

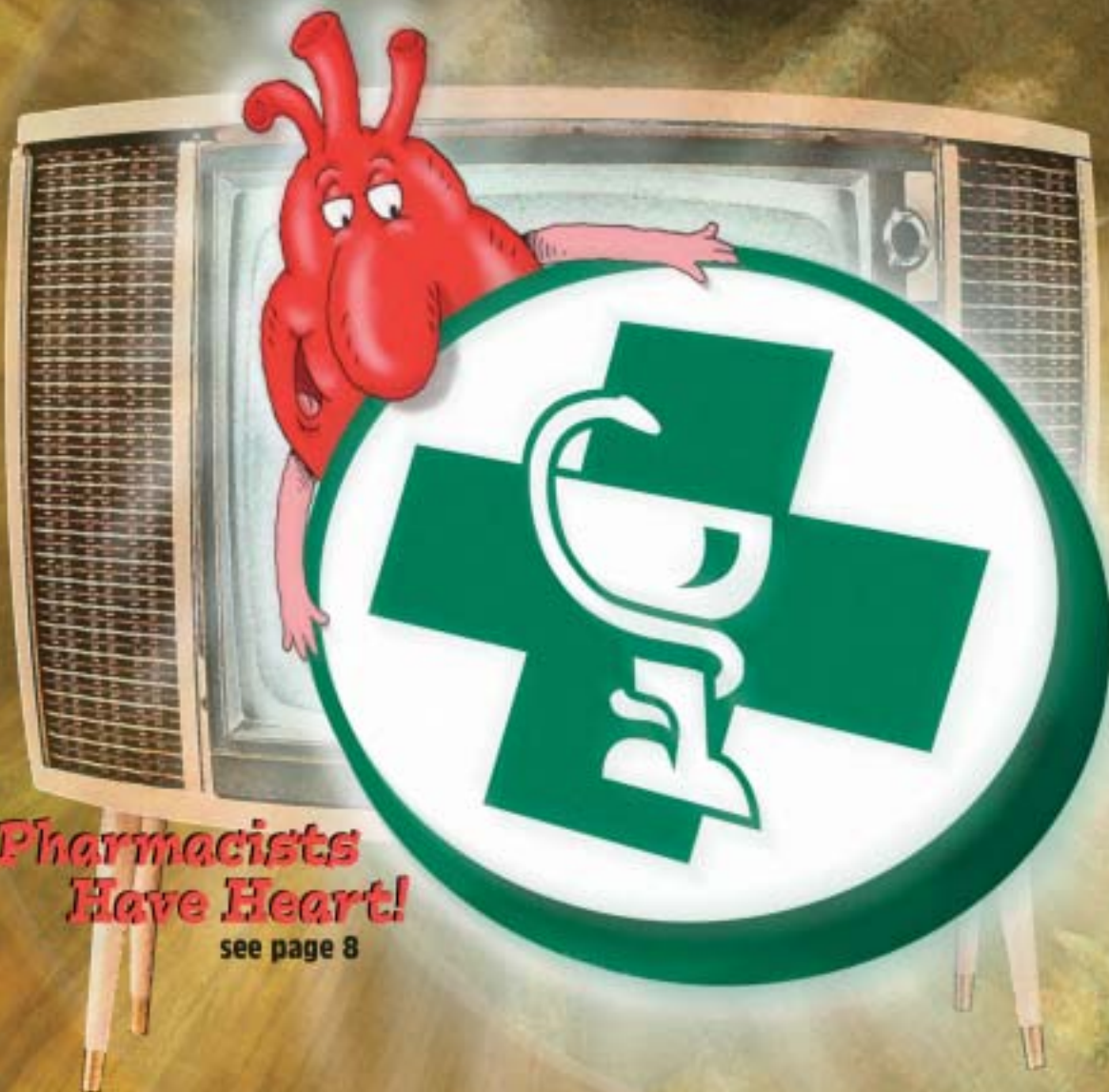
Pharmacy Connection



Official Publication of the Ontario College of Pharmacists

Annual
Pharmacy Fees
Due May 10, 2003

March/April 2003



**Pharmacists
Have Heart!**
see page 8

MMT Methadone
Maintenance
Treatment see
page 10



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.

Council Members

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

1 Marie Ogilvie	11 David Malian, <i>President</i>	PM Bob Drummond
2 Mark Scanlon	12 Vacant	PM Dean French
3 Oluremi Ojo	13 Donald Stringer	PM Tina Gabriel
4 Reza Farmand	14 Stephen Clement	PM Steve Gupta
5 Larry Hallok	15 Gurjit Husson	PM Katherine Hollinsworth
6 Alexander Wong	16 Albert Chalet	PM Mel Jones
7 Leslie Braden	17 Shelley McKinney	PM Stephen Mangos
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Statutory Committees

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

Standing Committees

- Finance
- Professional Practice

Special Committees

- 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

MEMBER

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.



EMERITUS

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.

**MEMBER
EMERITUS**

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:

- Encourage ongoing dialogue with pharmacists by communicating information on College activities and discussing issues of interest to members.
- Promote understanding and appreciation of the role of the pharmacist among members of our profession, allied health professions and the public, and provide access to resources that will facilitate the provision of pharmaceutical care.

We welcome original manuscripts for consideration. We publish six times a year, in January, March, May, July, September and November. Manuscripts should be received no later than 10 weeks prior to publication. If you intend to submit material, or would like a copy of the publishing requirements, please contact the Associate Editor. The Ontario College of Pharmacists reserves the right to modify contributions as editorial staff feel is appropriate. To be published, subject matter should promote the objectives of the journal. We also invite you to share with us any suggestions for topics, or journal criticisms, etc. Letters must include the name, address and telephone number of the author for verification purposes, and may be reprinted in the *Letters* column. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.



Deanna Williams
Registrar

Registrar's Message

What's a milestone birthday? Have you ever had one? According to everyone I know, I have one coming up and I am constantly being asked what big plans I have made to celebrate it. But plans for my big day aside, this milestone has prompted me to make a change that I have been contemplating for some time now. I am going back to using my birth name — Deanna Lynne Williams — both professionally and personally.

What makes a birthday, any birthday, a milestone? In one sense, I feel that every birthday marks another milestone—another year of being here. That's because I have already lost too many friends in my relatively short life. Indeed, since the beginning of this year, four friends and colleagues have died (all between the ages of 42 and 53). And, at our high school reunion last year, we realized that only 14 of the 18 women in our graduating class are still here. Very scary indeed.

I think that whether a birthday is “big”, whether it's a good one or not or whether it's a happy celebration or not depends completely on your personal outlook and where you are in your life at the time. I hated turning 40. But, looking back, I now know that how I felt then had everything to do with where I was in my personal and professional life.

I also now see that I have experienced more change in my life over the past ten years than I did in the previous forty, and it feels so very, very good. I'm not saying that change is comfortable. Any change, even good change, can be darned uncomfortable, but it is necessary to grow. As it is for most of us, many changes in my life have not occurred because I wanted them to. Some just happened, forcing me to react and then adjust, yet no matter how change occurs, it is *always* an opportunity for us to grow. The change in my life over the past ten years has resulted in tremendous growth for me — personally, professionally, emotionally and spiritually. And this is why this milestone birthday is one

that I embrace and look forward to.

There are many life experiences that we will have, although they will affect us all differently and sometimes not at all. But any life experience has the potential to change our lives forever. Life experiences are not always planned — birth, death, divorce, losing a job or perhaps even having that job offer that is “too good to be true” land on your desk when you least expect it. But no matter how differently each

of us is affected by these events, the fact is that they *do* change our lives, and the important thing is that somehow, and somewhere, we grow in the process.

Life is change, there's no getting around it. We just can't go forever doing the same thing over and over without something changing- eventually what we are doing will wear out or break down. A keynote presenter at a recent pharmacy association executive workshop spoke about “Managing Change”. Seems like an

oxymoron doesn't it? But he shared two thoughts that I think puts things into perspective and relate not only to life, but also to our profession.

