacturers often create line extensions of brand name products to provide new strengths and delivery mechanisms. Though these XR, LA, CD, SR, XL, MR, ER, and CR products may increase adherence, their similarity to the original product may be a contributing factor to medication errors. Proper assessment is necessary to ensure that the patient receives the correct drug and dose.

CASE:



A sixty-one year old patient took the above prescription to his usual community pharmacy for processing.

Diamicron® MR was dispensed as prescribed. However, Janumet® XR 50mg/1000mg was dispensed as Janumet® 50mg/1000mg. The patient took two tablets at bedtime as instructed.

Three months later, the patient returned to the pharmacy with another prescription for Janumet® XR 50mg/1000mg. On this occasion, the correct medication was dispensed.

The pharmacist initially thought that there was a change in the prescribed medication. However, upon reviewing the previous prescription, the error was identified.

POSSIBLE CONTRIBUTING FACTORS:

- The physician wrote "XR" between the two drugs and it was therefore missed.
- The pharmacist failed to note that Janumet® is usually taken twice daily while Janumet® XR is usually taken once daily.
- It appears that counselling did not take place as no documentation took place.

RECOMMENDATIONS:

- When dispensing medications, always assess the appropriateness of the drug therapy. Factors to be considered include the patient parameters, medication history, indication for use, the dose, dosing interval, duration of therapy, etc. In the above example, is Janumet® 50mg/1000mg taken once daily appropriate? Also, is Diamicron® MR taken twice daily appropriate as it could put the patient at risk of nocturnal hypoglycemia?

  The prescriber should always be consulted to discuss any discrepancies.

- Always check the patient's medication profile to identify prior and current medication use when dispensing both new and refill medications.
- Ensure the patient receives appropriate counselling. If counselling did not take place, document a valid reason for not providing it.
- Use caution when dispensing pharmaceuticals with line extensions to ensure the correct product is dispensed.

These include, but are not limited to:

Acular®	Acular® LS	Alphagan®	Alphagan® P
Seroquel®	Seroquel® XR	Clindoxyl®	Clindoxyl® ADV
Tri-cyclen®	Tri-cyclen® Lo	Biaxin®	Biaxin® XL
Timoptic®	Timoptic-XE®	Yaz®	Yaz® Plus
Cipro®	Cipro® XL	Janumet®	Janumet® XR

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com . Sharing your experience can prevent similar occurrences at other practice sites.

Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

Registrants are reminded that as part of the AIMS program, they must:

- Anonymously record all medication incidents and near misses via the AIMS medication event reporting platform.
- Document appropriate details of medication incidents and near misses in a timely manner to support accuracy.
- Analyze the incident in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident.
- Promptly communicate the appropriate details of a medication incident or near miss, including causal factors and actions taken as a result, to all staff.

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