

# Pharmacy Connection



Official Publication of the Ontario College of Pharmacists



September/October 2007

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## Council Members

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

- 1 Joseph Hanna
- 2 Elaine Akers
- 3 Sherif Guorgui
- 4 Tracey Phillips
- 5 George Phillips
- 6 Fayez Kosa
- 7 Tracy Wiersema
- 8 Iris Krawchenko
- 9 Bonnie Hauser
- 10 Gerald Cook
- 11 David Malian
- 12 Peter Gdyczynski
- 13 Donald Stringer
- 14 James Delsaut
- 15 Gregory Purchase
- 16 Doris Nessim
- 17 Shelley McKinney
- PM Joinal Abdin
- PM Thomas Baulke
- PM Andrea Chun
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- PM Salvatore Guerriero
- PM David Hoff
- PM Margaret Irwin
- PM Lewis Lederman
- PM Aladdin Mohaghegh
- PM Gitu Parikh
- PM Krishanthi Shu
- DFP Wayne Hindmarsh

## Statutory Committees

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

## Standing Committees

- Communications
- Finance
- Professional Practice

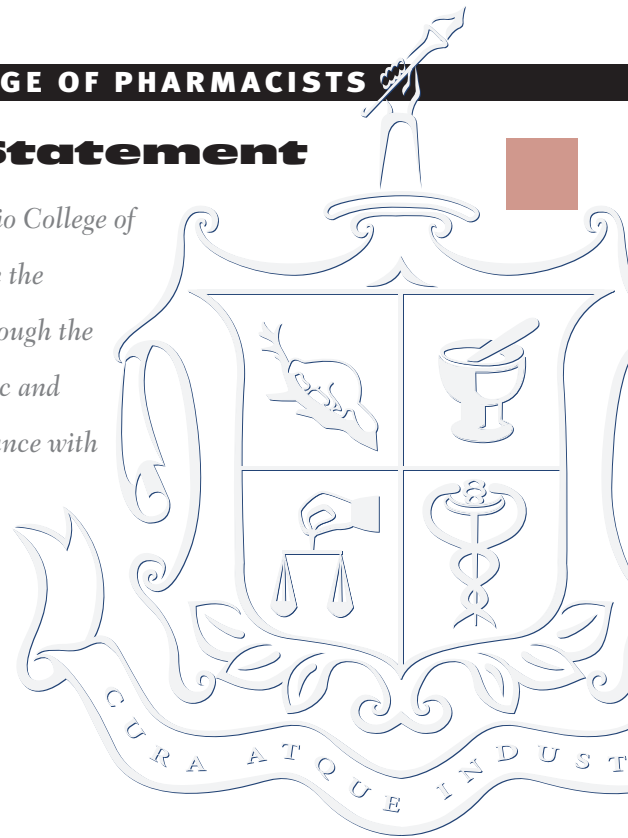
## Special Committees

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

# ONTARIO COLLEGE OF PHARMACISTS

## Mission Statement

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



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ISSN 1198-354X  
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### Pharmacy Connection

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

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

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

# REGISTRAR'S MESSAGE



Deanna Williams, R.Ph., B.Sc. Phm., CAE  
Registrar


**S**hould pharmacists *prescribe*? This is the question sweeping across the country right now. The word itself - when linked to any non- medical professional will certainly give rise to heartburn in some circles, but it all comes down to what we mean by “*prescribe*”. Interestingly, none of the profession-specific acts made under the *Regulated Health Professions Act*, ( RHPA) define *prescribing*, which leaves much open to interpretation. To understand its definition, we first need to recognize, and more importantly, appreciate the traditional intent behind the act of *prescribing*. *Prescribing* has traditionally and logically followed diagnosing so the argument can be made that unless pharmacists are trained in differential diagnosis and we currently are not then we should NOT *prescribe*.

Over the past decade, College Council has consciously worked towards optimizing the role of the pharmacist through delegation, medical directives and the establishment of collaborative practice models

rather than pursue the right to *prescribe*. Ontario, unlike other Canadian jurisdictions, operates within a “controlled act” model, which means only those professions permitted by statute to perform authorized or “controlled acts” may legally do so. However, under the RHPA, delegation of controlled acts is permitted; meaning that a regulated health professional may transfer the authority to perform his/her controlled act(s) to any person whom they determine has the knowledge, skills, ability and judgment to safely perform the delegated act(s).

Under delegation protocols or medical directives, many Ontario pharmacists in both hospital and community settings are already working alongside physicians and nurses, engaging in such practices as initiating drug therapy, ordering / reviewing lab tests and adjusting doses accordingly, and managing drug therapy for patients in INR clinics and palliative care settings. As a pharmacist, you are both permitted and encouraged to use professional judgment to fill or re-fill a prescription in appropriate situations, provided you believe it is clearly in the patient’s interest to do so, you believe that your action(s) are those that a peer in practice would take in the same situation, and you document your actions and communicate them in a timely manner to the patient’s primary care practitioner. Professional judgment is a privilege and allows us as regulated health professionals to do what we need to do for our patients, when the circum-

stances are right and appropriate. In fact, it is difficult for me to recall a day in my years of practice where I wasn’t called upon, in one way or another, to exercise my professional judgment.

I have to wonder why we want to use the “P” word when there are alternative, appropriate ways to achieve the same end- utilizing pharmacists to their full capacity and expertise in drug therapy management to optimize patient care. Pharmacists do not currently have the controlled act of *prescribing* in Ontario; obtaining the right would require strong political will as well as solid support and the collective approval of the pharmacy profession, the medical profession, other health regulatory professions, and the public. It would also require pharmacists to be adequately trained to take a medical history, perform a physical examination, order and interpret appropriate investigations, to arrive at, and communicate effectively, a differential diagnosis. Until we are able to do all of the above and the profession as a whole currently is not the College will continue to work towards advancing collaborative practice and models of interprofessional care, with the expectation that pharmacists will emerge and be fully recognized for what we are highly trained health professionals with a unique expertise in drug therapy management! 

# EDITOR'S MESSAGE




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

**M**ember accountability for protection of the public is a consistent message throughout this edition of Pharmacy Connection. Whether the member is a director, owner, designated manager or dispensing pharmacist, he or she is expected to act in the best interest of the public.

As health professionals, pharmacists are held to high standards by their peers and are seen as trusted professional by the public. The professional judgement that is involved in the dispensing of each prescription and the development of each process within a pharmacy is what makes a health professional stand apart from other occupations. The cases included in this publication are published to inform the profession so that

each of us can continue to learn and improve our practices.

As the profession advances, and pharmacists take on greater roles in patient care, professional judgement and public accountability remain paramount. 

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

## Nine professions now eligible for funding!

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

Guidelines and application forms will be made accessible in late September both electronically through the fund's website at [www.ahpdf.ca](http://www.ahpdf.ca)

as well as through direct mail to all eligible potential applicants.

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

For further information please contact the fund administrator by e-mail at: [rstas@ahpdf.ca](mailto:rstas@ahpdf.ca) or

[lsawaya@ahpdf.ca](mailto:lsawaya@ahpdf.ca) or by phone at: 905-602-6015 / 1-866-992-6015.

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

# MedsCheck

## MEDICATION REVIEW PROGRAM UPDATE

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*On April 1st, 2007, the Ministry of Health and Long-Term Care (MOHLTC) launched the MedsCheck program to promote better patient health outcomes by maximizing patient adherence to drug therapy. On July 17th, the ministry announced that the program has been expanded to include all Ontarians.*

**B**y now, most pharmacists throughout the province have completed at least one MedsCheck review. The program is easy to implement and integrate into your patient service routine. During the review, patients will have an opportunity to meet with you, one-on-one, to learn more about their medications and ensure that they are taking them safely and properly. The following is an overview of the program.

### **1. DETERMINING ELIGIBILITY**

To qualify for MedsCheck, a patient:

a. must have a valid OHIP card or

Ontario Drug Benefit (ODB) coverage

- b. must currently be taking three or more chronic prescription medications
- c. must not have completed a MedsCheck within the past year

### **Eligible Patients Who May Benefit Most**

- Patients who have several chronic medical conditions and are taking several medications;
- Patients who have recently been released from a hospital;
- Patients who have had major changes to their medicine schedule;

- Patients who are taking “high-alert” medications, such as opiates or digoxin;
- Patients who may have trouble managing their medication.

## 2. PREPARING FOR PATIENT INTERVIEWS

When scheduling a review, remind the patient to bring along all of their medication containers, including medications dispensed at other pharmacies, as well as any over the counter drugs, vitamins and herbal remedies they take. Caregivers should also be encouraged to attend the review, if appropriate.

To ensure privacy, meet with your patient in a private area of the pharmacy, away from other customers. This is important as you will be collecting personal, lifestyle and health information from the patient. If your pharmacy is not

currently equipped with an appropriate meeting area, you should consider establishing one.

## 3. CONDUCTING THE REVIEW


Review all medications with the patient to ensure they are being taken properly. Identify and help to resolve any problems they may be having in managing their medication regime.

Prepare an accurate medication list to accompany your recommendations. Remember, it is important to promote the value of your professional services. Take a few moments with the patient to review what services you provide and any follow-up plan. Be sure to reinforce your key recommendations. Ask the patient to sign the medication list and provide them with a copy. A copy of the signed medication list must be retained for a period of two

years for audit purposes. All MedsCheck claims submitted on the Health Network System (HNS) are subject to post-payment verification and recovery.

Following the completed MedsCheck review, you can make a claim for payment. MedsCheck claims for ODB and non-ODB recipients will be reimbursed at the same rate of \$50 per review per year. For updated details on submitting a claim for reimbursement, visit:

[http://www.health.gov.on.ca/english/providers/pub/drugs/meds\\_check/medscheck\\_mn.html](http://www.health.gov.on.ca/english/providers/pub/drugs/meds_check/medscheck_mn.html)

For further reference, the OCP has developed a framework and sample forms for conducting medication reviews, as well as comprehensive medications consultations: [www.ocpinfo.com](http://www.ocpinfo.com). 

## NOTICE TO PHARMACISTS

*Reprinted from: Information Notice issued by the Ministry of Revenue – July 2007*

### Retail Sales Tax Exemption for Nicotine Replacement Therapies

Nicotine replacement therapies that are not prescribed by a physician are currently taxable as non-prescription medications. Nicotine replacement therapies come in a variety of delivery mechanisms, including transdermal patches, gums, lozenges, inhalers, sprays and sublingual tablets.

Effective August 13th, 2007, non-prescription nicotine replacement therapies that have been assigned a drug identification number by the federal government and that are sold for the sole purpose of assisting the purchaser to stop smoking tobacco will be exempt from RST at the point of sale. This temporary exemption will cover all sales of nicotine replacement therapies made over the counter after August 12, 2007 and before August 13, 2008.

For more information call the Ministry Information Centre at 1-800-263-7965 or visit [www.rev.gov.on.ca](http://www.rev.gov.on.ca)

# Methadone Locked Boxes

**R**ecent communication<sup>1</sup> by the College of Physicians and Surgeons of Ontario (CPSO) to their MMT prescribing physicians asks physicians to be aware of guidelines for MMT regarding the use of locked boxes (locked containers) as an added security measure for all patients given carries. Physicians are asked to be proactive by having locked boxes available for patients. The issue of locked boxes for methadone carries has been identified in recent methadone deaths.


The use of a locked box is also identified in *Methadone Maintenance: Pharmacist's Guide to Treatment* (second edition) under Tips to Minimize Diversion (pg 92) as well as other sections. The guidelines emphasize the need for proper storage, transportation and security.

Pharmacist-Physician communication is essential where physicians are requiring patients to use and maintain locked boxes for their take home or carry doses.

This provides an opportunity for pharmacists to communicate and discuss the use of a three way agreement between pharmacist-patient-physician. This will assist the physician in reinforcing their treatment plan

for the patient as well as promoting compliance with such an agreement.

Pharmacists should be proactive in communicating with physicians when there is an apparent change in a patient's treatment plan or requirements. The need for clear communication cannot be underestimated. The following are some points to consider when discussing the use of a locked box:

- Type of locked box to be used, e.g. construction requirements
- Responsibility for supplying locked box e.g. physician or pharmacist
- Recommendation that locked boxes are included in new agreements
- Criteria for deciding exemptions to the locked box requirement
- Action expected if patient does not bring back locked box
- Action expected if locked box damaged or lost
- Action expected if patient refuses to use locked box
- Recommendation to amend existing agreements 

<sup>1</sup> CPSO, Methadone News March 2007, Issue 20

## PRACTICE

# Q&A



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

### **Q** Does the College have any guidelines or policies regarding the practice of receiving verbal prescriptions?

While there are no specific College guidelines or policies regarding the practice of receiving verbal prescriptions, pharmacists are expected, as identified in the *Standards of Practice* (SOP 6, 6.2), to ensure that all aspects of their operation are safe and designed to protect the public, i.e., systems and procedures, and implementation of best practices.

