

Pharmacy Connection



Official Publication of the Ontario College of Pharmacists

May/June 2003

Are you making the most of

Schedule II Drugs?

INSIDE:

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Practice Reviewp. 16**

**Self-Perceived Learning Needs
and Experiencesp. 18**

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- Communications
- Standards of Practice Working Group
- Structured Practical Training
- Task Force on Primary Health Care Reform
- Working Group on Certification Examination for Pharmacy Technicians
- Working Group on Pharmacy Technicians



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.

MEMBER EMERITUS

It is fee renewal time and some of you may be questioning if you really need to maintain your practice license given how you spend your time. If you are retired or working in a position removed from pharmacy practice with no intention of ever practicing again, but wish to stay connected with the profession you contributed to for many years, you may be interested in knowing about the College's Member Emeritus Roll.

Members who have been on OCP's Register for 25 years or more, are in good standing and who voluntarily resign their membership are entitled to become a Member Emeritus. On the Member Emeritus Roll, you have no practice privileges, you pay no fees, but you will continue to receive Pharmacy Connection and other select member

notifications from the College. You will also receive a certificate indicating your status as a Member Emeritus with the College.



If you meet the criteria for emeritus membership, please return your fee form noting that you wish to resign your active practice license and indicate that you wish to become a Member Emeritus.



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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.

EDITOR'S MESSAGE



Della Croteau
Deputy Registrar/Director of Programs

These are very interesting times for pharmacy as governments consider primary health care models. Yet health policy decision-makers continue to overlook the valuable role that pharmacists play in providing first-line therapy in the community. Why have we been over-

The Standards of Practice Working Group urges pharmacists to provide appropriate pharmaceutical care to every patient based on their needs and medical conditions — not based on where the drug is kept or displayed in the pharmacy.

looked? Doesn't the public fully understand the valuable role that pharmacists play? Doesn't the public also know that, along with counselling and prescription drug therapy monitoring, pharmacists can also assist them with many self-limiting conditions that are best treated with drugs from Schedule II and III?

A more basic question is: Does the public appreciate why certain drugs are available over-the-counter

and others behind-the-counter?

This *Connection* contains an article from Leslie Braden, our past president and current chair of the Standards of Practice Working Group. In it, Ms. Braden urges you to exercise their full scope of practice for Schedule II and Schedule III products.

Why is that, although it was previously important for patients to receive counselling when Ibuprofen 400mg was a prescription drug, pharmacists feel there is less need to ensure their patients receive counselling now that the drug is listed in Schedule III?

Pharmacists help many patients with minor ailments and pains, as well as triaging and counselling those with more serious complaints to see other health care providers. But why do we think that this is not worth documenting?

Many patients who come to a pharmacy for first-line therapy have

not yet been seen by a physician, and will rely on our advice and counselling. As a result, we need to learn to keep better records which includes consistently recording the times when we assess patients and provide advice on which products will best treat their symptoms. We also need to note whenever we advise patients to avoid certain over-the-counter medications, and whenever we refer patients to other services/resources.

As a consumer I know that most retail and service sector businesses that I frequent have records of my purchase habits and activities. My video store documents every video I rent, my sporting store knows what make and size sneakers I purchase and my sports club knows how often I work out. So, why doesn't my pharmacy have a record of the cough syrup they recommended that worked so well for me, or a record of the multi-vitamins I always purchase from them? Why doesn't my pharmacist have such a record so that I can buy the same product when I come down with another cold six months later?

Perhaps the reason is that the public and decision-makers do not recognize pharmacists as primary health care providers. Perhaps the reason is that we focus on patient-interactions with Schedules II and III as *commodity sales with a customer* and not as *pharmaceutical care events with a patient*.

As the role of the pharmacist as primary health care provider is reviewed, and as we propose a possible expanded scope of practice for pharmacists, let's make sure that we all have the fundamental foundations of practice solidly in place.

Let's make sure that the public is receiving the full benefit of our knowledge and expertise, not just for Schedule I drugs but for Schedule II and III products as well. 📧

Letter to College Staff and Editor:

Thank you for informing me about the resolution of my complaint.

I would like to thank the College for the active consideration it has given to my claim. I am very satisfied with the way the College has handled this and with its conclusion.

I'm sure that the College also understands that this complaint was not brought before the College solely for myself. What I was more concerned about is that senior citizens residing near where I live must have experienced the same.

Again, I am very satisfied with the serious attention the College has given to this matter and to upholding integrity.

Yours Very Truly,

A. Brandl, Mississauga



IMPORTANT SPT NOTICE

Canadian and US Graduate Interns:

Please note that some changes have been recently made to the Structured Practical Training Program for Canadian and US graduate Interns, effective May 1, 2003.

The SPT Program *assessment process* has been slightly revised. One of the previous formal assessments will now be replaced with the shorter one-page *Target Objective Conference* form (TOC).

This decision was made as a response to preceptor feedback that sought the College to decrease the amount of paperwork expected from preceptors. The *SPT Activities* have also been edited to clarify what preceptors and interns are required to submit to the College.

Please review the *2003 SPT Internship Manual* for more information.

Note: Similar changes will be made to the SPT assessment process for international pharmacy graduate students and interns in the near future.



OCP COUNCIL REPORT

MARCH 2003

MEMORANDUM OF UNDERSTANDING WITH QUEBEC

A Memorandum of Understanding (MOU) with Quebec has been approved by Council to enhance the mobility of pharmacists between Ontario and Quebec. This agreement will allow pharmacists who have graduated from a *Canadian Council for Accreditation of Pharmacy Programs* (CCAPP) accredited school of pharmacy within the last five years to move more easily between jurisdictions. The details of the agreement will be provided in an upcoming issue of *Pharmacy Connection*, once the MOU has been finalized.

STRATEGIC PLANNING RETREAT

As part of the March Council meeting, held March 23-25, Council participated in a facilitated planning session to set the strategic directions for the College over the next three to five years. In developing the strategic plan, Council members focused on five key questions: 1) How can the College, through effective regulation, address the impact of technology on pharmacy practice?; 2) How can we enhance/communicate the value of pharmacists in a changing healthcare environment?; 3) How can we ensure the best use of pharmacy human resources in Ontario?; 4) How should we deal with scope of practice issues in pharmacy?; and 5) How can we effectively meet our core mandate of enforcing self-regulation within available resources?

These questions led to the formulation of five strategic directions including rationales and goals which will be incorporated into a framework, setting out the strategic directions for the College over the next three to five years. A formal report on the retreat is being finalized for Council's consideration and final approval at

its next meeting in June. The strategic directions will be printed in an upcoming issue.

CONFERENCE OF THE ONTARIO PHARMACISTS' ASSOCIATION SPONSORSHIP


Council has agreed with the Executive Committee's recommendation that the College provide financial support for an educational session at the annual *Conference of the Ontario Pharmacists' Association* that was held May 2-3, 2003. Council noted that the College has traditionally sponsored an educational session at the conference and agreed that this year, a grant of \$1,500 will be provided to sponsor the session entitled "*Drug Dependence – Prescription and OTCs*" by L. Nicky Corkum, B.Sc Phm.

SECURITY PROCEDURES AT THE COLLEGE

In keeping with security measures implemented at other health regulatory colleges in Ontario, Council has endorsed an Executive Committee recommendation that College management take steps to review security procedures at the College and that they be revised as appropriate. While

every effort will be made to continue the “open door” policy that has always been at the College, visitors to the College can expect some changes with respect to sign-in/visitor identification procedures in the upcoming months.

**COUNCIL APPROVED
AUDITED STATEMENTS FOR
COLLEGE OPERATIONS IN
2002 AS PREPARED BY
GRANT THORNTON
CHARTERED
ACCOUNTANTS**

The *Statement of Operations* for the period ending December 31, 2002 reflects a deficit of revenue over expenditure, prior to depreciation, of \$63,156 as compared with a budgeted surplus of \$54,357. This small deficit was achieved despite approximately \$500,000 being spent for additional discipline costs and for the prosecution of the Canadian Drugstore Inc. for holding themselves out as a pharmacy. The overruns in these two expense areas were known early in the fiscal year and the efforts of Council, Committees and staff to contain costs as much as possible in other areas are credited for keeping the deficit small. 

STATEMENT OF OPERATIONS - YEAR ENDING DECEMBER 31, 2003

	BUDGET <i>Un-audited</i>	ACTUAL
Revenue		
Pharmacist Fees	4,216,282	4,297,717
Pharmacy Fees	1,561,480	1,614,080
Registration Fees and Income	381,460	332,346
Investment	100,000	73,782
Sundry	169,500	223,699
	6,428,722	6,541,624
Expenses		
Council & Committees	1,535,600	1,743,301
College Administration	4,702,790	4,800,944
Property, net	102,975	41,371
Niagara Apothecary, net	33,000	19,164
	6,374,365	6,604,780
Excess (deficiency) of revenue over expenditure from operations, before depreciation	54,357	(63,156)
Depreciation expense	328,000	398,039
Excess (deficiency) of revenue over expenditure	(273,643)	(461,195)



Schedule II

Making the Most of

We lost another one! Loperamide (Imodium®) moved to unscheduled status in the National Drug Schedule.

As of January 17th, 2003, Loperamide can be sold at any retail outlet.

As a pharmacist, how does that make you feel? How well do you counsel patients on Loperamide when they come into your pharmacy? Are you available to give them advice and answer their questions? Are you documenting the use of Loperamide and sending the patients for further assessment when warranted?

SCHEDULE II AND SCOPE OF PRACTICE

The *Standards of Practice Working Group*, in conjunction with a subgroup looking at the scope of practice, has been researching and exploring opportunities for an expanded role for pharmacists.



*Leslie Braden, B.Sc.Pharm.
Chair, Standards of Practice Working Group*

Schedule II Drugs

In their report to Council in March 2002, the Working Group brought forward several recommendations for expanding the scope of practice for pharmacists, but foremost in the report was the point that, along with expanding the scope of practice, we must also ensure that pharmacists are practicing optimally within the *current* scope.

At the same time, the Working Group identified Schedule II products as a category of drugs that pharmacists often ignore the rights and responsibilities that the schedule provides.

THE WORKING GROUP RECOMMENDED:

“In order to ensure consistent application of *Standards of Practice* of products in Schedule II, the Standards of Practice Working Group should develop a process for applying the

standards to Schedule II products, particularly when the product originally had status in Schedule I and requires more pharmacist intervention and counselling.”

The above recommendation was made in light of the numbers of medications which are either being removed from prescription status and put into Schedule II or III, or have even become unscheduled and can now be sold anywhere.

The Standards of Practice Working Group urges members to take their role seriously in assisting patients with drug therapy or medications in Schedules II and III. The *Standards* (see Operational Component 4.4 on page 10) emphasize the role of pharmacists in drug therapy—no matter which schedule the drug is listed. Patients often require more advice and counselling for

Making the Most of Schedule II Drugs

STANDARDS OF PRACTICE, 2003 EXCERPT

Schedule II and III products as they usually have not consulted another health care provider in these instances.

Pharmacists can provide vital information to patients needing medication for acute, self-limiting conditions such as diarrhea, headache, heartburn, coughs and colds and allergies. As the most accessible health care provider, the community pharmacist assesses patients every day and makes recommendations for safe medication use for symptomatic relief.

It is a standard of practice that as the pharmacist, you must be clearly identifiable and available, accessible and approachable to consult with a patient who seeks to self-medicate. You must take reasonable steps to enter into a dialogue with such a patient to assess their medication needs.

You also have an even greater opportunity to assure safe and effective use of Schedule II products such as Acetaminophen with Codeine 8 mg preparations, head lice products, pin worm treatments and high potency iron products. Schedule II products must be kept in an area that does not allow self-selection by the patient and it is a standard of practice that the pharmacist must always be involved in the decision to sell a Schedule II product.

How well are pharmacists conforming to the Standards for non-prescription products as well as making use of the opportunities for providing direct patient care that the Standards insist on?

We all remember the investigative journalism conducted some years ago when Terfenadine and Astemizole were made Schedule C (the historic equivalent of today's Schedule II) products. The journalists found that many pharmacists provided Astemizole and Terfenadine to patients without any of the required dialogue.

HOW WELL DO YOU COUNSEL PATIENTS ON SCHEDULE II DRUGS?

How do you handle Schedule II products in your practice now? How many times in your day is the "point and nod" method or "raised eyebrows from 20 feet" is your only interaction with a patient requesting a Schedule II product? For how many Schedule II products do you also provide your patient with written information to reinforce your counselling?

