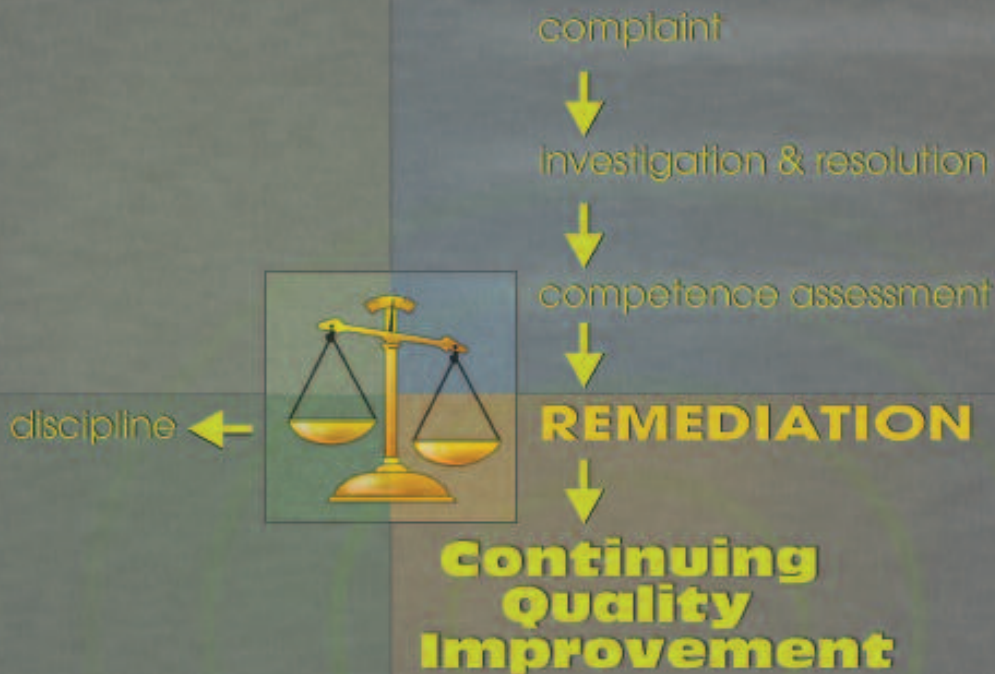


# Pharmacy Connection



Official Publication of the Ontario College of Pharmacists

March/April 2006



## INSIDE:

- *A Culture of Continuing Quality Improvement . . . page 7*
- *Understanding the Inspection Process . . . . . page 25*
- *Non Supervision of Pharmacies . . . . . page 38*

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- Discipline
- Fitness to Practice
- Patient Relations
- Quality Assurance
- Registration

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- Finance
- Professional Practice

### Special Committees

- Communications
- Standards of Practice Working Group
- Structured Practical Training
- Task Force on Optimizing the Pharmacist's Role
- Working Group on Certification Examination for 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.*

*What was the most important thing you learned from **your** Preceptor?*



**STUDENTS AND  
INTERNS  
NEED YOU.**

*Call Vicky Gardner at the College to enroll as a Preceptor.*

**416-962-4861 x 297**

# contents

Registrar's Message .....	4
Pharmacy Annual Fees .....	6
A Culture of Continuing Quality Improvement .....	7
Employment Opportunity .....	12
Close-up on Complaints .....	13
Q&A Practice .....	16
Q&A SPT .....	17
Q&A Registration .....	18
Notice to Pharmacists .....	19
Letters to the Editor .....	20
Health Canada Notices .....	22
Quality Assurance .....	24
Inspectors' Corner .....	25
Notice to Pharmacists .....	28
Privacy Obligations in Long Term Care Settings .....	28
Deciding on Discipline .....	29
Non Supervision of Pharmacies .....	38
Focus On Error Prevention .....	39
Are You Displaying Your Point of Care? .....	40
CE Events .....	42
Bulletin Board .....	42

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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, topics suggestions, or journal 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.

Shelley McKinney, R.Ph., B.Sc.Pharm.  
President

## The Electronic Health Record

*Canada Health Infoway, a federally funded agency, has been mandated to foster the development and adoption of electronic information systems across Canada.*

Lately, I have been thinking about the Electronic Health Record (EHR), the opportunities and challenges it will provide when it becomes available and accessible to all healthcare professionals, and in particular, to pharmacists. It is on my mind because at my workplace, a hospital, we are preparing for the Canadian Council of Health Services Accreditation (CCHSA) survey scheduled in 2006.

The CCHSA survey recently incorporated new patient safety goals. The Required Organizational Practices to improve communication include several goals related to reconciling patient medications, one of which is detailed as follows.

### *Patient Safety Area 2: Communication*

*Goal 2: Improve the effectiveness and coordination of communication among care/service providers and with the recipients of care/service across the continuum.*

- *Reconcile the patient's/client's medications upon admission to the organization, and with the involvement of the patient/client*
- *Reconcile medications with the patient/client at referral or transfer, and communicate the patient's/client's medications to the next provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization*

Reconciliation of medications is the process of compiling the “best available” medication list, this includes obtaining the name, dosage, frequency, and route of administration, and then using this list to optimize care for a patient. It requires comparing the patient's list of current medications against the prescriber's admission, transfer, and/or discharge orders. The EHR is intended to help facilitate the reconciliation process.

Optimizing patient care in our current system is a challenge because patients often move from primary care, to acute care, to rehabilitation, to long term care, and back again depending on the dynamics of their disease state(s). Not only do patients receive medications from various pharmacy providers (community, hospital, long term care) as they move through the healthcare system, but their medications may also be adjusted, discontinued, and/or changed during this process.

So, what progress has been made towards implementing an EHR? Canada Health Infoway, a

federally funded agency, has been mandated to foster the development and adoption of electronic information systems across Canada. One of the components of the EHR is the Drug Information System, which will give authorized health care providers access to medication histories, facilitate electronic prescribing, and provide databases for checking medications, dosages, drug interactions, and dispensing information.

In Ontario, Canada Health Infoway has funded a project to allow hospital emergency departments in the province access to the drug claims history of recipients of the Ontario Drug Benefit (ODB) and Trillium Drug Programs via the web-based viewer called the Drug Profile Viewer Systems. The full provincial roll-out is expected to be completed by the summer of 2006. The project has received criticism because the ODB drug claims history may not give an accurate medication profile of the patient. Still, what if the emergency department project extended to all drugs for all persons and was readily available to


all pharmacists? Would our patient medication profiles then be accurate and up to date?

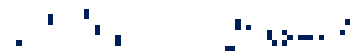
In the community setting, our patient medication profiles include the name of the drug, the dosage, the route and frequency of administration, as ordered by the prescriber. What happens when the patient is directed to adjust the dose and/or to discontinue one of the medications? Do our profiles accurately capture the changes? Do we consistently record the use of OTC medications and herbal remedies which are not covered on the patient's drug plan?

In the hospital setting, institution-specific drug formularies are developed. Our automatic substitution policies allow us to switch patient medications to the "formulary" agent within a therapeutic category. Upon discharge, the patient's medication may not be switched back to the original drug, which may create confusion. Are we able to accurately capture a medication history at the various stages of admission, transfer, and discharge?

The implementation of the EHR will facilitate the transfer of a cur-

rent and accurate medication profile only if we develop the required processes to continually update and record the medication changes. Yes, it will be a useful tool -- but still only a tool.

As we move forward towards the creation of the EHR we must remember that patient records have the most value if our pharmacy teams work to ensure our information is as up-to-date as possible. It would be a wise investment of time for pharmacy teams across the province to review their medication reconciliation and documentation procedures in preparation for the arrival of the EHR. 



# Pharmacy Accreditation Renewals 2006

Your annual pharmacy accreditation renewal fee of \$781.58 is due no later than May 10, 2006. Renewal forms will be mailed to pharmacies by mid-March.

## FEE PAYMENTS

### Annual Pharmacy Fees Due May 10, 2006

Pharmacy renewal fees have increased 4.35% effective this year; the increase was approved during the September 2005 Council Meeting.

Pharmacy fees of \$781.58 (\$730.45 + \$51.13 GST) must be received or postmarked no later than May 10.

## PAYING BY CHEQUE

Make your cheque payable to "The Ontario College of Pharmacists" or "OCP" in the amount of \$781.58 (\$730.45 + \$51.13 GST), and please remember to sign the cheque. The pharmacy accreditation number and the invoice number should be written on the front of the cheque. NSF (non-sufficient funds) cheques are treated as late and incur both a late penalty and a \$20 NSF service charge. All unsigned cheques will be returned for signature.

## PAYING BY CREDIT CARD

The College accepts payment by VISA, MasterCard or American Express. Please enter the **credit card number** and the **expiry date** of the credit card in the box under "Payment Information" on your renewal form. Please be sure to sign the credit card section, giving the College authorization to process the credit card payment in the amount of \$781.58.

*The certificates of accreditation and income tax receipts are mailed to pharmacies by the College after the financial transaction has been completed.*

## LATE PAYMENTS

Late payments are subject to a late payment fee of \$107 (\$100 + \$7 GST) (if paid within 30 days after the due date) or \$160.50 (\$150 + \$10.50 GST) (if paid more than 30 days after the due date). This includes cheques that are received early but postdated after May 10, 2006. Late payments will not be processed until the late payment fee has been received.

## RECORDS UPDATE

Updates are required for the following:

- Pharmacists (with and without signing authority), and technicians who are practising at the pharmacy
- "Lock and leave" procedures
- Methadone dispensing
- Participation in the Point of Care program
- Pharmacy website information
- Indication of which of the College-approved drug information services the pharmacy subscribes to

As outlined in the Standards for Designated Managers, acknowledgement of all directors and Designated Managers is a requirement of every pharmacy reporting a change of designated manager. You can update this information on the fee form or download the Acknowledgment/Change of Designated Manager form which is in the Forms section of the College website [www.ocpinfo.com](http://www.ocpinfo.com).

### For Further Information:

Contact Client Services at  
(416) 962-4861  
or by e-mail at  
[ocpclientservices@ocpinfo.com](mailto:ocpclientservices@ocpinfo.com)

## College Programs Collaborate to Promote a Culture of

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# Continuing Quality Improvement

*Tracy Wiersema  
Chair, Complaints Committee*

*The mandate of the College is to  
protect the public interest.*

*The way in which the College  
implements its mandate reflects a  
philosophy of remediation and  
quality assurance; the College's  
activities reflect a belief that seizing  
opportunities to improve its  
members' practices is an effective  
way to protect the public interest.*

Opportunities for the College to support practice improvement by members present themselves to the College in numerous ways, including – the practice review of the Quality Assurance Program, the investigation of complaints from the public about members, and the inspection of pharmacies.

Complaints received by the College are investigated as part of the Investigations and Resolutions Programs. The Continuing Competency Programs manage all ongoing continuing learning of members and administer the Quality Assurance Program. Part of the latter program is the development of remediation for members who fall below standard in the practice review. This knowledge of remediation is now being transferred to the complaints process. “Complaints about pharmacy practice provide very important information necessary for practice improvement,” explains Nora MacLeod-Glover, former Manager

# Continuing Quality Improvement

of Continuing Competency Programs. “While it is true that no pharmacist wants to be complained about, or, more importantly, to fall below the Standards of Practice for the profession, the reality is that if this occurs, it can play a role in the growth and improvement of their pharmacy practice.”