The first is that nothing will result in faster and more dramatic change than a “burning platform”. Most of us resist change until the platform gets so “hot” that we feel the need to jump off. One look at pharmacy today and it's not hard to identify the issues that are causing a slow burn of our platform: Internet practice, pharmacist shortages, a more educated and demanding public, increased pressure to do more for less, and the increased difficulty in finding and maintaining that work/life balance that is so important to our quality of life.

Our platform, which has been smoldering for some time now, is starting to burn. Will this be the burning platform that will finally change the face of pharmacy practice?

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Can we really expect that things will change if we continue to do the same things? Are we ready to do things differently?

President's Message

Dave Malian
President



As part of Council's strategic direction to increase the public's knowledge of the full range and value of pharmaceutical services that are provided by pharmacists, the College created the *Point of Care* Program in 2002. It has been one full year since the start of the program, and we are pleased to report that the majority of pharmacies display the *Point of Care* symbol. The symbol is very important in helping the profession communicate consistently, across all pharmacies, the range of pharmaceutical services consumers can expect from their pharmacist. It is now the College's responsibility to help foster strong consumer recognition and understanding of what the *Point of Care* symbol means.

As I previously mentioned in a letter sent in December to all designated managers, we are pleased to announce that we are currently producing a unique and creative television commercial that will communicate the importance of both the pharmacist/patient relationship and the role of the College in regulating our profession. I am sure that you will be delighted by the quality of the commercial and hopefully, pleasantly surprised.


The commercial will begin airing March 24 and continue through the months of April and May and subsequently in 2004 and 2005. The commercial will be broadcast across Ontario on CBC and CTV and our goal is for all Ontario pharmacies to be displaying the symbol by the time the ad airs.

As such, if you do not already display the symbol in your pharmacy, I would encourage you to order a *Point of Care* kit in the next few weeks.

I am pleased that the College's strategic direction to: "*Communicate the value and range of pharmaceutical services to the public to facilitate their optimal protection through enhanced awareness of the pharmacists' role in meeting their health needs*" is well on its way to being fully fulfilled.

The Communications Committee, lead by Past-President Leslie Braden, has worked extremely hard to meet its mandate and I would like to congratulate them on a job well done. Don't

hesitate to provide your feedback once you have seen the commercial.

Remember to watch for our commercial on CBC and CTV come March 24. 

Our goal is for all Ontario pharmacies to be displaying the symbol by the time our commercial airs.



Seeking Best Practices!

The Standards of Practice Committee wants to hear about Ontario pharmacists' best practices. The Committee is exploring an expanded scope of practice and would like to hear from you.

- *What initiatives have you taken in your practice to provide better patient care?*
- *What have you done to advance your practice?*
- *Can you identify cases where you could provide better patient care if an expanded scope of practice was available to you?*

Tell us about your experiences.

Please write, email or send a fax to the Chair, Standards of Practice Committee c/o:

Louise Todd

Fax: (416) 847-8283


ltodd@ocpinfo.com


Registrar's Message

continued from page 4

The presenter's second thought was the most meaningful to me: "We can't expect anything to change when we continue to do the same things over and over". In pharmacy, we have been talking the talk for the thirty years that I have been in the profession; talking about the cognitive role of pharmacists and the right of pharmacists to be recognized for what we are: drug therapy experts and not just dispensers of pills. The talk has been getting louder and the pressure from within our profession to propel pharmacists into an expanded scope of practice and role is increasing, but can

we really expect that things will change if we continue to do the same things? Are we ready to do things differently? Are we ready for real change?

I know that my message is more philosophical than usual but please indulge me with your patience-after all, I have a "milestone birthday" coming up! 



Attention Pharmacy Owners/Operators

By mid March you should have received your annual accreditation renewal form. You will notice some significant changes on this year's form – changes which are aimed at increasing awareness of owners' responsibility to adhere to legislation affecting pharmacy regulation.

As reported to you last summer through the *Standards for Designated Managers*, acknowledgement of directors and designated managers is now an annual requirement of every pharmacy.

In addition, we will be seeking information on the drug information service that your pharmacy subscribes to as well as confirmation that any change to the corporate structure of your pharmacy is accurately reported and in compliance with the regulations. To achieve this, the College requires the submission of either a CIA Annual return or a Corporation Profile as confirmation that the corporation information filed with the College corresponds to the Ministry's records.

Note: The fee form requires the signature of all directors to confirm the corporate structure and to acknowledge the *Standards for Designated Managers*. Although we have provided ample time for owners/operators to complete the form and submit the payment together, we realize that some pharmacies may have difficulty obtaining all the required signatures (copy of the CIA - Annual Return or the Corporation Profile) in time for the deadline. Please be sure to submit your payment on time and remember that the penalty is for late *payment*, not late *filing*.

ANNUAL PHARMACY FEES DUE MAY 10, 2003

Pharmacy fees of \$749 (\$700 + \$49 GST) are due by May 10, 2003. Renewal forms will be mailed to each pharmacy head office address (as recorded with the College) by mid-March; please contact the College if you have not received your form by March 31, 2003.

Once processed, the certificate of accreditation and income tax receipt are mailed to the head office.

Fee Payments

As prescribed in the OCP by-laws, pharmacy owners are responsible for timely renewal and payment. Owners are equally responsible for filing information relating to the pharmacy and its ownership structure.



May 10th Deadline

All completed forms and fees must be received and/or postmarked no later than May 10, 2003. The sooner your form and payment are received, the sooner it will be processed and the sooner you will receive your receipt and certificate of accreditation. (We will try to notify you prior to May 10 if there is a problem with either the form or the payment.)

Late Payments

It is important that you submit your pharmacy fees on or before the deadline to avoid penalties. Payments made after May 10, **and paid within 30 days after the deadline**, are subject to a fee of \$107 (\$100 + \$7 GST). The penalty fee **for payments made after June 10, 2003** will increase to \$160.50 (\$150 + \$10.50 GST). This includes cheques received early but postdated after these dates.

Furthermore, late payments are not processed until the penalty has been received (fee + late penalty fee). NSF cheques are treated as late and incur both a late penalty fee and a \$5 NSF charge.

Records Update

The records update section continues to require information on:

- Which pharmacists (with and without signing authority), and technicians are practising at the pharmacy
- Lock and leave practices
- Methadone dispensing
- Participation in the *Point of Care* program
- Pharmacy website information

In addition to these items, we require you to:

- Indicate which of the College-approved Drug Information Services the pharmacy subscribes to
- Have all directors sign the form to acknowledge the *Standards for Designated Managers* and as a declaration that no changes have been made to the corporate ownership structure since the last corporate information filing with the Ministry of Consumer and Business Services

Make sure your cheque is signed and made payable to the Ontario College of Pharmacists or OCP for the correct amount of \$749.00.

