January/February 2008

Pharmacy Connection

Official Publication of the Ontario College of Pharmacists

ONTARIO COLLEGE OF PHARMACISTS 2008

Annual Pharmacist Fees Due March 10, 2008

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Council Members

Council Members for Districts 1-17 are listed below according to District number. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. DFP indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. DSP indicates the Director, School of Pharmacy, University of Waterloo.

1 Joseph Hanna
2 Elaine Akers
3 Sherif Guorgui
4 Tracey Phillips
5 Donald Organ
6 Fayez Kosa
7 Tracy Wiersema
8 Saheed Rashid
9 Bonnie Hauser
10 Gerald Cook
11 David Malian
12 Peter Gdyczynski
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PM Salvatore Guerriero
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PM Gitu Parikh
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Statutory Committees

- Executive
- Accreditation
- Complaints
- Discipline
- Fitness to Practice
- Patient Relations
- Quality Assurance
- Registration

Standing Committees

- Communications
- Finance
- Professional Practice

Special Committees

- Standards of Practice Working Group
- Working Group on Certification of Pharmacy Technicians
- Working Group on Pharmacy Technicians

ONTARIO COLLEGE OF PHARMACISTS

Mission Statement

The mission of the Ontario College of Pharmacists is to regulate the practice of pharmacy, through the participation of the public and the profession, in accordance with standards of practice which ensure that pharmacists provide the public with quality pharmaceutical service and care.

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regular features:

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Pharmacy Connection

The objectives of *Pharmacy Connection* are to communicate information on College activities and policies; encourage dialogue and to discuss issues of interest with pharmacists; and to promote the pharmacist's role among our members, allied health professions and the public.

We publish six times a year, in January, March, May, July, September and November. We welcome original manuscripts (that promote the objectives of the journal) for consideration. The Ontario College of Pharmacists reserves the right to modify contributions as appropriate. Please contact the Associate Editor for publishing requirements.

We also invite you to share your comments, suggestions, or criticisms by letter to the Editor. Letters considered for reprinting must include the author's name, address and telephone number. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.

EDITOR'S MESSAGE

Della Croteau, R.Ph., B.S.P., M.C.Ed.
Deputy Registrar/Director of Professional Development

Ten years of Quality Assurance Practice Reviews! Its difficult to believe. This edition of Pharmacy Connection presents some of the data on the quality assurance program for pharmacists that has now been in place for over ten years. Pharmacists as a profession have actually performed very well in the peer-driven process which was set up to ensure that they are maintaining their knowledge and skills necessary for provision of patient care. Those few who have not met the standard, have been given the opportunity to participate in education with a goal of returning them to the standard set by their peers. It is difficult to find out that you don't meet the standards, but most pharmacists have recognized the opportunity they have been given to get the education they need to return to an acceptable level of practice.

It is an appropriate time to recognize all those pharmacists who participate in the quality assurance process. There are pharmacists from various parts of the province, from both rural and urban communities, and from various types of pharmacy practice who meet regularly to support the peer review. Some pharmacists write multiple choice questions and standardized patient cases that are common to their practices. Others review questions and cases with their peers, and still others set the standards which they would expect a pharmacist to perform on each multiple choice question and each standardized patient scenario. We also have a group of pharmacist assessors who attend the peer review weekends, and who have been trained to provide consistent and reliable assessments of their peers in the standardized patient scenarios. Thank you to each and every one of those pharmacists who have participated in the development of this program over the past ten years. You have each contributed to making our QA program for pharmacists in Ontario relevant to every day practice.

I want to acknowledge the more than 2000 pharmacists who have gone through the practice review, despite their anxiety and concerns, and the many who have become ambassadors for the process. I would also like to acknowledge the Council of the day who had the vision to support this rather ambitious project to develop a peer review, which would go beyond inspections of pharmacies, and would actually assess the knowledge and communication skills of individual pharmacists. We cannot rest on our laurels as the profession is growing and changing, but we can take a moment to reflect on how far we have come over the last ten years.

OCP COUNCIL REPORT

DECEMBER 2007

COUNCIL APPROVES BY-LAW AMENDMENTS RESPECTING ELECTORAL DISTRICT TERMS

In June 2007, a working group was struck to consider how electoral districts and processes would need to change to accommodate the two pharmacy technician seats on Council starting in 2010. The new Council composition comes into force upon proclamation of the new Pharmacy Act, 2009.

To transition from our current electoral boundaries, Council endorsed the decision that terms for those members elected in 2008 and 2009 be amended so that all terms expire in 2010, at which time, an election will be held in all newly defined districts. Accordingly, the following amendment was approved:

4.5 *Term of Office. The term of office of a person elected to Council is three (3) years, unless specified otherwise, provided no person shall be eligible for election as a Council member for more than nine (9) consecutive years.*

4.5.1 *The term of office of a person elected to Council in 2008 is two (2) years, and the term of office of a person elected to Council in 2009 is one (1) year.*

CHANGES PROPOSED TO ELECTORAL BOUNDARIES

As previously reported, in order to accommodate the new Council composition that will come into force upon proclamation of the new *Pharmacy Act*, the Working Group, through the Executive Committee, also made recommendations to Council respecting electoral boundaries. In order to maintain the required number of elected seats at seventeen, two of which will represent pharmacy technicians, Council considered and approved, in principle, a model which defines the electoral districts by postal codes as opposed to municipal or street addresses. Furthermore, to demonstrate this College's commitment to providing leadership to the profession, Council also approved in principle, that one seat on Council will be held by a pharmacist member at large who will be practicing in a way considered by peers as innovative, pioneering or outside the reach of traditional pharmacy. While details have yet to be considered and approved, these proposed changes will see 12 seats being held by pharmacists representing the province, one seat being held by a pharmacist member at large, two seats for hospital pharmacists and two for pharmacy technicians.

It is to be noted that all these changes have been approved in principle so as to allow the Working Group to proceed further with developing a detailed model for further discussion by Council at a later meeting, including specific criteria and application/nomination process details for the newly-created seat for the pharmacist member at large.

ONTARIO TO REJOIN NAPRA

Over the past year, there has been considerable discussion between representatives from NAPRA, the National Association of Pharmacy Regulatory Authorities, and this College as well as the Ordre des pharmaciens du Quebec about both Colleges rejoining NAPRA. Presentations were made to OCP Executive over the summer to discuss the proposed changes to the vision, funding and governance models

that NAPRA hoped would entice Ontario and Quebec to rejoin. In November, President Gdyczynski and Registrar Williams, as well as Ms. Lambert, Registrar, Ordre des pharmaciens du Quebec attended a visioning and strategic planning session of NAPRA where their governance model, size of the board, committee to board relationship, voting structure and funding issues were discussed. The result of this session was that NAPRA Council agreed to approve a consensus-based governance model, strongly supported by both Ontario and Quebec, similar to the one adopted by the Federation of Health Regulatory Colleges of Ontario. Council was satisfied that this model will focus on similarities rather than the differences, and will ensure that all NAPRA activities move forward on a consensus basis.

Council also supports the new funding structure which requires Alberta, British Columbia, Ontario and Quebec to pay annual fees of $75,000, a significant drop from the previous per capita levy of $26.57 when Ontario withdrew membership in 2001.

Council's unanimous support of this endeavour will ensure that once Quebec rejoins NAPRA, anticipated in early January, NAPRA will become a truly national pharmacy regulatory organization.

NATIONAL PHARMACY TECHNICIANS COMPETENCIES DOCUMENT ADOPTED

In November 2006, NAPRA initiated a process to establish national competencies for pharmacy technicians at entry to practice. NAPRA recognized the need for a national competency document that will serve as a foundation for national educational, accreditation and examination standards.

Recognizing the considerable work already completed by other pharmacy stakeholder organizations, NAPRA facilitated a workshop that included pharmacy technicians from each province, and representatives from provincial regulatory organizations such as the Pharmacy Examining Board of Canada, the Canadian Society of Hospital Pharmacists, Canadian Pharmacy Technician Educators Association, Association of Faculties of Pharmacies of Canada, Canadian Association of Pharmacy Technicians and Canadian Council for Accreditation of Pharmacy Programs. The resulting document was compared with the Ontario's Competency Profile for Pharmacy Technicians and Council was satisfied that overall, there was a high degree to consistency between the two documents, and accordingly, Council adopted the NAPRA *Professional Competencies for Canadian Pharmacy Technicians at Entry to Practice*.

Details or variations in the role that this College wishes to reflect will be accomplished when the standards of practice are finalized in spring 2008.

NOTICE TO PATIENTS UPDATED

Starting December 2007, the Ministry of Health and Long-Term Care began to provide more health care providers with access to the drug claims history of ODB recipients for the purpose of providing health care. In collaboration with the College, the Ministry has updated the Notice to Patients section (yellow poster) to include statements to reflect the potential disclosure of ODB drug information by the Ministry.

INTERPROFESSIONAL COLLABORATION

This College is committed to working collaboratively with the Ministry of Health and Long-Term Care and other health professions in order to provide the public of Ontario with high quality health care. This College's input continues to be sought by other Colleges as they review their scopes and to this end, the President as well as the Registrar and senior staff at the College regularly meet with stakeholders

to engage in discussions respecting interprofessional collaboration and to develop solutions where gaps in care exist.

STRATEGIC PLAN/GOVERNMENT RELATIONS

Progress continues towards meeting the goals and objectives set out in the Strategic Plan developed in March 2006. The five strategic directions are: (1) To maximize the role of the pharmacist and to optimize patient medication safety; (2) To promote the value of the profession to the following groups: Public, Government, Health Care Professionals, Members; (3) To regulate and integrate Pharmacy Technicians; (4) To continue to maintain and build effective relationships with key stakeholders; and (5) To continue to effectively meet core mandate of self-regulation, including exploring new approaches, in a fiscally responsible manner.

The Plan is monitored by the Executive Committee to ensure that Council objectives are met and College Council received an update respecting progress on each strategic direction, much of which occurred through the work done by either a College Committee or a Working Group.

With regard to the Strategic Direction #2, Council noted that the Daisy Consulting Group has continued to advance the College's expectations and their progress report respecting government relations activities that occurred from August 1, 2007 to November 15, 2007 was reviewed by Council.

COUNCIL MEETING DATES FOR 2008:
MARCH 27 & 28, 2008 (New date)
JUNE 16 & 17, 2008 AND
SEPTEMBER 15 & 16, 2008.

QUALITY assurance

10 Year Review

This year, 2007, marks the completion of the tenth year of the Quality Assurance Program. The following article shares statistics and successes of the Program.

Background

The Quality Assurance Program, mandated by the Regulated Health Professions Act, was implemented in 1997 to help ensure competency of practicing pharmacists and thereby protect the public. The Program consists of the Learning Portfolio, which every pharmacist is required to maintain, and the Practice Review. The Practice Review has two phases. The first phase, the Self Assessment Survey, is completed by all Part A pharmacists once every five years. The Self Assessment has been revised and will be available through the OCP Continuing Professional Development On-line Portal in the new year. The second phase, the Peer Review, involves bringing approximately 2 % of Part A pharmacists, randomly chosen, to the College to undergo a written assessment and an objective structured clinical exam (OSCE) involving standardized patients. (Figure 1)

Figure 1: Quality Assurance Program

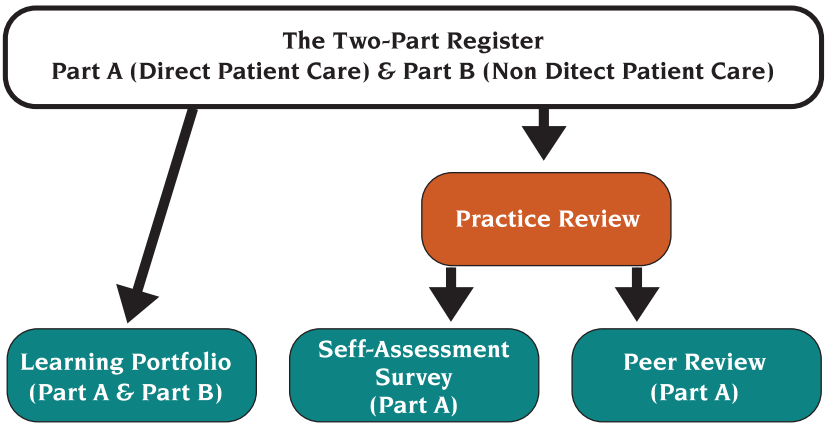
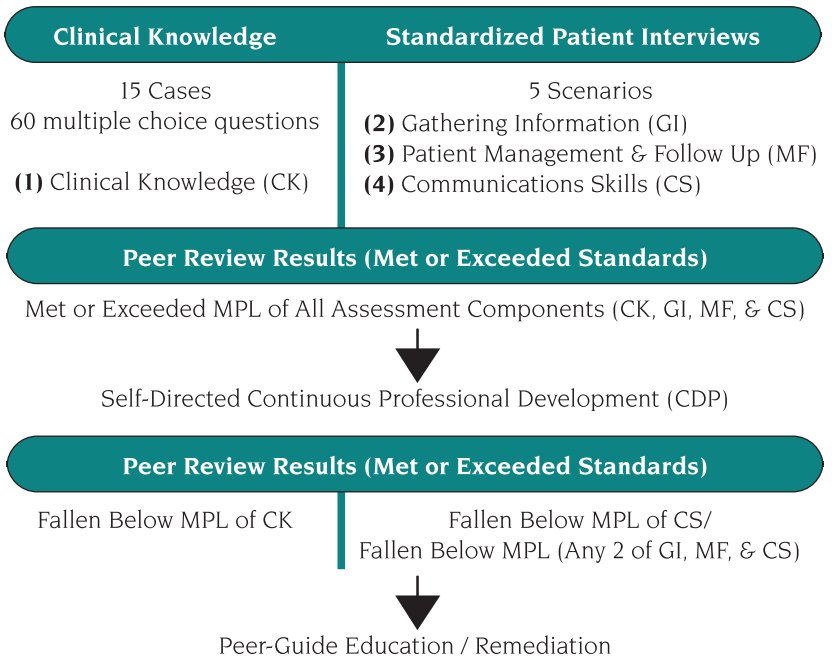


Figure 2: Peer Review Assessment Components & Results



The Peer Review

The Peer Review consists of the following components:

Clinical Knowledge Assessment – A multiple choice case based written exam. There are 15 cases and 60 questions.

Standardized Patient Interviews – In addition to one practice case, there are five Standardized Patient Interviews that are assessed by trained assessors.

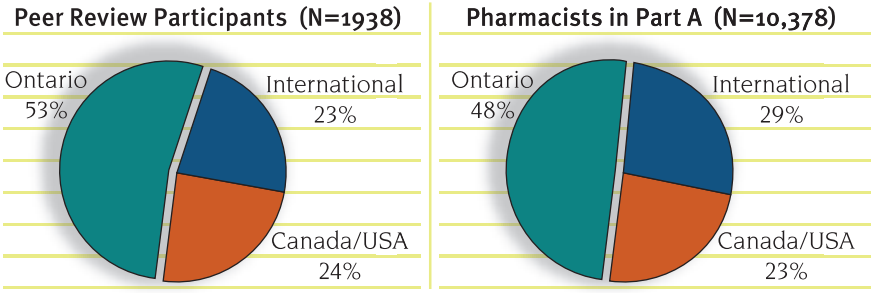
Learning Portfolio Sharing Session - In this facilitated session, pharmacists share their learning experiences and use of the Learning Portfolio.

Participants are assessed with respect to their skills in (Figure 2):

(1) Clinical Knowledge
(2) Gathering Information
(3) Patient Management and Follow-up
(4) Communication

The entire Peer Review Process is peer-driven; from the creation of the cases for the written assessment and the standardized patient interviews to the setting of standards and Minimum Performance Levels (MPLs). A cross-section of pharmacists from different practice settings, including community, hospital, urban and rural, and of varying age and background is used, thereby ensuring that the cases are relevant to practice and that the assessment is truly a peer review.

Figure 3: Place of Graduation

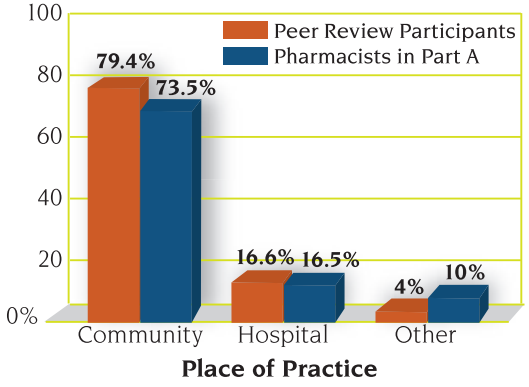


Peer Review Participants

As mentioned above, participants for the Peer Review are chosen through a computer generated randomization process from all pharmacists who are registered with the College and who are on Part A of the Register. Figure 3 compares pharmacists who have participated in the Peer Review over the last ten years to all the pharmacists in Part A of the Register by their place of graduation. From the graphs, it is apparent that the population chosen to undergo the Peer Review is reflective of the general population.

Figure 4 compares pharmacists who have participated in the Peer Review over the last ten years to all pharmacists in Part A of the Register by their place of practice. Again, the population chosen to undergo the Peer Review is reflective of the general population.

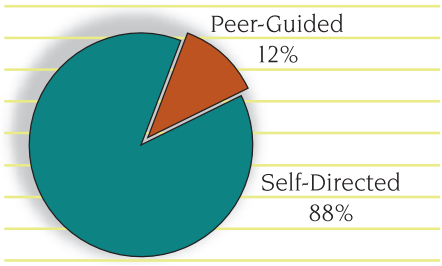
Figure 4: Place of Practice



Peer Review Results 1997 – 2007

Participants receive their performance reports in the four assessed components with the MPL to indicate whether they have met or fallen below the expected level of competency.

Figure 5: Peer Review Results 1997-2007 (N=2013)

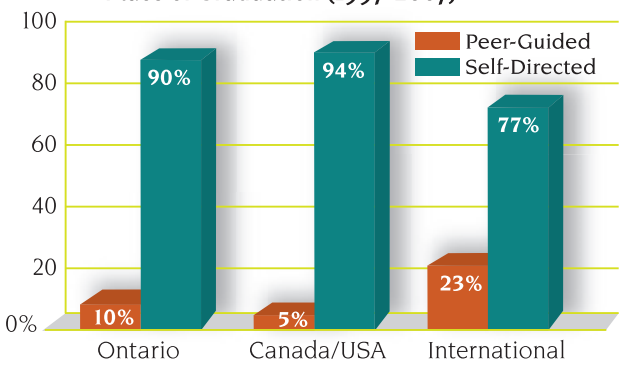


Results of the past ten years have been consistent. Twelve percent of the participants require peer-guided education or remediation to reacquaint themselves with the current standards of practice.

From a more detailed analysis of results, further information can be derived. As depicted in Figure 6, success in the Peer Review is related to the pharmacist's place of graduation. For international graduates, almost one quarter of pharmacists require peer-guided education. The likely explanation is that the roles and expectations of pharmacists in other countries may not be the same as roles and expectations in Canada.

