



Ontario College
of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

FALL 2017 • VOLUME 24 NUMBER 4

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

AN OPIOID STRATEGY FOR PHARMACY:

Putting the Pieces Together to
Tackle Ontario's Opioid Crisis **14**

ALSO IN THIS ISSUE:

Preventing Diversion **18**

Practice Assessments:
An Important Component
of Quality Assurance **26**

What Would You Do? **30**

College Selects CQA
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COUNCIL MEMBERS

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

H Régis Vaillancourt
 (President)
 H Vacant
 K Esmail Merani
 K Tracey Phillips
 L Billy Cheung
 L James Morrison
 L Sony Poulose
 M Mike Hannalah
 M Kyro Maseh
 M Laura Weyland
 (Vice President)
 N Gerry Cook
 N Karen Riley
 N Leigh Smith
 P Rachelle Rocha
 P Douglas Stewart
 T Ruth-Ann Plaxton
 TH Goran Petrovic

PM Kathy Al-Zand
 PM Linda Bracken
 PM Christine Henderson
 PM Robert Hindman
 PM Javaid Khan
 PM James MacLaggan
 PM Elnora Magboo
 PM Sylvia Moustacalis
 PM Joan A Pajunen
 PM Shahid Rashdi
 PM Joy Sommerfreund
 PM Dan Stapleton
 PM Ravil Veli
 PM Wes Vickers
 U of T Heather Boon
 U of W David Edwards

Statutory Committees

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

Standing Committees

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



**Ontario College
 of Pharmacists**
 Putting patients first since 1871

Strategic Framework 2015-2018

Mission

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

Vision

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

Values

Transparency



Accountability



Excellence

Strategic Priorities

Core Programs
 Fulfillment of Mandate



Optimize Practice
 within Scope



Inter & Intra
 Professional
 Collaboration

Strategic Initiatives

Patients First
Effective Communications
Continuous Quality Improvement

The objectives of *Pharmacy Connection* are to communicate information about College activities and policies as well as provincial and federal initiatives affecting the profession; to encourage dialogue and discuss issues of interest to pharmacists, pharmacy technicians and applicants; to promote interprofessional collaboration of members with other allied health care professionals; and to communicate our role to members and stakeholders as regulator of the profession in the public interest.

We publish four times a year, in the Fall, Winter, Spring and Summer.

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

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FALL 2017 • VOLUME 24 NUMBER 4

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Régis Vaillancourt,
O.M.M., C.D., B. Pharm.,
Pharm. D., R. Ph.

President

I am honoured to enter my second term as Council President and would like to extend a warm welcome to our newly elected professional and public Council members. There has never been a more transformative time to be a part of Council and to actively contribute to serving in the public interest. Given how much the role of pharmacy professionals in our health system continues to grow and evolve and how much patients and the public look to us to play a leadership role in promoting safe and quality patient care, the significance of this responsibility cannot be understated.

We have been and should always be driven by a commitment to put patients first, as a regulator and as professionals. The *Protecting Patients Act 2017*, which was passed as law earlier this year, is a tremendously powerful reminder that we have all been entrusted with keeping patients at the centre of everything we do. I know that each and every one of us on Council is eagerly looking forward to working with pharmacy

professionals throughout the province in the pursuit of our public-protection mandate.

There are so many important issues and initiatives that are presenting both challenges and opportunities for the profession of pharmacy and the broader healthcare system. But there is no question that one of the most pressing health concerns in our society today is the opioid crisis. For that reason, we have made opioid-related issues a central theme of this edition of *Pharmacy Connection*.

The human impact of the opioid crisis – one that affects not just our province, but the country and the continent – compels us all to act. As pharmacy professionals, we have an important role to play. As a College, we are helping to define what that role can be with the creation of a new [Opioid Strategy for Pharmacy](#).

“The human impact of the opioid crisis – one that affects not just our province, but the country and the continent – compels us all to act.”

This strategy, approved at our recent Council meeting, recognizes pharmacy professionals as medication and clinical experts who can be instrumental in our health system's collective effort to prevent harm to patients and promote healthier communities in which we all live and serve.

There is always an expectation that pharmacy professionals are using their knowledge and skills to support their patients, including

engaging in ongoing education, collaborating with prescribers, identifying opportunities for harm reduction and prevention of overdose and addiction, and ensuring that they and their pharmacies are providing safe, ethical and quality patient care. Our strategy is built around these expectations and the initiatives and activities that will flow from this strategy are focused on enabling and supporting your role in responding to this public health crisis.

The development of our strategy is just our first step. Our priority now is to bring this strategy to life.

In this issue of *Pharmacy Connection* you will learn more about what our strategy will focus on so that you can begin to think about how you can contribute to its success, both individually and collectively.

As the College engages pharmacy professionals and other health system stakeholders in the development of a practical plan to move this work forward, I encourage you to continue to watch for updates and embrace your role in an opioid strategy that we believe will have a real and sustained impact on people's lives throughout the province. 

SEPTEMBER 2017

COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on September 18th and 19th, 2017.

COUNCIL ELECTIONS FOR 2017-2018 COUNCIL TERM

Following elections held earlier in August, Council welcomed newly elected members Mr. Mike Hannalah and Mr. Kyro Maseh (District M), Ms. Leigh Smith (District N), Ms. Rachelle Rocha (District P) and Ms. Ruth-Ann Plaxton (District T). Newly appointed public members, Mr. Robert Hindman (Shuniah) and Mr. Dan Stapleton (Toronto) were also welcomed. Re-elected to Council were Ms. Laura Weyland (District M) and Mr. Doug Stewart (District P).

Each September, Council holds elections for the positions of President, Vice President and Committee Chairs. We are pleased to announce that Dr. Régis Vaillancourt was re-elected College President and Ms. Laura Weyland was elected Vice-President. We are also pleased to announce the following Committee Chairs:

- Executive – Régis Vaillancourt
- Accreditation and Drug Preparation Premises – Christine Donaldson*
- Discipline – Doug Stewart
- Finance and Audit – Javaid Khan
- Fitness to Practise – Kathy Al-Zand
- Inquiries, Complaints and Reports – Laura Weyland
- Patient Relations – Joy Sommerfreund
- Quality Assurance – Tracey Phillips
- Registration – Ravil Veli

*Has subsequently resigned and Billy Cheung was appointed Chair.

A complete list of Committee membership will be posted to the public website by early October following the appointment of non-Council committee members.

2018 OPERATING AND CAPITAL BUDGET APPROVED

Council approved the 2018 College budget. The budget includes a plan to draw down on reserves as necessary to cover a shortfall of revenue against expenses. As a result, no fee increases are recommended for 2018. The budget supports the fulfillment of key initiatives set out in the third and final year of the current strategic plan and the ongoing activities associated with our regulatory responsibilities.

Council will undertake a strategic planning process in the spring of 2018 to set the direction and priorities for a new strategic plan commencing in 2019. This planning exercise will seek to further align College strategy with health-system priorities and government initiatives such as those stemming from the *Protecting Patients Act, 2017* including the development of regulations that will advance the College's public-protection mandate and strengthen public confidence in the work of Ontario's health regulatory colleges.

COUNCIL APPROVES OPIOID STRATEGY

The College is committed to supporting and complementing action undertaken by provincial and federal governments and other health system stakeholders to reduce the abuse and misuse of opioids and prevent overdose and addiction. To this end, an Opioid Task Force was created to support the development of a [College Opioid Strategy](#). The Strategy, which was presented to and approved by Council at this September meeting, supports the



College's mandate to serve and protect the public's interest and focuses on four key priorities:

1. Education for Pharmacy Professionals Regarding Opioid Issues

- For example, identifying and collaborating on the development of a morphine equivalent dosing (MED) tool.

2. Opioid Dependence Treatment and Harm Reduction

- For example, increasing access to naloxone (in pharmacies) for high risk opioid use patients.

3. Prevention of Overdose and Addiction

- For example, enabling pharmacist adaptation of controlled substances to support tapering of opioids and targeted substances.

4. Quality Assurance of Practice

- For example, initiating collaboration among healthcare providers to address management of opioids in hospital operating rooms and emergency departments.

The next steps will be for College staff to prioritize and implement the key initiatives identified in the Strategy. The CEO and Registrar will provide a progress update on opioid-related initiatives at each Council meeting.

Council also welcomed a presentation by Dr. David Juurlink on the opioid crisis in North America.

Dr. Juurlink is an Eaton Scholar and Professor of Medicine and Pediatrics at the University of Toronto. He is also a Senior Scientist at the Institute for Clinical Evaluative Sciences (ICES) and Head of the Division of Clinical Pharmacology and Toxicology at the University of Toronto. His presentation touched on the role of prescribers and dispensers of opioids, patient safety and the factors that led to the development of the opioid culture and the public health crisis we're faced with today.

PROPOSED CHANGES TO THE PHARMACY ACT, 1991 APPROVED FOR PUBLIC CONSULTATION

In September 2016, Council approved frameworks for updating quality assurance and registration regulations that would allow the College to proceed with drafting amendments that are outcomes-based and that are supported by standards, policies and guidelines which can change over time to enable the evolution of pharmacy practice. Amendments to these regulations were drafted in accordance with the approved frameworks and presented to Council at the September 2017 meeting.

The proposed amendments will assure greater transparency to the public, streamline the registration process and improve accountability by:

- implementing an Intern Pharmacist and Intern Pharmacy Technician class of registration;
- incorporating pharmacy technicians into the quality assurance regulations;
- eliminating unnecessary steps in registration; and



- shifting from an hourly reporting of practice to a self-declaration of competency in conjunction with practice assessments.

Council approved the recommendation that these proposed regulation changes be circulated for open consultation. In accordance with the *Regulated Health Professions Act, 1991* the proposed changes will be posted on our public website for 60 days. The deadline for input and comment on the regulations is November 20, 2017. A consultation report, including a summary of feedback, will be presented to Council for consideration in December 2017.

CANNABIS FOR MEDICAL PURPOSES

After receiving a report on the status of legalization of cannabis and after a discussion involving members of Council who declared no conflict of interest on this meeting item, Council agreed to establish a task force to review and make recommendations on the role of pharmacy related to cannabis for medical purposes. The task force will report back to Council at a future meeting.

PROTECTING PATIENTS ACT, 2017 UPDATE

Council received an update on the *Protecting Patients Act, 2017 (PPA)* including a summary of changes made to the *Regulated Health Professions Act, 1991 (RHPA)* and *Drug and Pharmacies Regulation Act, 1990 (DPRA)*. The PPA was introduced to strengthen Ontario's zero-tolerance policy on sexual abuse by regulated health professionals and support greater accountability and transparency in the healthcare system.

The College is looking forward to ongoing dialogue with the Ministry of Health and Long-Term Care as the government moves forward with developing draft regulations over the coming months. Member and public communication and education as regulations come into effect will be a top priority.

COUNCIL MEETINGS IN 2017

- Monday 11 December, 2017

Council meetings are open to the public and are held in the Council Chambers of the College at 483 Huron Street, Toronto, ON M5R 2R4. If you plan to attend, or for more information, please contact Ms. Ushma Rajdev, Council and Executive Liaison at council@ocpinfo.com. You can also follow along via Twitter as the College now live-tweets during Council meetings.

REGIONAL MEETINGS

The College hosted a series of member regional meetings this fall. Meetings were held in Toronto (October 10), Ottawa (October 12), London (October 26) and Sudbury (November 1). Webcast options were available for the Toronto and London events. 



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COUNCIL

2017/2018

2017/2018 Committee Appointments

ACCREDITATION AND DRUG

PREPARATION PREMISES

COUNCIL MEMBERS:

Billy Cheung (Chair)
Elnora Magboo
Goran Petrovic
Joy Sommerfreund

NON-COUNCIL MEMBERS:

Dean Miller
Tracy Wiersema
Ali Zohouri

STAFF RESOURCE: Tina Perlman (Acc)
Judy Chong (DPP)

EXECUTIVE

COUNCIL MEMBERS:

Régis Vaillancourt – President & Chair
Laura Weyland – Vice President
Esmail Merani – Past President
Kathy Al-Zand
Christine Henderson
Sylvia Moustacalis
Doug Stewart

STAFF RESOURCE: Nancy Lum-Wilson

FINANCE AND AUDIT

COUNCIL MEMBERS:

Javaid Khan (Chair)
Linda Bracken
Gerry Cook
Esmail Merani
Dan Stapleton
Doug Stewart

STAFF RESOURCE: Connie Campbell

FITNESS TO PRACTISE

COUNCIL MEMBERS:

Kathy Al-Zand (Chair)
Christine Henderson
Javaid Khan
James Morrison
Ruth-Ann Plaxton

NON-COUNCIL MEMBERS:

Jocelyn Cane
Dina Dichek
Mark Scanlon

STAFF RESOURCE: Maryan Gemus

PATIENT RELATIONS

COUNCIL MEMBERS:

Joy Sommerfreund (Chair)
Kathy Al-Zand
Linda Bracken
Sony Poulouse
Karen Riley
Rachelle Rocha
Dan Stapleton

NON-COUNCIL MEMBERS:

Fel dePadua

STAFF RESOURCE: Todd Leach

DISCIPLINE

COUNCIL MEMBERS:

Doug Stewart (Chair)
Kathy Al-Zand
Heather Boon
Linda Bracken
Gerry Cook
Dave Edwards

Mike Hannalah
Christine Henderson
Robert Hindman
Javaid Khan
James MacLaggan
Kyro Maseh
Esmail Merani
James Morrison
Sylvia Moustacalis
Joan A Pajunen
Tracey Phillips
Ruth-Ann Plaxton
Sony Poulouse
Karen Riley
Shahid Rashdi
Rachelle Rocha
Leigh Smith
Dan Stapleton
Régis Vaillancourt
Ravil Veli
Wes Vickers

NON-COUNCIL MEMBERS:

Chris Aljawhiri
Jennifer Antunes
Anuoluwapo Bank-Oni
Ramy Banoub
Erik Botines
Charles Chan
Michael Cheung
Alicia Chin
Fel dePadua
Dina Dichek
Jim Gay
Jillian Grocholsky
Stephana Hung
Rachel Koehler
Andreea Laschuk
Katherine Lee
Chris Leung
Cara Millson
Doris Nessim
Don Organ
Akhil Pandit Pautra
Aska Patel
Mark Scanlon
Jeannette Schindler
Connie Sellors
David Windross

STAFF RESOURCE: Maryan Gemus

QUALITY ASSURANCE

COUNCIL MEMBERS:

Tracey Phillips (Chair)
Robert Hindman
Elnora Magboo
Sylvia Moustacalis
Ruth-Ann Plaxton
Leigh Smith

NON-COUNCIL MEMBERS:

Lavinia Adam
Tina Boudreau
Shelley Dorazio
Jon MacDonald

STAFF RESOURCE: Susan James

INQUIRIES, COMPLAINTS AND REPORTS (ICRC)

COUNCIL MEMBERS:

Laura Weyland (Chair)
Kathy Al-Zand
Heather Boon
Linda Bracken
Billy Cheung
Gerry Cook
Mike Hannalah
Christine Henderson
Robert Hindman
Javaid Khan
Elnora Magboo
Kyro Maseh
James Morrison
Sylvia Moustacalis
Joan A Pajunen
Goran Petrovic
Sony Poulouse
Shahid Rashdi
Rachelle Rocha
Joy Sommerfreund
Ravil Veli

NON-COUNCIL MEMBERS:

Elaine Akers
Sajjad Giby
Frank Hack
Bonnie Hauser
Mary Joy
Elizabeth Kozyra
Chris Leung
Jon MacDonald
Dean Miller
Akhil Pandit Pautra
Vyom Panditpautra
Aska Patel
Chintankumar Patel
Saheed Rashid
Jeannette Schindler
Ian Stewart
Dan Stringer
Asif Tashfin
Frank Tee
Tracy Wiersema
Debra Willcox

STAFF RESOURCE: Anne Resnick

REGISTRATION

COUNCIL MEMBERS:

Ravil Veli (Chair)
Billy Cheung
Robert Hindman
Esmail Merani
Sony Poulouse
Karen Riley
Wes Vickers

NON-COUNCIL MEMBERS:

Tammy Cassin
Sajjad Giby
Vyom Panditpautra
Deep Patel
Dean
Dave Edwards
Ontario Pharm Tech Program Rep.
Sharon Lee

STAFF RESOURCE: Sandra Winkelbauer

2017/2018

P

K

L

M

N

Province-wide

H Hospital

T Pharmacy Technician

TH Hospital Pharmacy Technician

PUBLIC MEMBERS



Kathy Al-Zand
Ottawa



Linda Bracken
Marmora



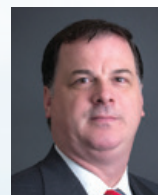
Christine Henderson
Toronto



Robert Hindman
Shuniah



Javaid Khan
Markham



James MacLaggan
Bowmanville



Elnora Magboo
Brampton



Sylvia Moustacalis
Toronto



Joan A Pajunen
Kilworthy



Shahid Rashdi
Mississauga



Joy Sommerfreund
London



Dan Stapleton
Toronto



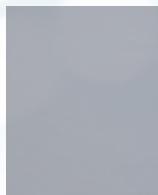
Ravil Veli
North Bay



Wes Vickers
LaSalle

ELECTED MEMBERS

District **H**



Vacant



Régis Vaillancourt
PRESIDENT
Ottawa

District **K**



Esmail Merani
Carleton Place



Tracey Phillips
Westport

District **L**



Billy Cheung
Markham



James Morrison
Burlington



Sony Poulou
Hamilton

District **M**



Mike Hannalah
Toronto



Kyro Maseh
Toronto



Laura Weyland
VICE-PRESIDENT
Toronto

District **N**



Gerry Cook
London



Karen Riley
Sarnia



Leigh Smith
Cambridge

District **P**



Rachelle Rocha
Espanola



Douglas Stewart
Sudbury

Faculty of **PHARMACY**



Heather Boon
Leslie Dan Faculty
of Pharmacy
University of Toronto



David Edwards
Hallman Director
School of Pharmacy
University of Waterloo

District **T/TH**



Ruth-Ann Plaxton (T)
Owen Sound



Goran Petrovic (TH)
Kitchener



This feature in *Pharmacy Connection* is a place to find information about news stories we're following. Here, you'll read summaries of recent stories relating to pharmacy in Ontario and Canada. For the latest updates, stay tuned to [e-Connect](#) and www.ocpinfo.com

NEW REPORTING MECHANISMS PROPOSED FOR DRUG COMPANY PAYMENTS TO HEALTHCARE PROFESSIONALS

New legislation was introduced in the Ontario legislature on Wednesday, September 27, 2017, that [will require pharmaceutical companies and medical device makers to report payments and benefits that they've given to healthcare providers](#), including meals, hospitality, travel associated expenses and financial grants. The onus will be on the drug companies and device manufacturers to publicly report this information. The government has indicated that they will be establishing a searchable database, where members of the public can search for an individual healthcare professional by name.

This legislation will apply to all of Ontario's 26 regulated healthcare professions. It is anticipated that data collection will begin in 2019.

Pharmacy professionals are reminded that under the [Pharmacy Act O.Reg 130/17](#), they must not practice the profession while in a conflict of interest. Additionally, the Code of Ethics speaks specifically to conflicts of interest and ethical business practices, including Standard 4.31: "Members enter into relationships with industry which are appropriate and in compliance with this Code and which allow them to maintain their professional integrity and retain public trust and confidence."

OHIP+, PHARMACARE PROGRAM FOR CHILDREN AND YOUTH, BEGINS JANUARY 1

Starting January 1, 2018, all children and youth aged 24 and under who are OHIP insured will be automatically covered under the Ontario Drug Benefit (ODB) Program as a result of OHIP+. Children and youth will not have out of pocket costs for benefits currently covered under ODB, including the more than 4,400 drug products on the ODB Formulary and medication eligible through the Exceptional Access Program (EAP).

To receive coverage for an EAP drug, a funding request must be submitted by a patient's prescriber (with specific information on the medical circumstance to support access). For children and youth who are currently stable on a medication for a chronic condition that is not covered by ODB but have been paying out of pocket or through private insurance, the Ministry of Health and Long-Term Care is planning a streamlined EAP request process for coverage under OHIP+.

To ensure a smooth transition for patients, the Ministry is encouraging prescribers to submit EAP requests for patients as soon as possible. Pharmacy professionals are encouraged to stay up to date on changes related to OHIP+ by visiting the [OHIP+ webpage for healthcare professionals](#) and/or joining the OHIP+ mailing list by emailing OHIPplus@ontario.ca to receive regular updates from the Ministry.

NEW PROTECTIONS FOR FACILITIES PROVIDING ABORTION SERVICES, INCLUDING PHARMACIES

The provincial government [recently passed the Safe Access to Abortion Services Act, 2017](#). The law allows for safe access zones to be established around facilities that offer abortion services, the homes of facility staff, and the homes and offices of regulated health professionals who provide these services. The safe access zone prevents individuals from intimidating or interfering with individuals accessing or providing abortion services. Pharmacies who dispense Mifegymiso can apply for safe access zones of up to 150 metres. Pharmacy professionals can also receive safe access zones around their homes, if necessary.

Pharmacy professionals are reminded that Mifegymiso has been publicly funded since August 10, 2017 for all Ontarians with a valid Ontario health card and valid prescription. Pharmacy professionals may wish to review the [Ministry of Health and Long-Term Care's Ontario Public Drug Program resources](#), including the Notice from the Executive Officer: Funding of Mifegymiso, a FAQ for health care providers, and a FAQ for patients (all published on August 3, 2017).

As well, please note that OCP has created [Guidance for Pharmacy Professionals Who Are Dispensing Mifegymiso](#).

ONTARIO ANNOUNCES CANNABIS DISTRIBUTION MODEL

The Ontario [government has announced their framework to facilitate the sale of legalized recreational cannabis](#) in accordance with the federal government's plan to legalize cannabis by July 2018. Key elements of the framework include oversight by the LCBO through new standalone cannabis stores and an online order service, with approximately 150 stores to be opened by 2020. The province will set a minimum age of 19 to use, purchase or possess recreational cannabis and use will be prohibited in workplaces and public places. Details related to taxation and pricing are not yet available.

It is anticipated that medical cannabis will continue to only be allowed for purchase directly from a federally licensed producer online or over the phone as per the existing federal program.

The [National Association of Pharmacy Regulatory Authorities \(NAPRA\)](#) has [adopted the position](#) that pharmacy professionals must not be involved in the distribution of cannabis for non-medical purposes. The College endorsed this position in June 2017. The NAPRA statement also recognized that there has been discussion around distribution of medical cannabis through pharmacies and that the regulatory colleges continue to discuss the safeguards necessary if distribution through pharmacies were to happen.

College Council has discussed, and will continue to discuss, the cannabis issue and has directed the establishment of a task force to review and make recommendations on the role of pharmacy related to cannabis for medical purposes. Updates will be provided at a future Council meeting.

CONSULTATION UNDERWAY ON EMPLOYMENT STANDARDS ACT EXEMPTIONS FOR PHARMACY PROFESSIONALS

On October 18, 2017, the Ontario Ministry of Labour [announced that they are seeking public input](#) on the current special rules and exemptions under the *Employment Standards Act, 2000* for certain professions, including pharmacists.

An overview of the Ministry's consultation and instructions on how to submit feedback are available through [Ontario's Regulatory Review website](#). The College will also be conducting a consultation exercise on this issue in the coming months in order to provide feedback to the Ministry. More updates will be provided through e-Connect and on our website. **Pe**

PRACTICE TIP!

GET A NEW PRACTICE TIP EVERY WEEK ON TWITTER

As you may be aware, the College has an official [Twitter account](#). On a daily basis, we tweet out helpful regulatory news and updates, new practice tools, important member reminders and much more. Every week we give you a new practice tip (followed by the hashtag #OCPPracticeTip).

Tips are developed from actual observations and encounters in practice and include: record keeping and documentation, methadone dispensing, narcotics reconciliation, clinical decision making, patient counselling, and much more.

Be sure to follow [OCP on Twitter](#) so you can see each new tip once it is published!



An
**Opioid
Strategy**
for
Pharmacy



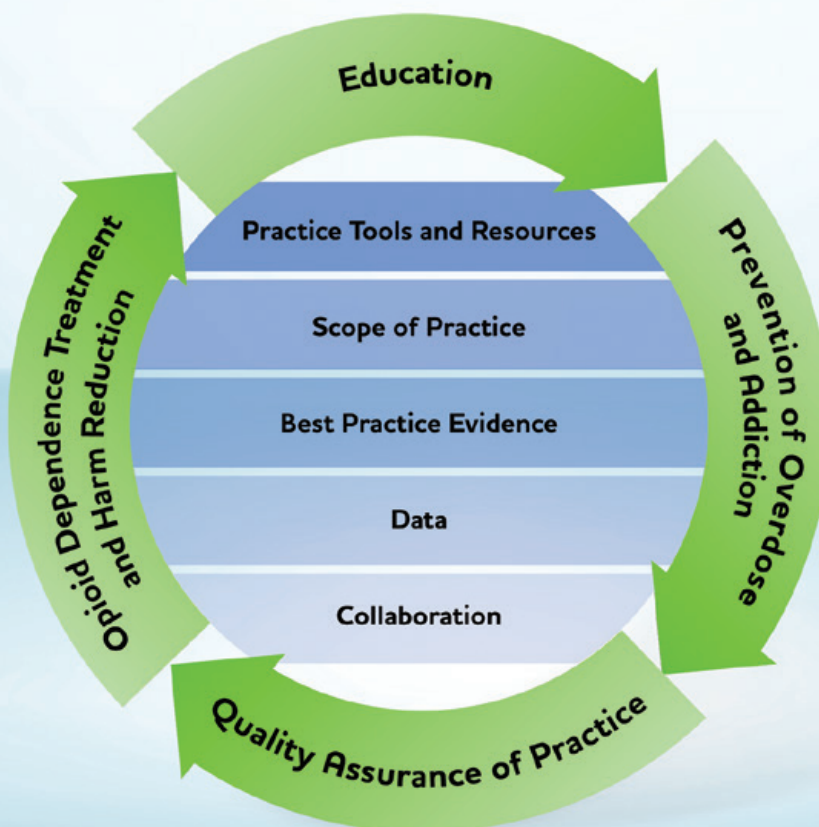
Pharmacy professionals play an important role in the procurement and distribution of narcotic and controlled substances for use in patient care and therefore have a professional responsibility to take action to decrease the burden of current opioid issues faced by society. As medication experts, pharmacists are also in a unique role to support the appropriate use of and access to narcotic and controlled substances and collaborate with other healthcare professionals.

The College recognizes that no single initiative will “fix” Ontario’s opioid-related issues and is committed to implementing a comprehensive opioid strategy that will align with national and provincial opioid-related goals. To ensure that a sustainable and effective approach is taken to addressing opioid-related issues,

the College has developed a multi-pronged strategy to simultaneously address relevant areas of practice. The development of this strategy was led by an Opioid Task Force, which included Council members, pharmacy professionals and other experts. The [Opioid Strategy](#) was approved at the September 2017 Council meeting.

THIS STRATEGY WILL SUPPORT THE COLLEGE IN MEETING ITS MANDATE TO SERVE AND PROTECT THE PUBLIC’S INTEREST BY:

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



The opioid strategy has identified four strategic priorities, each supported by five areas of focus that will guide initiatives in response to the opioid crisis.