It is this kind of approach towards quality improvement that has contributed towards a paradigm shift at the College, from disciplining its members for dispensing errors, to finding the best means of remediation. The Continuing Competency department has been collaborating with the Investigations and Resolutions Programs at the College to develop remediation-based solutions to practice-based complaints. This process draws upon this department’s experience and expertise in competence assessment and development of learning plans to identify these opportunities as part of an investigation process, according to Ms. MacLeod-Glover. “We believe that from a quality improvement perspective, the information that is received about a member’s practice as part of a complaint can be as insightful about a member’s practice weaknesses as an assessment of a member’s practice

obtained as part of the practice review, in that it identifies opportunities for practice improvement. Outcomes of complaints that are of a remediative nature make a lot of sense.”

## REMEDICATION AS PART OF THE INVESTIGATION PROCESS

Under the RHPA, when the College receives a complaint about a member, the complaint needs to be investigated and reviewed by the Complaints Committee. Upon reviewing the results of the investigation, the Committee may dispose of the complaint in a number of ways. The Committee may also refer the member to the Discipline Committee. What is critical, however, is that the decision of the Complaints Committee be reasonable. “In the past, many cases involving significant clinical practice breaches, like dispensing errors, were referred to the Discipline Committee”, explains Claudia Skolnik, Manager, Investigations & Resolutions. “In recent years however, the trend for the Complaints Committee has increasingly been to assess the practice deficits that contributed to the error or breach and order suitable remediation.” The result is that cases that formerly would have been

### Complaints Committee Decisions Related to Dispensing Errors

Council Year	98/99	99/00	00/01	01/02	02/03	03/04	04/05
Complaints about errors reviewed	46	31	34	41	39	30	73
Referrals to Discipline Committee	10	8	5	13	0	0	3*
Remediation	0	0	1	0	7	8	17

\* These cases involved errors accompanied by serious aggravating conduct

referred to the Discipline Committee are now being resolved at the Complaints Committee level with remediation.

### **REMEDIATIVE APPROACH WELL RECEIVED BY MEMBERS AND COMPLAINANTS**

Remediative outcomes are more desirable for the members and the complainant alike than a referral to discipline. While decisions of the

Complaints Committee are confidential, they are provided to the complainant and the member, both of whom have the right to appeal the decision. The Committee's direction to the member to undergo remediation is clearly described in its written decision, as is the reason for its requirement. "We find that the complainants are satisfied with the remediation ordered," says Ms. Skolnik. "They feel that the remediative approach responds directly to the issues in their

## **Putting It Into Context: Case 1**

The College received a complaint about a member alleging 29 incidents over 2 years. There were many similarities among the incidents; primarily, they concerned issues related to dispensing errors and poor recordkeeping. The member's documented response to the issues when identified demonstrated an abdication of professional responsibility.

Continuing Competency reviewed the investigation and identified that the underlying causes of the incidents were related to remediable deficiencies on the member's part, including: an inadequate communications skills, both when dealing with pharmacist colleagues and with other allied health professionals; an ineffective therapeutic thought process, which, when combined with rote prescription processing skills resulted in inappropriate dispensing; ineffective error management skills; and a lack of awareness of professional accountability.

Continuing Competency recommended the member engage in an education program which included the International Pharmacy Graduate program participation in applied therapeutics, communication skills, a basic professional practice lab, and professional practice theory, including drug information sessions and jurisprudence. To train the member in communicating more effectively during difficult conversations following an error, Continuing Competency recommended an additional communication strategies program. To assist the member in understanding error management, the Ontario Pharmacists' Association Confronting Medication Errors program was included.

In deciding to direct the remediation and not to refer the member to Discipline, the Complaints Committee recognized that this was an extensive remediation program designed to ensure meaningful learning, which benefits the member and also upholds its public protection mandate. Given the number of incidents in the complaint, its intensity is both appropriate and meaningful. The member signed an Undertaking confirming her commitment to successfully complete the remediation within 18 months. Benefits for the member included receiving a targeted learning program to address practice deficits and avoiding a potentially lengthy and complicated discipline case which would have only delayed the commencement of the member's practice improvement. The process and the program developed for the member acknowledges that professionals come to work with the intention to do good; it also distinguishes between the member's conduct and practice. The Committee was satisfied that the extensive remediation required, coupled with the requirement that the member attend for an Oral Caution, adequately addressed the public interest concerns raised in the complaint without the need for a referral to Discipline.

complaint, that it goes a long way to ensuring that the member's practice improves and that this kind of an error will not likely recur. It is really a win-win situation – the complainant is satisfied; the member's practice is improved, and the system has been improved."

The Committee takes the view that by requiring and directing remediation, it is using the College's processes to take more meaningful steps towards promotion of patient safety. To date, there have been no appeals made by any complainants or members of a Committee decision requiring remediation.

## COLLABORATION BETWEEN CONTINUING COMPETENCY AND INVESTIGATIONS & RESOLUTIONS

The involvement of the Continuing Competency department in the development of complaint-based remediation is a critical feature of the complaints resolution program, as it ensures college-wide consistency in practice assessment and remediation requirements. The collaboration draws upon the separate expertise in investigations on the one hand, and assessment and remediation on the other, to meet the joint objective of patient safety.

The investigator gathers relevant information about the complaint, which includes the member's response. The member's response provides critical information in understanding the sequence of events that led to a complaint. It provides insight into the member's practice, procedures, and knowledge base. Sometimes the investigation process in and of itself is the remediative tool that presents the member with the opportunity for reflection and self-identification of the learning opportunities and initiatives to be taken voluntarily. Other times the member's explanation may illustrate the practice problem, even though the member does

not recognize this as a problem.

"College investigators are trained to ask not only "*What happened?*" but also "*Why did it happen?*" says Ms. Skolnik. "They're thinking of remediation options as part of the investigation – in fact, the opportunity for improvement shapes the investigation process." Indeed, the investigator routinely consults with the Continuing Competency staff, who reviews the case for its remediative potential. "The investigation gathers a wealth of information that provides a clear indication of practice deficits," says Ms. MacLeod-Glover. "Using our competence-based assessment skills as well as our expert knowledge of the remediation options available, we are able to advise the Complaints Committee about remediation options to consider that will be meaningful and reasonable."

"The collaborative effort makes sense, because when an assessment of the complaint shows the complaint is likely due to a gap in a practice skill or knowledge, engaging in learning is a meaningful way to ensure public protection in the future," says Ms. MacLeod-Glover.

When information is brought to the College's attention through a complaint, the College assesses four main lines of inquiry:

1. Did the member err or fail to meet the standard of practice?
2. Was the failure to meet the standard reflective of a practice- or knowledge-based deficit?
3. Can the practice deficit be remediated so that the member's practice can be improved to prevent a recurrence?
4. What does the remediation look like?

Based on an assessment of this nature, the Committee is well positioned to determine whether remediation is best suited for the resolution of the complaint.

## **PARTNERING WITH THE MEMBER**

Ensuring that the College is accountable for its remedial approach, processes have been developed to ensure that remediation is a suitable and accountable alternative to discipline. When the Committee has identified that remediation may be suitable, the member is approached by College staff to enter into an Undertaking whereby they commit to the College to successfully complete the remediation proposed, at their own expense, and within the time frame stipulated. Once the member signs the Undertaking, the committee is assured that this approach is suitable and that the member shares its vision of commitment to continuing quality improvement. The written decision also includes a reference to the fact that the member signed an Undertaking as a further measure to demonstrate that the decision is reasonable.

The Committee has directed a wide variety of remediation directives, including referrals to the International Pharmacy Graduate Program (IPG), web-based courses, courses at the Ontario Pharmacists' Association (OPA), and others. The

benefits of this process include that it recognizes the member's intention is to do what is best for the patient and this makes it a meaningful process for both the member and public. It provides an opportunity for the member to engage in learning associated with an identified practice gap and averts the need for discipline. The Continuing Competency Program is continuously expanding its menu of options because the wider the spectrum of suitable remediation options, the better the College is able to utilize its continuing competency and complaints process to further implement its vision of continuing quality improvement. <sup>P</sup>

## **Putting It Into Context: Case 2**

The College received a complaint involving a dispensing error resulting from a pharmacist's erroneous instructions for frequency.

Continuing Competency reviewed the investigation and was able to identify that the underlying causes of the incident were related to remediable deficits, including an ineffective therapeutic thought process being used during prescription filling, and ineffective error management and communication in response to patient concerns when the error was identified.

To assist the member in developing more effective communication processes when dealing with upset patients, Continuing Competency recommended a communications strategies course. To help the member gain awareness and skills associated with the therapeutic thought process, home-study programs were suggested, specifically, a course on evidence-based pharmacotherapy, and web- and print-based courses which have a strong focus on the therapeutic thought process used in clinical decision-making. The member entered into an Undertaking to the College confirming her commitment to the remediation required, which supported the Committee's decision to resolve the matter by way of remediation and not to refer the case to the Discipline Committee.

## Position Available:

# Professional Development Advisor (Pharmacist)

The Ontario College of Pharmacists is currently seeking a creative pharmacist interested in joining the College in the role of Professional Development Advisor. The successful candidate is able to communicate in a caring and supportive manner while assisting pharmacists in understanding and complying with continuing professional development activities. The individual will demonstrate the ability to deal effectively with people of varied cultural backgrounds, using judgment and discretion in providing information which may be sensitive in nature.

As a member of the Continuing Competency Program area of the College, the individual will provide oversight in research, development and maintenance of the Learning Portfolio program, develop relationships with continuing education providers, oversee the volunteer Continuing Education Coordinator team, as well as direct remediation activities which include the delivery of professional development workshops. In addition, the Professional Development Advisor will assist the Manager, Continuing Competency, with both phases of the Quality Assurance Program.

The successful candidate will have a good understanding of the issues and challenges facing pharmacists and pharmacy practice. An understanding of adult education principles and experience in training would be an asset.

If you are interested in joining the College staff in this position, please forward your resume by April 15, 2006 in confidence stating salary expectations to:

**Lisa Baker, CHRP**

*HR & Administrative Services Coordinator*

Ontario College of Pharmacists

483 Huron Street

Toronto, ON M5R 2R4

fax: (416) 847-8279

lbaker@ocpinfo.com

*Only those chosen for an interview will be contacted*



# Dispensing Doses: Multiple Medications Require Close Attention

*by Wendy Gaonac'h, B.A.  
Complaints Officer*

The following case demonstrates how the Complaints Committee uses remediation in a practical sense. The Committee looked at the various errors identified in a complaint and ensured that the remediation would address each of the issues raised.

## THE COMPLAINT

The complaint was filed by the daughter of a patient receiving treatment for heart disease and lung cancer. The patient, who was the complainant's mother, was prescribed medication to regulate blood pressure for the management of her heart disease, and medication for pain and nausea to help her cope with her cancer treatment. Upon the patient's release from hospital, a list of her prescriptions was faxed to the pharmacy so that they could be dispensed for pickup the following day. The complainant preferred to have the pharmacist make up the dosette that her mother would need, as she was not familiar with her mother's medications. The complainant contacted the pharmacy five times throughout the fol-

lowing day, and still the dosette was not ready. She finally received the dosette late in the day.

