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PHARMACY CONNECTION

WINTER 2020 • VOLUME 27 NUMBER 1
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THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

QUALITY ASSURANCE PROGRAM:

Assessing Competency, Supporting Learning, Improving Patient Care **28**

IN THIS ISSUE:

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COUNCIL MEMBERS

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

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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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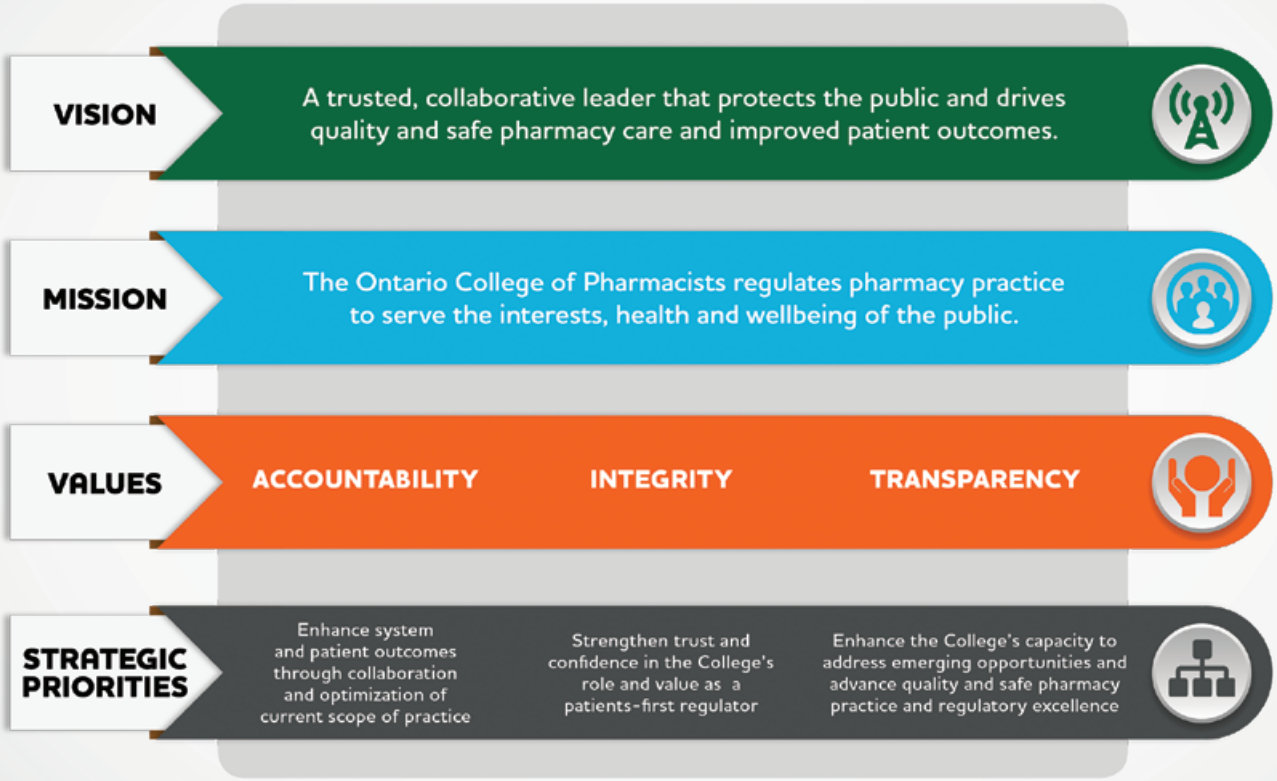
(2019-2021) OCP STRATEGIC FRAMEWORK



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

Dear Colleagues,

One of the priorities of the College, defined within what are known as "objects" outlined in the Health Professions Procedural Code within the *Regulated Health Professions Act* is the development of programs to assure the quality of pharmacy practice in the province. There are a number of ways that we do this, from practice assessments of pharmacists and pharmacy technicians and operational assessments of community and hospital pharmacies, to the implementation of a standardized medication safety program, to the provision of a formal Quality Assurance Program.

Each of these, and many other programs and initiatives led, coordinated and supported by the College are vitally important parts of our responsibility as a regulator. However, it's important not to view these simply as programs and activities that you participate in; they should also be considered valuable mechanisms to support you and/or your pharmacy to help you provide the best possible care to your patients. While we have a regulatory responsibility to uphold, our desire is to work collaboratively with the entire profession and the sector on matters of joint importance in order to maintain, and strengthen, the confidence and trust the public has in pharmacy.

In this issue of *Pharmacy Connection*, we provide an update on our work to evolve the Quality Assurance Program which we hope will help better explain how the process works, what it involves and why we do it. It's important for everyone to understand this process and the activities in which we engage the profession so that the experience and the outcomes associated with this work are maximized for your benefit.

You will read about our latest work in helping the profession and sector reduce the risk of medication errors in pharmacy through the roll out of a Pharmacy Safety Self-Assessment tool. Starting with a roll out involving a limited number of pharmacies, we will work collaboratively on refining this important patient-safety tool before it is rolled out across the province later this year.

And you will read about our ongoing work to prepare for expanded scope of practice of Ontario pharmacists, the progress we're making in our Quality Indicators for Pharmacy initiative and Opioid Strategy, and a number of other articles developed to provide you with practical and insightful information you can consider in your everyday practice.

But one of the new features you'll see in this issue of *Pharmacy Connection* is something we have named, **Registrar's Reflection**. As you'll discover, the column will focus on a particular topic of interest to the regulator and the profession and provide me the additional opportunity to express my insights, views and ideas to all of you. In this inaugural edition of my column, I highlight the work that we're doing in response to the growing feedback we're receiving from registrants related to concerns about the community practice environment. We're listening to this feedback, so please take a moment to read this important message.

I'd like to close my letter by acknowledging the incredible contribution of the former Director of Conduct and Deputy Registrar Anne Resnick, who retired in January. Anne spearheaded several key initiatives at the College, including our AIMS Program and was an important team member who helped to bring forward, lead or champion a number of other important priorities in support of our mandate over the years. She was a valuable member of our team who provided thoughtful and steady leadership over the past 15 years, in addition to the many years prior in which she served on Council and Committees. She will be missed, and we wish her all our best in her retirement.

As we look towards the future, I'm pleased to introduce Angela Bates as our new Director of Conduct. With her many years of experience in professional regulation and health care, we are fortunate to have Angela aboard as we move forward with the important work before us.

Regards,

Nancy Lum-Wilson

CEO and Registrar
Ontario College of Pharmacists

DECEMBER 2019 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held on December 9th, 2019.

COUNCIL APPROVES THE CIRCULATION OF COLLEGE BY-LAW NO. 6 FOR CONSULTATION

Council reviewed and approved the draft By-Law No. 6 to enable changes to the governance structure of the College. Council has also proposed amendments that would put in place annual cost of living fee increases. The College will post these by-law changes for open consultation for a period of 60 days, after which Council will receive a report on the input received through the consultation for consideration at the next Council meeting in March 2020.

The governance changes are grounded in adopting best practices and increasing the ability of the College to foster and strengthen the trust of the people of Ontario. The main components that underpin the changes to the By-Law are:

Nomenclature – Council will be known as the Board of Directors and the President and Vice President will be known as Chair and Vice Chair to better reflect the fundamental role of the positions. College Members will be known as Registrants to better reflect the relationship with the College and acknowledge the responsibility of the College to those it regulates and protects.

Reduction in Board Size – In September 2020, the College Board of Directors will comprise nine Elected Directors who are also Registrants (two of which are Pharmacy Technicians), nine Public Directors appointed by the Lieutenant Governor in Council (LGIC) and the two Deans of Pharmacy from the Universities of Toronto and Waterloo respectively. This will bring the total number of Directors to 20, down from 28.

Competency-Based Board – Candidates seeking election to the Board of Directors will be screened using established and published competency criteria based on their eligibility, skills, knowledge and experience.

Board Composition – Registrant candidates seeking election to the Board of Directors will be screened based on the patient populations served to allow for diverse perspectives of the needs and issues of the patients of Ontario. This replaces the former geographical electoral district framework and more clearly aligns with the College's public protection mandate.

Separation of Board and Statutory Committees – As much as it is permitted by statute, members of the Board of Directors will not serve on Statutory Committees. Elected Directors will only serve on the Discipline Committee while Public Directors will continue to serve on a number of statutory committees. The College will recruit Lay Committee Appointees to represent the public voice on committees that do not require Public Directors or to supplement those that do.

Changes to the Standing Committees – The Board of Directors will have two new committees replacing the Elections and Nominating Committees: the Screening Committee will independently screen those applying for Board elections and committee appointments and qualify those who may run for election; and the Governance Committee will determine the recruitment strategy, plan for the succession of Chair and Vice Chair positions and prepare the committee appointment slate for Board approval.

Honorarium – The College will move to a new honorarium based remuneration model for Elected Directors and Committee Appointees.

Fees - The College fees will be prescribed in schedules within the By-Law and will have cost of living adjustments linked to the consumer price index starting annually on January 1 each year commencing 2021.

COUNCIL APPROVES THE 2020 OPERATING AND CAPITAL BUDGET

Council approved the proposed 2020 break-even budget with incoming revenue equaling the budgeted operating and capital expenditures. Council reviewed and approved the resource allocation plans associated with the operations of the College and was informed of the initiatives underway to ensure the College is identifying and leveraging the opportunities for efficiency.

COUNCIL APPROVES THE PROPOSED CHANGES TO THE REGISTRATION RESOLUTIONS

In December 2019, the National Association of Pharmacy Regulatory Authorities (NAPRA) Pharmacy Technician Bridging Program is being discontinued. Established in 2013, this program was initially developed to support the transition registration pathway as the regulation of technicians was established. Currently the program is used as bridging education for International Pharmacy Technician Graduates (IPTG) who are required to complete a bridging program, unless they successfully complete the Pharmacy Examining Board of Canada (PEBC) Qualifying exam on their first attempt.

In 2018, NAPRA first signaled that this program will be discontinued as all transition pathways have closed. Several regulators (ON, MB, AB and BC) as well as the PEBC who also use the program for IPTG applicants, attempted to maintain the program for the long term, but have determined that there are insufficient applicants to make it sustainable. NAPRA, along with these organizations, will continue to pursue an alternative bridging program for IPTG applicants, and in the interim Council approved that the Registration Committee will review these applications on an individual basis to determine which education courses are necessary for them to complete in order to demonstrate that they possess the knowledge, skills and judgment equivalent to graduates from accredited pharmacy technician programs in Canada.

SCOPE OF PRACTICE – MINOR AILMENTS UPDATE

In response to the Minister of Health's request, the College provided Council with an update on the development of regulations that would enable pharmacists to prescribe drugs for certain minor ailments. These proposed regulations are due to the Minister on June 30, 2020.

The College has continued to work closely with the Ministry, and has established the Minor Ailments Advisory Group (MAAG) which comprises patient advisors as well as experts in medicine, public health, health systems research, and pharmacy in order to provide input and guidance on how these changes can improve patient health outcomes. The advisory group's terms of reference can be found on the College website. Additionally, broad preliminary feedback is being solicited which includes meeting with pharmacy associations, administering a survey to registrants, and through public focus groups to help build a strong, evidence-informed foundation for deciding which minor ailment conditions to include. The Ministry has expressed that the focus of the minor ailments under consideration should be tailored to those that result in unnecessary emergency department visits to decrease the burden on patients and the health care system.

Council reviewed the preliminary list of 18 minor ailments for consideration and was informed that the Ministry has expressed the desire to have the list further refined to 10 to 12 minor ailments. A motion was put forward and passed to add post exposure prophylaxis for Lyme disease to the list of minor ailments, given the importance of timely treatment and the growing risk areas in Ontario.

The regulatory submission will be presented at the March 2020 Council meeting and following approval of Council, the proposed regulations will be posted on the College's website for open consultation for a period of 60 days.

NEXT COUNCIL MEETING

The next scheduled meeting will be held Monday, March 23, 2020. 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 Ms. Sarah MacDougall, Council and Committee Liaison at council@ocpinfo.com. You can also follow highlights from the Council meetings via Twitter.

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MEMBERSHIP RENEWAL REMINDER

DEADLINE IS MARCH 10

NOTE: No form will be mailed to you, however email reminders will be sent. If you fail to pay your fees on or before 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.

REGISTRAR'S Reflection

Patients First, Safety Always:

Shared Accountability in the Delivery of Safe and High Quality Care in Community Pharmacy

We're listening.