In addition to pharmacists trained internationally, more mature pharmacists may also find the Peer Review challenging. As shown in Figure 7, over 25% of pharmacists who graduated more than 25 years ago required peer-guided education. Again, one possible explanation is that the expectations at the time of graduation for these pharmacists are quite different from the expectations of graduates today.

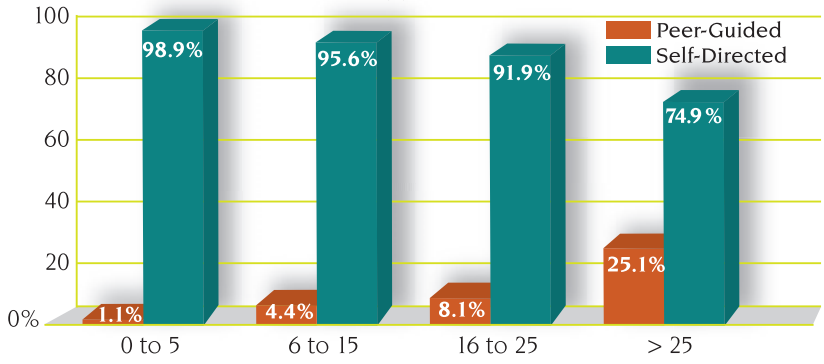
Figure 6: Peer Review Results Based on Place of Graduation (1997-2007)



Remediation

For those candidates that are not successful on their first attempt at the Peer Review, the College offers peer support, a remedial educational program (the Pharmacy Skills Professional Enhancement Workshop), and the College's Professional Development Advisor assists candidates in developing an education action plan. With this support, 70 % of pharmacists that require reassessment are successful in their first attempt at reassessment.

Figure 7: Peer Review Results Based on Years Since Graduation (1997-2007)



Conclusion

In the past 10 years, over 2000 pharmacists have been assessed through OCP's Peer Review process. Although pharmacists who were trained internationally or who graduated more than 25 years ago may require some additional remediation, overall the results of the Peer Review are positive, with only 12 % requiring peer guided education.

Continuous Professional Development (CPD)

What is Continuous Professional Development (CPD)?

CPD has been defined as "…post graduate professional education, involving a cycle by which individual practitioners assess their learning needs, create a personal learning plan, implement the plan, and evaluate the effectiveness of the education intervention as it applies to their pharmacy practice."[1]

Although CPD incorporates both traditional continuing education (CE) and workplace learning, the emphasis in CPD is on the approach or process rather than the individual learning activity.(see Figure 1) With traditional CE, the focus is on structured, organized educational programs. CPD differs from traditional CE because it emphasizes the practitioner's self-identified learning needs; it is linked to needs within the practitioner's practice and it focuses on outcomes.[2]

Figure 1 - CPD Learning Cycle

Why is CPD important?

As healthcare professionals, pharmacists are required to maintain competence throughout their careers. However, requirements and expectations for maintaining competence have varied by jurisdiction and over time. For example, in some areas, collection of continuing education units (CEUs) is required; whereas, other areas require demonstration of competence through performance-based assessment.[2]

In Ontario, the requirements have shifted from a system based on CEUs to one that emphasizes continuous professional development. In a CEU-centred system, the focus is on the number of credits earned with little emphasis on the practitioner's needs or the outcomes in the practitioner's practice. Research has shown that such passive, teacher-centred learning methodologies have limited impact on practice.[3,4]

In contrast, the CPD process focuses on outcomes in the practitioner's practice rather than number of hours devoted to learning activities. By having the practitioner self-identify learning needs that relate to his/her practice and by encouraging the practitioner to reflect on how new knowledge can be incorporated into practice, the CPD process makes learning meaningful and more likely to impact that practitioner's practice.

The CPD Process

The CPD self-directed learning cycle has five stages or steps.[2] (See figure 1)

Step 1: Self-Appraise

The initial step in CPD is reflecting on one's practice to identify learning needs. This is a crucial step in the process because learning will only be meaningful and impact practice

if it relates to the practitioner's learning needs. Learning needs can be divided into two categories: those required to maintain competency and those required to advance professionally.

Step 2: Plan
Once learning needs have been identified, a plan is created to help ensure that goals are achieved. In the plan, learning objectives are documented and resources or activities, that will help achieve these goals, are identified and, those most appropriate for the practitioner, are chosen. The final step is to set a target date to complete the objectives.

Step 3: Act
At this stage, the practitioner completes the learning outlined in the plan.

Step 4: Document
At this stage, educational activities are recorded. Sometimes the documentation activity is pictured in the centre of the learning cycle because all stages are recorded.

Step 5: Evaluate
Another critical step in the process is the final stage of evaluation. By reflecting on his / her learning, the practitioner is able to identify what was learned and how it can be incorporated into practice. Without this process, CPD is just traditional CE.

Some practitioners may currently be partially engaged in the above process. For example, some pharmacists might assess their current learning needs and seek out appropriate CE, but then fail to complete the final step of bringing the learning into practice. With the adoption of the CPD process described above, the practitioner uses a systematic approach which incorporates implementing practice change. This crucial process of bringing the CE to one's place of practice and using it, is how CPD impacts patient care and what makes CPD distinct from CE.

References:
1. Hanson AL. Fifth lifelong learning in pharmacy conference, Rhodes University, Grahamstown, South Africa. Pharm J. 2002;269:171-3.
2. Austin Z, Marini A, Glover N et al. Continuous professional development: a qualitative study of pharmacists' attitudes, behaviors, and preferences in Ontario, Canada. Am J Pharm Educ. 2005;69(1):25-33.
3. Margolis A, Alvarino F, Niski R et al. Continuing professional development of physicians in Uruguay: lesions from a countrywide experience. JCEHP 2007;27(2):82-5.
4. Driesen A, Verbeke K, Simoens S et al. International trends in lifelong learning for pharmacists. Am J Pharm Educ. 2007;71(3):Article 52:1-10.

Introducing the Continuous Professional Development (CPD) On-line Portal

As described in the previous article, the Continuous Professional Development (CPD) process differs from traditional continuing education (CE) because it focuses on pharmacists' self identified learning needs and by extension on outcomes for patients in practice. To support pharmacists in their CPD efforts, OCP is working with Claymore Inc. to create an On-line CPD Portal. The CPD Portal will house both the newly revised Self-Assessment Tool and the Learning Portfolio. The following screen shots will describe some aspects of the CPD Portal.

The home page will have an illustration of the CPD learning cycle (see Figure 1). By clicking on any component of the learning cycle, which correspond to the tabs found at the top of the screen, the user encounters a tool to assist with that stage of the learning cycle. For example, if the user clicked on Self-Appraise, he/she enters the Self-Assessment Tool.

Self-Appraise

The Self-Assessment tool will help the practitioner identify his/her learning needs, both those required to maintain competency and those required to advance professionally. The revised Self-Assessment Tool has four sections.

The first section focuses on Standards of Practice. In this section the practitioner rates himself against a series of statements which reflect the Standards of Practice. Once the Self-Assessment has been completed, the practitioner is able to see how he compares to the aggregate in his rating and he will have an indication if further learning is required in any of these areas. This information is then used to develop learning objectives and form the basis for the Education Action Plan.

The second section is a Clinical Knowledge Assessment. This section is included because clinical knowl-

Figure 1

edge is a core component of pharmacy practice. This is a heuristic tool – it is intended to provide the practitioner with a sense of their ability in dealing with a variety of clinical scenarios, rather than a definitive result on the practitioner's knowledge in a particular therapeutic area. Once the Self-Assessment has been completed, the practitioner is provided feedback on his responses, identifying where further learning would be useful. As above, this information is incorporated into the Education Action Plan in the form of learning objectives.

The third section focuses on the pharmacist's practice environment. By asking the practitioner to identify frequently asked questions, their patient population demographics, and common therapeutic issues and disease states encountered, the Self-Assessment helps identify areas that the practitioner may want to focus on to enhance competency and / or advance professionally.

Plan

In the final portion of the Self-Assessment Tool, the Education Action Plan, the practitioner uses the feedback from the other sections of the Self-Assessment Tool, to identify their learning needs. These needs are stated as specific learning objectives. The practitioner is also asked to identify learning resources and timelines. The Education Action Plan, provides the practitioner with a learning plan over a specified time period (usually a year).

Document

Once the Education Action Plan is in place, the practitioner engages in learning and records the educational activities in a Learning Portfolio. The CPD Portal incorporates the Learning Portfolio by providing an easy-to-use documentation system for completed learning activities. (see Figure 2) In the future, CE providers will likely be able to input data into the Learning Portfolio section of the CPD Portal for pharmacists that have participated in their CE programs.

Evaluate

The final step in the learning cycle is evaluation. In this critical step, the practitioner evaluates the CE that was completed, identifies whether the learning has been incorporated into practice, and identifies whether further CE in that area is needed / desired. This information is used in conjunction with the Self-Assessment Tool to develop the Education Action Plan for the following year. The CPD Portal assists with this process by providing a Review section, where the practitioner can easily review his / her plans and actions for previous years.

Figure 2

Part A versus Part B Where should you be?

Although the choice of Part A versus Part B of the Register is a simple one for most pharmacists, some pharmacists, because of their unique practice circumstances, find this decision more challenging. The following article provides some guiding principles to assist pharmacists in electing the appropriate part of the Register.

Two-Part Register – Background

Each year, on the annual fee form, pharmacists elect into one of the two parts of the Register, Part A or Part B.

Part A is the "direct patient care" part of the Register. Pharmacists who continue to elect into Part A are retrospectively declaring that they have worked a minimum of 600 hours in direct patient care over the past three years on each annual fee form. If a pharmacist is in Part B and wishes to move to Part A, he / she cannot do so by declaration. In this situation, the pharmacist must undergo the Quality Assurance Peer Review.

Part B is the "non-direct patient care" part of the Register. Pharmacists electing into Part B cannot work as a pharmacist in an Ontario pharmacy or perform any of the controlled acts that are associated with providing pharmacy services to the public. Part A pharmacists can move to Part B at anytime.

Considerations when Electing Part A or Part B

When deciding which part of the Register is appropriate, the following should be considered.

Are you practicing direct patient care?

The College considers that a pharmacist is providing "direct patient care" if they are providing pharmacy services directly to the public. This includes: dispensing, selling and/or compounding drugs; providing non-prescription drugs, health care aids and devices; providing information related to drug use; and directly supervising the part of a pharmacy where drugs are kept.

In addition, if you do any of the following activities, as a pharmacist you are expected to elect Part A:

- counsels or dialogues with patients or their agents about medications including nonprescription medications and health care aids
- provides information related to drug use, in the course of practicing the profession, directly to patients or their agents
- any compounding or dispensing function in which the pharmacist performs either cognitive or technical aspects, or both
- supervising the compounding or dispensing function as noted above
- directly supervising the part of a non-accredited pharmacy where drugs are kept
- any prescription or order review for individual patients, any patient profile review/clinical review for individual patients
- developing drug therapy protocols or policies directly related to drug therapy practices specific to the institutional setting in which the pharmacist practices.

Are you maintaining your therapeutic knowledge base?

Pharmacists in Part A of the register are expected to maintain their competency. This is accomplished both through continued direct patient care practice and through engaging in continuing professional development. For pharmacists practicing mostly in non-direct patient care, maintenance of the knowledge and skills required to practice safely in direct patient care is potentially more difficult. For this reason, the regulations, when defining a Part A pharmacist, indicate that a specified number of hours must be spent in direct patient care practice in addition to maintaining a learning portfolio.

Examples

Scenario 1: A hospital pharmacist is considering a position as a Director of Pharmacy. Because this position

does not have a clinical component, the pharmacist is wondering if she should switch to Part B status.

In this situation, the pharmacist in her new Director of Pharmacy position will have an integral role on the hospital's Pharmacy and Therapeutics Committee. Because she is developing drug therapy protocols and policies directly related to the drug therapy practices for the patients in her hospital, she should again elect part A of the Register.

Scenario 2: A pharmacist, who became a sales representative for a pharmaceutical company two years ago, is wondering if he can remain in Part A of the register. He previously worked full-time in a community setting.

As a sales representative, this pharmacist is not practicing direct patient care. However, he has only been in this position for two years. Theoretically, this pharmacist can opt for Part A of the register because over the past three years he completed 600 hours of direct patient care practice. In order to stay in Part A, he will have to decide if he would like to take on a part-time position to maintain his direct patient care hours.

Scenario 3: A licensed pharmacist decides to go to medical school. He works part-time at a pharmacy while in school. Once he becomes licensed as a physician and is working in a medical practice, he decides to give up his part-time pharmacist position. He is wondering if he can retain his Part A status.

It is important to note that election into Part A or Part B is self-declared. In other words, the College expects the pharmacist to assess his or her situation and using his/her professional judgement determine whether Part A or B is appropriate. In this case, if the physician, in his medical practice, feels he is providing direct patient care as defined above and feels he is maintaining his pharmacy knowledge and skills, the physician could opt for Part A. As for all other pharmacists in Part A, he will be required to participate in the Practice Review if randomly selected and he is required to maintain a learning portfolio.

If the physician decided to specialize in ophthalmology and felt that in his new practice he was not keeping up-to-date with his pharmacy knowledge and skills, he would be ethically obligated to opt into Part B of the Register.

HEALTHFORCEONTARIO'S ALLIED HEALTH PROFESSIONAL DEVELOPMENT FUND EXPANDED AND CONTINUED IN 2007-08

Pharmacists now eligible for funding!

This year, the Allied Health Professional Development Fund has been increased and the program expanded to include funding for professional development of Dietitians, Pharmacists and Respiratory Therapists. The Fund will continue to support skill and knowledge development opportunities for Medical Laboratory Technologists, Physiotherapists, Medical Radiation Technologists, Occupational Therapists, Speech-Language Pathologists, and Audiologists.

Guidelines and application forms are accessible both electronically through the fund's website at www.ahpdf.ca as well as through direct mail to all eligible potential applicants.

Until all the details have been finalized you are encouraged to keep documentation such as proof of payment and proof of successful completion of professional development activities that you have completed since April 1. 2007 or will be completing by March 31st, 2008.

For further information please contact the fund administrator by e-mail at: rstas@ahpdf.ca or lsawaya@ahpdf.ca or by phone at: 905-602-6015 / 1-866-992-6015.

HealthForceOntario is an innovative health human resources strategy designed to ensure the province has the right number and mix of appropriately educated health care providers when and where they are needed. The Allied Health Professional Development Fund is a program that provides financial support to allied health professionals to participate in professional development opportunities.

Coroner's Report on C. Difficile

The College gratefully acknowledges Linda Dresser, PharmD
Pharmacy Practitioner - Infectious Diseases North York General Hospital,
Assistant Professor, Leslie Dan Faculty of Pharmacy University of Toronto, for her review of this article

The Office of the Chief Coroner established an expert review committee to examine each of the 26 cases in Sault Ste. Marie in 2006 where C. *difficile* was suspect of contributing to the death. Of the cases reviewed, it was determined that C. *difficile* caused ten of the deaths and was a contributing factor in another eight.

The following three recommendations from the five made by this coroner's jury may be of interest to pharmacists:

1. All hospitals and health care facilities in Ontario are reminded to be familiar with the Ministry of Health and Long Term Care's "Best Practices Document for the Management of Clostridium difficile in all health care settings"
2. All health care practitioners are reminded of the importance of prescribing antibiotics only where clear indications exist and after careful consideration of the risk/benefit ratio.
3. All health professionals are reminded of the importance of educating patients about antibiotics and the potential risks of widespread usage.

What is Clostridium Difficile?

The following is an excerpt from *Ministry of Health and Long-Term Care - Best Practices document for the Management of Clostridium difficile in all health care settings - Nov. 2007 revision*

1. Background

Clostridium difficile is a Gram positive, spore forming anaerobic bacillus. It is widely distributed in the environment and colonizes up to 3-5% of adult humans without causing symptoms (Bouza 2005). Certain strains can produce two toxins: toxin A, which is mainly responsible for diarrhea, and toxin B, a cytotoxin detected by diagnostic testing.

C. *difficile* produces spores that are resistant to destruction by many environmental influences, including a number of chemicals. Spread of C. *difficile* occurs due to inadequate hand hygiene and environmental cleaning; therefore, proper control is achieved through consistent hand hygiene and thorough cleaning of the patient environment.

C. *difficile* has been a known cause of health care associated (nosocomial) diarrhea for about 30 years. Reported rates range from 1 to 10 cases per 1000 discharges and 17 to 60 cases per 100, 000 bed-days (Simor 2002). C. *difficile* can cause asymptomatic infections or may result in severe, life-threatening disease. It can be acquired in both hospital and community settings.

Since 2000 there has been an increase in the rates of C. *difficile* in some health care settings (McDonald 2006). In some of these settings this has been associated with the appearance of an epidemic strain of C. *difficile*. Some characteristics of this strain include the presence of binary toxin, increased resistance to clindamycin and fluoroquinolones, and potential for increased adverse events. This strain has been associated with outbreaks in Europe,

the United States and Canada.

This increase in C. *difficile* associated disease (CDAD) has resulted in significant additional costs to the health care system. A recent study in U.S. hospitals estimated that each case of CDAD in a hospital was associated with $3699.00 (USD) in excess health care costs and 3.6 extra days of hospitalization (McDonald 2006).

2. Risk Factors for C. *difficile*

Certain people are at increased risk for acquiring CDAD. These risk factors include:

- A history of antibiotic usage
- Bowel surgery
- Chemotherapy
- Prolonged hospitalization

Additional risk factors that predispose some people to develop more severe disease include:

- Increased age
- Serious underlying illness or debilitation

What Can Pharmacists Do?

The "Best Practices Document for the Management of Clostridium difficile in all health care settings" has just been revised by the Provincial Infectious Diseases Advisory Committee and can be found at www.health.gov.on.ca Hospital pharmacists should be familiar with this document.

There is a role for pharmacists in both hospital and community settings to ensure that patients who are discharged from hospital on antibiotics get the information they require regarding antibiotic-associated diarrhea, as these patients are at higher risk for developing CDAD. Patients in the community are also at risk of developing CDAD and this is an emerging concern. It is imperative that all patients who receive a prescription for an antibiotic be counselled appropriately about what to do if they develop diarrhea and when they should seek medical attention. The onset of CDAD can be after a single dose or as much as 60 days after exposure to the antibiotic so a thorough medication history is very important. Patients in the community also need information on the proper cleaning of household materials as well as proper hand washing.

Although CDAD is not a reportable infection in Ontario, public health units and local health care institutions will want to be informed of any community-associated CDAD activity. Pharmacists may be the first-line group to identify a C. *difficile* problem in a community.

A copy of a patient information sheet on Clostridium Difficile from The Ottawa Hospital is printed here with permission as well as an information sheet on antibiotic-associated diarrhea. This provides a good template for patient counselling regarding CDAD and antibiotic-associated diarrhea. Pharmacists should also counsel patients to seek medical attention if the diarrhea is not resolving or is getting worse within a few days after they have been started on medication for CDAD.

In addition to the above counselling pharmacists can also continue to educate patients about the appropriate use of antibiotics and the potential risks of widespread usage. Even though this may seem like routine information to pharmacists, for each member of the public, the information is often being heard for the first time, and needs to be communicated clearly.