The process of accepting and transcribing verbal prescriptions, by its nature, introduces the possibility of error, and can be challenging. For example, the number of intermediaries involved between the prescriber and the completed prescription may be greater than for a written prescription. As well, misinterpretation of the spoken language owing to accents, mispronunciation, poor articulation, or sound-alike drugs is a possibility. Pharmacists should review and ensure that their practice of receiving verbal prescriptions minimizes the potential for error during and after transcribing.

The Institute for Safe Medication Practice (ISMP) published an article, "Writing it Right" in the spring of 2006, to address the practice of accepting verbal orders in hospitals. The article can be found online: <http://www.ismp-canada.org/download/CACCN-Spring06.pdf>

Although the article was written for hospital practice, it raises awareness of the many variables that could lead to an error and which are common in all practice sites. It includes several suggestions or recommendations that pharmacists may wish to implement as best practices for use in staff training and education in their pharmacy.

#### **RECOMMENDATIONS FOR BEST PRACTICES:**


- Document the name of the person giving the order, the

time and date, and the name of the person receiving the order, as well.

- Minimize background noise and distractions.
- Ensure all telephone or verbal orders are complete, i.e., patient's name and full address, medication, dose, time/frequency of dose, route of administration and age/weight (where appropriate).
- Transcribe the order with the date and time that the order was received.
- Avoid problematic or ambiguous abbreviations.
- Read back all orders to confirm accuracy, using words to identify confusable letters (e.g., "B" as in "Bob," "V" as in "Victor,") and giving dosage information using individual numerals (e.g., "50mg" as "five, zero milligrams" to prevent it being heard as "15mg.")
- Verify indication for medication(s) ordered if medication does not appear to make sense with the patient's therapy.
- Call the prescriber and clarify any concerns where questions or uncertainty about the patient, drug, or therapy arise.
- As with any best practice, document everything diligently to maintain an accurate chain of personnel involved and events in the dispensing process.

Some pharmacies have developed pre-printed blank Rx pads to assist staff in ensuring that they capture the components required in a verbal prescription.

Flagging verbal prescriptions for counselling, whether the patient has had it in the past or not is another useful practice to ensure that pharmacists can verify the accuracy of the order with the patient or agent.

Pharmacists are encouraged to visit the ISMP website [www.ISMP-Canada.org](http://www.ISMP-Canada.org) as well as to download "Writing it Right" to assist and educate staff on best practices when taking verbal prescriptions. 



# What's in a Name? .... Plenty!

## *New Legislation Gives Pharmacy Technicians Title Protection*

For some people, the title of their occupation carries little significance, but for many, it is an important statement about who they are. It is common for people to describe their employment by their title, for instance, "I am a pharmacy technician." Since the title defines the role, it is not surprising that pharmacy technicians, about to experience a title change as a result of new legislation in the profession designed to protect the title, are expressing some apprehension about what it all means.


Title protection will certainly affect many pharmacy technicians. Perhaps the most difficult change for them to accept will be the College's decision to discontinue the Certified Pharmacy Technician, or CPhT designation, as we prepare for the transition to the qualification of Registered Pharmacy Technician, or RPhT. There are currently more than 3,000 CPhTs who will be obliged to adapt to the change.

The College is discontinuing certification, as a result of creating a new qualification process to obtain the new designation of RPhT. Additionally, since not all current CPhTs will want to become RPhTs, the concept of two very similar sounding designations could be a source of confusion for many.

For pharmacy technicians intending to become RPhTs, the change in title may require only a minor adjustment. For CPhTs who don't choose to become registered with the College, it will have much more impact. This is because individuals who do not register with the College when title protection comes into effect (at a date

to be determined, but within approximately two years) will lose the right to use the CPhT designation and will have to discontinue using any form of title containing the words "pharmacy technician." The legislation that was passed in June 2007 states "no person other than a member [of the Ontario College of Pharmacists] shall use the title ... 'pharmacy technician' ..., a variation or abbreviation, or an equivalent in another language."

Therefore, Certified Pharmacy Technicians who choose not to become registered will need to identify themselves with a new title, perhaps "pharmacy assistant," which, admittedly, does not convey the same message about the designation they have achieved. In fact, the College has heard from pharmacy technicians that this feels like a loss of identity. We would like to emphasize that although the CPhT title may no longer be used, it does not alter the fact that the certification has been earned, and individuals may continue to communicate this achievement to others on a resume, in a professional portfolio, or in any other manner.

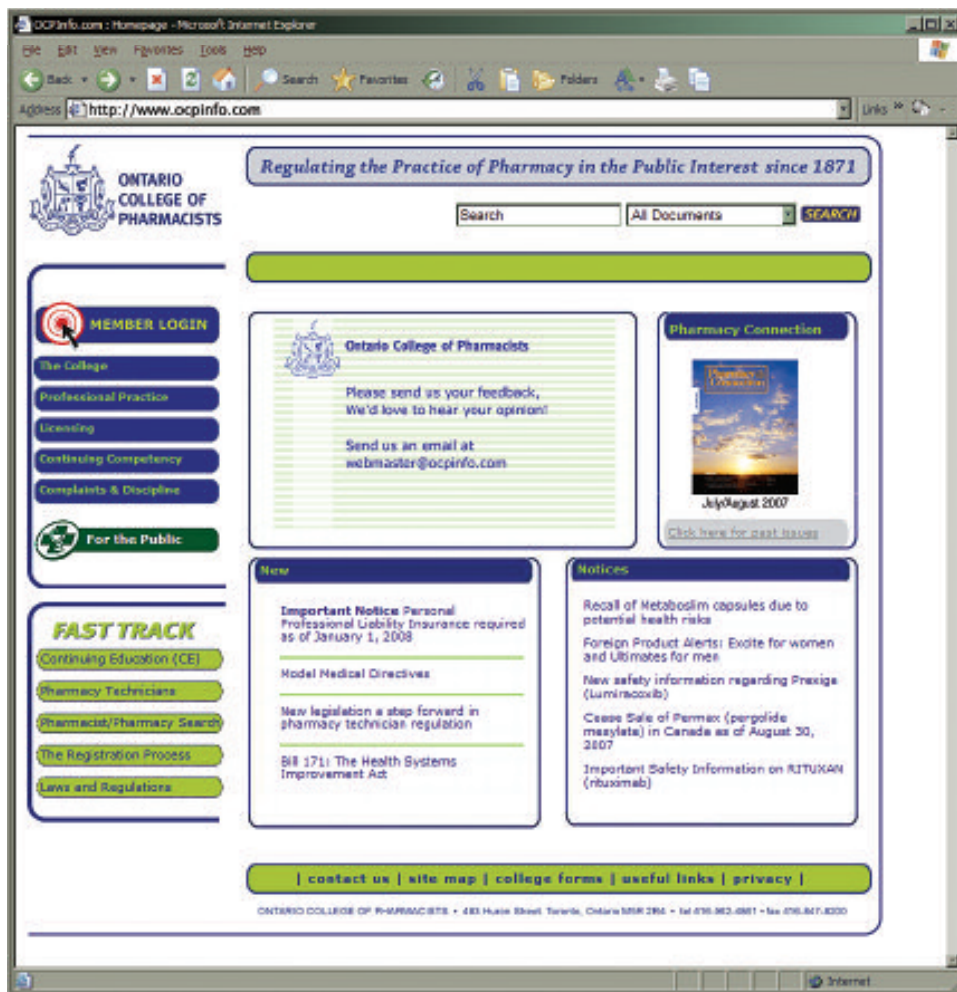
Likewise, individuals who have not completed the certification exam, and do not intend to do so but plan to continue working in their current role, will need to use a title other than "pharmacy technician" when the legislation takes effect. The College, will be reviewing titles currently in use and seeking terms to more clearly differentiate the various categories of individuals who all play an important role in the delivery of pharmacy services. 

# Announcing the launch of a **new** and **improved** College website!

We've been busy here at the College and are now pleased to announce the launch of a **brand new** [www.ocpinfo.com!](http://www.ocpinfo.com)

Thank you to all of the members who provided qualitative and quantitative feedback throughout this process. You helped us to identify the improvements we needed to make, and confirmed that the new site will offer more value to our members.

We hope that in the next few weeks, you'll have a chance to explore [www.ocpinfo.com](http://www.ocpinfo.com). In the meantime, here is a preview of some of the highlights you'll find next time you visit the site:



- **EASIER NAVIGATION**
- **BETTER SEARCH ENGINE**
- **POLICIES, STANDARDS AND GUIDELINES NOW GROUPED AND CATEGORIZED**
- **CLEANER, SIMPLER DESIGN**
- **ONLINE REPOSITORY OF Q&AS AT YOUR FINGERTIPS**

- **PHARMACY CONNECTION ARTICLES - PAST AND PRESENT**
- **EASIER ACCESS TO CONTINUING EDUCATION COURSES, RESOURCES AND EVENTS**
- **LINKS TO OTHER HEALTH RELATED SITES**

**We encourage you to let us know what you think, as we continue to add relevant, meaningful content and improve functionality and ease of use for our members.**

The College acknowledges this article is reprinted from GREY AREAS – July 2007 :  
a newsletter published by Steinecke Maciura LeBlanc – a law firm practicing in the field of professional regulation.

# Informed Consent



*“Better a friendly refusal than an unwilling consent.” Spanish Proverb*

Informed consent might be one of those principles that is honoured more in its breach than in its practice. A fundamental concept for all professions, client consent is essential to the professional relationship. Without it the trust necessary for the professional relationship to work is missing.

## **APPLIES TO ALL PROFESSIONS**

While perhaps originating in health care, the principle of informed consent applies to all professional relationships. Often other terms are used to describe the concept such as: informed choice, acting on client instructions, the “know-your-client” rule and receiving a project mandate. Regulators can foster consent by practitioners through educational initiatives.

## **SPHERES OF CONSENT**

In fact, the need for consent generally arises in three distinct areas:

1. consent to provide professional services,
2. consent to collect, use and disclose personal information, and
3. consent for the billing arrangements with the client.

Often practitioners need to be reminded to obtain consent in all three spheres.

## **NEED FOR CONSENT**

Failure to obtain consent can result in professional, civil and even criminal liability (e.g., assault, theft, fraud). Some professionals ignore the need to obtain consent in the hope that they will not be held civilly liable for damages because the client would have agreed to the professional service if the client had been informed of all of the facts. However, in a recent Ontario Court of Appeal case a physician was sued successfully for failing to obtain informed consent even though there was no negligence: *Huisman v. MacDonald*, 2007 ONCA 391. The court concluded that this particular patient might not have voluntarily assumed the risks that the physician assumed she would take.

*“Nobody can hurt me without my permission.”*  
Mahatma Gandhi

The values of our society reject, with increasing frequency, the arrogance of the proposition that the professional knows what is best for the client. Such an approach to clients is now viewed almost universally as unacceptable paternalism. Certainly such conduct is becoming an increasingly significant

source of complaints for regulators. It is no longer sufficient to say “leave it with me”. As in personal relationships, professional relationships should not operate on the principle that “it is better to ask for forgiveness afterwards than to ask for permission first”.

## OBTAINING CONSENT

To be genuine, consent must be based on a discussion of the relevant considerations in making the decision. Clients have to understand the nature of what is proposed to be done on their behalf. They need to know why it should be done. They have to be acquainted with what could go awry and the chances or odds of that happening. It is equally as important that clients must appreciate their options, including the alternative of doing nothing. Clients must have the ability to raise any individualized issues that may separate them from the “usual” client. Only then is the practitioner safe in accepting that they have authority to act.

It is not adequate to say that the matter is too complicated to explain. Even though clients come to you for your expertise in an area that they do not understand, it is still possible to give clients the “big picture” of what is involved and a sense of what the risks and benefits are.


Many practitioners assume that obtaining written instructions is sufficient to protect them. This

assumption is incorrect. A written document that has not been explained and understood by the client is of no value. In many hearings clients assert that they were rushed to sign a paper they did not read and did not appreciate that they had a choice. This type of assertion is often credible because it resonates with the experiences we all have every day at the bank, the dry cleaner, renting a car or surfing the internet.

Real consent is obtained by the meeting of the minds between the client and the practitioner. A broad spectrum of strategies is necessary to achieve these goals including:

1. using handouts,
2. verbal explanations,
3. employing visual aids where feasible,
4. seeking client feedback as to what they understand,
5. asking clients if they have any questions,
6. proper use of a consent form,
7. documentation in the file of the consent obtained, and
8. frequent updates and reports while providing the service.

Of course, the ability to communicate clearly in non-technical language is a huge asset.