Operational Component 4.4

Nonprescription Drugs

The pharmacist takes reasonable steps to enter into a dialogue with the patient or agent and offers service, assistance or advice, if the patient:

- Requests help in selecting a Schedule II, III or other nonprescription product
- Appears to be having difficulty selecting a nonprescription product
- Is perceived or observed to make frequent or repeat purchases, or to purchase inappropriate quantities of nonprescription products
- Is recognized as someone for whom self-selection and use of a nonprescription product may pose a risk (such as pregnant or nursing women, the elderly, infants or young children, and those with known medical conditions or those currently on other drug therapy)
- In an institution, requests information and advice

4.4.1 When entering into dialogue, the pharmacist interacts with the patient or agent to receive and provide information needed.

4.4.2 The pharmacist interviews the patient or agent to determine and assess as appropriate to the request:

- Condition or symptom(s) to be treated
- Current, relevant disease state(s) drug allergies or sensitivities
- Current medications
- Other medications or treatments patient may have already tried
- The need for referral to another health professional, the appropriateness of drug therapy or the advisability of non-drug therapies

As part of the patient/pharmacist dialogue, the pharmacist consults and reviews the patient profile and ensures that it is updated as appropriate.

4.4.3 The pharmacist discusses with the patient any recommended drug therapy including, where appropriate:

- Directions for proper use
- Common adverse effects
- Expected response
- When to seek the attention of another health professional

4.4.4 Where it is deemed important for continuity of care of the patient, the pharmacist documents relevant information in a readily retrievable format, such as the patient's profile or health record.

Every time you exercise the “point and nod” to give your approval to sell a Schedule II medication, your patient is denied your valuable knowledge and judgement. Couldn't the corner gas station attendant provide the same level of care as your raised eyebrows from 20 feet? Is it any wonder that there is no public outcry as potent medications such as Loperamide slide into general public access?

The next time someone requests Tylenol® #1, take the reasonable required steps to dialogue with the patient. Assess their need for pain relief and provide alternative choices and appropriate treatments.

Ask yourself: Am I assessing for medication-induced headache? Do I have literature available to assist and educate my patients about medication-induced headaches? Do I feel it's appropriate to sell 200-tablet-size bottles of a Codeine-containing product to anyone who requests it? Have I considered whether a large-volume bottle might contribute to a patient's inappropriate or overuse of a medication? What is a reasonable quantity for occasional personal or family needs and for safe storage?

If your patient suffers frequent migraines, have they been assessed recently by a physician for preventative therapies? If patients ask frequently about relief for dental pain, have they been assessed by their dentist? Pharmacists are not only skilled and knowledgeable about advising patients about their medications, but are also able to assess whether the patient needs further assessment by another health care professional. This triage role is invaluable to the patient's overall care.

DOCUMENTATION IS INTEGRAL

Documenting your recommendations, along with the products used by your patients, is integral to overall therapy. You should be documenting the recommendations you make, as well as referrals to other health care providers, to ensure continuity of care for your regular patients.

Remember the *Standard of Practice* requiring you to “endeavour to enhance patient awareness of the benefits, limitations appropriate use

Are we as pharmacists doing any better with Schedule II medications now? On a surprise quiz, how many Schedule II products could you list? (See our Schedule Quiz on page 11)

and risks associated with nonprescription products.”

Also ensure that your staff know that only a pharmacist, intern or registered pharmacy student (under the direct supervision of a pharmacist) may provide information or advice on non-prescription medications, natural health products or complementary medications.

WORKING GROUP TO SET DOCUMENTATION GUIDELINES

The Standards of Practice Working Group recognizes that pharmacists have traditionally been documenting *prescription* information rather than *patient* information. The Working Group is currently working with the Professional Practice Committee to develop a set of guidelines that will assist pharmacists in further developing their documentation skills.


The Working Group sees many existing opportunities for pharmacists to evaluate and make recommendations on Schedule II and III products.

Furthermore, the College's Pharmacy Practice field inspectors report that pharmacists' application of the *Standards of Practice* for Schedule II products remains inconsistent.

The Working Group wants to stress that if we, as a profession, wish to advance our scope of practice, we need to maximize opportunities to deliver patient care within the scope that we currently have.

I challenge you to make Schedules II and III the first frontier for advancing

the scope of practice by fully applying all the standards in your practice.

If the Standards of Practice Working Group can assist you with implementing these standards in your pharmacy, let us know. If you have some success stories you can share with others, please let us know those too. If we as pharmacists wish to expand our role, it is important that we first ensure that we have solidly implemented the current standards for all patients — regardless of the category of medication they might need. 

PRACTICE

Q&A



Greg Ujiye, B.Sc.Pharm.
Manager, Pharmacy Practice Programs

Q What factors are used to place drugs in Schedule II?

The recommendations used to schedule drugs are based on a "cascading principle" from the highest (Schedule I) to the lowest risk (Unscheduled).

See: www.napra.ca/pdfs/drugsched/stds.pdf

"Factors" rather than "criteria" are considered to be more appropriate assessment tools as they are contingent, conditional and dependent. A process using factors allows judgment by reviewers to find the best fit and facilitate a re-evaluation process of scheduled drugs when new knowledge or practice experience emerge. The factors were initially adapted from established standards for prescription drugs, proposed guidelines for drugs monitored by pharmacists, and the World Health Organization's guidelines for non-prescription drugs. These were then modified through national consultation.

The decision to sell a Schedule II product must be made by the pharmacist.

The *Standards of Practice* should assist pharmacists in determining the appropriate level of professional intervention and advice necessary for the safe and effective use of these drugs

by consumers. Pharmacists should consider some or all of the factors listed below when intervening or assisting a patient in making a decision on a Schedule II drug.

Factors for Schedule II:

- 1. The initial need for a drug is normally identified by the practitioner, in addition, chronic, recurrent, or subsequent therapy MUST be monitored by the pharmacist.**

A prescription should not be required to obtain a drug if the patient can understand directions for continued use through the intervention of the pharmacist.

Therefore, the patient should have access to the drug for subsequent treatment and use following the first diagnosis and prescription by the practitioner. This collaborative approach enhances patient care.

- 2. The drug must be readily available under exceptional circumstances when a prescription is not practical.**

Such a drug might be required for a serious medical situation and the patient should have access to it to prevent a possible health emergency. An example of such an exceptional circumstance is availability of injectable epinephrine for anaphylactic reactions.

- 3. The drug is intended for administration in a health care setting or under direction of a health care professional, or is in an injectable dosage form and is not otherwise included in Schedule I.**

Examples include preoperative or diagnostic agents and products used for immunization or desensitization.

- 4. Evidence of abuse of the drug has been reported due to its inherent pharmacological action which has the potential for abuse.**

Monitoring by a health care professional is necessary.

- 5. The selection of the drug requires intervention by the pharmacist to confirm that an appropriate self-assessment has been made by the patient.**

Dosage form, for example, may be an important consideration.

- 6. Use of the drug may delay recognition or mask the symptoms of serious disease.**

Intervention by the pharmacist is necessary to ensure appropriate referral to the practitioner.

- 7. The drug may cause important adverse reactions (including allergies) or may interact with other drugs, foods, or disease states that cannot be adequately addressed through product labelling.**

Intervention by the pharmacist is necessary to assess patient risk to prevent such problems for an individual patient through interpretation and clarification of labelling.

- 8. Use of the drug requires reinforcement or an expansion of the directions for use, through pharmacist - patient dialogue.**

Such reinforcement and expansion may include the explanation of the use of a drug delivery system.


- 9. The drug is a new ingredient for self-medication and monitoring by the pharmacist and is necessary to facilitate observation and reporting of any unexpected event.**

- 10. The maximum labelled dosage directions exceed the generally accepted or usual limits for Schedule II status.**

Pharmacists should review and develop questions based on the factors to facilitate interventions on Schedule II products. The above, and factors for the other Schedules, can be found in the NAPRA website at: www.napra.ca.

Q Can I place unscheduled or Schedule III drugs in the Schedule II area to insure sales are under the control of a pharmacist?

Yes. Pharmacists have the responsibility for safe drug distribution and to ensure that drugs are not abused. A pharmacist can use their discretion to place drugs under their control for sale. The most common example is Gravol® which has been the subject of abuse over the years. Another example is pseudo-ephedrine, especially the long acting version. Depending on the demographics of a location and the potential for misuse, pharmacists have placed stricter controls by intervening on the sale of these products.

Reminder: Pharmacists should familiarize themselves with the *National Drug Schedules* on the NAPRA website and regularly print an updated list for their pharmacy. Many drugs have multiple schedules depending on the strength or dosage form and all staff should be familiar with these. 

INSPECTOR'S CORNER: DRUG SCHEDULES

Rose Fitzgerald, B.Sc.Pharm.

Pharmacy staff can verify drug schedules by referring to the NAPRA website: www.napra.org.

A list can be generated on-line and viewed at the pharmacy or printed-off periodically and filed in your OCP Manual.

In what schedule are the following drugs?

	Schedule		Schedule
1. Asaphen® (ASA) 80mg		28. Methadone powder	
2. Asaphen® (ASA) 81mg		29. Muro-128 (Sod. Chloride 5%) eye drops/oint.	
3. Bactroban® (mupirocin) oint.		30. Motrin® IB (ibuprofen) 200mg tabs	
4. Benylin® DM syrup 100 mL bottle		31. Motrin® IB Extra Strength (ibuprofen) 300 mg tabs	
5. Benylin® DM syrup 250 mL bottle		32. Motrin® IB Super Strength (ibuprofen) 400 mg tabs	
6. Betadine® (povidone 10%) vaginal gel		33. Motrin® (ibuprofen) 600 mg tabs	
7. Bonamine® (meclizine) 25mg tabs		34. Nicorette® (nicotine) 2mg gum	
8. Caladryl® cream		35. Nicorette® (nicotine) 4mg gum	
9. Calamine lotion with antihistamine		36. Nitrolingual® (nitroglycerin) spray	
10. Camphorated oil		37. Nix (permethrin) rinse	
11. Claritin® (loratadine) Adult		38. Neo Citran® DM (box of 10)	
12. Claritin® (loratadine) Pediatric		39. Neo Citran® DM (box of 20)	
13. Dermarest Plus® gel .		40. Norflex® (orphenadrine citrate) tabs	
14. DHEA		41. Norgesic® Forte (orphenadrine citrate, ASA, caffeine)	
15. Epi-Pen® (epinephrine) pre-filled syringes		42. Palmer's Skin Success® Fade (hydroquinone) cream	
16. Graval® (dimenhydrinate) injection		43. Prevnar® (pneumococcal vaccine)	
17. Graval® (dimenhydrinate) tablets		44. Potassium Permanganate	
18. Hepatitis A vaccine		45. Progesterone cream	
19. Hepatitis B vaccine (pediatric)		46. Orifer-F®	
20. Hepatitis B vaccine (adult)		47. Quinine	
21. Imodium® (loperamide) 2mg tabs		48. Selenium 200mcg tabs	
22. Insulin		49. Sudafed (pseudoephedrine) tabs	
23. Kava Kava		50. Syringes	
24. Kwellada (lindane) shampoo		51. Tylenol® with Codeine Elixir (8mg/5mL)	
25. Lustra-AF® (hydroquinone) cream		52. Varivax II® (varicella) vaccine	
26. Melatonin		53. Vaxigrip® (influenza) vaccine	
27. Menomune® (meningococcal vaccine)		54. Vitamin B 12 (cyanocobalamin) injection	

Please review answers on page 46

TECHNICIAN

Q&A



*Bernie Des Roches, Ph.D.
Manager, Continuing Education /
Pharmacy Technician Programs*

Q One of the pharmacy technicians recently participated in a technician recertification program at our facility.

The technician said that she was taught that the expiry date on a stock bottle of medication refers to the beginning and not the end of the month (i.e. if the expiry date is listed as May 2003, this would imply an expiry of May 1 rather May 31).

I always thought that the expiry date referred to the end of the month, and everyone that I've spoken to agrees. Are you able to clarify this issue?

The Food and Drug Act (FDA), Section C.01.001 defines "expiration date" as:

"Expiration Date" means the earlier of:

- (a)** *the date, expressed at minimum as a year and a month, up to and including which a drug maintains its labelled potency, purity and physical characteristics, and*
- (b)** *the date, expressed at minimum as a year and month, after which the manufacturer recommends that the drug not be used."*

The expiry date of a product fits into either (a) or (b) because the date in question may change if, for example, there is a need to reconstitute a drug - hence the expiry date changes as per the manufacturer's specifications. In both interpretations, the expiry date of the month is either "up to and including" or "after which".