Most colds and flue are caused by a virus. Many people expect an antibiotic in these cases, which leads to overuse and antibiotic resistance. Pharmacists can provide recommendations for symptomatic treatment of these symptoms, and in the cases where antibiotics have been prescribed, the following are key messages.

- Take all of your antibiotic, even though you will probably feel better before its finished.
- Take your antibiotic on schedule.
- Don't use other people's antibiotics or share yours with others.
- Don't keep antibiotics for next time.

More information and patient education resources on the use of antibiotics can be found at http://www.antibiotics-org/

The Ottawa Hospital | L'Hôpital d'Ottawa

ANTIBIOTIC-ASSOCIATED DIARRHEA PATIENT INFORMATION

If you have received antibiotics while in hospital, or have been prescribed antibiotics that you are to take following discharge from hospital, please review this information sheet on antibiotic-associated diarrhea. If you have any questions, ask your nurse, doctor, or pharmacist.

Taking an antibiotic causes diarrhea in up to one third of people who need them. Most often, the diarrhea is mild. Sometimes, a more serious type of diarrhea associated with taking antibiotics is caused by the *Clostridium difficile* bacterium.

WHY CAN DIARRHEA OCCUR WITH ANTIBIOTICS?

Bacteria are normally present in your bowel. Diarrhea can occur because antibiotics kill some of the bacteria that usually live in your bowel. This upsets the normal balance. Harmful bacteria such as Clostridium difficile, if present in your bowel, can overgrow leading to diarrhea and other symptoms. The risk of Clostridium difficile is higher if you have been in the hospital.

WHAT ARE THE SYMPTOMS?

Diarrhea from antibiotics is usually mild, consisting of loose and/or frequent bowel movements.

Symptoms of Clostridium difficile may be more severe and may include:

- Watery diarrhea that may contain mucus and/or blood
- Abdominal pain or tenderness
- Loss of appetite
- Nausea
- Fever

WHAT SHOULD YOU DO IF YOU GET DIARRHEA?

If you are taking an antibiotic and have mild diarrhea, and it is not bothersome, continue to take the antibiotic as prescribed. The diarrhea should go away after the antibiotic is finished.

CALL YOUR DOCTOR IF you have any of the following symptoms:

- Diarrhea which is bothersome or severe, or which is bloody
- Abdominal pain
- Fever
- Diarrhea which continues after the antibiotic is finished
- Diarrhea which starts after you have finished taking the antibiotic(s).

Remind your doctor that you have recently been on antibiotics.

DO NOT take anti-diarrhea medications that you can buy without a prescription (example Imodium® or Kaopectate®) without first checking with your doctor. These may cause a more serious health condition.

HOW CAN YOU TAKE CARE OF YOURSELF?

- Follow your doctor's advice regarding rest, activity, medication and diet.
- Wash your hands frequently, especially after using the washroom.
- If your doctor prescribes a new antibiotic for your diarrhea, take all of the medicine as prescribed.
- Be sure that you drink plenty of fluids to keep hydrated.

The College acknowledges The Ottawa Hospital's contribution of the following patient information to the Ministry of Health and Long-Term Care - Best Practices document for the Management of Clostridium difficile in all health care settings - Nov. 2007 revision

CLOSTRIDIUM DIFFICILE PATIENT INFORMATION

What is Clostridium Difficile (C DIFF)?

C diff is one of the many germs (bacteria) that can be found in stool (a bowel movement).

What is C Diff Disease?

C diff disease occurs when antibiotics kill your good bowel bacteria and allow the C diff to grow. When C diff grows, it produces substances (toxins). These toxins can damage the bowel and may cause diarrhea. C diff disease is usually mild but sometimes can be severe. In severe cases, surgery may be needed and in extreme cases C diff may cause death. C diff is the most common cause of infectious diarrhea in hospital.

The main symptoms of C diff disease are:

- Watery diarrhea
- Fever
- Abdominal pain or tenderness

Who gets C Diff?

C diff disease usually occurs during or after the use of antibiotics. Old age, presence of other serious illnesses and poor overall health may increase the risk of severe disease.

How will your doctor know that you have C Diff?

If you have symptoms of C diff, your doctor will ask for a sample of your watery stool. The laboratory will test the stool to see if C diff toxins are present.

How is C Diff treated?

Treatment depends on how sick you are with the disease. People with mild symptoms may not need treatment. For more severe disease, an antibiotic is given.

How does C Diff spread?

When a person has C diff disease the germs in the stool can soil surfaces such as toilets, handles, bedpans, or commode chairs. When touching these items our hands can become soiled. If we then touch our mouth we can swallow the germ. Our soiled hands also can spread the germ to other surfaces.

How to prevent spread in the hospital?

If you have C diff diarrhea you will be moved to a private room until you are free from diarrhea for at least 2 days. Your activities outside the room will be restricted. Everyone who enters your room wears gown and gloves. Everyone MUST clean their hands when leaving your room.

Always wash your hands after using the bathroom. Cleaning hands is the most important way for everyone to prevent the spread of this germ. As well, a thorough cleaning of your room and equipment will be done to remove any germs.

What should I do at home?

Healthy people like your family and friends who are not taking antibiotics are at very low risk of getting C diff disease.

Hand care

Wash your hands for 15 seconds:

- After using the toilet or touching dirty surfaces
- Before eating or preparing meals.

Cleaning the house

Use either a household cleaner diluted according to the instructions or diluted household bleach:

- Wet the surface well and clean using good friction
- Allow the surface to air dry
- Pay special attention to areas that may be soiled with stool such as the toilet and sink. If you see stool remove first and then clean as described above.

Cleaning clothes/other fabric

Wash clothes/fabric separately if they are heavily soiled with stool:

- Rinse stool off,
- Clean in a hot water cycle with soap
- Dry items in the dryer if possible.

Cleaning dishes:

Regular cleaning, you can use the dishwasher or clean by hand with soap and water.

It is very important that you take all your medication as prescribed by your doctor. You should not use any drugs from the drugstore that will stop your diarrhea (e.g., Imodium®). If diarrhea persists or comes back, contact your doctor.

Pharmacists' Annual Fees Due March 10, 2008

Your pharmacists' fee of $564.81 ($537.91 + $26.90 GST) is due no later than March 10, 2008. You may complete your renewal and pay your fee online at any time. Renewal forms will be mailed to you in mid-January; please contact Client Services at the College if you have not received your form by January 31.

Renewing and Paying On-Line via OCP Online Services

Payment by Credit Card or INTERAC can be made online in a secure environment digitally protected by Moneris ™. You can also update your personal and practice information online including adding the details of your personal professional liability insurance.

Pharmacists who pay their fees online, make any necessary changes to their personal and practice information and provide details of their personal professional liability insurance online, will not be required to sign or return the renewal form to the College. Your online payment is equivalent to your confirmation signature. As always, your payment must be received by March 10.

MEMBER LOGIN can be found at www.ocpinfo.com. Simply click on the *Member Login* link at the left and follow the instructions. (We recommend that you access the service with Internet Explorer 5.0 or higher.)

User ID: This is your OCP number
Password: The first time you login and until you change it, your password is the last six digits of your social insurance number. After your initial log in, we encourage you to change your password.

Paying by Mail with a Cheque

Make sure your cheque is signed and made payable to the "Ontario College of Pharmacists" or "OCP" for the amount of $564.81. Please write your OCP number and Invoice number on the front of your cheque. NSF cheques are treated as late and incur both a late penalty fee and a $20 NSF service charge. All unsigned cheques will be returned for signature.

Once processed, your wallet card and income tax receipt will be mailed to your residence.

Late Payments

Late payments are subject to a late fee of $105 ($100 + $5 GST) (if paid within 30 days after the due date) or $157.50 (if paid more than 30 days after the due date). This includes cheques that are received early but post-dated after March 10, 2008. Late payments are not processed until the late payment fee has been received.

Member Emeritus

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

What's New For This Year's Renewal?

Language Preference:

In order to better understand the demographics of our members, the College has added a new field to the renewal process to capture the language preference (English or French) of each College member.

Personal Professional Liability Insurance required as of January 1, 2008

By now every member should be aware of the College's new requirement to maintain personal professional liability insurance, with specific coverage criteria, effective January 1, 2008. This requirement applies to all pharmacists in Part A and interns seeking registration and registration renewal. The College has pre-qualified seven different brokers/insurance products as having met the criteria prescribed in the by-law. Members who have purchased one of the pre-qualified products needn't be concerned about compliance during renewal time. Members who have insurance through other carriers are reminded that it is their responsibility to ensure that his/her insurance is compliant. This new section of by-law, along with a list of qualified providers can be viewed on the College's website www.ocpinfo.com

As part of the 2008 annual membership renewal, all members will be asked to provide evidence of insurance, noting specifically:

- **Insurance Company**
- **Insurance Broker**
- **Policy/Certificate number**
- **Term of Insurance – Start date and End date**

We have expanded our online services so that members can log in and update/verify their insurance details at any time.

Members who have purchased insurance through one of the pre-qualified providers do not need to send a copy of their insurance certificate to the college with the renewal form, unless specifically requested to do so. The information submitted by members will be cross referenced against lists that insurance companies will provide to the College. If you indicate a policy expiry mid-year, after annual fee renewal, you will be required to confirm that you continue to maintain insurance upon expiry. To facilitate this confirmation, please ensure the email address recorded with the College is current so we can automatically notify you by email. This notification will remind you to update your insurance information online or to provide updated policy information directly to the College.

Members who have insurance through carriers that have not been pre-qualified by the College will need to provide a copy of their policy to the College at the time of renewal so that compliance with the by-law can be confirmed. If you do not have coverage or your coverage is not in compliance, you may be required to suspend practicing until such time as you can secure compliant coverage.

If your personal professional liability insurance was purchased prior to September 30, 2007 you can rely on that coverage to meet the College's requirements until the policy expires, or September 30, 2008, whichever comes first.

For further information contact Client Services by emailing ocpclientservices@ocpinfo.com

REGISTRATION Q&A

Chris Schillemore, R.Ph., B.Sc.Phm. M.Ed.
Manager, Registration Programs

Q I am an internationally educated pharmacist who was licensed in Ontario several years ago. I went off the register to pursue another career and I recently got licensed again in another province. What do I need to do to get licensed in Ontario? Why can't I come to Ontario via the Mutual Recognition Agreement?

The Mutual Recognition Agreement (MRA) allows anyone who is licensed in a signatory province on or before July 1, 2001 to come into an equivalent part of the register of another province by successfully completing that province's jurisprudence requirement. If you are licensed in a province after July 1, 2001 the College's Registration Committee can look at what requirements you completed to enter practice. Each province may have different requirements for pharmacists re-entering practice, For example, another province may require completion of the OSCE and 500 hours of training. In Ontario, the College's Registration Committee will look at each case individually and determine what additional training and/or examinations are required, depending on factors such as how long the person has been out of practice. If you are an international pharmacy graduate coming from another province, you can provide any additional information you think would be helpful for the Registration Committee to consider, such as how long you practised as a pharmacist in that province.

Q I am an internationally educated pharmacist licensed in another province and I don't understand why I must do another language proficiency test to register in Ontario. Could you please clarify this requirement for me?

The Mutual Recognition Agreement states that a candidate must have "attained the language requirements at a level consistent with the 'Language Fluency Requirements for Licensure as a Pharmacist in Canada.'" This document was written by the National Association of Pharmacy Regulatory Authorities (NAPRA) and these are the language proficiency requirements Ontario has adopted. While the provinces which signed the MRA agreed with these requirements, some provinces had slightly different language requirements and had to make legislative changes before enacting the NAPRA standards. If someone comes from another province and has not met all the language proficiency requirements, a panel of the Registration Committee may require him or her to provide evidence of language proficiency through one of the objective tests. For more information on Ontario's language proficiency requirements, you can go to the OCP website: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Language+Proficiency.

Q I am a pharmacist registered in the province of Quebec. Is there any labour mobility agreement with Ontario?

Quebec and Ontario signed a Memorandum of Understanding (MOU) on May 7, 2003 in Montreal. This agreement recognizes the structured practical training undertaken by pharmacists who have graduated from a program accredited by the Canadian Council for the Accreditation of Pharmacy Programs (CCAPP) with a minimum of 125 credits within the last five years. If you have not graduated from a CCAPP-accredited program, you need to make a request to a panel of the Registration Committee so that it can determine what requirements you must meet. While Quebec does not require the PEBC Qualifying Exam for licensure, Ontario does. You can go to the OCP website to view the Memorandum of Understanding.

OCP Pharmacy Technician Certification Exam

The next sitting of the Certification Exam is:

Saturday, April 5, 2008

Due to the large volume of applications received at the College for evaluation of pharmacy technician credentials and the amount of time involved in setting up individual files/records for all those applying for the upcoming sittings of the examination, the following dates will be strictly adhered to:

a) Application to Evaluate Pharmacy Technician Credentials, with the applicable documentation and evaluation fee, must be received by OCP no later than January 5, 2008.

Please refer to the Pharmacy Technician Registration Application Information for details and application form.

b) Application to Write the Pharmacy Technician Certification Exam together with the 2008 exam fee of $371.00 must be received by OCP no later than February 15, 2008. This package is mailed out by OCP staff only to those technicians who have been deemed eligible to sit the examination as a result of the submission and approval of the Application to Evaluate Pharmacy Technician Credentials as per item a) above.

Final Exam Date - October 25, 2008

Stay Informed!

If you'd like to receive e-mail notifications about new developments in the regulation of pharmacy technicians, please visit the college's website, www.ocpinfo.com, and click on the green "Pharmacy Technicians" button on the left menu. Once the page opens see "Stay Informed!" and click to submit your name and email address.

In the November issue of this publication, **Anjala Bhalla** contributed the article "Optimal Care of Patients", outlining her perspective as a summer student working at the College last summer.

We sincerely regret the omission of her name as author.


Optimal Care of Patients

The Institute for Safe Medication Practices Canada (ISMP Canada) is an independent national nonprofit agency established for the collection and analysis of medication error reports and the development of recommendations for the enhancement of patient safety.

The Healthcare Insurance Reciprocal of Canada (HIROC) is a member-owned expert provider of professional and general liability coverage and risk management support.

Volume 7, Issue 5 **ISMP Canada Safety Bulletin** November 13, 2007

Fentanyl Patch Linked to Another Death in Canada

Incidents associated with fentanyl patches have previously been described by both the Institute for Safe Medication Practices Canada (ISMP Canada) and its US counterpart (ISMP). In August 2006, ISMP Canada highlighted the deaths of two Canadian adolescents, reviewed the voluntary reports that had been received to date, and made recommendations for preventing similar incidents.[1] ISMP (US) recently reported that fentanyl patches continue to be inappropriately prescribed, dispensed, and administered to opioid-naïve patients with acute pain.[2] Advisories and warnings about the use of fentanyl patches have been issued by Health Canada [3,4,5] the US Food and Drug Administration,[6] and manufacturers[7]. In addition, according to a recent news report, the Office of the Chief Coroner for Ontario is reviewing several deaths involving fentanyl patches.[8] Use of transdermal fentanyl can be an effective option for the treatment of chronic pain; however, its use also continues to pose problems for health care providers and their patients.

The following case was recently reported to ISMP Canada and is shared to provide an additional alert:

> An adult patient with a history of chronic obstructive pulmonary disease (COPD) presented to an emergency department for management of severe back and leg pain. The patient had been receiving acetaminophen with codeine on an as-needed basis (to a maximum of 480 mg codeine per day) and had received a prescription for oral hydromorphone 2-4 mg every four hours as needed the day before from the family physician. In the emergency department, the patient was treated with intravenous ketorolac with effect, and a fentanyl patch was applied. The patient was also instructed to continue taking the previously prescribed pain medications as needed. Three days later, the patient was experiencing severe pain and returned to the family physician, who increased the fentanyl patch dose from 75 mcg/hour to 125 mcg/hour. The prescription for the new patch also included instructions for the patient to continue taking the oral hydromorphone as needed for pain. The patient returned to see the family physician the next day, reporting that the pain had improved. That evening, the patient appeared confused. The following morning, the patient was found unresponsive. Although emergency services were called, resuscitation measures were unsuccessful and the patient died.

ISMP Canada did not receive all the necessary information required for an in-depth root cause analysis[9] but the following factors were identified as *possibly* contributing to this sentinel event:

- significant increase of opioid dose within a short time frame;
- complexity of titrating fentanyl patch doses;
- lack of awareness on the part of the patient and family members about the potential side effects of opioid use that would require immediate medical attention; and
- the presence of underlying COPD.

Recommendations

In addition to the recommendations made in a previous bulletin on this topic,[1] the following measures are recommended to reduce the risk of medication incidents associated with fentanyl patch therapy.

1. Prescribing and Administration of Fentanyl Patches

- Ensure that the complete medical history and full medication history are available to verify that all criteria for initiating and continuing fentanyl patch therapy are met.
- Consider the value of adjunctive treatment (e.g., a nonsteroidal anti-inflammatory agent) to decrease the opioid dose requirement.
- Ensure the patient is sufficiently opioid-tolerant for the fentanyl patch dose prescribed (e.g., for a 25 mcg/hour fentanyl patch, patients should be receiving the equivalent of at least 60 mg oral morphine per day, and have been taking the opioid around-the-clock for an extended period of time.[10] Refer to the product monograph for additional information).
- Ensure that the patient and family members understand how the product is to be used, are aware of the signs and symptoms of opioid overdose and know to remove the patch and seek immediate medical attention should signs of overdose occur. (The Duragesic® monograph identifies a number of key issues to be reviewed with patients and provides a consumer information sheet.[10])
- When possible, ask family members who are with the patient at various times of the day and night if the patient is unknowingly experiencing any dangerous side effects.

2. Dispensing of Fentanyl Patches

- Ensure that each patient's medication profile is reviewed in full by a pharmacist whenever a new prescription or dose change for fentanyl patch therapy is received.
- Consider implementing computerized alerts in pharmacy information systems for scenarios that may require extra attention (e.g., dosage increase of a fentanyl patch that is greater than 25 mcg/hour or a dose increase prescribed in less than 6 days).
- For outpatients, provide and review written information with the patient (and family) whenever a new fentanyl patch dose is dispensed to ensure that information (e.g., signs and symptoms of overdose) is not overlooked.

3. Manufacturers of Fentanyl Patches

- The following considerations for product monographs for the fentanyl patch are recommended:
  - Include information that will assist practitioners to assess opioid tolerance. Such information is currently lacking in the product monographs for all brands of fentanyl patches.
  - Include in the product monograph a checklist or algorithm for initiation and titration of the fentanyl patch.

ISMP Canada gratefully acknowledges the expert review of this bulletin provided by (in alphabetical order):
Patti Cornish, RPh, BScPhm, Patient Safety Service, Sunnybrook Health Sciences Centre;
John Iazzetta, Pharm.D., Drug Information Service, Department of Pharmacy, Sunnybrook Health Sciences Centre;
Meldon Kahan, MD, CCFP, FRCPC, Medical Director of Addiction Medicine Service, St. Joseph's Health Centre Toronto and staff physician at Centre for Addiction and Mental Health;
Jeff Myers, MD, CCFP, MSEd, Assistant Professor, Division of Palliative Care, Department of Family and Community Medicine; Head, Palliative Care, Sunnybrook Health Sciences Centre;
Dan Perri, BScPhm, MD, FRCPC, Divisions of Clinical Pharmacology and Therapeutics, and Critical Care Medicine, Department of Medicine, McMaster University and Graduate Department of Pharmaceutical Sciences, Leslie Dan Faculty of Pharmacy, University of Toronto;
John Senders, PhD, Professor Emeritus, Faculty of Applied Sciences, University of Toronto; and
Homer Yang, MD CCFP FRCPC, Professor Chair and Chief Anesthesiology, University of Ottawa and The Ottawa Hospital.