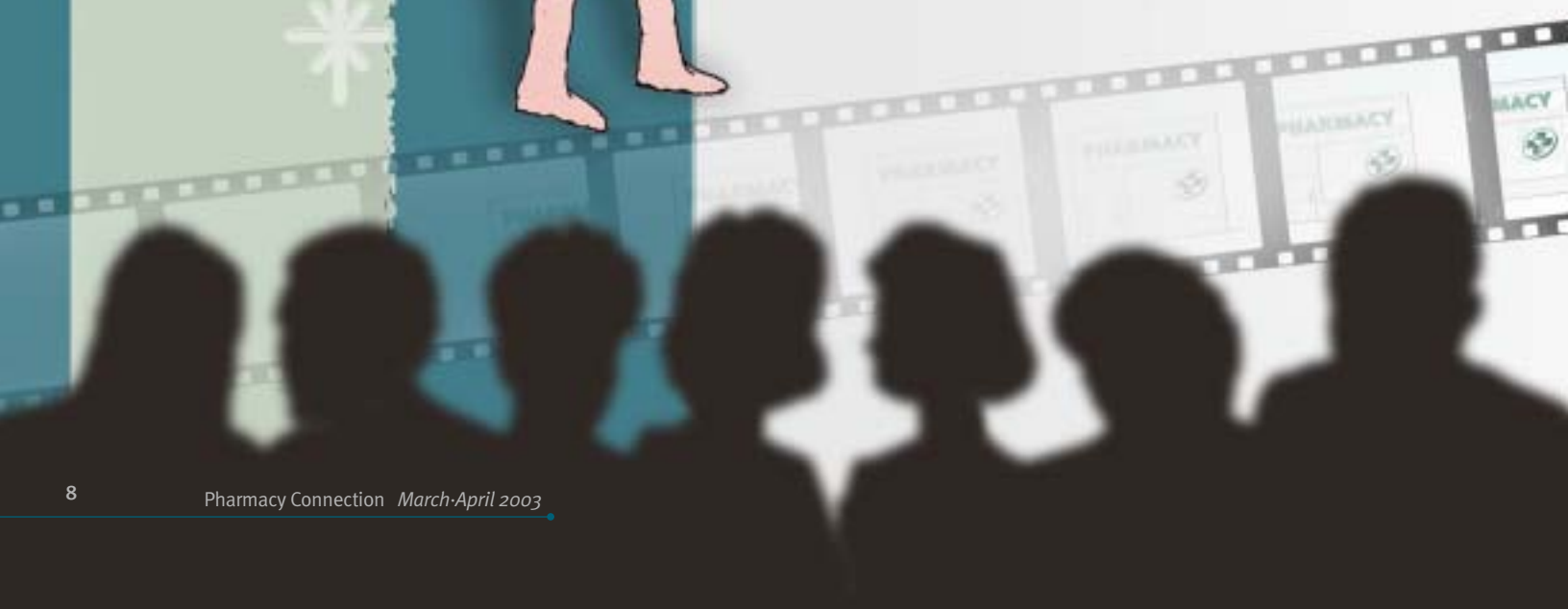
For further information contact:

Member Services
 Roland Starr (416) 962-4861 x 237
 rstarr@ocphinfo.com
 Maria Beck x 298, mbeck@ocpinf.com
 Ifrah Osman x 230, iosman@ocpinf.com

Pharmacists Have Heart!



Look for this symbol at your local pharmacy!





Leslie Braden, B.Sc.Pharm.

*Chair, Communications
Committee*

The College will soon be broadcasting its first television commercial to promote the value of the pharmacist/patient relationship as well as introduce the new *Point of Care* symbol to the public.

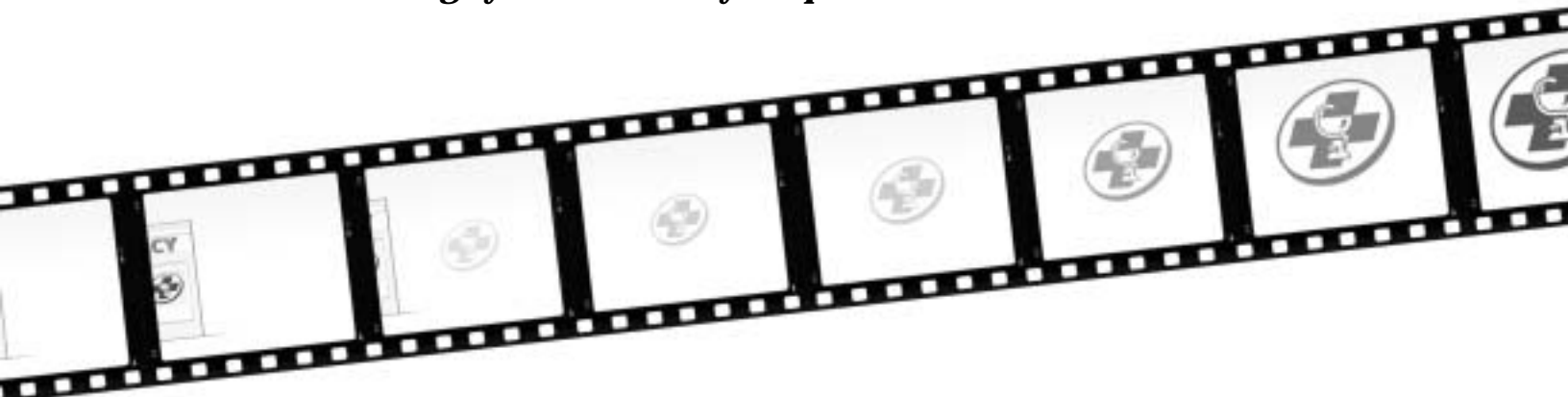
Based on extensive research, an animated commercial was developed as the most effective way to communicate our key messages to our target adult audiences as well as serve as a commercial that will break through the “clutter” of usual television advertising. This commercial focuses on the important issues of drug interactions and pharmacist intervention, issues reported as most important by patients and pharmacists alike.

Together with the Communications Committee and College staff, the commercial was conceived by GroundZero Marketing and Communications Inc. and created by leading animator Bob Fortier and XYZ Edit, both of Toronto.

While our role is to ensure the public understands the value of the pharmacist/patient relationship and the nature of self-regulation we also want to ensure that pharmacists support the messages that are being communicated to the public on behalf of the profession. We were pleased to find during our testing, with both the public and pharmacists that this commercial concept and messages were well understood and accepted. Indeed, pharmacists in our focus groups applauded the College for taking this important step in public education.

Airing on both CBC and CTV stations across Ontario, we have chosen to broadcast the commercial during news and news-related programming. We anticipate that audiences watching such programming will also be in a more receptive frame of mind for the unique messages offered in our commercial. For example, the ad will run during nightly national news broadcasts on both networks.

Please encourage your staff and your patients to watch for the commercial!



Starting March 24, 2003, the *Point of Care* ad will run for eight weeks, ending the week of May 19. Broadcast across both CBC and CTV Ontario networks, the commercial will air on 9 stations from Thunder Bay to Ottawa to Windsor.



Albert Chaiet

Chair, Professional
Practice Committee

Methadone Maintenance Treatment

Policy for Dispensing Pharmacies

Council recently approved the recommendations of the Professional Practice Committee and is publishing the following policy to establish the College's expectations for a standard of practice regarding *methadone maintenance treatment* (MMT).

Methadone may be prescribed for treating pain, or as a substitute narcotic to treat opiate dependence. The following policy specifically applies to the methadone dispensing for opioid dependence and is meant to reinforce the more specialized management requirements for these patients.

The College is concerned with current methods of methadone dispensing and administration in Ontario. There have been increased incidences of accidental methadone

overdoses resulting in death, as well as numerous complaints from both patients and practitioners. Several other College committees also have concerns about how methadone services are being provided. We need to ensure consistency and safety in the dispensing of methadone for better patient care. Similarly systems are needed to minimize the risks of diversion and to assist pharmacists from unnecessary manipulation during dispensing.

The Professional Practice Committee is aware of the many challenges associated with methadone dispensing and will continue to review the education, training and resource requirements to ensure pharmacists across Ontario can provide appropriate methadone treatment and management.

MMT

METHADONE MAINTENANCE TREATMENT PRESENTS A UNIQUE SITUATION FOR PHARMACISTS AND PHARMACIES:

The *Narcotic Regulations* prohibit physicians from prescribing methadone. Physicians wishing to prescribe methadone must first be trained and registered with the College of Physicians and Surgeons of Ontario as part of a Federal program.

Patients agreeing to take part in MMT must also be registered with the CPSO. This program is well-structured and operated through CPSO with support from the Ministry of Health and Long-Term Care.

On the other hand, the *Narcotic Regulations* do not prohibit any pharmacist from dispensing methadone. The *Regulations* do, however, have requirements surrounding the recording of the purchase and sales of methadone. And while there are no restrictions nor mandatory programs for pharmacists who wish to dispense methadone, the College, the CPSO and the Centre of Addiction and Mental Health (CAMH) strongly recommend that policies be put in place.

Accessibility varies across Ontario. Access to either a pharmacy dispensing methadone or a physician authorized to prescribe methadone is difficult in some areas and non-

existent in others. This has led to various problems including: pharmacists who are not prepared to provide services to methadone patients, difficulties in finding knowledgeable or trained pharmacists, pharmacies unable to accept more patients, and issues with reimbursement.