STRATEGIC PRIORITIES

1. Education for Pharmacy Professionals Regarding Opioid Related Issues



To provide optimal patient care, pharmacy professionals require access to appropriate continuing education, training and resources regarding treating

conditions such as acute and chronic pain, making pharmacologic and therapeutic decisions regarding opioid therapy, communicating with patients and other healthcare professionals, and identifying patients at risk for opioid dependence or misuse.

The College will collaborate with relevant stakeholders to ensure that educational and training opportunities and resources to support appropriate opioid dispensing and pain management treatment are available and communicated to pharmacy professionals. An example of an initiative under this priority is identifying and collaborating on a morphine equivalent dosing (MED) tool.

2. Opioid Dependence Treatment and Harm Reduction



Optimal delivery of opioid dependence treatment by pharmacy professionals requires the development, identification and communication of resources

to support evidence-based treatment and integrate a holistic approach to therapy that decreases the stigma surrounding substance abuse and harm reduction.

The College will assist pharmacy professionals by developing updated guidance to support practice related to opioid dependence treatment. The College will also identify additional resources to support the treatment of opioid use disorder and the implementation of harm reduction strategies, such as increasing access to naloxone for high risk opioid patients.

3. Prevention of Overdose and Addiction



As healthcare professionals, pharmacists and pharmacy technicians have a duty to ensure that patients are not harmed by their medications and benefit from therapy. This includes providing patient-centred care and supporting appropriate prescribing and dispensing of opioids.

The College will build on and align with the National Association of Pharmacy Regulatory Authorities (NAPRA) Standards of Practice and additional supplementary documents to support standards of practice and competencies for pharmacy professionals that enhance patient care around opioid issues. An example of an initiative under this priority is enabling pharmacist adaptation of controlled substances to support tapering of opioids and targeted substances. The College will also engage government in discussions regarding the need for access to electronic health records and system-wide data analytics.

4. Quality Assurance of Practice



The primary mandate of health regulatory colleges is public protection, which is achieved by holding pharmacy professionals accountable for the safe, effective and ethical delivery of pharmacy services. To ensure that practice requirements are understood and being met, the College must focus on opportunities to improve monitoring and enforcement of opioid procurement and distribution by pharmacies, narcotic security and control in pharmacies and the safe return and destruction of opioids. For example, one initiative under this priority is initiating collaboration among healthcare providers to address management of opioids in hospital operating rooms and emergency departments.

The College will monitor and enforce the security of opioid distribution and the provision of opioids to patients by using data to inform and measure College actions and identify and focus on high-risk practices.

AREAS OF FOCUS

The College will use the following to support the achievement of the four strategic priorities.



PRACTICE TOOLS AND RESOURCES

The College will collaborate to identify gaps and needs in practice and ensure that both internal and external tools and resources are communicated to pharmacy professionals to support the provision of appropriate opioid-related services, including pain management.



SCOPE OF PRACTICE

The College will consider how to optimize pharmacy professionals' scope of practice to best support patient outcomes and access to services.



BEST-EVIDENCE PRACTICE

The College will support pharmacy professionals in the application of the best available evidence, best practices and current prescribing guidelines around pain management



DATA

The College will commit to using relevant and current data to inform College activities.



COLLABORATION

The College will continue to build collaborative relationships with other health regulators, educators, government and other relevant healthcare organizations and leaders to support integrated and patient-centred care.

NEXT STEPS

With the approval of the strategy, College staff will continue to identify, confirm, prioritize and implement specific key initiatives that support each strategic priority. These activities will be supported by an external working group where required. Progress on opioid-related initiatives will be reported through the Registrar's Report at each Council meeting. 

[Learn more about the College's opioid strategy and read the strategy FAQs on our website](#)



PREVENTING DRUG DIVERSION:

Expectations of Pharmacy Professionals and Pharmacy Managers

Pharmacists, pharmacy technicians and pharmacy managers (i.e., Designated Managers and those who are in charge of a hospital pharmacy) have certain responsibilities to ensure that all controlled substances are securely stored and maintained and that all appropriate measures are taken to reduce the opportunities for diversion and manage any losses that are identified.

In this article, the College has outlined some of the key expectations that pharmacy professionals and pharmacy managers must meet to prevent diversion, and to safely control and dispense narcotics regardless of practice setting. While many resources are outlined

in this article, it is up to pharmacists, pharmacy technicians and pharmacy managers to ensure they are meeting all applicable legislation, standards, policies and guidelines. A good place to start is the [Narcotics Practice Tool](#).

SAFE STORAGE

Under the [Narcotic Control Regulations](#), pharmacists must take all reasonable steps to protect the narcotics under their control. Pharmacy managers and pharmacy professionals must be familiar with policies and procedures to monitor and prevent narcotic losses. Pharmacy managers should be able to demonstrate the precautions they have taken to ensure narcotics are not easily accessible and that they have taken appropriate measures to identify and address any risks or gaps. Considerations for safe storage can include:

- Layout of the pharmacy/premises
- Inventory tracking procedures
- Access control (e.g. keys/protocols for accessing narcotics)
- Systems to hire and screen new staff
- Broader facility security and restricted access to the pharmacy and drug storage areas (e.g. hospitals)

Damaged, unserviceable or outdated narcotics need to be secured and appropriately destroyed. No prior authorization is required for destruction of these drugs. They can be destroyed locally on site at the pharmacy or hospital or returned to a company that is licensed to destroy the controlled substance. Regardless of the method used, it must be appropriately documented. Review the [Fact Sheet: Destruction of Narcotics, Controlled Drugs and Targeted Substances](#).

MEDICATION RECONCILIATION

Under the [Medication Procurement and Inventory Management Policy](#), the pharmacy manager must do a regular physical count and reconciliation of all narcotics, controlled drugs and targeted substances at least once every six months.

Reconciliations are done to validate that the inventory count on hand is accurate and that the pharmacist has met their obligation to protect or secure the drugs. A reconciliation is a detailed audit of the quantity of a drug purchased and dispensed, compared with the current stock on hand to determine whether there are any losses or overages. This process can help identify a problem in dispensing processes or inventory control.

A reconciliation can only be done where there is a validated starting inventory and good record keeping processes, which include retaining purchase records, filing prescriptions and maintaining narcotic sales reports.

Where there is a high risk of diversion (e.g. large pharmacy/institution staff, change in ownership or management, staff turnover, concerns that security has been compromised, such as through a breach

in procedures) inventory counts should be done more frequently (either with a full reconciliation or in between reconciliations). The count should never be conducted by the same person who enters narcotic, controlled drugs and targeted substances purchases into the purchase records.

REPORTING OF LOSSES AND FORGERIES

Pharmacists must report any thefts, losses or forgeries of controlled substances (or their precursor chemicals) to the Office of Controlled Substances no later than 10 days after its discovery. Thefts, forgeries and large unexplained losses should also be reported to the police.

Pharmacists are expected to take all reasonable precautions to ensure the validity of a narcotic prescription (see [Fact Sheet: Identifying Forgeries and Fraudulent Prescriptions](#)). Reporting a forgery is the same as reporting a loss with one exception: a forgery must be reported even if the forged prescription was not filled. The Health Canada reporting form has fields to indicate whether the forged prescription was filled or not filled, along with the required details. As part of its ongoing compliance and monitoring activities, Health Canada is conducting inspections at community pharmacies across Canada. Their [Community Pharmacy Inspection Program Annual Report](#) summarizes some of the key issues observed during their activities, including those related to security and recordkeeping.

Review the [Fact Sheet: Narcotic Reporting of Forgeries and Losses](#) and [Health Canada: Loss, Theft and Forgery Reporting Forms](#).

PRACTICING ETHICALLY

Pharmacy professionals must be guided by the principles and standards outlined in the [Code of Ethics](#). Standard 4.11 requires that pharmacy professionals “take appropriate steps to prevent and report the misuse or abuse of substances by themselves, patients, colleagues, other healthcare professionals or other pharmacy employees.” To do this, they must be aware of and comply with all relevant legislation, standards policies and guidelines as well as recognize and respond to “red flags” that may present in practice.

If a pharmacist or pharmacy technician becomes aware of professional incapacity, incompetence or unethical behaviour by their pharmacy colleagues or any other healthcare professional (for example, physicians or nurses) they must report that to the appropriate regulatory authority (Code of Ethics 4.10). This reporting is in addition to any internal reporting procedures. 

ONTARIO COLLEGE OF PHARMACISTS SELECTS **PHARMAPOD TO IMPLEMENT MEDICATION ERROR REPORTING SYSTEM** FOR ONTARIO PHARMACIES

*Announcement marks a major milestone in what will be
the largest medication safety program of its kind in Canada*

The Ontario College of Pharmacists is pleased to announce its selection of [Pharmapod Ltd](#) to implement a medication error reporting system and standardized approach to continuous quality assurance in pharmacies throughout the province. The first phase of this medication safety program is set to roll out later this fall among at least 100 community pharmacies, with full implementation among the province's more than 4,000 community pharmacies set to commence in late 2018.

In June 2017, College Council unanimously endorsed the implementation of a medication safety program for Ontario's pharmacies. Among the core elements of this program is the introduction of a requirement for pharmacies and pharmacy professionals to anonymously report medication errors to a third party. Reasons behind medication incidents, including near misses, would be analyzed and shared throughout the province to prevent errors from recurring and, ultimately, protect patients.

Along with working with the College to develop all aspects of the medication incident

reporting platform, Pharmapod will be responsible for providing training and continuous quality improvement processes and tools for Ontario pharmacies, analyzing provincial medication incident data and making available reports to individual pharmacies. The College will receive aggregate data which will help it understand and monitor trends and work with Pharmapod and other partners to share learnings and develop tools and resources to help pharmacies apply these learnings to their practice.

Pharmapod's alliance with the Canadian Pharmacists Association (CPhA) will support a successful implementation among

pharmacies in Ontario and the sharing of information not just throughout the province but across the country.

With a letter of intent now completed, the College and Pharmapod will work together toward a formal agreement over the coming weeks. As this moves forward, the College will continue to explore opportunities to develop partnerships and collaborative initiatives with organizations such as the Institute for Safe Medication Practices (ISMP) Canada and other patient-safety and regulatory groups in advancing a nation-wide focus on medication error prevention. 

“

Understanding why errors happen can help reduce the risk of recurrence and ultimately protect patients. Our goal, therefore, is the implementation of a comprehensive, practical and flexible continuous quality assurance program for pharmacies that will help reduce the risk of medication incidents and enhance patient safety.

We believe Pharmapod's solution is an ideal choice for us as Canada's largest pharmacy regulator whose mission is to serve and protect the public. We also believe it is an ideal choice for Ontario's pharmacies, which will benefit from an innovative technical platform developed by pharmacy professionals for pharmacy professionals. We are very pleased to be moving forward with this important provincial patient-safety initiative and look forward to working with all of our partners in building a national medication safety data set that we all can benefit from.

– **Nancy Lum-Wilson, CEO and Registrar, Ontario College of Pharmacists**

”

“ Even a single event that can be prevented can have a significant impact on the lives of patients as well as pharmacy professionals. Ontario's pharmacies and pharmacy professionals play an important role in our health system and this program will strengthen their role in helping patients have access to quality and safe health care.

I lost my son Andrew to a medication error which is why I wanted to do what I could so that his legacy would be a safer healthcare system across the country. I'm proud to have been a part of this initiative and am very pleased that the College is making great progress toward this medication safety program becoming a reality in Ontario.”

– **Melissa Sheldrick, patient safety advocate and public member of the College's Medication Safety Task Force**

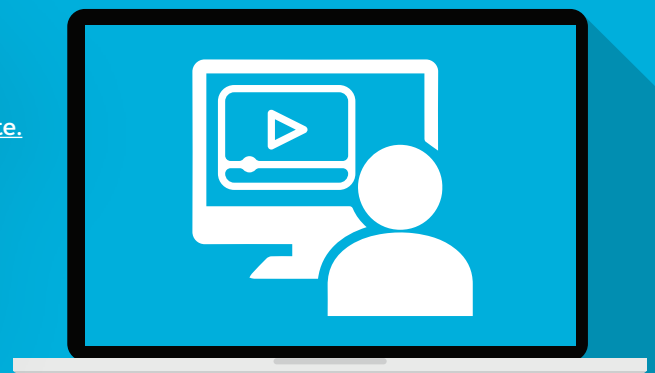
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LEARN MORE AND AN UPDATE ON VOLUNTEER RECRUITMENT

[Learn more about the CQA Program on the College website.](#)

Thank you to all of the pharmacies and pharmacy professionals who volunteered to participate in the first phase of implementation. The College is currently reviewing applications and will be touch soon with the selected pharmacies in order to prepare for training and first phase implementation.



PROTECTING PATIENTS ACT:

What's Currently in Force and What's Next

The [Protecting Patients Act, 2017](#), previously known as Bill 87, received royal assent on May 30, 2017. The Act protects patients by strengthening and reinforcing Ontario's zero tolerance policy on sexual abuse of patients, supports additional accountability and transparency within the health system and emphasizes patient safety and protection as the first priority for Ontario's health colleges and healthcare professionals. The Act applies to all of the health regulatory colleges and professions.

While the Act has received royal assent, not all parts are currently in force, as the government works to develop regulations to support the provisions of the legislation.

CURRENTLY IN EFFECT

- ✓ Increased fines for failing to make a mandatory report of sexual abuse (up to \$50,000 for individuals and up to \$200,000 for corporations).
- ✓ Minimum one-year period of prohibition on sexual relationships with former patients.
- ✓ Additional roles and functions of the Patient Relations Committee, who have a mandate to administer funding for therapy and counselling for patients who have been sexually abused.
- ✓ The Inquiries, Complaints and Reports Committee can make an interim order to suspend a member's certificate of registration prior to referral to Discipline or Fitness to Practise, which is earlier than previously allowed for in the process.