According to the complaint, the member dispensing the medications explained that two strengths of the M-Eslon prescribed for the patient were not in stock, so the Member would need to obtain authorization from a doctor to substitute another drug for these. The complainant states that the Member suggested that her mother take the medication which had already been prescribed for her pain, Statex, in more frequent doses, instead of the longer-acting M-Eslon. The complainant did not like this solution, as her mother would have to take pills more frequently through the night to achieve the same effect as M-Eslon would produce. The member found two acceptable substitutes for the morning and evening strengths of the prescribed M-Eslon, but only dispensed enough of the bedtime narcotic for two evenings, asking the complainant to return the following day for the remainder. She returned home only to find that she did not have the vial of Statex.

The complainant said she also noted that the Member had placed the Friday's pills in the Sunday compartment of the dosette, so she rearranged them.


She returned to the pharmacy the following day to pick up the outstanding Statex and the remainder of bedtime narcotic pills. The member sent her to another pharmacy to pick up the latter medication. Later that day, the complainant discovered that the dosette was missing some of the morning M-Eslon pills, which the pharmacy had informed her would be ready the following morning. Returning to the pharmacy yet again the complainant discovered that the dosette was not labelled properly. In fact, there was no label for the dosette itself, only photocopies of the prescription labels taped to the dosette.

## THE DECISION

The Committee examined all submissions from the various parties in this case, and considered each of the five key issues of the case individually, but made its disposition based on an overview of all the issues.

The first issue considered was the delay in preparing the dosette. The Committee noted that the member was a relief pharmacist working in a very busy pharmacy; and while filling dosettes is a time-consuming process, pharmacists should consider this in prioritizing their work. The member was found to have delayed beginning the process of filling the dosette, which compounded the delay in finding a substitution for the drugs which were not in stock.

The second issue was the substitution of the M-Eslon. Although the Committee commended the member for attempting to find a substitution, thus demonstrating his regard for the patient's well-being, it found that the absence of an original prescription for the substituted drugs, which were narcotics, constituted a breach of Standard 2 of the Standards of Practice. The Committee suggested that the member's original idea of contacting another pharmacy would have been the best solution, and that he should not have accepted the advice of a technician against this course of action. The Committee was struck by the fact that the member confirmed his chosen substitution with an emergency room doctor, but did not use that doctor's name when processing the prescription. Instead, the member used the name of the doctor who had originally prescribed the M-Eslon, unbeknownst to that doctor and without documentation of this change. Furthermore, the member's notes indicate that a two-day supply was dispensed, but the hard copy indicates that it was a seven-day supply. If this was indeed the case, then a large number of pills were dispensed



without any documentation of authorization whatsoever.

The third issue concerned the dispensing of the Stax, which the complainant said she did not receive on her initial visit. The member explained that he had dispensed it in a separate vial because it was for pain and that the complainant had left it behind. If so, the Committee thought that the member ought to have made reasonable efforts to contact the complainant and/or deliver the vial to the patient.

The fourth issue was the incorrect filling of the dosette. The complainant stated that pills were not in their proper slots compartments while the member had no recollection of this. Faced with divergent accounts, the Committee could not prefer one account over the other, and therefore, took no further action on this aspect of the complaint.

The fifth issue was the inappropriate labelling of the dosette. The Committee was dismayed to note that the label for the dosette was a photocopy of the faxed list of prescriptions, reduced to fit the box and taped to the top. The member and the complainant differ on their recollection of whether or not the photocopies were taped to the box. Regardless, a properly labelled dosette would have included computer-generated labels for each prescribed medication, each of which would have included a physical description of the medication.


## REMEDICATION

The Committee considered the issues and was left with serious concerns about the member's practice, which led them to order remediation in two forms. The Committee solicited the member's signed undertaking to attend and successfully complete two courses which were selected by the Committee because they believed that they would provide suitable resolution to the practice

deficits identified by its investigation, and would serve the public interest. The member provided this undertaking, acknowledging both the concerns of the Committee regarding his dispensing practices, and his obligation to ensure his continuing competence in all areas of pharmacy practice and therapeutics.

The two courses are part of the International Pharmacy Graduate Program. In the first course, "Basic Professional Practice Labs", participants are expected to prepare prescriptions, maintain patient profiles, perform documentation activities, and demonstrate organizational skills. Telephone simulations improve communication skills, while documentation improves writing skills. In the second course, "Advanced Professional Practice Labs", participants consolidate jurisprudence, drug information, and prescription processing skills in preparation for independent practice. Drug information requests are researched and documented. Compounding calculations, techniques, and preparations are completed, and patient care plans are devised. Workshops on devices provide practical experience, while tutorials on third-party management issues offer practical solutions to common practice problems.

Finally, the member was required to appear before the Committee for an oral caution.

This case demonstrates that remediation can be used to address practice concerns, improving both member professionalism and patient safety. 

## PRACTICE



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

**Q** A patient of mine who is having difficulty taking a prescription medication wants to return it. Is it professional misconduct to take medications back from patients?

No, it is not professional misconduct to accept medications that a patient wishes to return. Taking back a medication or providing a refund for a returned medication is a business decision. However, as the Regulations describe, it is professional misconduct for a pharmacist to return to stock any medication that has been returned by a patient/agent, or to attempt to re-sell or re-dispense a medication that has already been sold to a patient or their agent.

Returning to stock or again selling or dispensing a drug previously sold or dispensed and delivered is considered professional misconduct as per the Pharmacy Act, O.R. 681/93 s.1 (25).


**Q** Where can I find more information about expectations regarding the selling of Schedule II drugs?

The article in the March/April 2003 *Pharmacy Connection* entitled *Making the Most of Schedule II Drugs* is a great source of information. In addition, information about the Drug Schedules and factors used to determine scheduling can be found on the NAPRA website, [www.napra.org](http://www.napra.org).

**Q** The Ontario Drug Benefit fee is currently \$6.54. My Usual and Customary fee (U&C) is \$10.00. Can I bill the difference to the patient or to their insurance carrier?

No. The Ontario Drug Benefit Act (s.4 (1)) determines who a pharmacy can charge or accept payment from. When dispensing or supplying a listed product for an eligible person, a pharmacist can only charge the Ministry the fee as determined by the Regulations and can only accept payments from the Ministry. In essence, you cannot charge the patient or an insurance carrier the difference between your U&C and the ODB fee, nor can you accept any payments from the patient or an insurance carrier except as determined by the Act or Regulations.

This section does permit the pharmacy to charge or accept payment from an eligible person or insurance carrier when dispensing or supplying a listed product in an amount not greater than the maximum co-payment allowed by the Regulations. Currently, the maximum co-payment that may be charged to the patient or insurance carrier is the lesser of \$6.11 or your U&C.

For more information concerning billing ODB and any exceptions to the rule please refer to the Ontario Drug Benefit Act and its Regulations. This Act can be accessed through our website at [www.ocpinfo.com](http://www.ocpinfo.com) or by going to [www.e-laws.gov.on.ca](http://www.e-laws.gov.on.ca) 

# Structured Practical Training



*By Roxanne Hook, R.Ph., B.Sc.Phm.,  
Diana Spizzirri, R.Ph., B.Sc.Phm.,  
Deanna S. Yee, R.Ph., B.Sc.Phm., M.Sc.,  
Registration Advisors*

**Q I am a recent Canadian graduate currently completing a hospital pharmacy residency program? Does my residency count towards the College's internship requirement? If so, do I need to register as an intern with the College?**

This answer also applies to U.S. graduates. Hospital residency training can be applied towards the College's internship requirement of a minimum of 12 weeks of in-service training, provided all of the competencies are met. Whether or not you register with the College is your choice.

Registration is not mandatory if you are practising in an in-patient hospital pharmacy setting. Registering as an intern gives a resident the privilege of performing the controlled acts of a pharmacist in an accredited pharmacy, so you must register with the College if you wish to practise in a community pharmacy or an accredited hospital out-patient pharmacy as an intern.

Hospital residency programs consist of post-graduate clinical practice during which participants must successfully complete rotations in drug distribution, drug information, and administration, as well as several clinical practice areas, such as general medicine and cardiology. Through these rotations, totalling one year in length, it is possible to demonstrate the SPT internship competencies.

To grant credit for the SPT internship the College requires the following:

- Residents must register their preceptor (for example, the residency coordinator) and in-service training with


the College. It is preferred registration be done prior to the commencement of training, but must be done no later than or at least 12 weeks before its completion, in order to receive credit for that training.

- The resident must successfully complete the rotations, including drug distribution, administration, drug information, and clinical practice, for the purpose of demonstrating the required SPT competencies. Residents are not required to complete the SPT activities, since they are completing other activities required by their residency program.
- The resident and preceptor, must complete the documentation required by the SPT internship program (a final set of assessments and the Declaration of Completion).

The residency coordinator or hospital manager/director may be the preceptor for more than one pharmacy resident for the purpose of coordinating the assessment process.

**Q I noticed that one of the SPT activities for studentship involves completing prescription transfers by telephone. Are we required to actually do this verbally, or is a faxed transfer report acceptable? Since most pharmacies now perform this task by fax, I do not understand the need for this activity.**

SPT staff is aware that most pharmacies conduct prescription transfers by facsimile; however, it is important that students/interns and pharmacists know what information is legally required for the completion of a prescription transfer, should they be required to do so by phone. Technology reduces the possibility of error, but it is not always available. Since it is the intent of the SPT to provide students with the opportunity to learn and apply pharmacy practice policies in a practice setting, it is mandatory that the prescription transfer be completed verbally.

When contacting the transferring pharmacy by telephone, the preceptor or student should explain that the verbal prescription transfer is one of the required activities for studentship. SPT staff is likewise aware that facsimile transmission is also the means by which many physicians order new prescriptions. As with prescription transfers, students need to actually take new prescriptions over the telephone to complete the activity correctly. 

## REGISTRATION



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

### **Q** Is it true that a license is not required to work in a hospital as a pharmacist?

While it is true that a pharmacist can work in a hospital without being licensed with OCP, that person may not call or represent himself/herself as a pharmacist unless he/she is licensed. The title of “pharmacist” is a legally protected title. Hospitals may have unlicensed pharmacists working as technicians or in other roles but these staff may not call themselves pharmacists.

The Ontario College of Pharmacists has the authority to regulate the pharmacy practice site and the pharmacist in Ontario under various pieces of legislation including the RHPA, DPRA and Pharmacy Act. However, Hospitals are governed by the Public Hospitals Act so inpatient pharmacies are not required to be accredited by OCP.


From a liability perspective, most hospitals want to ensure the quality of the credentials held by the personnel they are hiring. If hospitals are hiring pharmacists to provide direct patient care to its patients (eg. dosage adjustments, patient counselling and even prescribing under a delegation protocol from the Medical Advisory Council), they generally want to ensure that the person has the knowledge, skills and judgment to provide that level of care. By hiring pharmacists licensed with OCP, the hospital is ensuring its personnel are competent, regulated practitioners.

If you wish to review the relevant pharmacy legislation, you can go to [www.ocpinfo.com](http://www.ocpinfo.com) and click on “OCP Manual” and go to “legislation”.

### **Q** I want to do the internet based TOEFL to demonstrate the fluency requirement. Will OCP accept the internet based TOEFL and what scores do I need to meet the fluency?

OCP plans to meet with other regulators across the country to set the standards for the internet based TOEFL. It is important that the provinces agree on the fluency standard of the internet based TOEFL so that internationally educated pharmacists moving from one province to another under the Mutual Recognition Agreement do not have to do another objective fluency test.

In the event that someone has taken the internet based TOEFL, a panel of the registration committee will review the results on a case by case basis.