Pharmacists' reluctance to dispense methadone may result from a lack of knowledge of the program and a failure to implement guidelines and policies that ensure appropriate professional relationships exist with the patient and physician, as well as with other pharmacy staff.

The following policy was developed to assist pharmacists and pharmacies who dispense methadone to patients and recognizes the uniqueness and inherent complications of managing this complex therapy. [📄](#)

See policy on page 12

A new revised edition of the CAMH publication "*Methadone Maintenance: A Pharmacist's Guide to Treatment*" will be available June 1, 2003. Pharmacists are asked to wait for the new publication before ordering.


CONTACT INFORMATION FOR PHARMACISTS WHO DISPENSE METHADONE		
WHO	WHAT	NUMBER
College of Physicians and Surgeons of Ontario	<ul style="list-style-type: none"> To verify a Methadone Prescriber 	Tel: 416-967-2661
Centre of Addiction and Mental Health	<ul style="list-style-type: none"> To order the required text: <i>Methadone Maintenance: A Pharmacist's Guide to Treatment</i> (CAMH) To obtain information on CAMH Methadone Training Workshops 	Tel: 416-595-6059 or 1-800-661-1111 Fax: 416-595-6644
Health Canada	<ul style="list-style-type: none"> To direct a hospital physician to obtain authorization to prescribe methadone 	Tel: 613-946-5139
Ontario College of Pharmacists	<ul style="list-style-type: none"> To verify a Methadone Prescriber To obtain practice-related information 	Tel: 416-847-8293

Methadone Maintenance Treatment Policy

POLICY FOR PHARMACISTS AND PHARMACIES WHO DISPENSE METHADONE TO PATIENTS REQUIRING METHADONE MAINTENANCE TREATMENT

- The owner/designated manager of a pharmacy that dispenses methadone shall inform the College of this practice and shall inform the College whether they are accepting new patients and the names of pharmacists who are trained in the dispensing of methadone
- Pharmacies dispensing methadone shall maintain the most recent edition of the publication, *Methadone Maintenance: A Pharmacist's Guide to Treatment* (CAMH) as a required reference for the pharmacy library. In addition, the following publication produced by the College of Physicians and Surgeons of Ontario (CPSO) is recommended: *Methadone Maintenance Guidelines* (CPSO, CAMH, OCP, 2001)
- All pharmacies dispensing methadone shall adhere to the principles and guidelines developed in the publication, *Methadone Maintenance: A Pharmacist's Guide to Treatment* by Centre for Addiction and Mental Health (CAMH) in the treatment of MMT
- Pharmacies shall use a three-way agreement between the patient, pharmacist and physician (or four-way agreement to include social worker) in dispensing methadone. The agreement will outline the expectations in methadone treatment therapy of all parties
- The agreement will include consent to access personal health information with respect to methadone treatment
- The pharmacy will use a log file (which may include photograph of patient) for signing-off drink and carry doses by the patient and a pharmacy staff witness. At a minimum, positive identification must be shown if the patient is unknown to staff
- Pharmacies will maintain a bulk-compounding log file that contains:
 - Date, name (printed) and signature of two staff members (pharmacy technician/pharmacist for double-checking purposes) preparing the stock solution, quantity and lot number of methadone used as well as final quantity made

- Quantity of stock solution used, date, Rx number and name (printed) and signature of two staff members (pharmacy technician/pharmacist) who dispensed/mixed the stock solution with vehicle as prescribed
- Pharmacies must maintain either a Class A prescription torsion balance or an approved electronic scale and maintain a supply of measuring devices suitable for accurately measuring required doses, such as calibrated syringes, measuring pumps, etc
- The label on stock solution bottles must be distinct and easily identified from other bottles. The label on stock bottles shall state the date of manufacture, expiry date, concentration and lot number of methadone used
- Methadone for MMT will be dispensed in a suitable vehicle in unit doses as outlined in the CAMH Guidelines
- Labels on all dispensed unit-dosed bottles of methadone shall be in accordance with the *Drug and Pharmacies Regulations Act*, section 156. In addition, each unit dose must be uniquely identified with date for ingestion, and the total dose contained in the bottle
- The use of the following auxiliary label: "Methadone may cause serious harm to someone other than the intended patient. Not to be used by anyone other than the patient for whom it was intended."

Note: The required *Narcotic Regulations* must be followed in addition to the *Standards of Practice* and the *Code of Ethics*. 

The following education guidelines are also recommended to pharmacists and pharmacies who dispense methadone to patients requiring MMT:

- The owner/designated manager shall ensure that all pharmacists are trained in MMT and that all pharmacy staff are trained/knowledgeable in MMT
- All pharmacists dispensing methadone for MMT obtain training via CAMH workshops and/or other College-approved courses and that training be updated every five years
- Pharmacists dispensing methadone are recommended to take methadone training as soon as possible to meet these new guidelines, and ensure public safety



Greg Ujiye, B.Sc.Pharm.

Manager, Pharmacy
Practice Programs

Q&A

Pharmacy Practice

M E T H A D O N E

Q I currently have one methadone patient. Do I need to notify the College that I am dispensing methadone and will I need to follow the new policy passed by Council in December 2002?

Yes. All pharmacies that dispense methadone are required to follow the *Methadone Maintenance Treatment Policy* approved by OCP Council in December 2002.

The owner or designated manager of a pharmacy that dispenses methadone shall inform the College of this practice and whether or not they intend to accept new patients. The names of pharmacies accepting new methadone patients will be released only to authorized methadone prescribers and pharmacists who are seeking a dispensing site for patients.

Q How can I confirm whether a physician is allowed to prescribe methadone?

Names of authorized methadone prescribers and methadone pharmacies are confidential and not for distribution. However, pharmacists and pharmacy staff can confirm whether a physician is a prescriber for methadone (for either pain or methadone maintenance therapy) by contacting the College of Physicians and Surgeons at 416-967-2661 or by contacting the Ontario College of Pharmacists at 416-847-8293.

Q A methadone patient has been admitted to our hospital. Can any of our physicians write a prescription for this patient?

A methadone prescriber must get prior approval from Health Canada to prescribe methadone. A physician in the hospital who requires temporary prescribing authorization should be directed to call Health Canada at 613-946-5139.

Q Can I accept a prescription for methadone by fax?

Pharmacists can accept any prescription by fax, including methadone prescriptions as well as other narcotic and controlled drugs, provided the prescription is faxed from the methadone prescriber's office and verifiable. All pharmacists are required to adhere to the fax policy and should ensure that faxed prescriptions are dated and signed by the physician. In addition, the pharmacist should verify the disposition of the original prescription with the prescriber.

Q The December 2002 methadone policy passed by Council indicates that bottles must be uniquely identified.

What does that mean?

Methadone prescriptions can pose as a labelling problem. To ensure that all dispensed unit-dose bottles can be traced, the labels must identify the date for ingestion and the total dose contained in the bottle. The labels must also be maintained in accordance to Section 156 of the *Drug and Pharmacies Regulations Act*.

Q Where can I obtain the required auxiliary label for methadone dispensing?

The following auxiliary label is recommended in the methadone policy:

"Methadone may cause serious harm to someone other than the intended patient. Not to be used by anyone other than the patient for whom it was intended."

We have learned that the label can be obtained from Pharmasystems Inc. (1-888-475-2500). Pharmacists may also check with other label providers. Alternatively,

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HEALTH CANADA

Advisories & Notices

DATE	TYPE	GENERIC NAME	TRADE NAME
December 17 / 02	Public Advisory – Important Safety Information Regarding the Use of Kineret® (anakinra) in Combination with etanercept	Anakinra	Kineret®
December 17 / 02	To Health Professionals - An Advisory on Important Safety Information Regarding the Use of Kineret® (anakinra) in Combination with etanercept	Anakinra	Kineret®
December 18 / 02	Public Advisory – Liver Problems Associated With the Use of Accolate® (zafirlukast) in Some Patients	Zafirlukast	Accolate®
December 18 / 02	To Health Professionals – Liver Problems Associated With the Use of Accolate® (zafirlukast) in Some Patients	Zafirlukast	Accolate®
December 19 / 02	Important Safety Information	Cyproterone acetate / ethinyl estradiol	Diane-35®
December 2002	To Health Professionals - Important Safety Information Regarding Bextra™	Valdecoxib	Bextra™

For an electronic mailing of the Health Canada Advisories / Warnings health professionals, subscribe online at: www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/mail_list.html

Q&A Pharmacy Practice

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pharmacists may contact their software vendors for guidance on how to input the auxiliary label into their pharmacy software system.