- ✓ Mandatory suspension of certificate of registration as a new minimum penalty for findings of sexual abuse where the mandatory revocation does not apply.
- ✓ Mandatory revocation of certificate of registration related to broader instances of sexual abuse and criminal offences (to be specified in regulation) and immediate suspension between a finding and a penalty hearing in those cases.
- ✓ Greater transparency by requiring the Colleges to make available more information about regulated health professionals in their public registers.

NOT YET IN FORCE

- Expanded and earlier access to funding for individuals who have been sexually abused.
- Definition of a patient in relation to professional misconduct involving sexual abuse (to be defined in regulation).
- New self-reporting obligations:
 - o Registration with other regulatory bodies and any findings of misconduct or incompetence with those bodies
 - o Offense charges and bail conditions

NEXT STEPS

The Ministry of Health and Long-Term Care plans to move forward with regulations in phases, supported by consultation with relevant stakeholders over the next few months. The first phase will likely address: identifying the minimum criteria that regulatory colleges must consider when determining whether an individual is a patient for sexual abuse purposes; specifying additional information as the minimum required for posting to the public register; and setting out criminal offences that would result in mandatory revocation.

The second phase is anticipated to address composition of college panels and committees, additional roles and functions of the Patient Relations Committee, and additional practices the Colleges must follow during the complaints, investigations and discipline processes.

The College will continue to engage in ongoing dialogue with the Ministry and colleagues at other health regulatory colleges. Updates will be provided at each Council meeting as well as communicated out in e-Connect and future issues of Pharmacy Connection. 

Access the College's [e-Learning Module on Professional Boundaries](#)

Review the College's [Guideline on Preventing Sexual Abuse and Harassment](#)



Dr. Juurlink pictured with OCP President Régis Vaillancourt and OCP CEO and Registrar Nancy Lum-Wilson.

Q How do healthcare professionals balance the benefits opioids may bring to relieve suffering with the significant potential harms?

All drugs have potential benefits and potential harms. What we're trying to do every time we prescribe is afford the patient more benefit than harm. The problem with opioids is that this assessment—the balance of benefits vs. harms—can be very difficult. Why? Because people develop opioid dependence within days, such that when they try to reduce the dose or stop treatment, they become unwell with opioid withdrawal symptoms that often include pain and dysphoria. Of course these remit when the drug is resumed, and it's easy for a patient to therefore infer that the medication is helping or even essential. And as tolerance sets in and doses go up, this issue becomes even more important. Does the patient on a fentanyl 100 mcg patch need the drug (which they surely do) primarily for analgesia or to primarily avoid withdrawal? I think it's most often the latter, and it's essential that doctors and pharmacists think past the anecdotes of benefit to the pharmacology underlying those anecdotes. When we do that thoughtfully, what we often see is net harm. We owe it to patients to help them understand that the higher the dose, the likelihood that the patient is experiencing a net benefit diminishes.

Q Are there ways that pharmacy professionals, considering their role as medication experts and their frequent interaction with and accessibility to patients, can help combat the opioid crisis?

There are a few things pharmacists can do to help their patients. First of all, don't start someone on over-the-counter codeine. Ever. Second, do what you can to ensure that patients on high dose opioid therapy are not cut off suddenly. Otherwise they will experience withdrawal, it will sometimes be awful, and they'll look to other sources for drugs to relieve their suffering.

An Interview with DR. DAVID JUURLINK

Dr. David Juurlink is an Eaton Scholar and Professor of Medicine and Pediatrics at the University of Toronto. He is also a Senior Scientist at the Institute for Clinical Evaluative Sciences (ICES) and Head of the Division of Clinical Pharmacology and Toxicology at the University of Toronto. He also practiced as a community pharmacist for five years. Following his presentation at the September Council Meeting, he spoke with Pharmacy Connection on opioids, the importance of naloxone and how pharmacy professionals can help their patients. This conversation has been edited and condensed.

Given the profusion of bootleg fentanyl compounds in the street drug supply, this couldn't be more dangerous. Third, discourage the co-prescribing of opioids and benzodiazepines. Fourth, engage in comprehensive counselling for a patient who is just starting opioids. It is important to communicate to patients the symptoms of opioid withdrawal and acknowledge that it could affect them. Finally, pharmacists should try to engage patients who have been on long term opioids, especially those on high doses, in discussion about the possibility of the drug not helping as much as they think it is. It's not easy – these are some of the toughest conversations to have with patients.

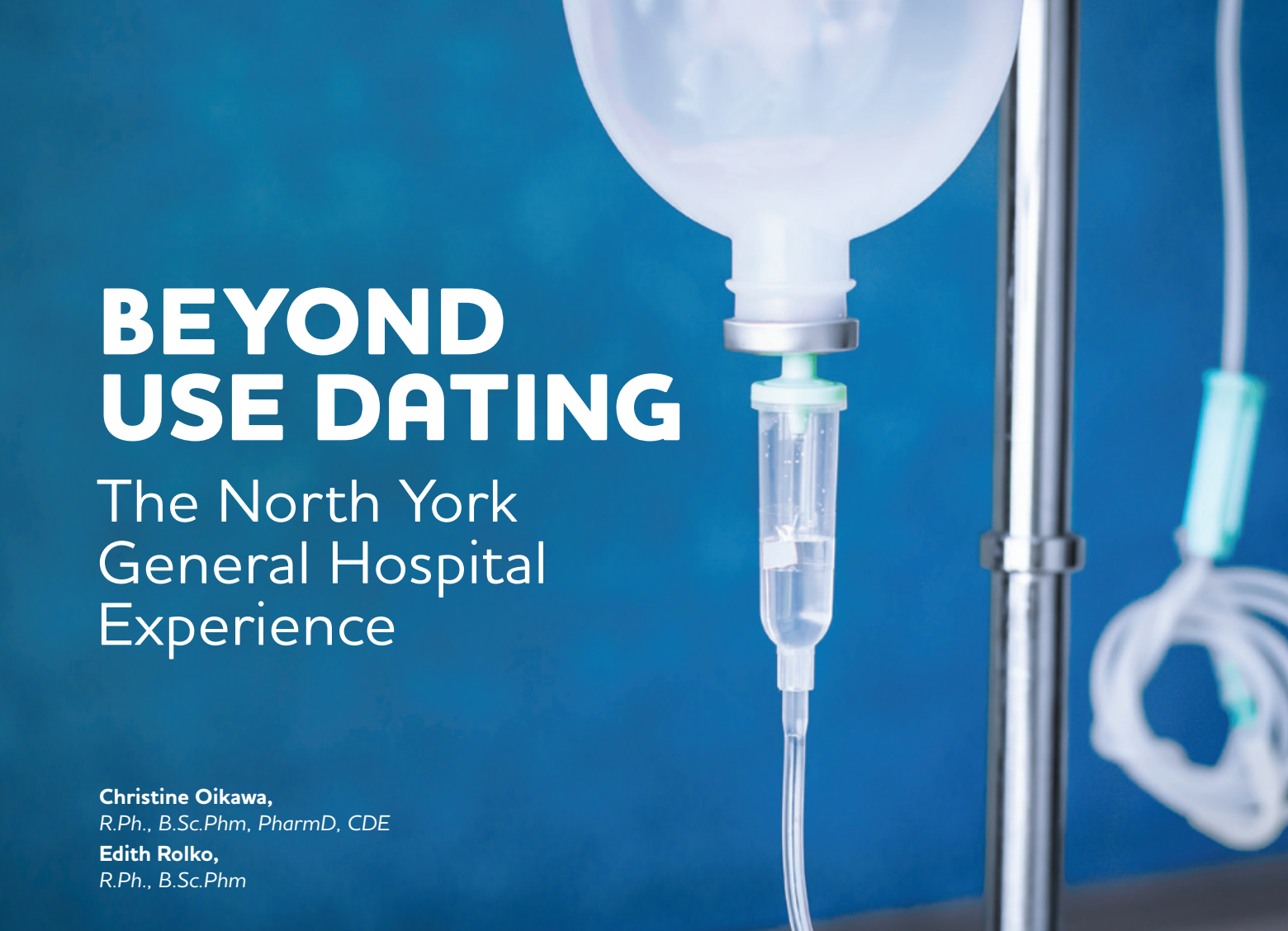
Q You spoke about the importance of naloxone. Why is wide access to naloxone so important?

Every pharmacy should stock naloxone. It isn't just for patients with addictions. A strong case can be made that patients on opioids for chronic pain, especially high doses of them, should have naloxone at home and their family should know how to use it.

Q How can pharmacy professionals work with other healthcare professionals to help prevent harm to patients who are taking opioids?

Pharmacists, in addition to prescribers, need to make sure that patients are adequately counselled about the risks of opioids, especially those related to withdrawal and especially in patients who are just starting an opioid prescription.

If pharmacists can help prescribers in any way, it is engaging in the tapering process. A lot of physicians just don't know how to taper. Tapering needs to be at the patient's pace, and often very gradual. It can be a tough process, especially with variations in dosage formulations. Pharmacists really are a great resource for this. **PC**



BEYOND USE DATING

The North York General Hospital Experience

Christine Oikawa,
R.Ph., B.Sc.Pharm, PharmD, CDE

Edith Rolko,
R.Ph., B.Sc.Pharm

Compounding IV medications is an important core competency of pharmacy practice both in hospital and community settings. In September 2016 the Ontario College of Pharmacists adopted the [NAPRA Model Standards for Pharmacy Compounding for both Non-hazardous](#) and [Hazardous Sterile Preparations](#). These documents have provided the standards and framework that pharmacies must follow in order to ensure the quality of products dispensed.

The standards are broken into three main areas: training, product preparation and quality assurance. The quality assurance component includes consideration of what beyond use dates (BUD) should be given to products.

As pharmacies try to provide efficient pharmacy services, there has been a move to have products in a ready to administer format rather than to compound just-in-time. This move has resulted in the need for

pharmacies to have medications prepared in anticipation of an order or prescription. Prior to the introduction of these standards, many pharmacies only took the stability of the product into account when assigning beyond use dating. However, the NAPRA Model Standards for Pharmacy Compounding also takes the sterility of the product into consideration and therefore, in many instances, the length of time that products can be safely stored has decreased. This has become a

significant challenge for pharmacies that tried to compound less frequently to increase efficiencies.

As North York General Hospital (NYGH) was implementing the new BUD standards, where the maximum BUD that can be applied to medium risk products is nine days refrigerated or 30 hours at controlled room temperature, it was recognized that these time periods are not always practical to meet patient needs. To extend BUD, end product sterility testing (EPST)

must be conducted. The following is a step-by-step description of how NYGH implemented end product sterility testing to extend BUDs.

It is important to note that only facilities that have met the standards and reviewed the [College's Extending the Beyond-Use Dates for Sterile Preparations Guideline](#) should attempt to extend BUDs.

STEP 1: CIVA PRODUCT ANALYSIS

EPST could be costly from both a materials and staffing perspective if all products undergo testing. Therefore, it makes sense that not all products with long chemical stability should undergo EPST. To determine the short-list of products to consider, each organization needs to define the criteria under which EPST is appropriate. The following are the list of criteria NYGH Pharmacy used to determine products that need to have extended BUD:

- Currently batched: If the product is not batched already then EPST does not need to be done.
- Floor stock products: These products often have unpredictable usage patterns and therefore a limitation of nine days may result in significant wastage.
- Inventory turnover rate for each product: If a product is a fast mover and is always used up in less than nine days then EPST would not be needed.
- Cost analysis of conducting EPST vs. more frequent compounding: Products that have minimal production costs, such as tubing for pumps, may not be very costly to compound more regularly. Staffing patterns for the cleanroom may also play a role in this requirement. If staff are not available on a regular basis to compound, then longer shelf-life is needed for products.

Once NYGH completed this analysis, only nine products were appropriate for EPST.

STEP 2: SELECT AN EPST PRODUCT

There are various EPST products on the market and each organization will need to conduct their own review to determine which product they want to use. NYGH focused on those products that were simple to use and did not require a significant capital investment. When choosing a product, it is important to consider the cost of the test relative to the cost of the product being tested. If the test is more expensive than the potential wastage, it may not be worthwhile to do the test.

STEP 3: DEVELOP POLICY AND PROCEDURE FOR EPST

A policy and procedure document was developed, incorporating standards from USP 71 Sterility Tests. The document specified the number of samples required for sterility testing based on batch size, the incubation temperature (with acceptable deviations), the duration of incubation, when a batch could be released for use, an outline of investigation procedures to follow in case of a positive EPST, and the quarantine/recall procedure.

STEP 4: EDUCATION/ TRAINING OF STAFF

Before implementing EPST, pharmacy staff needed to be educated on the policies and procedures, how to perform the EPST, how to read/interpret the sterility testing sample, the documentation process, and what to do in case of a positive EPST result. For successful implementation, it is important to look at how to incorporate these activities into existing workflow.

STEP 5: "QUARANTINE" AND RELEASE OF PRODUCT

To ensure products undergoing EPST are not used prior to passing the EPST, it is important to designate a "quarantine" location for these products. At NYGH this was accomplished by using a different coloured bin and designating a specific area to store quarantined room temperature and refrigerated temperature products. In addition, laminated quarantine cards were used to help identify the earliest date quarantined products could be released if EPST results were negative.

STEP 6: RECORD KEEPING AND CONTINUOUS QUALITY IMPROVEMENT (CQI)

Proper documentation of each EPST performed, including the results, must be available in a readily retrievable format. At NYGH, all EPST and corresponding compounding worksheets are scanned to facilitate easy retrieval.

With implementation of any new process, an important step is to perform a review of the new processes regularly, and after any changes to the process, to continually evaluate it for potential areas for improvement to ensure patient safety, reproducibility and efficiency.

CONCLUSION

End product stability testing may seem daunting to implement at first glance, but the experience at NYGH showed that in reality only a handful of sterile products require EPST. The majority of the sterile compounds did not need extended BUD. While it took effort and resources to implement, with a particular focus on staff training, the actual additional workload has not been significant. 