However, we strongly suggest that candidates take one of the objective fluency tests that currently have standards set already. These tests would be the Cantest and IELTS and you can review the scores for these tests by going to [www.ocpinfo.com](http://www.ocpinfo.com) and click on “Registration Package” and then “fluency”. 

## NOTICE TO PHARMACISTS

### **Advisory Notice - "Off Formulary" Interchangeability**

Please be advised, effective immediately, of the College's position respecting "off Formulary" interchangeability. The College confirms that only drugs that are listed as interchangeable in the Ontario Drug Benefit Formulary can be dispensed as such, and, where products are not listed as interchangeable, a physician's order is required. In accordance with legal opinion obtained by the College, pharmacists are further advised that, where a physician indicates "generic ok" on a prescription, you are NOT authorized to substitute a generic product that is not listed in the Formulary. In order to substitute a drug in Ontario, whether it is a generic or therapeutic equivalent, the prescriber must be contacted for authorization.

The College has communicated this position to Green Shield Canada, other third party payers, government, the Ontario Pharmacists Association, and the College of Physicians and Surgeons of Ontario.

Any queries should be directed to the College's Professional Practice Programs at 416-962-4861.

Yours truly,

**Deanna L. Williams**, R.Ph., B.Sc.Pharm., CAE

Registrar

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### **EDITOR'S NOTE**

As recently as the January/February issue of Pharmacy Connection, we have endeavoured to clarify "interchangeability" for pharmacists in Ontario who are bound by the Drug Interchangeability and Dispensing Fee Act (DIDFA) and regulations.

The advisory notice reprinted here reminds pharmacists that in order to dispense a specific brand of drug that is not deemed interchangeable by law, the prescriber must authorize that particular product, and may need to be contacted in order for this specific direction to be obtained. Pharmacists are encouraged to document such communications and are further reminded that neither OCP nor the College of Physicians and Surgeons of Ontario support the use of "blanket authorizations".

Pharmacists are again referred to the May/June 2004 Practice Q&A for more detail.

# Letters to the Editor

The following letter was received in response to the publication of the Discipline Committee decision pertaining to Ali Laal in the November/December 2005 Pharmacy Connection. Mr. Laal had misrepresented himself as an intern and a pharmacist when, in fact, he was a student.

*I just can't believe the final disposition of this case. Besides being a terrible black eye on Pharmacy, how could the decision be made to allow this man to be able to return to the college under any circumstances?*

*Not being privy to all of the information in this case, it seems fairly clear from what information there is in the report on discipline, that we do not need a liar, a cheat and an outright scoundrel in our profession.*

*Perhaps no one can say they have never done wrong, but this is ridiculous!*

*Shame on us.*

*Perhaps the people who hired him should be reviewed as well.*

*Murray Berman, B.Sc.Pharm 5T7 Emeritus  
Richmond Hill, Ontario*

## **Editor's Comments**

The above case involved misconduct of a former member who at the time of the disciplinary hearing was no longer a member of this College. In order to become a member of the College in the future, the individual would need to make an application to the Registration Committee, which would have complete access to the applicant's discipline history. The Registration Committee exercises its discretion when directing the Registrar to register an applicant; it can direct the Registrar not to register the applicant as a member or to register the applicant with terms and conditions or limitations. The Registration Committee considers the discipline history of an applicant when deciding how to direct the Registrar. As well, results of discipline hearings are located on the College's public register and are accessible to other regulatory bodies provincially, nationally, and internationally.

## **Correction**

The "Deciding on Discipline" article pertaining to the Ali Laal decision erroneously stated that "BCPS," as a designation, does not exist. In fact, while not a legal designation or an indication of licensure, "BCPS" or "Board Certified Pharmacotherapy Specialist" is a designation recognized by the Board of Pharmaceutical Specialties (BPS) in the United States since 1988. As stated by the BPS, "board certification indicates a pharmacist has demonstrated an advanced level of education, experience, knowledge and skills -- beyond what is required for licensure -- in a particular specialty practice area."

Dear Pharmacy Connection Editor,

Thank you for your recent article about Medication Consultation Services. In the article, Iris Krawchenko uses the ongoing IMPACT\* study as an example of the projects demonstrating the usefulness of pharmacist-conducted medication reviews. We are pleased that our project has been used as example and agree that pharmacists in the IMPACT project are gaining experience on the process and practicalities of conducting medication consultations.

The wording in the article suggests that the pharmacists working in the IMPACT study are “advanced practice pharmacists.” We are writing to provide some useful information for your readers to clarify this statement. The pharmacists working as part of the IMPACT study, in family practice clinics across Ontario, were not required to have an advanced degree. They were selected from a pool of applicants who had a variety of education and experience. The minimum requirements were an undergraduate pharmacy degree and licence to practice in Ontario. Community and/or hospital pharmacy experience, experience working with interdisciplinary teams, as well as additional training or certifications (eg. residency, diabetes, asthma, geriatrics, post-graduate pharmacy degree etc.) were considered assets. We also considered the pharmacists' ability to be flexible, innovative and efficient in a fast-paced environment. Only one of the first seven pharmacists originally hired for IMPACT had a Doctor of Pharmacy degree.<sup>1</sup> We believe that any pharmacist with the necessary skills, knowledge, and commitment would be able to meet the needs of patients and physicians in family practice. We provided an initial two day transitional training program to assist the IMPACT pharmacists with their transition into the unfamiliar environment of the family practice setting. We also provided an ongoing mentor support program as help for pharmacists to advance their knowledge, skills and integration into practice. The pharmacists have identified and are learning how to overcome a number of challenges to providing medication consultation services within primary care practice. Our evaluation of the usefulness of IMPACT project supports, as well as the types and complexity of patients referred to the pharmacists, has also helped to identify additional knowledge and skills that will be needed by pharmacists working in these practices in the future. We anticipate that pharmacists entering positions on family practice teams will benefit from the learning gained from this project and be able to integrate faster and more effectively with continued training and support.

Sincerely,

Barbara Farrell, B.Sc.Pharm., Pharm.D., FCSHP, Co-Principal Investigator

Lisa Dolovich, B.Sc.Pharm., Pharm.D., M.Sc., Principal Investigator

(on behalf of the IMPACT investigators)

\*Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics (IMPACT)

[www.impactteam.info](http://www.impactteam.info)

This project is funded by the Ontario Ministry of Health and Long-Term Care through the Primary Health Care Transition Fund.

<sup>1</sup> Babcock K, Farrell B, Dolovich L, Sellors C. “Hiring a pharmacist to work in primary care.” Canadian Journal of Hospital Pharmacy 2005;58(suppl 1):48

# HEALTH CANADA

## *Advisories & Notices*

DATE	TYPE
09 Feb 2006	Health Canada is warning consumers not to use 13 Chinese herbal products manufactured by the Hong Kong Chi Chun Tang Herbal Factory due to bacterial contamination that could lead to serious health risks.
07 Feb 2006	Health Canada is advising Canadians about a possible link between use of the antibiotic Ketek and potentially serious liver problems.
06 Feb 2006	Health Canada is warning consumers not to use the product M1T(methyl-1-testosterone) Andro Technologies, or any other supplements containing the synthetic steroid methyl-1-testosterone, due to such potentially serious health risks as liver disorders and hardening of the arteries.
01 Feb 2006	Health Canada is warning consumers not to use the Chinese medicinal product White Peony Scar-repairing pills, manufactured in Hong Kong by White Peony Pharmaceuticals Limited, due to high levels of lead.
01 Feb 2006	Health Canada Endorsed Important safety information concerning certain ACCU-CHEK Aviva glucose monitors. Roche Diagnostics is informing consumers and health care professionals of a corrective action involving certain ACCU-CHEK Aviva blood glucose meters. Affected units may develop an electronic malfunction which could cause the meter to report an incorrect reading.
31 Jan 2006	Health Canada is advising Canadians that blood lancing devices labelled for personal use should not be shared due to the risk of transmitting blood-borne viruses, including hepatitis B and hepatitis C.
27 Jan 2006	Health Canada is warning consumers not to use the prescription drug Octreotide Acetate Omega 500 µg/mL from lot number 5J970 as some vials from this lot may mistakenly contain the antipsychotic drug fluphenazine.
26 Jan 2006	Notice to Hospitals – Health Canada Endorsed Important Safety Information on the Association of WinRho SDF [Rho(D) Immune Globulin (Human)] with Intravascular Hemolysis in the treatment of Immune Thrombocytopenic Purpura -Cangene Corporation Recent cases of intravascular hemolysis, in which red blood cells are broken down in the blood vessels, have been associated with WinRho, when used to treat Immune Thrombocytopenic Purpura. In very rare cases, they lead to complications of abnormal clotting and death.
26 Jan 2006	Health Canada is warning consumers not to use the natural health product Libidfit because it has been found to contain an undeclared ingredient that could lead to serious health risks, especially for patients with existing medical conditions such as heart problems.
23 Jan 2006	Novartis Pharmaceuticals Canada Inc. is voluntarily recalling the following lot numbers of Estalis* Transdermal Therapeutic System: Item 2834, Estalis* 250/50 mcg lot# 16130111, expiry date 06-2007 Item 2836, Estalis* 140/50 mcg lot# 15948131, expiry date 05-2007
23 Jan 2006	Health Canada Endorsed Important Safety Information on the association of Macugen (pegaptanib sodium injection) with hypersensitivity reactions. - Pfizer Canada Inc. This communication informs the public and ophthalmologists of case reports of hypersensitivity and anaphylaxis in patients receiving Macugen.
19 Jan 2006	African herbal products M2 Formula and Energy 2000 pose potential health risks. Health Canada is warning consumers not to use the Nigerian herbal products M2 Formula and Energy 2000 capsules because they may contain toxic herbal ingredients and could lead to serious health risks. M2 Formula and Energy 2000 may contain the toxic ingredients Strophanthus sarmentosus or Aristolochia.

*continued on page 23*

DATE	TYPE
18 Jan 2006	Important Safety Information on anti-TNF Therapy: ENBREL (etanercept), HUMIRA (adalimumab), and REMICADE (infliximab). Reactivation of hepatitis B virus (HBV) infection has been reported rarely with the anti-TNF agents Enbrel, Humira, and Remicade. The main indication for these drugs is Rheumatoid Arthritis. Persons at risk of HBV infection should be screened before initiation of these drugs. - Amgen Canada, Inc., Abbott Laboratories, Ltd., and Schering Canada, Inc.
13 Jan 2006	Notice to Hospitals: Association of Blood Lancing Devices with Transmission of Blood-Borne Diseases. The misuse of blood-lancing devices may result in transmission of blood-borne viruses, including Hepatitis B and C. Health Canada reminds health care workers that these devices must be used with caution to minimize the risk of transmission of blood-borne diseases.
28 Dec 2005	Notice to Hospitals: Important Safety Information on Medical Telemetry Systems. This notice is to remind health care facilities of potential risk of electromagnetic interference for any medical telemetry systems operating in the 460 - 470 MHz frequency band.
28 Dec 2005	Health Canada is warning consumers not to use Kaizen Ephedrine HCL tablets for the unauthorized purposes of weight loss or increased energy because of serious, potentially fatal adverse effects associated with the misuse of the product.
23 Dec 2005	Health Canada is advising consumers to be cautious if buying the prescription drug Tamiflu over the Internet and to avoid any products claiming to be "generic" Tamiflu, as there are no authorized generic versions of the antiviral on the market.
22 Dec 2005	Health Canada Endorsed Important Safety information on Paxil (paroxetine) and increased risk of cardiac defects following exposure during first trimester of pregnancy.
21 Dec 2005	Health Canada warns consumers not to ingest the herb chaparral in the form of loose leaves, teas, capsules or bulk herbal products because of the risk of liver and kidney problems.
21 Dec 2005	Health Canada Endorsed Important Safety Information on the association of Avandia (rosiglitazone) and Avandamet (rosiglitazone/metformin) with new onset and/or worsening of macular edema (vision problems) reported in diabetic patients. - GlaxoSmithKline Inc.
20 Dec 2005	Health Canada Endorsed Important Safety Information on the Association of Tequin (gatifloxacin) with serious low blood sugar (hypoglycemia) and high blood sugar (hyperglycemia). - Bristol-Myers Squibb Canada.