That's the first and most important message I'd like to convey in my inaugural edition of Registrar's Reflection which will be published in each issue of *Pharmacy Connection*. This will be a new way to allow me to share my thoughts, insights, views and ideas related not just to the regulation of pharmacy, but to overall quality and safe pharmacy practice in the province.

Over the past few years, we have conducted a number of engagement activities with registrants including Regional Meetings, open consultations for the College and on behalf of other stakeholders such as government, and engaged with stakeholders informally through direct communication and dialogue on various topics, from new regulations to quality improvement initiatives. These are valuable mechanisms to listen to and learn from those whom we have all entrusted to provide safe pharmaceutical care to our patients and each other.

The most common feedback theme received through these engagement activities is related to the practice environment in community pharmacy. Specific concerns that have been raised include reduced professional autonomy, increased workload and other pressures placed on pharmacists and pharmacy technicians to meet operational priorities and the impact this has, real or perceived, on their ability to meet practice expectations and standards.

Similar issues have also been identified by patients. While we consistently hear through our public engagement activities about the important role pharmacies and pharmacy professionals play in the lives of patients, we have also heard concerns about the ability of patients to access care in increasingly busy pharmacies and the need for adequate staffing as the expansion of pharmacists' scope of practice is considered.

I want to assure everyone, especially registrants, that we are very much aware of the feedback and are taking the concerns being shared with us very seriously. Ultimately, safe patient care is everyone's business, and ensuring safety and quality in pharmacy at all times is a shared accountability not just among pharmacy professionals, but among those who own, operate or influence the operation of pharmacy as well.

Indeed, these are not new issues nor are they unique to Ontario. However, patients deserve to be assured that their pharmacies, those who own and operate them and those who work in them are all committed to quality care above all else. They are, after all, patients first and their safety and health outcomes should always be the number-one priority.

As we consider the ongoing roll out and maturity of our medication safety program, the implementation of important quality improvement initiatives, and the evolution and expansion of pharmacist scope of practice in the province, I believe very strongly that shared accountability within pharmacy is more important than ever.

Data on its own isn't information. But data with context is.

It's important to note that we're not just listening to the feedback received through our consultations and engagements. As an organization increasingly focused on risk-based regulation, we're also 'listening' to data to help us make informed decisions. This was an important part of our message shared at last year's Regional Meetings.

Medication incidents anonymously reported by pharmacy professionals through our AIMS Program are providing important insights into various causal factors

that may be contributing to errors and near misses. The September AIMS snapshot indicated that staffing, workload and environmental factors were the single most commonly noted contributors to medication incidents, comprising 23.6% of the 4,426 incidents reported by onboarded community pharmacies.

Data like this is powerful, and empowering. There is no question that the AIMS Program data along with the ongoing concerns being expressed by registrants together make it evident that workload and staffing related challenges are top-of-mind for many community pharmacy professionals. And as the regulator with a mandate to protect the public, it is top-of-mind for us too.

Recognizing the limitations of our authority over business practices in pharmacy, we believe that we do have a role to play within our legislated mandate and objects to help better understand and identify appropriate solutions to what is a complex issue. After all, those who own and operate pharmacies are accountable to the Standards of Operation, just as pharmacy professionals are accountable to the Standards of Practice. Patient safety is a shared accountability which is why addressing patient safety in community pharmacy is best informed through thoughtful, respectful and meaningful collaboration and engagement with pharmacy professionals, those who own, control and operate pharmacies, system stakeholders and patients.

Bringing stakeholders together and listening to diverse perspectives

As you will have seen in e-Connect and other communication, the College is launching a **Community Practice Environment Initiative** that will involve the active collaboration and participation of stakeholders with the initial goal of better understanding confirmed and potential barriers to professional autonomy and patient safety in community pharmacy.

The first phase of this initiative will be aimed at developing a set of essential shared accountability principles. It is expected that these principles will guide the development of specific solutions and strategies to further strengthen the quality and safety of pharmacy care and address the issues that have been made apparent in our consultations and AIMS Program data. Ultimately, we believe this work will help position pharmacy for ongoing success as it plays an increasingly important role in the health and wellbeing of Ontarians.

Just as we have listened to the feedback of stakeholders and used data to help make informed decisions in the launch of this new initiative, we will continue to listen to and engage pharmacy professionals, patients, and other stakeholders throughout this work. There will be many opportunities to get involved and provide input and I encourage you all to watch for these opportunities that will be promoted in e-Connect and on our website.

The bigger picture: the role of provider experience on quality health care

The feedback being shared with us is a reminder that pharmacy, like other areas of healthcare, is a people industry, where patients are cared for by highly qualified healthcare professionals – pharmacists and pharmacy technicians – who dedicate their lives to meeting the health needs of others.

Given this, it is becoming increasingly acknowledged that the needs of healthcare professionals must be better understood and considered in the health system's ability to influence, and improve, quality and patient outcomes. Pharmacy should be no different. In fact, our work with Health Quality Ontario (now a part of Ontario Health) in the development of our Quality Indicators for Pharmacy over the past two years has led us to commit to developing indicators specific to *provider experience* within the pharmacy setting, and doing so is a priority for us in 2020.

Along the way, we will need your ongoing input, insights and ideas to help us better understand the issues being expressed by the profession, along with your commitment to work collaboratively toward addressing them to help protect the interests, health and wellbeing of the public – our shared accountability. PC

Nancy

AIMS Assurance and Improvement in Medication Safety

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

Moving Forward with the Pharmacy Safety Self-Assessment

One of the key expectations of the Assurance and Improvement in Medication Safety (AIMS) Program is analyzing a medication incident or near miss in a timely manner for causal factors, and taking appropriate steps to minimize the likelihood of recurrence.

Under the supplemental Standard of Practice and Standards of Operation, pharmacy professionals will be required to complete a Pharmacy Safety Self-Assessment (PSSA) once it is made available through the AIMS reporting platform. The PSSA must be completed within the first year and then at least once every two to three years. It can be done more frequently if there is a significant change in the pharmacy.

The PSSA is an informative quality-improvement tool that acts as a baseline of the pharmacy's efforts to enhance patient safety over time. It can be used to proactively identify areas of potential risk, enabling pharmacy teams to plan improvement activities effectively and demonstrate system improvements.

The College is now moving forward with a preliminary rollout of the PSSA involving about 40 volunteer pharmacies that will test and provide feedback on the tool. This input will be valuable in guiding any changes that may be needed prior to rolling out the PSSA to all community pharmacies later this year.

Once this initial work is complete, the PSSA will be made available to community pharmacies as one of the Continuous Quality Improvement (CQI) tools in the AIMS reporting platform. The Designated Manager is responsible for ensuring that the PSSA is completed, but the pharmacy team should be involved in the process and associated actions for improvement.

Onboarding and Implementation of AIMS

Already, many community pharmacies and pharmacy professionals in Ontario have embraced the AIMS Program and a safety culture that supports and promotes accountability, shared learnings and a commitment to continuous quality improvement. All pharmacies now have access to the AIMS reporting platform.

The College acknowledges the valuable contribution of pharmacy professionals who are using the platform to record incidents and near-misses, which is key to understanding how these medication safety events occur and what actions can be taken to prevent recurrence.

All pharmacy staff are encouraged to read the Response Team bulletin, an independent analysis of the preliminary data from the AIMS Program that provides important insights and recommendations aimed at reducing the risk of medication events involving pharmacies. The next bulletin will be made available in the spring.

You can learn more about AIMS and access more resources, including frequently asked questions, on the College website.

UPCOMING 2020 *COUNCIL ELECTIONS*

In December 2019, College Council approved the draft By-Law No. 6 to move to open consultation. The draft By-Law contains changes to the timing and structure of the Council elections as well as other governance changes. At the March 23 meeting, Council will review the consultation feedback and additional changes or adjustments could be made to the By-Law. It is important to be aware of how these proposed changes, if approved, would impact the 2020 nomination and election process for Council.

Under the proposed By-Law, the following changes would be made to the elections process for 2020:

- **A one-year transition process to accommodate the reduction in size of Council.** In order to accommodate the decrease in number of elected Council members to nine, there will be a one-year transition period in 2020, before resuming the usual three-year terms of office for elected Council members. During the election in August, all positions on Council will be up for election, with the exception of two members who are on the Executive Committee, who will provide continuity through the transition.

- **Voting for all candidates.** As there will no longer be electoral districts, all registrants who hold a valid certificate of registration, who practice or reside in Ontario, and who are not in default of payment of fees will be able to vote for up to five pharmacist candidates and up to two pharmacy technician candidates (as there will be five pharmacist and two technician positions available). Those elected in 2020 will be assigned varying term lengths, depending on the amount of votes they received – this will allow for the commencement of staggered elections over the coming years.

- **Earlier nomination timeline and enhanced screening of applications.** Nominations for the 2020 election will open in April, with all registrants being advised of their eligibility to vote, the number of positions available and the profile for competencies sought for the position. Those interested in applying for nomination will need to complete the application form and provide references. The Screening Committee will review the applications against the selected competencies, desired experiences with select patient populations and eligibility requirements in the By-Law to determine whether they are eligible to run for election.

The election will take place from July 8 to August 5. As with previous years, voting will be done via online ballot. Pharmacists and pharmacy technicians who are interested in serving on a College committee should look for further recruitment information in the spring.

Registrants will receive an email from the College in April confirming the nomination and election process. In the meantime, please stay tuned to the College's website and e-Connect for further updates on the By-Law and any changes to the governance of the College. Pc

NON-STERILE COMPOUNDING PHASE 2 IMPLEMENTATION:

Placing the Focus on Training, Quality Assurance and Policies and Procedures

The NAPRA Model Standards for Pharmacy Compounding of Non-Sterile Preparations apply to every pharmacy and pharmacy professional engaged in compounding.

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 to protect patients and prevent 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.

THE IMPORTANCE OF CONTINUITY OF CARE

Compounding is within the scope of practice and authorized acts for pharmacy professionals defined in the *Pharmacy Act*, and compounding non-sterile preparations according to recognized guidelines and standards is an entry-to-practice competency for both pharmacists and pharmacy technicians. It is reasonable that the public and other health practitioners expect any pharmacy to provide some compounding services. The requirements for "all levels of compounding" (Section 5 in the NAPRA standards), corresponding to Level A, should be attainable for all pharmacies already engaged in compounding. Moreover, the Code of Ethics expects that "members make every reasonable effort to provide quality cost-effective pharmacy care and services to patients and society."

As explained in the standards, "given that pharmacists and pharmacy technicians are expected to maintain competency in basic compounding skills, they are also expected to provide compounded preparations within their level of expertise and within the limitations of available and appropriate facilities and equipment." The Designated Manager/department head must ensure, with the best interest of the patient in mind, that the pharmacy has the resources necessary to compound a preparation in a safe and appropriate manner. When this is not possible, they have an ethical obligation to "assume responsibility for making reasonable efforts to ensure continuity of patient care when they are unable to provide requested pharmacy services." Patient care should not be jeopardized by abrupt cessation of compounding services due to the transition to the new standards.

AN OVERVIEW OF PHASES 1, 2 AND 3

The College has prepared a checklist to provide guidance to pharmacy professionals and pharmacies as they work to implement the requirements but it is not intended to replace the standards. It is the responsibility of the pharmacy professional/pharmacy to review and ensure compliance with the standards. For more information about implementation, please visit the Non-Sterile Compounding Key Initiative on the OCP website.

All sections referred to in parentheses are from the Guidance Document for Pharmacy Compounding of Non-Sterile Preparations document.

PHASE 1 – DEADLINE JANUARY 1, 2020

Verify that the following requirements have been completed, according to the deadline for implementation of Phase 1. Pharmacies and registrants should now be working towards completing the requirements for Phase 2.

☐ **Review the NAPRA Model Standards for Pharmacy Compounding of Non-Sterile Preparations and the Guidance Document for Pharmacy Compounding of Non-Sterile Preparations.**

- Read the *Pharmacy Connection* article Timelines Announced for Non-Sterile Compounding Standards (Winter 2019).
- Read the *Pharmacy Connection* article Implementing the Non-Sterile Compounding Standards: The Community Pharmacy Experience (Summer 2019).
- Read the *Pharmacy Connection* article Consider These Steps While Preparing for the First Phase of Non-Sterile Compounding Compliance: The Hamilton Health Sciences Experience (Spring 2019).

☐ **Designate a regulated pharmacy professional to be the non-sterile compounding (NSC) supervisor. (Section 5.1)**

- Identify all personnel engaged in non-sterile compounding and associated cleaning.