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EXPANDED ROLE FOR PHARMACISTS IN

Ontario's Colorectal Can

Ontario pharmacists will soon be given an opportunity to play a key role in a program designed to detect the disease early enough to save lives.

Ontario has one of the highest rates of colorectal cancer in the world. This year, it is estimated that 7,800 people in the province will be diagnosed with the disease, and 3,250 will die from it. Colorectal cancer is the second deadliest form of cancer and yet it is very curable if detected early. Ontario pharmacists will soon be given an opportunity to play a key role in a program designed to detect the disease early enough to save lives.

The Ontario Ministry of Health and Long-Term Care, in collaboration with Cancer Care Ontario (CCO), is implementing a province-wide screening program aimed at reducing mortality from colorectal cancer by increasing early detection. The program, the first of its kind in North America, targets men and women, 50 years of age and older.

For the vast majority of people, about 75 per cent, the diagnosis of colorectal cancer is 'out of the blue', says Dr. Linda Rabeneck, medical director of Ontario's Colorectal Cancer Screening Program, regional vice president of CCO, and chief, Odette Cancer Centre, Sunnybrook Health Sciences Centre, Toronto. "Family history is a factor associated with colorectal cancer but that accounts for only 15 to 20 per cent of those diagnosed. There is a real lack of dependable predictors in most cases, so consequently early-detection screening is really the best option for combating this disease."

In Ontario today, only one out of five people 50 years and older is screened for colorectal cancer using any method, says Rabeneck. Considering the fact that Ontario has one of the highest rates of colorectal cancer in the world, the need for a screening program is very clear. "Although all the evidence points to a bullet-proof case for screening, it's just not happening and screening rates are appallingly low," says Rabeneck. "This program's fundamental goal is to increase the screening of eligible people."

The Ontario program recommends a simple fecal occult blood test (FOBT) for those at average risk for colorectal cancer. For those with a positive FOBT, colonoscopy is advised. Colonoscopy is also advised for those at increased risk because of a family history of one or more first-degree relatives (parent, sibling or child) who have been diagnosed with the disease. There is significant evidence from landmark randomized controlled trials to support this approach. These trials showed that FOBT screening every two years, followed by colonoscopy for those who have a positive FOBT, reduces death from colorectal cancer by an average of 16 per cent over 10 years of screening.

Pharmacists and Pharmacies:

Beginning in April 2008, community pharmacists and pharmacies will play an important role in supporting Ontario's colorectal cancer screening program. Through pharmacists and pharmacies, average risk patients, age 50 years and over, who do not have a primary care physician – so-called "unattached patients" will have access to the screening program and can receive an FOBT kit.

Pharmacists will be asked to screen patients for eligibility and provide education or instructions on the use of the kit. Unattached patients will receive their test results from the program and the program will facilitate referral to colonoscopy for those with a positive test result. Unattached patients at increased risk will be directed to the program which will facilitate referral to a colonoscopy.

"This is an extremely important initiative," said Carlo DeAngelis, Oncology Pharmacy Coordinator at Sunnybrook Hospital and owner of a community pharmacy. "Pharmacists are always looking for opportunities to get more involved in the health of their patients, and this program

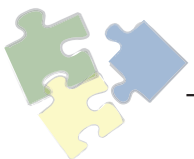
cer Screening Program

gives them a great chance to do exactly that."

Pharmacies and pharmacists will receive more information on colorectal cancer screening through the health care professional awareness and support campaign underway to ensure that health care providers have a strong knowledge foundation in place before a public education campaign is initiated. This fall and winter, information kits, regional information forums, patient counselling materials, clinical references, journal articles, and a multifaceted Continuing Education program are being rolled out in partnership with the Ontario College of Family Physicians, the Ontario Pharmacists' Association, the Ontario Medical Association, and the Nurse Practitioners' Association of Ontario. Prior to the program launch in April, pharmacists will also be receiving tip and fact sheets, FAQs, and other tools to ensure they are able to fully take part in the program.

Colorectal Cancer Screening Program:
Other key features of the program include increased funding for screening colonoscopies – in May 2007, the Ontario government allocated $11 million to 54 hospitals, allowing approximately 34,000 more Ontarians to have access to colonoscopies during 2007/2008. There are also new quality standards for colonoscopy; there will be broad distribution of FOBT kits in 2008 through family physicians, pharmacists and Telehealth Ontario; and monitoring and evaluation will be supported by a new information management system.

For more information about Ontario's new Colorectal Cancer Screening Program, go to www.cancercare.on.ca or by email at colorectalcancerscreening@cancercare.on.ca or contact 1-866-662-9233.



Stay Informed!

If you'd like to receive e-mail notifications about new developments in the regulation of pharmacy technicians, please visit the college's website, www.ocpinfo.com, and click on the green "Pharmacy Technicians" button on the left menu. Once the page opens see "Stay Informed!" and click to submit your name and email address.

HEALTH CANADA *Advisories & Notices*

DATE	TYPE
23 Oct 2007	RE: COLLEAGUE Triple Channel Mono, CX and CXE VOLUMETRIC INFUSION PUMPS. PRODUCT CODES: 2M8153, 2M8163, 2M9163, DNM 8153, and DNM9163 Baxter has recently received six (6) reports from 3 customers in Canada that COLLEAGUE triple channel infusion pumps stopped infusing during specific use conditions.
25 Oct 2007	Foreign Product Alert – Xie Gan Wan Xie Gan Wan is a Proprietary Chinese Medicine with unknown indication for use.
25 Oct 2007	Foreign Product Alert – Red Yeast Rice, Red Yeast Rice/Policosonal Complex and Cholestrix Red Yeast Rice, Red Yeast Rice/Policosonal Complex and Cholestrix are promoted as dietary supplements for the treatment of high cholesterol.
1 Nov 2007	Important Safety Information on rosiglitazone (AVANDIA, AVANDAMET and AVANDARYL) GlaxoSmithKline Inc., in consultation with Health Canada, would like to inform you of important new restrictions on the treatment of type 2 diabetes mellitus with the rosiglitazone-containing products: AVANDIA® (rosiglitazone), AVANDAMET® (rosiglitazone and metformin), and AVANDARYLTM (rosiglitazone and glimepiride).
5 Nov 2007	Manufacturer temporarily suspends marketing of Trasylol in Canada At the request of Health Canada, the manufacturer Bayer Inc. has temporarily suspended marketing of the drug Trasylol (aprotinin), pending a review of preliminary results from a clinical trial (the BART study) that suggested an increased risk of death. Bayer Inc. will work with Health Canada so that the drug can be made available to certain patients in cases where the doctor believes the potential benefit clearly outweighs the risk.
15 Nov 2007	Foreign Product Alert - Steripaste Medicated Paste Bandages, batch numbers: 07085930 / 07085932 / 07085673 Medlock Medical Ltd in the U.K. is recalling Steripaste Medicated Paste Bandages, batch numbers 07085930, 07085932 and 07085673 due to failed pouch seals which pose a risk of microbial contamination.
15 Nov 2007	Foreign Product Alert - Royal Medic No.1 Chinese Caterpillar Fungus (lot numbers RM 630021, RM 630023 and RM 6300026) The Hong Kong Department of Health (HKDH) advised the public not to purchase or consume three batches of the proprietary Chinese medicine, Royal Medic No.1 Chinese Caterpillar Fungus (lot numbers RM 630021, RM 630023 and RM 6300026) due to microbial contamination.
26 Nov 2007	Health Canada Endorsed Important Safety Information on rosiglitazone (AVANDIA, AVANDAMET and AVANDARYL) GlaxoSmithKline Inc., in consultation with Health Canada, would like to inform you of important new restrictions on the treatment of type 2 diabetes mellitus with the rosiglitazone-containing products: AVANDIA® (rosiglitazone), AVANDAMET® (rosiglitazone and metformin), and AVANDARYLTM (rosiglitazone and glimepiride).
26 Nov 2007	Health Canada Endorsed Important Safety Information on Trasylol [aprotinin] Bayer Inc. (Bayer) would like to update you on important information concerning the availability of Trasylol® (aprotinin). Trasylol® is indicated for prophylactic use to reduce perioperative blood loss and the need for blood transfusion in those patients undergoing cardiopulmonary bypass in the course of coronary artery bypass graft (CABG) surgery who are at increased risk for blood loss and blood transfusion requirement.
28 Nov 2007	Important Safety Information on Axcil and Desirin. Axcil and Desirin are promoted as sexual enhancement products and have been found to contain sildenafil. Sildenafil is a prescription drug used for the treatment of erectile dysfunction, and should only be taken under the guidance of a health professional.

For complete information & electronic mailing of the Health Canada Advisories/Warnings/Notices subscribe online at: http://www.hc-sc.gc.ca/dhp-mps/medeff/index e.html

MedEffect e-Notice is the new name which replaces Health Canada's Health Prod Info mailing list. The content of the e-notices you receive will remain the same and are now part of MedEffect, a new Health Canada Web site dedicated to adverse reaction information. MedEffect can be visited at www.hc-sc.gc.ca/dhp-mps/medeff/index e.html

Health Canada Notices are also linked under "Notices" on the OCP website: www.ocpinfo.com

Past Presidents' Reunion Dinner

On September 15, 2007, past presidents and registrars of the Ontario College of Pharmacists joined President Gerry Cook and Registrar Deanna Williams for a reunion dinner. The evening, organized by the College every 3-5 years presents the opportunity to renew friendships and for each Past President to share the unique challenges and accomplishments during his or her term of office. A lovely evening was had by all.

Back row, left to right: B. Phillips, G. Cook, D. Malian, S. Hirsh, P. Hudson, R. Elliott, B. Mann, D. McInness. Middle row: D. Fatum, N. Truong, M. Belitz, L. Boggio, B. Lewis, J. Monaghan, D. Croteau. Front row: B. Wensley, D. Williams, M. Monaghan, I. Krawchenko, L. Braden, S. McKinney, J. Dunsdon

PRACTICE ADVISORY

Greg Ujiye, R.Ph., B.Sc.Phm.
Professional Practice Advisor

Many members tell us how much they look forward to the Practice Q&A section of the Pharmacy Connection. This section, like the other Q&A sections of the Pharmacy Connection, is an integral part of the various program areas of the College.

Most of the Q&As are published as a result of calls to the Practice Advisory staff. To offer members a clear understanding of the Practice Advisory Department, in this issue we are foregoing the usual Q&A feature and instead will outline the role and function of the Practice Advisory function of the College; to help you to maximize and utilize the department more efficiently.

Practice Advisory Department

The Practice Advisory is one the many services offered for members and operates within the Professional Practice area of the College. Its purpose is to help pharmacists assess situations and provide recommendations on general practice issues by clarifying legislation, policies and guidelines. In general, the department covers professional practice, both legislative and regulatory as well as pharmacy operational topics.

The Practice Advisory has many responsibilities at the College regarding professional practice and pharmacy operations:

- Provides a resource for members by clarifying legislation, regulatory and ethical matters encountered in practice by responding to phone or e-mail questions
- Responds to general inquiries from external stakeholders and the public on legislative. regulatory matters and standards of practice of the profession
- Supports the activities of various committees regarding practice, standards, policies and guidelines
- Supports the inspectors and inspection process
- Monitors emerging practices
- Provides as well as review specific articles for the Pharmacy Connection
- Participates in external stakeholder meetings

In addition to the above responsibilities, staff normally receive approximately 30 calls a day, with an additional 5-10 queries sent by e-mail. However, the number of calls can rise to 50 per day depending on the current issues.

Understanding the Role of the Department

Many members believe that advisory staff have the ability to make decisions, approve a particular practice, or speak on behalf of the College. This is not the case. The role of staff is to provide advice, guidance and clarification. All answers are limited to the information provided at that time, rather than on theoretical situations and assumptions.

The Practice Advisory does not operate as an emergency call centre and should not be treated as such. Members frequently call with urgent situations, requesting immediate attention. Although staff attempt to answer and return calls the same day, members calling Practice

Advisory should be aware that an immediate response is often not possible, as many questions require consideration and research before a complete and accurate response can be provided.

The Practice Advisory exists to assist pharmacists with meeting the Standards of Practice and to respond to general practice questions. Members are expected to use their knowledge, experience and professional judgement in dealing with the various day to day situations that may arise.

The Practice Advisory *cannot* and *does not* provide legal advice or legal opinions. The department cannot tell a member what course of action to take, or make any decisions for a member. The advisory department can only *assist members with the interpretation* of any legislative, regulatory or ethical issues, and the options and risks involved in taking various courses of action.

Information provided by a caller remains confidential and will not be shared or used by other programs/departments of the College except in the following situations:

- where action is taken against the College in relation to the information/consultation provided,
- where the College has a legal obligation to release the information (e.g. discovery purposes at Discipline),
- where it is necessary in the interest of public safety (duty to warn)
- where the caller has requested and therefore consented to the release

Time Saving Practice Support Tips :

1. Learn to navigate the College Website www.ocpinfo.com and the "Search" function
2. Utilize the NAPRA website for drug scheduling questions
3. Keep informed and updated by reading Pharmacy Connection
4. Develop systems and procedures for communicating notices to all staff
5. Call the appropriate Regulated Health College for questions concerning their member practices as your College cannot answer questions or interpret scopes of practice for other health professionals.
6. If you do need to call the Practice Advisory, ensure you leave your name, phone, OCP registration number and a brief description of your question or reason for calling.

Many of your questions can be answered utilizing these tips. We encourage members to visit the new and improved OCP website; now more user-friendly and organized, to help you find what you're looking for quickly and easily!

Members have come to expect appropriate, professional responses in a timely manner. With your help we can continue to provide such service.

BUPRENORPHINE:

A New Treatment For Opioid Dependence

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Introduction

After much anticipation by health care providers providing addiction services in Canada, buprenorphine is now available for the treatment of opioid dependence. It is marketed as **Suboxone**® by Schering-Plough, Canada, in combination with naloxone in a sublingual tablet. This medication has been available for several years in many parts of the world, including the United States. Pharmacists in Ontario now have an opportunity play an important role in the management of Suboxone® treatment with other members of the treatment team.

Buprenorphine treatment provides an alternative to methadone maintenance treatment in Canada. Opioid maintenance therapy, whether with buprenorphine or methadone, has been shown to be far more effective than detoxification in improving health outcomes in those with severe dependence or long standing opioid abuse.[1] Research on opioid substitution therapy has been conducted primarily in heroin dependent individuals. Studies are currently underway in the US to determine buprenorphine's role in the treatment of prescription opioid abuse, which has become an issue of increasing concern relative to heroin use in Ontario.[2]

Over the last 5 years, some patients seeking treatment at the Centre for Addiction and Mental Health for opioid dependence have been treated with buprenorphine through the special access program. This article reflects the current evidence regarding buprenorphine treatment, as well as the authors' experience in working with these patients.

As with methadone treatment, patients prescribed buprenorphine should be carefully monitored within a framework of medical, social, and psychosocial support as part of a comprehensive opioid dependence treatment program.[3] Pharmacist involvement in buprenorphine treatment can include the supervision of drug administration, monitoring patients, communicating with the treatment team, providing encouragement and support, and dispensing take-home doses ('carries'). Involvement in the treatment of opioid dependent patients with buprenorphine has the potential for pharmacists to expand their scope of practice and provide a satisfying professional opportunity to participate in the recovery of individuals dependent on opioids. This area of practice may be of particular interest to those pharmacists currently involved in the provision of methadone maintenance treatment. Opioid dependence is a complex disorder; therefore pharmacists who take training specific to buprenorphine therapy and other treatment options will be well positioned to provide pharmacy services to these patients. With buprenorphine maintenance treatment, as with methadone maintenance treatment, patients benefit from physicians and pharmacists working together effectively to provide optimal treatment.

Key Messages for Buprenorphine

- Suboxone® is an opioid prescription medication containing buprenorphine 2 mg and 8 mg (in *sublingual* tablets) in fixed combination with naloxone 0.5 and 2 mg respectively (to deter injection drug use).

- Buprenorphine:
  - is efficacious as substitution therapy in the treatment of opioid dependence.[4-6]

- is an alternative to, but not a substitute for, methadone maintenance treatment.[7]
- acts primarily as a partial agonist at mu-opioid receptors.[3]
- is considered safer in overdose than methadone, although if combined with other CNS depressant drugs (e.g., benzodiazepines) respiratory depression can occur.8 If clinical symptoms of overdose occur it may require higher doses of naloxone or other measures for treatment.[9]
- may have a lower potential for abuse and dependence than pure agonists such as morphine[9-11], although abuse does occur.[10;12] The addition of naloxone to the Suboxone® product formulation is intended to deter injection.
- can be titrated to an effective dose within days, in contrast to methadone which typically may take weeks to achieve.
- prescribed at maximal doses may not be sufficient for all patients. When the maximum daily dose does not stabilize a patient, consideration should be given to using methadone.
- may induce withdrawal in patients dependent on opioids if administered too soon after last use of full opioid agonists.
- may be easier to taper from than methadone
- may be associated with less stigma than methadone

- dissolution of Suboxone® sublingual tablets usually takes 2 to 10 minutes. A suitable, confidential area in the pharmacy is needed where patients can wait while the dose is dissolving under the observation of the pharmacist.

- a possible barrier to treatment may be the cost of Suboxone® (approximately $90 – 460 per month drug cost, plus fees) and it is not yet available on ODB.

How Buprenorphine Works

Buprenorphine is a synthetic opioid with a unique profile: it is a **partial mu-opioid receptor agonist**.[3] Buprenorphine has a **lower intrinsic activity** at the mu-opioid receptor than a full agonist (e.g., methadone or oxycodone). This means that there is a "ceiling effect" to its opioid agonist effects at higher doses[13] making it safer in overdose and reducing its potential for abuse.[3] For example, above doses of 16-32mg daily, there is no increased effect from increasing the dose further.[13] Although it is a partial agonist, buprenorphine has a very **high affinity for** (i.e., binds tightly to) **the mu receptor**. This tight binding means that buprenorphine can block the effects of other opioid agonists (e.g., methadone or oxycodone), and it may even precipitate withdrawal in those physically dependent on opioids by displacing agonists from opioid receptors.[3] The tight binding is also associated with a **slow dissociation** from the mu receptor resulting in a long duration of action.[3] This is why buprenorphine is associated with a milder withdrawal syndrome and has been used to assist in detoxification (unapproved indication in Canada) from other opioids.[8;14]

Buprenorphine's partial mu-opioid agonist activity is beneficial in the treatment of opioid dependence because:
- It reduces craving for opioids.
- It may block the effects of other opioids (e.g., morphine, oxycodone, heroin).[3]
- It can attenuate opioid withdrawal.[3]

Pharmacokinetic Characteristics Specific to Buprenorphine[15]

Buprenorphine's pharmacokinetic properties allow it to be utilized as a feasible substitution treatment for opioid dependence. Its slow onset of action and extended duration of action are both desired features in a treatment for opioid dependence. Buprenorphine has poor oral bioavailability due to extensive metabolism by intestine and liver. Sublingual administration allows absorption through the oral mucosa and thus prevents breakdown via first-pass metabolism. Suboxone® tablets are formulated to be dissolved under the tongue. The onset of action is slow with peak effects from sublingual administration occurring 3 - 4 hours after dosing. Buprenorphine is converted in the liver primarily by cytochrome P450 (CYP) 3A4 to an active metabolite (norbuprenorphine) with weak intrinsic activity. Both norbuprenorphine and buprenorphine are subject to hepatic glucuronidation. The mean elimination half-life is indicated as 37 hours in the product monograph[3], with evidence in the literature of large inter-individual variation (24 to 69 hours) following sublingual administration.[15] Most of dose is eliminated in the feces, with approximately 10 – 30 % excreted in urine.