For complete information & electronic mailing of the Health Canada Advisories/Warnings/Notices subscribe online at: <http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/>

**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)

Sandra Winkelbauer, R.Ph., B.Sc.Ph., CAE  
Manager, Continuing Competency Programs

# The Practice Review is seeking French-speaking Assessors

The College's Quality Assurance Program is now in its ninth year. The success of the program is only made possible through the efforts of many practicing pharmacists who contribute to its development and delivery. At this time, we are seeking French-speaking pharmacists to join the team of Assessors for the Practice Review. This is to enable us to deliver the Standardized Patient Interview portion of the Practice Review in the French language.

**WHAT TRAINING IS PROVIDED?**  
Our education consultant provides training to ensure Assessors are


fully trained with respect to their role and responsibilities. Assessors are trained during a Practice Review weekend, so you can learn both from the Education Consultant and experienced Assessors. The Practice Review is held five times a year over a weekend and during the following times; Friday night (5-9 p.m.), Saturday (8 a.m. – 5 p.m.) and Sunday (8 a.m. - 5 p.m.). Assessors typically assess one to two Practice Reviews yearly.

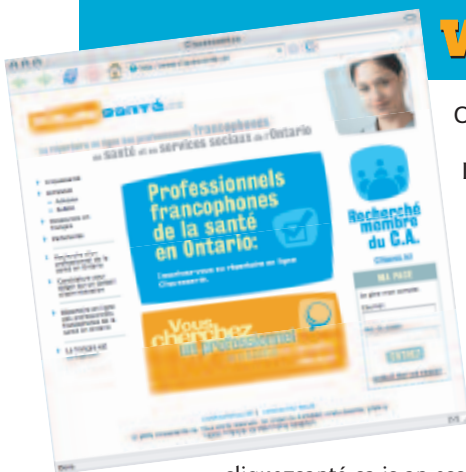
### WHO CAN APPLY?

To participate you must have successfully completed the Practice Review and be in Part A of the Reg-

ister. As someone who has been through the Practice Review first hand, you can provide a perspective that will serve to improve the process and make it more relevant to everyday practice.

### HOW DO I APPLY?

Please apply in writing stating your interest in becoming an Assessor, your name, OCP number and a brief summary of your professional background. Address your correspondence to Lori Sheppard either by mail or email at [lsheppard@ocpinfo.com](mailto:lsheppard@ocpinfo.com). 



## www.cliquesante.ca

Ontario is home to more than 500,000 Francophones – and they want health care **in French!**

In Ontario's health and social services sectors, there are scores of professionals dedicated to helping and caring for the public, including opticians, addiction counsellors, physiotherapists, pharmacists, doctors and acupuncturists, to name but a few.

**Cliquesanté.ca** is a new database that will allow Ontario's Francophones to readily access health care and social services in French. By visiting [www.cliquesante.ca](http://www.cliquesante.ca), they can consult a directory of French-speaking professionals in these sectors and find the one they need in their region.

"I am well aware of the importance of receiving care in one's own language.

cliquesanté.ca is an essential tool in that it enables Ontario's Francophone community to obtain services in French in the health and social services sectors," said Christiane Fontaine, Executive Director of RIFSSSO.

"Your support in this matter is vital. Please tell everyone you know about **cliquesanté.ca!**"

## Register Today!

*A message from the Regroupement des intervenantes et intervenants francophones en santé et en services sociaux de l'Ontario (RIFSSSO)*

# Understanding the Inspection Process

## Review of Documentation of Dialogue on Initial Prescriptions

*Rose Fitzgerald, R.Ph., B.Sc.Pharm*  
*Pharmacy Inspector*

In order to protect the public and ensure the safe distribution of drugs, the College has the authority, under the Drug and Pharmacies Regulation Act (DPRA), to inspect pharmacies and pharmacy operations. Inspections provide the College with the opportunity to assess pharmacists' and pharmacies' compliance with legislation, College policies, and the Standards of Practice. At the same time, inspections offer members an opportunity for personal contact with a representative of the College and a chance to ask questions about their practice.

Documentation is an essential function performed by health professionals in the provision of patient care. Dialogue is important as it

helps pharmacists ensure the safe and appropriate use of medication. Documentation and dialogue are two different functions that are expected to occur with all new prescriptions, as identified in the Standards of Practice.

Introduced in 1996, the Standards were revised in 2000 and again in 2003. Sections 4.3, 4.3.1, and 4.3.2 deal with documentation of dialogue.

### 4.3 Prescribed Drugs

The pharmacist takes reasonable steps to enter into dialogue with the patient or agent on all initial prescriptions in a community setting, in established programs in an

institutional setting, or when made necessary by professional judgment of the pharmacist, the need of the patient or agent, or upon their request.

4.3.1 The pharmacist documents the dialogue in a readily retrievable format, including the date the dialogue occurred, with whom, and the identity of the pharmacist.

4.3.2 Should dialogue not take place, the pharmacist documents the reason.

Documentation of dialogue is one of the areas of practice which is assessed as part of the inspection process. In fact, in the majority of pharmacies inspected each year, the level of compliance by pharmacists with this particular Standard is found to meet or exceed expectations.

In some cases however, insufficient or incomplete documentation of dialogue may be identified during an inspection. Some pharmacists who consistently conduct dialogue with patients may not be documenting this dialogue. It becomes difficult for an inspector to identify the

pharmacist(s) who are not documenting such dialogue, especially in situations where the dispensing pharmacist may not be the same as the one who has the dialogue with the patient. This highlights the importance of having proper systems and procedures in place to ensure that dialogue occurs and is documented.

The Inspector may ask the Designated Manager to identify the pharmacists who are not documenting dialogue, or, whose levels of documentation do not meet the Standards of Practice. Where a number of pharmacists are employed in one pharmacy, and levels of documentation of dialogue are minimal, the Designated Manager should have each pharmacist address the issue for which an action plan is required.

In some cases, where levels of documentation of dialogue are minimal or inconsistent, a re-inspection of the pharmacy will result. In situations where compliance has not been achieved after a re-inspection, a referral will be made to the Accreditation Committee.

To help both Designated Managers and pharmacists, here is a list of the most common issues identified by inspectors at inspections.

## DOCUMENTATION ISSUES IDENTIFIED AT INSPECTIONS

### (1) Blank dialogue slips:

If no dialogue has occurred, the reason must be documented, along with identification of the pharmacist providing the reason. A blank dialogue slip could mean either that there was no dialogue or the pharmacist forgot to document it. If this is a continuation of a previous therapy, then that should be clear. Often pharmacists use short forms such as “R” for “Repeat” and “HB” for “Had before”.

### (2) Prescriptions “copied” from older ones on file:

Prescriptions copied from an older prescription show a last-fill date on the hard copy. If this is a new prescription and the last-fill date is long past, then some documentation should take place, even if there is no dialogue slip.

### (3) The pharmacist who conducted the dialogue is not identified:

It cannot be assumed the pharmacist who does the dialogue is the same as the dispensing pharmacist. The identity of each pharmacist must be unique and confirmable; if

# INSPECTORS' CORNER

all pharmacists use a check mark the identity of any particular pharmacist is difficult to determine. Often pharmacists will identify themselves by initials, OCP numbers, or some distinctive mark.

#### **(4) Agents not identified:**

This occurs mostly with prescriptions filled for children. Inspectors find many examples where the patient is identified as the person spoken with, although the patient may only be three years old. The agent or person acting on the patient's behalf should be identified, i.e., mom, friend, neighbour etc.

#### **(5) Legibility of documentation:**

Documentation that is not clear or legible is unacceptable.

#### **(6) Electronic documentation:**

Some pharmacy software will print the message "Dialogued in Person" on the hard copy BEFORE dialogue occurs. If used, the message must be "marked" AFTER dialogue occurs.

#### **(7) Multiple hard copy records with only one dialogue slip completed:**

Each prescription must be documented for dialogue, as one entry

does not cover multiple prescriptions.

#### **(8) Pharmacy technicians conducting and documenting dialogue:**

Pharmacy technicians are asking patients "Have you had this medication before?" or "Do you want to speak to the pharmacist?" and when the patient says "No," they document a refusal of dialogue. The responsibility for compliance with Standards of Practice rests with pharmacists, and not technicians.

#### **(9) No documentation for delivered prescriptions:**


The delivery of a prescription to a patient or agent to a location out of the pharmacy is not an acceptable reason for the absence of dialogue. Attempts should be made to contact the patient by phone prior to delivery or after the delivery has been made. This should be documented.

#### **(10) Dialogue slips kept separate from the hard copy record (usually in a notebook):**

This is acceptable, provided the inspector can do an audit. The slips must be "readily retrievable" - i.e. filed chronologically or numerically.

In the case of patients in a non-licensed home where there is no consultant pharmacist, consideration must be given to how counselling will be performed and documented. In a case where the patient is unable to care for him/herself, it is expected that dialogue will occur with a nurse or caregiver, and this will be documented.

Documentation of dialogue does not necessarily have to be on the dialogue slips provided by the software vendor. It can be done manually on the hard copy, as long as all required elements are included.

This article has dealt with documentation of dialogue concerning new or initial prescriptions. The inspection process also reviews levels of other forms of documentation and interventions done by pharmacists. For more information on documentation, see the College's Guidelines for Documentation on our website [www.ocpinfo.com](http://www.ocpinfo.com). 

## NOTICE TO PHARMACISTS

### NOTICE: DRUG SCHEDULE CHANGE - EPHEDRINE AND PSEUDOEPHEDRINE

**Scheduling status changes were approved for ephedrine and pseudoephedrine effective April 10, 2006**

**Pseudoephedrine** and its salts and preparations in **single-entity** products are now in **Schedule II**; **pseudoephedrine** and its salts and preparations in **combination** products are now in **Schedule III**. **Ephedrine and its salts in single entity products move to Schedule II and its salts in combination products are in Schedule III.**

*[Note: Pharmacists are advised that in areas where there is evidence of abuse or particular concern about abuse, pseudoephedrine products should not be located in a self-service area of the pharmacy]*

Impact on pharmacies - two areas of pharmacy practice will be affected by this change:

1. Schedule II Sections: Designated Managers and Pharmacists will need to review their Schedule II sections to ensure that they will be able to accommodate the single-entity products. Pharmacists should also review their responsibilities and the Standards of Practice with respect to the sale of Schedule II products to ensure that these products are being used appropriately.
2. Lock and leave operations: Designated Managers and Pharmacists should be reviewing their front store operations to ensure that these products are secured behind the "lock and leave" area or that suitable fixtures are ordered to comply with legislative requirements.