In answer to the question then, based on the FDA definition, the expiry date of a product with the date expressed as month/year will be at the end of that month in the year stated. If we use the example in the question, it would be May 31, 2003. ☐

Pharmacy Technician and Certification Exam

The next sittings of the voluntary Pharmacy Technician Certification Examination are: Monday, October 20, 2003, Saturday, April 17, 2004, and Saturday, October 2, 2004.

Effective January 1, 2003 all fees processed by OCP were increased by 9% and as a result the current fees which apply to pharmacy technicians, including GST, are:

- a. Evaluation of pharmacy technician credentials: \$29.16
- b. Sitting the Pharmacy Technician Certification Examination: \$233.26
- c. Annual fee for Certified Pharmacy Technicians (due September 10th of each year): \$58.32

Volunteers Needed

Would you like to add your name to our list of volunteers to possibly sit on the various pharmacy technician working groups/committees at the College? Do you have story ideas for Pharmacy Connection? Would you like to enquire about continuing education activities?

Would you like to report an upcoming CE event for promoting in Pharmacy Connection and/or the College website?

Do you want to request accreditation for a CE event?

If so, contact Bernie DesRoches or Celia Powell at (416) 962-4861, x 249 or 251

fax: (416) 847-8281, or bdesroches@ocpinfo.com or cpowell@ocpinfo.com

Demystifying the Practice Review

Steve Balestrini, B.Sc.Pharm., Chair, Quality Assurance Committee
 Nora MacLeod-Glover, BSc. (Pharm), Manager, Continuing Competency Programs
 Dr. Anthony Marini, Ph.D., Education Consultant

While the College's Quality Assurance Program has been in place for five years we find many pharmacists remain anxious about the prospect of being selected to come to the College to participate in a practice review.

In an effort to remove some of the mystique and help reduce the anxiety associated with the Practice Review, following is an excerpt from the orientation session held at the start of every *Practice Review* session:

ORIENTATION

Pharmacists who participate in the Practice Review begin with a 30 minute orientation that provides insights into the day and the follow-up after the assessment.

LEARNING PORTFOLIO SHARING SESSION

Candidates participate in an hour-long

open discussion with College staff and their peers; sharing their experiences about their self-directed professional development. Candidates support each other by sharing suggestions on how to better use their learning portfolio to plan and record learning. There is no assessment component in this portion of the day.

CLINICAL KNOWLEDGE CASES

This is an open-book assessment. Candidates may use the references provided as well as their own references. The open-book format reflects a pharmacist's ability to access references during their work. The challenge of an open-book exam however comes from one's inherent desire to look up every question to ensure the accuracy of their answers. Therefore, similar to a pharmacist's regular work environment, time becomes a challenge and needs to be managed accordingly.

Candidates are provided two hours to complete 60 questions. The recommended approach is to do an initial read-through, then answer the questions that can be done without consulting the references.

References can then be used to help in answering the remaining questions.

STANDARDIZED PATIENT INTERVIEWS

Candidates rotate through five standardized patient interviews in offices set up to mimic private counselling rooms. Candidates are given 12 minutes for each patient interview.

At the 10 minute mark, a knock at the door provides a two-minute warning. The cases are created so that there is never a need to contact a physician; in fact you will not need to use the phone or a computer. All patient cases are presented to you as new to your practice. References are available for use if needed and each counselling room is supplied with a screened-off area to provide the pharmacist with privacy for reference review, if desired.


Also in the room is a peer assessor who observes the interaction between the pharmacist candidate and standardized patient. Using a case-specific checklist, they watch for and record important aspects of the interaction as they relate to gathering information, patient management and follow up, and the overall communication skills demonstrated.

WHEN WILL I GET MY RESULTS?

The statistical analysis of the results takes approximately six weeks. The Quality Assurance Committee then meets to review the results and subsequent to this, candidates are sent letters, along with a booklet outlining their personal performance results on each case. On average, candidates can expect to receive their package eight weeks after their practice review.

HOW CAN I PROVIDE FEEDBACK ON THE PRACTICE REVIEW AND ITS PROCESS?

Feedback is critical to the ongoing development of the Quality Assurance

Program. Each candidate is given a handbook in which they can record comments about each component of their Practice Review. Of particular interest is their assessment of the relevancy that each of the cases has to their every day practice. Candidates can also record their assessment of case complexity, effectiveness of the standardized patient (where relevant) and any additional comments. A feedback session at the Practice Review day's end also provides pharmacists with an additional opportunity for input. 



PRACTICE REVIEW SNAPSHOT

The Practice Review is held four times a year. Candidates participate in a 5-6 hour assessment which includes:

- An orientation session
- An educational and sharing session on continuous learning and the learning portfolio
- A written assessment of clinical knowledge consisting of 15 cases, each followed by four multiple choice questions
- Standardized patient scenarios consisting of five cases and a practice case
- A general feedback session at the end of the review process

Once the orientation is complete, three groups of five candidates move through the three core components of the Practice Review, gathering at the end of the session for a light meal and a feedback session.



*Bernie Des Roches, Ph.D.
Manager, Continuing Education/
Pharmacy Technician Programs*

Self-Perceived Learning

OVERVIEW OF 2002 RESPONSES

Your Survey input, combined with that from approximately 1,700 colleagues each year, serves as a valuable function in the education cycle as explained in this report.

The College started the second five-year cycle of its Quality Assurance Practice Review in 2002. All pharmacists in Part A of the Register once again become eligible for random selection to complete the *Self-Assessment Survey and Summary of Continuing Education Activities* (Survey). For most of you selected in 2002 it was a familiar process as you had completed a similar learning assessment form at some point in the last five years. Some new questions were added in 2002 and others were refined to provide a better opportunity for pharmacists to self-identify learning needs and enhance the value of sharing with others.

It is important to remind ourselves of the place the self-assessment holds in the logic of the QA Program. From the outset, the College's QA Program has been based on an educational approach with an end goal of ensuring that each pharmacist continuously meets the *Standards of Practice* established by our peers. The self-assessment reflects this philosophy and serves as both the member's and the College's way of assessing a

member's knowledge base and identifying future member learning needs.

The new QA process relies on you to maintain your own competence through whatever means works best for you; be it from practice experience, traditional CE (e.g., seminars, home-study programs), non-traditional learning activities (e.g. serving as a preceptor, public speaking) or any combination of these. And, while you work to identify and upgrade your knowledge or skills, the College is here to assist you with guidance, resources and advice.

This self-learning assessment phase of the QA process requires each selected member to submit a survey. The survey is based on the College's *Standards of Practice* and a self-assessment of clinical knowledge. Pharmacists continue to benefit from this exercise as it helps them focus and reflect on their acquired knowledge and identify new opportunities for learning.

Your survey input, combined with that from approximately 1,700 colleagues each year, serves as a valuable function in the education cycle as explained later in this report.

Needs and Experiences

Characteristics of Survey Respondents

In 2002, 1691 pharmacists submitted completed surveys. Having been randomly selected, the demographic profiles of the respondents accurately reflect that of the total pharmacist population in Part A of the Register.

Type of Practice

77% - Community pharmacies
17% - Hospital or long-term care facilities
6% - Other settings, e.g., government, association or unemployed

Employment Status

19% - Owners or directors
20% - Designated managers
53% - Staff pharmacists
7% - Other
1% - Unemployed

Qualifying degree

51% - Ontario
18% - Another province
25% - Another country
6% - U.S.

Graduation

63% - graduated more than 15 years ago

Registration

37% - registered with College more than 15 years ago

2002 Ranking of Comfort Level with the Standards of Practice

Data was gathered on the six *Standards*¹ approved by the College:

1. Practice pharmaceutical care
2. Assume ethical, legal and professional responsibilities
3. Access, retrieve, evaluate and disseminate relevant information
4. Communicate and educate effectively
5. Manage drug distribution
6. Apply practice management knowledge and skills
7. Clinical knowledge¹

ACCORDING TO ALL RESPONDENTS

For the seven categories, the mean comfort levels reported by the group ranked as follows (3.00 being the highest comfort level possible, 1.00 the lowest):

1. Drug distribution	2.45
2. Ethical, legal, professional responsibilities	2.37
3. Practice management	2.37
4. Pharmaceutical care	2.29
5. Communicate and educate	2.22
6. Clinical knowledge	2.16
7. Access, retrieve, evaluate, disseminate information	2.08

These results are very similar to those that have been gathered since 1996 (recognizing that the 12 standards originally surveyed were collapsed into six in 1999). It is encouraging that respondents generally report an increasing comfort level on all standards as the years progress.

In 1997 and 1998, means were as low as 1.81; compared to the lowest mean of 2.08 reported in 2002. These figures may reflect pharmacists' increased confidence in their ability to meet the standards as they gain experience in addressing them. This trend is particularly strong for *clinical knowledge*. We recognize, however, that the data still indicates a significant need for assistance with some standards. We will continue to address these needs.

For each standard reviewed in the survey, there are several associated competencies. For several of these competencies, a considerable number of pharmacists (arbitrarily selected as a response rate greater than 10%) indicated that they **would benefit** from assistance.

The competencies for which pharmacists indicated a need for more education include (abbreviated here due to space):

Pharmaceutical Care

- Identify, document, report an adverse drug reaction (13%)
- Evaluate and modify a plan of care (21%)
- Document and follow up on interventions (13%)

Ethical, Legal & Professional Responsibilities

- Knowledge of labour legislation (24%)
- Legal responsibilities in cases of suspected child abuse (15%)
- Legal responsibilities in cases of suspected abuse by a health professional (17%)
- Maintaining record of continuous learning activities (13%)

Access, Retrieve, Evaluate, Disseminate Information

- Communicate with other health professionals (31%)

Communicate and Educate

- Seek opportunities to develop partnerships with stakeholders in health care (39%)
- Develop/implement plans to overcome wellness barriers (27%)
- Identify educational needs of individuals or groups (19%)
- Select appropriate educational methods, resources etc. to meet learner's needs (19%)
- Assess whether learner's needs were met (17%)

Practice Management Knowledge and Skills

- Conduct performance appraisals of auxiliary personnel (14%)
- Explain and put into practice principles of inventory management (14%)

¹These six titles are as they appear in the *Self-Assessment Survey* form; some of the terminology differs from that used in the *Standards of Practice 2003* subsequently published in the November/December 2002 issue of *Pharmacy Connection*. For conciseness, "Clinical Knowledge" is used as a "seventh" category for assessment purposes only.

ACCORDING TO YEARS IN PRACTICE AND PLACE OF GRADUATION

Generally, those who graduated 15 or fewer years ago expressed a higher comfort level on the standards than do their more senior colleagues. For some, this represents a statistically significant difference.

In this group, there was also a generally higher comfort level on *Communicate and educate* and *Clinical knowledge*. On *Drug distribution* and *Practice management*, those who graduated more than 15 years ago expressed a higher comfort levels than more recent graduates. This is not surprising and is consistent with previous survey results.

Analysis of data based on place of graduation produces more interesting results if we compare the comfort levels of those who graduated in Canada and the U.S. with those of graduates from non-North American universities. Graduates of non-North American universities rated themselves as more comfortable on **all** standards than do graduates of North American universities. This is consistent with the pattern seen in previous surveys with the differences being statistically significant for *Pharmaceutical care*, *Communicate and educate*,

Access, retrieve and disseminate information, and *Clinical knowledge*. The reasons for these differences are not known.

ACCORDING TO PRACTICE SETTING

Past survey results, for pharmacists in community or hospital practice (including long-term care facilities) have shown both predictable and surprising variations in reported comfort levels.

Pharmacists in community practice express statistically significant higher comfort levels than their hospital-based colleagues on *Ethical, legal, professional responsibilities*, *Practice management*, and showed higher but not statistically significant comfort levels in *Clinical Knowledge*. Hospital pharmacists report slightly higher, but not statistically significant comfort levels for *Access, retrieve, disseminate information*, and *Communicate and educate*.²

COMFORT WITH CLINICAL KNOWLEDGE

In that clinical knowledge is the foundation of our professional role; we focused on respondents' self-assessment of learning needs on clinical topics in order to help in the development and access to relevant resources.

The survey presented a list of 82 topics for comment.

While not all topics are reported here, the complete results (by region) have been shared with provincial and national agencies involved in developing and disseminating educational resources. For example, we provided the Regional CE Coordinators with region-specific findings so that they can target programs to meet needs specific to pharmacists in their area (visit our website for a list of all CE coordinators.) We also provided provincial program developers and providers such as the Leslie Dan Faculty of Pharmacy, Ontario Pharmacists' Association, Canadian Society of Hospital Pharmacists (Ontario Branch) and drug manufacturers with data on province-wide trends.