Notes about naloxone:

Naloxone, a pure opioid antagonist, is contained in Suboxone tablets in combination with buprenorphine, with

the intention of deterring patients from dissolving and injecting the tablet. When Suboxone® is used sublingually, naloxone is largely unabsorbed and does not exert pharmacological activity.[15] When injected, naloxone may attenuate the effects of buprenorphine or cause opioid withdrawal effects in opioid-dependent individuals.

Treatment Program

Initially, Suboxone® must be dosed under supervision of a health professional (e.g., a pharmacist) for a minimum of 2 months.[3] The exception to this is in circumstances in which the pharmacy is not open on weekends; in that case, suitable patients may receive take-home doses for Saturday and/or Sunday.[3]

Induction

Therapy is initiated when the patient is **experiencing opioid withdrawal symptoms**:

- at least 4 hours after use of short-acting opioid (e.g., heroin, oxycodone)[3]

or

- at least 24 hours or longer after the use of a long-acting opioid (e.g., methadone).
  - Note: For methadone maintenance patients wanting to switch to Suboxone®, it is recommended that the methadone dose be tapered down to 30 mg or less before buprenorphine treatment is initiated to minimize the possible precipitation of intense withdrawal symptoms.

Initially a single dose of 2 to 4mg is given under supervision. An additional 4 mg may be administered later on in the same day depending on the individual patient's requirement.

Maintenance

The dose should be increased progressively according to the individual patient's needs and should not exceed a maximum daily dose of 24 mg according to the product monograph.[3] The dose is titrated according to reassessment of the physical and psychological status of the patient.[3] Once a patient has been stabilized on a maintenance daily dose, there is the option to reduce the frequency of administration to less than daily dosing (e.g., double the dose given every second day. See product monograph for details.)

Take-home doses

After the initial time period of two months of supervised dosing, take home dosing can be considered based on the assessment of clinical stability, length of time in treatment and the patient's ability to safely store the drug. Patients with take home doses should be assessed and reviewed on a regular basis.

Take home doses should be kept in the original strip packaging. Use of childproof closures are recommended. Take home doses need to be securely stored.

Management of Missed Doses

Compliance with buprenorphine treatment needs to be tracked by the pharmacist. Any missed doses should be communicated to the prescriber. The pharmacist should consult the prescriber to develop a plan on how to continue with buprenorphine treatment after several (e.g., 3 or more) missed consecutive doses.

Management of Intoxicated Patients

Patients should be assessed for intoxication prior to dosing. An intoxicated patient should not be given a dose of Suboxone®. The prescriber should be consulted regarding a management strategy (e.g., delaying the dose), keeping patient safety paramount.

Transitions of Care

When a patient is switching pharmacies, communication must occur among pharmacists and other health care providers (as with methadone maintenance treatment) to ensure that there are no omissions or overlaps in buprenorphine dosing. This is also important when the patient is admitted or discharged from institutions such as hospitals or jails.

Adverse Effects

It is important to distinguish *adverse effects* from *withdrawal symptoms* that can be precipitated by buprenorphine.

After the first dose of buprenorphine there may be some precipitated opioid withdrawal symptoms, such as headache, gastrointestinal upset, nausea, diarrhea, runny nose, sweating.

Adverse effects during buprenorphine treatment are dose related and similar to other opioids. Most common are constipation, headache, CNS depression (e.g, sedation) euphoria, sweating, nausea, insomnia and orthostatic hypotension.

Toxic effects can be caused by buprenorphine alone or in combination with other CNS depressants. Since buprenorphine is a partial agonist, there is a ceiling effect on respiratory depression; however, very high doses of buprenophine in some individuals have been associated with severe symptoms. Respiratory depression, when it occurs, may be delayed in onset and more prolonged than with opioids such as morphine, and reversal with naloxone is more difficult due to buprenorphine's very tight binding to opioid receptors. Other treatment approaches may be necessary (e.g., assisted ventilation).

Drug Interactions

Serious respiratory depression has occurred when buprenorphine has been combined with CNS depressants including other opioids, alcohol, benzodiazepines, certain antidepressants, sedating H1-receptor antagonists, barbiturates.[3] Special caution is recommended with the use of benzodiazepines and buprenorphine as this combination has resulted in respiratory depression, coma and death.[3] Medications with CNS effects should be avoided and patients counselled regarding the risks associated with alcohol and benzodiazepine use.[3]

Buprenorphine is primarily metabolized by CYP3A4. Inducers (e.g., phenytoin, carbamazepine, rifampin) or inhibitors (e.g., ketoconazole, fluvoxamine, erythromycin, indinavir, saquinavir) of this enzyme would be expected to interact with buprenorphine. Ketoconazole, a powerful inhibitor of CYP3A4, has received particular attention and it has been reported to significantly increase peak plasma concentrations of buprenorphine.[16] Careful patient monitoring and adjustment of buprenorphine dose when necessary, is recommended.

Special Patient Populations:

Pregnant Patients

The role of buprenorphine in pregnancy has not been clearly elucidated and Suboxone® is not approved for use in this population.[3] Initial studies have shown that buprenorphine is efficacious, well tolerated and safe in pregnancy,[17-19] however, use of the combination product with naloxone is not appropriate at this time. Buprenorphine crosses the placenta.[15] Neonatal withdrawal can occur, although some sources indicate that symptoms are mild or absent in many cases.[9;20] The current standard for care for opioid dependency in pregnancy is methadone treatment.

Patients with Renal or Hepatic Failure

The dose of buprenorphine does not have to be significantly adjusted in renal impairment.[15] It is possible that the dose may need to be modified in chronic liver disease.[15]

Abuse of Buprenorphine

Buprenorphine is considered to have a lower potential for abuse due to its pharmacological properties (i.e., partial opioid agonist activity) compared to opioids which are full agonists, for example, oxycodone or morphine. However, abuse has been reported in countries where both buprenorphine alone and in combination with naloxone are available.[10-12] Buprenorphine has been abused by crushing and then administration by snorting or by the intravenous route.

Supervised daily dosing in the first 2 months of buprenorphine treatment is intended to reduce the risk of diversion. Pharmacists may minimize diversion through careful dispensing and dose monitoring, watching for "double doctoring" and communicating possible diversion (e.g., lost or stolen carries) to the physician.

Diversion to other people can result in overdose, particularly when combined with alcohol, benzodiazepines or other CNS depressants. Diversion for use in a person dependent on methadone or other opioids can cause them to experience precipitated withdrawal.

Practical Tips for Pharmacists

- Patients need to be positively identified, for example, with photo ID.
- Pharmacists should assess patients for intoxication and compliance prior to dosing.
- Tablets should not be handled, but should be tipped into the mouth from a medication cup.
- If the dose consists of more than one tablet, tablets should be put under the tongue at the same time.
- Suboxone® tablets require some time to dissolve under the tongue (up to 10 minutes). Dosing is best done in a quiet area of the pharmacy where the patient can sit undisturbed by other patients, yet be observed by pharmacist. From time to time, check under the tongue to assess dissolution (discreetly and respectfully). The first few minutes are the most important for avoidance of dose diversion — i.e., once the tablet dissolves into a pulpy mass it would be more difficult to divert.
- Drinking water/fluids prior to medicating may facili-

tate dissolution of tablets and speed up the process of medicating.

- Patients should be instructed not to swallow their saliva while tablets are dissolving.
- If the patient vomits after the dose, there is no impact on buprenorphine absorption once the tablet has dissolved.
- Patients should refrain from drinking for about 5 minutes after tablets have dissolved in order to make sure that all medication has been absorbed.
- If more than one pharmacy is used, communication among pharmacists must occur in order to ensure that no double dosing or dosing after tolerance is lost occurs
- Pharmacists should consider using a treatment agreement with the patient (similar to methadone patients).

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Comparison of Buprenorphine to Methadone

	Buprenorphine	Methadone
Formulation	Sublingual tablet	Oral liquid
Effective treatment for opioid dependence?	Yes	Yes
Physician exemption required to prescribe?	No (but training recommended)	Yes
Pharmacology at opioid receptors	*Partial* mu-agonist	*Full* mu agonist
Onset of action	Slow sublingually	Slow orally
Duration of action	Very long	Long
Titration time to stable dose	Days (to weeks)	Weeks
Supervised doses	Yes	Yes
Take-home doses possible?	Yes	Yes
Need for extemporaneous preparation by pharmacist	No	Yes
Time to ingest dose	Minutes (need to dissolve under tongue)	Seconds (swallowed)
Alternate day dosing possible?	Yes	No
Ceiling dose for opioid substitution effects?	Yes	No (can titrate dose higher for patients who require it)
Ceiling dose for respiratory depressant effects?	Yes (may be safer in overdose)	No
Sedation	May be less	May be more pronounced
Withdrawal	May be less/milder	May be more difficult
Abused ?	Yes (naloxone included to ↓ IV abuse)	Yes (juice added to ↓ IV abuse)
Concern of added toxicity when combined with CNS depressants?	Yes	Yes
CYP3A4 interactions	Yes	Yes
Stigma	May be less	Possibly more
Does counseling improve treatment outcomes?	Yes	Yes
Ontario Drug Benefit Coverage	Not at this time	Yes
Reimbursement for services	Not yet determined	Established structure

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BUPRENORPHINE - IMPACT ON PHARMACY

Q What buprenorphine products are available in Canada?

Subutex® and Suboxone® have been approved by Health Canada for the treatment of opioid dependence. However, only Suboxone® (buprenorphine and naloxone) has been introduced to the Canadian market.

Q What is the regulatory status of buprenorphine?

Buprenorphine is a narcotic. It is found in Schedule I of the Controlled Drugs and Substances Act (CDSA) and subject to all the requirements of the Act and Narcotic Control Regulations. It requires a written prescription and is a reportable narcotic.

Q Will physicians need an exemption to prescribe Suboxone®, similar to methadone?

Unlike methadone, physicians do not require a section 56 exemption from Health Canada to prescribe buprenorphine products. However, the College of Physicians and Surgeons of Ontario (CPSO) has recommended that physicians wishing to prescribe buprenorphine have training in the area of opioid dependency treatment and/or addiction medicine prior to initiating treatment.

Q Can buprenorphine be prescribed for pain?

No, buprenorphine is indicated for the treatment of opioid dependence only.

Q Are there guidelines for the use of buprenorphine in Ontario?

Guidelines specific to buprenorphine practice in Ontario are under development, and both physicians and pharmacists will be notified when these guidelines are complete.

OCP expects that anyone intending to dispense buprenorphine be familiar with the CAMH Methadone Maintenance Guidelines for Pharmacists and apply relevant principles for the treatment of substance dependence.

Q Where can I learn more about buprenorphine?

For clinical issues on buprenorphine or methadone, you can contact CAMH at their Addiction Clinical Consultation Service 1-888-720-ACCS. In addition, a medical education/training program for physicians and pharmacists is available online at www.suboxonecme.ca. As with methadone, pharmacists are expected to familiarize themselves with any requirements for physicians and pharmacists. The module directly relating to pharmacists is Module 6.

WORKSHOP

Strategies for the Safe Prescribing, Dispensing and Administering of Opioids

Physicians, pharmacists, and nurses are invited to participate in a one-day workshop on the safe prescribing of opioids. Learn how to avoid common problems in opioid prescribing, dispensing and administering. Topics for discussion include:

- The role of interprofessional collaboration in the safe management of opioids
- Identification of high-risk patients
- Review of drug interactions
- Protocols for safe titration of opioids
- Assessment, monitoring and education of patients on opioids
- Warning signs of opioid toxicity

This workshop will be part of a research trial. You will be asked to either listen to a presentation or to participate in an interactive session. The theme of both groups will be increased patient safety through the careful management of opioids.
You will be contacted three months after the workshop to complete a follow-up questionnaire.

Presenters: Kahan, MD; Anita Srivastava, MD; Eva Janecek, B.SC, PHM;
Anne Resnick, R.PH, B.SC PHM; Lesley Hirst, RN, MN
This program meets the accreditation of the College of Family Physicians of Canada and has been accredited for up to 4.25 Mainpro-M1 credits and is also eligible for CCCEP accreditation from the Ontario College of Pharmacists
Place: Centre for Addiction and Mental Health,
33 Russell Street, 2nd Floor, Room 2029, Toronto ON, M5S 2S1
Time: 8:00 a.m. – 1:30 p.m.
Dates: (Choice of four dates)
Saturday February 2, 2008
Sunday February 3, 2008
Saturday February 9, 2008
Sunday February 10, 2008
Fee: No fee
(Includes continental breakfast and lunch)

FOR MORE INFORMATION AND TO REGISTER (Deadline January 18, 2008)
Contact Ava Rubin
Research Coordinator, Canadian Patient Safety Institute Grant Project
416-535-8501 ext 4420

CASE 1

Member: Harvey Organ
Pharmacy: Kohler's Drug Store
Hearing Date: November 12, 2007

The Facts

Mr. Organ owned and operated both an accredited pharmacy (Kohler's Drug Store) and a pharmaceutical export business (CanadaRX). Kohler's, like other Ontario pharmacies, dispensed prescription medication to Ontario patients on the basis of prescriptions written by Ontario physicians.

CanadaRX received prescriptions written by US physicians, and on that basis shipped prescription medications (obtained from Kohler's) to those US physicians or to their US patients. Kohler's shipped medication absent prescriptions from Ontario or Canadian physicians.

Mr. Organ's position was that CanadaRX operated under a federally regulated export exemption and that the CanadaRX export business fell under the jurisdiction of the federal authorities and was therefore not subject to the provincial regulations, policies and standards of the College that regulate the dispensing of medication.

The College conducted a lengthy investigation of Mr. Organ's operation of Kohler's and its interaction with CanadaRX, and referred the matter to the Discipline Committee. The College's position was that Mr. Organ's operation of CanadaRX did not fall within the export exemption, that the dispensing of drugs by Kohler's to patients in the US remained within the jurisdiction of the College, and that it contravened the Drug and Pharmacies Regulation Act, and the Food and Drug Regulations, as well as various College policies.

The Undertaking and Motion

In resolution, Mr. Organ provided the College with an undertaking to move the Canada RX export business out of Ontario by November 30, 2007, and further undertook not to return Canada RX or any similar export business to Ontario in the future. In addition, Mr. Organ agreed to reimburse the College $95,000 for costs which the College incurred in proceeding with this matter.

Accordingly, the parties made a joint submission to the Discipline Committee to issue an order for a stay of the disciplinary proceedings against Mr. Organ.

Reasons for Decision

The Discipline Committee accepted the joint submission of the parties, as well as Mr. Organ's undertaking to the College, and issued an order staying the disciplinary proceedings against Mr. Organ.

CASE 2

Submitting false or misleading charges or accounts

Member: Alli-Nasir Mohamed
Date: October 31, 2007

Facts

When a patient at one of the pharmacies owned and managed by Mr. Mohamed raised questions about prescription drug expenses claimed against his insurance plan and the Workplace Insurance and Safety Board, the insurance company commenced an audit. The audit identified approximately 123 transactions of concern, involving six patients.

In his response to the audit, Mr. Mohamed could not produce records that fell outside the two-year record retention period set out in the Drug and Pharmacies Regulation Act. He provided only some records regarding some of the transactions within the previous two years. Mr. Mohamed reimbursed the insurance plan for the full amount of $6,182.97 for the problematic claims identified in the audit.

After the insurance plan cancelled the billing arrangement with Mr. Mohamed's pharmacies, and lodged a complaint with the College, Mr. Mohamed sold his pharmacies and continued to work as a pharmacist in other pharmacies. Mr. Mohamed executed an undertaking to the College that he would not own or manage any pharmacy until the hearing before the Discipline Committee. Mr. Mohamed has complied with this undertaking.

At the time of the hearing, three of the six patients identified in the audit were too elderly or otherwise infirm to attend and give testimony. The other three patients, had they testified, would have stated that they never requested or received the various drugs and medications that were claimed in their names by Mr. Mohamed's pharmacies. There were 36 such transactions in total.

Acknowledgement of Professional Misconduct

Mr. Mohamed admits that he committed acts of professional misconduct with respect to the transactions identified above, in that he failed to maintain the standards of practice, failed to keep records as required, and submitted accounts or charges for services that he knew were false or misleading.

Reasons

The Panel accepted the Joint Submission on Penalty made by the parties.

The Panel stated that Mr. Mohamed's misconduct had been reprehensible and amounted to a breach of the public trust. False or misleading billing practices, failing to maintain standards of practice, and failing to keep required records are significant transgressions. Moreover, they amount to a flagrant breach of the trust which the public places in pharmacists and which pharmacists place in each other as colleagues. Aside from harming of patients, a breach of trust is perhaps the most egregious kind of professional misconduct, since it is deliberate and entirely avoidable.

The Panel took into account the fact that Mr. Mohamed had divested himself of his pharmacies, and had undertaken not to own or manage another pharmacy. Further, he had made full restitution on the insurance plan claims, and other claims not directly related to this case, demonstrating that he had accepted responsibility for his actions. As well, by pleading guilty, Mr. Mohamed had spared the College and witnesses the burden of a protracted hearing.

As regards specific elements of the Joint Submission on Penalty, remedial course work can only be of benefit for any member. The restrictions on ownership were necessary in this case, due to the breach of trust and the potential for Mr. Mohamed to repeat the misconduct. The Panel truly hoped that restrictions on ownership would provide Mr. Mohamed with further time to reflect on the privilege and responsibility of pharmacy ownership and management.

The magnitude of the costs is consistent with the time and effort that goes into investigating and prosecuting such acts of misconduct. The period of suspension was commensurate with the seriousness of the misconduct, and comparable to past Discipline Committee decisions.