Obtaining consent should be viewed as a process, not an event. 

Determining capacity to consent is an important component of providing effective patient care. Recognizing this, the CPSO published an informative article on this subject in the July issue of Dialogue. The article, which is abridged from “A Practical Guide to Capacity and Consent Law of Ontario for Health Practitioners Working with People with Alzheimer Disease,” was developed by the Mini Task Force on Capacity Issues, the Dementia Network of Ottawa. Although the guide is written for physicians, the principles that are discussed are relevant to all health care practitioners. Of particular interest are the provisions available in the absence of an Attorney for Personal Care and health care practitioners’ responsibilities in assessing capacity to give or refuse consent. The article, can be accessed at [www.cpso.on.ca/publications/dialogue/july07/toc.htm](http://www.cpso.on.ca/publications/dialogue/july07/toc.htm)

# The Patient Relations Program

by Sasmita Rajaratnam, Policy Analyst

*Excellent communication skills are the foundation of a meaningful patient-centered therapeutic relationship. As the role of the pharmacist changes, placing greater emphasis on the pharmacist's cognitive skills, the pharmacist-patient relationship becomes even more central to effective practice.*

The recent acceptance of the College's proposal to regulate pharmacy technicians is a milestone in enhancing opportunities for pharmacists to fully use their cognitive skills and abilities in caring for patients.

The pharmacist is in the unique position of being the most accessible health care provider in the community. A recent review of College initiatives demonstrated that, going beyond its fundamental obligation of sexual abuse prevention, the College's Patient Relations Program (the Program) is geared towards increasing opportunities for members to provide quality healthcare by enhancing the pharmacist-patient relationship. Indeed, OCP's ongoing commitment to strengthening its relationship with members is consistent with the Colleges' new object under the revised *RHPA, 1991*, namely, "to promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public."

As part of its legislated monitoring function, the Patient Relations Committee assessed the Program earlier this year. The findings demonstrate that patient relations activities permeate all areas of the College and successfully target members, the public, and College Council and staff.

## MEMBERS

Focusing on members, the College educates pharmacists on effective communication with patients broadly, and on sexual abuse prevention specifically, at every level of member regulation. At the entry-to-practice level, the College offers Jurisprudence Seminars at least four times per year to undergraduate and International Pharmacy Graduate (IPG) students to review ethics and issues concerning communication and interaction with patients. Improving communication skills is also an important aspect of the Structured Practical Training (SPT) Program, which is designed to help students communicate effectively and develop trusting relationships with patients. One of the goals of the SPT and the International Pharmacy Graduate (IPG) Program is to help students understand the values and norms of Canadian pharmacy practice, including the collaborative model in which the patient is considered a partner in his/her care, as opposed to a passive recipient of services. The College uses these opportunities to educate present and future members on the Sexual Abuse Prevention Plan (SAPP). In this context, members are educated about the College's policy on dating patients, funding for therapy for victims of sexual abuse, and penalties that the legislation imposes on members found guilty of sexual abuse.


In ensuring continuing competency, the Quality Assurance Program uses a peer review process, including Standardized Patient Interviews (SPI), to assess communication skills, requiring candidates who fall below the standard to take suitable remediation courses. In providing guidance on daily pharmacy practice, the College uses guidelines, standards of practice, and an easily accessible practice advisory service to assist pharmacists with issues such as maintaining confidentiality, meeting privacy requirements, involving the patient in the decision making process and recognizing personal, cultural, and educational differences. When remediation becomes necessary, College committees will order courses on interviewing techniques, patient care skills, and implementing effective communication skills. In addition, when appropriate, the committees engage an equity consultant to provide coaching to members about sexual harassment and matters of boundary violation in the pharmacy. The College communicates with its members through its website and by publishing articles concerning patient relations in *Pharmacy Connection*. The Patient Relations Committee has identified the need to maintain awareness of the Program among members as an ongoing goal.

## THE PUBLIC

The College's long-standing commitment to ensuring openness and transparency to the public about its programs is fully aligned with some major changes that have been made to the amended *RHPA, 1991*, which enable patients to have increased access to information and promote greater accountability to the public. The College's website provides information on the role of the College and its processes and on members through the now mandatory on-line Public Register. Patients can also access information on the complaints process and obtain a complaint form on the website as well as through the Complaints Department. Supported by the Communications Department, the College has a dedicated Communications Committee whose focus is on public education and outreach. One of the key projects of the Committee has been overseeing the College's advertising campaign, which promotes the value of the pharmacist-patient relationship using the heart and lung cartoon characters. Together with the Point of Care symbol, the advertisement reinforces to the public the value of communicating with pharmacists and the College's role in promoting the public interest.

## COUNCIL AND STAFF

Recognizing that leadership by example is essential to positive pharmacist-patient relationships, the College communicates the importance of effective and respectful communication to its Council and staff. Some of the ways in which the College ensures information and guidance is easily accessible is by orienting all new employees to the SAPP and the College's policies on harassment and conflict resolution, and by providing cultural sensitivity training to Council and College staff.

The College's patient relations activities demonstrate that the focus of its program is broader than sexual abuse prevention. The Program builds public confidence, maintains and raises awareness around the role of the College to protect the public, and communicates fairness and transparency in College processes. Recognizing that pharmacists provide a critical link between a patient's drug therapy and effective health outcomes, the Program is committed to supporting pharmacists as the practice of pharmacy evolves to increase opportunities for direct patient care and enrichment of the pharmacist-patient relationship. 

## REGISTRATION

# Q&A



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

**Q** I have an internationally educated pharmacist on a work permit working as an intern at one of my pharmacy sites and I would like to move her to another of my sites in different city. Since she has a work permit for my organization, is there any problem with simply transferring her to the new site?


The federal government's Temporary Foreign Worker Program allows eligible foreign workers to work in Canada for an authorized period of time for employers who can demonstrate that they have been unable to find suitable Canadian citizens or permanent residents.

The employer must ensure that an internationally educated pharmacist working in his or her pharmacy has the necessary permit and that the company, location, and time limits stated therein are correct. It would violate your foreign intern's conditions of employment to have her start working at a new site in another city without getting a new permit. New or extended work permits should be requested two months prior to the expiry date.

For more information, visit the Human Resources and Skills Development Canada website: [www.sdc.gc.ca/en/home.shtml](http://www.sdc.gc.ca/en/home.shtml).

**Q** I am a newly licensed pharmacist in Ontario and I'm here on a work permit. I have recently left my employer; can I apply for a new work permit myself?

If you do not have immigration status in Canada, you must have a valid work permit to work as a pharmacist. Under the Immigration and Refugee Protection Act, foreign nationals may work in Canada under certain conditions. Generally, work permits are granted if it can be shown that there is a shortage of skilled personnel for a particular occupation. The work permit is usually valid for a specific job and stated length of time. Before you apply for a work permit, an employer must first offer you a job. Once you have an offer of employment, HRSDC (Human Resources & Skills Development Canada) will provide advice to CIC (Citizenship and Immigration Canada). HRSDC must confirm that allowing a foreign national to fill the position is unlikely to have a negative effect on the Canadian economy and labour force.

Once HRSDC confirms that a foreign worker may fill the job, the information is entered into a common database and you can apply to CIC for a work permit. For more detailed information, you can go to the CIC website: [www.cic.gc.ca](http://www.cic.gc.ca). 

## PHARMACISTS:

### Be a Mentor for an International Pharmacy Graduate Student

- Volunteer to share your experience and expertise with students enrolled in the International Pharmacy Graduate Program
- Pharmacists in the GTA in most demand
- Contact Bill Dingwall, Mentorship Coordinator, at 905-475-1395 or [bdingwall@rogers.com](mailto:bdingwall@rogers.com)
- For more information, visit our website at [www.ipgcanada.ca](http://www.ipgcanada.ca)



# Finding a Preceptor

There is a constant need for preceptors for the Structured Practical Training (SPT) of students and interns. SPT is one of the entry-to-practice requirements for registration as a pharmacist in Ontario. A pharmacist who has been licensed in a Canadian jurisdiction and has been practising direct patient care for at least one year may be eligible to serve as a preceptor. Before training can begin, both the preceptor and the site must meet the SPT criteria and be approved by OCP. Finding a preceptor is the responsibility of students and interns—and it gives them flexibility to choose their preceptors and training sites. Similarly, preceptors may choose someone they believe would be a good fit in their practice site.

The task of finding a preceptor can be challenging. Timing of the search is an important factor to keep in mind. Summer can be particularly challenging as preceptors may be on vacation and Canadian and American graduates are also completing their training requirements.

Students and interns should put as much diligence into finding a preceptor and training site as they would in searching for employment. The following steps will help students/interns in their search for a preceptor.

### 1. BEGIN THE PROCESS EARLY.

Many students and interns need preceptors throughout the year. It may take time to find a preceptor who is available and willing to take on this responsibility and who is a good fit for you.

### 2. REVIEW THE SPT PRECEPTOR AND SITE CRITERIA.

Review these criteria on our website to make sure you

have an understanding of who may act as a preceptor and where you may complete your training. During your search, you should ask questions to ensure that your potential preceptor and the pharmacy meet these criteria.

### 3. PREPARE A RESUME AND COVER LETTER.

Have a well-written cover letter that indicates the length of training that you must complete, your goals and objectives for training, and areas of interest in pharmacy practice. Ensure your resume is up to date and clearly outlines your work or volunteer experience. Send your resume with a cover letter to the attention of the contact person responsible for hiring, or drop it off in person and follow up with that individual in a few weeks.

### 4. GO IN PERSON.

Visit various pharmacy practice sites to see if you would be interested in training there. Keep in mind that a pharmacy may be busier at certain times of the day and week. If you wish to speak with a pharmacist, call ahead and arrange for a mutually convenient time. This gives you an opportunity to introduce yourself and discuss your training requirements and interests. It is easier to make an impact in person than it is on paper.

### 5. USE THE PRECEPTOR LIST OR REFER A POTENTIAL PRECEPTOR TO OCP.

You may request a list of preceptors by e-mail (vgardner@ocpinfo.com). This list of pharmacists who are trained and currently eligible to serve as preceptors provides you with the starting point of preceptors' contact information. It is not a guarantee of their availability. You will need to contact them and apply for training much as

# Structured Practical Training

you would for another job or position. You may also refer a pharmacist to OCP for preceptor training if he/she meets the SPT Preceptor Criteria. If you find a pharmacist who is willing to be your preceptor, refer this person to our website for a list of workshop dates and ask them to contact SPT staff to register for a workshop.

## 6. CONSIDER RELOCATING OR COMMUTING

Finding a preceptor in the larger cities, such as the Greater Toronto Area, is more difficult since many students/interns choose these areas to complete their training. You will be competing with many more individuals for a preceptor in the GTA than in some of the smaller cities or towns throughout the province. There are wonderful training opportunities in Ontario that you may wish to consider; this may require increased travelling time or a temporary move, but the learning experience will be worthwhile.

## 7. REFER TO WEBSITES FOR JOB POSTINGS.


Some pharmacy organizations have a career section on their websites that advertise student and intern positions. For example, the International Pharmacy Graduate Program has postings for its students that are updated on a regular basis. Other chains and pharmacy associations may have similar services.

## 8. WORK AS A PHARMACY ASSISTANT.

Experience as a pharmacy assistant will provide you with an understanding of Canadian pharmacy practice that may be useful in preparing you for training. It increases your chances of a training position, since you will have developed a work relationship with a pharmacist who eventually could serve as your preceptor. Aside from that, he or she has excellent potential to be an employment reference.

## 9. BE PERSISTENT.

Be aware that it may take time to find a preceptor and a position that are suitable for you. This past spring, some students and interns were initially discouraged by their lengthy search for a preceptor. However, by following the above steps with perseverance and by networking with their colleagues, all of them secured a training position on their own.

If students/interns have exhausted all of the above steps and made every effort to find a preceptor but have not found one, they may contact OCP staff in the Registration Program for assistance at (416) 962-4861, extension 297, or by e-mail at (vgardner@ocpinfo.com). 

## Volunteers needed for LHIN's Advisory Committee

The Local Health Integration Networks are a fundamental component of the government's plan to build a stronger health care system in Ontario. Each LHIN will establish its own Health Professionals Advisory Committee, comprised of volunteer members from a variety of health services professions. This multi-disciplinary committee will have the important responsibility of providing advice to the network on how to achieve patient-centred health care and further develop the leadership role of health professionals in promoting integrated health care delivery.