☐ **Evaluate the pharmacy's current and/or anticipated compounding services and preparations to assess and determine risk. (Section 4)**

- Identify the non-sterile preparations being compounded and the compounding ingredients (including any Active Pharmaceutical Ingredients) required. (Section 6.3)
- Determine if each preparation is still being made or if a comparable manufactured product is commercially available, therefore eliminating the need for compounding. (Section 2.1 and 3)
- Identify ingredients classified as hazardous by reviewing the NIOSH List of Hazardous Drugs.
- Identify ingredients that pose a potential health hazard according to WHMIS by reviewing the safety data sheets (SDS) provided by the supplier or manufacturer.
- Perform a risk assessment for each preparation compounded by the pharmacy using the Decision Algorithm for Risk Assessment as a guide. (Section 4.2)

☐ **Determine, using the results of the risk assessments and taking into account the frequency and quantity of compounding and risk mitigation measures, if your pharmacy compounding space currently meets the requirements needed to prepare Level A, B, or C compounds (Section 8)**

- Read the *Pharmacy Connection* article Implementing the Non-Sterile Compounding Standards: A Closer Look at Personal Protective Equipment (Summer 2019).
- Read the *Pharmacy Connection* article Non-Sterile Compounding FAQs (Summer 2019).

☐ **Perform a gap analysis to compare the pharmacy's current practices to the minimum standards.**

- The Non-Sterile Compounding Assessment Criteria document may be used for this activity.
- Identify any gaps in the knowledge and skills of compounding/cleaning personnel. (Section 5.2)
- Develop a plan of action to address the identified gaps based on the Phase 2 and 3 implementation deadlines.
- Read the *Pharmacy Connection* article Preparing for Phase 2 of the Non-Sterile Compounding Standards (Fall 2019).

PHASE 2 – DEADLINE JULY 1, 2020

In Phase 2, policies and procedures to meet and maintain the standards, including personnel training, should be developed along with a quality assurance program. Planning for Phase 3 should happen in tandem with Phase 2, as the physical or space changes needed may require additional time and resources.

- ☐ **Create Master Formulation Records for each preparation, which must include all necessary information to compound the preparation. (Section 6)**
  - Assign a beyond-use date for each preparation. (Section 6.1)
- ☐ **Develop policies and procedures for all aspects of non-sterile compounding. (Section 5.3)**
  - Begin with those related to personnel (e.g., conduct, hygiene, attire).
  - Hazardous preparations require additional policies and procedures. (Section 9.3, 9.4, 9.5)
- ☐ **Complete a skills assessment for existing non-sterile compounding/cleaning personnel. (Section 5.2)**
- ☐ **Develop a training program for non-sterile compounding personnel. (Section 5.2)**
  - Ensure there is training on policies and procedures as they are developed.
- ☐ **Develop a quality assurance (QA) program for personnel to verify ongoing effectiveness of, and compliance with, policies and procedures. (Section 7.3, 7.4)**
- ☐ **Begin developing other components of the pharmacy's QA program. (Section 7)**

PHASE 3 – JANUARY 1, 2021

In Phase 3, the focus will be on ensuring that the facility and equipment required for the preparation of all non-sterile compounds are in compliance with the standards.

- ☐ **Establish protocols and schedules for cleaning and maintenance of the compounding area facilities and equipment to maintain the quality and integrity of the final preparations. (Section 5.4)**
  - Document these activities in the general maintenance log. (Section 5.4)
  - Ensure facilities and equipment (including C-PEC) is certified and maintained as per standards. (Table 6)
  - Implement proper deactivation, decontamination, and cleaning procedures for hazardous preparations. (Section 9.2, 9.3)
  - Ensure that an environmental monitoring plan is in place for hazardous preparations. (Section 9.6)
- ☐ **Ensure that the proper facilities are in place for Level C requirements, including lighting, heating, ventilation and air conditioning systems, water supply, work surfaces, furniture, walls and flooring. (Section 9.1)**
- ☐ **Develop a quality assurance program for facilities, equipment, preparation processes (including those in Section 6), and documentation (Section 7).**

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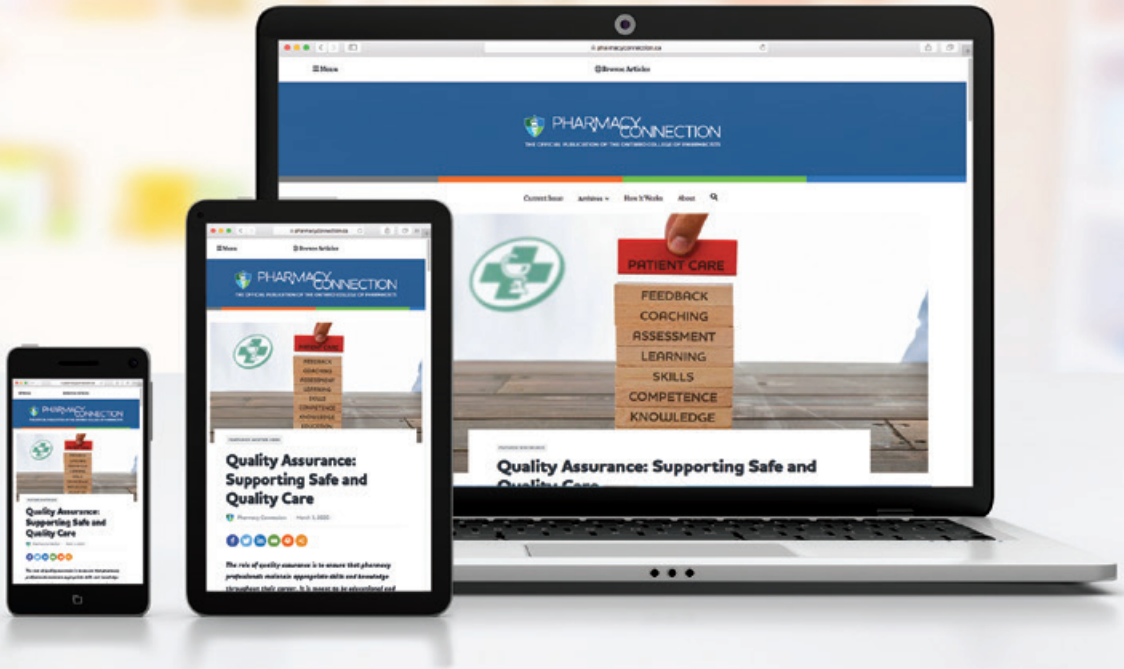

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EXPANDED SCOPE OF PRACTICE:

Consulting and Engaging with Health System Partners and the Public

The College is committed to consulting broadly with pharmacy professionals, the public, other healthcare professionals and health system stakeholders in our work to enable pharmacists to prescribe for certain minor ailments. This engagement is key to drafting regulations that promote safe and quality care for patients.

Pharmacy professionals play an important role in a patient's healthcare journey. Understanding that role within the continuum of care and working with healthcare partners is an important part of our collective efforts to enhance coordination and communication between different parts of the healthcare system, which will ultimately improve health outcomes.

With this in mind, the College has taken a collaborative approach to expanding scope of practice, engaging different parts of the healthcare system – patients, registrants, physicians, nurse practitioners and other healthcare providers, public health experts, professional associations, regulators and others – to gain valuable insights that have and will continue to inform our work to enable expanded scope of practice. It also enhances our ability to identify necessary resources and guidance to support the profession as these changes are implemented.

COLLABORATION IN THE EARLY STAGES

Last year, the College consulted broadly on the first set of draft regulatory amendments to expand pharmacists' scope of practice. These amendments include administration of the flu vaccine to patients as young as two years old, as well as patient services that pharmacists have been providing for a number of years, such as administering certain substances by injection and/or inhalation - which will be expanded for purposes beyond patient education and demonstration.

Consultations included early engagement with a broad range of stakeholders to help guide the work in developing the regulatory changes, as well as an open public consultation on the draft regulations before they were submitted to the government for consideration in late November.

PRELIMINARY LIST OF MINOR AILMENTS

1. Urinary Tract Infection (uncomplicated)
2. Dermatitis (Atopic-mild/ moderate eczema, allergic contact and irritant contact)*
3. Insect bites, urticaria (hives)
4. Conjunctivitis (pink eye) – bacterial, viral and allergic
5. Acne (mild to moderate)*
6. Allergic rhinitis* (hay fever)
7. Candidal stomatitis* (oral thrush)
8. Oral aphthae* (canker sores)
9. Herpes labialis (cold sores)
10. Hemorrhoids*
11. Diaper dermatitis
12. Vulvovaginal candidiasis (yeast infection)
13. Dysmenorrhea* (menstrual cramps)
14. Musculoskeletal sprains and strains
15. Impetigo
16. Nausea and vomiting during pregnancy
17. Gastroesophageal Reflux Disease (GERD)
18. Pinworms and threadworms
19. Lyme disease, post-exposure prophylaxis

** Common ailments that have been approved for pharmacist prescribing in 7 out of 7 provinces.*

COLLABORATION IN PRESCRIBING FOR MINOR AILMENTS

The College is applying a systems-focused approach to the next phase of draft regulations that would enable pharmacists to prescribe for minor ailments, consulting broadly with pharmacy professionals, the public and other healthcare professionals as it moves forward with this work.

The Minor Ailments Advisory Group (MAAG) was established to provide guidance and recommendations on regulatory, policy, implementation and evaluation considerations, with a view to improving health outcomes and health system quality while ensuring patient safety. It comprises patient advisors and experts in pharmacy, medicine, public health, health systems research, and anti-microbial stewardship.

The College has developed a preliminary list of minor ailments based on the recommendations of the MAAG, which serves as a starting point for further discussion with registrants and other stakeholders.

In developing this list, the MAAG took an evidence-informed approach, looking at conditions that have been approved in at least one other province, then considering which ones may have the highest potential to streamline care pathways for routine care in the community and reduce the burden on emergency departments.

CONSULTATIONS ON MINOR AILMENTS

Pharmacy professionals were able to provide their initial feedback on this list and prescribing for minor ailments through a survey, which closed at the end of January. The College is also consulting with health system stakeholders, including professional associations, and will continue to collaborate with them as well as registrants as this work moves forward.

There will be opportunities for the public, pharmacy professionals and other stakeholders to share their views on draft regulations on prescribing for minor ailments, including a 60-day open public consultation that will be posted on our website subject to approval at the March Council meeting.

TAKING A SYSTEMS-WIDE APPROACH

Health system challenges require health system solutions that involve cross-sector collaboration, innovation and insight. The College is committed to supporting the profession in adapting to these practice changes safely and with confidence.

We also remain committed to listening to and learning from the perspectives of those who receive and those who provide patient care. As we move forward, the College will continue to engage and collaborate with patients, registrants, pharmacy stakeholders and other health system partners and professionals to plan for and implement expanded scope and to do so in a manner that keeps patient safety as the number-one priority.

Learn more about the College's work on expanded scope on the OCP website.

Quality Indicators: *Progress and Next Steps*

The College is continuing its work on quality indicators for community pharmacy, a tool that will help drive improvement in pharmacy by providing registrants, health-system stakeholders and the public with a clearer picture of the impact of pharmacy care on patient experience and health outcomes.

LAUNCHING FIRST SET OF QUALITY INDICATORS

In June 2019, the College reached a significant milestone, launching the first set of indicators in partnership with Health Quality Ontario (now a part of Ontario Health). Covering four measurement areas, these seven indicators were developed by an expert panel that included patients, practicing pharmacists, academics and other health system stakeholders.

WHAT ARE THE SELECTED INDICATORS MEASURING?

- Patient/Caregiver Experience and Outcomes
- Appropriateness of Dispensed Medications
- Medication-related Hospital Visits
- Transitions of Care

These indicators will be publicly reported and provide the public with a better understanding of the overall quality of pharmacy care in Ontario, as well as support quality improvement efforts by pharmacy professionals and the College. They are not intended to track individual performance or be used for reimbursement, unlike other indicators established by insurance companies.

ICYMI: Read the Quality Indicators Leaflet

MAKING PROGRESS

Since the announcement of the first set of selected indicators, the College has engaged a work group comprised of health system and quality experts, including members of the Canadian Institute for Health Information (CIHI) and Ontario Health (Quality), to develop technical specifications for three administrative indicators associated with the appropriateness of dispensed medications, medication-related hospital visits, and transitions of care. These specifications, the importance of which was highlighted by the pharmacy sector during the indicator selection process, will ensure there is clarity behind the definitions and technical details of each of the three indicators.

Using these technical specifications, the Ministry of Health will provide the College with data for analysis. The College anticipates being in a position to report on these indicators later this year and they will be shared through various communication channels, including *Pharmacy Connection*.

NEXT STEPS

The second phase of indicator development is underway, and seeks to measure pharmacy professional experience and engagement, as there is a well-established link between provider experience, patient experience and health outcomes. In the coming months, the College will reach out to practicing pharmacy professionals to collaborate on developing and refining provider experience indicators.