Order

1. A reprimand.
2. Specified terms, conditions, or limitations on Mr. Mohamed's Certificate of Registration, and in particular,
   (a) that Mr. Mohamed complete successfully, at his own expense, within six months, the following courses and evaluations:
      (i) the Jurisprudence seminar and evaluation offered by the College
      (ii) Law Lesson 2 (Regulation of Pharmacy Practice) and Law Lesson 4 (Standards of Practice) from the Canadian Pharmacy Skills Program, offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto, and
   (b) that Mr. Mohamed shall continue to be prohibited, for a further period of 12 months, from
      (i) acting as a designated manager in any pharmacy
      (ii) having any proprietary interest in any pharmacy, as a sole proprietor, partner, director, or shareholder in a corporation that owns a pharmacy, or in any other capacity, or
      (iii) receiving any remuneration for his work as a pharmacist, other than remuneration based only on hourly or weekly rates, and not on the basis of any incentive or bonus for prescription sales
3. A suspension of Mr. Mohamed's Certificate of Registration for a period of three months, with one month of the suspension to be remitted on condition that he complete the remedial training exercises specified in paragraph 2, above
4. Costs to the College in the amount of $30,000.00

Reprimand

The Panel stated that Mr. Mohamed's actions were reprehensible to the profession, and also offended the public trust.

By submitting false or misleading claims to insurers he negatively

affected the public's opinion of pharmacists in general. Also, he had put at risk the relationship between pharmacists and insurance providers.

Pharmacists must be responsible for their actions, which affect more than just themselves or those immediately around them. Mr. Mohamed's failure to uphold the profession's standards of practice could have jeopardized patient care, as patient profiles would have been inaccurately maintained.

The Panel denounced Mr. Mohamed's actions. It found his behaviour appalling, and trusted that Mr. Mohamed will no longer initiate or participate in such unethical actions again.

CASE 3

Remote dispensing of methadone; failure to comply with college policies

Member: Herman Reich, Herman's IDA, Sudbury, and Thunder Bay IDA, Thunder Bay
Date: November 2, 2007

This case concerns the conduct of a pharmacist who dispensed methadone to patients of methadone clinics in Sudbury and Thunder Bay, and the related implications of federal and provincial legislation, professional standards of practice, and College policies and guidelines.

Methadone Dispensing Practices at the Pharmacy

Mr. Reich was the sole director, sole shareholder, Designated Manager, and dispensing pharmacist at Herman's IDA in Sudbury and, later, at Thunder Bay IDA in Thunder Bay. From June 2004, the Sudbury pharmacy provided daily doses of methadone to the Ontario Addiction Treatment Centre (OATC) clinic in that city. The methadone doses were labelled as diluted in orange drink, as the prescription required; in fact, the OATC staff received undiluted methadone doses, diluted them at the clinic, and administered them to patients there. Patients did attend at the pharmacy to obtain their initial methadone dose directly from a pharmacist, and a pharmacist would attend at the OATC clinic once a week to establish a pharmacist-patient relationship. This pharmacist would administer the doses that day, and would bring stock solution in order to adjust any doses as prescribed.

In July 2005, the Sudbury pharmacy also began providing methadone to two OATC clinics in Thunder Bay. Undiluted doses of methadone were sent from Sudbury to Thunder Bay for this purpose. In March 2006, Mr. Reich opened the Thunder Bay pharmacy, which took over dispensing to the Thunder Bay OATC clinics.

The pharmacies and the clinics subscribed to Toxpro software, which facilitated the on-line transmission of prescriptions to the pharmacy from the OATC, as well as the pharmacies' on-line access to prescription information before an actual signed prescription was received at the pharmacies. The default programming on Toxpro caused the pharmacy records, in certain situations, to reflect methadone as dispensed prior to the date it was prescribed. In addition, Mr. Reich and his pharmacies sometimes, without contacting the prescriber, adjusted the quantity authorized in a prescription so that overlapping prescriptions could be reconciled.

As well, since Mr. Reich believed that the OATC clinics took responsibility for the methadone once he had delivered it, he failed to report and destroy methadone when patients did not attend to receive their doses. Various other recordkeeping and operational deficiencies at Mr. Reich's pharmacies were identified in the College's investigation.

College Policies

In December 2002, the College approved its current policies for pharmacists and pharmacies dispensing methadone. In the March/April 2003 Pharmacy Connection, the College advised its members of these policies, which require pharmacists to comply with methadone dispensing guidelines developed by CAMH. The CAMH guidelines envision a pharmacist-patient relationship where the pharmacist provides information and counselling to the patient, gathers information about the patient's allergies and drug use history, and generally engages in ongoing dialogue with, and assessment of the patient, documenting the dialogue as the standards of practice require.

In September 2004, the College

issued a notice to its members instructing them to cease and desist from certain practices that were not in compliance with these policies. Members were advised that non-compliant practices could be subject to disciplinary action after December 31, 2004.

The College issued a further notice in November 2004, reiterating the earlier "cease and desist" notice, but extending the deadline for compliance to January 31, 2005. From January through April 2005, Mr. Reich and his lawyer exchanged correspondence with the College in which they questioned the College's "cease and desist" notice. Mr. Reich and his lawyer also proposed several alternate arrangements for the dispensing of methadone, which the College rejected on the basis that they did not meet the standards of practice of the profession.

The College issued a notice in November 2005 regarding joint initiatives being taken by the three regulators of the methadone program – the College of Pharmacists, the College of Physicians and Surgeons of Ontario, and the Office of Controlled Substances, Health Canada. This notice reiterated the "cease and desist" notice of September 2004. Mr. Reich and the pharmacy were referred to the Discipline Committee in connection with their continued method of dispensing methadone contrary to the College's directive.

In March 2006, the College issued an interim policy developed in collaboration with the CPSO and Health Canada (please refer to the College website for the May/June 2006 edition of Pharmacy Connection for more details about the interim policy). Under the College's interim policy, it became possible for methadone to be shipped in a secure manner as individual labelled doses of diluted methadone to an exempted physician, or to the physician's delegate, for administration. It also became possible for the pharmacist to dispense methadone directly to patients at another treatment location (i.e., a clinic). The interim policy reiterated that the pharmacist must establish a relationship with the patient, and comply with all the legislation and College policies on MMT (including the CAMH guidelines).

Acknowledgement of Professional Misconduct and Pharmacy Misconduct

Mr. Reich acknowledges that as the director, shareholder, and Designated Manager of the pharmacies, he failed to ensure that their operations were conducted in accordance with the standards of practice of the profession of pharmacy, with College policies and guidelines, and with federal and provincial requirements. Mr. Reich acknowledges that he failed to so ensure, and that prior to the interim policy of March 2006, he:

- failed to comply with the September 2004 and November 2005 notices from the College
- failed to maintain a standard of practice of the profession
- failed to keep records as required, and
- engaged in conduct, relevant to the practice of pharmacy, that, having regard for all the circumstances, would reasonably be regarded by members of the profession as unprofessional.

and that the pharmacies:

- contravened the documentation requirements of the DPRA.

Reasons

The Panel made findings of professional misconduct further to Mr. Reich's acknowledgement and plea. In considering the Joint Submission on Penalty, the Panel was directed by both the College and Mr. Reich to another recent Discipline decision respecting methadone dispensing. The Panel brought forward certain material findings from that decision, notably, that:

- the College's authority to regulate its members, and its legislative mandate to protect the public, must be respected
- College policies and procedures governing the dispensing of methadone in Ontario must be adhered to
- College policies and procedures were not developed in a vacuum, but in consultation with respected and authoritative stakeholders in this area of pharmacy practice
- the interim policy in March 2006 (which loosely mirrors some, but not all, of Mr. Reich's practice in at issue in this case) does not exonerate or correct his actions prior to the issuance of the

interim policy.

Further, and in particular:

> This Panel firmly believes that the Member's breaches of College directives and guidelines… demonstrated a complete disregard of the College's authority to self- regulate its members and its legislative mandate to protect the public…
>
> …The College directive and guidelines on the dispensing of methadone were in place to ensure public safety. Wilfully disregarding the College's instructions, when the College had been entrusted by the provincial legislature, through the RHPA, and federal government via Health Canada and its enabling legislation, to protect the public interest, constituted conduct by the Member that fell well below established standards of practice and placed the public at risk of harm.

In this specific case the Panel was frustrated by the fact that Mr. Reich not only continued to dispense methadone to the OATC Clinic in Sudbury after the January 31, 2005, the deadline imposed by the September 2004 "cease and desist" notice, but also further expanded his methadone dispensing to two OATC Clinics in Thunder Bay in July 2005, and continued to dispense to both Sudbury and Thunder Bay in this fashion after the November 2005 Notice.

The Panel recognized that Mr. Reich, both personally and through his counsel, communicated with the College and raised a proposal for the College's consideration. However, the Panel was offended that in the face of the College's rejection of the proposal and reiteration of College policies and procedures, Mr. Reich chose to continue to practise as he had been doing.

The Panel was also greatly troubled by the numerous operational and administrative issues that came to light in the course of the College's investigation. These included failing to keep records as required; not adequately documenting adjustments to quantity or ingestion start dates authorized by a prescription; not accurately reflecting the actual date prescribed, so that it appears in the records that methadone was being dispensed prior to the authorized prescription date; and failing to report the loss of methadone, among all the other practice errors listed in the Agreed Statement of Facts. While these offences may not appear as serious as improper methadone dispensing, significant patient harm could result from an apparently simple labelling error. Mr. Reich could have been prosecuted and had a significant penalty ordered against him for these administrative and operational issues alone.

In considering the Joint Submission on Penalty, the Panel was prepared to accept the proposed penalty. In evaluating this penalty, the Panel stated that it would be remiss to not consider the previously-referenced analagous case respecting methadone dispensing. The Panel agreed that Mr. Reich should receive a more severe penalty, and since the proposed penalty was in fact more severe, the Panel was satisfied with it.

Order

1. A reprimand
2. Terms, conditions, or limitations on Mr. Reich's Certificate of Registration requiring him to complete successfully, at his own expense and within 12 months of the date of the Order:
   - the Advanced Professional Practice Laboratories, including evaluations, in the Canadian Pharmacy Skills Program (the "CPS") offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto
   - the Methadone Maintenance Treatment Course offered by the Centre for Addiction and Mental Health
   - Law Lesson 2 (The Regulation of Pharmacy Practice); Law Lesson 4 (Standards of Practice); and Law Lesson 7 (Professional Liability) in the CPS
   - The Jurisprudence Seminar and evaluation offered by the College
3. Four months' suspension of Mr. Reich's Certificate of Registration, with two months of that suspension to be remitted on condition that he complete the above-mentioned remediation
4. Mr. Reich to pay costs to the College in the amount of $20,000
5. The pharmacy to pay costs to the College in the amount of $20,000

Reprimand

The Panel denounced Mr. Reich's actions as reprehensible and a breach of the public's trust. He might have placed the public at risk by not ensuring the proper administrative procedures were in place at the clinics involved. In this regard, he failed to exercise due diligence. Even in light of the current interim policies regarding the dispensing of methadone, his actions, for example, the delivery of undiluted methadone, fell below the acceptable standards of practice and compromised public safety.

The Panel found Mr. Reich's behaviour appalling and trusted that he would no longer initiate or participate in such reprehensible and unprofessional activities. As a member of a self-regulated profession, he is not free to make up his own rules. College policies and procedures dictate how methadone is to be dispensed in this province, and every member must, like it or not, operate according to them. Any member who strongly disagrees with a policy may certainly get involved with the College to facilitate change.

FOCUS ON

Error Prevention

Ian Stewart, R.Ph., B.Sc.Phm.
Practising Community Pharmacist in Toronto

Patient Unaware of Prescription Changes

Physicians often make changes to drug therapy based on the patient's response to a specific drug. The change and reasons behind the change are usually communicated to the patient. However, in some cases the patient may be unaware of a change in therapy. The reasons may include miscommunication between the physician and the patient; the patient may have misunderstood or forgotten the information provided by the physician or the physician may have inadvertently made an error in prescribing. Pharmacists must therefore ensure that any change in drug therapy is communicated to and understood by the patient.

CASE

An eighty one year old patient telephoned her regular pharmacy to request a refill of her Atacand® 8 mg tablets. A three month supply was subsequently processed and dispensed.

Two weeks later, the patient visited her physician for a regular check up. On leaving the physician's office, the patient was given the following written prescription.

Rx

Pravastatin 40 mg
Sig: p.o. nightly
Mitte: 3 months

Candesartan 16 mg
Sig: p.o. daily
Mitte: 2 months

The patient took the prescription to her regular pharmacy for processing. The pravastatin 40 mg and Atacand® 16 mg tablets were subsequently prepared by the pharmacy technician and checked by the pharmacist.

Later that day, the patient returned to the pharmacy for her medication. The pharmacy technician retrieved the package to give to the patient. On seeing the box of Atacand® tablets, the patient informed the technician that she had "lots of those" and therefore "do not need at this time". The technician then asked the patient if she had taken the pravastatin previously, to which the patient answered that she has been taking it for a long time. The patient therefore took the pravastatin tablets and left. No interaction occurred between the patient and the pharmacist. The Atacand® 16 mg tablets were subsequently cancelled and logged onto the patient profile. No information regarding the new strength was given to the patient. The patient therefore continued to take one Atacand® 8 mg tablet daily.

Approximately two months later, the patient telephoned the pharmacy to request a refill of her Atacand® tablets. The pharmacy technician checked the patient profile and selected Atacand® 8 mg for processing. Another ninety tablets were dispensed with the instructions to take one tablet daily.

Three months later, the patient again telephoned the pharmacy for a refill of her Atacand® tablets. On this occasion, no authorized refill remained. The physician was therefore contacted to obtain the authority to dispense Atacand® 8 mg tablets. The physician informed the pharmacist that the daily dose of Atacand® was increased to 16 mg approximately six months earlier. A check of the patient profile confirmed that Atacand® 16 mg was logged but never dispensed. The patient was unaware of the increase in dosage of Atacand® and therefore had been taking the incorrect daily dosage for approximately six months.

Possible Contributing Factors

- Miscommunication between the physician and patient regarding an increase in the daily dosage of Atacand®.
- The Atacand® 16 mg was not dispensed to the patient, pursuant to the written prescription.
- The pharmacy technician did not call the pharmacist over to counsel the patient.
- No interaction occurred between the pharmacist and the patient. Therefore the patient was not informed of the increase in dosage.
- The package of Atacand® 8 mg and 16 mg are similar in size, shape and colour. As a result, the patient did not detect the change in strength.

Recommendations

- Always check the patient profile to detect any change in dosage. Highlight the information and leave appropriate notes to ensure that this information is communicated to the patient before the medication is given out. If the patient is unaware of the change, contact the prescriber for verification.
- Have a system in place to flag new prescriptions for counselling
- Train staff to consider any changes to previous prescriptions such as strength, dosage or quantity as a new prescription. Changes are triggers to engage patients in a dialogue about their therapy.
- Educate pharmacy technicians to call the pharmacist to counsel the patient when medications are being dispensed pursuant to a new prescription. Patients may assume that they are receiving the same medication. However, patient counseling usually provides the last opportunity to detect a dispensing error.
- Train pharmacy technicians to always check for notes written by the pharmacist which indicate the need to speak with the patient. In these instances, the pharmacist must be called to communicate with the patient before they leave the pharmacy. If this opportunity is missed for any reason, the patient must be contacted by telephone to discuss the issue.
- When writing notes, use standardized note pads to ensure that the notes are not missed by the pharmacy staff.
- Whenever there is a change in dosage, inactivate previous prescriptions that are no longer valid.
- Contact your software vendor to implement a system whereby the last strength or dosage of a specific drug added to a patient profile can be easily identified whether the drug is dispensed or not.

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com

Thank You, Preceptors

Diana Spizzirri, R.Ph., B.Sc., B.Sc.Phm.
Deanna S. Yee, R.Ph., M.Sc., B.Sc.Phm.
Registration Advisors

On behalf of the College, we would like to thank the pharmacists who served as preceptors in the Structured Practical Training (SPT) program in 2007. By welcoming a pharmacy student or intern to their pharmacy team, these preceptors have continued the tradition of sharing their time, experience and enthusiasm for our profession with a future pharmacist colleague.

Students and interns continue to express their appreciation to their preceptors for the encouragement and learning opportunities that the preceptors have provided. Several preceptors discovered that having a student or intern enables new programs to be implemented in their pharmacy as a result of the SPT activities. Many interns took the initiative to apply their pharmaceutical care skills in community practice by implementing medication reviews as part of the Meds Check Program.

2007 Highlights

This year, more than 300 pharmacists attended one of 19 preceptor workshops across the province. The one-day workshops were offered in Burlington, Kingston, London, Ottawa and Toronto. Fourteen Orientation workshops were held for first-time preceptors or pharmacists who had last acted as a preceptor several years ago. An OCP Registration Advisor and an experienced preceptor facilitate the Orientation workshops to explain the goals of the SPT program, the role and responsibilities of a preceptor and the expectations for students and interns, and introduce pharmacists to a number of preceptoring skills. Using videos, role-playing and guided discussions, the pharmacists learn how to set expectations, motivate students and interns, provide practice opportunities, and provide feedback and assessment. In response to feedback from preceptors, a number of changes were made to the Orientation workshop. The pre-reading available on the OCP website was condensed and now includes some of the didactic material that used to be presented at the workshop. This has allowed more time to be spent during the workshop to discuss how to guide students and interns to complete the activities and to practise reviewing the studentship and internship activities before they are submitted to OCP.

The Advanced workshop is offered to preceptors who last attended a workshop more than three years ago and who wish to continue acting as preceptors. The Advanced workshop is intended to provide an opportunity for preceptors to enhance their skills and to share their experiences with other preceptors and Registration Programs staff. We were pleased to have Dr. Zubin Austin continue to conduct the "Teaching, Learning and Assessing Clinical Skills" in which preceptors had the opportunity to discover how clinical skills are taught to pharmacy students and to practise evaluating clinical skills and providing feedback. In March, Dr. Austin premiered the newest workshop, "Conflict Analysis & Resolution". This interactive workshop introduced preceptors to the way in which conflict may arise in the workplace, how to identify their own conflict management style and develop new methods for addressing disagreements and negotiating mutually acceptable solutions. Response to this workshop was positive and we will continue to offer it in 2008. Dr. Lionel Laroche continued to receive a very positive response to his workshop, "Managing Cultural Differences". This workshop provides preceptors with insight on cultural differences that may exist between Canadian and International Pharmacy Graduates (IPGs) and help them prepare to face the challenges and reap the opportunities of being preceptors to a diverse population of students. We look forward to continuing to work with both Dr. Austin and Dr. Laroche in 2008.

With the launch of the new OCP website, the SPT assessment forms and activity documentation forms are now available online. The SPT Studentship and Internship Manuals continue to be available online for members.

Once again, a sincere thank you to our preceptors, facilitators, presenters and reviewers for their valuable contribution to the SPT program and the future of pharmacy!