The table on the following page highlights those topics for which there was the greatest **need** (determined from response "benefit from assistance") and **interest** (respondents' indication of top ten topics they would like to address first).

² Data was analyzed at a significance level of $p < 0.001$ to adjust for sample size and reduce error of finding a difference where none exists.

TEN TOP THERAPEUTIC TOPICS OF GREATEST/LEAST INTEREST AND NEED - 2002

GREATEST INTEREST/NEED			LEAST INTEREST/NEED		
Want to Address First	Benefit from Assistance		Least Desire to Address First	Most Comfortable on These Topics	
✓	✓	Adrenocortical dysfunction	✓	✓	Allergies/allergic rhinitis
✓	✓	AIDS		✓	Arthritis
	✓	Alzheimer's disease		✓	Asthma
✓	✓	Cancer chemotherapy	✓		Contraception
	✓	Drugs in pregnancy and lactation	✓	✓	Constipation/diarrhea
	✓	Herbal remedies	✓	✓	Cough/cold
✓		Infertility in women		✓	Diabetes
✓		Pancreatitis	✓		Eczema/dandruff/skin care
	✓	Parkinson's disease		✓	GERD
✓		Poisoning and overdose	✓		Hemorrhoids
✓	✓	Prostate cancer		✓	Hypertension
✓	✓	Renal diseases	✓	✓	Lice/scabies
	✓	Schizophrenia		✓	Osteoporosis
	✓	Total parenteral nutrition	✓		Otitis media
			✓		Urinary tract infections
			✓		Sunscreens

These results are consistent with those of our previous surveys. Changes were made to the 2002 Survey form to include more topics listed under different therapeutic/disease categories, thereby allowing for more specific identification of needs. The consistency in results over time also gives us confidence that the Survey is a valid, trustworthy instrument which is being completed in a reflective, honest way by respondents.

One notable change has occurred – diabetes was always identified as a topic of need for more resources; however respondents no longer ranked it as such in 2002. That the desire for more information on some topics still persists as a priority six years since the last cycle (e.g. AIDS, prostate cancer) points to an ongoing need to develop resources in these key areas. On the other hand, continuing education providers may wish to reconsider developing province-wide programs for right column items (asthma, diabetes) as these do not seem to be a priority for the majority of practitioners.

COMFORT WITH PROFESSIONAL & BUSINESS SKILLS

In the 2002 Survey, we added a new section to determine comfort levels in the following areas of professional and business skills: communication skills, compounding/sterile preparation, documentation, identifying drug-related problems, jurisprudence, management, patient interview skills, presentation skills, and sales and marketing skills. Only during the last two has there been a significant indication that respondents felt they would benefit from assistance, namely in presentation skills (20%) and sales and marketing (25%).

Summary of Continuing Education Activities

As stated in the preamble, the data collected from the record of continuing education activities from such a large number of pharmacists provides us with an opportunity to gain insights into the ways in which you learn, the possible frustrations you encounter in locating suitable resources and the focus of your learning needs.

The following results will provide you with insights into the content and experiences of your colleagues' records of learning activities over the previous year. In requesting input, we used the College's *Professional Profile and Learning Portfolio* as the basis for entering data from the survey.

LEARNING OBJECTIVES

Respondents were asked to indicate the total number of learning objectives they had listed in their portfolio and the percentage of these objectives that they were able to achieve. Approximately 70% had listed three or more learning objectives they hoped to achieve (50% had listed 3-6 objectives). The significant majority (72%) achieved at least half of the objectives they set for themselves and 32% achieved 75-100% of their objectives. These figures are generally slightly lower than those reported in previous years. This also reflects a pattern of gradual decrease in objectives being achieved.

LEARNING ACTIVITIES

The College's model *portfolio* provides space for you to record individual learning activities - those for which you have identified learning needs, and the resources that you need to address them. Typically, learning needs arise during the course of daily practice, in response to a challenging patient problem or a complex request for information from a medical practitioner.

The *portfolio* also has a section to record structured CE activities, (e.g., seminars, workshops, conferences, and home study programs) where learning needs have been identified by someone else, such as a conference planning committee or lesson author.



INDIVIDUAL LEARNING ACTIVITIES

Almost 60% of the respondents identified six or more individual learning activities they had addressed in the previous year. There has been a slight increase in pharmacists (35% in 2001 to 37% in 2002) reporting that they had completed 1-5 individual learning activities.

About 52% of the respondents spent 16 or more hours during the year pursuing individual learning activities, while 24% spent more than 30 hours. (This is similar to past results.) One of the most significant outcomes that can arise from learning activities is a decision to change one's practice. In 2002 as in 2000, over 80% found at least one learning activity in the previous year caused them to make such a change.

The Self Assessment gives you an opportunity to evaluate yourself against our profession's practice standards

At the *Portfolio Sharing Sessions*, held as part of the Practice Review, we encourage pharmacists to be selective in terms of what they record as learning activities. You learn, with experience, to record only those activities which are significant, to which you may wish to refer at a later date, or to document as part of building your learning portfolio. This is a maturation process and the statistics indicate that this appears to be taking place.

STRUCTURED CE ACTIVITIES

As in the past, over 95% of the respondents report participation in at least one structured CE activity over the previous year, while 42% reported attending 1-5 such activities. The proportion of pharmacists spending 21 or more hours in structured CE activities (39%) is down from figures for previous years. The proportion who found that these activities prompted them to consider making a change to their practice (81%) is also down from previous years.

The most popular structured CE activity continues to be the live program formats with 92% of the respondents indicating seminars, workshops and conferences. The proportion who attended five or more such events is down 3% to 37% in 2002.

There are slight differences in other formats as well: participation in correspondence courses is down slightly to 50%, as is the number of pharmacists completing five or more courses (15%). There are similar patterns for use of video/audio programs, and participation in journal clubs/hospital rounds. Pharmacists continue to comment on how much busier they are in the workplace and this likely impacts on their available time to pursue learning endeavours.

CHALLENGES TO LEARNING: ACCESSING RESOURCES

Respondents were asked to identify which of the six standards challenged them most in terms of finding suitable learning resources. (Not having asked respondents to indicate reasons for their response, the assumption is that they could not find suitable resources they could access, regardless of their preferred learning methods.)

Documentation heads the list in the following comparisons. It is interesting to note the large increases in access need for the last three categories.

	2000	2001
Documentation	21.0%	18.3%
Technical competencies	20.7%	17.7%
Jurisprudence	13.1%	9.9%
Communication skills	9.1%	8.6%
Pharmaceutical care	6.9%	9.5%
Disease conditions	2.7%	13.0%
Drug therapy	2.6%	7.4%

LEARNING RESOURCE PREFERENCES

How do pharmacists prefer to learn?


- Live 80%
- Home study 63%
- Internet 61%
- CD ROM 57%
- Audio/videotapes 45%
- Videoconferencing 23%

Further analysis of the most popular method indicates that pharmacists prefer short live programs, (e.g. two-hour evening presentation (88%)) with progressively decreasing interest as programs get longer. For example, 69% prefer a one-day program on varied topics, 26% prefer a two/three-day program on varied topics, and only 14% prefer a program that is longer.

In this age of technology, a growing number of pharmacists are interested in Internet learning but may be frustrated by the shortage of such programs in areas of particular need. Those who develop such programs will likely only respond once they see a large enough potential market. In Ontario, it appears that market is growing. Almost 54% of pharmacists surveyed in 2002 indicated that they have Internet access (46% from home, 8% from work and 38% from both). Additionally 50% have high-speed access and 84% have sound on their computers.

SUMMARY

The value of data from the *Self-Assessment Survey and Summary of Continuing Education Activities* continues to be enhanced as pharmacists, like yourself, see that you are not judged on your survey responses and that you can be open and honest in your self-evaluation. As well as providing us with provincial data on the CE needs identified by pharmacists, this also gives you an opportunity to evaluate yourself against our profession's practice standards.

Indeed, as you become more comfortable and take charge of your personal learning, you will come to appreciate the value of the *Survey* and the *Portfolio* as tools to help you identify and address these needs and reflect on your progress. 

Career Fair for International Pharmacy Graduates

Zubin Austin, Assistant Professor
Leslie Dan Faculty of Pharmacy, University of Toronto

OUR FIRST "CAREER FAIR" FOR INTERNATIONAL PHARMACY GRADUATES WAS HELD ON FEBRUARY 5

International Pharmacy Graduate Program



Organized by the International Pharmacy Graduate Program, the Canadian Association of Chain Stores (CACDS), and the Ontario College of Pharmacists, this event was held for employers and international pharmacy graduates to meet and to facilitate the process for students to find placements for studentship, internship or other positions. Sponsored by the CACDS, the event attracted many employers and close to 200 international pharmacy graduates who are at various stages in the licensure process.


In addition to booths set up by employers, and the opportunity to speak with recruiters from a variety of pharmacy organizations, several speakers described elements of education, registration and employment that are important to international pharmacy graduates.

Chris Schillemore, Manager of Registration Programs at the College spoke about the licensure process in Ontario, highlighting the importance of structured practical training as a means to acquire the knowledge and skills necessary to provide effective patient care. I spoke about the IPG Program and how it was created out of a partnership between the College and the Faculty, with funding provided by the Ministry of Training, Colleges and Universities' Access to Professions and Trades

Unit. Finally, Christina Bisanz, Executive Director of the Canadian Association of Chain Drug Stores, spoke about the importance of well-qualified pharmacists to the health care system, and the ways in which students could best market themselves and their skills to employers.


Feedback from the attendees was positive. Most appreciated the opportunity to meet many potential employers in one place. Employers were impressed with the motivation, enthusiasm and professionalism of the international pharmacy graduates in attendance. Perhaps most importantly, many of the international pharmacy graduates were able to meet colleagues who are at different stages of the licensure process. As moving to another country and trying to get licensed as a pharmacist is both a very stressful and anxiety provoking process, the peer support among international pharmacy graduates is particularly important.

IPG Program staff were also in attendance providing information about the program and assisting individuals in understanding the educational, training, and regulatory requirements for licensure as a pharmacist in Ontario.

The event was very well received, and most attendees believed it helped them in working to secure employment for the future. Special thanks to Deb Saltmarche, Kris Wichman, Sharon Marjadsingh and Chris Schillemore for organizing this event. 

...A Pharmacist Makes a Choice

Eva Markowski, Complaints Officer



A young child's caregiver filed a complaint with the College citing that a pharmacist had refused to dispense Amoxicillin 250mg for the child after the child had lost her medication. The complainant said the pharmacist "should have filled the prescription", for in not doing so, further harm could have come to the child.

At the core of the complaint was the member's use of professional judgment and the choice and process he used to reach the decision not to dispense.

THE FACTS

The child, on a course of antibiotics dispensed by her local pharmacy, went on a school field trip for several days, where she lost her medication. The child's caregiver telephoned the pharmacy where the medication had been dispensed [Pharmacy A] to ask what could be done to get medication to the child. Pharmacy A suggested the caregiver attend a nearby pharmacy [Pharmacy B] and ask them to telephone Pharmacy A so that a transfer could be arranged.

The caregiver went to Pharmacy B and explained the situation to Pharmacist B. The pharmacist phoned Pharmacy A and obtained information regarding the child's prescription; following which Pharmacist B advised the caregiver that he could not fill a prescription as there was no existing prescription at Pharmacy A. As such, Pharmacist B said he could not enact a transfer because there were no repeats on file for the child's Amoxicillin — the prescription was for one course and was already filled and dispensed in full.

REASONS

Pharmacist B's responded to the complaint stating that he did not fill the prescription because he did not have the legal authorization to do so. Pharmacist B also said that he attempted to explain to the child's caregiver that it was not a question of one pharmacist giving another pharmacist permission to dispense – rather no pharmacist can authorize the dispensing of medications without a prescription to do so. Pharmacist B asserted firmly that he had exercised his professional judgment in this circumstance and that he had advised the child's caregiver to attend a local clinic to obtain a new prescription from a physician.

Was the caregiver correct? Was it unreasonable for Pharmacist B to refuse to dispense? The results of the investigation determined that Pharmacist B had only refused to dispense on learning that no repeats existed, and that the prescription had been dispensed in full. In his professional judgment there was no valid prescription to fill and as a pharmacist he did not have the legal authority to dispense. "A large part of my responsibilities as a pharmacist is exercising my professional judgment", said Pharmacist B.