For more information please refer to the NAPRA website at [www.napra.org](http://www.napra.org)


## Privacy Obligations in Long-Term Care Settings

The Privacy Commissioner of Ontario has clarified some information that is important to owners and employees of long-term care homes in Ontario as well as to residents, their family members, and their substitute decision-makers. Approved charitable homes for the aged within the meaning of the Charitable Institutions Act, homes or joint homes within the meaning of the Homes for the Aged and Rest Homes Act, and nursing homes within the meaning of the Nursing Homes Act are defined as health information custodians and therefore must comply with the Personal Health Information Protection Act (PHIPA), including the provisions related to consent and access to records of personal health information.

PHIPA, requires health information custodians to obtain the consent of the individual or his or her substitute decision-maker prior to the collection, use, or disclosure of personal health information, unless PHIPA provides otherwise. PHIPA further requires

health information custodians to provide an individual or his or her substitute decision-maker access to records of personal health information about the individual on request.

A fact sheet regarding consent and access under PHIPA as these relate to long-term care homes can be found at <http://ipc.on.ca/docs/fact-09-e.pdf>. All pharmacists providing services to long-term care facilities should make themselves familiar with this fact sheet.

The College continues its work of developing Standards of Practice for pharmacists providing services to the residents of long-term care facilities. This was identified in the Strategic Plan as a priority for the Professional Practice Committee. It is anticipated that there will be a recommendation on the standards to Council this year and members can look forward to publication of such standards in Pharmacy Connection for review. 

**CASE 1**

**Non-supervision of a pharmacy**

**Member:** Mann Auyeung, Toronto

**Hearing Date:** November 17, 2005

Mr. Auyeung was found to have:

- Failed to maintain a standard of practice of the profession
- Contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Mr. Auyeung's plea of professional misconduct, the facts of which were set out in an Agreed Statement and formed the basis of his plea.

**Facts**

The College received a complaint from a patient, who is a registered pharmacist himself, stating that when he attended a pharmacy with a prescription to have it filled, there was only one staff member on site. The staff mem-

ber filled his prescription and provided counseling on its use. In light of these actions, the complainant assumed that this individual was a registered pharmacist. Mr. Auyeung subsequently entered the pharmacy's dispensary area while the complainant was still there, which prompted the complainant to ask the person who filled his prescription if she was a registered pharmacist. Mr. Auyeung answered this inquiry by stating that he was a pharmacist and that the person who filled his prescription was a pharmacy student. The complainant subsequently learned that the person who filled and counseled on his prescription was a pharmacy technician, not registered with the College in any capacity. Mr. Auyeung was the only registered pharmacist scheduled to be on duty at the time of the complainant's visit; he was not present however, when the complainant arrived, as he had left the pharmacy in his car to pick up a pizza from a store a short distance away.

Mr. Auyeung admitted and acknowledged that he left the pharmacy for approximately 10 minutes and that no pharmacist was on site during that time. He further admitted that he took no steps to advise his pharmacy technician that she was not to perform any functions of a registered pharmacist in his absence.

**Joint Submission on Penalty**

The parties agreed to a penalty which was presented to the Panel by way of a Joint Submission on Penalty. The

Panel considered the proposed penalty to be appropriate and reasonable and made the following Order:

**Order:**

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Auyeung's Certificate of Registration and, in particular, that he complete successfully, at his own expense, within 12 months of the date of this Order, remedial training as follows:
  - a. the Pharmaceutical Jurisprudence Examination of the Ontario College of Pharmacists
  - b. the following courses and evaluations in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
    1. Law Lesson 2 – The Regulation of Pharmacy Practice
    2. Law Lesson 4 – Standards of Practice
    3. Law Lesson 7 – Professional Liability
3. A suspension of Mr. Auyeung's Certificate of Registration for a period of two months, with one month of the suspension to be remitted on condition that he complete the remedial training program specified in paragraph 2 above
4. Costs to the College in the amount of \$2,000

## CASE 2

**Non-supervision of a pharmacy; abdication of role as Designated Manager**

**Member:** Marvin Turk, Thornhill

**Hearing Date:** November 17, 2005

Mr. Turk was found to have:

- Failed to maintain a standard of practice of the profession

- Contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Mr. Turk's plea of professional misconduct, the facts of which were set out in an Agreed Statement and formed the basis of his plea.

**Facts**

This case dealt with the abdication of responsibilities of a member as Designated Manager of a pharmacy located in a grocery store. At all material times, the member, Mr. Turk was vice-president of operations for the corporation that held the Certificate of Accreditation of the Pharmacy. He is now president and, since the time of the incidents in question, has transferred from Part A of the Register to Part B.

Due to staffing difficulties in the pharmacy Mr. Turk assumed the role of Designated Manager on an emergency basis and staffed the pharmacy with a series of locums. He rarely attended at the pharmacy himself as the head office for the pharmacy, from which he worked, was located in another city. Rather, Mr. Turk routinely oversaw the operation of the pharmacy via telephone and fax communications with pharmacy staff.

On two occasions, approximately one month apart, the pharmacy remained open and continued to operate in the absence of an on-duty pharmacist. In the first incident, the registered pharmacist on duty left the pharmacy abruptly following a dispute with the front-store manager. Staff immediately telephoned Mr. Turk to report the pharmacist's departure and Mr. Turk advised staff that he would attempt to obtain a relief pharmacist for the remainder of the day. No relief pharmacist subsequently

attended at the Pharmacy that day. In the second incident, the locum pharmacist who was scheduled to work, did not arrive for his shift. In both instances there was no pharmacist on duty in the pharmacy for the balance of the pharmacy's operating day, approximately nine hours each day. On both days, the pharmacy remained open and pharmacy assistants continued to dispense prescriptions to patients, including narcotics, in the absence of an on-duty pharmacist.

Mr. Turk admitted and acknowledged that:

- a) He failed to properly supervise the pharmacy on the two occasions and that he took no action to close the pharmacy, so the pharmacy continued to operate and prescriptions were dispensed in the absence of a pharmacist on duty
- b) As Designated Manager he was responsible for supervising the pharmacy, ensuring that a registered pharmacist was on duty at all times and arranging for a substitute pharmacist when the need arose, failing which, it was his responsibility to instruct staff members to refrain from filling prescriptions and to close the pharmacy
- c) In the course of his duties as Designated Manager, when narcotic deliveries were made to the pharmacy, he signed for them when he was not physically present at the pharmacy to verify receipt of the narcotics as ordered
- d) He failed to meet his professional responsibilities as the pharmacy's Designated Manager

### **Joint Submission on Penalty**

The Panel carefully considered the suitability of the details of the Joint Submission on Penalty presented to them, as agreed upon by both the Member and the College. Noting that Mr. Turk is currently on Part B of the Register, the Panel acknowledged that there were limits to the range of penalties that could be imposed in a

case of this nature. In particular, ordering a period of suspension would not serve as a specific deterrence where a member is not actively practicing pharmacy. The Panel acknowledged that the significant cost award is intended to replace the lost income impact of a suspension. The Panel also recognized however, that restricting a member who is on Part B of the Register from acting as a Designated Manager has no effect unless, in the unlikely event, he applies to return to Part A of the Register.

The Panel agreed that the remedial coursework in the Joint Submission will be beneficial to Mr. Turk and to the organization of which he is currently president. It is the Panel's hope that the courses will assist Mr. Turk in guiding the organization in putting into place appropriate procedures governing pharmacy practice and standards, all of which will greatly assist in the protection of the public.

In response to the Panel's request for information about procedures in place to address the situation that gave rise to this matter, namely, that prescriptions were dispensed without a pharmacist on duty, Mr. Turk provided a document which purported to be a company-wide policy, outlining procedures to follow if a registered pharmacist was not on pharmacy premises. In particular, the purported policy allows the pharmacy to remain open for up to one hour without any pharmacist supervision. Having reviewed the document, the Panel was of the view that the policies contained therein do not comply with the Standards of Practice. The panel suggested that, to correct this deficiency, Mr. Turk, in his role as the organization's president, consider instituting a "lock and leave" system, pursuant to College guidelines, at those pharmacy locations experiencing difficulty in maintaining registered pharmacists on staff.

Having considered of all the facts of this case, the Panel was hesitant but, nevertheless, accepted the Joint Submission on Penalty and made the following order.

**Order:**

1. a reprimand
2. specified terms, conditions and limitations on Mr. Turk's certificate of registration and in particular:
  - i. that he be restricted from acting as a Designated Manager of any accredited Ontario pharmacy for a period of three years from the date of this Order
  - ii. that he complete successfully, at this own expense, within 12 months of the date of this Order, remedial training as follows:
    1. the Pharmaceutical Jurisprudence Examination offered through the Ontario College of Pharmacists
    2. the following courses and evaluations in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
      - a. Law Lesson 2 – The Regulation of Pharmacy Practice;
      - b. Law lesson 4 – Standards of Practice; and
      - c. Law Lesson 7 – Professional Liability; and
    3. costs payable to the College in the amount of \$10,000.00

## CASE 3

**Non-supervision of a pharmacy; abdication of role as Designated Manager**

**Member:** Bernard Katz, Toronto

**Hearing Date:** November 23, 2005

Mr. Katz was found to have:

- Failed to maintain a standard of practice of the profession
- Contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions

Act, 1991 or the regulations under those Acts

- Permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to the sale of drugs by a corporation of which he was a director

The Panel accepted Mr. Katz's plea of professional misconduct, the facts of which were set out in an Agreed Statement and formed the basis of his plea.

**Facts**

Mr. Katz is the sole director of a chain of pharmacies owned and operated by a grocery store chain. At all relevant times he was the Designated Manager of the pharmacy in which the misconduct occurred.

The College received a complaint alleging that the pharmacy was permitted to operate without a pharmacist present. Specifically, a patient was able to ask for and purchase Ferrous Gluconate 300mg, a Schedule II drug, in the absence of a pharmacist on site. During her attendance, the patient did not observe any sign indicating that there was no pharmacist on duty and in fact was advised by the staff at the pharmacy that the pharmacy was open, but that there was no pharmacist present.

On the day in question at approximately 10 a.m., Mr. Katz was informed by staff at the pharmacy that the locum pharmacist scheduled to be on duty had not arrived. Mr. Katz made attempts to locate a locum pharmacist. However, all attempts appeared to have failed and Mr. Katz was ultimately forced to attend himself, which he did, at 12 noon. The pharmacy was therefore open without a pharmacist present from 9 a.m. to noon. Although a number of prescriptions were prepared and/or processed at the pharmacy during this period, none were dispensed before 1 p.m.

Mr. Katz claimed that there was a protocol in place for

when the on-duty pharmacist was late or sick, which states:

- That a sign be posted stating that there is no pharmacist on duty
- That no prescription medications be released
- That no Schedule I or II medications be sold
- That medication profiles are not to be transferred to other pharmacies
- That assistants should not take verbal prescription orders
- That specific aisles requiring pharmacist intervention be blocked
- That assistants may process repeat prescriptions and new prescriptions on the computer and have prescriptions filled in order to be checked by the pharmacist when he or she arrives

Mr. Katz acknowledged that the protocol he provided

was inadequate in that it permitted the operation of the pharmacy in the absence of a pharmacist. He also acknowledged that he failed to maintain the Standards of Practice of the profession and that in his capacity as Designated Manager, he breached sections 146 and 149 of the Drug and Pharmacies Regulation Act, by allowing the pharmacy to operate in the absence of a registered pharmacist.