The "Preceptor Workshop" dates for 2008 are posted on the OCP website. If you would like to become a SPT preceptor, please contact Vicky Gardner at (416) 962-4861 x 297 or by e-mail at vgardner@ocpinfo.com

AJAX

Chris Aljawhiri
Pharma Plus Drugmart

Kevin Hsu
Pharma Plus Drugmart

Kevin Im
Wal-Mart Pharmacy

Basem Indrawes
Costco Pharmacy

Giovanni Spina
Shoppers Drug Mart

ALEXANDRIA

Helene Lauzon
Pharmacie Jean Coutu
Pharmacy

AMHERSTBURG

Mary Wolff
Shoppers Drug Mart

ANCASTER

Mahmood Najak
Wal-Mart Pharmacy

Cheong Yuen
Pharmacy City

ARNPRIOR

Linda Murphy
Shoppers Drug Mart

BARRIE

Donna Carlyle
Rexall Drug Store

Arulanathan Govender
Pharmasave

Sheri-Anne Kidson
Drugstore Pharmacy

Phiroza Mahomed
Drugstore Pharmacy

Marie (Angela) Miller
Wal-Mart Pharmacy

Cecilia Reyes
Pharma Plus Drugmart

Annette Sagum
Zellers Pharmacy

Frances Stansfield
Wal-Mart Pharmacy

Tracy Wiersema
Shoppers Drug Mart

BELLEVILLE

Vaughn Galloway
Pharma Plus Drugmart

Margarita Krysak
Geen's Pharmasave

Jugana Milosevic
Wal-Mart Pharmacy

Evan Sullivan
Shoppers Drug Mart

BOLTON

Medhat Awad
Total Health Pharmacy

Ethel Rizarri
Shoppers Drug Mart

BOWMANVILLE

Evelyn Travis
Shoppers Drug Mart

Lorraine Watson
Shoppers Drug Mart

BRAMPTON

Reginald Ackerman
Pharmacy 1 Drug & Food

Kalpesh Chauhan
Shoppers Drug Mart

Chuen (Clement) Chung
Wal-Mart Pharmacy

Hany Girgis
Bramiss Pharmacy

Rakhi Goel
William Osler Health Centre

James Hernane
Shoppers Drug Mart

Munawar Khan
Costco Pharmacy

Kimberly MacPhee
Drugstore Pharmacy

Jason Mah
Shoppers Drug Mart

Balvinder Marwaha
William Osler Health Centre

Rossana McArdle
Shoppers Drug Mart

Mehul Panchmatia
IDA Gore Pharmacy

Adam Pignataro
Pharma Plus Drugmart

Sarah Rowe
Brampton Civic Hospital
(formerly William Osler
Health Centre)

Naresh Sehdev
Shoppers Drug Mart

Piyushkumar Shukla
Drugstore Pharmacy

Parvinder Singh
Shoppers Drug Mart

Nadia Sourour
Zellers Pharmacy

Mirza Taimuri
The Pharmacy

Mohamed Walji
Westbram Pharmacy

Heather Woodhouse
Wexford Pharmacy

BRANTFORD

Bruno Bove
Shoppers Drug Mart

Dilip Jain
Drugstore Pharmacy

Christine Mundy
Shoppers Drug Mart

Kimberley Portelli
Avenue Pharmacy

Glenys Vanstone
The Brantford General
Hospital

BROCKVILLE

Leslie Groves
Pharma Plus Drugmart

BURLINGTON

Medhat Abdel Malek
Costco Pharmacy

Jaime Chan
Costco Pharmacy

Laurie Doyle
Shoppers Drug Mart

Jason Handa
Smartmeds Pharmacy Group

Tauseef Hassan
Smartmeds Pharmacy Group

Randolph Huebel
Medical Pharmacy

Dina Ibrahim
Shoppers Drug Mart

Samant Kataria
Smartmeds Pharmacy Group

Aleksandra Paszczenko
Smartmeds Pharmacy Group

Kathryn Pollock
Pharma Plus Drugmart

Angela Wylie
Smartmeds Pharmacy Group

CALEDONIA

Refka Mansour
Drugstore Pharmacy

Umair Nasim
Shoppers Drug Mart

CAMBRIDGE

Andrea MacPhee
Shoppers Drug Mart

Sanjay Patel
Drugstore Pharmacy

CARLETON PLACE

Aziz Dhalla
Carleton Place IDA Drugmart

Ghada Gabr
Shoppers Drug Mart

CHATHAM

Gary Deroo
Chatham Kent Health
Alliance

Diane Gillis
Chatham-Kent Health
Alliance

Peter Semchism
Zellers Pharmacy

COBOURG

Stephen White
Wal-Mart Pharmacy

COLLINGWOOD

Tonya McLellan
Wal-Mart Pharmacy

CONCORD

Heather Woodhouse
Glen Shields Pharmacy

CORNWALL

Abolhasan Ahangaran
Drugstore Pharmacy

Rupinder Bharaj
Wal-Mart Pharmacy

Michelle Ha
Cornwall Medical Pharmacy

DON MILLS

Bella Brody
Medico Pharmacy

DOWNSVIEW

Mandeep Bharaj
Shoppers Drug Mart

Ping-Ching (Penny) Chan
Zellers Pharmacy

Julie Choudhury
Humber River Regional Hospital

Amro Noureldin
Main Drug Mart

Refat Samuel
Jane Centre Pharmacy

Lekhmati Singh
Humber River Regional Hospital

DUNDAS

Jennifer Friedland
Daynight Pharmacy

Mariana Vernescu
Shoppers Drug Mart

ETOBICOKE

Saeed Tahir
Axis Al-Shafa Pharmacy

Lawrence Ura
Shoppers Drug Mart

Abdul Wajid
Drugstore Pharmacy

Nancy Zaytoon
Pharmacy 1 Drug & Food

GANANOQUE

Ann Ajram
Shoppers Drug Mart

Jean Tang
Pharmasave

GEORGETOWN

Fatima Vieira-Cabral
Halton Healthcare

GLOUCESTER

Raafat Khalil
Blair Road Pharmacy

GUELPH

Mohammad Alam
Shoppers Drug Mart

Dimiana Botros
The Medicine Shoppe

Shimon Cabrera
Zellers Pharmacy

Issac Gergs
Campus Drugmart

Tan Huynh
Pharma Plus Drugmart

Sanjita Laing
The Pharmacy

HAMILTON

Denis Angelatos
Hess Tower IDA Pharmacy

Maha Awad
The Medicine Shoppe

Yin (Rita) Chan
Hamilton Health Sciences Corp

Marco De Andrade
Shoppers Drug Mart

Heather Emerson
Wal-Mart Pharmacy

Riyaz Govani
Shoppers Drug Mart

Joanna Grabowski
Dell Pharmacy

Helen Habinski
Drug Basics

Jafar Hanbali
Shoppers Drug Mart

Neil Horvath
Pharma Plus Drugmart

Philip Hosiassohn
Day Night Pharmacy

Jolanta Jeziorowska
Hamilton Health Sciences Corp

Luay Khaled
Shoppers Drug Mart

Betty Kurian
Zellers Pharmacy

Saji Mathew
Zellers Pharmacy

Olivera Muratovic
Shoppers Drug Mart

Geoffrey Newton
King Medical Pharmacy

Carmine Nieuwstraten
St. Joseph's Hospital

Sony Poulose
Shoppers Drug Mart

Kusum Shukla
Shoppers Drug Mart

Khalid Syed
Day Night Pharmacy

Atul Thapar
Shoppers Drug Mart

Mary Thornewell
Hamilton Health Sciences Corp

Chau Tran
Hamilton Health Sciences Corp

Christine Wallace
St. Joseph's Hospital

HANOVER

Rajinder Rajput
Zellers Pharmacy

HAWKESBURY

Viorica Chirila
Zellers Pharmacy

Daniel Lariviere
Pharmacie Hawkesbury Essaim

KANATA

Lori Danyliw
Zellers Pharmacy

Marie Martineau
Pharma Plus Drugmart

Daniela Nitescu
Zellers Pharmacy

Munaza Wasey
Drugstore Pharmacy

KEMPTVILLE

Nghia Truong
Carepharma Drug Mart

KENORA

Cameron Buchanan
Drugstore Pharmacy

Kevin Nielson
Shoppers Drug Mart

KESWICK

Alfred Yu
Shoppers Drug Mart

KINGSTON

George Ho
St. Mary's of the Lake Hospital

Bozica Kokanovic Popovic
Drugstore Pharmacy

Al-Karim Ladak
Zellers Pharmacy

Jennifer Mather
Kingston General Hospital

Bonnie Ralph
Kingston General Hospital

Louise Reynen
Drugstore Pharmacy

Colin Schneider
Medical Arts Pharmacy

Andrea Slack
Shoppers Drug Mart

Mary Staddon
RM & E Rexall Drug Store

Gillian Turnbull
St. Mary's of the Lake Hospital

KITCHENER

Ehab Abdel Sayed
Central Pharmasave Pharmacy

Stacey Andrecyk
Shoppers Drug Mart

Ana Elefteriu
Drugstore Pharmacy

Marie (Johanne) Fortier
Riepert Pharmacy

Mark McNamara
Shoppers Drug Mart

Paul Schaub
Pollock And Williams Pharmacy

LASALLE

Robin Chang
Shoppers Drug Mart

LINDSAY

Meghan Beatty
Drugstore Pharmacy

Catherine Puffer
Pharma Plus Drugmart

David Walker
Shoppers Drug Mart

LISTOWEL

Nelia Ngo
Zellers Pharmacy

LONDON

Gamal Awad
Guardian Wonderland Pharmacy

Charles Bayliff
London Health Sciences Centre

David Bing-Wo
The Pharmacy

Milad Bosta
Zellers Pharmacy

Peter Drodge
Wal-Mart Pharmacy

Nina Hanif
Zellers Pharmacy

Samia Hanna
Drug Basics Pharmacy

Marius Jordaan
Wal-Mart Pharmacy

Syed Mahmood
Wal-Mart Pharmacy

Ola Moubayed El-Chabib
Wal-Mart Pharmacy

Sahleslassie Redae
Drugstore Pharmacy

Ian Saunders
Shoppers Drug Mart

Sharon Yuen
Zellers Pharmacy

MARKHAM

Kai (Ellen) Hu
Markham Stouffville Hospital

Rebecca Leong Ho
Supercare Pharmacy Markham

Ying (Ken) Lui
Wal-Mart Pharmacy

Faisal Motiwala
Fenton Discount Pharmacy

Faranak Pashang
Costco Pharmacy

Mabel Pau
Drug Basics

Christopher Yee
Shoppers Drug Mart

MIDLAND

David Bodunde
Zellers Pharmacy

Susan Donaldson
Wal-Mart Pharmacy

MILTON

Wassim Abdel-Malek
Glen Eden Pharmasave

Calvin Crawford
Zaks Pharmacy

Karim Hanna
Milton IDA Pharmacy

Michelle Moslim
Shoppers Drug Mart

Zahid Patel
Zaks Pharmacy

Dawn Ross
Shoppers Drug Mart

MISSISSAUGA

Akilhussein Adamjee
Wal-Mart Pharmacy

Jauher Ahmad
Shoppers Drug Mart

Nadeem Ahmed
Total Health Guardian Pharmacy

Andrew Awadalla
Total Health Guardian Pharmacy

Andrea Beaman
The Credit Valley Hospital

Amy Bernaldez
Shoppers Drug Mart

Maria Bernardino
The Trillium Health Centre

Yousef Botros
Peckett's Pharmacy

Dennis Cazzin
Guru Nanak Dev Pharmacentre

Divina Dela Cruz
Drugstore Pharmacy

Savminderjit Dhaliwall
The Trillium Health Centre

Salvatore Di Michele
Total Health Guardian Pharmacy

Jimmy Fung
The Credit Valley Hospital

Sherif Ghattas
Total Health Pharmacy

Nishith Ghelani
Meadowvale Prof Cntr Pharmacy

Tawhida Gobara
Zellers Pharmacy

Chaza Hadaia
Pharma Plus Drugmart

Maged Henein
Living Arts Pharmacy (Remedy's Rx)