Q Do I need to be trained to dispense methadone?

The College recommends that owners and/or designated managers ensure that their pharmacists are trained for MMT dispensing. Pharmacists are asked to contact the Centre of Addiction and Mental Health (CAMH) for information on their workshops.

In addition, requirements of the MMT Policy state that methadone pharmacies must have a copy of the text:

Methadone Maintenance: A Pharmacists Guide to Treatment (CAMH - Most recent edition).

Please call CAMH for information on training and purchasing their publication: Tel: 416-595-6059 or 1-800-661-1111 Fax: 416-595-6644.

Note: When reviewing the CAMH required reference: *Methadone Maintenance: A Pharmacists Guide to Treatment*, pharmacists should remember that guidelines are considered best practices. Any variance from the CAMH guidelines must be in collaboration with the prescribing physician and documentation is absolutely required. 



Focus on Error Prevention



Ian Stewart, B.Sc.Pharm.

When written clearly, pharmacists can readily identify and interpret the following Latin abbreviations:

Abbreviation	Latin	Meaning
b.i.d.	bis in die	twice a day
t.i.d.	ter in die	three times daily
q.i.d.	quater in die	four times daily

Many uncommon and confusing abbreviations exist. Take for example the Latin abbreviation s.i.d. (semel in die)¹.

In an informal survey, approximately twenty-five pharmacists were asked to provide the meaning of s.i.d. All confessed that they had not seen the abbreviation previously and therefore could not provide the translation. Although s.i.d. is an abbreviation commonly used by veterinarians when writing prescriptions to indicate once a day dosing, pharmacists rarely encounter this abbreviation in day-to-day practice. When speaking to veterinarians about this issue, most are unaware that pharmacists are not familiar with the meaning of s.i.d.

This gap in communication can lead and has led, to misinterpretation of s.i.d. When written poorly s.i.d. has been misinterpreted as b.i.d. (twice daily) and q.i.d. (four times daily). Pharmacists must remain vigilant and

cognizant of the terminology used by other health professionals as well as those trained in other jurisdictions. The following prescription demonstrates the potential for error:

Oneprazole 20mg qd

Possible Contributing Factors:

- The pharmacist's lack of knowledge of the Latin abbreviation s.i.d.
- The veterinarian's use of an abbreviation not often seen in pharmacy practice

Recommendations:

- Always contact the prescriber to clarify potentially confusing or ambiguous abbreviations
- Ensure that all pharmacy staff are aware of uncommon abbreviations such as s.i.d. Some veterinarians indicated that they also use the abbreviation u.i.d. to indicate once a day dosing
- Encourage veterinarians and other practitioners to avoid the use of abbreviations which can be misinterpreted. Suggest the directions for use be written out as "once daily" ^c

Reference:

1. Dorland's Illustrated Medical Dictionary, 28th Edition, page 1872



Chris Schillemore, B.Sc.Pharm.

Manager, Registration Programs

Q&A Registration

Q I'm an internationally trained pharmacist and I have heard that if I pass the PEBC Qualifying Exam Parts I & II, I can go directly into internship. If this is true, why would I want to do the International Pharmacy Graduate Program?


The College's registration regulation does not contain any provision for a blanket exemption from the requirements of studentship for international pharmacy graduates who pass both parts of the PEBC Qualifying Exam (currently comprised of 16 weeks of academic modules through the International Pharmacy Graduate Program, and 16 weeks of Structured Practical Training in a pharmacy). Candidates who were successful on the Qualifying Exam Parts I & II and wish to proceed directly to internship may request an exemption from the requirements of studentship from a panel of the Registration Committee.

Since the implementation of the new PEBC Qualifying Exam format in 2001, many international pharmacy graduates have been licensed in Ontario after successfully completing the new Qualifying Exam, structured internship and the jurisprudence exam. However, monitoring by College staff of interns' progress through the Structured Practical Training Program has shown that many interns require extended periods in internship despite their success on the new PEBC Qualifying Exam.

In light of these results, those applying for internship who have not completed the requirements of studentship may/will have their applications referred to a panel of the Registration Committee to determine if an exemption from

any of the requirements of studentship is warranted. The panel will consider what sort of experience an applicant has had previously in pharmacy. If an applicant has no experience working in a direct patient care setting in his/her previous jurisdiction, or their previous direct patient care experience was dissimilar to that found in Canadian pharmacy practice, it is possible that 16 weeks internship may not be sufficient preparation for his/her licensure.

There are many reasons why an applicant should complete both the International Pharmacy Graduate Program at the Faculty of Pharmacy and Structured Practical Training before attempting the PEBC Qualifying Exam. Indeed, the IPG Program and the structured training are the in-service training requirements approved by Council after careful consideration of what knowledge, skills, and values are needed to successfully practice pharmacy in Ontario. The IPG Program's curriculum will help you to prepare for practice and the PEBC Qualifying Exam through courses on communications, patient counselling, dispensing, pharmacy practice and therapeutics.

Without Canadian pharmacy practice experience it is difficult to be successful on the PEBC Qualifying Exam. Individuals who repeatedly attempt the Qualifying Exam without the aid of the IPG Program and Structured Practical Training are, in fact, delaying their licensure, not speeding it up. For more information on the IPG program, visit the website at www.newontariopharmacist.com/ipg. 



Stephanie Edwards, B.Sc.Pharm.

Q&A

SPT



Diana Spizzirri, B.Sc.Pharm.

Q What is the purpose of the Questions and Activities (Q&As) in the SPT Studentship and Internship programs?

These Q&As are designed to help the student or intern demonstrate their competence to their preceptor. *Questions* should be completed near the beginning of the rotation, while the *Activities* may have to be completed as a suitable situation arises.

Q What role do preceptors play in students' Q&As?


Preceptors and students/interns are asked to read and discuss the Q&As together when planning the rotation. They should consider whether or not the activities need to be scheduled or if they require facilitation by the preceptor.

Students will undoubtedly have questions for their preceptors and we suggest you schedule a regular discussion time with the student, e.g., 15 minutes/day, or 1 hour/week.

Q What are the requirements and responsibilities of preceptors to the Q&As?

Please review the Preceptor Guide that is provided in the preceptor manual. The SPT Manuals also contain a Q&A checklist to assist students and preceptors to plan and keep track of which of the Q&As have been completed. As *Questions* and *Activities* are completed, reviewed by the preceptor, and corrected by the student where necessary, the checklist should be dated and signed by both parties.

Q How does the College ensure the quality of the student's Q&A submission?

The College relies on preceptors to provide the necessary and immediate feedback to students as they prepare their Q&As. We encourage preceptors to expect the highest quality of work from their students and interns. When the completed Q&As are returned to the College through the random sampling process, SPT staff will review and record that the Q&As have been completed in accordance with the standards set out in the *Preceptor Guide*. SPT staff will only provide feedback to individual students or interns whose work does not meet these standards. 

Investigator

Investigations and Resolutions Programs

The Ontario College of Pharmacists is the licensing and regulatory body for the profession of pharmacy. We are currently seeking an Investigator who will apply his/her knowledge, analytical skills and problem-solving abilities to conduct investigations of pharmacists (as it relates to professional misconduct, incompetence or incapacity) and of pharmacies (as it relates to operational breaches and non-compliance with relevant legislation).