#### **Comments of Panel**

The Panel found it interesting that the Member's purported policy is entirely different from a corporate policy at the same chain of pharmacies recently filed before a differently composed panel of the Discipline Committee (Marvin Turk). The Panel in the recent case was highly critical of the policy filed at that hearing as it (the policy) permitted the pharmacy to remain open for one hour in the absence of a registered pharmacist. The Panel found

## **Decisions on Non-Supervision - Cases 1, 2, and 3**

In cases 1, 2, and 3, you will note that remediation has been ordered to ensure that the members understand and appreciate the statutory prohibition on non-supervision and their responsibility to prevent it. As is common in disciplinary penalties, the members can reduce the length of their suspensions if they complete this remediation by a certain deadline. Moreover, such remediation is always made a term, condition, or limitation on the members' Certificate of Registration, so that if they fail to complete the remediation at all, they are liable to further allegations of professional misconduct.

In the case of Mr. Auyeung, he was personally present at the pharmacy and (of the three cases) most directly responsible for the non-supervision, having actively left the pharmacy (albeit briefly). For this reason, the penalty was focused more on him personally (at least one month of suspension to be served) rather than on the business or financial aspect (\$2,000 costs).

In the cases of Mr. Turk and Mr. Katz, they were not physically present at the pharmacies in question just before the non-supervision occurred, but as Designated Managers, they were responsible for it. As executives in the corporation that owned the pharmacies also, they were responsible, not having ensured that there was a strong and clear chain-wide policy in place preventing such an eventuality. The penalties in this regard were focused on the financial/business aspect of the practice.

deficiencies with this policy as it does not require placing a physical barrier between the dispensary and all scheduled products and the public when there is no pharmacist present.

Further, it was obvious to the panel, from this case and the Marvin Turk case, that there is no consistent policy within one chain of pharmacies in regard to an appropriate protocol when a registered pharmacist is absent from the pharmacy. The Panel acknowledged that it was not the corporate entity that was before it in either case. However, as director and/or vice president of operations, the members were in a position to influence pharmacy practice and put in place compliant standards of practice that address the issue.

### **Joint Submission on Penalty**

The parties agreed to a penalty which was presented to the Panel by way of a Joint Submission on Penalty.

The Panel considered the Joint Submission on Penalty in relation to the facts of the case and specifically with reference to a number of decisions issued by the Committee in related cases. The Panel concluded that while the cases were unique on their facts, it could not help but be influenced by the Turk decision given the associated nature of the pharmacies at which this member and Mr. Turk both worked. The Panel recognized that the penalties needed to be different given the implications of Mr. Turk being registered on Part B of the Register whereas Mr. Katz is on Part A. Therefore, the Panel was pleased to see a suspension appropriately as part of the proposed penalty for Mr. Katz, even though, for the reasons identified in the Turk decision, his penalty order did not include a suspension. The Panel was of the view that the remediative coursework will be of benefit to Mr. Katz and to the pharmacy at which he is employed. As in the Turk matter, the courses will hopefully assist Mr. Katz in guiding the chain of pharmacies, of which he is sole director, in putting into place

appropriate procedures governing pharmacy practice and standards, all of which will greatly assist in the protection of the public.

The Panel accepted the Joint Submission on Penalty and made the following Order.

### **Order:**

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Katz'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 and evaluations:
  - a) Jurisprudence seminar and evaluation (examination) offered by the College
  - b) the following courses of the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
    - i) Law Lesson 2 (Regulation of Pharmacy Practice); and
    - ii) Law Lesson 4 (Standards of Practice)
3. A suspension of Mr. Katz's Certificate of Registration for a period of one month, to be remitted on condition that he completes the remedial training specified in paragraph 2 above
4. A fine in the amount of \$3,500
5. Costs to the College in the amount of \$2,000

## **CASE 4**

### **Unauthorized administration of an injection, Improper disposal of used sharps and Returning to stock drugs previously dispensed**

**Member:** Susan Sherk, Welland

**Hearing Date:** December 21, 2005

Ms. Sherk was found to have:

- Failed to maintain a standard of practice of the profession
- Contravened, the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 (RHPA) or the regulations under those Acts
- Returned to stock or again sold or dispensed a drug previously sold or dispensed and delivered
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Ms. Sherk's plea of professional misconduct, the facts of which were set out in an Agreed Statement of Facts and formed the basis of her plea.

#### **Facts**

The College received a complaint alleging that Ms. Sherk administered injections to patients, improperly disposed of the used needles and returned prescription migraine medication to stock that had previously been sold or dispensed and delivered.

Ms. Sherk admitted that as a favour, she injected Depo-Provera into a pharmacy technician, a co-worker in the pharmacy at which she was employed. After doing so, she recapped the needle but disposed of the used needle into the regular garbage container, not a sharps container. At the end of the day another pharmacy technician who was collecting the garbage was pricked with the used needle when she threw the garbage bag over her shoulder.

Ms. Sherk further admitted that on two other occasions, as a customer service, she administered Hepatitis B injections into two patients. Ms. Sherk acknowledged that administering a substance by injection is a controlled act defined at s. 27 (2) (5) of the RHPA, *prima facie*, outside of the scope of practice of a pharmacist, and that her actions did not fall within any of the exceptions listed at s. 29 under the RHPA.

With respect to the returning to stock allegation, Ms.

Sherk had a valid prescription for Zomig rapid melt tablets. She admitted that she borrowed two tablets from the pharmacy and replaced them back into pharmacy stock with two tablets from her own home supply.

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

The Panel was of the view that Ms. Sherk's improper disposal of the used needle was a breach of standard protocol and disregard for others in the workplace, and is inexcusable. The Panel found Ms. Sherk's characterization of injecting a substance in a patient as a customer service to be ludicrous; furthermore that the inappropriateness of returning to stock previously dispensed medication needed no further comment. For these reasons the Panel wholeheartedly supported the remedial aspects of the proposed penalty and accepted the Joint Submission on Penalty.

#### **Order:**

1. A reprimand
2. Specified terms, conditions and limitations on Ms. Sherk's Certificate of Registration that she successfully complete, at her own expense, within 12 months, the following courses and evaluations:
  - a) the Jurisprudence seminar and evaluation (examination) offered by the College
  - b) Law Lesson 2 (The Regulation of Pharmacy Practice); Law Lesson 4 (Standards of Practice); and Law Lesson 7 (Professional Liability) offered by the Canadian Pharmacy Skills Program at the Leslie Dan Faculty of Pharmacy, University of Toronto
3. A suspension of Ms. Sherk's Certificate of Registration for a period of one month to be remitted on condition that she complete the remedial training described at paragraph 2 above

**CASE 5****Improper use of patient information belonging to another member and consequently, Dispensing without authorization****Member :** Joseph Salek, Toronto**Hearing Date:** December 21, 2005

Mr. Salek was found to have:

- failed to maintain a standard of practice of the profession
- failed to keep records as required respecting his patients
- falsified a record relating to his practice
- signed or issued in his professional capacity, a document that he knew to contain a false or misleading statement
- contravened the Pharmacy Act, Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or regulations under those Acts
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Mr. Salek's plea of professional misconduct, the facts of which were set out in an Agreed Statement of Facts as follows:

**Facts**

A member notified the College that he was closing his pharmacy, the space of which he leased from a physician; and that he intended to transfer all pharmacy records and inventory to another pharmacy which he owned. Shortly thereafter Mr. Salek obtained a Certificate of Accreditation for a new pharmacy in the location vacated by the other pharmacist.

The College inspector conducted an inspection of Mr. Salek's newly accredited pharmacy and discovered irregularities in prescription records. The resulting investigation revealed that Mr. Salek was using patient information that pre-dated the accreditation of his pharmacy; specifically:

- in 40 instances, Mr. Salek created patient records that relied on and used information copied from prescription records belonging to the previous pharmacy
- in 11 instances of the 40 above, refill medication was dispensed without authorization, in reliance upon prescription information from the patient records of the previous pharmacy
- in four instances, receipts were issued to patients for transactions occurring on dates predating the date of accreditation of Mr. Salek's pharmacy

Mr. Salek admitted that upon occupation of his new pharmacy, the physician provided him with a computer disk that contained patient and prescription information belonging to the member who previously occupied a pharmacy in the same space. In particular, he acknowledged that:

- He failed to take any steps to verify that the computer disk containing the previous pharmacy's patient records had been provided to him with the knowledge and consent of the designated manager/owner of that pharmacy. Instead, he accepted the information without question, had it re-formatted to be compatible with his own computer system, and used the information for the benefit of his pharmacy.
- He failed to take any steps to verify the accuracy or completeness of the information contained on the computer disk before he used and relied on the patient information contained therein
- He improperly used the previous pharmacy's proprietary information to fill, dispense, and bill for prescriptions without authorization, to create patient records at

his pharmacy, and to issue receipts


- He failed to keep records as required, and instead relied on improperly obtained and unverified information
- He failed to recognize the patient harm that could occur in that a patient could present for a refill of the same prescription at both his pharmacy and the previous pharmacist's other pharmacy (as the previous pharmacy's records had been transferred to another pharmacy as well), potentially obtaining double the authorized amount of medication

Mr. Salek also explained however, that on being notified by the College that the disk had been misappropriated, he took timely steps to have the misappropriated records purged from his computer system.

#### **Reasons and Joint Submission on Penalty**

The parties agreed to a penalty which was presented to the Panel by way of a Joint Submission on Penalty. Of concern to the Panel was Mr. Salek's apparent disregard for the recordkeeping obligations imposed on pharmacists and, based on his prior finding of professional misconduct, an emerging pattern of disregard for the administrative aspects of the profession. The prior finding dealt with Mr. Salek's failure to sign prescriptions and labelling errors. Moreover, the Panel was distressed by the fact that, ethically, Mr. Salek did not appear to have realized or been aware at the outset that the misappropriation of someone else's proprietary information and the disclosure of patient's personal and confidential information was inappropriate. The Panel recognized however, that once it was brought to his attention, Mr. Salek did act appropriately. Given the above noted shortfalls in Mr. Salek's practice, the Panel fully supported the variety and extent of the remedial aspects of the proposed penalty and made the following Order.

#### **Order:**

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Salek's Certificate of Registration and, in particular, that he complete successfully, at his own expense, within 12 months, remedial training as follows:
  - i) the Pharmaceutical Jurisprudence Examination of the College
  - ii) the following courses and evaluations in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
    - (1) Law Lesson 2 – The Regulation of Pharmacy Practice
    - (2) Law Lesson 4 – Standards of Practice
    - (3) Law Lesson 7 – Professional Liability
3. A suspension of Mr. Salek's Certificate of Registration for a period of three months, with two months of the suspension to be remitted on condition that he complete the remedial training program specified in paragraph 2 above
4. Costs to the College in the amount of \$8,000 

# Non-Supervision of Pharmacies

Anne Resnick, R.Ph., B.Sc.Phm  
Associate Director,  
Professional Practice Programs

Claudia Skolnik, LL.B., LL.M  
Manager, Investigations & Resolutions

This edition of *Pharmacy Connection* reports on three recent decisions of the Discipline Committee in which the issue of non-supervision of a pharmacy was examined (see page 29). Through these decisions, the Committee has sent a strong message to all pharmacists that pharmacies must be physically supervised by pharmacists at all times, for reasons of both patient safety and regulation. These cases serve as a useful reminder of the sections of the Drug and Pharmacies Regulation Act which address supervision requirements, as well as the Standards of Practice for both Pharmacists and Managers.