PRACTICE ASSESSMENTS:

An Important Component of Quality Assurance

In 2015, the College began transitioning to practice assessments for community pharmacists. These evaluations of an individual professional's performance occur in the place of practice with a College practice advisor. They are separate from the pharmacy assessment, though they may take place during the same visit.

The new practice assessments support the role of pharmacists as medication experts and clinical decision-makers, and are consistent in approach to assessments of other primary healthcare practitioners.

The practice assessments are also a critical component of quality assurance, which exists to ensure that pharmacy professionals maintain appropriate skills and knowledge throughout their career and to assure the public that pharmacists and pharmacy technicians are practicing to the standard; this is a core part of the College's mandate. Additionally, the transition to assessments at the individual's place of practice reflects evolving public and patient expectations that the College regularly engages with pharmacists and pharmacy technicians to ensure that safe and appropriate patient care is being provided.

Ultimately, quality assurance activities are designed to help pharmacy professionals identify areas for improvement in their practice so that they can develop, maintain and enhance their skills and knowledge to support better patient health outcomes.

WHAT HAPPENS DURING A PRACTICE ASSESSMENT?

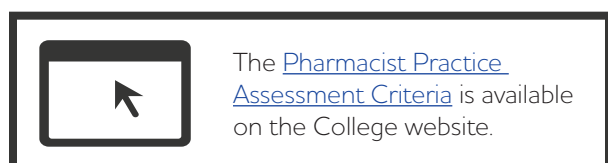
The practice advisors look at how pharmacists handle four areas: patient assessment, decision making, documentation and communication/education. Through a combination of observation and retrospective review of documentation (chart stimulated recall) practice advisors evaluate the processes in place for each of these areas with respect to new and refill prescriptions, adaptations/renewals, comprehensive medication reviews and



patient interactions related to over the counter medications. See the Practice Assessment visual overview on page 28.

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

If the pharmacy professional does not meet the standards indicated on their first assessment, they are given the opportunity to spend time with a quality assurance coach. This coach is not a College staff member, but rather a peer pharmacist who



can provide support specifically in areas where there is room for improvement. This half-day interactive session is designed to enhance the professional's practice and the care that is provided to patients. Following the session with the QA coach, the pharmacy professional will be reassessed by another practice advisor.

If there are still significant areas of practice that require improvement

following this second assessment, a QA assessment will take place and the results will be sent to the QA Committee for consideration. The QA Committee may provide recommendations to help the professional meet standards by identifying appropriate remediation, always recognizing that patient safety is the first priority.

With an emphasis on education, the goal of the practice

assessments is to increase adherence to practice standards, help pharmacy professionals practice to their full scope, and ultimately support optimal health outcomes. The results of a practice assessment are confidential and are not shared with employers, owners, colleagues or any College committee, other than the QA Committee.

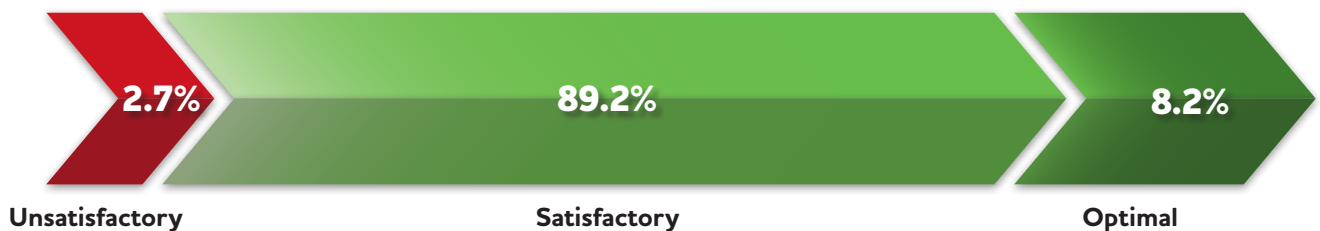
WHAT HAVE WE LEARNED SO FAR?

The majority of pharmacy professionals are practicing at a satisfactory level, meeting the standards outlined in the assessment criteria with some

coaching (on one or more standards) by the practice advisor. Almost 10% of pharmacists are practicing optimally – highlighting a significant opportunity to move the profession forward through continuous quality improvement.

There is a clear recognition that pharmacy professionals need to do more to help bridge what they know with how they practice to help provide quality patient care. A major goal of practice assessments is to enable this growth.

MOVING TOWARDS OPTIMAL PRACTICE



PHARMACY TECHNICIANS AND PHARMACISTS PRACTICING IN HOSPITAL OR OTHER HEALTHCARE SETTINGS

Practice assessments are now in place for pharmacists practicing in the community. The College is currently developing pharmacy technician assessment standards, with a pilot program set to commence late Spring 2018. It is anticipated that assessment standards for pharmacists practicing in hospital and other healthcare settings will follow.

HOW TO PREPARE FOR A PRACTICE ASSESSMENT

Pharmacists should review the [Pharmacist Practice Assessment Criteria](#). Use the "Guidance" section to self-assess current practice ahead of the assessment. The College also has five Practice Tools which provide resources related to the assessments:

- [Practice Assessments](#)
- [Patient Assessment](#)
- [Decision Making](#)
- [Documentation](#)
- [Communication and Education](#)





Ontario College
of Pharmacists
Putting patients first since 1871

OCP'S PHARMACIST ASSESSMENTS: A VISUAL OVERVIEW

1

Pharmacists Are Assessed in Their Pharmacy



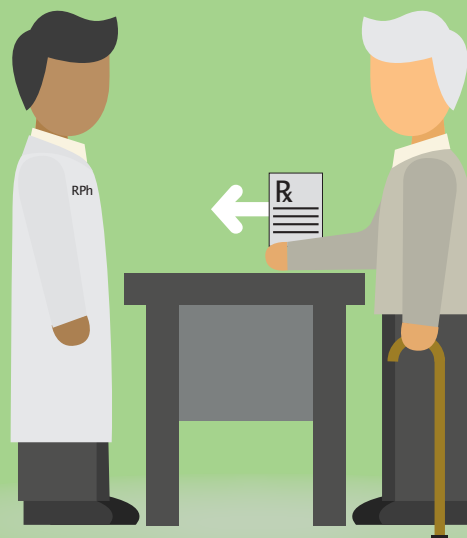
2

Assessment Focuses on Four Key Domains

A. Patient Assessment

If I'm not completing a patient assessment,
how can I be sure that the medication is
appropriate for that patient?

Have I reviewed the patient's profile and checked
in with the patient to determine if there have
been any changes to their overall health?



B. Decision Making

Is this the most appropriate medication based on
the patient, best practice and evidence?

Based on any patient-related issues identified,
is there an opportunity to make a pharmacist
intervention?

C. Documentation

Am I making sure to document relevant information accurately, completely and appropriately including my decisions, rationale and follow-up plans?

Is my documentation stored in a location that is easily retrievable and accessible by other staff members?



D. Communication/Education

Does the patient have a hearing impairment or any other health conditions that require me to make appropriate verbal and non-verbal adjustments?

Am I listening to the patient's questions, needs, and concerns, and asking appropriate open-ended questions?

*View the Pharmacist Practice Assessment Criteria on the [New Practice Assessments](#) page of the OCP Website

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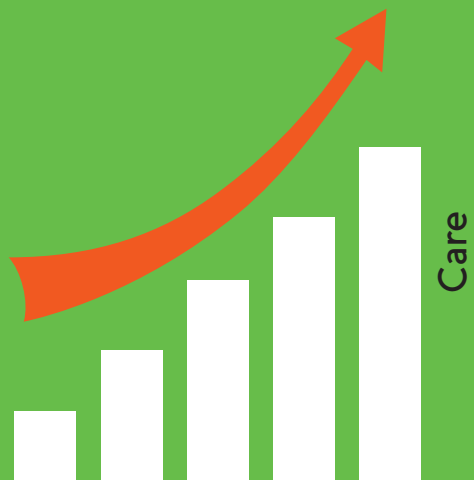
Practice Advisors Coach

Based on observations and conversations throughout the day, the practice advisor will coach pharmacists to help them enhance their practice.



4

The End Result is Improved Patient Care



WHAT WOULD YOU DO?



In the Spring 2017 edition of *Pharmacy Connection*, the College published [A Framework for Ethical Decision Making](#). The framework provided a process to guide decision making in practice that supports the commitment to serve and protect patients' best interests.

As part of a new feature in *Pharmacy Connection*, the College is launching “What Would You Do?” a new column that will explore issues in practice that present an ethical issue or dilemma for the pharmacy professional. This column will not provide a definitive answer to the dilemma, but will instead invite pharmacy professionals to make their own professional judgments in practice, while considering all appropriate guidelines and standards.



A patient of your pharmacy has presented a prescription for fentanyl 25mcg/h patches

The prescriber has indicated that a 90 day supply should be dispensed. The prescription does not appear to be fraudulent. However, this is the patient's first prescription for this drug. You are concerned that the 90 day supply will expose the patient to unnecessary risk. The patient says that they need the larger supply because they travel frequently.

What do you do?

It's helpful to utilize the broad steps of the ethical decision making framework to consider the issue.

IDENTIFY THE ISSUE

You can start by identifying the issue and examining the facts. The issue here is that the pharmacist believes that the 90 day supply may not be appropriate and may cause unnecessary risk to the patient, particularly as it is the first time that the patient is using this medication. Additionally, there is a risk to others around the patient (e.g. children in the household) and the broader community in allowing a large number of

opioids to be dispensed at one time. However, the prescriber has specifically indicated a 90 day supply should be dispensed. The patient has a condition that could be appropriately treated by opioids, is an existing patient of the pharmacy and has a legitimate-sounding reason for needing such a large supply: frequent and long-term business travel.

It is also critical to consider that in this specific case, there is broader societal concern related to opioids and their abuse and misuse. Opioids and other narcotics should be considered “red flag” medications.

APPLY GUIDELINES AND STANDARDS

The Ethical Principles and Standards in the Code of Ethics, the Standards of Practice, applicable legislation and regulations, college policies, guidelines and other supporting resources can be reviewed and applied when exploring an ethical dilemma. Examples that could be considered with this scenario include:

- [Code of Ethics](#)
 - o **Standard 2.5** Members challenge the judgment of their colleagues or other healthcare professionals if they have good reason to believe that their decisions or actions could adversely affect patient care.
 - o **Standard 3.4** Members listen to patients to seek understanding of their needs, values and desired health goals and respect their right to be an active decision-maker in their healthcare.
 - o **Standard 4.8** Members understand that their trust in the care provided by colleagues and other healthcare professionals must be balanced with critical evaluation.
 - o **Standard 4.9** Members must be diligent in identifying and responding to red flag situations that present in practice.
 - o **Standard 4.16** Members recognize that self-regulation of the profession is a privilege and that each pharmacist and pharmacy technician has a professional responsibility to merit this privilege by maintaining public trust and confidence in each member individually and the profession as a whole.
- [Standards of Practice](#): Standards under Standard 10, Standard 45 and Standard 60.
- [Patch for Patch Program Fact Sheet](#)
- [Opioid Practice Tool](#), including the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

EVALUATE POSSIBLE RESOLUTIONS

As a pharmacy professional, you must use your professional judgment to make decisions in practice. Your actions should: put your patient first, bear public scrutiny, be considered acceptable as a precedent for future behaviour, and support the commitment to serve and protect the best interests of patients.

Each patient is unique. Reflect on the patient in question. How long have they been a patient of

your pharmacy? What is their medication history? Is their condition acute or chronic and what is the prognosis? Are there lifestyle factors that would affect your decision?

Consider your scope of practice and the commitments you've made as a pharmacy professional to practicing to the Code of Ethics and Standards of Practice for the profession. What are your obligations as a healthcare professional? Utilize your knowledge of the drug in question, including potential harms and benefits. If a pharmacist colleague asked your opinion on this issue, what would you say?

Access to medication is an important patient issue. Does your pharmacy offer alternatives to in person visits? How are refills managed?

Collaboration is an important component of patient care and supports good patient health outcomes. Is there more information that you need from the prescriber to make a decision? Are you familiar with the prescriber and, if so, are there any ongoing concerns you have with their prescribing practices? What opportunities are there to communicate and/or collaborate with the prescriber in this case?

DOCUMENT YOUR DECISION MAKING

Once you have chosen the most appropriate course of action, you must document that decision, including your rationale and how it supports the best possible health outcome for the patient. This should include any communication with the patient and prescriber. This information is critical, particularly if there are any questions that arise at a later date regarding this decision.

REVIEW AND REFLECT

After any decision there is an opportunity to reflect on both the process and the decision itself. What did you learn from it? Is there anything you can do to be more prepared for a similar situation in the future? Are there learnings you can share with your colleagues, both at the pharmacy and in the larger community?

Ethical issues and dilemmas are a reality of everyday practice. The ability to make sound ethical decisions is a fundamental responsibility of pharmacists and pharmacy technicians as healthcare professionals. Use the [ethical decision making framework](#), the Code of Ethics, the Standards of Practice, and the resources on the College website to facilitate appropriate decision making. 



Coroner's Inquest Into the DEATH OF AN ELDERLY PATIENT ON ANTICOAGULATION THERAPY

CASE SUMMARY

A 77 year old woman died six weeks after admission to a Long Term Care Home (LTCH). **The reported cause of death was bilateral subdural hematomas as a consequence of anticoagulation therapy with a contributing factor of pneumonia.**

Concerns over the monitoring of anticoagulation therapy led the coroner's jury to refer the case to the Geriatric and Long Term Care Review Committee to assist the Office of the Chief Coroner in the investigation. The Committee's recommendations to several institutions are highlighted following the review of the case.