DECISION

The Complaints Committee concluded that the member was correct in his assessment; to fill in this instance would constitute an unauthorized fill. While the Committee felt that the pharmacist's professional judgment could have equally resulted in appropriately choosing to dispense the antibiotic in this circumstance, it could not fault the member for exercising his professional judgment and discretion in refusing to dispense.


Moreover, the Committee saw that to reprimand this member for exercising what every pharmacist holds dear – his or her professional judgment – would be tantamount to second-guessing each member of this College. The Committee directed that "no further action be taken" in this matter in that the member had acted "appropriately and within the standards of practice of his profession."

HOW COULD THIS COMPLAINT HAVE BEEN AVERTED?

Could there have been better communication between the parties so that the pharmacist could have better explained his rationale and the limits of the law?

Could the member have reasonably and appropriately opted to give the child enough medication until a legal prescription could be obtained?

Could the Member have telephoned the child's physician to obtain a verbal prescription?

How do you rely on your professional judgment? What would you do if you were confronted with this scenario? Let us know your views. 

DECIDING ON **DISCIPLINE**

In this edition, there are six cases of the Discipline Committee. One case involves prescription forgery and another involves tax evasion which was appealed to, and upheld, by the Divisional Court. The remaining four cases describe breaches of standards of practice that resulted in dispensing errors.

CASE 1**Prescription Forgery**

Member: Adam Khan, Mississauga

Hearing Date: March 20, 2002

Mr. Khan was found to have committed an act or acts 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 Discipline Committee accepted a plea of professional misconduct by the member and was provided with an Agreed Statement of Facts which formed the basis of his plea.

Facts

On February 7, 2001, Mr. Khan plead guilty to the criminal court to have knowingly used a forged prescription contrary to Section 368(1) of the *Criminal Code of Canada*. The facts leading to the criminal charge and the plea are that on eight separate occasions in June 1999, Mr. Khan attended a pharmacy, presented a new forged prescription for Duragesic® and, based on these presentations, obtained the drug. Having been found guilty of the criminal charge, Mr. Khan was granted an absolute discharge.

Mr. Khan agrees that the conduct referred to above constitutes professional misconduct and would be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

Reasons

The member and the College submitted a Joint Submission on Penalty which the Committee carefully considered. The Committee accepted the Joint Submission on Penalty having regard to Mr. Khan's positive lifestyle changes and commitment to refrain from any further improper conduct. The Committee was confident that the Joint Submission appropriately protects the public and maintains the reputation of the profession.

Order

The Committee therefore concluded that the proposed penalty was fair and reasonable and made the following Order:

1. A reprimand
2. A three-month suspension of his Certification of Registration
3. The Member's Certificate of Registration be restricted, as follows:
 - a. The Member is prohibited from having a direct or indirect proprietary interest in a pharmacy, either as a sole proprietor,

DISCIPLINE

- partner, director, or shareholder in a corporation that owns a pharmacy
- b. The Member is prohibited from working in a pharmacy or in a pharmacy setting in any capacity whatsoever whether community or hospital based or in any other clinical or related setting in which narcotics are present or available
- c. The Member is prohibited from dispensing or accessing or having any responsibility or control whatsoever over controlled substances and he is prohibited from being a narcotics signer

The Committee directed that Mr. Khan may apply to remove the restrictions on his Certificate of Registration set out at point 3 above if twelve months have elapsed from the date of its Order, and various other specific criteria relating to his health and recovery can be satisfied and endorsed by his medical specialist, including a suitable return to work contract. The Committee applauded Mr. Khan for his efforts in his recovery and wished him success.

CASE 2 :**Tax Evasion**

Members: John Davies, Owen Sound
Peter Rissi, Owen Sound

Hearing Date: January 10, 2002

Mr. Davies and Mr. Rissi were found to have:

- 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 in that as shareholders, directors and officers of Rissi-Davies Pharmacies Limited, which operates two pharmacies, they willfully evaded or attempted to evade the payment of the pharmacies' taxes by failing to report income of the pharmacies

Mr. Davies and Mr. Rissi appealed the decision of the Discipline Committee to Ontario Divisional Court. The Court subsequently upheld the decision of the Committee.

Facts

The facts of this case were not in dispute. Peter Rissi and John Davies were shareholders, officers and directors of Rissi-Davies Pharmacies Ltd. In the taxation years 1990, 1991 and 1992 Mr. Rissi and Mr. Davies were paid volume rebates by two pharmaceutical companies. This was income for Rissi-Davies Pharmacies Ltd., and was not reported to Revenue Canada. On February 21, 1997, Rissi-Davies Pharmaceuticals Ltd. was convicted of willfully evading or attempting to evade payment of tax in the amount of \$10,089.05 by failing to report income of the pharmacies in the amount of \$48,696.53 during the period of June 1, 1989 and August 31, 1992.

Reasons

Mr. Rissi and Mr. Davies maintained that the conviction for tax evasion of Rissi-Davies Pharmacies Ltd., of which they were shareholders, officers and directors, was not relevant to the practice of a pharmacist and therefore could not reasonably be regarded by members of the Ontario College of Pharmacists as disgraceful, dishonourable or unprofessional.

The Committee determined that the conduct in this case is relevant to the practice of pharmacy citing that Rissi-Davies Pharmacies Ltd. is in the business of the sale of pharmaceuticals that generated income that was not reported; this conviction arose from the evasion of taxes concerning this income. While it was the corporation that was convicted, Mr. Rissi and Mr. Davies were the sole shareholders, officers and directors of this company and directed the business of this pharmacy. The Committee noted that the subject matter of the hearing, namely the sale of pharmaceuticals, is in fact the very essence of the practice of pharmacy. The Committee therefore made a finding of professional misconduct.

When considering the appropriate penalty, the Committee noted that the members did not have a prior disciplinary record before this College and through their

company had paid a substantial penalty for the tax evasion. Therefore the Committee ordered the following penalty:

1. Mr. Rissi and Mr. Davies will each receive a reprimand
2. The Certificate of Registration of Mr. Rissi and Mr. Davies shall each be suspended for a period of three consecutive weeks

Appeal to Ontario Divisional Court

Mr. Davies and Mr. Rissi appealed this decision to Ontario Divisional Court.

On January 15, 2003 Ontario Divisional court dismissed the appeal and awarded costs to the College.

Reasons of the Court

It was the Court's opinion that "it was reasonable for the Discipline Committee to conclude that the Appellants could not hide behind the corporate veil of the corporation through which they carry on their pharmacy business for these purposes." The Court further noted that the Discipline Committee had directed its mind to the issue of whether the conduct was relevant to the practice of pharmacy, and concluded that it was.

CASE 3

Failure to Gather Information and to Counsel a Patient

Member: Biserka (Bira) Mitrovski, Toronto

Hearing Date: February 24, 2003

Ms. Mitrovski was found to have:

- Failed to maintain a standard of practice of the profession
The Discipline Committee accepted a plea of professional misconduct from Ms. Mitrovski and was provided with an Agreed Statement of Facts which formed the basis of her plea.

Facts

A patient was prescribed 300 Methimazole 5 mg, a medication used to treat hyperthyroidism, with directions to take two tablets daily (a total of 10 mg).

Ms. Mitrovski and the pharmacy technician had difficulty reading the prescription. They concluded that the prescription was for Methotrexate, a medication used to treat certain types of cancer, psoriasis and rheumatoid arthritis. Methotrexate bears a specific warning regarding the potential for serious toxicity and side effects, including death, especially with respect to high-dosage regimens.

Ms. Mitrovski overheard the pharmacy technician confirm with the patient that the drug was Methotrexate and that she had used the drug before. The patient had not been to the pharmacy before so there was no profile for her in the pharmacy's records.

Ms. Mitrovski was confused about the strength of 5 mg written on the prescription because she was aware that Methotrexate was only available in 2.5 mg tablets. She explained to the patient that the drug did not come in 5 mg tablets and that she would have to fill the prescription by providing 2.5 mg tablets with the directions to take four tablets daily instead of two tablets daily.

Ms. Mitrovski dispensed 400 Methotrexate 2.5 mg tablets with directions to take four tablets daily. She assumed that the patient was a cancer patient since she had previously dispensed Methotrexate for patients with various malignancies. She advised the patient that regular blood work was important because of the dosage being dispensed. The patient indicated that she was familiar with the medication because she had taken it before and that she did not require any further information. Ms. Mitrovski assumed that the patient did not wish to discuss her medical condition, which was assumed to be cancer. She did she ask the patient about her condition and was not advised that the patient was taking a drug for hyperthyroidism.

After the patient had taken the Methotrexate as directed for some time, she began suffering significant side effects and the dispensing error was discovered.

DISCIPLINE

When Ms. Mitrovski was notified of the error she called the patient the same day to apologize and offered to replace the medication. She was advised that the patient had been in contact with her physician to make an assessment of the appropriate response to the medication error.

Ms. Mitrovski acknowledges that:

- She failed to clarify what drug had been prescribed
- She failed in her communications with the client regarding the medication and the condition being treated
- She dispensed in error a drug that she knew was potentially toxic, with the possibility of very harmful side effects
- She failed to provide full counselling to the patient as required
- The dispensing error might have been detected if she had engaged in proper communications and counselling, thereby avoiding any harm to the patient
- The patient was without medication for her hyperthyroid condition because of her dispensing error

Reasons for Penalty

The Committee was provided with a Joint Submission on Penalty which was accepted. The Committee notes that there are aggravating circumstances in that the dispensing error was a serious one and the patient suffered harm. However, it was also noted that Ms. Mitrovski had no prior history of discipline with the College. Ms. Mitrovski has accepted full responsibility for her actions, is remorseful and has apologized to the patient and to the College.

The penalty addresses principles of deterrence and rehabilitation and sends the message that a failure to appropriately communicate is a significant breach of the *Standards of Practice* and can result in serious errors.

Order

1. A reprimand
2. Specified terms, conditions and limitations on Ms. Mitrovski's Certification of Registration and in particular, that Ms. Mitrovski successfully complete, at her own expense, within 18 months of the date of this order, remedial training in the "Advanced Interviewing Tech-

niques" course and evaluations in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto

3. A suspension for a period of two months, with one month of the suspension to be remitted on condition that Ms. Mitrovski complete the remedial training exercise specified above

CASE 4

Failure to Exercise Appropriate Care when Dispensing Codeine to a Small Child

Member: Merv Moskalyk, Toronto

Hearing Date: February 24, 2003

Mr. Moskalyk was found to have:

- Failed to maintain a standard of practice of the profession
The Discipline Committee accepted a plea of professional misconduct from Mr. Moskalyk and was provided with an Agreed Statement of Facts which formed the basis of his plea.

Facts

The patient, age 11 months, suffered second-degree burns to his hand and was taken to the hospital. The patient's parents were then provided with a prescription for Codeine, with instructions to administer the prescribed Codeine approximately 45 minutes prior to his appointment the following morning.

The prescription indicated that the baby was 11.2 kg and it listed Codeine 10 mg suspension PO Q6H x 20 doses. Mr. Moskalyk filled the prescription with 200 mL Codeine Phosphate 5 mg/mL with the directions to give two teaspoonfuls every six hours — five times the dose prescribed.

The following morning, the parents administered only 6-7 mL of the Codeine instead of the 10 mL directed by

Mr. Moskalyk, due to their concern over the large volume to be given. Upon returning to the hospital, red blotches were noticed on the baby's face and head. The medical staff confirmed that the baby had received a Codeine overdose.

Mr. Moskalyk responded promptly when notified of the error and expressed his apologies to the parents and acknowledged the negative impact on the child. Mr. Moskalyk was unable to explain the error, except to suggest that he must have misread the concentration of the Codeine Phosphate suspension incorrectly as 5 mg/5 mL instead of 5 mg/mL. Mr. Moskalyk confirmed that he should have:

- Reviewed the calculations through the computer
- Checked the prescription to ensure the dosage was consistent with a dose for a child of the relevant weight

Mr. Moskalyk recognizes that some harm was caused to the child and that very serious harm could have been caused if the dispensing error had not been detected after only one dose.

Reasons

Mr. Moskalyk and the College provided the Committee with a Joint Submission on Penalty. The Committee recognized that the dispensing error, while serious in nature, was detected in time to avoid serious harm. The Committee also noted that Mr. Moskalyk, a longstanding member of the College, has no prior history of discipline and that he has accepted full responsibility for his actions and is remorseful.