The Person

You have sound knowledge of the *Standards of Practice* and the legal framework that govern pharmacy in Ontario. Ideally you have a degree in pharmacy as well as a minimum of three years practice experience. You possess: excellent oral communications skills; experience in detailed report-writing; demonstrated knowledge of investigative interviewing techniques; and proficient computer skills including pharmacy related software and billing programs. You remain objective, consistent and fair in all interactions. You have a passion for learning; creatively look for new ways of achieving your goals; and are able to work either independently or within a team environment. You possess a valid driver's license.

The Position

Reporting to the Manager, Investigations and Resolutions Programs, you will: conduct investigations including onsite visits to pharmacies throughout the province; gather information/evidence; liaise and follow up with law enforcement and other agencies; provide assistance in preparing cases for discipline hearings and testify as required; and attend various committee meetings/hearings to provide clarification on cases.

If you are interested in becoming a member of this team, please forward your resumé with salary expectations by April 11, 2003, to:

Lisa Baker, Human Resources
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4
fax 416-847-8279 or email: lbaker@ocpinfo.com

We wish to thank all applicants for their interest in this position. Only those candidates chosen for an interview will be contacted.

Update on Pre-Admission Competency Testing

for International Pharmacy Graduate Program Students

Mike Galli, Artemis Diamantouros, PLA Coordinators

The IPG Program held its first competency assessment for incoming students on October 15, 2002.

This process, known as the Prior Learning Assessment (PLA), constituted a full day of testing and resulted in a significant learning experience for staff and students. The logistics required to run the testing day were substantial and included coordinating 31 IPG students, 14 pharmacist assessors, 5 linguistic assessors, 12 standardized patients, 2 track coordinators, and 6 invigilators. This was followed by data review of assessments and development of student learning plans.

The PLA process was designed to assess both pharmacy-related competence and linguistic competence for each participant. Activities were divided into two tracks, each lasting three hours. Students completed all stations.

Track 1 consisted of three stations for the following tasks:

- Reading Assessment
- Writing Assessment
- Oral Assessment

Each task was based on pharmacy-contextualized questions. The *oral assessment* was centered on a clinical situation where participants were given a patient case to review and then engaged in a discussion with a pharmacist-assessor based on standardized questions. The dialogue was taped and two language assessors later conducted separate linguistic assessments.

Track 2 was a more complex configuration of 15 separate stations:


- 5 OSCE-type patient counselling stations (video-taped for later linguistic assessment)
- 2 stations for receiving verbal prescriptions

- 2 drug information stations
- 2 prescription-checking stations
- 1 calculations station

The assessment process and expectations were a revelation for most students as it informed them of many aspects of pharmacy assessment in Ontario of which they were unaware. Both verbal and written feedback on the testing indicated that the day had been a positive learning experience for all. Participant comments included, “The day covered all aspects related to pharmacy practice”; “It was my first time (participating) in such a process, but I was comfortable during the PLA day” and “The PLA staff were very friendly and helpful”.

The results of this competency testing indicate that international pharmacy graduates possess both strengths and weaknesses in various areas of practice and communication —valuable information for both students and staff. The results of the testing suggest that international pharmacy graduates should be given an opportunity, in advance, to demonstrate their competence in these areas so they may possibly be exempted from certain modules of the IPG Program curriculum.

The pilot also helped us validate the process and tools of the PLA. The methods used for conducting assessments, tabulating results, and creating *individualized learning plans* for each participant was too time consuming and resource intensive for sustainability. As a result, we will modify aspects of the process for future sessions.

We anticipate that, building on the initial successes of the pilot, the prior learning assessment process will continue to evolve and will serve as a valuable tool in helping us assist international pharmacy graduates who come to our program seeking licensure in Ontario. 

NOTICE TO PHARMACISTS

AMENDMENTS TO DRUG SCHEDULES

Generic Drug Name	Schedule	Date of Change
TPN additives		
To improve clarity and consistency, the current Schedule I entry " <i>Electrolyte solutions for parenteral use</i> " will be deleted. Individual TPN additives will be identified and listed as separate Schedule I entries. See below.		
Calcium chloride in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Calcium gluconate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Copper sulfate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Dextrose injection in concentrated solutions for parenteral nutrition	Schedule I	January 17, 2003**
Lipid solutions in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Magnesium sulfate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Sodium acetate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Sodium chloride in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Sodium iodine in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Sodium phosphate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Vitamins in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Zinc chloride in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Zinc sulfate in injectable form for parenteral nutrition	Schedule I	January 17, 2003**
Chromic chloride (parenteral) amended to Chromium chloride (chromic chloride) in injectable form for parenteral nutrition	Moved to Schedule I	January 17, 2003**
Cupric chloride (parenteral) amended to Copper chloride (cupric chloride) in injectable form for parenteral nutrition	Moved to Schedule I	January 17, 2003**
Manganese and its salts (for parenteral use) amended to Manganese and its salts in injectable form for parenteral nutrition	Moved to Schedule I	January 17, 2003**
Selenium (for parenteral use) amended to Selenium in injectable form for parenteral nutrition	Moved to Schedule I	January 17, 2003**
Nicotine by inhalation	Schedule III	When approved by Health Canada
Loperamide and its salts in oral solid dosage forms.	Unscheduled	January 17, 2003**
Acetaminophen in sustained release formulations (up to and including 650 mg per unit) in package sizes containing no more than 50 units (Acetaminophen in sustained release preparations outside of these criteria will remain in Schedule III).	Unscheduled	January 17, 2003**
Brompheniramine and its salts as a single entity for the treatment of allergies. (NB: change in wording)	Schedule III	January 18, 2003*
Brompheniramine and its salts in combination products for the relief of cough and cold symptoms.	Unscheduled	January 18, 2003**
Docosanol (10% for topical use)	Unscheduled	October 2002**
Loratadine and its salts and preparations in products marketed for adult use (age 12 and over)	Unscheduled	October 2002**
Loratadine and its salts and preparations marketed for pediatric use (under 12 years of age)	Schedule III	October 2002**

** Date is in effect provided that no valid objections are received in the interim

* Please refer to the NAPRA drug schedules for more information at: www.napra.org
Please also continue to check the OCP website, www.ocpinfo.com for Health Canada drug notices as well as schedule changes.

KCl *in Ontario Hospitals*

Please review the following joint safety project regarding concentrated potassium chloride in Ontario hospitals. We encourage you to ensure that these strategies are implemented in your hospital & practice.

Medication Safety Support Service Project: System Safeguards to Prevent Error-Induced Injury with Concentrated Potassium Chloride

The Ontario College of Pharmacists is pleased to be member of the advisory committee for a new Medication Safety Support Service available to Ontario healthcare facilities. Members of this committee include the Ministry of Health and Long-Term Care, Ontario Hospital Association, College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, Ontario Pharmacists' Association, Canadian Society of Hospital Pharmacists, Ontario Medical Association, Registered Nurses Association of Ontario and the Institute for Safe Medical Practices Canada.

This service is a joint initiative of the MOHLTC, the OHA and the ISMP-Canada. The first project is to assist Ontario hospitals to implement strategies and safeguards for the prevention of patient injury from errors with potassium chloride.

Injury due to **inadvertent intravenous administration of concentrated potassium chloride (KCl)** is a serious patient safety concern that **has resulted in several deaths in Ontario hospitals**. A significant contributing factor in many of the errors reported to date is the availability of potassium chloride concentrate ampoules or vials in patient care areas.

In the United States (per JCAHO) and the United Kingdom (with government initiatives) steps have already been taken to remove concentrated KCl vials from patient care areas.

The first step in this project was a survey conducted in October 2002 to determine the extent to which concentrated potassium chloride is available in patient care areas in Ontario hospitals. The results indicate that among the 145 Ontario hospitals responding, many continue to stock concentrated potassium chloride on inpatient nursing units.

ISMP Canada has assembled a comprehensive package to assist in the removal of KCl concentrate from nursing units in Ontario hospitals. The package contains the rationale, the experience of many Canadian hospitals, examples of programs in other countries, draft letters to physicians, examples for automatic substitutions, sample hospital newsletters, posters, etc. Copies of this KCl package are available, free of charge, to all healthcare facilities in Ontario. For more information on this project, please visit www.ismp-canada.org or contact ISMP Canada via kclsupport@ismp-canada.org.