Charlene Houshmand
The Pharmacy

Kevin Huang
Shoppers Drug Mart

Jiten Jani
The Credit Valley Hospital

Gurdeep Kithoray
Shoppers Drug Mart

Ying (Jessica) Lau
Pharma Plus Drugmart

Hanh Le
The Trillium Health Centre

Jagjit Maghera
Shoppers Drug Mart

Rick Mak
Zellers Pharmacy

Ivonne Matta
Main Drug Mart

Hitesh Pandya
Shoppers Drug Mart

Jai Patel
Unicare Pharmacy

Amal (Maggie) Philemon
Eglinton Churchill Medical Pharmacy

Ramniklal Sachania
Heritage Hills Pharmacy

Anjana Sengar
The Trillium Health Centre

Manju Sharma
The Trillium Health Centre

Chee-Kong Shi
Shoppers Drug Mart

Carolyn Siauw
Sobeys Pharmacy

Sameh Sidrak
King Medical Arts Pharmacy

Yousuf Syed
Costco Pharmacy

Ahmad Waseem
Shoppers Drug Mart

Kausar Wasim
Good Luck Pharmacy

Violet Yousefi
Wal-Mart Pharmacy

NEPEAN

Georgeta Botehkan
Drugstore Pharmacy

Kathleen Jordan
Shoppers Drug Mart

Jefferson Kelly
Shoppers Drug Mart

Maya Najm
Drugstore Pharmacy

Paul Pineo
Shoppers Drug Mart

NEWMARKET

Nashaat Estafanous
Mulock Pharmacy

Francine Liu
Costco Pharmacy

NIAGARA FALLS

Ashraf Boulus
Wal-Mart Pharmacy

Jennie Pichelli
The Greater Niagara Gen Hosptl

Jennifer Schoenhals
Falls Pharmacy Limited

Philip Shum
Pharma Plus Drugmart

Fady Soliman
Pharmashield Dispensary

Barbara Trojanowska
Drugstore Pharmacy

Marnie Varley
Pharma Plus Drugmart

NORTH BAY

Josee Corbeil
North Bay Guardian Pharmacy Limited

Patricia Euler
North Bay General Hospital

Beverly Gordon
Shoppers Drug Mart

NORTH YORK

Dakshesh Amin
York Gate IDA Drug Mart

Hala Demian
Main Drug Mart

Ashraf Faltaous
Shoppers Drug Mart

Bahaa Mehany
Main Drug Mart

Hung Ng
Zellers Pharmacy

Behzad Peyrovan
Drugstore Pharmacy

Norman Tang
Branson Drugstore

OAKVILLE

Irene Asad
St. Mark's Pharmacy

Georgios Benakopoulos
Oakville Town Centre Pharmacy

Fabio De Rango
Shoppers Drug Mart

Saadia Fazil
Halton Healthcare Services

Sherif Gerges
Total Health Pharmacy

Amgad Hakim
River Oaks Medical Pharmacy

Balaji Pamalpadi
Drugstore Pharmacy

Kanwardip Sandhu
Shoppers Drug Mart

ORANGEVILLE

Mercy Assam
Drugstore Pharmacy

Curtis Latimer
Shoppers Drug Mart

ORILLIA

Clarissa De Peralta
Zellers Pharmacy

Uchenna Onwuocha
Wal-Mart Pharmacy

ORLEANS

Bashir Amir
Pharma Plus Drugmart

Perveen Gulati
Shoppers Drug Mart

Bassem Nashed
Crown Pointe Pharmacy

OSHAWA

Patricia Grayhurst
Lakeridge Health

Zaibin Lalani
Guardian Drugs

Leaggy Mwanza
Drugstore Pharmacy

Wynand Van Rooyen
Medical Pharmacy

OTTAWA

Shaghik Abdul-Al-Noor
Rexall Pharma Plus

Majed Abed
Drugstore Pharmacy

Samira Ali-Abdullah
The Drugstore Pharmacy

Shelagh Campbell
Pharma Plus Drugmart

Celine Corman
The Ottawa Hospital

Louis Desjardins
Pharmacie Desjardins Limited

Yousra El-Jaby
Drugstore Pharmacy

Ayman El-Tookhy
Drugstore Pharmacy

Samuel Fleming
Bayshore Pharmacy Limited

Issa Hamati
Zellers Pharmacy

Suzanne Hamzawi
Wal-Mart Pharmacy

Nabil Hanna
Shoppers Drug Mart

Rekha Ishwanthlal
Shoppers Drug Mart

Christine Landry
Montfort Hospital

Emil Megalla
First Care Pharmacy

Charles Rak
Pharma Plus Drugmart

Waseem Shaheen
Drugstore Pharmacy

Joseph Thibault
Shoppers Drug Mart

Patrick Wong
Shoppers Drug Mart

OWEN SOUND

John Paul Gloria
Zellers Pharmacy

PARIS

Donald Townsend
Pharma Plus Drugmart

PEMBROKE

Michelle Baltazar
Zellers Pharmacy

David Foran
Pharma Plus Drugmart

PETERBOROUGH

Dennis Choi
Drugstore Pharmacy

Hani Fam
Charlotte St Shoppers Drug Mrt

Lien Lien
Zellers Pharmacy

Rima Mamiche-Afara
Peterborough Regional Health Centre

Patricia Myall
Peterborough Regional Health Centre

Prasanna Vemula
Drugstore Pharmacy

Catherine White
Peterborough Regional Health Centre

PICKERING

Suraj Benegal
Wal-Mart Pharmacy

Irvin Ng
Zellers Pharmacy

Angela Wu
Pharma Plus Drugmart

PICTON

David Paul
Picton Clinic Pharmacy

PORT COLBORNE

Donald Edwards
Boggio Pharmacy Ltd

PORT ELGIN

Martin Keeping
Drugstore Pharmacy

PORT HOPE

Annaflor Feliprada
Drugstore Pharmacy

REXDALE

Adel Tadros
Austin Albion Pharmacy

RICHMOND HILL

Maher Abdel Malak
Bayview 16th Medical Pharmacy

Kai-Wing (Erwin) Au
A & W Pharmacy

Vera Avetissov
Shoppers Drug Mart

Atossa Babaie-Nami
Richmond Medical Pharmacy

Najma Jaffer
Cims Drug Mart

Sabrina Lam
The Pharmacy

Ehab Mekhail
The Medicine Shoppe

Karen Monaghan
Rexall Community Health Centre

Minoo Navabi
Pharmasante

Renu Pathak
York Central Hospital

Todd Phillips
Neighbourhood Pharmacy

Mirette Riad
Leslie & Major Mac. I.D.A. Pharmacy

Samy Saad
Richpoint Pharmacy

Johnny Wong
26419A & W Pharmacy

SARNIA

Rushabh Damani
Drugstore Pharmacy

Susan McQuaid
Shoppers Drug Mart

Katherine Yap
Shoppers Drug Mart

SAULT STE MARIE

Lou-Ann Blahey
Drugstore Pharmacy

Claudio Cavaliere
Merrett's Pharmacy

Sebastian Desumma
Market Mall Pharmacy

John MacDonald
The Medicine Shoppe

Tracy McCoy
Sault Area Hospital

SCARBOROUGH

Amgad Abdel Sayed
Extra Care Pharmacy

Ahmad Abdullah
Shoppers Drug Mart

Amir Attalla
Zellers Pharmacy

Parvin Bineshian
Kennedy-Eglinton Pharmacy

Thomas Chau
Providence Centre

Michael Chowdhury
Wal-Mart Pharmacy

Hugh Dong
Pharma Plus Drugmart

Sali Ghobrial
Guildwood Drug Mart

Kambiz Harirchi
The Pharmacy

Jerry Ip
Shoppers Drug Mart

Bassem Iskander
Main Drug Mart

Meenaz Jaffer
Drug Basics

Minaaz Kara
Pharmasave

Mohammed Khan
Pharmasave

Paul Lam
Medical Pharmacy

Man (Reginald) Liu
Shoppers Drug Mart

Erlinda Lo
Wal-Mart Pharmacy

Joanna Man
Bay Pharmacy

Emad Mankaruos
Woburn Medical Pharmacy

Agnes Martija
Wal-Mart Pharmacy

Chimanlal Mistry
Mornelle Drug Mart

Victoria Ng
The Scarborough General Hospital

Chi-Wai (Paul) Ng
Zellers Pharmacy

Oluremi Ojo
Guardian Corporate Pharmacy

Chirag Patel
Mornelle Drug Mart

Nayan Patel
Pharmasave

Ramachandran Ramapathy
Pharma Grace Drug Mart

Mark Savage
One Stop Medical Pharmacy

Zahir Visram
Henley Gardens Pharmacy

Edward Wassef
Lapsley Pharmasave

Siu-Ling Wong
Zellers Pharmacy

Terence Wong
Shoppers Drug Mart

Grace Wong
Scarborough Grace Hospital

SIMCOE

Jannette Pinson
Zellers Pharmacy

SOUTHAMPTON

Laurae Kloschinsky
Pharma Plus Drugmart

ST CATHARINES

David Costiniuk
Shoppers Drug Mart

Susan Cubelic
Niagara Health System

Moez Saju
Zellers Pharmacy

Monica-Ursula Stradinger
Drugstore Pharmacy

ST. CATHARINES

William Cuthbert
Dell Pharmacy

Tajammal Qureshi
Shoppers Drug Mart

STIRLING

Balmukund Patel
Balu's Pharmacy (Stirling) Ltd

STITTSVILLE

Aiman Abdull-Rahman
Stittsville IDA Pharmacy

Darlene Yee
Shoppers Drug Mart

STONEY CREEK

Salima Chatur
Hlthcr Plus Phcy & Wellness Cn

Arulanathan Govender
Supercare Pharmacy Stoney Creek Pharmasave

Eugenio Iannuzzi
Pharma Plus Drugmart

Mohammad Kabir
Shoppers Drug Mart

STRATFORD

Paul Roulston
Shoppers Drug Mart

SUDBURY

Joy Azunna-Kalu
Medical Pharmacy

Sami Dabliz
The Pharmacy

Christopher Mobbs
Michaud Medical Pharmacy

Patricia Thompson
Wal-Mart Pharmacy

Fiona Tjoa
Drugstore Pharmacy

TECUMSEH

Sun (Sam) Chan
Tecumseh Medical Pharmacy

THORNHILL

Hany Armanious
Baygreen Pharmacy

Fred Kohan
Pharmacy 1 Drug & Food

Maged Mallouk
North-Med Pharmacy

Samir Patel
Shoppers Drug Mart

Hema Rajawat
Pharmacy 1 Drug & Food

THUNDER BAY

Deborah Emery
St. Joseph's Hospital

Chi (Hao) Luu
Medi+Plus Pharmacy

Maria Catherine Manalili
Zellers Pharmacy

Angelica Rubio
Zellers Pharmacy

Marcia Wilson
Safeway Pharmacy

Mark Zurich
Drugstore Pharmacy

TILBURY

Georgia Kanelopoulos
Mill St. Pharmacy

TILLSONBURG

Annette Toonen
Shoppers Drug Mart

TIMMINS

Natalie Roy
Timmins And District Hospital

Lynette Skinner
Wal-Mart Pharmacy

TORONTO

Sabrina Anand
The Princess Margaret Hospital

Maha Awad
The Medicine Shoppe Pharmacy

Antonetta Bailie
Mount Sinai Hospital

Maria Barnes
Sunnybrook H.S.C.

Edwin Barrera-Liza
Drugstore Pharmacy

Edmund Bielawski
Summit Pharmacy Inc.

Aleksandra Bjelajac Mejia
The Hospital For Sick Children

Lauren Blatt
Toronto Rehab. Institute

Mark Bochan
Summit Pharmacy Inc.

Thomas Brown
Sunnybrook & Womens Col H.S.C

Betty Chan
The Toronto Western Hospital

Dora Chan
GeriatRx Pharmacy

Rita Cheung
St. Joseph's Health Centre

Barbara Cole
Pharma Plus Drugmart

Barbara Coulston
Toronto Rehab. Institute

Fabrizio Damiani
Shoppers Drug Mart

Leslie Duncan
The Princess Margaret Hospital

Ashraf Faltaous
Shoppers Drug Mart

Rifaat Fares
United Drug Mart

Fatemeh Fazeli
Drugstore Pharmacy

Gabriella Fozo-Nagy
The Toronto Western Hospital

Jill Garland
The Toronto General Hospital

Lillian Gavura
Toronto General Hospital Pharmacy

Nabil Gobran
Total Health Pharmacy

Dianne (Kathy) Grise
Drugstore Pharmacy

Henry Halapy
St. Michael's Hospital

Waguih Hanna
Main Drug Mart

Brian Hardy
Sunnybrook Health Sciences Centre

Jennifer Harrison
The Toronto General Hospital

Jun Higuchi
The Pharmacy

Ann Hirst
Drugstore Pharmacy

Jin-hyeun (June) Huh
The Toronto Western Hospital

Raouf Ibrahim
Stonegate Community Pharmacy (IDA)

Akeel Jaffer
Shoppers Drug Mart

Shiva Kalani
Shoppers Drug Mart

Olga Karniol
Drugstore Pharmacy

William Kassel
Kassel's Pharmacy Limited

Clarissa Kim
St. Joseph's Health Centre

Michelle Kim
Shoppers Drug Mart

Alaric Kimson
Wal-Mart Pharmacy

Brenda Kisic
The Toronto General Hospital

Alan Kong
Northcliffe Pharmacy

Josephine Kong
Costco Pharmacy

Ivan Kraljevic
Shoppers Drug Mart

Allen Kula
The Medicine Shoppe

Ri-feng (Richard) Lam
Drugstore Pharmacy

Mei (Connie) Lam
Drugstore Pharmacy

Joanne Lapointe
Toronto East Gen & Ortho Hosp

Po-Yan Ruth Law
St. Joseph's Health Centre

Kori Leblanc
University Health Network Tgh

Ki-Seok (Daniel) Lee
Bloor Park Pharmacy

Chung Lee
Pharma Plus Drugmart

Amy Lee
Drugstore Pharmacy

Richard Lin
Shoppers Drug Mart

Angie Lo
Shoppers Drug Mart

Michel Makary
Main Drug Mart

Kaye Mekawi
Zellers Pharmacy

Sami Mikhaeil
Sam's I.D.A. Pharmacy

Manijeh Mohammadi Kiasarai
Drugstore Pharmacy

Adriana Nedea
Summit Pharmacy Inc.

Angelina Ng
Welcome Guardian Drugs

Fanika Nikiforovski
Drugstore Pharmacy

Benson Ning
Princess Margaret Hospital Pharmacy

Mohamed Osman
Zellers Pharmacy

Parisa Pakbaz
Shoppers Drug Mart

Malay Panchal
City Pharmacy

Marissa Panganiban
Zellers Pharmacy

John Papastergiou
Shoppers Drug Mart

Phoebe Quek
Ambulatory Patient Pharmacy

Javad Ramazankhani
Shoppers Drug Mart

Brigitte Reiner
Kassel's Pharmacy Limited

Abraam Rofael
Zellers Pharmacy

Mostafa Roshan
Drugstore Pharmacy

Katayoun Sabet
Pharma Plus Drugmart

Paola Saccucci
St. Michael's Hospital

Sameh Salib
Woodgreen Discount Drugs

Richard Sigesmund
Scarborough Village Pharmacy

Gordon Silverton
Medical Pharmacy

Adam Silvertown
Pharma Plus Drugmart

Biljana Simic-Zivkovic
Shoppers Drug Mart

Tetyana Sklierenko
Best Drug Mart

Luladay Solomon
Shoppers Drug Mart

Safwat Sourial
Shoppers Drug Mart

Nadia Sourour
Keele & Rogers Pharmacy

Beth Sproule
Addiction Research Foundation

Oksana Stepczuk
St. Michael's Hospital

Carmine Stumpo
Toronto East Gen & Ortho Hosp

Kenny Tan
Shoppers Drug Mart

Pablo Tiscornia
Pharma Plus Drugmart

Penelope Tsang
Pharma Plus Drugmart

Wilhelm Venter
Shoppers Drug Mart

Judith Vepy
Baycrest Hospital

Jackie Vo
The Pharmacy

Janet Weber
Pharma Plus Drugmart

John Weymouth
Don Russell Drug Mart

Amy Wong
The Pharmacy

Cindy Wong
Mount Sinai Hospital

Kam Wong
The Toronto Western Hospital

Kamal Yeganegi
Zellers Pharmacy

Peter Youhanna
Islington Medical Pharmacy

Kamal Yousf
Greendale Drugs

Clement Yuen
The Toronto General Hospital

Roudolph Zaky
Sone's Pharmacy

TRENTON

Fiona Arbiter
Pharma Plus Drugmart

Debra Moffatt
Shoppers Drug Mart

Emilija Tasevska
Wal-Mart Pharmacy

UXBRIDGE

Gautam Bhatia
Drugstore Pharmacy

VANIER

Anishkumar Sanghavi
Drugstore Pharmacy

VAUGHAN

Pirasteh Adab
Drugstore Pharmacy

Nineta Anghelache
Sobeys Pharmacy

Jamil Ebrahimzadeh Ahari
Drugstore Pharmacy

Manuela Moldovan
Drugstore Pharmacy

Soheila Rajablarijani
Shoppers Drug Mart

WALLACEBURG

Jennifer Meades
Pharma Plus Drugmart

WASAGA BEACH

Basem Ghatas
Shoppers Drug Mart

WATERDOWN

Saly Thomas
Drugstore Pharmacy

WATERFORD

Robert Sloot
Pharma Plus Drugmart

WATERLOO

Veneta Anand
Shoppers Drug Mart

Mahboob Fatima
Drugstore Pharmacy

Stefan Gudmundson
Shoppers Drug Mart

WELLAND

Elizabeth Jackson
Rexall Clinic Pharmacy

Shawn Severin
Zellers Pharmacy

WHITBY

Waseem Baig
Shoppers Drug Mart

Susan Bowser
Shoppers Drug Mart

Maria Enrique
Wal-Mart Pharmacy

Norman Lexovsky
Shoppers Drug Mart

Parnia Razi
Whitby Mental Health Centre

WILLOWDALE

Albert Cheng
Pharma Plus Drugmart

Hany Doss
Main Drug Mart

Ara Kolandjian
Shoppers Drug Mart

Parisa Pakbaz
Metro Pharmacy

Renee Rode
Shoppers Drug Mart

Malgorzata Samuel
Drug Basics Pharmacy

Robert Scherz
Zellers Pharmacy

Shohreh Torabi
Metro Pharmacy

WINDSOR

Timothy Brady
Shoppers Drug Mart

Cathie Bunt
Hotel-Dieu Grace Hospital

Kristin Cada
Shoppers Drug Mart

Carmela Catizzone
Erie Rexall

Dennis Koren
Avenue Pharmacy

Michael Ledoux
Windsor Regional Hospital

Ricardo Obusan Jr.
Zellers Pharmacy

Eulalia Ocampo
Windsor River Pharmacy

Lynnette Ridley
Windsor Regional Hospital

Vesna Spadafora
Hotel-Dieu Grace Hospital

WOODBRIDGE

Seh-Hwan Ahn
The Pharmacy

Imran Latif
Costco Pharmacy

Caterina Mazza
Pharma Plus Drugmart

Mona Raphael
Hendersons Woodbridge Medical Pharmacy

WOODSTOCK

Peter Drodge
Wal-Mart Pharmacy

Leigh Heald
Medical Pharmacy

Josiah Odumodu
The Dispensary

Elizabeth Silverthorne
Shoppers Drug Mart

CE EVENTS

Visit the College's website: www.ocpinfo.com for a complete listing of upcoming events and/or available resources. A number of the programs listed below are also suitable for pharmacy technicians.

GTA

January 16-18, 2008: Toronto
Advanced Cardiology Pharmacy Practice Part III
The Leslie Dan Faculty of Pharmacy, University of Toronto
Office of Continuous Professional Development
Contact: Maria Bystrin
Tel: 416-978-2889
Email: cpd.pharmacy@utoronto.ca
http://cpd.phm.utoronto.ca/cardiology_pharmacy.html

January 22, 2008: Scarborough
January 24, 2008: Vaughan
Guide Your Patients to a Smoke Free Future
Clinical Tobacco Intervention (CTI) Program Training
Ontario Pharmacists' Association
Contact: Tania Antenucci
Tel: 416-441-0788
Email: tantenucci@opatoday.com
http://www.ctica.org/training/train.html

January 26-30, 2008: Toronto
Canadian Society of Hospital Pharmacists
Professional Practice Conference (PPC) 2008
Contact: Desarae Davidson
Tel: 613-736-9733 ext. 229
Email: ddavidson@cshp.ca
http://www.cshp.ca

March 30, 2008: Toronto
Methadone Maintenance Treatment (MMT) Classroom Workshop
Centre for Addiction and Mental Health
Contact: Rosalicia Rondon
Tel: 416-535-8501 ext. 6658
Email: rosalicia_rondon@camh.net
http://www.camh.net/education/Classroom_courses_forums_events/CPE_course_calendar/methadone_maintenance_cpeclass.html

ONTARIO

February 16, 2008: Ottawa
The Ottawa Valley Regional Drug Information Service
Annual Conference
Contact: Linda Ahmad
Tel: 613-737-8347 ext. 1
Email: lahmad@ottawahospital.on.ca

NATIONAL

May 31-June 3, 2008: Victoria, BC
Canadian Pharmacists Association
Annual National Conference
http://www.pharmacists.ca

INTERNATIONAL

March 14-17, 2008: San Diego, USA
American Pharmacists Association
Annual Meeting and Exposition
Tel: 1-877-842-3133 or 1-972-395-1119
Email: APhA2008@badgeguys.com
http://www.aphameeting.org

TELECONFERENCES

January 30, 2008 (1:30pm – 3:00pm)
Safe Use of Automated Dispensing Cabinets: Choosing Safety over Convenience
Institute for Safe Medication Practices
http://www.ismp.org/educational/teleconferences.asp

ONLINE COURSES & WEBINARS

January 21, 2008
Methadone Maintenance Treatment (MMT) Online Course (7 weeks)
Centre for Addiction and Mental Health
Contact: Rosalicia Rondon
Tel: 416-535-8501 ext. 6658
Email: rosalicia_rondon@camh.net
http://www.camh.net/education/Online_courses_webinars/methmaint_online_overview.html

January 21-28, 2008
Exposure to Psychotropic Medications & Other Substances during Pregnancy & Lactation (Webinar Series)
Centre for Addiction and Mental Health
Contact: Robyn Steidman
Tel: 416-535-8501 ext. 6640
http://www.camh.net/education/Online_courses_webinars/safe_baby_webinars.html

January to March 2008: Various Dates
Methadone Education Program
Optimizing Treatment of Patients on Methadone Maintenance Treatment (MMT)
Ontario Pharmacists' Association
Contact: Janice Tang
Tel: 416-441-0788 ext. 2225
Email: jtang@dirc.ca
http://www.dirc-canada.org/methadone.asp

Laws & Regulations - February 2008

Drug and Pharmacies Regulation Act (DPRA) *▲
Amended 2007
Regulations to the DPRA:
DPRA R.R.O. 1990, Regulation 545 – Child Resistant Packages
DPRA Ontario Regulation 297/96 Amended to O.Reg. 180/99 – General
DPRA R.R.O. 1990, Regulation 551 Amended to O.Reg. 179/99 – General

Drug Schedules **
Summary of Laws Governing Prescription Drug Ordering, Records, Prescription
Requirements and Refills - June 2007 OCP
Canada's National Drug Scheduling System – December 5, 2007 NAPRA (or later)

Regulated Health Professions Act (RHPA) *▲
Amended 2007
Regulations to the RHPA:
Ontario Regulation 39/02 -Certificates of Authorization Amended to O.Reg. 666/05
Ontario Regulation 107/96 – Controlled Acts Amended to O.Reg. 296/04
Ontario Regulation 59/94 – Funding for Therapy or Counseling for Patients Sexually Abused by Members

Pharmacy Act (PA) & Regulations *▲
Amended 2007
Regulations to the PA:
Ontario Regulation 202/94 Amended to O.Reg. 270/04 – General
Ontario Regulation 681/93 Amended to O.Reg. 122/97 – Professional Misconduct

Standards of Practice ▲
Standards of Practice, January 1, 2003 OCP
Standards of Practice for Pharmacy Managers, July 1, 2005

Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations *▲
Amended 2007
Regulations to the DIDFA:
R.R.O. 1990 Regulation 935 Amended to O.Reg. 558/06 – General
R.R.O. 1990 Regulation 936 Amended to O.Reg. 205/96 – Notice to Patients

Ontario Drug Benefit Act (ODBA) & Regulations *▲
Amended 2007
Regulations to the ODBA:
Ontario Regulation 201/96 Amended to O.Reg. 559/06 – General

Food and Drugs Act (FDA) & Regulations ✇**
Updated as of Dec. 31, 2006
Amendment 1478 & 1491 – Addition of two medicinal ingredients to Part I of Schedule F. Reg. SOR/2007-224, Oct 25/07
Amendment 1476, 1502, 1511 and 1512 – Addition of nine medicinal ingredients to Part I of Schedule F. Reg SOR/2007-234, Oct 25/07

Controlled Drugs and Substances Act (CDSA) **
Current as of November, 2007
Regulations to the Controlled Drugs and Substances Act (CDSA) **
All regulations updated March, 2007
Benzodiazepines & Other Targeted Substances Regulations
Marihuana Medical Access Regulations
Precursor Control Regulations
Regulations Exempting Certain Precursors and Controlled Substances from the Application of the Controlled Drugs and Substances Act

Narcotic Control Regulations **
Current as of November, 2007

OCP By-Laws By-Law No. 1 – December 2007 ▲
Schedule A - Code of Ethics for Members of the Ontario College of Pharmacists - December 2006
Schedule B - "Code of Conduct" and Procedures for Council and Committee Members - December 2006
Schedule C - Member Fees - Effective January 1, 2007
Schedule D - Pharmacy Fees - Effective January 1, 2007
Schedule E – Certificate of Authorization – Jan. 2005
Schedule F - Privacy Code - Dec. 2003

Reference ▲
Handling Dispensing Errors, Pharmacy Connection Mar/Apr 1995
Revenue Canada Customs and Excise Circular ED 207.1
Revenue Canada Customs and Excise Circular ED 207.2
Guidelines for the Pharmacists on "The Role of the Pharmacy Technician"
OCP Required Reference Guide for Pharmacies in Ontario, June 2007

* Information available at **Publications Ontario** (416) 326 5300 or 1 800 668 9938 www.e laws.gov.on.ca
** Information available at **www.napra.org**
✇ Information available at **Federal Publications Inc.** Ottawa: 1 888 4FEDPUB (1 888 433 3782) Toronto: Tel: (416) 860 1611 • Fax: (416) 860 1608 • e mail: info@fedpubs.com
▲ Information available at **www.ocpinfo.com**

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