Throughout this process, the College will be engaging with key stakeholders, including registrants and patients, to identify implementation considerations and what tools and resources pharmacy professionals will need to support their quality improvement efforts.

The College values this feedback as it moves forward with this work, which will provide the public and health system with information about the quality of pharmacy care and support efforts to improve patient outcomes and patient safety.

Advancing the College's OPIOID STRATEGY

THE IMPORTANT ROLE OF PHARMACY PROFESSIONALS IN SUPPORTING PATIENTS

As medication experts, pharmacists are in a unique role to support the appropriate use and access to narcotic and other controlled drugs. Additionally, pharmacy professionals are often the most accessible healthcare providers for patients and so may have opportunities to develop and identify best practices and provide additional support and education around opioid issues.

FRAMEWORK FOR IMPROVING THE SAFETY AND SECURITY OF CONTROLLED SUBSTANCES IN HOSPITAL HIGH RISK AREAS PUBLISHED

As announced in the Fall 2019 edition of *Pharmacy Connection*, 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 use of controlled substances in our communities.

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.

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.

Learn more about the Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas on the OCP website.

ADDITIONAL PROGRESS MADE REGARDING THE COLLEGE'S OPIOID STRATEGY

The College is committed to supporting and complementing action undertaken by provincial and federal governments and other health system stakeholders to reduce opioid-related harms and prevent overdose and addiction. Initiatives and activities undertaken by the College that are aligned with the Opioid Strategy and its strategic priorities include:

- Publication of an Opioid Dispensing in Ontario: 2018 Snapshot that provides an overall look at opioid dispensing patterns in community pharmacy in Ontario related to three areas of analysis that are considered high-risk dispensing practices
- Sponsorship of and participation in the Partnered Table to Improve the Safety and Security of Controlled Substances in Hospital High Risk Areas to produce a framework that contains 13 recommendations to enable healthcare system stakeholders to proactively identify and prevent the diversion of controlled substances in hospitals
- Development of an Opioid Policy outlining the College's expectations for pharmacy professionals regarding opioids
- Creation of an Opioid Practice Tool as a hub for relevant resources
- Promotion of external resources on best opioid prescribing and dispensing practices
- Education of pharmacy professionals on their obligations related to opioid security
- Guidance on the dispensing of naloxone
- Encouragement of interprofessional collaboration between prescribers and pharmacy professionals

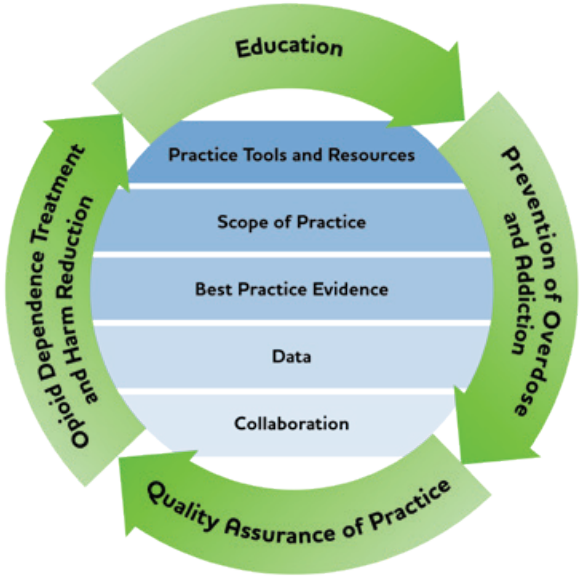
The College continues to look for opportunities to address the strategic priorities identified in the Opioid Strategy and to address the opioid-related harms that are still having a significant impact on communities throughout the province.

THE COLLEGE'S OPIOID STRATEGY FOR PHARMACY

In 2017, the College published an Opioid Strategy for Pharmacy. The strategy, which was developed by the Opioid Task Force, addresses relevant areas of practice, and considers the health and social factors that are related to problematic opioid use. The full strategy was approved by College Council at its September 2017 meeting.

This strategy supports the College in meeting its mandate to serve and protect the public's interest by:

- advancing opioid-related education for pharmacy professionals,
- improving harm reduction strategies and delivery of opioid dependence treatment,
- preventing overdose and addiction by supporting evidence-based and appropriate dispensing practices, and
- strengthening oversight of the provision of narcotic and controlled drugs to patients and the security of drug distribution.



Read the Ontario College of Pharmacists: Strategy to Address Opioid Use Disorder in Ontario.

Patient Safety and Infection Prevention and Control

Public Health Ontario describes Infection Prevention and Control (IPAC) as "evidence-based practices and procedures that, when applied consistently in health care settings, can prevent or reduce the risk of transmission of microorganisms to health care providers, clients, patients, residents and visitors."

Pharmacy professionals have an ethical obligation to act in the best interest of their patients by placing their well-being first and foremost and, whenever possible, preventing harm from occurring. Under the Standards of Operation, pharmacies should be designed to mitigate risk and maintain safe drug distribution practices. To effectively safeguard the health of the public, infection prevention measures must be considered by registrants in all practice settings. The nature and extent of these measures will depend on several factors, such as applicable legislation, the professional services provided and the characteristics of the patient population.

PHARMACY PREMISES

The Standards of Operation require all accredited pharmacy premises to be designed and maintained to ensure the safe and appropriate storage of all drugs and medications, including the proper conditions of sanitation. The pharmacy must ensure regular cleaning of the premises the pharmacy is operated from including all furniture, equipment and appliances. Personnel engaged in dispensing or compounding activities must adhere to appropriate hygienic behaviour including using appropriate hand washing techniques and wearing suitable protective equipment as needed in accordance with the College's Guidance on Accreditation and Operation of a Pharmacy (see the College's Community Pharmacy Assessment Criteria for specific guidance.)

Regulations under the *Public Hospitals Act* require hospitals to establish a committee to oversee an infection control program. Keeping the hospital's medication supply free of potential contamination requires collaboration between Pharmacy and other departments, in consultation with the IPAC committee, when developing policies and procedures (see the Hospital Pharmacy Assessment Criteria for specific guidance). In the community setting, Designated

Managers are responsible for implementing procedures and quality assurance mechanisms to meet the standards.

PROFESSIONAL SERVICES

Ontario Regulation 202/94 under the *Pharmacy Act* stipulates that a pharmacist may only administer a substance by injection in an environment that is clean and safe for the patient and with appropriate infection control procedures in place. Injection-trained pharmacists must have completed training according to the Public Health Agency of Canada's Canadian Immunization Guide (see the Key Immunization Information and Infection Prevention and Control sections of the guide).

As scope of practice continues to expand and pharmacy professionals become increasingly engaged in patient care activities – especially those involving piercing the dermis – the need for effective infection prevention measures is heightened. Ontario's Public Health Units also have a responsibility to investigate IPAC complaints related to the administration of a substance by injection or performing of a procedure beneath the dermis, as outlined in the Infection Prevention and Control Complaint Protocol.

In the event of a communicable and/or infectious disease transmission risk related to the professional conduct of a regulated pharmacy professional, the regional board of health will involve the College on the matter, per the protocol.

INFECTION PREVENTION AND CONTROL RESOURCES FOR PHARMACY PROFESSIONALS

The following list is by no means exhaustive. Additional resources are available from other government ministries, professional associations and jurisdictions.

PROVINCIAL (ONTARIO)

Ministry of Health and Long Term Care (Public Health Standards)

- Infection Prevention and Control Protocol, 2019
- Infectious Diseases Protocol, 2018

Public Health Ontario (PHO) and **Provincial Infectious Diseases Advisory Committee (PIDAC)**

- Best Practices for Infection Prevention and Control Programs in Ontario In All Health Care Settings, 3rd edition (May 2012)
- Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition (Nov 2012)
- Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings (April 2018)
- Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014)
- Infection Prevention and Control for Clinical Office Practice (April 2015)

FEDERAL

Public Health Agency of Canada (PHAC)

- Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings (2013)

Infection Prevention and Control Canada

- Infection Prevention and Control (IPAC) Program Standard (Dec 2016)

OTHER

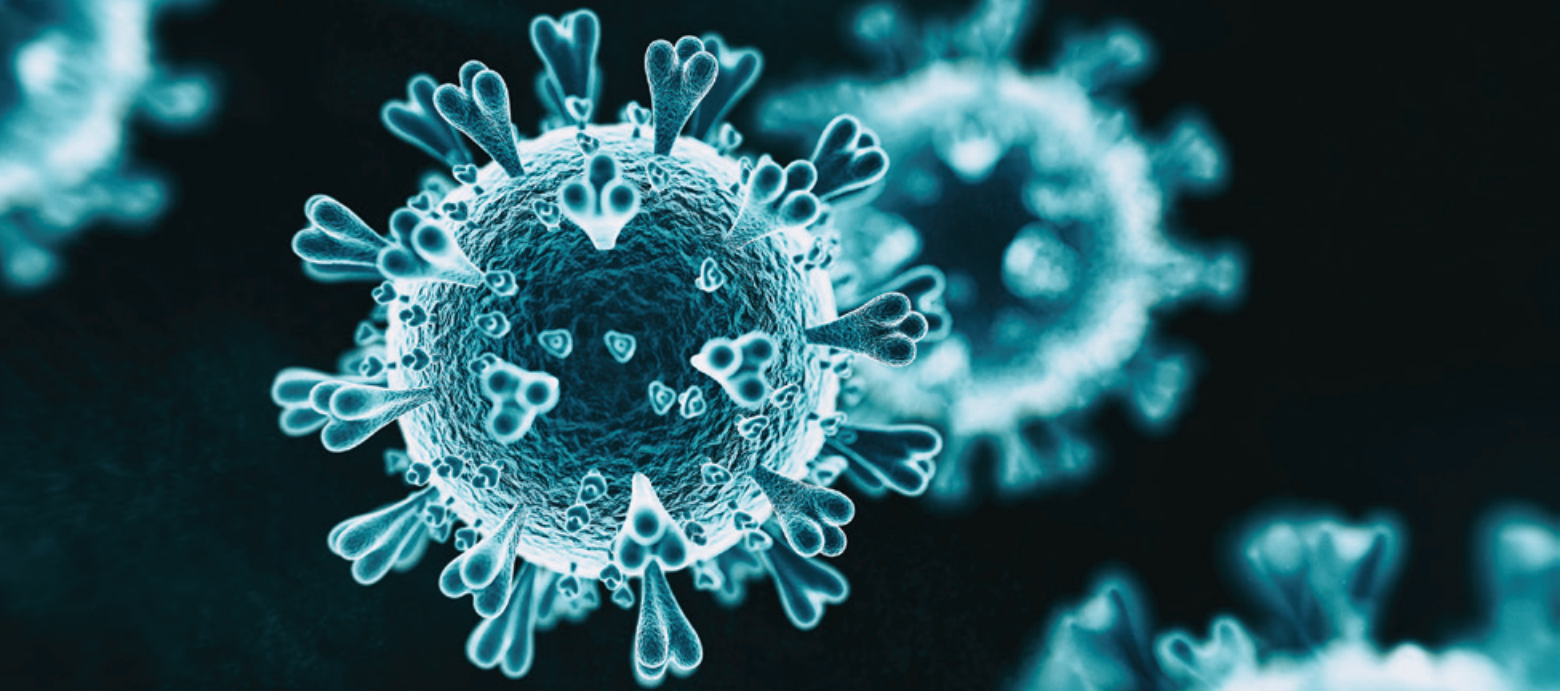
Centre for Disease Control (CDC, United States)

- Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care

Canadian Patient Safety Institute: Infection Prevention and Control

Ontario Public Health Association (OPHA)

Canadian Public Health Association (CPHA)



2019 NOVEL CORONAVIRUS (COVID-19)

Guidance for Pharmacies

A guidance document, "Novel Coronavirus (COVID-19) Guidance for Community Pharmacies" is available on the Ministry of Health's COVID-19 Guidance for the Health Sector webpage.

We strongly advise all registrants to read this document, which includes information on patient screening and triage, and Infection Prevention & Control advice for pharmacy professionals. Professional judgment should be used when applying the guidance in your pharmacy.

You can also call the Ministry's Healthcare Provider Hotline at 1-866-212-2272 if you have additional questions or need more information. The College will support the communication of any further updates to the guidance materials.

Registrants are reminded that if they form the opinion that a patient has or may have COVID-19, they must report this information to their region's public health unit or medical officer of health as soon as possible, in accordance with the *Health Promotion and Protection Act*.

Pharmacy patients and members of the public should consult the Ministry's COVID-19 webpage for the public – which is updated daily – and call Telehealth Ontario (1 866-797-0000) if they need medical advice.