The penalty addresses the principles of deterrence and rehabilitation and sends the message that failure to check appropriate dosing when dispensing medication to a small child constitutes a breach of the *Standards of Practice* and can result in a serious error.

Order

1. A reprimand
2. Specific terms, conditions and limitations on Mr. Moskalyk's Certification of Registration in that he shall attend at and participate in "Confronting Medication

Errors", offered by the Ontario Pharmacists Association, including Module #1, "Understanding the Issues and Dealing With Incidents", and Module #2, "Taking Action to Improve Patient Safety", at his own expense, within 12 months of the date of this order

3. A suspension for a period of one month, with the suspension to commence on March 3, 2003 and continue until April 2, 2003

CASE 5

Failure to Exercise Appropriate Care When Dispensing Codeine to a Small Child

Member: Dalia Salib, Nepean

Hearing Date: February 24, 2003

Ms. Salib was found to have:

- Failed to maintain a standard of practice of the profession
The Discipline Committee accepted a plea of professional misconduct from Ms. Salib and was provided with an Agreed Statement of Facts which formed the basis of her plea

Facts

The patient, a three year-old child, was prescribed 15 mg (equivalent to 3 mL) of Codeine, every four hours as needed, after being released from a hospital where he had his tonsils and adenoids removed. Ms. Salib dispensed the Codeine with directions to "give three teaspoonsful every four hours when needed". The dosage given by Ms. Salib was five times the dosage prescribed. The child's mother gave him the Codeine in accordance with the instructions on the bottle and the child experienced an adverse reaction.

Ms. Salib explained that a pharmacist's assistant prepared the label and another pharmacist's assistant placed the label on the vial and filled the prescription. Ms. Salib checked the child's name, the doctor's name and the prescribed drug, and compared the DIN on the

DISCIPLINE

label to the DIN on the stock bottle, as well as checking the instructions on the doctor's prescription and comparing them with those on the label. In doing so, she did not identify that the dosage on the doctor's prescription of 15 mg had been incorrectly converted and printed on the label as three teaspoons. Ms. Salib counselled the child's father, was advised that the patient had just had his tonsils removed, and checked to ensure the child's body weight was correct.

Ms. Salib has since taken steps to prevent further incidents as follows:

- Review and re-evaluate her dispensing procedures to attempt to avoid the occurrence of any similar incident in the future
- Write the strength of the dispensed medication directly on the original prescription and check to ensure that they are the same

Reasons

Ms. Salib and the College provided the Committee with a Joint Submission on Penalty. In considering whether to accept the Joint Submission, the Committee noted that there were aggravating circumstances in that the dispensing error was a serious one and the patient, a child, suffered harm. The Committee also noted that Ms. Salib has no prior history of discipline with the College, has accepted full responsibility for her actions and is remorseful.

In making the following Order, the Committee addressed the principles of deterrence and rehabilitation and endeavored to send the message that a failure to check appropriate dosing when dispensing medications to a small child constitutes a breach of the *Standards of Practice* and can result in a serious error.

Order

1. A reprimand
2. Specified terms, conditions and limitations on Ms. Salib's Certification of Registration and in particular, that Ms. Salib successfully complete "*The Pharmacy Practice Laboratories Course*" of the Canadian Pharmacy Skills I, tailored to paediatric dispensing and "*The Pharmacy*

Practice Laboratory Milestone Module", at her own expense, within 12 months of the date of this Order

3. A suspension for a period of two months, with one month of the suspension to be remitted on condition that Ms. Salib complete the remedial training courses specified in paragraph 2 above

CASE 6

Failure to Appropriately Counsel or to Intervene on Behalf of a Patient

Member: Harold Primmer, Thunder Bay

Hearing Date: February 18 and 19, 2003

In this contested hearing, the member entered a plea of not guilty to the allegations of professional misconduct in connection with dispensing Zithromax® to a child. The Discipline Committee heard evidence over two days.

The Facts

The patient, aged two years and eleven months, was diagnosed with a sinus, throat and ear infection and was prescribed Zithromax® (Zithromycin) 200 mg/5 mL liquid by the family physician with directions to give 3.75 mL on the first day and then 1.875 mL for the next four days. After one course of the antibiotic, the physician prescribed another course, which the patient's mother took to Mr. Primmer's pharmacy to be filled in the evening on January 18, 2000.

Mr. Primmer dispensed the Zithromax®. However, instead of providing a dosage direction of 1.875 mL once a day as prescribed, Mr. Primmer provided the dosage direction of 4.5 mL once a day.

The patient's mother had thought that the dosage was incorrect because it was more than the volume dispensed with the first prescription. She raised her concern with Mr. Primmer, who reviewed the prescription and the concentration of the Zithromax® with her and advised her again that the dose of 4.5 mls per day was correct.

continued on page 36

practice

CODEINE FOR

Did you know that, when you confuse “mg” with “mL” on a prescription for Codeine Phosphate Elixir, you are infact dispensing a dose that is FIVE TIMES what is prescribed? This can seriously harm a child.

A common complaint to the College is from parents whose small child has suffered the effects of an overdose as a result of a dispensing error. Outlined below are the common dispensing errors that occur with Codeine prescriptions for the pediatric patient.

RECENT CODEINE PRESCRIPTION ERRORS:

*ADR: Adverse Drug Reaction

	Patient's Age / Weight	Dose Prescribed	Dose Dispensed	What Happened
1	11 months Weight: 11.2 kg	Codeine 10 mg suspension PO q6h x 20 doses	Codeine Phosphate 5 mg/mL (200 mL) Give 2 teaspoonsful every 6 hours	Child given 6-7 mL (approx. 65 mg) * ADR: red blotches
2	3 years Weight not on Rx. Not requested by pharmacist	Codeine Elixir 10 mg tid prn 100 mL	100 Codeine Phos Syrup 5mg/SYR (Codeine Phosphate) Man: TCH Give 10 mL three times daily when needed	Child given one dose of 10 mL (50 mg) ADR: vomiting, drowsiness, weakness
3	3 years Weight not on Rx. Not requested by pharmacist	Codeine 15 mg q4h prn	Codeine Phosphate 5 mg/mL Give 3 teaspoonsful every 4 hours when needed	Child given 3 teaspoonsful (15 mL = 45 mg) ADR: vomiting, eyes rolling back in head
4	16-month Weight not on Rx. Not requested by pharmacist	Codeine 7.5 mg q4h prn	Codeine Phosphate 5 mg/mL Take one and one-half teaspoonsful by mouth every four hours as needed for pain	Child given 5 doses of 7.5 mL (each dose = 37.5 mg) ADR: patient would only sleep

advisory

PEDIATRICS

DISCUSSION

In all four examples the patient ingested five times the dose prescribed.

The prescriptions were written by hospital physicians or pediatricians and, as you can see, all were written in milligram doses. In the dispensing / filling process both pharmacy technicians and pharmacists contributed to the errors made. It appears that all of the directions were interpreted as “mL” instead of “mg”.

In each case, the pharmacist counselled the parent/caregiver on the required, albeit, incorrect dose. In three cases the parents questioned the pharmacist when they noted that the volume was more than what a child would normally take. In all four cases, after ingesting the incorrect dose, the child was taken to hospital emergency for observation on symptoms resulting from Codeine overdose.

Considerations for pharmacy staff when filling prescriptions for children :

- Pharmacy staff must communicate with parents/caregivers/prescribers on the age and the weight of the child
- Prescriptions from pediatricians and hospital prescribers are often written in milligram doses per kilogram. If the dose is unclear, call the prescriber for further information

- Pharmacists must confirm doses for children with a current pediatric dosing reference guide
- Pharmacy staff must check milligram strength of stock bottles of liquids
- Pharmacy staff should confirm calculations between metric (milligrams/milliliters) apothecary and household measurements
- Have another pharmacist or a pharmacy technician do the calculation and check your calculation with theirs. If you have no trained staff on hand with whom to confirm your calculations, call your drug information service or another pharmacy
- Provide oral syringes to measure doses for children
- Household teaspoons are too varied in size, not considered accurate and may cause additional errors
- Demonstrate the use of the oral syringe with the parents/caregiver
- Mark the correct dose on the oral syringe
- During counseling, make sure parents/caregivers are aware of possible adverse drug reactions
- If you realize an error has been made contact the prescribing physician and the parents/caregivers of the child immediately. When necessary, refer the patient to an emergency department of the nearest hospital
- Listen to the concerns of the parents. In most cases where the parents had questioned the amount to be given as being more than usual for a child

After the child became lethargic and slept more than usual, the mother learned that the dosage direction provided by Mr. Primmer was erroneous. The mother contacted Mr. Primmer on January 19, 2000 and informed him about the mistake, at which point Mr. Primmer checked the original prescription and confirmed his error. Mr. Primmer did not advise the mother to consult with her son's physician or a hospital regarding a possible overdose to her child.

Mr. Primmer subsequently reviewed the prescription with the prescribing physician who confirmed that he intended for the child to have 1.875 mL of Zithromax® 200 mg/5 mL once per day. Mr. Primmer then called the mother on January 19, 2000 to request that she return the prescription bottle so that he could put a corrected label on the bottle. He informed her that he had spoken to the physician and that the overdose could cause no harm and that she should continue to give the child the medication in the prescribed amount of 1.875 mL once a day.

Reasons for Findings of Professional Misconduct

Mr. Primmer made a number of misinterpretations and erroneous assumptions, as he thought that:

- The prescription for "1.875 mL X 4 days, mitte 4 days, mitte 8cc" was incomplete as it did not provide the frequency of the dosage per day, nor the strength or concentration of the 1.875 mL. (Zithromax® paediatric suspension is available in 100mg per 5 mL and 200 mg per 5 mL concentrations)
- It was unusual to see a prescription in mls to the third decimal point, which would be difficult for the client to measure, even using a syringe
- The physician intended to refer to a dosage once per day of 4.5 mL of Zithromax® in the 200 mg/5 mL concentration
- The physician intended the "1.875 mL" to be "187.5 mg" Mr. Primmer then completed his calculations by dividing the amount he interpreted as 187.5 mg by 200 mgs to yield a result of 4.6875 mL, which he rounded off to 4.5 mL. He was aware that the pediatric dosage guidelines for pharyngitis and tonsillitis (age 2 years above) based on

body weight of 17 kg, and using 200 mg/5 mL suspension would be 5 mL for days 1 through 5, calculated on the basis of 12 mg/kg once daily.

In the circumstances, the Committee found that Mr. Primmer failed to maintain the *Standards of Practice* of the profession and exercised unreasonable professional judgment in that he failed to:

- Ask if the prescription was for the first course of the antibiotic (days 1-5) or for a subsequent course
- Ask what medical condition the child was being treated for
- Contact the physician for clarification regarding the prescription prior to dispensing, in an effort to ensure accuracy
- Inquire about the child's weight (rather, he approximated that the child weighed 17 kg as he was aware that the child was almost three years old)
- Advise the mother to follow-up with her physician to discuss any ill health effects that could have arisen from the error

Moreover, he effectively:

- Rewrote the prescription, resulting in two and one half times the prescribed dose
- Disregarded material information indicated on the prescription, that being, the total volume of medication to be dispensed ("mitte 8cc"). (The Committee acknowledges that this medication is only available in 15 or 23 mL).
- Disregarded the concerns of the patient's mother

Finally, the Committee found that the member's conduct, in its totality, would reasonably be regarded by members as disgraceful, dishonorable or unprofessional.

Penalty Deliberations

Having made findings of professional misconduct, the Committee considered the following relevant factors as part of its deliberation over an appropriate penalty:


- The apparent lack of remorse by Mr. Primmer in exercising inappropriate professional judgment

DISCIPLINE

- That Mr. Primmer has a previous finding of professional misconduct involving five separate occasions in which he dispensed a prescription for a narcotic after the quantity of the narcotic specified in the prescription had been dispensed and on one occasion dispensed a substance other than the substance prescribed
- The penalty ordered in this case is consistent with similar penalties ordered by this Committee

Order

Based on the reasons noted above, the Committee made the following order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Primmer's Certification of Registration and in particular, that he successfully complete, at his own expense, within 12 months of the date this order, remedial training in the following courses and evaluations at Leslie Dan Faculty of Pharmacy, University of Toronto:
 - (1) *"Advanced Interviewing Techniques"*
 - (2) Law Lesson 2 – *"Regulation of Pharmacy Practice"*
 - (3) Law Lesson 4 – *"Standards of Practice"*
 - (4) Law Lesson 7 – *"Professional Liability"*
3. A suspension for a period of two and one half months, with one month of the suspension to be remitted on condition that the member complete the remedial training as specified in paragraph 2 above
4. Costs to the College in the amount of \$2,500 



CORONER'S REPORT

The College regularly receives reports from the Ontario Coroner's Office. Following is a summary of the findings of a recent case along with recommendations that have an impact on pharmacists and pharmacy practice.