**If you are interested in this exciting volunteer opportunity, visit [www.lhins.on.ca](http://www.lhins.on.ca).**

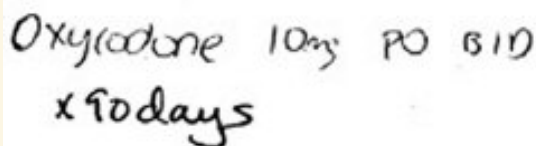
# Error Prevention

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

## UNCLEAR MEANING OF A PRESCRIPTION

Pharmacists often encounter physician handwriting that is difficult to decipher. Misinterpretation of the poor handwriting is a common cause of medication error. In some cases, the prescriber's handwriting is clear. However, the intended meaning can be ambiguous or unclear. The following case highlights this issue.

### CASE



Oxycodone 10mg PO BID  
x 90 days

The daughter of an eighty year old patient took the above prescription to her regular pharmacy for processing. The pharmacy technician entered the prescription into the computer as 180 Oxy-IR® 10 mg (oxycodone HCl immediate release) tablets to be taken twice daily. The technician then prepared and labelled the tablets for checking by the pharmacist. The pharmacist checked the prescription, contents of the vial, and after signing the prescription, placed the medication in the drawer for pick up.


The following day, the patient's daughter returned to the pharmacy to pick up the medication. On this occasion a second pharmacist retrieved the medication to counsel the daughter on how the tablets should be taken. Upon reading the labelled instructions for use as twice daily for the immediate release tablets, the pharmacist decided to check the original prescription to confirm that

the information had been entered into the computer correctly. On checking the directions for the prescription prior to counselling the daughter, the second pharmacist was uncomfortable with the twice daily instructions used with an immediate release tablet. He then explained to the patient's daughter that he will need to contact the prescriber to confirm his intention. Upon contacting the prescriber, he confirmed that he had intended to prescribe oxycodone controlled release tablets (OxyContin® 10 mg) to be taken every twelve hours.

## POSSIBLE CONTRIBUTING FACTORS

1. The prescriber did not specify the formulation to be dispensed.
2. Most of the prescription was written by a support staff at the doctor's office. The prescriber added the days supply to be dispensed and signed the prescription.
3. Initially, the dispensing pharmacist did not contact the prescriber to clarify the ambiguous prescription.
4. The dispensing pharmacist did not identify the twice daily dosing as inappropriate for the immediate release tablets.
5. The dispensing pharmacist did not check the patient's medication history to notice that the patient was currently taking Oxycocet® every four hours when necessary.
6. Both Oxy-IR® and OxyContin® are available in a 10 mg strength tablet.

## RECOMMENDATIONS

- Check the instructions for use for appropriateness.
- Use the patient's medication history to assist in confirming the appropriateness of the drug prescribed.
- Always contact the prescriber to clarify prescriptions that are ambiguous.
- Use the opportunity to counsel as the final check on the appropriateness of the medication 

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

# HEALTH CANADA

## Advisories & Notices

DATE	TYPE
27 July 2007	The Government of Canada is reminding consumers about certain chili products recalled from Wal-Mart stores on July 22, 2007 due to potential serious health risks.
27 July 2007	Health Canada is advising Canadians not to use the unauthorized smoking cessation product Resolve, because of the potential health risk to consumers.
26 July 2007	Health Canada is warning Canadians not to use Neem Active Toothpaste with Calcium, manufactured by Calcutta Chemical Co. Ltd. in India and found on the Canadian market, because it has been found to contain unacceptable levels of diethylene glycol (DEG).
25 July 2007	<p>CADD® Medication Cassette Reservoirs</p> <ul style="list-style-type: none"> <li>• 100-ml Medication Cassette Reservoir, Reorder No. 21-7002-24, - Lot Nos. 081X16 through 229X16</li> <li>• 50-ml Medication Cassette Reservoir, Reorder No. 21-7001-24, - Lot Nos. 102X16 through 226X16</li> <li>• 100-ml Medication Cassette Reservoir, Yellow, - Reorder No. 21-7100-24, Lot Nos. 083X16 through 225X16</li> </ul> <p>Smiths Medical is voluntarily issuing this product recall notification for the above listed CADD® Medication Cassette Reservoirs ("Affected Cassettes"). Smiths Medical has become aware that an increase in pH may occur with some medications when instilled in the Affected Cassettes. Also, a small number of catheter occlusions have been reported from one customer in the United States when these Affected Cassettes have been used for delivering Flolan®. An increase in pH of an instilled drug product may lead to degradation of the drug which could result in diminished drug efficacy.</p>
23 July 2007	Health Canada is advising consumers not to use Liviro3, a natural health product marketed for sexual enhancement, due to concerns about possible side-effects. The product is not authorized for sale in Canada and has not been found in the Canadian marketplace, but is for sale on the Internet, and may have been brought into the country by travellers.
20 July 2007	Health Canada is warning consumers not to use Zencore Tabs, a product advertised as a dietary supplement for sexual enhancement, because it contains an undeclared pharmaceutical ingredient similar to the approved drug tadalafil. Tadalafil is a prescription medication indicated for the treatment of erectile dysfunction and should only be used under the supervision of a health professional. The use of Zencore Tabs could pose serious health risks, especially for patients with existing medical conditions such as heart problems, those taking heart medication, or those at risk of stroke.
18 July 2007	Health Canada is advising consumers not to use the sleep supplement product Optimum Health Care Sleep Easy, because it contains the undeclared drug clonazepam, which can be habit forming when used for as little as a few months. Consumers who may still have this product in their homes are advised to consult with a health care professional before they stop taking the pills, because of the risk of serious withdrawal symptoms.
9 July 2007	Health Canada is warning Canadians not to use the dietary supplement MdMt, or any other supplements containing the synthetic steroids methyl-1-testosterone or methyldienolone that are obtained without a prescription, due to potentially serious health risks including reduced fertility and liver disorders.
6 July 2007	Further to the Health Canada warning issued earlier today, ongoing testing on a counterfeit product falsely labelled as Colgate Fluoride Toothpaste Maximum Cavity Protection has identified a third bacterium of concern, which is a common environmental micro-organism. Health Canada continues to advise Canadians to discontinue use of this product because of the presence of bacteria that pose significant health risks, especially to children and individuals with compromised immune systems.
6 July 2007	Further to a warning issued on June 29, Health Canada is warning Canadians not to use a counterfeit product falsely labelled as Colgate Fluoride Toothpaste Maximum Cavity Protection. Ongoing testing has resulted in preliminary evidence of a further, potentially harmful bacterial contamination. If confirmed, the presence of this bacterium could pose a serious health risk.
5 July 2007	Further to its Warning on June 29, 2007, regarding diethylene glycol (DEG) in toothpaste from China, Health Canada testing has confirmed the presence of DEG in three additional unapproved Chinese toothpaste products being sold on the Canadian market. This brings to 24 the number of DEG-containing toothpastes from China found in Canada. None of these products are approved for sale by Health Canada. Fluoride-containing toothpastes that have been approved for sale in Canada will contain either an eight-digit Drug Identification Number (DIN) or a Natural Product Number (NPN).

DATE	TYPE
29 June 2007	Health Canada is warning Canadians not to use Chinese toothpaste found on the Canadian market because 21 products to date have been found to contain unacceptable levels of diethylene glycol (DEG). DEG is a poisonous chemical used in antifreeze and as a solvent that may cause nausea, abdominal pain, dizziness, urinary problems, kidney failure, breathing problems, lethargy, convulsions, coma and even death when ingested. While toothpaste is not meant to be swallowed, it is often swallowed by young children. The potential health risks from chronic exposure to DEG are a particular concern in specific vulnerable populations such as children and consumers with kidney or liver disease.
29 June 2007	Health Canada is warning Canadians that counterfeit toothpaste products, falsely labelled as Colgate Fluoride Toothpaste Herbal and Colgate Fluoride Toothpaste Maximum Cavity Protection, have been found to contain high levels of harmful bacteria. These products have been found on the Canadian market and pose a significant risk to health, especially to children and individuals with compromised immune systems. Health Canada is assisting in the criminal investigation that is being conducted by the Royal Canadian Mounted Police.
25 June 2007	Health Canada is warning consumers not to use the product Encore Tabs for Men, because it contains an undeclared pharmaceutical ingredient similar to the approved drug tadalafil. Tadalafil is a prescription medication indicated for the treatment of erectile dysfunction and should only be used under the supervision of a health professional. The use of Encore Tabs for Men could pose serious health risks, especially for patients with existing medical conditions such as heart problems, those taking heart medication, or those at risk of stroke.
21 June 2007	There have been a number of international warnings and product recalls involving toothpaste manufactured in China and elsewhere that may contain diethylene glycol (DEG), an ingredient used in antifreeze and as a solvent. Health Canada is monitoring these recall notices and the actions of other regulators, and is taking steps to ascertain whether any of the products found or suspected to contain DEG elsewhere are present on the Canadian market.
15 June 2007	Health Canada is aware of the growing body of evidence on the role of vitamin D in relation to health. Before Health Canada can issue a revised recommendation concerning vitamin D, a comprehensive review that looks at both benefits and safety needs to be undertaken.
14 June 2007	Health Canada is advising consumers not to use Optimum Health Care SleePlus TCM or BYL SleePlus, because the products contain the undeclared drug clonazepam, which can be habit-forming when used for as little as a few months. Consumers who may still have one of these products in their homes are advised to consult with a health care professional before they stop taking the pills, because of the risk of withdrawal symptoms.
13 June 2007	Health Canada is advising consumers using certain lots of Fraxiparine (0.6 ml) and Fraxiparine Forte (0.8 ml) pre-filled glass syringes of a recall of the products because the syringes may crack or break which could lead to health risks for patients. Patients are advised to contact their physician to obtain another suitable product but should not discontinue their medication before consulting their health care provider.
12 June 2007	Health Canada endorsed important safety information on the association of AVASTIN (bevacizumab) with tracheo-esophageal fistula. Tracheo-esophageal fistula has been reported in association with the use of Avastin, chemotherapy and radiation for treatment of small cell lung cancer.
08 June 2007	Health Canada endorsed important safety information on the voluntary recall of FRAXIPARINE graduated syringes, 0.6 mL and FRAXIPARINE FORTE graduated syringes, 0.8 mL. Breakage of the syringe prior to or during injection could occur, which may cause injury during administration. In addition, there is a potential, but small, risk to sterility should the crack propagate over the shelf life of the product.

**For complete information & electronic mailing of the Health Canada Advisories/Warnings/Notices subscribe online at: [http://www.hc-sc.gc.ca/dhp-mps/medeff/index\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html)**

**MedEffect e-Notice is the new name which replaces Health Canada's Health\_Prod\_Info mailing list. The content of the e-notices you receive will remain the same and are now part of MedEffect, a new Health Canada Web site dedicated to adverse reaction information. MedEffect can be visited at [www.hc-sc.gc.ca/dhp-mps/medeff/index\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html)**

**Health Canada Notices are also linked under "Notices" on the OCP website: [www.ocpinfo.com](http://www.ocpinfo.com)**

# Guidelines & CE Lessons

By Certina Ho, R.Ph., B.Sc.Pharm., M.I.St., M.Ed.,  
Professional Development Advisor, Continuing Competency Programs

## ONLINE GUIDELINES

Being a part of front-line health care providers, pharmacists are expected to be aware of up-to-date evidence-based clinical practice guidelines. The following websites will become handy when searching for the latest recommended management of different therapeutic conditions.



### **Canadian Medical Association (CMA) Infobase Clinical Practice Guidelines**

<http://mdm.ca/cpgsnew/cpgs/index.asp>

Pharmacists can look for guidelines by simply entering the therapeutic area of interest into the Keyword Search box on this website.



### **Guidelines Advisory Committee (GAC)**

<http://gacguidelines.ca/>

Pharmacists can easily retrieve clinical practice guidelines by scrolling through the alphabetical index of therapeutic areas or by performing a Topic Search in the search field provided.



### **Medication Use Management Services (MUMS)**

<http://www.mumshealth.com/>

This is a place where pharmacists can order or pre-order the following guidelines:

- Respiratory (Asthma/COPD) Guidelines for Family Practice – 2007 edition
- Anti-infective Guidelines for Community-Acquired Infections – 2008 edition
- Guidelines for the Management of Anemia – 2007/2008 edition
- Hypertension Guidelines for Family Practice – 2007/2008 edition

# ONLINE CE LESSONS

Increasing ease of access to the Internet has brought pharmacists to the world of online learning. Pharmacists can access home study continuing education (CE) lessons from various websites. Some examples are as follows.



## **rxPassport**

<http://www.rxpathport.ca/>

rxPassport is a one-stop access to Pharmacy Gateway

<http://www.pharmacygateway.ca> and rxBriefCase <http://www.rxbriefcase.com> websites, where pharmacists can participate in Canadian Council on Continuing Education in Pharmacy (CCCEP) approved CE lessons and keep abreast of health-related news and practice issues.