CASE HISTORY

The patient was admitted to the LTCH from her private residence on December 1, 2015. She had several co-morbid conditions which are listed in Appendix A. Medications at the time of admission to the LTCH are listed in Appendix B. The admitting physician conducted an admission history and physical which noted that she was treated with warfarin for atrial fibrillation. An admission INR and creatinine were ordered. The INR was reported as 2.7 which was within normal limits for a therapeutic range of 2-3 for atrial fibrillation. The creatinine level was 157 with an eGFR of 27. The patient had difficulty settling into her new environment. She became less ambulatory and ate poorly as a result of the transition.

SUMMARY OF EVENTS LEADING TO HOSPITAL ADMITTANCE

December 14, 2015	Started on nitrofurantoin for an urinary tract infection
December 16, 2015	Chest congestion and placed on respiratory precautions
December 19, 2015	Pruritic rash on lower legs, described as petechiae
December 21, 2015	Two hematomas on the back of her knees
December 30, 2015	Became nauseated
December 31, 2015	Vomited
January 1, 2016	Vague, confused and mumbled speech, with large bruises on her body
January 1, 2016	Recent INR results from the LTCH could not be located and she was transferred to an acute care hospital

While in the acute care hospital, the INR level was found to be significantly elevated at 10 (normal range 2-3). The patient was treated with Vitamin K and Octiplex. A CT scan of the head revealed bilateral extensive subdural hematomas. She was admitted

to the ICU and subsequently placed on comfort measures until her death on January 13, 2016.

DISCUSSION

The Committee's review reflected that no regular monitoring of the INR was ordered by the physician upon admission to the LTCH. It was also noted that this was not flagged by the staff or pharmacist.

Factors that affect the dose-response relationship between warfarin dose and INR include the following:

- Nutritional status, including vitamin K intake,
- Activity level,
- Infections and hypermetabolic states,
- Drug interactions,
- Smoking and alcohol use,
- Renal, hepatic, and cardiac function, and
- Genetic variation.

Acute illnesses, especially infections and gastrointestinal episodes, may alter anticoagulation through effects on dietary vitamin K intake, warfarin metabolism, and medication interactions. Monitoring intervals are generally increased in any patient with an infection requiring antibiotic therapy. One of the ways antibiotics contribute to variability in the INR is by reducing intestinal vitamin K synthesis. This may occur through the disruption of intestinal microflora and effects on the hepatic CYP2C9 or other cytochrome P-450 isoforms. Other drug interactions, such as the use of as needed acetaminophen, may also play a role in INR variation.

The patient experienced several of these contributing factors during her stay at the LTCH. Warning signs for excessive anticoagulation include petechiae, excessive bruising and hematuria. Despite warning signs being noted, no reassessment of the INR was ordered. Although the LTCH had an electronic medical record with standard admission order sets, there were no automatic orders for INR monitoring or monitoring of other drugs that may have required adjustment to achieve therapeutic levels.

RECOMMENDATIONS:

The Geriatric and Long Term Care Review Committee (GLTCRC) made the following recommendations as a result of their review of this case:

1. The attending physicians, registered staff and pharmacist for this long term care home should review the Anticoagulant Therapy Protocol and be aware of the need for regular and as needed monitoring of the INR, especially when there is a change in health status.
2. All long term care homes should revise their standardized admission order sets to include automatic monitoring of INR on a prescribed basis and reassessment with medication changes, changes in dietary intake or health status. Further modifications could include monitoring of medications requiring dosage adjustments for toxicity or therapeutic range.
3. Healthcare providers in long term care homes are reminded of previous recommendation made by the GLTCRC pertaining to identification, assessment and management of changes in health status to residents. 



APPENDIX A: PATIENT CONDITIONS

- polycystic kidney disease with acute decompensation requiring transient dialysis
- chronic obstructive pulmonary disease (COPD)
- previous smoker
- spinal stenosis
- dyslipidemia
- stable adrenal mass
- partial thyroidectomy with hypothyroidism
- osteoporosis
- paroxysmal atrial fibrillation
- right vertex calcified brain lesion (stable)
- transient ischemic attack (TIA)
- severe pulmonary hypertension
- dependent edema with chronic venous stasis
- dementia

APPENDIX B: PATIENT MEDICATIONS AS INDICATED BY CORONER'S REPORT

Scheduled Medications:

- warfarin 2.5 mg daily
- metoprolol 100 mg bid
- furosemide 80 mg daily
- escitalopram 10 mg daily
- donepezil
- memantine
- digoxin 0.0625 mg daily
- calcitriol 0.25 mcg daily
- rosuvastatin 20 mg hs
- bisacodyl 10 mg daily
- ferrous fumarate 300 mg daily
- tiotropium 18 mcg inhaled qam
- fluticasone/salmeterol 250/50 inhaled bid
- vitamin D 1000 units daily

PRN Medications:

- risperidone 0.5 mg q12h prn
- salbutamol 2 inhalations q4h prn
- acetaminophen
- dextromethorphan
- dimenhydrinate
- guaifenesin
- sennosides
- aluminum hydroxide
- fleet enemas

REFERENCES

1. Ansell J, Hirsh J, Hylek E, et al. Pharmacology and management of the vitamin K antagonists: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). Chest 2008; 133:160S.
2. Ansell J, Hirsh J, Poller L, et al. The pharmacology and management of the vitamin K antagonists: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest 2004; 126:204S.
3. Juurlink DN. Drug interactions with warfarin: what clinicians need to know. CMAJ 2007; 177:369.
4. Hylek EM, Heiman H, Skates SJ, et al. Acetaminophen and other risk factors for excessive warfarin anticoagulation. JAMA 1998; 279:657.
5. Clark NP, Delate T, Riggs CS, et al. Warfarin interactions with antibiotics in the ambulatory care setting. JAMA Intern Med 2014; 174:409.

PRACTICE TIP!

If you're unfamiliar with a particular medication, review appropriate resources to ensure the medication you're dispensing won't harm the patient AND is therapeutically appropriate <http://www.ocpinfo.com/library/practice-related/download/CloseUpOnComplaintsWinter2016.pdf> #OCPPPracticeTip

Follow @OCPinfo on Twitter and get a helpful practice tip each week.
#OCPPPracticeTip



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

TAKING APPROPRIATE CARE WHEN HANDLING OPIOID PRESCRIPTIONS

SUMMARY

This incident occurred when a patient visited the pharmacy with a prescription, containing only a stamped signature, for fentanyl 100 mcg/hr patches, once daily, 30 as needed for a 30 day supply*. The patient presented an empty box of fentanyl patches, labelled and dispensed by another pharmacy. The pharmacist reported that he checked the old label with the patient's name on his health card and checked the name of the physician who prescribed the medication previously and noticed it was the same physician.

As it was the patient's first time at the pharmacy, and it was a narcotic prescription, the pharmacist gave the patient a couple of patches and said he would have to verify the prescription with the physician before dispensing more. The pharmacist said that he phoned the physician's office and asked to speak with the physician, although there was no documentation or record of the phone call. The receptionist put him on hold and then an individual answered and confirmed the prescription when asked. The pharmacist dispensed the prescription as written.

It was subsequently discovered that the individual who answered the phone was not the physician, but rather a member of the physician's staff. It was also confirmed that the patient in question was not a patient of the physician whose name was on the prescription and that the prescription was, in fact, a forgery.

WHY DID THIS HAPPEN?

This incident illustrates a lack of appropriate care with a narcotic prescription.

The prescription as presented was for the highest possible strength for fentanyl patches and was from a new patient unknown to the pharmacy. The dose specified, 100mcg once daily, was not therapeutically appropriate. The prescription did not have an authentic signature, a necessary component for a valid prescription. These are all significant red flags, or issues of concern, that the pharmacist failed to notice or address.

COMPLAINT OUTCOME

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

In this case, the panel had significant concerns with the pharmacist's practice in relation to this prescription. The pharmacist dispensed a forged prescription that did not make therapeutic sense. While the pharmacist stated that he telephoned the physician's office and verified the prescription, he failed to document it, making it impossible to verify that this occurred.

The pharmacist was also the pharmacy's Designated Manager. Designated Managers have additional obligations to ensure that the pharmacy's procedures in filling narcotics prescriptions are appropriate, comply with all relevant policies and legislation, and are fully in place at the pharmacy.

**This case occurred prior to the implementation of the Patch for Patch program.*



ORAL CAUTIONS

An oral caution is issued as a remedial measure for serious matters where a referral to the Discipline Committee would not be appropriate. Oral cautions require the pharmacy professional to meet with the ICRC in person for a face-to-face discussion about their practice and the changes they will make that will help avoid a similar incident from occurring in the future.

REMEDIAL TRAINING (SCERPs)

A SCERP is ordered when a serious care or conduct concern requiring a pharmacist or pharmacy technician to upgrade his or her skills has been identified. The ICRC orders SCERPs when they believe that remediation is necessary.

For all complaints filed after April 1, 2015, the College posts a summary of the oral caution and/or SCERP and its date on the "Find a Pharmacy or Pharmacy Professional" tool.

The Panel noted that the pharmacist failed to effectively implement these requirements in his pharmacy and, in his response to the College's investigation, did not provide details on the changes he would make as result of this incident.

Due to the seriousness of the incident, the panel ordered that the pharmacist appear in person to receive an oral caution, and that he complete remedial training — a specified continuing education or remediation program (SCERP) — on pharmacy management as well as review the College's resources on narcotics dispensing.

LEARNINGS FOR PHARMACY PROFESSIONALS

Pharmacy professionals must comply with all legal requirements and ethical principles of practice, including federal and provincial legislation, regulations, by-laws, Standards of Practice, policies and guidelines. It is a basic tenet that pharmacists ensure that prescriptions received are complete, authentic and appropriate.

Pharmacists should take a systematic approach to screening prescriptions before filling, such as checking the dose, frequency, and the indications for drug use. In this case, a therapeutic assessment would have identified that the prescription was not appropriate for the patient, thus raising a red flag for the pharmacist. Speaking with and observing the patient may also provide clues suggesting a fraudulent prescription. As per the College's [Fact Sheet: Identifying Forgeries and Fraudulent Prescriptions](#), considerations can revolve around four key areas: the patient (e.g. their behavior, their medication history), the prescriber (e.g. familiarity with them and their practice), the prescription (e.g. alterations or errors, appropriate for indication) and the situation (e.g. patient in a hurry).

When assessing any prescription, if a pharmacist is unsure of either its authenticity or appropriateness, it is their responsibility to confirm the prescription with the prescriber (see the College's position statement on [Authenticity](#)

[of Prescriptions using Unique Identifiers for Prescribers](#)).

Additionally, the Standards of Practice require that pharmacists document their decisions and actions, including rationale for making any decisions and all communication of relevant patient care information to a patient's healthcare providers (such as confirming the authenticity of a prescription).

LEARNINGS FOR DESIGNATED MANAGERS

Designated Managers must ensure that systems and training are in place at the pharmacy to support the verification of the authenticity and appropriateness of prescriptions prior to dispensing. Staff members must also be appropriately trained on the steps to be taken when they identify a forged or suspect prescription.

Under the Narcotic Control Regulations, any thefts, losses or forgeries of controlled substances must be reported to the Office of Controlled Substances no later than 10 days after its discovery. Reporting a forgery is the same as reporting a loss with one exception: a forgery must be reported even if the forged prescription was not filled.

Appropriate narcotic dispensing goes hand in hand with appropriate narcotic inventory management and staff training. Designated Managers must ensure that they are regularly engaging in narcotic inventory counts and narcotic reconciliations to identify any shortages or other issues, as per the College's [Medication Procurement and Inventory Management Policy](#). As with any medication incident, the Designated Manager should use an incident of prescription forgery as an opportunity for

staff discussion, with the goal of sharing learnings and identifying possible changes to systems, policies or procedures.

PUTTING PATIENT SAFETY FIRST

Pharmacy professionals are entrusted to appropriately procure, manage and dispense narcotics and other controlled substances for use in patient care. Accordingly, they must use their medication expertise, knowledge and skills to support appropriate use and access as well as engage with other healthcare professionals to care for their patients.

In line with the Code of Ethics, and especially with the ongoing opioid crisis, pharmacists and pharmacy technicians must recognize that they have a professional responsibility to identify and implement ways they can help decrease the harm that opioids are doing to their patients, community and society. 



RELATED RESOURCES

[Chat, Check, Chart – Assessment and Documentation](#)

[ISMP: Opioid Stewardship Resources](#)

[Narcotics Practice Tool](#)

REMINDER: STAY INFORMED ON RECALLS, SHORTAGES AND OTHER SAFETY NOTICES BY SUBSCRIBING TO HEALTH CANADA ALERTS



Pharmacy professionals should stay informed on medication, health product and medical device issues that may affect patient safety, including recalls, shortages, adverse reactions and other safety notices. Health Canada provides the following convenient resources:

- [Health Product InfoWatch](#) – Monthly publication by Health Canada that provides clinically relevant safety information on pharmaceuticals, biologics, medical devices and natural health products.

- [MedEffect e-Notice](#) – An “as needed” email alert from Health Canada that provides health product alerts regarding advisories, recalls and other important information.
- [Canada Vigilance Program](#) – This program collects reports of suspected adverse reactions and makes the information available in an online database for healthcare provider and public access.

It is important that pharmacists and pharmacy technicians report

adverse reactions to vaccines and medications. Read more in the Summer 2017 *Pharmacy Connection* article: [Reporting Adverse Reactions to Vaccines and Medications](#). 

PUBLIC CONSULTATION NOW OPEN ON PROPOSED REGULATORY AMENDMENTS UNDER THE PHARMACY ACT

At its September 19, 2017, meeting, Council approved changes to registration and quality assurance regulations under the *Pharmacy Act, 1991* for public consultation. Following the 60 day consultation period, a consultation report, including a summary of feedback, will be presented to Council for consideration in December 2017.

A final submission will then be made to government.