"The way to prevent tragic deaths from accidental intravenous injection of concentrated KCl is excruciatingly simple -- organizations must take it off the floor stock of all units. It is one of the best examples I know of a 'forcing function' -- a procedure that makes a certain type of error impossible."

— **Lucian L. Leape, M.D.,**
Harvard School of Public Health

The OCP encourages the support of our members in this patient safety initiative.

Deciding on
Discipline

2002 DISCIPLINE Committee Activity Summary Discussion



Larry Boggio, B.Sc.Pharm.

The Discipline Committee was very busy in 2002; going a long way to clearing a backlog of cases that had accumulated. There were 45 sittings of Discipline Committee panels involving allegations against 54 pharmacists and four pharmacies (compared to 2001 where there were 12 sittings of panels involving 13 members and one pharmacy and one motion involving one member.)

These sittings were mostly for uncontested hearings, but included four contested hearings, and several motions. One 2002 decision of the Committee was appealed to the Divisional Court, heard, and subsequently upheld in a decision released early this year. A Committee decision from 1998 which had been upheld at Divisional Court in 2001, was heard at the Court of Appeal in 2002 and overturned.

RANGE OF ORDERS

In reading recent decisions, you will note that the trend over the past year has been for panels of the Discipline Committee to make more targeted and comprehensive orders than they had previously. An increase in the suspension periods being ordered, as well as fines/costs being applied in cases involving serious misconduct pertaining to moral turpitude, both reflect the College's and the Discipline Committee's view that such conduct must be curtailed.

Specifically, the Discipline Committee's orders in 2002 resulted in the suspension of certificates of registration, for

varying amounts of time, of 33 members, nine of whose could be completely remitted, eight of whose could be partially remitted and 16 could not be remitted at all. While four suspension orders were for a period of twelve months, only one case resulted in an order of revocation of the member's certificate of registration.

Where a case concerns a member's overall practice, unannounced inspections of the member's practice at the member's own expense, continue to be ordered to monitor his/her continuing quality and practice compliance. As always, all ordered penalties include a reprimand to the member. Made directly upon completion of the proceedings, reprimands provide an important opportunity for the panel to make confidential remarks to the member. For purposes of general education, transparency and consistency, all Discipline Committee decisions are published in *Pharmacy Connection*.

DISPENSING ERRORS AND REMEDIATION

Thirteen cases involved serious dispensing errors, cases in which the member's actions fell below the *Standards of Practice*. The orders made in such cases now focus on remediating any knowledge or practice system deficit that was identified to have contributed to the error. The Committee will continue to strive to make orders for dispensing error cases more meaningful with the goal of not only reprimanding a member for their past actions, but to also better

equip each member to return to excellence in their practice.

Such orders usually included suspensions, but where appropriate, some or all of the suspension could be remitted (cancelled) if the member attends and successfully completes remediation courses, (i.e. “Professional Practice Laboratories” or “Advanced Interviewing Techniques or Applied Therapeutics Lectures or Law Lessons” (correspondence) of the Canadian Pharmacy Skills Program at the Leslie Dan Faculty of Pharmacy, University of Toronto.)

Other remediation measures ordered included the Jurisprudence Seminar and Examination offered by the College, and the Ontario Pharmacists’ Association’s course on medication errors. Specific learning opportunities or needs were also met by ordering, for instance, the “Basic Compounding” course offered through the American College of Apothecaries, and the “Management of Medication Errors” course offered at the Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta.

REFERRALS TO THE QUALITY ASSURANCE PROGRAM

Several members were also ordered to participate in the College’s Quality Assurance Program. These were ordered, not as a punishment, but as an appropriate effort to more accurately assess practice deficits identified through a member’s conduct and to institute constructive measures to support them in future practice.

FAILURE TO EXERCISE PROFESSIONAL JUDGMENT AND TO INTERVENE

Interestingly, four cases involved pharmacists *not* doing the right thing; that is, to not intervene in situations of multiple-doctoring for narcotics — situations that should have been obvious to the members. We hope that the risks of such cases occurring in our profession serve as a reminder to all of us who enjoy the privilege of professional judgment and self-regulation — a source of envy to many pharmacists in other parts of the world.

PHARMACY OPERATIONAL ISSUES AND BILLING IRREGULARITIES

Some cases involved major improper operations of a pharmacy or improper billing practices by a pharmacist/owner. The order in six such cases appropriately included restrictions on the member’s future ability to own a pharmacy, be

a *Designated Manager*, be a narcotic signer, or be paid by any other means than a set salary. The Committee’s expanded use of its powers in these cases reflect its zero tolerance position on all acts of fraud or dishonesty, and on members who, through their actions, do not merit the privilege of pharmacy ownership and control over the practice setting which is unique to our profession in this province. By its orders, the Committee recognizes and demonstrates its obligation to significantly restrict the offending members’ practice privileges to ensure that the public (and the profession) is protected from unethical practice.


In a similar vein, one Committee decision recognized that responsibility for the operation of a pharmacy also rests with (among others) the pharmacist director(s) of the corporation owning that pharmacy.

CRIMINAL CONVICTIONS

In 11 cases, decisions of professional misconduct resulted from (or were related to) criminal convictions: tax evasion, assault, forgery, trafficking, and theft. Where a member’s misconduct (as seen in some of the criminal cases) was associated with a health condition or disorder (such as substance dependence), the order included terms and conditions requiring the member to enter into appropriate treatment and aftercare. In all of these cases, the Committee had to examine whether the conviction would remain relevant to the member’s suitability to practise. Misconduct proceedings are important in these cases because, regardless of what occurs in the criminal courts, only the College has the ability to regulate a member’s practice and correspondingly protect the public from unsafe or unethical conduct.

PROJECTIONS FOR 2003

In this issue, five recent uncontested cases are presented; four of which involve significant dispensing errors and one that relates to oversights in accuracy of reporting obligations.

While clearing the case backlog is well underway, we expect that 2003 will present as another busy and active year for the Discipline Committee, estimating an average of five cases per month. I wish to commend the members of the Discipline Committee in 2002 for their reliability and commitment of time and effort in balancing their contribution with their demanding careers. 

Deciding on Discipline

CASE 1

Dispensing Error

Member: Robert Mandel, Oshawa

Hearing Date: December 17, 2002

Mr. Mandel was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

The Discipline Committee accepted Mr. Mandel's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

Facts:

This matter arose from a referral from the Complaints Committee. This case involved a dispensing error made by Mr. Mandel in March 1999, wherein he dispensed 360 tablets of Glyburide instead of Baclofen which had been prescribed at a dose of 7½ tablets at various times throughout the day.

Shortly after the dispensing error occurred, the patient contacted the pharmacist on duty, questioning the change in size and shape of her pills. She was reassured by the pharmacist that manufacturers change the appearance of medications from time to time and that the correct medication had been dispensed to her. The call was not brought to the attention of Mr. Mandel who was the Designated Manager.

During the period that the patient consumed the Glyburide, she was not taking the Baclofen that had been prescribed for her. In addition to this, having consumed the incorrect medication at the daily dosage prescribed (for the Baclofen), the patient received an overdose of Glyburide. This resulted in the patient being hospitalized repeatedly over the next seven months leading ultimately to emergency surgery being scheduled, at which point the error was discovered.

It was noted that had the patient's call been directed to Mr. Mandel, Mr. Mandel would not have provided the assurance regarding the medication dispensed as described by the patient, without examining the medication himself.

Reasons:

The member and the College submitted a Joint Submission on Penalty, which the Committee accepted for the following reasons: i) Mr. Mandel has no prior disciplinary history with the College in 40 years of practice; ii) Mr. Mandel was not informed of the dispensing error until approximately 15 months after the error occurred. Therefore, Mr. Mandel did not have an opportunity to address the error nor notify the physicians involved in the patient's treatment. At the time he was notified of the error, Mr. Mandel acknowledged his responsibility immediately and expressed regret at not being involved in the prior handling of the patient's complaint. He acknowledged the error and expressed his remorse to the patient and family; iii) Mr. Mandel has entered a plea of professional misconduct, thereby saving the College the time and expense of a lengthy hearing.