## THE DRUG AND PHARMACIES REGULATION ACT (DPRA)

Section 146(1) of the DPRA states that “No person shall operate a pharmacy unless... it is under the supervision of a pharmacist who is physically present...” Section 149(1) says that “...no person other than a pharmacist or an intern or a registered pharmacy student acting under the supervision of a pharmacist who is physically present shall compound, dispense or sell any drug in a pharmacy.”

These sections very clearly pro-

hibit a non-pharmacist (e.g. a pharmacy technician) from operating a pharmacy or dispensing a drug in a pharmacy, so it is obviously professional misconduct on the part of any registered pharmacist who allows this to occur. In some cases, the fault may lie with the owner or the Designated Manager (DM) of the pharmacy, but in others, it may be the dispensing pharmacist who has left the pharmacy without closing it or ensuring that no pharmacy operations will take place in his or her absence.

## STANDARDS OF PRACTICE

The Standards of Practice for Managers states that the DM shall ensure that “a licensed pharmacist is on duty during all hours of operation.” In addition, the Standards of Practice for all pharmacists includes several provisions relevant to the pharmacist’s responsibility to ensure appropriate supervision of a pharmacy; specifically,

**Standard 2** “The pharmacist practises within legal requirements


**Standard 5.2.3** “The pharmacist ensures that all personnel know... that only a pharmacist, intern, or registered pharmacy student under the direct supervision of the pharmacist may provide information or advice respecting the use of non-prescription products...”

**Standard 6.3** “The pharmacist or the pharmacist in collaboration with

pharmacy management takes reasonable steps to maintain adequate and appropriate staffing to ensure that pharmacy practice is in accordance with these Standards.”

You will note that Standard 5.2.3, arguably, goes even further than does the legislation in prohibiting non-pharmacists from counselling on the use of non-prescription products.

## LOCK AND LEAVE PROCEDURES

When the pharmacy is located within a larger retail operation, it is the entire larger operation that is accredited as a pharmacy. However, s.78 of Regulation 551 under the DPRA makes provision for the larger operation to remain open while the dispensary proper is closed. It states, “The parts of a pharmacy in which prescriptions are compounded and dispensed for the public or drugs are stored or sold by retail shall be so constructed that they may be locked and made not accessible to the public in the absence of a pharmacist.” The College has developed guidelines for proper lock and leave construction. As one of the reported cases demonstrates, inadequate makeshift attempts to block the aisles of the pharmacy area are not acceptable. (See the “Practice Q&A” section of the July/August 2003 *Pharmacy Connection*.) 

# FOCUS ON Error Prevention

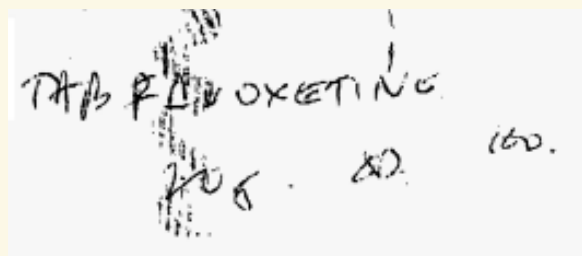
Ian Stewart, R.Ph., B.Sc.Pharm.  
Practising Community Pharmacist in Toronto

## Use of facsimile (fax) technology

The use of facsimile (fax) technology by prescribers to transmit new prescriptions to a pharmacy is now commonplace in practice. A pharmacist can receive any type of prescription from a prescriber by fax, including a straight narcotic or controlled drug (see OCP Policy on Faxed Prescriptions (June 1999).

Faxed prescriptions retain most of the characteristics of written prescriptions, and avoid some of the problems associated with verbal prescriptions. However, distortions and/or markings that may appear on faxed prescriptions can contribute to the misinterpretation of the prescriber's handwriting or printed text and consequent confusion or error as to the medication intended.

### CASE



The above is from a prescription faxed to a community pharmacy for filling. The prescription was interpreted and processed as paroxetine 20mg once daily. The pharmacist began to counsel the patient on paroxetine. However, the patient indicated that he had expected a repeat of the Prozac® capsules that he was currently taking.

Upon contacting the physician's office for verification, the pharmacist learned that the prescriber's intent was to give the patient fluoxetine and not paroxetine.

Possible factors contributing to the confusion regarding this prescription were:

1. The quality of the printed fax was poor.
2. The written prescription was not clearly legible.
3. "Fluoxetine" and "paroxetine" can look alike when poorly written.
4. In error, the physician wrote "TAB" to indicate tablets, while fluoxetine is available in capsules.
5. Both drugs are available in 20mg oral dosage form.
6. Both drugs are usually taken once daily.
7. The patient was new to the pharmacy; therefore, a medication history was not readily available.

### RECOMMENDATIONS

1. Examine all faxed prescriptions carefully. Look for lines, streaks, and other marks which could lead to the misinterpretation of what medication the prescriber intended.
2. When contacting the physician's office to confirm the source of the fax, use the opportunity to likewise confirm the prescriber's intent, if it is unclear.
3. Ensure routine maintenance of the pharmacy's fax machine to prevent or eliminate lines, marks, etc.
4. Be aware of pairs of drugs that look alike and/or sound alike, since such similarities can be a contributing factor in the dispensing of the incorrect drug. An extensive list of similar pairs can be found at <http://www.usp.org/patientSafety/newsletters/qualityReview/qr762001-03-01.html>.
5. When dispensing a look-alike drug, double-check the prescription to confirm that you have correctly interpreted the prescriber's intent. ☒

# ARE YOU DISPLAYING YOUR POINT OF CARE?





If you are interested in including the Point of Care symbol into your permanent pharmacy signage or on your pharmacy's website, please contact the Communications Department at 416-962-4861 or send us an e-mail at [webmaster@ocpinfo.com](mailto:webmaster@ocpinfo.com). You may also go online at [www.ocpinfo.com](http://www.ocpinfo.com) and select "Point of Care" to view the graphic usage standards.

# C E 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

May 12-13, 2006

### OPA Conference

Toronto, ON

contact: Mary-Anne Cedrone

tel: 416-441-0788 ext 4266

email: [mcedrone@opatoday.com](mailto:mcedrone@opatoday.com)

March 24 – 26, 2006

### Certified Geriatric Pharmacist Preparation Course (Part II)

Toronto, ON

contact: Penny Young

tel: 416-385-2440 ext 2209

email:

[pyoung@ontpharmacists.on.ca](mailto:pyoung@ontpharmacists.on.ca)

## ONTARIO

March 9, 2006, Haliburton, ON

March 22, 2006, Bracebridge, ON

March 27, 2006, Belleville, ON

March 29, 2006, Fort Erie, ON

### Guide Your Patients to a Smoke Free Future

contact: Sherrie Hertz

tel: 416-441-0788 ext 4232

email: [shertz@opatoday.com](mailto:shertz@opatoday.com)

## CANADA

June 3 – 6, 2006

### CPhA Conference

Edmonton, AB

[www.pharmacists.ca](http://www.pharmacists.ca)

## INTERNATIONAL

March 17-26, 2006

### American Pharmacists Association Meeting & Exposition

San Francisco, CA

web: [www.aphameeting.org](http://www.aphameeting.org)

tel: 1-800-237-2742, ext. 325

email: [aphameeting@aphanet.org](mailto:aphameeting@aphanet.org)

## BULLETIN BOARD

**Lori Sheppard** joined the College as the Administrative Assistant for the Continuing Competency Program area. Lori has a strong administrative background, recently supporting the Executive Director for a consulting organization who provided psychometric reporting for vocational rehabilitation agencies.

**Nadia Sutcliffe** joined the College as our newest inspector in the Professional Practice Program area. Nadia has 13 years of experience with Pharma Plus, having held positions of Staff Pharmacist, Pharmacy Manager and Pharmacy Development Co-ordinator.

**Nora MacLeod-Glover**, Manager, Continuing Competency Programs commenced the University of Toronto's PharmD program this fall. In order to be able to dedicate the time and energy required to complete this program, Nora has stepped down from her role as Manager but has been retained on a part time contract basis to provide support to the area during this time of transition.



**Sandra Winkelbauer** has been hired as the newest member of the College's management team in the role of Manager, Continuing Competency Programs. Sandra has experience in both the hospital and community settings and comes to us from the Ontario Pharmacists' Association where she held the position of Drug Information Pharmacist in the Drug Information and Research Centre, and was the Director of Education for the last 5 years.

The College is pleased to announce that **Susan James** will be joining us in April as Project Director, Pharmacy Technicians. Working with the existing management group, Susan will be responsible for directing the activities associated with the regulation of Pharmacy Technicians. Susan is an Occupational Therapist by training and spent many years in clinical practice before joining the College of Occupational Therapists in 2000 and has been their Deputy Registrar since August of 2001.

# O C P M A N U A L - April 2006

Each issue of *Pharmacy Connection* includes an up-to-date summary of all current *OCP Manual* items in the table shown. 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 2004

Regulations to the DPRA:

- DPRA R.R.O. 1990, Regulation 545 – Child Resistant Packages
- DPRA R.R.O. 1990, Regulation 547 Amended to O.Reg. 548/93 – Dentistry
- 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 - May 2005 OCP

Canada's National Drug Scheduling System – January 31, 2006 NAPRA (or later)

## Regulated Health Professions Act (RHPA) \*

Amended 2004

Regulations to the RHPA:

- Ontario Regulation 39/02 -Certificates of Authorization
- 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 1998

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 ▲

New Standards of Practice, January 1, 2003 OCP

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

Amended 2004

Regulations to the DIDFA:

- R.R.O. 1990 Regulation 935 Amended to O.Reg. 644/05 – General
- R.R.O. 1990 Regulation 936 Amended to O.Reg. 205/96 – Notice to Patients

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

Amended 2004

Regulations to the ODBA:

- Ontario Regulation 201/96 Amended to O.Reg. 645/05 – General
- Ontario Regulation 150/05 Personal Information

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

Updated Health Canada Version as of Dec. 31, 2003

Amendment 1329 - Schedule F - 19 May, 2004; Registration: SOR/2004-108, Canada Gazette II

Amendment 1398 - Addition of colouring agent to paragraph C.01.040.2(4)(a), April 5, 2005; Registration: SOR/2005-95, Canada Gazette II April 25, 2005

Amendment 1272 - Levonorgestrel, April 19, 2005; Registration: SOR/2005-105, Canada Gazette II May 4, 2005

Amendment 1402 - Access to Medicines, June 1, 2005; SOR/2005-141 Food and Drugs Regulations; SOR/2005 Medical Devices Regulations

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

Updated NAPRA version as of October 25, 2000

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

All regulations updated as per NAPRA February, 2005

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 NAPRA Version as of February, 2005

## OCP By-Laws By-Law No. 1 – December 2005 ▲

Schedule A - Code of Ethics, May 1996

Schedule B - Conflict of Interest Guidelines for Members of Council and Committees - Oct 1994

Schedule C - Member Fees - Jan 1, 2006

Schedule D - Pharmacy Fees - Jan. 1, 2006

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, October 2005

Structure and Function of Pharmacy in Ontario

\* 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)

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