The regulations, if enacted, will allow for a more efficient registration process and an enhanced approach to quality assurance. They will also result in greater transparency to the public and improve accountability by:

- implementing an intern pharmacist and intern pharmacy technician class of registration and removing the pharmacy student class;
- incorporating pharmacy technicians into the quality assurance regulations;
- eliminating unnecessary steps in registration; and
- shifting from an hourly reporting of practice to a self-declaration of competency in conjunction with practice assessments at the place of practice.

The College has taken an outcome-based approach to revising these regulations. The value of this approach is that the expected outcomes will have the weight of legislation, while providing the College with the flexibility to update standards and expectations in policies and guidelines as needed to better reflect the current practice environment.

REGISTRATION AMENDMENTS

There is currently no graduated licensing approach available to pharmacy technicians, meaning there is no option for them to register post-graduation but prior to completing all entry exams and practical assessment/training. Additionally, there is overlap between the requirements for the existing student and intern classes for pharmacists. The proposed amendments establish an intern class for both pharmacists and pharmacy technicians and remove the pharmacy student class.

Registration as a student has become an unnecessary registration requirement due to changes in education programs over time. As with other health professions, the *Regulated Health Professions Act, 1991* has provisions to permit students to practice while in an education program, and recent changes to the *Drug*

and *Pharmacies Regulation Act, 1990* allow these provisions to apply to pharmacy students as well.

The amendments revise the language proficiency requirements to highlight the desired outcome to speak, read, write and comprehend English or French with reasonable fluency to meet the standards of practice of the profession. Language proficiency is an important element in providing excellent care to patients, and a pharmacy professional must be able to demonstrate language proficiency that allows them to practice to the standards of the profession, both at entry to practice and throughout their practice career.

QUALITY ASSURANCE AMENDMENTS

Currently, pharmacists are required to register either in Part A (provides patient care) or Part B (does not provide patient care) of the Public Register. Through this approach, the public can easily identify pharmacists who are actively engaged in patient care. The amendments will expand the register to include a similar requirement for all pharmacy technicians.

The amendments also shift from requiring a report of practice hours to a yearly confirmation of competence. With the implementation of member practice assessments, the College has the opportunity to evaluate individual pharmacy professionals at their practice site as a better measure of competency. This approach is in line with the College's focus on providing pharmacy professionals with coaching and support to improve practice.

The major components of the College's Quality Assurance Program are already stated at a high level within the regulations, reflecting the requirements of the *Regulated Health Professions Act*; therefore, only a few changes are required in the proposed regulations to remove specificity, reflect outcomes, and support a new program design.

Changes to registration processes and the public register associated with the proposed regulations will be communicated in advance of implementation. 

All pharmacy professionals are encouraged to review the proposed changes and provide feedback through the [Consultations page on the College's website](#).

THE DEADLINE FOR FEEDBACK IS NOVEMBER 20, 2017.



FREQUENTLY ASKED QUESTIONS

from Pharmacy Practice

This column is a new feature in *Pharmacy Connection* that will share selected questions frequently asked by pharmacy professionals, and the accompanying answers.

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

Q Can you clarify the circumstances in which a third party payer (for example, employer-funded insurance company) can require a patient to go to one pharmacy over another?

A In general, employers purchase group benefit plans from insurance companies, negotiating and deciding the terms of the plan on behalf of their employees. The College has no jurisdiction over the practices of employers or insurance companies. Although one *Pharmacy Act* [regulation](#) prohibits a pharmacist from restricting a patient's choice of pharmacy without their consent, often in these arrangements (i.e. "preferred provider" contracts) consent is given by the employee when they opt-in or enroll for benefits. Should a patient have any concerns about how their benefits are administered, they should speak with their

employer directly. The pharmacy professional(s) involved in a patient's care must still uphold the Standards of Practice and their professional responsibilities.

Q Are nurse practitioners allowed to prescribe narcotics, controlled drugs and targeted substances?

A As of April 19, 2017, nurse practitioners (NPs) in Ontario who have successfully completed approved controlled substances education can prescribe controlled substances. A controlled substance is defined as any drug under the federal [Controlled Drugs and Substances Act](#).

NPs who have not completed this education are not authorized to prescribe controlled substances. Their profile on the College of Nurses of Ontario's (CNO) public register, "[Find a Nurse](#)," will state "Entitled to practice with restrictions. This member cannot prescribe controlled substances. They have not completed the education needed to do so."

For more information, please see the news release, "[NPs can now prescribe controlled substances](#)," on the CNO website. If you have any questions about NP prescribing, please contact CNO at practicesupport@cnoemail.org

Questions about another healthcare professional's scope of

practice or prescribing authority are best addressed through collaboration with the professional directly and, if needed, consulting the appropriate healthcare professional's regulatory body.

Q Can we accept prescriptions for methadone for MMT from out of province clinics/prescribers?

A Pharmacy professionals who accept prescriptions for any drug from an out of province prescriber should refer to OCP's [Fact Sheet on Out of Province Prescriptions](#). In addition, pharmacists should be familiar with [OCP's Methadone Maintenance Treatment \(MMT\) and Dispensing Policy](#) prior to dispensing any methadone prescriptions. Pharmacists should have and refer to the required reference Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorder (CAMH). Collaboration with the prescriber may be required to ensure methadone prescriptions are written in accordance with Ontario MMT policies as well as the [Narcotic Safety and Awareness Act](#) requirements. If a pharmacy professional is unsure of the scope of practice and prescribing authority of another regulated health professional, they should contact the individual's regulatory body for clarification. 

IT'S FLU SEASON



Influenza is the most common infectious disease cause of death in Canada, and it is estimated that 3,500 Canadians die in a given year from influenza and its complications.¹ Therefore, it is particularly important for high risk groups, including patients 65 years or older, women who are pregnant and patients with chronic health conditions, to receive the flu vaccine.²

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

- be participating in Ontario's UIIP;
- have completed an OCP-approved injection training course and registered their training with the College; and
- hold a valid certification in CPR and First Aid.

Pharmacists participating in the UIIP are also authorized to provide the FluMist vaccine to patients age 5 to 17. Patients outside this age range can receive the publicly-funded FluMist vaccine from their family physician.

The College's [Administering Injections Practice Tool](#) contains important information on training and

registration requirements. Pharmacists can also refer to their [UIIP agreement and FAQs](#) from the Ministry of Health and Long-Term Care.

ADDRESSING PATIENT CONCERNS

Pharmacists play an important role in supporting patient well-being and facilitating a healthier community. Patients who are hesitant or ambivalent about vaccination may be more comfortable with reassurance from their pharmacist.

Encourage patients to review the Ministry's resources on the [Flu](#) and [Flu Vaccine Safety](#). Common questions and answers on the flu shot are available on the [Get The Facts About the Flu Shot factsheet](#). 

REFERENCES:

1. The flu. Retrieved at: <https://www.ontario.ca/page/flu-facts>
2. Flu Consult Toolkit. Retrieved at <http://www.health.gov.on.ca/en/pro/programs/publichealth/flu/resources.aspx>
3. Get the facts about the flu shot. Retrieved at http://www.health.gov.on.ca/en/pro/programs/publichealth/flu/uiip/docs/flu_uiip_concerns_handout_2015-16_en.PDF

DID YOU KNOW?

There are currently 9,867 pharmacists in Ontario who are trained and registered to administer injections.



DISCIPLINE DECISIONS



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Yogesh Patel (OCP #604597)

Findings of Professional Misconduct

At a hearing on July 24, 2017 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Patel with respect to the following incidents:

- That he was found guilty on April 19, 2017, of criminal offences, and in particular:
 - o Trafficking of a controlled substance (fentanyl) contrary to s. 5(1) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o Possession of a controlled substance for the purpose of trafficking x3 (fentanyl, hydromorphone and morphine) contrary to s.5(2) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o Knowingly forging a document as if it were genuine (a prescription) contrary to section 368(1)(a) of the Criminal Code of Canada;
 - o Fraud over \$5,000 (against Rexall Pharmacy), contrary to section 380(1)(a) of the Criminal Code of Canada; and,
 - o Theft over \$5,000 x2 (against Rexall Pharmacy and the Ontario Drug Benefit Plan), contrary to section 334(a) of the Criminal Code of Canada;

In particular, the Panel found that he:

- Was found guilty of criminal offences relevant to his suitability to practise;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o section 5(1) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o section 5(2) of the Controlled Drugs and Substances Act, S.C., 1996, c. 19;
 - o section 368(1)(a) of the Criminal Code of Canada;
 - o section 380(1)(a) of the Criminal Code of Canada; and/or,

o section 334(a) of the Criminal Code of Canada; and

- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand;
2. Directing the Registrar to revoke the Member's certificate of registration; and
3. Costs to the College in the amount of \$2,500.

In its reprimand, the Panel noted that integrity, trust, and professional conduct are the core of the practice of pharmacy and the delivery of the care to the public, and that, in return, the profession is held in high regard by the people of Ontario.

The Panel observed that Pharmacy is a self-regulated profession and must ensure that it maintains the trust of its members and the public it serves. The practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession, and to oneself.

The Panel expressed its view that Mr. Patel's conduct demonstrated flagrant disregard for the privilege of practising pharmacy. The Panel pointed out that trafficking in narcotic and controlled substances is antithetical to the pharmacist's role and has the potential to be injurious and destructive to individuals and the community.

The Panel indicated that Mr. Patel's conduct was deserving of revocation.

Acknowledgment & Undertaking

Mr. Patel entered into an Acknowledgment & Undertaking as part of the resolution of allegations of professional misconduct at a hearing of before a Panel of the Discipline Committee.

Pursuant to the Acknowledgment & Undertaking dated July 20, 2017, Mr. Patel undertook that he will not reapply to the College or in any way seek the reinstatement of his certificate of registration with the College for any class of membership.

Stay of Allegations

Also at the hearing on July 24, 2017, the Panel made an order staying certain allegations of professional misconduct against Mr. Patel. The allegations, referred by the Inquiries, Complaints and Reports Committee, are that he:

- Submitted accounts or charges for services that he knew were false or misleading to the Ontario Drug Benefit program for one or more of certain identified prescriptions;
- Falsified pharmacy records relating to his practice in relation to claims made to the Ontario Drug Benefit program for one or more of certain identified drugs and/or products;
- Falsified pharmacy records relating to the purported transfer of narcotics to the pharmacy for one or more of certain identified prescriptions;
- Falsified pharmacy records relating to the purported transfer of narcotics from the pharmacy to one or more of certain identified pharmacies;
- Falsified pharmacy records by forging prescriptions for certain identified clients; and/or,
- Failed to exercise appropriate professional diligence prior to dispensing drugs to certain identified clients, which resulted in the filling of forged prescriptions and/or prescriptions that were rendered invalid after the physician no longer had prescribing privileges.

In particular, it is alleged that he:

- Failed to maintain a standard of practice of the profession;
- Sold or dispensed drugs for an improper purpose;
- Falsified records relating to his practice;
- Submitted an account or charge for services that he knew was false or misleading;
- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:
 - o sections 5 and 15(1)(b) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder

The Panel ordered that the stay shall remain in effect for as long as the Undertaking, Agreement & Acknowledgement signed by Mr. Patel on July 20, 2017, remains in full force and effect and Mr. Patel complies with all terms and conditions of that Undertaking, Agreement and Acknowledgment.

Lisa Galassi, R.Ph. (OCP #115525)

At a hearing on July 26, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Galassi with respect to the following incidents:

- That between 2012 and 2016, she made inaccurate or false declarations on her Annual Renewal form by declaring that she met the criteria for eligibility as a Part A pharmacist when she did not meet the requirements of s. 45(3) of O. Reg. 202/94; and/or
- That between 2006 and 2016, she made inaccurate or false declarations on her Annual Renewal form by failing to fully and accurately provide the name and address of each business for which she engaged in the practice of pharmacy, or to notify the College of changes to such information.

In particular, the Panel found that she

- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement; and
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as dishonourable and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration requiring that:
 - (a) the Member successfully complete, within six (6) months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, for the purpose of addressing the professional and ethical obligations with respect to providing mandated

information to the College; and the following terms shall apply to the course:

- (i) the number of sessions shall be at the discretion of the consultant, but shall be a minimum of 2 meetings and a maximum of 3 meetings;
 - (ii) the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;
 - (iii) the Member shall be responsible for the cost of the course;
 - (iv) the Member shall provide to the consultant the following documents, in advance of the course, to facilitate the design of the course:
 - a) the Notice of Hearing;
 - b) the Agreed Statement of Facts;
 - c) this Joint Submission on Order; and
 - d) the Panel's Decision and Reasons, if and when available; and
 - (v) the Member will request a report from the consultant confirming that the Member has completed the course to the satisfaction of the consultant, and the Member will provide a copy of the report to the College within six (6) months of the date of this Order.
 - (b) the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in paragraph 2(a), if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest.
3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition the Member complete the remedial training program as specified in paragraph 2 above. The suspension shall commence on July 27, 2017 and continue without interruption until September 26, 2017. If the remitted portion of the suspension has to be served, the further suspension shall commence on January 27, 2018 and continue without interruption until February 26, 2018,

unless the time for completing the remedial steps in paragraph 2(a), above, is extended by the Registrar, in which case, the date the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

4. Costs to the College in the amount of \$2,000.00

In its reprimand, the Panel noted that the public register of the College helps to tell the world who pharmacists are, and tells the public what pharmacists, as health care professionals, are legally entitled to do.

The Panel observed that the Member was listed in Part A of the College's public register, and that she misled the public about who she was, what she was legally entitled to do, and where she worked. The Panel observed that this misconduct was carried over for a number of years, that numerous annual opportunities to update and correct the information were not utilized, and the erroneous information essentially became further from the truth each year.

The Panel noted that as a registered health care professional, the Member should not have been holding herself out to be a duly licensed health care practitioner, with all of the privileges, rights, and legalities associated with that specific designation. The Panel expressed its view that doing so put the public at risk.