CASE

BRUCE REID AND TAMMY MOORE

Tammy Moore and Bruce Reid were found dead January 12, 2001 at Ms. Moore's residence. Both died from overdoses of the drug hydromorphone. Intravenous drug administration paraphernalia and numerous drugs, including hydromorphone, were found at the death scene. The drugs were originally the property of patients who Ms. Moore had been treating in her professional capacity as a Registered Nurse providing home care nursing to palliative patients. It was later revealed that Ms. Moore would visit patients' homes a day or so after patients died and tell surviving family members that she was there to pick up the leftover drugs so that she could return them to the pharmacy for destruction. Ms. Moore kept these drugs for her own use.

Several recommendations were made to the College of Nurses of

Ontario, the provincial government and pharmacy. We present the recommendations which have particular implications for pharmacists who provide homecare or palliative care services in their community.

RECOMMENDATION #1 TO THE COLLEGE OF NURSES OF ONTARIO

"Nurses of palliative care to take co-responsibility with family member of other authority figure including pharmacist to co-sign for disposal method of medication. This to be done on triple carbon – One copy for home, one for the nurse/agency, one for the pharmacy or hospital."

The coroner's jury found that Ms. Moore was able to easily obtain medication from the homes of recently deceased patients. In spite of "tight" controls on narcotics in more formal clinical settings, the jury found there was a serious gap in accountability and safe disposal for the leftover medication of patients who die at home.

Pharmacists are in a key position to provide leadership and guidance to homecare agencies and palliative care nurses in developing procedures around the safe handling and disposal of narcotics upon the death of a patient. Patients often have various medications which, if not disposed of safely, could be harmful to the environment, children, pets, or to people prone to abusing drugs.

RECOMMENDATION # 7 TO THE PROVINCIAL GOVERNMENT

"The Regulated Health Professions Act should be amended to make it mandatory for all health professionals covered by the act to report to the appropriate regulatory body, other health professional covered by the act whose level of capacity puts patient welfare at risk. The reporting should be mandatory, regardless of how the health professional became aware of the capacity issue."

Several doctors and nurses later said that they knew Ms. Moore had a drug problem as she had been treated for drug and substance abuse. None of her medical caregivers reported her to the College of Nurses of Ontario— all citing their recognition of constraints due to patient confidentiality.

There are also great concerns that many professionals abusing drugs are less likely to seek out early help, or voluntarily present themselves for care, as they fear it would lead to mandatory reporting by a caregiver to the person's regulatory college. Indeed, during the coroner's investigation, the Registrar of the College of Physicians and Surgeons of Ontario iterated his College's position that physicians have an obligation to report any professional whose incapacity would put patients at risk.

REPORTING INCAPACITY

Many pharmacists feel very uncomfortable reporting a colleague or another health professional. However, if you believe a colleague's conduct is either unsafe or unethical, you are required to report this information to the person or body that has the means

or authority to intervene for the sake of public protection. You may also find that depending on the circumstances, you may need to report the situation to other individuals and organizations, as well as the College.


While it is not a requirement mandated by legislation, the College strongly encourages its members to bring information to its attention where it involves conduct that has the potential of harming the public's safety and/or well being. The College responds to all reported information and takes action whenever appropriate. The College is also working to develop protocols for incapacity reporting by members. Please also review the March/April 2003 *Pharmacy Connection* article on mandatory reporting.

RECOMMENDATION TO PHARMACIES

"Pharmaceutical companies have method of disposal on every prescription literature that is environmentally safe and acceptable. This information is to be legible and not in fine print on the side of the bottle or container."

The coroner's jury was concerned that it is neither safe nor good for the environment for surviving relatives to be told simply to flush leftover drugs down a toilet. Recognizing the College of Pharmacists as the body that sets and regulates standards for both the pharmacy profession and pharmacies across the province, the jury directed this recommendation to the Ontario College of Pharmacists.

In its reply to the Coroner, the College stated that it does not have jurisdiction over pharmaceutical manufacturers and/or their labelling of products. Furthermore, the College has no control over the actions of patients or caregivers once a medication has been dispensed and delivered.

However, the College does believe that practising pharmacists do have a central role in safe drug handling. Indeed, pharmacists in both hospital and community pharmacy are in an important position to be able to take a leadership role in facilitating the environmentally safe destruction of drugs. 

Safe Drug Disposal

- All pharmacists should actively participate in, and communicate, medicine cabinet clean-up programs with their patients
- Pharmacists should have permanent systems in place to handle requests to dispose unused or expired medications brought to the pharmacy by patients or caregivers
- Each pharmacy should arrange a contract with a disposal company that accepts bio-hazardous waste

Points of Care in Ontario



Bayview 16th Medical Pharmacy,
RICHMOND HILL



Pharma Plus Drug Mart, RICHMOND HILL



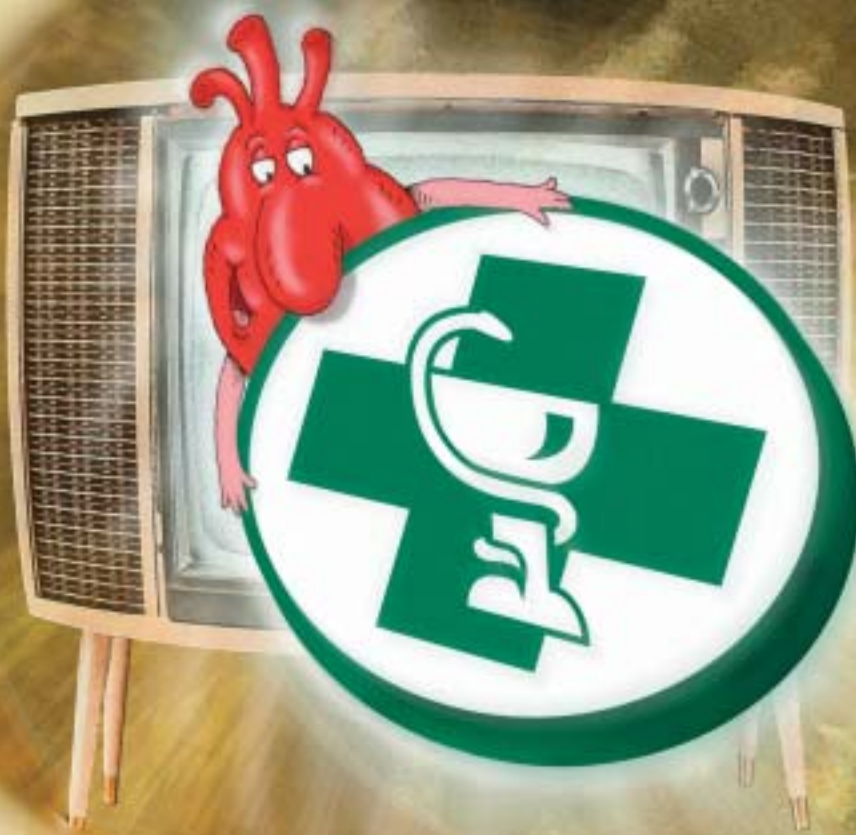
Optimum Compounding Pharmacy,
RICHMOND HILL



Hoopers Pharmacy Website

Pharmacists Have Heart!

Have you seen the College's new
public education commercial?



View the commercial online at
www.worthknowing.ca
or at www.ocpinfo.com

www.worthknowing.ca

FOCUS ON Error Prevention



Ian Stewart, B.Sc.Pharm.



Although a pharmacist correctly dispenses medication while filling a prescription, correctly labelling the vial is of equal importance as mislabelling errors can easily result in an incorrect dose being taken by the patient. The following case highlights this issue.

CASE:

A 73 year-old patient presented the following prescriptions at his local community pharmacy for filling.

Norvasc® 5mg	Monopril® 10mg	Zocor® 20mg
Sig: 2 tablets daily	Sig: 1 tablet daily	Sig: 1 tablet at bedtime
Mitte: 2 months	Mitte: 2 months	Mitte: 2 months

The pharmacy technician correctly entered the prescriptions into the computer and generated the prescription labels. A second technician retrieved the correct stock bottles, counted 120 tablets of Norvasc® 5mg and then poured them into a 12-dram vial. This unlabelled vial was then placed in a basket with the original stock bottle.

The technician then counted 60 Monopril® 10mg tablets, poured them into a 12-dram vial, and then put the unlabelled vial, with its original stock bottle, into the same basket as the Norvasc®. The Zocor® 20mg tablets were then counted, poured into a 7-dram vial, and also placed, with its stock bottle, into the same basket as the other drugs.

When labelling the vials, the technician applied the Zocor® prescription label to the correct vial, but she then mistakenly placed the Norvasc® and Monopril® labels on the wrong vials.


On checking the prescriptions, the pharmacist correctly compared the DIN on each stock bottle that printed on the computer-generated hard copies to confirm that the correct drug had been dispensed for each order. However, the mislabelling error was not detected. The patient therefore received Norvasc® 5mg tablets labelled as Monopril® 10mg tablets and vice versa.

On the following day, the patient opened the vial labelled Norvasc® to take his dose, but having previously taken this medication, he noticed the difference in shape and size of the contents. The patient then contacted his pharmacist to inform him that an mislabeling error had been made.

Possible Contributing Factors:

- The pharmacy technician left all three vials unlabelled in one basket
- Both the Norvasc® and Monopril® tablets were poured into 12-dram vials
- The pharmacists did not check the contents of the vial when checking the prescription and DIN

Recommendations:

- Encourage pharmacy staff to label each prescription vial immediately after counting the appropriate number of tablets. The potential for error exists whenever two or more unlabelled prescription vials are placed in close proximity
- Visually check the contents of the prescription vial during the checking process. Compare the prescription label with the content of the vial to confirm accuracy
- Take a final opportunity to visually check the contents of the prescription vial at the time of patient counselling. (This is especially important for patients who have not taken the drug before) 

The Ontario College of Pharmacists recommends all pharmacists, intending to dispense methadone, to participate in a CAMH workshop prior to caring for methadone patients.

Centre for Addiction and Mental Health

METHADONE MAINTENANCE TREATMENT WORKSHOPS

Dates for 2003 - 2004:

Saturday, June 21, 2003
 Saturday, September 20, 2003
 Saturday, January 17, 2004
 Saturday, March 13, 2004

Location:

Centre for Addiction and Mental Health (CAMH)
 Meeting Centre, Addiction Research Foundation Site
 33 Russell Street, Toronto
(At Spadina Avenue and College Street)

Contact:

Ms. Robyn Steidman
 (416)535-8501 x. 6640

Fee:

Approximately \$200 (Includes treatment manual, materials and lunch)

Registration:

The registration form can be downloaded from the CAMH website:
http://www.camh.net/ets/cpe/pdfs/ets_calendar_fall2002.pdf
(Calendar to be updated as appropriate)

The CAMH workshops are open to pharmacists, physicians and counsellors and currently accommodates 30 participants per course.

Please also check the CAMH website for additional information. Go to: www.camh.net and select *Community Health and Education*.