The College continues to participate in regular system updates with the Ministry of Health, provincial public health officials and other health system partners and will support any communication and additional guidance specific to pharmacy professionals as it becomes available.

This information was published March 5, 2020. Due to ongoing developments, this information may change. Please stay updated on information provided by the Ministry of Health.

At the September 2019 meeting, College Council 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 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 begin with a land acknowledgement, starting with the December 2019 meeting, which will help 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.

The College's Indigenous cultural competency and safety initiative has emerged from our growing awareness of the disparities in healthcare and health outcomes for Indigenous people. Our 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.

Work this year at the College will focus on establishing relationships with members of the Indigenous communities in Ontario, and identifying and implementing ways to heighten cultural competency within the organization. It will also focus on making helpful resources available to all registrants as an important first step towards more formal opportunities in future years.

In this issue of *Pharmacy Connection*, we are pleased to reprint a recent story from *Pharmacy Practice + Business* magazine that provides pharmacy professionals with some tips on how to support the health and well-being of Indigenous youth.

5 TIPS ON SUPPORTING *the Mental Health and Wellness of Indigenous Youth*

By: Jaris Swidrovich
Story reprinted with permission from Canadian Healthcare Network.

Approximately 5% of people in Canada are self-identified as Indigenous.[1] In the Canadian context, the term Indigenous is used interchangeably with the term Aboriginal, which is defined in the Constitution Act of 1872 as Indian (now more appropriately referred to as First Nations), Métis or Inuit persons.[2] Despite comprising only about 5% of the Canadian population, Indigenous peoples are drastically overrepresented in terms of accessing the healthcare system, with mental health and wellness being of particular concern.

Indigenous youth aged 15–24 in Canada experience a rate of suicide that is five to six times higher than the rate witnessed in non-Indigenous youth.[3,4] The overall number of completed suicides by males, and specifically young Indigenous males, is larger than the number of completed suicides by females; however, the difference in rate of death by suicide among First Nations females is much greater than that seen in non-First Nations females. First Nations males aged 10–19 in Saskatchewan, for example, experience a rate of suicide that is six times higher than the suicide rate for non-First Nations males of the same age group, while First Nations females of this age group experience a rate of suicide that is 26 times higher than the suicide rate among their non-First Nations counterparts.[5] In Nunavut, the suicide rate for young Inuit males aged 15–24 is 40 times the national rate of suicide.[3,4]

Indigenous youth have cited a number of contributing factors to the high suicide rate, including the impact of bullying and cyberbullying, lack of emotional support, lack of physical safety, lack of activities and its impact on emotional and mental wellness, and the impact of substance use.[6] Other known contributing factors to the disproportionally high rates of suicide experienced by Indigenous youth in Canada versus non-Indigenous youth include all forms of racism, intergenerational trauma, access to healthcare services, the historical and ongoing child welfare crisis for Indigenous children, a history (and ongoing experience of) colonialism and other social determinants of health.[2]

While pharmacists can support the mental health and wellness of Indigenous youth in Canada in many ways, the following five suggestions are offered as a starting point.

1. Dedicate both personal and professional time to learning about Canada's historical and ongoing "truths."

In our age of Truth and Reconciliation, it is critical for pharmacists (and all Canadians) to learn the historical and ongoing truths of our nation and of the people living in it. Thankfully, taking the time to learn does not have to come at any personal financial cost. Consider consulting your local public library for a list of suggested readings and other sources of learning, including online and loanable videos and podcasts, as well as websites and in-person programming. Contact KAIROS Canada to arrange a Blanket Exercise for your pharmacy staff, which will build understanding about our shared history as Indigenous and non-Indigenous peoples in Canada. Read the Truth and Reconciliation Commission of Canada's report and all 94 Calls to Action.[7] Participating in reconciliation and other programs, interventions and initiatives without first dedicating time to "truth" has the potential to be harmful and insincere if coming from an uninformed, or not fully informed, position.

2. Establish, build and reaffirm relationships with Indigenous peoples, communities and organizations in or near your own community.

A foundational element of Indigenous world view is relationality and the interconnectedness of all things. Supporting the mental health and wellness of Indigenous youth also means supporting the health and wellness of the people and communities surrounding and supporting the youth. Indigenous youth have cited intergenerational trauma as one of the many contributing factors to their emotional health and wellness, which means we must include

all generations in our efforts to support the mental health and wellness of Indigenous youth versus just the youth themselves. Some starting points might include your local Indigenous (First Nations / Métis / Inuit) Friendship Centre, local reserves and/or tribal council(s), and the urban offices for First Nations, Métis and Inuit communities. Success will be enabled through positive and lasting relationships.

3. Partner with Indigenous youth.

A common saying and a philosophical approach to truth and reconciliation is "nothing about us without us." In order to have the most authentic and genuine participation in contributing to the mental health and wellness of Indigenous youth, you must work directly with Indigenous youth. For assistance in locating Indigenous youth in your own area, a starting point might be to connect with the Assembly of First Nations (AFN) National Youth Council.

4. Familiarize yourself with support services and programs in your community and remotely accessible supports.

While 50% of First Nations people in Canada live off-reserve, the other 50% live on reserves where access to services may be dramatically lower than what is available in urban settings.[8] Although many reserve communities do have access to the internet through cellular data and/or WiFi, some reserve (and Northern, rural and remote) communities do not. As such, resources that support the mental health and wellness of Indigenous youth may need to be accessible without access to in-person or internet-based services, and resources should be inclusive of the physical, mental, emotional and spiritual dimensions of health and well-being. Expanding and promoting the services of your pharmacy is important; however, recognizing that mental health and wellness extends far beyond pharmacists and pharmacies, pharmacists must have the ability to connect Indigenous youth with other supports and services that are accessible to them—wherever they are.

5. Practise anti-racism and be an anti-racist leader.

Considering the identified impacts of racism on the mental health and wellness of Indigenous youth, it is not enough to "not be racist"—we must be anti-racist. While engaging with your local library, consider also adding anti-racist materials to your inquiry. Be an anti-racist leader and mentor to the other staff, students and professionals you interact with. Focus on the social determinants of health that have impacted, and continue to impact, the mental health and wellness of Indigenous youth; practise from this perspective instead of from a perspective that assumes each individual Indigenous youth is in complete control of their own mental health and wellness.

Jaris Swidrovich (jaris.swidrovich@usask.ca) is an assistant professor in the College of Pharmacy and Nutrition at the University of Saskatchewan on Treaty 6 territory and the traditional homelands of the Métis in Saskatoon, SK. He is a member of Yellow Quill First Nation and is the first self-identified First Nations Doctor of Pharmacy and faculty member in pharmacy in Canada.

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QUALITY ASSURANCE:

Supporting Safe and Quality Care

The role of quality assurance is to ensure that pharmacy professionals maintain appropriate skills and knowledge throughout their career. It is meant to be educational and collaborative, not punitive, and benefit both patients and pharmacy professionals.

For pharmacists and pharmacy technicians it is intended to:

- validate the things they are already doing well,
- help them identify areas for improvement in their practice in order to better support their patients, and
- support ongoing skill and knowledge development at all levels of their career.

Quality assurance is also a major component of the College's role in protecting the public and promoting continued competency by evaluating pharmacy professionals against the standards of the profession. It focuses on specific performance indicators that have a significant impact on patient care.

Quality assurance is a confidential process where results are not shared with employers, owners, colleagues or any College committee, other than the Quality Assurance Committee.

COMPONENTS OF QUALITY ASSURANCE

The College's Quality Assurance Program consists of four major components: a self-assessment, a knowledge assessment, a practice assessment and a learning portfolio. While the self-assessment, the knowledge assessment and the practice assessment are coordinated by the College, pharmacy professionals are expected to engage in continuous professional development and keep their learning portfolio up to date on an ongoing basis.

Self-Assessment: Identifying Learning Needs

The self-assessment is a tool that assists registrants in identifying their learning needs (both those to maintain competency and those to advance professionally) and creating a plan for learning.

Every year, 20% of pharmacists in Part A of the Register and pharmacy technicians will be randomly selected to complete the self-assessment Tool. Although registrants are only required to complete the self-assessment once in every five-year cycle, voluntarily completing the assessment on a yearly basis is encouraged.

Knowledge Assessment: Assuring Current Knowledge and Skills

The knowledge assessments for pharmacists and pharmacy technicians are currently under development, with knowledge assessments for pharmacists expected to begin in 2021. The blueprint for the upcoming knowledge assessment will cover topics on ethics/professionalism/jurisprudence and knowledge transition, in addition to clinical knowledge.

Practice Assessment: Evaluating Performance

A practice assessment is an evaluation of an individual Part A pharmacist's or pharmacy technician's performance. The practice assessment occurs in the place of practice with a College practice advisor. Starting January 2020, practice assessments are separate and distinct from pharmacy operational assessments.

Practice assessments of pharmacists support their role as medication experts and clinical decision-makers, and are consistent in approach to assessments of other primary healthcare practitioners. Practice assessments of pharmacy technicians support their technical role within the pharmacy/organization.

During a practice assessment, practice advisors use the practice assessment criteria to evaluate a registrant's practice. For the community pharmacist practice assessment this includes four domains: **patient assessment, decision making, documentation,** and **communication and education**. For the pharmacy technician practice assessment this also includes four domains: **patient care support activities, collaboration and decision making, documentation, and communication and education.** It is important to note that practice assessments are intended to evaluate the registrants' *processes* in place for each of the domains.

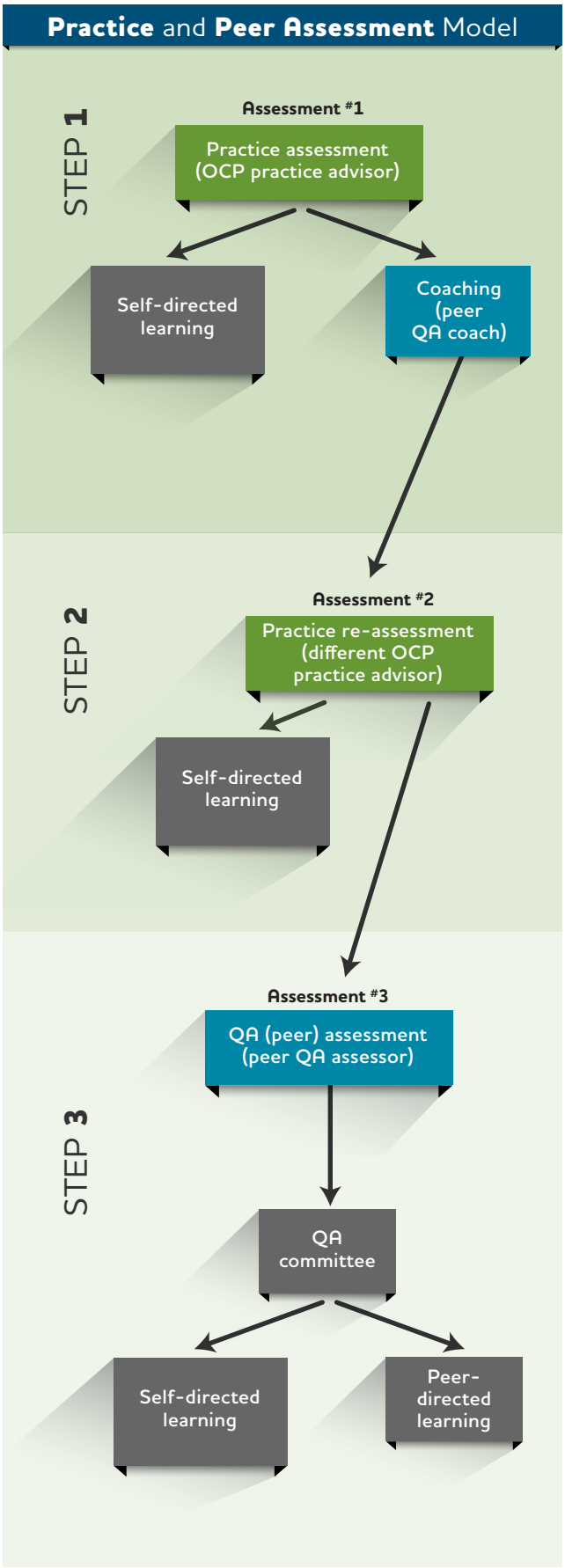
Throughout and following the assessment, the practice advisor provides feedback outlining areas of practice where the pharmacy professional is doing well and meeting standards as well as areas where there is an opportunity for improvement. They offer support through coaching and conversation, pointing out opportunities to enhance practice, probing the thinking behind certain actions and decisions, and indicating where to access helpful resources.