## **Canadian Pharmacists Association (CPhA) Home Study Online Learning Centre**

[http://cpha.learning.mediresource.com/select\\_catalog.asp](http://cpha.learning.mediresource.com/select_catalog.asp)

Similarly, CCCEP-accredited CE programs are available from the CPhA Home Study Online Learning Centre. Pharmacists can preview or print the CE lesson before purchasing the corresponding post test.



## **PHARMALearn**

<http://www.pharmalearn.ualberta.ca/home.cfm>

Three Internet-based CCCEP-accredited courses are offered by the PHARMALearn website:

- Anticoagulation
- Diabetes
- Hypertension



## **University of British Columbia (UBC) Continuing Pharmacy Professional Development (CPPD) Virtual Learning Centre**

<http://pharmacy.ubc.ca/cppd/index.html>

The UBC CPPD Virtual Learning Centre is another place where some CCCEP-accredited distance education online programs can be found.

## **Additional Online CE for Pharmacists**

Visit our website (<http://www.ocpinfo.com>) for additional online CE programs for pharmacists.

## AN IMPORTANT PRINCIPLE FOR PHARMACEUTICAL CARE:

# Collaboration Amongst Healthcare Professionals

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

A multidisciplinary healthcare team consists of health professionals who are experts in various aspects of patient care. A pharmacist, with expertise in drug therapy, is an important member of this team. In order to ensure safe medication practices and optimal patient outcomes, pharmacists are expected to collaborate with other professionals within the healthcare team. Collaboration allows pharmacists to obtain important information; having done so, they use their professional judgement in making decisions that will be in the best interest of the patient. It also provides pharmacists with the opportunity to suggest therapeutic interventions that will ensure optimal patient outcomes. Although collaboration happens more naturally in a hospital setting, and community pharmacists may find it more challenging to establish than their hospital counterparts, it is critical.

## COMPLAINT

The Complainant's son ("the Patient") had been diagnosed with recurring kidney stones and his physician continually prescribed Percocet®, resulting in the Patient's reliance on this medication. Over a period of 14 months, the Patient was prescribed both opioids and benzodi-

azepines by the same physician, and the multiple prescriptions were dispensed by three different pharmacies. The Patient passed away as a result of hydromorphone intoxication the day after 150 tablets of Dilaudid® were prescribed and dispensed.

Initially, the Complainant contacted the College with concerns about the dangers associated with the dispensing of narcotics in community pharmacies. She later filed a formal complaint about the pharmacist who dispensed 150 tablets of Dilaudid®, 275 tablets of Percocet® and 175 tablets of Diazepam® to her son the day before he passed away. The Complainant explained that the physician who prescribed these had prescribed additional Dilaudid® and Percocet® for her son to obtain 10 days later. This, according to the Complainant, would have suggested to the Patient that he was to consume the initial 150 tablets of Dilaudid® within 10 days.

The Complainant believed that the Member failed to uphold professional standards of practice when he:

- did not question the physician about the Dilaudid® dosage.
- dispensed the prescription despite having concerns about the dosage.

## MEMBER'S RESPONSE

The Member stated that the Patient had been regularly purchasing medications, including pain management medication, from the pharmacy over a period of 18 months. The Member had never questioned the Patient regarding his need for these medications. When the Patient came in with a new prescription for Dilaudid® prescription, the Member assumed that the current pain medication was no longer effective and the physician had determined a need to prescribe a stronger drug. The Member felt that the prescribed dosage of one or two 8mg tablets, to be taken three to four times a day, might be excessive, and counselled the Patient that a better approach would be to begin with 4mg of Dilaudid®, to be taken for breakthrough pain. While the Member advised the Patient that this was a strong and potentially dangerous drug, he did not feel it necessary to contact the prescriber to formally change the prescribed dose.

The Member was not aware that the Patient was having prescriptions dispensed at other pharmacies. The Member also believed that the physician was appropriately monitoring the Patient. Given these circumstances, the Member did not call the physician and believed that his recommendations to the Patient provided a balanced approach that addressed the needs of the Patient while maintaining the sanctity of the patient-prescriber relationship. The Member assumed that the Patient did not comply with his professional recommendation, which resulted in the overdose.

## DECISION AND REASONS

The Complaints Committee acknowledged that the Dilaudid® prescription was a valid one and that, while the dose

was unusual, it was not inconsistent with what might be prescribed to a patient with a history of narcotic use for pain management. The Committee questioned whether the Member fell below the standards of practice when he failed to contact the prescriber.

In the Committee's view, the following questions are to be considered when determining whether a pharmacist has appropriately exercised professional judgement:

1. Did the pharmacist act in the best interest of the patient?
2. Did the pharmacist use professional knowledge and expertise?
3. Did the pharmacist's decision prove to be one that peers would consider reasonable?
4. Did the pharmacist document his or her concern and advice given?

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*In order to ensure safe medication practices and optimal patient outcomes, pharmacists are expected to collaborate with other professionals within the healthcare team.*

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The pharmacist members of the Committee acknowledged that, based on the Patient's history at the pharmacy, a pharmacist would likely conclude that the Patient had a high tolerance to narcotics and that, in these circumstances, the Dilaudid® dosage prescribed was appropriate. The pharmacist members also acknowledged that, in similar circumstances, they too would likely have dispensed the prescription as written. The Committee concluded that since the Member was not aware that the Patient had additional prescriptions and was getting them filled at other pharmacies, the Member did exercise his professional judgement to appropriately dispense the prescription. Further, the College of Physicians and Surgeons, had found that the prescriber had committed an act of professional misconduct.

In consideration of the above facts, the Committee proceeded to remind the Member that when a patient presents with a prescription that causes him to counsel the patient contrary to the prescriber's instructions, he is

advised to intervene by contacting the prescriber and voicing his professional concerns. The Committee further reminded the Member of the importance of engaging in collaborative practice with other members of the patient's healthcare team.

### CONCLUSION

Pharmacists often use professional judgement to make decisions that will improve a patient's quality of life. In order to do this, it is necessary for them to have a complete medical history of the patient. When pharmacists

are unable to obtain this directly from the patient, they should endeavour to do so by collaborating with the patient's multidisciplinary healthcare team, when deemed necessary in the best interest of the patient. If a pharmacist, upon review of the patient's complete medical history, determines that the medication prescribed should not be dispensed as written, it is essential that the pharmacist collaborate with members of the multidisciplinary team in order to suggest therapeutic alternatives to achieve the intended outcomes. In fact, collaboration can mean the difference between life and death. 


## Collaborative Initiatives to Enhance Patient Medication Safety

The above case is an excellent illustration of various systemic contributors that impact pharmacy practice and patient medication safety. These include:

- The inability of pharmacists to access patient profiles from other pharmacies.
- The need for pharmacists to be able to trust and rely on the narcotic prescribing practices of other healthcare professionals.

The College is playing an important collaborative role with other healthcare regulators and institutions in pursuit of its strategic direction to enhance the safety of patient medication systems. Leading by example, the College hopes to instil in pharmacists the value of multidisciplinary collaboration. The following are some of the College's activities in this regard:

1. The College is collaborating with the College of Physicians and Surgeons of Ontario, the College of Nurses, and the Centre for Addiction and Mental Health on a project sponsored by the Canadian Patient Safety Institute. The purpose of this project, to promote safe prescribing and dispensing of opioids, will be achieved

- through a series of workshops and educational and office materials for physicians, pharmacists, and nurses. This collaboration will also serve to strengthen communication among these health care professionals.
2. The College is working with other regulatory bodies and the government to promote methods by which health professionals can easily share information while still ensuring that individuals retain their right to privacy.
  3. The College and the Institute for Safe Medication Practices (ISMP) are working together to find ways to improve the medication use system in Ontario pharmacies, particularly as it relates to narcotics. The College is taking the following initiatives in this regard:
    - Educating members about the principles of safe medication practices and reporting of incidents.
    - Informing members of the existence of, and services offered by, ISMP Canada.
    - Encouraging pharmacists to report incidents and near-misses to the prescriber, the designated manager, the ISMP and other bodies in order to promote learning and change, and to prevent similar occurrences. 

**CASE 1****Remote Dispensing of Methadone; Failure to Comply with College Policies; Directorship Accountability**

**Member:** Susan Wong, Pharmacy on King, Kitchener

**Date:** April 25, 2007

This case involves the conduct of a pharmacist associated with the practice of dispensing methadone to patients at methadone clinics in remote locations, and the related implications of federal and provincial legislation, professional standards of practice, and College policies and guidelines.

**METHADONE DISPENSING PRACTICES AT THE PHARMACY**

The member was a director and dispensing pharmacist at Pharmacy on King (the "Pharmacy"). From 2003 to February 2006, the Pharmacy provided individual patient daily doses of methadone to Ontario Addiction Treatment Centre (OATC) clinics. The Pharmacy and the clinics subscribed to Toxpro software, which facilitated the online transmission of prescriptions to the Pharmacy from the OATC, and the Pharmacy's online access to prescription information before an actual signed prescription was received at the Pharmacy.

Accordingly, a week's worth of individual patient daily doses (undiluted) was prepared at the Pharmacy. The doses were labelled as "diluted in orange vroom" (an orange drink), but they were not in

fact yet diluted in 100ml of orange drink. These daily doses were not administered to the patients at the Pharmacy, but were shipped to the OATC clinic by courier. The OATC prescriber had directed that the doses not be diluted in orange drink prior to their delivery. At the OATC clinics, nurses rather than pharmacists or physicians, diluted the patient doses with orange juice and administered the doses to the patients.

Sometimes a patient's dose was changed mid-week by the treating physician, so that the amount of methadone contained in the daily doses already dispensed was different from the (newly) prescribed amount. To adjust these doses, OATC staff used stock methadone solution maintained at the clinic to augment the amount of methadone in the daily dose bottles already dispensed by the Pharmacy. In these cases, the OATC staff manually adjusted the doses on the label; the Pharmacy's records, however, reflected the doses shipped out, not the doses actually administered to the patients.

**COLLEGE POLICIES**

In December 2002 the College had approved its current policies for pharmacists and pharmacies dispensing methadone. In the March/April 2003 *Pharmacy Connection*, the College advised its members of these policies. The College's policies require pharmacists to comply with methadone dispensing guidelines developed by CAMH. The CAMH guidelines contemplate

a pharmacist-patient relationship, where the pharmacist provides information and counselling to the patient, gathers information about the patient's allergies and drug use history, and generally engages in ongoing dialogue, assessment of the patient, and documents such dialogue as per professional practice requirements.

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

The College issued a further notice in November 2004, reiterating the earlier "cease and desist" notice, but extending the "deadline" for compliance to January 31, 2005.

In accordance with the September 2004 notice, the member personally ceased to dispense methadone to OATC clinic patients after January 31, 2005. The Pharmacy, however, continued to do so. Records later obtained from the Ontario Drug Benefit program indicate that the number of methadone claims submitted by the Pharmacy expanded from February 2005 to December 2005.

The College issued a notice in November 2005 regarding joint initiatives being taken by the three regulators of the methadone program – the College, the College of Physicians and Surgeons of Ontario (CPSO), and the Office of Controlled Substances, Health Canada.

This notice reiterated the "cease and desist" notice of September 2004. The member and the Pharmacy were referred to the Discipline Committee in connection with their continued method of dispensing methadone contrary to the College's directive.

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

### **ACKNOWLEDGEMENT OF PROFESSIONAL MISCONDUCT AND PHARMACY MISCONDUCT**

The member acknowledges that as a director and owner of the Pharmacy, she was required to ensure that its operations were conducted in accordance with the standards of practice of pharmacy, College policies and guidelines, and federal and provincial requirements. The member acknowledges that she failed to

so ensure, and that prior to the interim policy of March 2006, the Pharmacy:

- failed to comply with the September 2004 and November 2005 notices from the College;
- dispensed daily methadone doses incorrectly labelled as already diluted in 100ml of orange drink;
- dispensed doses of undiluted methadone solution knowing that these doses might be altered prior to administration at OATC clinics;
- failed to ensure that its records were accurate, in that those records:
  - o incorrectly reflected:
    - methadone being dispensed before it was prescribed and authorized,
    - methadone being dispensed before it was ingested,
  - o did not reflect adjustments in authorized quantities of methadone and start dates of ingestion,
  - o did not document discussions with prescribers concerning the need for daily dispensing of non-methadone drugs
  - o did not accurately record prescriber information.

The member therefore acknowledges that she:

- Failed to maintain a standard of practice of the profession,
- Failed to keep records as required, and
- Engaged in conduct, relevant to the practice of pharmacy, that having regard for all the circumstances, would reasonably be regarded by members of the profession as unprofessional,

and that the Pharmacy:

- contravened the documentation requirements of the DPRA.