Please also review the College's *Methadone Maintenance Treatment Policy*.
(Pharmacy Connection, March/April 2003 or at www.ocpinfo.com)

MMT

CE EVENTS

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

ONTARIO

June 10: Toronto

Paediatrics for Pharmacists
Conference, Drug Information
Department of Pharmacy
Hospital for Sick Children
tel (416) 813-6703
druginfo@sickkids.ca

June 18: London

Respiratory Emergencies: ER
Ontario Respiratory Care Society
Best Western Lamplighter Inn
Sheila Gordon-Dillane
tel (416) 864-9911, x 236
fax (416) 864-9916
orcs@on.lung.ca

June (21-22) 23-25: Thunder Bay

2003 National Education Conference
Community and Hospital Infection
Control Association - Canada
Valhalla Inn
Marilyn Stewart - tel (807) 625-5907
fax (807) 623-2369
marilyn.stewart@tbdhu.com
Patricia Piaskowski
tel (807) 343-3170
fax (807) 768-2259
piaskowp@tbh.net
Gerry Hansen - tel (204) 897-5590 or
1-866-999-7111; fax (204) 895-9595
chicacanada@mts.net
www.chica.org/2003_confe.html
Jeff Chan: chanj@tbh.net

Aug. - Oct: Toronto

Certification Review for Pharmacy
Technicians - 2003, Humber College
Classes (total of five) will be held on
Sundays from 9 am to 4 pm: Aug. 24;
Sep. 7, 14 & 21; Oct. 5
tel (416) 675-5000
Major credit cards accepted
To order Humber College's
"Certification Study Guide for Pharmacy
Technicians":
tel (416) 675-6622, x 4555

CANADA

June 7-11, St. John's NL

CADE-ACED 2003 Conference
The Canadian Association for
Distance Education (CADE)
Fairmont Newfoundland Hotel
tel (709) 737-7922
fax (709) 737-3520
jharris@mun.ca
www.cade-aced.ca

June 15-18: Calgary AB

The Future of Health Care: Valuing
Children, Youth and Families,
Canadian Association of Paediatric
Health Centres
Shelley Callaghan
tel (613) 798-8029
purpledog@sympatico.ca
www.caphc.org

Aug. 16-19: St. John's NL

CSHP Annual General Meeting
Canadian Society of Hospital
Pharmacists
Delta St. John's Hotel
Gloria Day
tel (613) 736-9733, x 29
fax (613) 736-5660
gday@csph.ca

RESOURCES

Ontario Pharmacists' Association

- *Guide Your Patients to a Smoke Free Future; Open to pharmacists and pharmacy technicians*
- Sherrie Hertz
tel (416) 385-3472, x 2205
1-800-268-8058
- *Pharmacist-Patient Dialogue Workshop 1: Enhancing Adherence*
- *Diabetes Patient Care - Level 1 Certificate Program*
- *Confronting Medication Errors 1 - Understanding the Issues and Dealing with Incidents*
- *Confronting Medication Errors 2 - Taking Action to Improve Patient Safety*

Karen Cameron
tel (416) 441-0788 x 4235
fax(416) 441-0791

kcameron@ontpharmacists.on.ca

web: www.opatoday.com

- *Asthma Consensus Guidelines - 2003 Ontario Respiratory Care Society; open to pharmacists and pharmacy technicians*
- Sheila Gordon-Dillane
tel (416) 864-9911, x 236
fax (416) 864-9916
orcs@on.lung.ca
- *Learning Portfolio Sharing Session Available through your Regional CE Coordinator/Associate*

NEW CE COORDINATORS

CE Region 8:

Karen Matwijec
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fax (416) 752-4408
e-mail: kmatwijec@yahoo.ca

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CE Region 16

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fax (905) 871-1065
e-mail: gerard@forterie.com

CE Region 23

Ms Mary Ann Hornick
(519) 351-2424
(519) 351-2992

The College is looking for pharmacists interested in joining the CE Coordinator Volunteer Team to represent the following Regions:

CE Region 10: Astorville, Bala, Bracebridge, Burks Falls, Callander, Corbeil, Hunstville, Mactier, Mattawa, McKellar, Minden, North Bay, Novar, Onaping, Parry Sound, Port Carling, Port Sydney, Powassan, Rosseau, South River, Sundridge, Utterson

CE Region 14: Alliston, Angus, Baldwin, Barrie, Beeton, Borden, Brechin, Coldwater, Collingwood, Cookstown, Creemore, Cumberland Beach, Elmvale, Everett, Gravenhurst,

Hawkestone, Hillsdale, Innisfil, Lefroy, Lisle, Midhurst, Midland, Minesing, New Lowell, Orillia, Oro Station, Penetanguishene, Perkinsfield, Phelpston, Port McNicoll, Shanty Bay, Stayner, Stroud, Thornton, Utopia, Victoria Harbour, Wasaga Beach, Washago, Waubaushene, Wyevale

CE Region 18: Ailsa Craig, Arva, Aylmer, Belmont, Courtland, Delaware, Denfield, Dorchester, Eden, Fingal, Granton, Ilderton, Ingersoll, Innerkip,

Iona Station, Komoka, London, Lucan, Mount Brydges, Nairn, Norwich, Port Stanley, Salford, Seaford, Southwold, Sparta, Springfield, St Marys, St Thomas, Straffordville, Thamesford, Thorndale, Tillsonburg, Val Therese, Woodstock

If you are interested in volunteering, contact Bernie DesRoches at 416-961-4861, x 249; fax: 416- 847-8281; e-mail: bdesroches@ocpinfo.com



CANADIAN COUNCIL ON CONTINUING EDUCATION IN PHARMACY

CORRESPONDENCE COURSE PROGRAM - 2003

The 2003 CCCEP Homestudy Programs are now available.

Lesson topics for 2003

C1: The Pharmacist's Guide to Psychiatric Disorders in Children and Adolescents	2.0 CEUs
C2: Evidence-Based Drug Therapy: A Practical Guide for Pharmacists	3.0 CEUs
C3: Update on Pharmacotherapy for Asthma/COPD	3.5 CEUs
C4: Herbal Medicine in Canada Part II	3.0 CEUs
C5: Living with Congestive Heart Failure (CHF): How Can the Pharmacist Help?	2.5 CEUs
C6: An Overview of Infertility for the Pharmacist	2.0 CEUs

In addition to the above, the following CCCEP lessons are still available:

Lesson topics for 2002 & 2001

C7 Acute Ischemic Stroke	3.5 CEUs
C8 Managing Insomnia	2.5 CEUs
C9 Therapeutic Management of Diabetes	3.0 CEUs
C10 Epilepsy	2.0 CEUs
C11 Non-Malignant Chronic Pain (NMCP)	3.0 CEUs
C12 Schizophrenia	2.5 CEUs
C13 Dementia & Delirium in the Elderly	3.5 CEUs
C14 Parkinson's Disease	3.0 CEUs
C15 Respiratory Tract Infections	3.0 CEUs
C16 HIV Infection	5.0 CEUs
C17 Dyspepsia	3.0 CEUs
C18 Influenza and the Common Cold	2.5 CEUs

Please visit our website www.ocpinfo.com, look under continuing education, resources for a list of topics and an order form. Alternatively, an order form may be requested in writing from:

Pharmagraph Systems
P.O. Box 141, Postal Station P
704 Spadina Avenue, Toronto, ON M5S 2S6

Class 7T3 30th Reunion

A return visit to the Fern Resort in Orillia, Sept 19-21, 2003. The package rate is \$260pp, double accommodation and 6 meals. Deposit of \$125pp is required before a firm deadline of Jun 1/03. Reserve now by phoning the Fern Resort at 800-567-3376 for payment information, (File 986).

Reunion details from Tom/Liz Betts 905-945-9078, Bill Dingwall 905-475-1395, Vera Smith 705-326-8290. We hope to see you there!

Advanced Workshop: Intercultural Communication and IPG Program held on Thursday, June 5, 2003.



Class of 7T8 25th Reunion

Your 25th Pharmacy Reunion is planned for October 3-5, 2003 at Nottawasaga Inn Resort in Alliston. For future contact and more information, please forward your email and home address with phone numbers to Doris Kalamut (Hallmann) 35 Anderson Avenue, Toronto, Ontario M5P 1H5 (416-485-2067) or dkalamut@rogers.com.

Class 8T3 20th Reunion

If you are organizing or want to help organize the 20th Pharmacy 8T3 Reunion, please contact Ray Chan at: (519) 758-9762, work: (519) 759-3784, fax: (519) 759-1524 or ray.chan@sympatico.ca.

INSPECTOR'S CORNER:
DRUG SCHEDULE ANSWERS

SCHEDULE:

1. II	19. II	36. II
2. III	20. I	37. II
3. I	21. Unscheduled	38. Unscheduled
4. Unscheduled	22. II	39. III
5. III	23. Cannot be sold as per Health Canada	40. III
6. II	24. II	41. III
7. III	25. II	42. II
8. II	26. Cannot legally be sold in Canada except as an Emergency Drug authorized by Health Canada	43. II
9. II	27. II	44. Unscheduled
10. II	28. I	45. I
11. Unscheduled	29. II	46. II
12. III	30. Unscheduled	47. I
13. II	31. III	48. Unscheduled
14. Cannot legally be sold in Canada except as an Emergency Drug authorized by Health Canada	32. III	49. Unscheduled
15. II	33. I	50. Unscheduled
16. II	34. Unscheduled	51. I
17. III	35. Unscheduled	52. I
18. I		53. II
		54. II

OCP MANUAL CONTENTS

Changes as of March 31, 2003 - As Highlighted

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.

Individual copies, or complete sets of the legislation (with binder and tabs), can also be ordered from the College. The *OCP Manual*, sold with the *OCP Policy Handbook* (complete with index and copies of reference articles), is \$85 (\$90.95 with GST). Sold separately, the *OCP Manual* is \$64.20 (GST included) and the *OCP Policy Handbook* is \$32.10 (GST included).

ONTARIO LEGISLATION

Available from OCP or Publications Ontario

Drugs and Pharmacies Regulation Act (DPRA) & Regulations

- Version – Office Consolidation Aug 27, 1999 (Publications Ontario)

Regulated Health Professions Act (RHPA)

- Version – Office Consolidation Jun 30, 1999 (Publications Ontario)
- Ontario Regulation 39/02 Addendum - Certificates of Authorization - February 8, 2002

Pharmacy Act (PA) & Regulations

- Version – Office Consolidation May 28, 1999 (Publications Ontario)
- Ontario Regulation 548/99 Amending O.

Reg. 202/94 – Nov 29, 1999

- Ontario Regulation 550/99 Revoking O. Reg 620/93 – Nov 29, 1999

Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations

- Version – Office Consolidation Dec 4, 1998 (Publications Ontario)
- Ontario Regulation 73/99 Amending Reg. 935 of R.R.O. 1990 – Feb 25, 1999
- Ontario Regulation 496/00 Amending Reg. 935 of R.R.O. 1990 – Aug 28, 2000
- Ontario Regulation 15/01 Amending Reg. 935 of R.R.O. 1990 – Jan 26, 2001

Ontario Drug Benefit Act (ODBA) & Regulations

- Version – Office Consolidation May 12, 2000 (Publications Ontario)
- Ontario Regulation 495/00 Amending Reg. 201/96 – Aug 28, 2000
- Ontario Regulation 16/01 Amending O. Reg. 201/96 – Jan 26, 2001

Publications Ontario

Tel: (416) 326-5300 or 1-800-668-9938

FEDERAL LEGISLATION

Available from OCP or Federal Publications Inc.

Food and Drug Act (FDA) & Regulations

- Updated NAPRA Version as of Oct 25, 2000
- Amendment – Paragraph C.01.004 (1) (b) – Sep 1, 2000
- Updated Health Canada Version as of December 19, 2001
- Amendment 1248 - Ibuprofen - Jan. 31, 2002

Controlled Drugs and Substances Act (CDSA)

- Updated NAPRA Version as of October 25, 2000
- Amendments – Schedules III and IV – Sep 1, 2000
- Regulation 1091 – Benzodiazepines and Other Targeted Substances Regulations – June 1, 2000

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

NAPRA DOCUMENTS

Drug Schedules

- Canada's National Drug Scheduling System – May 16, 2002 NAPRA

Narcotic Control Regulations

- Updated NAPRA Version as of October 25, 2002

Available at: www.napra.org

OCP DOCUMENTS

Available from OCP or www.ocpinfo.com

Drug Schedules

- Summary of Laws Governing Prescription Drug Ordering, Records, Prescription

Standards of Practice

- Reference Page to Policy Handbook, and
- New *Standards of Practice*, Jan 1, 2001 OCP

OCP By-Laws

- By-Law No. 1 (Year 2000) – Jan 4, 2001
- 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 – Dec 11, 2000
- Schedule D – Pharmacy Fees – Dec 11, 2000

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, 1996
- Guidelines for the Pharmacists on "The Role of the Pharmacy Technician"

COLLEGE STAFF

Frequently Accessed Extensions

Registrar's Office x 243
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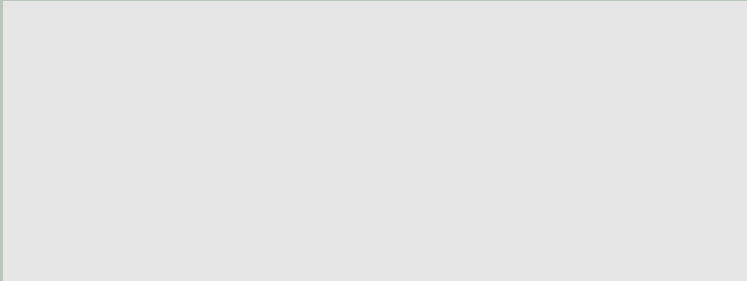
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