With an emphasis on education, the goal of the practice assessments is to increase adherence to practice standards, help pharmacy professionals practice to their full scope, and ultimately support optimal health outcomes. Routine practice assessments are scheduled every four to six years.

If a pharmacy professional does not meet the standards indicated on their first assessment, he/she is given the opportunity to spend time with a quality assurance coach (peer practitioner) who can provide support specifically in areas where there is room for improvement. Following that session, the pharmacy professional will be reassessed by another practice advisor.

If there are still significant areas of practice that require improvement following this second assessment, a QA assessment will take place and the results will be sent to the Quality Assurance Committee for consideration. The committee may provide recommendations to help the professional meet standards by identifying appropriate remediation, always recognizing that patient safety is the first priority (see flowchart on the next page for an overview of the process).

Practice assessments are currently ongoing for pharmacists in community practice and for pharmacy technicians in community and hospital practice. Assessment tools for pharmacists in non-community settings (including hospitals) are currently under development, with a pilot expected in the Fall of 2020.



Learning Portfolio: Supporting Ongoing Development and Reflecting Learnings From the Other Quality Assurance Activities

All registrants of the College are expected to engage in continuing professional development, regardless of whether electing into Part A or Part B of the register, throughout their career. A record of learning must be maintained, either through the College's My Learning (CPD Portal) or through another method. Records of activities are required to be retained for five years. Some types of activities that registrants may wish to document include, but are not limited to, workshops, self-study courses, reading articles or studies, exploring or discussing an issue with colleagues, or other activities that meet their practice and personal goals.

PREPARING FOR QUALITY ASSURANCE ACTIVITIES

Many registrants express concerns when contacted by the College to participate in any of the above quality assurance activities. Pharmacy professionals are encouraged to review the College's resources on the quality assurance components, available on the OCP website, to not only feel more prepared in advance of the activity, but also to support ongoing learning and development throughout every year of their career.

- Learn more about Practice Assessments, review the Practice Assessment Criteria for Community Pharmacists or the Practice Assessment Criteria for Pharmacy Technicians, including using the Guidance section to self-assess current practice and identify opportunities, and read the Practice Assessment Resources.

- Complete the Self-Assessment Tool on a yearly basis through the My Learning (CPD Portal). Although, the College only requires registrants to complete this once in every five year cycle, completing it more frequently will help to determine a plan for learning, as well as provide familiarity with the tool in advance of this request.

- Whether using the My Learning (CPD Portal) or another method, update the Learning Portfolio on a regular basis. Ensure that the records and supporting documents are retained for at least five years.

IMPORTANT MESSAGES ABOUT PRACTICE ASSESSMENTS

PHARMACISTS (PART A) AND PHARMACY TECHNICIANS: PLEASE UPDATE YOUR DESIGNATED PRACTICE ASSESSMENT SITE IF YOUR PRACTICE LOCATION CHANGES

For the purpose of your practice assessment, part A pharmacists and pharmacy technicians are required to identify a place of practice in Ontario where they are providing patient care. This is called a Designated Practice Assessment (DPA) Site, and may be the same, or different, from your primary place of practice.

It is imperative that your DPA Site is updated in OCP's Online Services portal if it has changed. You are now able to change your DPA site at any time online.

It's important to ensure this information is up-to-date as the College and practice advisors depend on the accuracy of this information to facilitate your practice assessment in the location where you provide patient care.

REORGANIZATION OF ASSESSMENT TEAMS ENHANCES FOCUS ON OPERATIONAL AND PRACTICE ASSESSMENTS

As of January 1, 2020, the Assessment Team at the College has reorganized into three teams with a more specific focus in order to help improve your experience and better support your practice:

1) Hospital Pharmacy (operations) Assessments

2) Community Pharmacy (operations) Assessments

3) Practice Assessments (hospital and community based assessments of individual registrants' practice)

What Does this Mean for You?

Pharmacy (Operations) and Practice Assessments will be completely separate and distinct, both in terms of day and time. This includes the fact that there will be a separate Hospital Operations Advisor and Hospital Practice Advisor (for Hospitals) or Community Operations Advisor and Community Practice Advisor (for Community Pharmacy) who will schedule and conduct your Pharmacy (operations) and Practice Assessments, respectively.

Visit our website to learn more about the College's practice assessments and operations assessments. If you have any questions, please email ocpassessments@ocpinfo.com.

Communicating with Patients in a Thoughtful and Inclusive Way: New Guidance from the Canadian Public Health Association

Many of the complaints the College receives each year are focused on communication between pharmacy professionals and patients. When patients feel judged, disrespected or excluded during their encounters with pharmacists and pharmacy technicians, they may feel unwelcome or unsafe in the pharmacy, which could lead to negative health impacts.

The Canadian Public Health Association recently released a guidance document to help healthcare professionals have conversations with patients in a respectful and non-judgmental manner, with a focus on sensitive topics around sexuality, substance use and sexually transmitted and blood borne infections. The document provides overarching principles for respectful language, in addition to specific examples.

To assist healthcare professionals, the document lists terms to avoid or use with caution, an explanation of why they are problematic and what to use instead. A selected few examples are listed below, though it is important to note that patients may wish to use words that they feel best describe their own experience and healthcare professionals should be respectful of that choice.

Pharmacy professionals are encouraged to review the Language Matters guidance document to look for opportunities to examine and potentially adjust their language choices in practice. An additional useful resource is Changing the Language of Addiction from the Canadian Centre on Substance Use and Addiction.

Selected Examples from Language Matters

TERMS TO AVOID/ USE WITH CAUTION	EXPLANATION	USE INSTEAD
"substance abuse", "substance misuse", "abuser", "junkie", "habit" in reference to substance use	These can be interpreted as communicating that the use of substances or addiction represents failure of morals, personality and willpower.	"substance use", "substance use disorder/ opioid use disorder", "problematic substance use", "person who uses [substance]", person with a substance use disorder
"lapse", "relapse", "slip"	'Lapse,' 'relapse' and 'slip' are words that may still be commonly used by people who use substances and those working with them. However, some people feel that they imply blame and judgment toward the person who is using substances.	"experienced a recurrence of [symptoms]", "resumed"
"non-compliant", "unmotivated", "resistant" with respect to someone's participation in services/care	These terms reinforce paternalistic models of health care/social services. Individuals have agency, choice, and preferences, and should be active participants in decisions about their health and well-being. The use of these words can work against this goal.	"not in agreement with treatment plan", "opted not to", "has not begun", "experiencing ambivalence about change"
"wife", "husband", "boyfriend", "girlfriend", "mother", "father"	These words, if used without enough information about the person you are referring to, can assert an incorrect assumption about the nature of the relationship between people and an assumption about the gender of the person being referred to.	"spouse", "partner", "parent", "guardian"

Table adapted from "Language Matters: Using respectful language in relation to sexual health, substance use, STBBIs and intersecting sources of stigma." Canadian Public Health Association. 2019

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.

Q Are pharmacies still required to subscribe to a drug information service?

A No. Revisions to the College's Required Reference Guide for Ontario Pharmacies, approved at the September 2018 Council meeting, made a subscription to a Drug Information Service optional instead of mandatory. This change occurred along with the approval of the Standards of Operations for Pharmacies in Ontario.

At a *minimum*, every pharmacy should have at least one reference in each of the following areas:

- A Canadian Drug Reference / Compendium
- A Drug Interaction Publication
- A Drug Therapy Publication
- A Patient Counselling Guide

By removing the Council-approved list of specific references, pharmacy professionals gained the flexibility to select the resources in each area they deem most appropriate to support them in the delivery of patient care. Registrants are also encouraged to assess their practice and select additional references based on the pharmacy's patient population and the professional services provided. References should be reviewed, evaluated and updated on a regular basis to ensure each remains relevant, current and suitable for its intended purpose: to allow registrants to meet the Standards of Practice.

Q Now that the Cannabis Regulations allow the sale of edibles and topicals, can a patient bring their own cannabis to a pharmacist to have it compounded into a capsule or a cream?

A No. *The Cannabis Act* states that activities with cannabis are prohibited unless authorized. Under the Act, it is prohibited to obtain, or offer to obtain cannabis by any method or process, including altering its chemical or physical properties. As such, any compounding activity by a pharmacy professional involving cannabis would require enabling regulations, in addition to complying with applicable provincial requirements.

Cannabis is regulated federally by Health Canada's Cannabis Legalization and Regulation Branch (CLRB), who is responsible for enforcement of the *Cannabis Act* and Cannabis Regulations as well as issuance of any licenses that may be issued to conduct activities with cannabis.

For additional information, please review the College's Cannabis Strategy for Pharmacy or contact the CLRB at cannabis@canada.ca

Q We received a prescription with a statement that it was electronically signed by the prescriber but there is no actual signature on it. What are the regulations around this?

A The requirements for a prescription to be "signed" are established in the federal regulations relevant for the schedule of the drug. There is nothing in the regulations mandating the use of a "wet" signature. As explained in the related 2014 article, Navigating Electronically Generated Prescriptions, "Health Canada has broadly defined 'signing' as *whatever is determined to be necessary to authorize and validate the order*".

The College's Position Statement Authenticity of Prescriptions using Unique Identifiers for Prescribers (July 2013) describes three examples of distinct authorization methods:

- a traditional pen-and-ink signature, or
- an electronically captured image of a unique signature (generated on a signature pad), or
- a unique prescription authorization process which ensures that the prescriber has reviewed and authorized each individual prescription

There may be many different technologies available to prescribers, especially as computerized order entry and electronic prescriptions become increasingly common, to implement a unique authorization process and generate an order without an actual image of a signature.

Dispensers should review the Position Statement in its entirety, especially the guidance provided in the section *The Responsibility of the Member*. If the pharmacist decides that they need to verify the authenticity of the order, this may be done verbally or in writing (via fax). Prescribers should seek guidance from their regulatory College. PC

Please note the following message from the National Association of Pharmacy Regulatory Authorities (NAPRA):

NAPRA UPDATES ITS POLICY ON NATURAL HEALTH PRODUCTS

NAPRA is updating its policy on and approach to Natural Health Products (NHPs) in NAPRA's National Drug Schedules with the best interest of the public as its first and foremost concern.

NAPRA will remove NHPs currently listed within the National Drug Schedules (NDS) in a stepwise, risk-based approach:

1) Effective January 2, 2020: NHPs currently listed within the Unscheduled category and within Schedule III will be removed from the NDS. At Health Canada's request, ephedrine and pseudoephedrine will continue to be subject to the conditions of sales as outlined in NDS Schedule III until January 2, 2021.

2) Effective January 2, 2022: NHPs currently listed within Schedules I and II will be removed from the NDS.

As of 2022, all products with a Natural Product Number (NPN) or Drug Identification Number-Homeopathic Medicine (DIN-HM) from Health Canada will be considered outside the scope of NAPRA's National Drug Schedules.

The NDS were developed before Health Canada began regulating the sale of NHPs in Canada. When the Natural Health Products Regulations came into force in 2004, many products that were included in the NDS became re-classified as NHPs by Health Canada. Although NHPs are beyond the scope of NAPRA's NDS, NAPRA agreed to maintain the substances that were already listed in the NDS on an interim basis until direction could be provided by the federal government regarding a framework for determining conditions of sale for NHPs in Canada.

This interim measure was never meant to be a permanent solution to address the risks of the entire class of NHPs. The NDS were developed to assess drugs and are not conducive to the review of NHPs, which have significantly different requirements to obtain authorization for sale in Canada than non-prescription drugs. The NDS only include a few NHPs that used to be classified as drugs before Health Canada re-classified them as NHPs. There are many other NHPs which may also present risks that have no restrictions on sale, because the federal NHP Regulations do not address conditions of sale.

Given that the interim measure initiated many years ago only addresses the risk of a small subset of NHPs while others are available to consumers without directed conditions of sale, NAPRA has determined that this approach is no longer in the best interest of the public. For full public safety, all NHPs should be evaluated for conditions of sale by an appropriate framework designed for that purpose by relevant stakeholders.

Over the past 10 years, NAPRA has recommended the development of a framework that addresses the risks of the entire class of NHPs. NAPRA will continue to work with stakeholders to encourage the development of such a framework, which would provide the public with a consistent and comprehensive approach to the sale of all NHPs in Canada.

See NAPRA's Policy on NHPs for more information.

CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING:

From Guideline to Clinical Practice

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INTRODUCTION

Emily is a 44-year old patient known to your pharmacy. She has two young children and often seeks advice from the pharmacists at the pharmacy when her kids are unwell. Today she comes in alone and tells you that she was recently diagnosed with early-stage breast cancer. She is coping well with the news and is thankful that the cancer has not spread to other organs in her body. She will be starting chemotherapy next week. She proceeds to hand you information sheets and prescriptions given to her by the oncology team. Based on the information provided, she will be started on a chemotherapy regimen called dose-dense AC (doxorubicin/cyclophosphamide)-Paclitaxel (AC-T) and trastuzumab for eight treatment cycles. Her prescriptions for the first component of her chemotherapy, AC, consists of:

1. Olanzapine 5 mg PO daily on days 1 – 4
2. NEPA (palonosetron 0.5 mg PO and netupitant 300 mg PO) x 1 on day 1
3. Dexamethasone 8 mg PO daily on days 2 - 4
4. Prochlorperazine 10 mg PO q4-6h PRN nausea/vomiting

Emily was told to fill the prescriptions and bring them to clinic on the day of chemotherapy. She believes that they are for nausea and vomiting but she is surprised there are so many different medications on the prescription. She will meet with the pharmacist at the oncology clinic next week. She is hoping you could help explain these medications to her, including how to take them.

This scenario may be familiar to those who provide care to patients with cancer. However, the treatment of chemotherapy-induced nausea and vomiting (CINV) has changed substantially in the past year in Ontario so the medications may be unfamiliar to even those who are experienced in the management of CINV.

This article will review the new Cancer Care Ontario Antiemetic Guideline released in 2019 and discuss the implications to clinical practice.

BACKGROUND

Chemotherapy-induced nausea and vomiting (CINV) remains a feared side effect of cancer treatment for many patients. Despite the tremendous advances in the management of CINV over the past decade, prevention remains suboptimal and presents a clinical challenge to healthcare providers and patients undergoing cancer treatment.

The pathophysiology of CINV is complex and involves many receptors and neurotransmitters. The main targets for treatment involve 5-hydroxytryptamine (5-HT3) and its receptors, substance P and the neurokinin-1 receptors, and dopamine and its receptors (See Table 1). In addition to these well-studied neurotransmitters, other mechanisms also contribute to management of CINV as demonstrated by the effects of medications such as dexamethasone or lorazepam.

CINV can occur in three distinct phases following a dose of chemotherapy: The **Acute** phase of CINV occurs within the first 24 hours after chemotherapy administration. **Delayed** CINV generally occurs

after the 24-hour mark but there may be some overlap with the acute phase. **Breakthrough** CINV can occur at any time during the acute and delayed phase despite prophylaxis. We expect some degree of breakthrough CINV and it is considered mild if treated with one to two doses of rescue medication. Additionally, patients may also experience **anticipatory** nausea and vomiting. This occurs when patients experience suboptimal control of emesis or nausea in a previous cycle. Anticipatory CINV is thought to be a conditioned response as opposed to a physiologic response to chemotherapy since the symptoms occur before chemotherapy is administered. For example, patients with anticipatory CINV will complain of emesis while waiting to receive cancer treatment.

Table 1: Common neurotransmitters and receptors responsible for CINV

Neurotransmitter	Receptor	Phase of CINV
5-hydroxytryptamine	5-hydroxytryptamine	Acute
Substance P	Neurokinin- 1	Delayed, Acute
Dopamine	Dopamine	Breakthrough, Acute

MANAGEMENT OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING

The management of CINV focuses on preventative strategies to control and minimize the incidence of nausea and vomiting. The optimal antiemetic regimen will be tailored to the emetic potential of the regimen as well as individual patient factors. The regimen may include multiple medications to ensure that all phases and associated neurotransmitters are adequately addressed. Therefore, the optimal regimen may consist of three to five medications aimed at acute, delayed and breakthrough CINV.

The 2019 Antiemetic Recommendations for Chemotherapy-Induced Nausea and Vomiting: A Clinical Practice Guideline[1] provides guidance for the prevention of highly emetogenic chemotherapy (HEC), moderately emetogenic chemotherapy (MEC), low emetogenic chemotherapy and minimally emetogenic chemotherapy regimens. In addition, there are recommendations for the management of multiday intravenous chemotherapy as well as oral chemotherapy. A review of the literature was also conducted to gather evidence for the role of cannabinoids and medicinal cannabis in the management of CINV. Tables 2 to 6 summarize the recommendations for the management of CINV from the Cancer Care Ontario Antiemetic Clinical Practice Guideline.

Table 2: Management of Highly Emetic Single-Day Intravenous Chemotherapy[1]

Dosing on day of chemotherapy¥	Dosing on subsequent days
Choose one NK_1 receptor antagonist: Aprepitant 125 mg PO **OR** Fosaprepitant 150 mg IV **OR** NEPA (netupitant 300 mg + palonosetron 0.5 mg) PO	Aprepitant 80 mg PO daily (days 2 – 3)[a] if started on Day 1
Choose one 5-HT_3 receptor antagonist: Granisetron 2 mg PO or 1 mg IV **OR** Ondansetron 8 mg PO BID or 8 mg IV **OR** Palonosetron 0.25 mg IV or 0.5 mg PO[b]	No 5-HT_3 RA recommended after day of chemotherapy
Dexamethasone[c] 12 mg PO or 10 mg IV	Dexamethasone[c] 8 mg PO or 10 mg IV (days 2 – 3 or 4)
Olanzapine 5 mg PO	Olanzapine 5 mg PO daily (or 2.5 mg BID) days 2 – 4

+ In breast cancer population receiving a combination of anthracycline and cyclophosphamide (AC), may consider limiting dexamethasone to day 1, when minimizing corticosteroid is desirable. Dexamethasone does not need to be continued after day 1 with the use of palonosetron.

¥ Antiemetics should be given as a one-time dose (unless otherwise specified) an hour prior to chemotherapy administration, on the day of chemotherapy.

[a] Aprepitant is given on subsequent days only if used on day of chemotherapy. Do not give aprepitant on subsequent days if fosaprepitant or netupitant is given on day of chemotherapy.

[b] Palonosetron 0.5 mg PO is not approved for HEC by Health Canada.

[c] Dexamethasone dose listed is if used with NK_1 receptor antagonist. If NK_1 receptor antagonist is not used, dexamethasone dose is 20 mg on day of chemotherapy and 16 mg on days 2 – 3 (or 4).

Table 3: Management of Moderately Emetic Single-Day Intravenous Chemotherapy[1]

Dosing on day of chemotherapy¥	Dosing on subsequent days
Choose one 5-HT$_3$ receptor antagonist: Granisetron 2 mg PO or 1 mg IV **OR** Ondansetron 8 mg PO BID or 8 mg IV **OR** Palonosetron 0.25 mg IV or 0.5 mg PO	No 5-HT$_3$ RA recommended after day of chemotherapy
Dexamethasone 8 mg PO or 10 mg IV	No dexamethasone recommended after day of chemotherapy
OPTIONAL ON SUBSEQUENT CYCLES if inadequate control of CINV in previous cycle£:	
Choose one NK$_1$ receptor antagonist: Aprepitant 125 mg PO **OR** Fosaprepitant 150 mg IV **OR** NEPA (netupitant 300 mg + palonosetron 0.5 mg) PO	Aprepitant 80 mg PO daily (days 2 – 3)[a] if started on Day 1
OR Olanzapine 5 mg PO	Olanzapine 5 mg PO daily (or 2.5 mg BID) days 2 – 4

+ Patients receiving carboplatin AUC ≥ 5 should receive an NK$_1$ receptor antagonist up front with a 5-HT$_3$ receptor antagonist and dexamethasone.

¥ Antiemetics should be given as a one-time dose (unless otherwise specified) an hour prior to chemotherapy administration, on the day of chemotherapy.

£ Consider olanzapine if patient experiences suboptimal control of nausea and NK$_1$ RA if patient experiences suboptimal control of emesis, after the first cycle.

[a] Aprepitant is given on subsequent days only if used on day of chemotherapy. Do not give aprepitant on subsequent days if fosaprepitant or netupitant is given on day of chemotherapy.

Table 4: Management of Low Emetic Single-Day Intravenous Chemotherapy[1]

Dosing on day of chemotherapy¥	Dosing on subsequent days
Dexamethasone 8 mg PO or 10 mg IV	No dexamethasone recommended after day of chemotherapy

¥ Antiemetics should be given as a one-time dose (unless otherwise specified) an hour prior to chemotherapy administration, on the day of chemotherapy

Table 5: Management of Minimally Emetic Single-Day Intravenous Chemotherapy[1]

Dosing on day of chemotherapy	Dosing on subsequent days
No antiemetics recommended	No antiemetics recommended

Table 6: Management of Chemotherapy-Induced Nausea and Vomiting in Oral Anticancer Medications[1]

Emetic Risk	Management
High to Moderate	Consider prophylaxis daily as per patient experience of CINV * • 5-HT$_3$ Receptor Antagonist (granisetron 2 mg PO or ondansetron 8 mg PO BID)
Low to Minimal	No routine prophylaxis; PRN recommended • Prochlorperazine 10 mg PO then q4-6h PRN **OR** • Metoclopramide 10-20 mg PO then q4-6h PRN

* Insufficient evidence to recommend routine prophylaxis; Consider if patient develops significant nausea or vomiting and re-assess routinely. Use clinical judgement for individual cases where primary prophylaxis may be warranted.

The management of CINV with oral anticancer medications takes a slightly different approach than with intravenous chemotherapy. Since patients usually take oral anticancer medications daily for weeks at a time, there is the potential for tolerance to nausea and vomiting and unnecessary side effects (e.g. constipation with indefinite

daily 5-HT3 receptor antagonists) to occur. Thus, the approach is to consider providing routine antiemetic prophylaxis for HEC and MEC oral agents and only as needed for low and minimal emetic risk oral agents. If routine prophylaxis is initiated, CINV should be assessed routinely (e.g. weekly) to determine if ongoing routine treatment is required. This approach differs from international guidelines where a 5-hydroxytryptamine receptor antagonist (5-HT3 RA) is recommended to all patients taking a HEC or MEC oral agent.

Cannabinoids in the Management of Chemotherapy-Induced Nausea and Vomiting

Due to the lack of high quality clinical trials, no recommendation can be made to incorporate synthetic or non-synthetic cannabinoids as part of standard antiemetic therapy. If a cannabinoid is used, it should be after optimal therapy (including combination therapy with a 5-HT3 RA, NK1 RA, dexamethasone and olanzapine) has failed to provide adequate control of nausea and vomiting. Patients may ask for advice on the use of cannabis and in these cases, they should be guided to seek advice from a health care professional familiar with cannabis and use products with consistent concentrations from a reputable source.

Back to our patient, Emily...

Emily will be starting systemic treatment with AC-T given in a dose-dense manner for her high risk, early stage breast cancer. A number of resources can be used to determine the emetic risk of a chemotherapy regimen. Cancer Care Ontario's Drug Formulary website is a good resource as it is Ontario-specific. The British Columbia Cancer Agency also has a Drug Information website that provides information on systemic treatment regimens, supportive care as well as patient information resources. The National Comprehensive Cancer Network and the American Society of Clinical Oncology also provide information on the risk of emesis for cancer drug therapies.

With respect to the AC-T chemotherapy regimen, the Cancer Care Ontario Drug Formulary designates AC regimens as high emetic risk while paclitaxel (Taxol™) is designated as low emetic risk. Let us look at the prescriptions provided (Table 7) to see if the antiemetic regimen is appropriate for her AC-T regimen.

Table 7: Emily's Antiemetic Regimen

Drug	Role in CINV
AC given every 2 weeks for 4 cycles	
Olanzapine 5 mg PO daily on days 1 – 4	For the prevention of acute and delayed CINV
NEPA (Akynzeo™) x 1 on day 1 • palonosetron 0.5 mg PO • netupitant 300 mg PO	Palonosetron (second generation 5HT-3 receptor antagonist) is used for the prevention of acute CINV; Netupitant (NK1 receptor antagonist) is used for the prevention of delayed CINV
Dexamethasone 8 mg PO daily on days 2 - 4	For the prevention of delayed CINV (days 2 – 4); Day 1 dexamethasone (given IV/PO in clinic) is used to augment the effects of a 5-HT3 receptor antagonist in acute CINV
Prochlorperazine 10 mg PO q4-6h PRN nausea/vomiting	For the management of breakthrough CINV
Paclitaxel given every 2 weeks for 4 cycles	
Prochlorperazine 10 mg PO q4-6h PRN nausea/vomiting	For the management of breakthrough CINV

The uptake of the antiemetic recommendations may take some time to see in clinical practice. In June 2019, NEPA (palonosetron and netupitant) was listed on the Ontario Drug Benefit program. The use of this combination product is likely to increase as it offers the convenience of two medications in one capsule, thereby reducing the pill burden. Olanzapine is associated with significant sedation and may increase the risk of falls, especially in elderly patients and those taking other medications that are associated with sedation. Despite the sedation, multiple studies have demonstrated olanzapine's efficacy in HEC and MEC regimens, particularly when nausea is uncontrolled.[2-5]

Based on Emily's prescriptions, she is on the most appropriate antiemetic regimen for her AC-T chemotherapy regimen. However, we must ensure that she understands how to take her antiemetic mediations appropriately (adherence) and to monitor her for uncontrolled CINV in the next two to three days after her first cycle. It is also important that she understands the side effects she may experience with the medications and when she may want to contact her oncology team to discuss uncontrolled symptoms.