### **FINDING OF PROFESSIONAL MISCONDUCT**

Following the member's plea, the Panel made a finding of professional misconduct, considering the following undisputed facts:

- The Pharmacy had continued to dispense methadone to OATC clinics after the September 2004 and November 2005 notices from the College, even though the member did not personally dispense methadone after the January 31, 2005, deadline imposed by the College.
- The Pharmacy had dispensed undiluted methadone pursuant to the direction of the Medical Director of the OATC, indicating that the doses would be diluted for the patient at the clinic.
- The Pharmacy shipped methadone to persons not authorized to receive/possess methadone, namely at the clinics. Those shipments were made by the same courier service which was used by licensed dealers to ship the methadone to the Pharmacy. That courier service guaranteed a chain of possession, and signatures were required upon receipt by OATC clinic nurses. Methadone had never been diverted during these shipments.
- The ingestion of methadone dispensed by the Pharmacy was witnessed by OATC nurses, not by pharmacists. Although pharmacist observation was specifically directed on the OATC clinic pre-

scriptions, it was submitted that this instruction referred only to pharmacies that were not delivering doses to the OATC clinic itself.

- The Pharmacy dispensed methadone doses, knowing that they might later be altered by OATC clinic nurses, thus making the Pharmacy's records incorrect. The Pharmacy did, however, have access to the correct information via the Toxpro software system.
- The Pharmacy made adjustments to authorized methadone amounts and start dates (as required by the Toxpro software system), without replacement prescriptions being obtained from the prescriber. As a result, dispense dates sometimes preceded prescription dates. Some of these errors were the result of "defaults" on the Toxpro system.
- Some non-methadone drugs were dispensed daily by the Pharmacy, where the nature of the medication did not require this. However, this daily dispensing was further to the prescriber's orders.
- Pharmacy records did not reflect the correct address of some prescribers, merely the address of the OATC head office. This had been corrected by the Pharmacy when it was pointed out during the course of the investigation.

The member would point out that many of these breaches flowed inevitably from the participation of the Pharmacy in the overall OATC system of methadone provision. It was submitted that many patients preferred to receive their methadone doses outside of a pharmacy.

## REASONS FOR DECISION

The Panel firmly believed that the member's breach of College directives and guidelines demonstrated a complete disregard for the College's authority to self-regulate its members and its legislative mandate to protect the public. Although she stopped personally dispensing methadone further to the College's September 2004 notice, the member failed in her role as a director to prevent the Pharmacy from continuing its non-compliant practices.

The College and the member agreed that the CAMH guidelines were recognized as good practice in dealing with methadone, and are an integral part of the College directives regarding methadone dispensing. The member had conceded that her pharmacy's failure to follow those guidelines was a breach of standard pharmacy practice. The Panel noted that as employees take their direction and guidance from a director, the director of a pharmacy is ultimately responsible for the actions and omissions of the pharmacy's employees.

The Panel noted the argument that College directives, guidelines and policies do not have the force of law, but are only frameworks that a panel may consider in deciding whether there was misconduct in a particular case. The Panel pointed out, however, that the federal regime that governs methadone dispensing is overseen by only a few officers across Canada. Administrative necessity weighs heavily in favour of transferring enforcement and accountability for methadone practices to self-regulated profes-

sions and their regulators, such as the College and the College of Physicians and Surgeons of Ontario (the "CPSO").

Entrusted by the provincial and the federal governments to protect the public interest, the College implemented policies and guidelines respecting the dispensing of methadone to ensure public safety. Any policy drafted by the College is developed in consultation with respected and authoritative stakeholders who have particular expertise in methadone dispensing, such as the Centre for Addiction and Mental Health. Thus, the College is in effect delegated by Health Canada to oversee the regulation of methadone dispensing, and by the province to regulate pharmacists. Therefore, in this area of overlapping federal and provincial jurisdiction, the College's policies should be considered as highly persuasive and enforced as law. In any event, absent compelling or exceptional reasons to do so, the member had no authority to establish her own process and disregard College procedures. A prudent pharmacist who disagreed with a College policy would contact the College for assistance and discussion, rather than demonstrating flagrant disregard for the College's directives and authority. The Panel therefore views the member's wilful disregard of College instructions to have constituted a failure to maintain the standards of practice, placing the public at risk of harm.

The member suggested that the current interim policy loosely mirrored the member's conduct in this

case, and is therefore the new standard of practice, and that this somehow validates the member's prior conduct. The Panel disagreed. The current interim policy was not in force at the time of the member's misconduct. It had since been adopted temporarily due to the complex nature of methadone dispensing, and the need for continued therapy in the interest of public safety. The current interim policy only provides alternatives if College and CPSO guidelines cannot be followed due to geographical issues. It may change again once there is agreement from all parties involved, and it does not at all "grandfather" previous misconduct such as the member's, or render it less serious.

## REASONS FOR PENALTY ORDER

The Panel agreed that a suspension and remediation was well warranted and would assist the member in practising properly in the future. The awarding of costs was also completely justified in the circumstances, since the College's lengthy and costly investigation had been caused not by the member's inadvertence, but by the member's wilful and complete disregard of the College's directives and guidelines. The hearing of this matter was ultimately uncontested between the parties, and that had saved further time and expense. However, in the Panel's view it was appropriate that the member should pay some of the expenses caused by the course of conduct she had undertaken.

## ORDER

A reprimand.

Terms, conditions or limitations on the member's certificate of registration requiring her to complete successfully, at her own expense and within twelve months of the date of the order:

- The Basic Professional Practice Laboratories, including evaluations, in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
- The Advanced Professional Practice Laboratories, including evaluations, in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
- The Methadone Maintenance Treatment Course offered by the Centre for Addiction and Mental Health.

Three months suspension of the member's certificate of registration, with one month of that suspension to be remitted on condition that the member complete the above-mentioned remediation.

The member pay costs to the College in the amount of \$10,000.

The Pharmacy on King pay costs to the College in the amount of \$25,000.

## REPRIMAND

The Panel had adjourned following the hearing to write its decision. Therefore, it will schedule a future date to convene again to administer the reprimand to the member.

## COMMENTS:

The recent decision of the College's Discipline Committee in the case of Susan Wong highlights the accountability of directors for the operation of a pharmacy. The subject of directorship accountability has received a great deal of media attention over the past few years, shaping the way in which corporations are managed, and setting the standards for directors' conduct.

Between 2000 and 2001, amidst revelations of insider trading, misleading accounting practices, and overstated assets, shares in Enron Corporation of America dropped from \$90 each to 30¢ each. The company that had claimed to be worth \$50 billion declared bankruptcy in the biggest corporate scandal in living memory. As a result, there was a renewed focus worldwide on the responsibilities of corporations, and of corporate directors and executives.

The Enron scandal in the United States made it clear to all that while directors owe a duty of loyalty to the corporation and to maximizing profits for the corporation, society will enact various pieces of legislation to protect itself from, and place limits on, the corporation's pursuit of profit.

Corporations are obliged to scrupulously abide by such legislation. Therefore, the directors of the corporation also owe (to society as well as to the corporation) a duty of care. This duty of care requires that directors make all best efforts to ensure that the corporation does not undertake any illegal or improper action.

These concepts and expectations for directorship accountability apply

equally within the pharmacy context. For a corporation operating a pharmacy in Ontario, it is clear that the directors have important responsibilities – because those directors must, in effect, be experts on the business and practice of the pharmacy. The directors are responsible for designating the pharmacy’s narcotic signers, and are accountable for ensuring that a pharmacy’s operation is compliant with all legislation and College policy and standards of practice. Indeed, directors are liable for every offence against the Drug and Pharmacies Regulation Act (DPRA) by any person employed or supervised by the corporation, if the offence is committed with the director’s permission, consent or approval, express or implied (s.166). Moreover, amendments to the DPRA implemented by the Health Systems Improvement Act indicate that directors can be subject to personal disciplinary consequences stemming from the pharmacy’s breaches of legislation and policy.

While the directors do not personally oversee the day-to-day operation of the pharmacy, they are expected to have oversight responsibility for the corporate practices of the operation. Every corporation has its particular culture and the beliefs and views of the leadership tend to be reflected in those of the employees and staff of the corporation. Pharmacies are no different, which is why pharmacist directors set the tone for how the pharmacy is operated, and are required to give priority to sound and ethical pharmacy practice.

Under the DPRA, the majority of directors of a corporation that owns and operates a pharmacy must themselves

be pharmacists (s.142). As an integral part of the pharmacy accreditation process, directors and their professional histories are carefully considered prior to the issuance of a certificate of accreditation. This means that the accountability of a pharmacist director for the operation of the pharmacy is further compounded, over and above that of the non-pharmacist director. That is, as a member of the College, the pharmacist director is also accountable to the College in a personal professional capacity for the corporation’s compliance and enforcement of standards of practice.

#### **Relevant Discipline Case Decisions**

In the Wong case, the Discipline Committee recognizes the leadership role expected of pharmacist directors. It states that “A director/owner is ultimately responsible for the actions or omissions of its member employees who will naturally take their direction and guidance from an employer.”

The Wong case is not the first in which the Discipline Committee at this College has reaffirmed the accountability of pharmacist corporate directors for a pharmacy’s failure to comply with legislation. In 2002, the Discipline Committee held a pharmacist director accountable for a pharmacy’s deficient “lock and leave” arrangement, which had failed to prevent the purchase of a scheduled drug without pharmacist intervention.

In 2004, the Discipline Committee found two pharmacist directors liable because in their corporate capacity they had directed pharmacists in pharmacies operated by the corporation to offer a bonus or inducement to pa-

tients, contrary to a policy adopted by the Council of the College.

The role and accountability of pharmacist directors was well captured by the pharmacists’ acknowledgement:

“as directors of...a corporation that owns and operates pharmacies and that impacts upon the manner in which other pharmacists practice...they are accountable, as directors, for their conduct in relation to all policies and practices relating to pharmacy practice. As directors, it is their individual responsibility to advocate and to make best efforts to ensure that all applicable laws and regulations take precedence over any competing proposed corporate decision that may impact upon the operation of pharmacies and the standard of practice for pharmacists working in any of the pharmacies... As directors of a corporation that owns and operates a pharmacy... it is their individual responsibility not to create a conflict between the professional obligations and standards of practice of pharmacists who work at the pharmacy on the one hand and [the corporation’s] promotions and initiatives on the other hand.”

#### **Conclusion**

With the enactment of the changes to the DPRA, directors are ever more accountable for their involvement in pharmacy operations. Pharmacy directorship accountability is an important part of the College’s ability to regulate the profession of pharmacy, and to do so in the public interest.

## CASE 2

### **Sale of unapproved medications, sale of prescription-only medication without prescriptions, inadequate recordkeeping**

**Member:** Jack Mark Rosenhek  
**Hearing date:** June 28, 2007

#### **FACTS**

Mr. Rosenhek was the owner and Designated Manager of a pharmacy at which the Patient obtained Armour Thyroid on a number of occasions in 2003 and 2004. Armour Thyroid is a natural preparation derived from porcine thyroid glands for use in the treatment of hypothyroidism and other medical conditions. At that time, a similar drug (Thyroid®) was back-ordered, with shortages of the medication across Canada.

There was a dispute as to whether Mr. Rosenhek had obtained prescription authority from a physician to dispense Armour Thyroid on these occasions. More important, and undisputed, was the fact that Health Canada had not tested the quality and safety of Armour Thyroid, and had not approved it for sale in Canada. Therefore, Armour Thyroid had not been assigned a Drug Identification Number (DIN), so no prescription could have authorized the dispensing or sale of it.

After taking Armour Thyroid for several months, the patient experienced negative side effects, and stopped taking it. The patient stated that no one from the pharmacy, including Mr. Rosenhek, ever coun-

selled her about the drug with respect to possible side effects or interactions. There is no documentation of counselling.

During a routine inspection of the pharmacy after these events, a College inspector observed Armour Thyroid in the dispensary, but did not advise that it was not approved for sale in Canada. However, when the College later investigated this specific complaint, it found that:

- Armour Thyroid had been dispensed to a number of patients over 200 times (many with “purported prescriptions” for this unapproved medication);
- Armour Thyroid had been assigned a DIN at the pharmacy, although Health Canada had never assigned it a DIN. Mr. Rosenhek advised that he had assigned the DIN merely to track inventory;
- Fifteen other unapproved medications were available for sale in the pharmacy; ten of those medications contained substances which federal and provincial legislation required be sold only further to a prescription, but they were available for purchase in the self-serve or over-the-counter part of the pharmacy;
- On several occasions, the pharmacy had dispensed medications pursuant to a fax prescription, where the original of the prescription had not been obtained, as required under the College’s fax policy;
- On several occasions, the pharmacy had dispensed medications labelled as “30-day supply” when the quantity dispensed actually

represented a much larger supply. Mr. Rosenhek explained that the computer software defaulted to indicate a 30-day supply, and this number had not been amended on these occasions.