The Panel related that while serving her suspension, the Member is not permitted to call herself a pharmacist, and that the suspension removes her identity as a pharmacist and the privileges that come with being a legally registered member of this College.

The Panel expressed its expectation that the Member will not appear before a Panel of the Discipline Committee again.

Akop Shaboian (OCP #215101)

Findings of Professional Misconduct

At a hearing on September 7, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Shaboian with respect to the following incidents:

- a) He dispensed certain identified products in a different quantity than the quantity indicated as dispensed on pharmacy records;

- b) He falsified pharmacy records and/or information recorded on the prescription relating to the dispensing of certain identified prescription drugs;
- c) He charged dispensing fees for the dispensing of certain identified products in less than the full amount prescribed without informed authorization or proper justification;
- d) He dispensed prescription drugs without a prescription and/or proper authorization with respect to certain identified products;
- e) Between in or about November 2014 and in or about February 2016, he falsified oral prescriptions and dispensed prescription drugs when no prescription was ordered with respect to certain identified products;
- f) In or about April 2016, he charged dispensing fees for certain identified products without dispensing the products;
- g) He did not maintain accurate records of prescriptions dispensed to [Patient] in that pharmacy records indicate that a different quantity of product was dispensed than was actually dispensed for certain identified products;
- h) He failed to keep records with respect to certain identified products in accordance with the requirements of section 37 and 38 of the General Regulation

In particular, the Panel found that he:

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patient
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional

Acknowledgment & Undertaking

Mr. Shaboian entered into an Acknowledgment & Undertaking as part of the resolution of allegations of professional misconduct at a hearing of before a Panel of the Discipline Committee.

Pursuant to the Acknowledgment & Undertaking dated April 25, 2017, Mr. Shaboian undertook to permanently resign as a member of the College, effective September 7, 2017.

Order

The Panel imposed an Order which included as follows:

1. A reprimand
2. Costs to the College in the amount of \$5,000

In its reprimand, the Panel pointed out that members of the public hold pharmacists in high regard, and that Mr. Shaboian failed in his professional obligation to conduct himself in a manner that is respectable, responsible, and maintains public confidence.

The Panel noted that pharmacy is a self-regulated profession. Members have a responsibility to ensure that the public is adequately protected and to maintain the public's confidence in their ability to govern themselves.

The Panel expressed its view that, as a result of his misconduct, Mr. Shaboian has let down the public, the pharmacy profession, and himself. The Panel expressed its confidence that Mr. Shaboian's decision to resign will ensure the public is protected.

Murray Salomon, R.Ph. (OCP #67393)

At a hearing on September 5, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Salomon with respect to the following incidents:

- That he failed to obtain and/or document the consent of patients for the delegated controlled acts of performing a procedure below the dermis in relation to the INR blood tests performed by pharmacists, including for approximately 180 of the 215 patients for whom the tests were performed on or about December 23, 2013; December 27, 2013; December 30, 2013;

January 2, 2014; and/or January 16, 2014;

- That he failed to obtain and/or document the required information and records in relation to MedsCheck and Pharmaceutical Opinion Program services claimed for all patients, including the following information regarding approximately 290 MedsCheck and/or 275 Pharmaceutical Opinion Program services claimed for 345 patients on or about December 23, 2013; December 27, 2013; December 30, 2013; January 2, 2014; and/or January 16, 2014:
 - o for the MedsCheck services, the standard disclaimer, patient gender, primary prescriber information, and/or medication details (including generic or brand drug name, strength, dosage form, quantity, date dispensed and/or directions for use); and/or
 - o for the Pharmaceutical Opinion Program services, the original or refill prescriptions to be attached or cross-referenced; and/or
- That he failed to keep records as required in relation to other discrepancies in the documentation for MedsCheck and Pharmaceutical Opinion Program services claimed for patients.

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand
2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration and, in particular, requiring the Member to:
 - (a) retain, at the Member's expense, a practice mentor, approved by the College, within three

(3) months of the date of this Order;

- (b) meet at least five (5) times with the practice mentor, at a place to be determined by the practice mentor, for the purpose of reviewing the Member's ethical and professional obligations in relation to consents, compliance with program claim requirements, maintaining accurate records, and any other issues raised by the facts and findings of professional misconduct in this case, and identifying areas in the Member's practice with respect to these issues that require remediation. These meetings shall take place from time to time, at the discretion of the practice mentor, for a period of twelve (12) months from the date of this Order;
- (c) provide the practice mentor with the following documents related to this proceeding:
 - (i) the Notice of Hearing;
 - (ii) the Agreed Statement of Facts;
 - (iii) the Joint Submission on Order; and
 - (iv) the Panel's Decision and Reasons, if and when available.
- (d) develop with the practice mentor a learning plan to address the areas of the Member's practice requiring remediation;
- (e) demonstrate to the practice mentor, in a manner directed by and acceptable to the practice mentor, that the Member has achieved success in meeting the goals established in the learning plan;
- (f) ensure that the practice mentor reports the results of the mentorship program to the Manager, Investigations and Resolutions at the College, after its completion, which shall be no later than twelve (12) months from the date of this Order;
- (g) refrain from acting as Designated Manager at any pharmacy until the mentorship program has been completed to the satisfaction of the practice mentor; and
- (h) the Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in

paragraph 2, if the Registrar is of the view that it would be in the interests of fairness to do so and that it would not be contrary to the College's mandate to serve and protect the public interest.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of four (4) months, with one (1) month of the suspension to be remitted on condition the Member complete the mentorship program as specified in paragraph 2 above. The suspension shall commence on September 6, 2017 and continue without interruption until December 5, 2017. If the remitted portion of the suspension has to be served, the further suspension shall commence on September 6, 2018 and continue without interruption until October 5, 2018, unless the time for completing the remedial steps in paragraph 2 above is extended by the Registrar, in which case, the date the remitted portion of the suspension shall commence, if required, shall be adjusted accordingly.

4. Costs to the College in the amount of \$4,000.00.

In its reprimand, the Panel noted that the practice of pharmacy is a privilege that carries with it significant obligations to the public, the profession, and oneself. Through his conduct, the Member put public confidence in the profession in jeopardy, and brought

discredit to the pharmacy profession and himself.

The Panel expressed its view that the Member's conduct was totally unacceptable to his fellow pharmacists. The Panel pointed out that when the College identified documentation deficiencies in his practice in 2013, the Member assured the College that these were anomalies and corrective action would take place. This Panel viewed the failure to take said corrective action very seriously.

The Panel observed that this was not the Member's first appearance in front of a panel of the Discipline Committee. The Panel expressed its trust that this disciplinary process has caused the Member to reflect on his practice and will motivate him to make changes, and that this will be the last time he appears before a panel of the Discipline Committee of the Ontario College of Pharmacists. **Pc**

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

PRACTICE TIP!

Documentation on every prescription – new or refill – should reliably demonstrate it has been reviewed for both technical and clinical aspects before being dispensed to the patient #OCPPPracticeTip
http://www.ocpinfo.com/library/pharmacy-connection/download/OCP_PharmacyConnection_Spring2017_FourRs_of_Doc.pdf

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#OCPPPracticeTip**

A SUMMER STUDENT'S EXPERIENCE AT OCP



Elena Danyluk, Doctor of Pharmacy Candidate (2020), University of Toronto, Leslie Dan Faculty of Pharmacy

HOW WOULD YOU DESCRIBE YOUR EXPERIENCE AT THE COLLEGE THIS SUMMER?

Coming into this experience, I would have to say that my understanding of the role of the College was pretty limited beyond the public protection mandate. What struck me the most in my first week was how much the staff at the College genuinely care about improving the quality of pharmacy practice and how the College works to encourage pharmacists to practice to their full scope. Over the past summer, I had the opportunity to work with six different departments at the College. I was also able to attend a Disciplinary Hearing, an Opioid Task Force meeting, a Community Practice Assessment, the June Council meeting, and a Patient Relations Committee meeting. These projects and meetings gave me exposure to the inner workings of the College including the

complaints and discipline processes, the Quality Assurance Program, and the intensive process of creating policies and guidelines.

WHAT WAS THE MOST INTERESTING PROJECT YOU WORKED ON?

My work on the distribution of cannabis for medical purposes was one of the most interesting and challenging projects I engaged in at OCP. After attending the June 2017 Council meeting, I was intrigued by this controversial and complex topic and wanted to become involved in whatever way I could. I was asked if I could contribute to the drafting of an information document to help Council form a position statement on the distribution of cannabis for medical purposes. This topic is something that I will continue to think about as I resume school in September and I will be closely following any of the College's developments in this area.

WHAT WAS YOUR FAVOURITE PART ABOUT WORKING AT THE COLLEGE?

Being able to attend meetings and collaborate with the skilled staff at OCP and contribute to some projects on important issues in the world of pharmacy truly enriched my time here. For example, after learning about the increasing rates of opioid abuse and misuse in school, I was able to attend an Opioid Task Force meeting in which various initiatives outlined by OCP's opioid strategy were discussed in an effort to take action against

the opioid crisis. Not only was my experience directly relevant to my studies, but I was also able to provide input as to what types of projects I wanted to get involved with. Another interesting project that I worked on was the development of a draft guideline for initiating, adapting, and renewing prescriptions. This allowed me to gain a better understanding of the extensive process behind developing practice resources for pharmacists' use. From my first day to my last, the staff at OCP were entirely welcoming and wanted to make sure that I got the most out of this experience.

HOW DO YOU THINK YOUR EXPERIENCE THIS SUMMER WILL HELP YOU WITH YOUR FUTURE CAREER IN PHARMACY?

The insight I gained into the role of the College is truly invaluable to me. Coming into this position fresh out of my clinical rotation in a community pharmacy, I experienced a view of the pharmacy profession from a completely different angle. I now feel a renewed sense of pride in my future profession and comfort in the College initiatives to ensure public protection. In order to compliment the public protection mandate, the College encourages pharmacists to practice to their full scope and to embrace their role in the interprofessional health care team as an autonomous decision maker with unique professional judgment as medication experts. The exposure I've had to these principles will help me become a skilled and mindful pharmacist in the future. 

FOCUS ON ERROR PREVENTION

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

PATIENT IDENTITY

I have received numerous reports of medication errors resulting from a failure to correctly identify the patient. The potential for patient harm is an obvious concern. In addition, patients receiving medications meant for another patient may also receive confidential personal health information belonging to that patient including medication history and name of their physician, along with identifying information like their name or address.

Pharmacists must be reminded that as health information custodians, we “shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian’s custody or control is protected against unauthorized disclosure”¹. The inadvertent unauthorized disclosure of a patient’s private information should be seen as a privacy breach.

In some instances (such as repeated incidences of unauthorized disclosure), the health information custodian must report the privacy breach to the Ontario Information and Privacy Commissioner².

The following cases have been reported:

CASE 1:

A patient visited a walk-in clinic and received a prescription for Amoxicillin. In error, the clinic attached the incorrect patient information (name, address,

phone number, health card and date of birth) to the prescription. Without looking at the prescription, the patient brought it to a local community pharmacy for processing.

The pharmacy assistant did not confirm the patient’s identity and therefore processed the prescription for the incorrect name listed on the prescription. Upon checking the prescription, the pharmacist failed to detect the error. Fortunately the error was detected when the patient returned for the medication and his name could not be found in the system.

CASE 2:

Mr. Harold Smith returned to his local community pharmacy to pick up his medication. The pharmacy assistant looked into the pick-up drawer and saw a prescription bag for Harry Smith. Assuming that it

is the correct patient, she retrieves the bag and quickly states “Harry Smith?”

The patient did not hear her remarks clearly and due to the similarity in names assumed that she had said Harold Smith. The incorrect medication was therefore given to the patient along with confidential information for Harry Smith. Fortunately the error was detected when the patient arrived home and the incorrect medication was not consumed.

CASE 3:

A patient returned to his community pharmacy and stated that he was there to pick up his EpiPen®. The pharmacy assistant noticed an EpiPen® ready for pick up on the counter and assumed it belonged to the patient. The EpiPen® was given out to the incorrect patient.



On arriving home, the patient noticed that the EpiPen® and confidential information in the bag did not belong to him.

RECOMMENDATIONS:

- When processing prescriptions, always confirm the patient's identity by collecting the patient's full name, their address and date of birth. There have been instances where a parent and child have the same name and live at the same address.
- When selecting patients from a list, use extra care to ensure the correct "John Smith" is selected. Ideally, use the patient's date of birth to ensure that the correct profile is retrieved.
- When checking prescriptions, always confirm that the medication is being added to the correct patient profile. Confirm that all paperwork/documentation included belongs to that patient only.
- When providing prescriptions to patients at pick up, always confirm the patient's full name and address. Speak clearly when

stating the patient's name. Barriers to communication may include hearing deficiencies and peculiar pronunciation due to an accent.

- Always remove any patient identifier from a product before it is returned to stock. This will prevent the inadvertent release of that information to another patient. 

REFERENCES:

1. *Personal Health Information Protection Act, 2004.*
2. Reporting a Privacy Breach to the Commissioner, available at: <https://www.ipc.on.ca/wp-content/uploads/2017/08/health-privacy-breach-notification-guidelines.pdf>
Accessed October 4th, 2017.

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

REMINDER: YOUR OBLIGATIONS AS HEALTH INFORMATION CUSTODIANS



Pharmacy professionals, as health information custodians, have certain obligations under the *Personal Health Information Protection Act* (PHIPA). One such obligation is to have a written public statement available that includes: a general description of the custodian's information practices, who to contact in the case of questions about the

practices, a explanation of how an individual can get access to their personal health information, and a description of how to make a complaint to the custodian and the Information and Privacy Commissioner.

Health information custodians (i.e. Designated Manager or delegate) may create their own statement as

along as it meets the requirements and obligations set out by PHIPA. The Office of the Information and Privacy Commissioner of Ontario also makes available free [health information and privacy posters and brochures](#) to assist in fulfilling your obligations in this area. 