PRACTICAL INFORMATION

Practice varies between oncology day clinics across the province and the country. In Ontario, some chemotherapy day clinics may provide the pre-chemotherapy antiemetics including dexamethasone, 5-HT3 receptor antagonist and NK1 receptor antagonist (rarely) intravenously. Sometimes they provide them via oral route in the clinic. In other clinics, they give patients a prescription for all three medications to use before treatment.

Drug Access Facilitators are relatively new roles in many cancer centers. They help patients explore their eligibility for financial and compassionate access to available drug programs (e.g. Trillium program, compassionate programs through pharmaceutical companies). If a patient experiences financial burden, advise them to speak with their Drug Access Facilitator, if available, at their cancer center. Pc

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White Coat Ceremonies at UNIVERSITY OF TORONTO *and* UNIVERSITY OF WATERLOO

The University of Toronto and University of Waterloo recently hosted ceremonies to formally mark the beginning of the professional journey of incoming pharmacy students. During the ceremonies, students make their commitment to ethics and integrity and are welcomed into the professional community.

White Coat Ceremony for The Leslie Dan Faculty of Pharmacy at the University of Toronto on January 14, 2020.

White Coat Ceremony for the School of Pharmacy at the University of Waterloo on January 9, 2020.

"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

This incident occurred when a complainant raised concerns about services provided by a pharmacy to her cousin, who has developmental disabilities and lives in a group home. The complainant has power of attorney for her cousin's affairs and raised a number of issues regarding the pharmacy, including that pharmacy staff obtained consent from a personal support worker who did not have the authority to provide it and sought to have her cousin sign forms despite her cousin having questionable capacity to do so. She also noted that the pharmacy failed to seek authorization for payments on her credit card, that they were not transparent about costs and fees, and that she had trouble getting both receipts and answers to her questions about fees. Finally, the complainant was sent another patient's personal information during her interactions with the pharmacy.

WHY DID THIS HAPPEN?

This incident occurred because there was a lack of clear systems, good communication and attention to detail at the pharmacy.

The pharmacy did not have a structure in place to determine and record who was authorized to provide consent for patients. The Designated Manager inappropriately relied on the group home staff to assess whether the patient had the capacity to sign the document.

There was a significant breach of patient privacy when pharmacy staff gave the complainant personal information about another patient.

There was no record of notification to the complainant of changes to the pharmacy's billing practices and no written documentation of payment authorization, including consent by the complainant to ongoing payment and use of the credit card. When the complainant raised concerns about costs and fees, the Designated Manager delegated her pharmacy technician to contact the complainant, even though it was clear the complainant was already frustrated and that this case involved a vulnerable patient, which meant that the situation should have been handled more thoughtfully.

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 a number of concerns about how the pharmacy approached and responded to each of the issues identified in the complaint. The panel noted that there was no clear system in place at the pharmacy related to the authorization of charges and felt that the billing system should be clearly explained to the patient/agent and written documentation obtained before any charges are made.

In regards to the issues raised about costs and fees, and the complainant's concern about insufficient transparency, the panel pointed out that the Designated Manager should have paid special attention to communication in this matter, considering that the patient was vulnerable due to the inability to give consent. While there was disagreement between the Designated Manager and the complainant as to whether the changes to the pharmacy's billing system were discussed, there was no record of any discussions or other notification on the patient's file.

The panel was concerned that there was no system to determine who could provide consent for a patient and ensure that that information was documented. The panel pointed out that the Designated Manager and staff should have taken extra care to ensure informed consent was obtained, especially for a vulnerable patient, and should not have relied on the group home staff to validate that.

Finally, the panel noted that the breach of patient privacy pointed to a lack of attention to detail at the pharmacy. They felt that the Designated Manager did not appropriately react to the breach, including not reporting it to the affected patient or the Information and Privacy Commissioner and not providing an appropriate action plan to prevent it from happening again in the future.

In light of the above, the panel issued the Designated Manager an Oral Caution and required the completion of specified remediation on professional responsibility to assist in analyzing pharmacy processes, identifying areas of risk, addressing those areas of risk and improving communication with patients and agents.

USEFUL RESOURCES FOR PRIVACY BREACHES

- Quick links to the Office of the Information and Privacy Commissioner of Ontario
- *Pharmacy Connection* article Reporting Privacy Breaches

LEARNINGS FOR PHARMACY PROFESSIONALS

There were numerous issues involved in this complaint, with each presenting the opportunity to highlight learnings for pharmacy professionals and particularly Designated Managers.

Designated Managers are responsible for the overall operation of the pharmacy including professional supervision of the pharmacy, record keeping and documentation, training and orientation and safe medication practices.

Policies and procedures must be in place for consistent record-keeping and documentation to ensure that all staff are aware of when it is necessary to document information. Relevant information should be recorded in a manner that is timely, readily retrievable and easily accessible. Thorough and complete documentation demonstrates accountability and responsibility for a pharmacy professional's decisions, and also supports both patient and professional understanding of the discussions, decisions and actions that have occurred.

Clear and transparent communication on fees supports the development of relationships with patients and their agents that are marked by professional courtesy, effective communication skills and a caring and professional attitude. The Code of Ethics requires that pharmacy professionals are transparent in the fees that they charge and ensure that these are communicated to patients in advance of the provision of the service or product provided.

Additionally, open and timely communication with patients/agents may help to resolve misunderstandings or concerns sooner, thus providing an opportunity to potentially de-escalate challenging situations and support ongoing patient relationships.

Situations that present red flags, such as those involving patients who may not have the capacity to provide informed consent, require particular attention and care from the pharmacy professionals involved. Appropriate consent should be obtained before providing care, including critically assessing who can provide that consent. Documentation of consent should be recorded on the patient record to ensure that all staff at the pharmacy are aware.

It is a serious issue to breach patient privacy. Designated Managers are responsible for making sure that appropriate pharmacy protocols are in place to ensure that the privacy of patients' health information is protected. This includes informing patients when the confidentiality of their personal information may have been compromised. Additionally, pharmacies are considered health information custodians under the *Personal Health Information Protection Act* (PHIPA), which require them to meet certain expectations and put safeguards in place. In the event of a privacy breach, the responsible health information custodian must notify the individual(s) affected at the first reasonable opportunity. When the custodian notifies a patient of a privacy breach, they must also inform the patient that they can make a complaint about the breach to the Information and Privacy Commissioner of Ontario.

Finally, it is the Designated Manager's responsibility to ensure that there are processes in place to evaluate the quality of the pharmacy services provided and make the necessary changes to improve practice. When a complaint, breach, incident or other issue is raised, it is incumbent on the Designated Manager to critically assess what additional measures may be required to prevent it from happening again.

IMPORTANT REMINDER:

ACCURATE BILLING AND DISPENSING RECORDS

Registrants are reminded that the College expects that the dispensing of medications to patients is accurately reflected in the billing and patient medication profile. For example, this means that patients billed weekly for their medications are actually receiving their medications on a weekly basis.

Accurate documentation is always important to enable continuity of care for the patient across the healthcare system (i.e. if the patient is admitted to hospital). Additionally, and in accordance with the Code of Ethics, registrants have a professional responsibility to maintain the public trust. Registrants must not submit charges to patients or to any third party drug payment plan for services that they know or ought to know are false or fraudulent.

Designated Managers, as well as directors and corporations involved with the operation of pharmacies, ultimately share accountability with individual registrants for maintaining the Standards of Practice and Code of Ethics.

Thank you From Registration Programs

PACE, SPT, Jurisprudence Exam

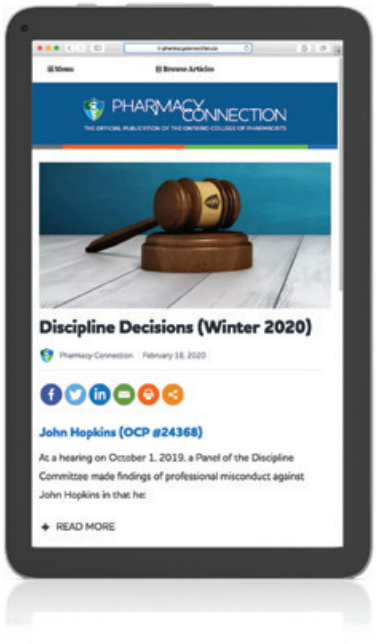
Many pharmacists and pharmacy technicians continue to demonstrate their commitment to the profession by ensuring that new registrants have met the entry-to-practice standards for the College's practice-based and jurisprudence registration requirements. These assessors, preceptors, writers and standard setters also ensure that our registration programs reflect the current Standards of Practice.

Thank you for your ongoing dedication to excellence and support of the profession!

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 WINTER 2020 DECISIONS:

- John Hopkins (OCP #24368)
- Jason Newman (OCP #214873)
- Xiao Ning (Sean) Xu (OCP #609448)
- Adewale Aderinto (OCP #606964)
- Allen Kula (OCP #28479)
- Murray Salomon (OCP #67393)
- Salam Abdul (OCP #217373)
- Daniel Hanna (OCP #210352)
- Maged Ghobrial (OCP #613350)
- Nisha Groodoyal (OCP #606825)

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

FOCUS ON ERROR PREVENTION

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

Patients with chronic medical conditions often receive healthcare from multiple providers including their family physician and specialists. Failed communication between healthcare practitioners can lead to therapeutic problems including duplication of drug therapy.

CASE:

A seventy-two year old patient had been receiving amiodarone for an extended period of time from his usual community pharmacy with the instructions to take one 200mg tablet once daily.

Following a visit to his cardiologist, the patient received the following prescription.

Rx:
Amiodarone
Sig: 100mg once daily
Mitte: Three months

The patient was given amiodarone 200mg tablets with the instructions to "Take half a tablet once daily".

Three days later, the pharmacy received a written prescription from the patient's family physician for amiodarone 200mg once daily. Since the patient received a three month supply of amiodarone three days earlier, this prescription was logged in the event the 200mg daily dose would be required once again in the near future.

The following month, the patient (or his agent) presented another prescription from the cardiologist for amiodarone 100mg once daily. This prescription was also logged as the refill would be early.

The patient's file therefore contained two active logged prescriptions from two different prescribers for two different doses of amiodarone.

After the patient exhausted his supply of amiodarone tablets, he (or his agent) self-ordered the amiodarone prescribed by his family physician at a dose of 200mg once daily.

This prescription was therefore processed and the patient received amiodarone 200mg tablets with the instructions to take one tablet daily. The pharmacist dispensing the medication failed to note that the latest prescribed dose (by the cardiologist) was the reduced dose of 100mg once daily.

A few days later, the patient's spouse contacted the pharmacy to express her displeasure regarding "the incorrect directions for taking the medication on the prescription label". She stated that "this error can cause patient harm".

POSSIBLE CONTRIBUTING FACTORS:

- Lack of communication between the two prescribers resulting in the prescribing of two different daily doses of amiodarone.
- The presence of two active prescriptions of amiodarone with differing daily doses in the patient's profile.
- The pharmacist failed to review the patient's medication history when checking the prescription for appropriateness. They therefore failed to identify that the most recent prescribed dose of amiodarone was 100mg once daily.

RECOMMENDATIONS:

- In circumstances where two prescribers prescribe duplicate therapies or differing dosages of the same therapy, take steps to ensure each prescriber is aware of the potential therapeutic problem.
- Whenever there is a change in a patient's drug therapy or dosage, establish a system to deactivate or discontinue all medications/ prescriptions which should no longer be dispensed. Add a notation to the patient's profile to link these deactivated prescriptions to the new prescription.

- Remind all pharmacy staff to carefully review and act upon all DUR notes including change in therapy, early/late refill, etc. If necessary, contact your software vendor to ensure this information is prominently displayed and easy to read.

- Always use the patient's medication profile to perform a therapeutic check when dispensing both new and refill medications.

- Remind patients of the importance of sharing information regarding any change in drug therapy with all appropriate healthcare providers.

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.

This is a friendly reminder that as part of the AIMS program, pharmacists and pharmacy technicians 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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Ontario College of Pharmacists

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