#### **ACKNOWLEDGMENT OF PROFESSIONAL MISCONDUCT**

Mr. Rosenhek admitted his responsibility in respect of this misconduct in that:

- a) he failed to maintain the standards of practice of the profession,
- b) he failed to keep records as required, and was responsible for the discrepancies in dispensing and transferring prescriptions and/or record-keeping,
- c) he falsified records in relation to his practice,
- d) he signed or issued, in his professional capacity, documents that he knew contained a false or misleading statement,
- e) he contravened sections of the Drug and Pharmacies Regulation Act, the Food and Drugs Act, and the Regulations under the Food and Drugs Act,
- f) by reason of the foregoing acts, his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, or unprofessional.

#### **REASONS FOR PENALTY**

The Panel accepted the penalty proposed jointly by the parties, finding it to be appropriate and commensurate with Mr. Rosenhek’s misconduct. The Panel found that Mr. Rosenhek’s misconduct was very conscious and deliberate, and that

there was no indication that he was unaware that Armour Thyroid and the other medications in question were not approved for sale in Canada. The fabrication of a DIN by Mr. Rosenhek represented to the public at large that Armour Thyroid was a safe drug which had been approved for use in Canada, which it was not.

Pharmacists dispense only drugs which are approved for sale in Canada, and pursuant to valid and legitimate prescriptions. To do otherwise, or to label medications falsely or misleadingly regarding these requirements, undermines the authority under which pharmacists practise.

#### ORDER

- A reprimand
- Specified terms, conditions, or limitations on Mr. Rosenhek's Certificate of Registration, and in particular, that he complete successfully, at his own expense, within twelve months of the date of this Order, the following courses, seminars, and evaluations:
  - a) Law Lesson 2 (The Regulation of Pharmacy Practice), Law Lesson 4 (Standards of Practice), and Law Lesson 7 (Professional Liability), from the Canadian Pharmacy Skills Program, offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto,
  - b) the Jurisprudence seminar and evaluation offered by the College, and
  - c) Applied Ethics in Pharmacy

Practice, offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto, and taught by Professor Zubin Austin.

- A suspension of Mr. Rosenhek's Certificate of Registration for a period of four months, with two months of the suspension to be remitted on condition of completion of the above-noted remediation.
- Further specified terms, conditions, or limitations on Mr. Rosenhek's Certificate of Registration, to take effect on October 1, 2007, for a period of one year, prohibiting him from acting in the capacity of a Designated Manager of any pharmacy.
- Costs to the College in the amount of \$10,000.

#### REPRIMAND

Mr. Rosenhek purchased, stocked, and made available for sale in his pharmacy medications that were not approved for sale in Canada. This was done under the guise of them having been approved for sale in Canada when in fact they were not. Some of those medications contained ingredients that would normally require prescriptions for them to be sold in Canada, yet Mr. Rosenhek sold them in the self-serve section of his pharmacy, without prescriptions. The public was thus put at risk in that people could have purchased potentially dangerous products.

The public puts their trust in pharmacists to stock, sell, and recommend products which have been approved for sale in Canada

as safe and effective. As a pharmacist, Mr. Rosenhek should respect the regulations that govern the practice of pharmacists and the availability of drugs in Canada, whether or not he agrees with those regulations. The Panel trusts that medications that are currently available in Mr. Rosenhek's pharmacy are approved for sale in Canada, and that Mr. Rosenhek will not appear before the Discipline Committee again.

### CASE 3

#### Sale of unapproved medications, inadequate recordkeeping

**Member:** Richard Mitchell

**Hearing date:** June 28, 2007

#### FACTS

Mr. Mitchell was a dispensing pharmacist at a pharmacy where the Patient obtained Armour Thyroid on a number of occasions in 2003 and 2004. Armour Thyroid is a natural preparation, derived from porcine thyroid glands, for use in the treatment of hypothyroidism and other medical conditions. At that time, a similar drug (Thyroid®) was back-ordered, with shortages of the medication across Canada.

Health Canada had not tested the quality and safety of Armour Thyroid, and had not approved it for sale in Canada. Therefore, Armour Thyroid had not been assigned a Drug Identification Number (DIN), and no prescription could have authorized the dispensing or sale of it.

After taking Armour Thyroid for several months, the Patient reported

to her physician that she was experiencing physical side effects, including hair loss, agitation, and difficulty sleeping. On the advice of her physician, the Patient stopped taking Armour Thyroid . Then, she complained to the College, stating that no one from the pharmacy, including Mr. Mitchell, ever counselled her about the drug with respect to possible side effects or interactions. The pharmacy has no documentation of counselling.

When the College investigated this complaint, and Mr. Mitchell's practice in general, it found that:

- Mr. Mitchell had dispensed Armour Thyroid some 59 times, to a number of patients,
- the Armour Thyroid had been sold bearing a DIN, although Health Canada had never assigned it a DIN, and that
- another, similar drug, Thyroid PFI, had been dispensed by Mr. Mitchell and billed to the Ontario Drug Benefit as "30-day supply," when the directions on the prescription indicated otherwise. The quantities actually dispensed by Mr. Mitchell ranged from 60 to 200 days' supply. Mr. Mitchell explained that the computer software defaulted to indicate a 30-day supply, and the quantities had not been amended in these cases.

#### **ACKNOWLEDGMENT OF PROFESSIONAL MISCONDUCT**

Mr. Mitchell admitted that:

- a. he failed to maintain the standards of practice of the profession;
- b. he failed to keep records as

required regarding his patients with respect to discrepancies in dispensing, billing, transferring prescriptions, and/or in record keeping;

- c. he contravened sections of the Drug and Pharmacies Regulation Act, the Food and Drugs Act, and the Regulations under the Food and Drugs Act;
- d. by reason of the above actions his conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable, or unprofessional.

#### **REASONS FOR PENALTY**

The Panel noted that Mr. Mitchell had acknowledged that it was his professional responsibility to ensure that all drugs which he dispensed had been properly approved for sale in Canada and had been assigned legitimate DINs. Mr. Mitchell clearly failed to execute this professional responsibility.

This case highlights the fundamental principle that the College's members are individually responsible for their own actions. They cannot rely on others to discharge their professional obligations, nor can they turn a blind eye to actions in the workplace which they know, or ought to know, are inappropriate and/or illegal. Pharmacists are professionals, whether they are Designated Managers, shareholders, or simply employees. They have an obligation to do what is right, whether or not their employer or Designated Manager directs them, or puts them in a position to do otherwise.

#### **ORDER**

- A reprimand.
- Specified terms, conditions, or limitations on Mr. Mitchell's Certificate of Registration, and in particular, that the Member complete successfully, at his own expense, within twelve months of the date of this Order, the following courses, seminars and evaluations:
  - a) Law Lesson 2 (The Regulation of Pharmacy Practice), Law Lesson 4 (Standards of Practice), and Law Lesson 7 (Professional Liability) from the Canadian Pharmacy Skills Program, offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto
  - b) the Jurisprudence seminar and evaluation, offered by the College and
  - c) Applied Ethics in Pharmacy Practice, offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto, and taught by Professor Zubin Austin.
- A suspension of Mr. Mitchell's Certificate of Registration for a period of two months, with one month of the suspension to be remitted on condition that Mr. Mitchell complete the above-noted remediation.
- Costs to the College in the amount of \$2,000.

#### **REPRIMAND**

Pharmacists are continually amongst the most trusted professionals in Canada. Patients trust them to recommend and provide

effective products every day. When pharmacists provide medications that have not been approved for sale in Canada, they breach that trust.

All pharmacists have a responsibility to their patients to make sure that the products they receive are suitable, whether that suitability refers to strength, dose, product chosen, or safety of the source of a product.

It is incumbent upon all pharmacists working in direct patient care to make sure that they act in the patients' best interests. The Panel was of the belief that the course work that Mr. Mitchell had agreed to would enhance his knowledge and skills, and his interpretation of his responsibilities, and would help to make him a better pharmacist. The Panel hoped and expected that Mr. Mitchell would not appear before the Discipline Committee again.

#### **CASE 4**

#### **Breach of standards resulting in a dispensing error, Providing misleading information to the College**

**Member:** Mark Haditaghi

**Hearing Date:** June 21, 2007

#### **THE FACTS**

The Complainant had her prescription for Methotrexate filled by the Member at a pharmacy he owned and managed. The prescription instructions required the patient to take four tablets, one day a week. The next week when she was going to begin taking the medication, she noticed that the label on the vial said Apo-

Azathioprine instead of Methotrexate. When she telephoned the pharmacy, a female staff member advised her that Apo-Azathioprine was the generic name for Methotrexate.

The Complainant took the medication, and experienced negative side effects. Her physician advised her to spread the four tablets out over the course of the day. The next week she did so, and did not experience negative side effects. The following week, however, when the patient took the medication, she experienced further adverse effects.

The Complainant telephoned her physician regarding these side effects, and her physician telephoned the Member's pharmacy. The Member and the Complainant spoke on the telephone, and he asked her to bring the prescription in to the pharmacy. The Complainant could not do so, as she was out of town. The Complainant took the prescription vial to another pharmacy, and the pharmacist there confirmed that Apo-Azathioprine is not a generic name for Methotrexate and that the Complainant had been ingesting the wrong medication.

The records from the Complainant's third party insurer show that on the original date she received the medication from the Member's pharmacy, it billed for Apo-Azathioprine, but that on the date that she spoke to the Member on the telephone this claim was reversed by the pharmacy and changed to Methotrexate. The original service date and the prescription number were not changed.

#### **THE COLLEGE INVESTIGATION**

Despite the College's request, the Member did not provide the original prescription or hardcopy. Instead, he provided a series of signed prescription hardcopies that had been produced at later dates, after the alteration of the information on the pharmacy computer.

As well, the Member provided factually incorrect information regarding the name of his pharmacy technician, the date she had left his employment, and the sequence of events regarding the original dispensing of the incorrect medication and the later correcting of the computer records. He also provided inaccurate information regarding his conversation with the Complainant.

#### **PROFESSIONAL MISCONDUCT AND ACKNOWLEDGMENTS**

The Member pleaded guilty to professional misconduct in that:

- he failed to take appropriate care in dispensing prescription medication, resulting in the dispensing error;
- when he learned of the dispensing error, he amended the third party records to inaccurately show that the correct medication had been dispensed originally;
- he failed to provide the College with the original hard copy of this prescription transaction;
- during the course of the investigation by the College he did not provide the College with the correct spelling or employment history of his pharmacy assistant;
- his written submissions to the

College, through his then counsel, were factually incorrect in several material respects.

### MITIGATING FACTORS

The Member was suffering from extreme stress during the relevant period. In particular he was the owner and manager of two pharmacies, the sole pharmacist at one of them, and the sole caregiver for his seriously ill mother. He was later diagnosed as suffering from depression and anxiety. The Member sold both pharmacies subsequent to the complaint, and has been under the regular care of a psychiatrist since that time, helping him deal with his depression and anxiety.

#### Reasons for Acceptance of the Joint Submission on Penalty

The Panel considered this a very distressing case. While it accepted the Joint Submission on Penalty, the Panel did not believe that any of the information before it reflected sufficient remorse on the part of the Member. The Panel noted that the Complainant in this case had suffered harm as a result of the Member's dispensing error, and his lack of appropriate follow-up.

The Member's subsequent actions had negatively effected the College's ability to conduct an efficient and effective investigation, and had delayed the conclusion of this matter and closure for the Complainant. As part of a self-regulated profession, members have an obligation to act and respond reasonably to requests for information and assistance from the College. Member compliance with the

College's regulatory authority is imperative to maintain the public's respect for the independence and jurisdiction of the College to discipline its members. By his actions, the Member had placed that trust in jeopardy.

### ORDER

1. A reprimand.
2. Specified terms, conditions or limitations on the Member's certificate of registration, and in particular, that:
  - (a) the Member complete successfully, at his own expense, within six months of the date of this order, the following courses and evaluations:
    - i. the Jurisprudence seminar and evaluation offered by the College; and,
    - ii. Applied Ethics in Pharmacy Practice
    - iii. Law Lesson 2 (The Regulation of Pharmacy Practice), and Law Lesson 4 (The Standards of Practice) in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto; and
  - (b) the Member be prohibited from acting as a designated manager in any pharmacy for a period of six months from the date of this order, fully remitted in recognition of the Member's voluntary withdrawal as a designated manager for six months after the service of the Notice of Hearing.

3. Suspension of the Member's certificate of registration for a period of three (3) months, with two (2) month of the suspension to be remitted on condition that the Member complete the remedial training exercises.
4. Directing the Member to pay costs to the College in the amount of \$7,500.

### REPRIMAND

The Panel finds it appalling that the Member gave insufficient concern to the health and welfare of the Complainant. It is the Panel's opinion that the Complainant deserved an apology if one had not already been provided. Dispensing errors occur because human beings are involved; but it is the pharmacist's responsibility to ensure that once dispensing errors occur they are not exacerbated by attempts to cover them up. Members of the College are trusted professionals, and the Member's misconduct has undermined that trust. The Panel hoped that this was an isolated incident for the Member, and that the Complainant had not lost trust in the practice of pharmacy. <sup>P</sup>

# C E V E N T S

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

## GTA

**September 26-28, 2007: Toronto**  
**Advanced Cardiology Pharmacy Practice Part III**

The Leslie Dan Faculty of Pharmacy,  
University of Toronto  
Office of Continuous Professional  
Development  
Contact: Maria Bystrin  
Tel: 416-978-2889  
[cpd.pharmacy@utoronto.ca](mailto:cpd.pharmacy@utoronto.ca)  
[http://cpd.phm.utoronto.ca/cardiology\\_pharmacy.html](http://cpd.phm.utoronto.ca/cardiology_pharmacy.html)

**September 28, 2007: Toronto**  
**Paediatrics for Pharmacists Conference**

The Hospital for Sick Children  
(HSC)  
Contact: HSC Drug Information  
Department  
Tel: 416-813-6703  
[sara.mcdermott@sickkids.ca](mailto:sara.mcdermott@sickkids.ca)

**September 29, 2007: Toronto**  
**Methadone Maintenance Treatment (MMT) Classroom Workshop**

Centre for Addiction and Mental  
Health  
Contact: Rosalicia Rondon  
Tel: 416-535-8501 ext. 6658  
<http://www.camh.net/education>

**October 11, 2007: Toronto**  
**Chronic Obstructive Pulmonary Disease (COPD) Program**

Ontario Pharmacists' Association  
Contact: Penny Young  
Tel: 416-441-0788 ext. 2209  
[pyoung@dir.ca](mailto:pyoung@dir.ca)  
<http://www.opatoday.com/live.asp>

**October 11-14, 2007 (CRE): Toronto**

**October 12-14, 2007 (CAE): Toronto**  
**Asthma and COPD Patient Care – CAE/CRE Preparation Course**  
Ontario Pharmacists' Association  
Contact: Penny Young  
Tel: 416-441-0788 ext. 2209  
[pyoung@dir.ca](mailto:pyoung@dir.ca)  
<http://www.opatoday.com/live.asp>

**October 12-14, 2007: Toronto**  
**Diabetes CDE Preparation Course – Level 2 Certificate Program**

Ontario Pharmacists' Association  
Contact: Penny Young  
Tel: 416-441-0788 ext. 2209  
[pyoung@dir.ca](mailto:pyoung@dir.ca)  
<http://www.opatoday.com/live.asp>

**October 18-19, 2007: Toronto**  
**Patient Safety Course**

Ontario Hospital Association  
Contact: Teresa Turiziani  
Tel: 416-205-1347  
[tturiziani@oha.com](mailto:tturiziani@oha.com)  
<http://www.oha.com/courses>

**November 1, 2007: Markham**  
**How does your Breathing Measure up?**

The Ontario Respiratory Care Society (ORCS)  
The Lung Association  
Tel: 416-864-9911  
[orcs@on.lung.ca](mailto:orcs@on.lung.ca)  
<http://www.on.lung.ca>

**November 7-9, 2007: Toronto**  
**3rd Annual Patient Adherence and Chronic Disease Prevention Conference**

The Strategy Institute  
Tel: 1-866-298-9343  
[registrations@strategyinstitute.com](mailto:registrations@strategyinstitute.com)  
[http://www.strategyinstitute.com/110707\\_pa3/dsp.php](http://www.strategyinstitute.com/110707_pa3/dsp.php)

**November 8, 2007: Toronto**  
**Confronting Medication Incidents Program**

Ontario Pharmacists' Association  
Contact: Janice Tang  
Tel: 416-441-0788 ext. 2225  
Email: [jtang@dir.ca](mailto:jtang@dir.ca)

**November 16-18, 2007 (Part I): Toronto**

**November 30 – December 2, 2007 (Part II): Toronto**  
**Certified Geriatric Pharmacist Preparation Course**

Ontario Pharmacists' Association  
Contact: Penny Young  
Tel: 416-441-0788 ext. 2209  
[pyoung@dir.ca](mailto:pyoung@dir.ca)  
<http://www.opatoday.com/live.asp>

**November 17, 2007: TBA**  
**2007 AGM/Educational Sessions**

Ontario Branch, Canadian Society of Hospital Pharmacists  
Contact: Susan Korporal  
Tel: 613-736-9733 ext. 4  
[skorporal@cshp.ca](mailto:skorporal@cshp.ca)

## ONTARIO

**September 26, 2007: Thunder Bay**  
**Hot Topics in Respiratory Care**

The Ontario Respiratory Care Society (ORCS)

CONTINUED

# C E V E N T S

The Lung Association  
Tel: 416-864-9911  
orcs@on.lung.ca  
<http://www.on.lung.ca>

**October 2, 2007: Barrie  
Chronic Disease Management: A  
Respiratory Focus**

The Ontario Respiratory Care  
Society (ORCS)  
The Lung Association  
Tel: 416-864-9911  
orcs@on.lung.ca  
<http://www.on.lung.ca>

**October 4, 2007: Windsor  
Respiratory Health for All Ages:  
What inspiring minds want to  
know!**

The Ontario Respiratory Care  
Society (ORCS)  
The Lung Association  
Tel: 416-864-9911  
orcs@on.lung.ca  
<http://www.on.lung.ca>

**October 16, 2007: Sarnia  
Respiratory Support Above &  
Below the Diaphragm**

The Ontario Respiratory Care  
Society (ORCS)  
The Lung Association  
Tel: 416-864-9911  
orcs@on.lung.ca  
<http://www.on.lung.ca>

**October 18, 2007: Cambridge  
A Fall Harvest of Respiratory Care**

The Ontario Respiratory Care  
Society (ORCS)  
The Lung Association  
Tel: 416-864-9911  
orcs@on.lung.ca  
<http://www.on.lung.ca>

## NATIONAL

**September 2007 to March 2008:  
Various Dates/Locations  
(Vancouver, Calgary, Winnipeg,  
Toronto, Ottawa, Montreal,  
Quebec City, Halifax)**

**Obesity Certificate Program**  
Ontario Pharmacists' Association  
Contact: Penny Young  
Tel: 416-441-0788 ext. 2209  
pyoung@dirc.ca  
<http://www.opatoday.com/live.asp>

## INTERNATIONAL

**September 25, 2007:  
Tampa, FL, USA**

**October 9, 2007:  
Chicago, IL, USA**

**November 5, 2007:  
Rockville, MD, USA**

**December 1, 2007:  
Las Vegas, NV, USA**

**Using Data Effectively to Manage  
the Risks to Medication Safety**  
Institute for Safe Medication  
Practices (ISMP) and the United  
States Pharmacopeia (USP)  
[http://www.ismp.org/educational/ism  
puspworkshops.asp](http://www.ismp.org/educational/ism<br/>puspworkshops.asp)

## ONLINE COURSES & WEBINARS

**September 17-25, 2007  
Exposure to Psychotropic  
Medications & Other Substances  
during Pregnancy & Lactation  
(Webinar Series)**  
Centre for Addiction and Mental  
Health

Contact: Robyn Steidman  
Tel: 416-535-8501 ext. 6640  
[http://www.camh.net/education/Online\\_courses\\_webinars/safe\\_baby\\_webinars.html](http://www.camh.net/education/Online_courses_webinars/safe_baby_webinars.html)

**October 1, 2007  
Methadone Maintenance  
Treatment (MMT) Online Course  
(8 weeks)**

Centre for Addiction and Mental  
Health  
Contact: Rosalicia Rondon  
Tel: 416-535-8501 ext. 6658  
[http://www.camh.net/education/Online\\_courses/index.html](http://www.camh.net/education/Online_courses/index.html)

**Rosiglitazone in the News: Putting  
Evidence into Perspective**  
College of Pharmacy, Dalhousie  
University  
Division of Continuing Pharmacy  
Education (Online Programs)  
ce.division@dal.ca  
[http://pharmacy.dal.ca/Continuing%  
20Pharmacy%20Education/](http://pharmacy.dal.ca/Continuing%<br/>20Pharmacy%20Education/)

# Laws & Regulations - October 2007

These items are available and can be printed off from our website: [www.ocpinfo.com](http://www.ocpinfo.com).

## Drug and Pharmacies Regulation Act (DPRA) \*

Amended 2007

Regulations to the DPRA:

DPRA R.R.O. 1990, Regulation 545 – Child Resistant Packages

DPRA Ontario Regulation 297/96 Amended to O.Reg. 180/99 – General

DPRA R.R.O. 1990, Regulation 551 Amended to O.Reg. 179/99 – General

DPRA R.R.O. 1990, Regulation 548 Amended to O.Reg. 705/93 – Medicine

DPRA R.R.O. 1990, Regulation 550 Amended to O.Reg 550/93 – Optometry

## Drug Schedules \*\*

Summary of Laws Governing Prescription Drug Ordering, Records, Prescription

Requirements and Refills - June 2007 OCP

Canada's National Drug Scheduling System – July 1, 2007 NAPRA (or later)

## Regulated Health Professions Act (RHPA) \*

Amended 2007

Regulations to the RHPA:

Ontario Regulation 39/02 -Certificates of Authorization Amended to O.Reg. 666/05

Ontario Regulation 107/96 – Controlled Acts Amended to O.Reg. 296/04

Ontario Regulation 59/94 – Funding for Therapy or Counseling for Patients Sexually Abused by Members

## Pharmacy Act (PA) & Regulations \*

Amended 2007

Regulations to the PA:

Ontario Regulation 202/94 Amended to O.Reg. 270/04 – General

Ontario Regulation 681/93 Amended to O.Reg. 122/97 – Professional Misconduct

## Standards of Practice ▲

Standards of Practice, January 1, 2003 OCP

Standards of Practice for Pharmacy Managers, July 1, 2005

## Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations \*

Amended 2007

Regulations to the DIDFA:

R.R.O. 1990 Regulation 935 Amended to O.Reg. 558/06 – General

R.R.O. 1990 Regulation 936 Amended to O.Reg. 205/96 – Notice to Patients

## Ontario Drug Benefit Act (ODBA) & Regulations \*

Amended 2007

Regulations to the ODBA:

Ontario Regulation 201/96 Amended to O.Reg. 559/06 – General

Ontario Regulation 150/05 Personal Information

## Food and Drugs Act (FDA) & Regulations ☺ \*\*

Updated as of Dec. 31, 2006

Amendment 1434 – Addition of ten medical ingredients to Part I of Schedule F Reg. SOR/2007-83, May 16/07

## Controlled Drugs and Substances Act (CDSA) \*\*

Updated as of February, 2007

Regulations to the Controlled Drugs and Substances Act (CDSA) \*\*

All regulations updated March, 2007

Benzodiazepines & Other Targeted Substances Regulations

Marihuana Medical Access Regulations

Precursor Control Regulations

Regulations Exempting Certain Precursors and Controlled Substances from the Application of the Controlled Drugs and Substances Act

## Narcotic Control Regulations \*\*

Updated March, 2007

## OCP By-Laws By-Law No. 1 – December 2006 ▲

Schedule A - Code of Ethics for Members of the Ontario College of Pharmacists - December 2006

Schedule B - "Code of Conduct" and Procedures for Council and Committee Members - December 2006

Schedule C - Member Fees - Effective January 1, 2007

Schedule D - Pharmacy Fees - Effective January 1, 2007

Schedule E – Certificate of Authorization – Jan. 2005

Schedule F - Privacy Code - Dec. 2003

## Reference ▲

Handling Dispensing Errors, Pharmacy Connection Mar/Apr 1995

Revenue Canada Customs and Excise Circular ED 207.1

Revenue Canada Customs and Excise Circular ED 207.2

District Excise Duty Offices - Oct. 10/96

Guidelines for the Pharmacists on "The Role of the Pharmacy Technician"

OCP Required Reference Guide for Pharmacies in Ontario, June 2007

\* Information available at **Publications Ontario** (416) 326-5300 or 1-800-668-9938

\*\* Information available at **www.napra.org**

☺ Information available at **Federal Publications Inc.** Ottawa: 1-888-4FEDPUB (1-888-433-3782) Toronto: Tel: (416) 860-1611 • Fax: (416) 860-1608 • e-mail: [info@fedpubs.com](mailto:info@fedpubs.com)

▲ Information available at **www.ocpinfo.com**

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