The Committee noted that, had the appropriate procedures, which are the ultimate responsibility of the Designated Manager, been in place when the pharmacist on duty took the call from the patient questioning her medication, the severity of patient harm could have been reduced. Specifically, the pharmacist should have investigated the patient's concern more thoroughly and if an error had been detected, the Designated Manager should

have been involved. The Committee agreed that the proposed penalty was appropriate and reasonable in that it provides specific remedial training, and made the following Order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Mandel's Certificate of Registration, that he attend and participate in the education program, "Confronting Medication Errors", offered through the Ontario Pharmacists' Association, including both workshop modules: "Understanding the Issues and Dealing with Incidents" and "Taking Action to Improve Patient Safety", at his own expense, within 12 months of the date of this Order
3. A suspension of Mr. Mandel's Certificate of Registration for a period of one month, the suspension to be remitted on condition that he complete the remedial training exercise in accordance with the terms set out in paragraph 2 above

CASE 2

Billing Reporting Discrepancy

Member: Michael Gleason, Barrie

Hearing Date: December 17, 2002

Mr. Gleason was found to have:

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

The Discipline Committee accepted Mr. Gleason's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

Facts:

This matter arose from a complaint received at the College

in March 1999 from a third-party insurer regarding Mr. Gleason's billing practices. It involved 20 incidents from August to December 1998 in which Mr. Gleason submitted online claims for \$2 in excess of the amount actually charged to the patient. This resulted from the fact that the computer entry did not reflect a \$2 discount provided to the patient. In this particular drug plan, the patient is required to bear the costs of medication until a deductible limit is reached. While the pharmacy provided a \$2 discount to the patient for each prescription, the amount input into the computer included the \$2. However, the receipt provided by the pharmacist to the patient, and ultimately submitted by the patient to the insurer, accurately reflected only the amount paid.

Mr. Gleason explained that he offered the \$2 discount to customers to remain competitive; but that it did not occur to him to notify the insurer of his discounting practices. There were no apparent financial consequences to the insurer, although Mr. Gleason's billing practices could have led to the insurer erroneously calculating that the deductible had been reached before it actually had.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. The Committee accepted the proposed penalty noting that Mr. Gleason recognizes the pharmacist's professional responsibility to be accurate when reporting information about transactions, and that he has taken steps to correct his billing systems to ensure that this does not occur again. He cooperated throughout the investigation and admitted responsibility at an early instance; entered a plea of professional misconduct saving the College the time and expense of a hearing. Also, Mr. Gleason has no prior discipline history before this College.

In conclusion, the Committee found the proposed penalty to be fair and reasonable in the circumstances and made the following Order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Gleason's Certificate of Registration, that he successfully complete the following self-study exercises, offered through the Canadian Pharmacy Skills Program, Lesley Dan Faculty of Pharmacy, University of Toronto, at his own expense, within six months of the date of this Order:
 - i) Law Lesson #6: Standards of Practice
 - ii) Law Lesson #7: Professional Liability

CASE 3**Medication Dispensing Error****Member:** Michael Johnson, Kitchener**Hearing Date:** January 22, 2003

Mr. Johnson was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

The Discipline Committee accepted Mr. Johnson's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

Facts:

This matter arose from a referral from the Complaints Committee involving a medication dispensing error on a prescription for Codeine for a 16-month old child dispensed by Mr. Johnson on December 24, 1999. The prescription called for 10 doses of 7.5mg (equivalent to 1.5ml) of Codeine every 4 hours as needed. Mr. Johnson dispensed the Codeine with directions to "take one and one-half teaspoonfuls by mouth every four hours as needed for pain...", five times the amount of Codeine prescribed. According to the complainant, Mr. Johnson was twice questioned about the amount of Codeine and whether it was too much, however Mr. Johnson responded by repeating the directions to give one and one half teaspoonfuls every

four hours, when needed for pain. The child's parents gave five does of the Codeine in accordance with the instructions as indicated on the label, after which the child slept for an overly long period. He was then taken to hospital, at which time a nurse examined the bottle of Codeine and immediately identified that the wrong dose was indicated.

Mr. Johnson learned of his error on December 26, 1999. He immediately checked a pediatric dosage handbook and determined that the dosage was double the maximum recommended and attempted to contact the child's parents. He met with them on December 30, 1999. He apologized for the error and provided them with the name of his supervisor and the address of the College. It was Mr. Johnson's recollection, that the conversation in which the complainant expressed concern about the dosage amount took place at a subsequent meeting, not at the time of dispensing.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. In considering the proposal, the Committee acknowledged the College's submissions with respect to the seriousness of a dispensing error involving a child. However, the Committee also found Mr. Johnson to be genuinely remorseful and trusted that this type of error will not happen again in his practice. For these reasons, the Committee accepted the Joint Submission on Penalty and made the following Order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Johnson's Certificate of Registration, that he successfully complete the following courses, offered through the Canadian Pharmacy Skills Program at the Leslie Dan Faculty of Pharmacy, University of Toronto, within 12 months of this Order:
 - i) The Pharmacy Practice Laboratories Course tailored to paediatric dispensing

- ii) The Pharmacy Practice Laboratory Milestone Module
3. A suspension of Mr. Johnson's Certificate of Registration for a period of one month

CASE 4

Dispensing Error

Member: John Ellis, Sudbury

Hearing Date: December 17, 2002

Mr. Ellis was found to have:

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, and the *Regulated Health Professions Act*, and the regulations under those Acts with respect to a medication dispensing error

The Discipline Committee accepted Mr. Ellis's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

Facts:

This matter arose from a complaint received at the College in July 1997 involving two errors on a prescription for Valium® and Surmontil®. The complainant obtained a new prescription from her physician in May, 1997 at which point he made changes to her daily medication schedule as follows:

- 6:00 am – 10mg Valium®
- 9:00 am – 5mg Valium®
- 12:00 pm – 10mg Valium®
- 3:00 pm – 7.5mg Valium®
- 6:00 pm – 7.5mg Valium®
- Bedtime – 100mg Surmontil®

On June 2, 1997 Mr. Ellis dispensed 180 Diazepam (Valium®) 10mg with the following directions: 1 tablet at 6am, 1/2 tablet at 9am, 1 at noon, 1 1/2 tablets 3pm and 1 1/2

tablets at 6pm. The directions provided by Mr. Ellis for the doses at 3pm and 6pm were incorrect in that they would have entailed 15mg doses rather than the 7.5mg doses that had been prescribed.

The complainant recognized that the directions provided by Mr. Ellis were recorded incorrectly and took only the doses as prescribed by her physician — using a pre-existing supply of Valium® 5mg to make up the 3pm and 6pm doses. The complainant returned to the pharmacy on June 10, 1997 and notified Mr. Ellis of the error. In an attempt to correct the error, Mr. Ellis dispensed an additional 90 Diazepam (Valium®) 5mg with directions to take 1 1/2 tablets at 3pm and 6pm. In doing so, Mr. Ellis dispensed the additional 90 Diazepam 5mg without authorization in that no prescription was provided for the additional amount of Diazepam.

The second error involved the prescription for Surmontil® which Mr. Ellis filled on July 2, 1997. Mr. Ellis dispensed a medication in a container labelled 60 Novo-Tripramine (Surmontil®) 50mg. The patient noticed that the medication differed in colour from the Surmontil® previously provided, but consumed the medication as directed assuming that she had been provided with a generic brand of the proper medication. The patient began to experience increased anxiety, exhaustion and depression and decided to return the medication to the pharmacy on July 10, 1997. Mr. Ellis apologized for the error and replaced the medication with tablets that the patient recognized as the tablets she had been provided with on previous occasions. Mr. Ellis did not, however, fully inform the complainant that the wrong medication had been dispensed. He did not advise her to speak to her physician nor did he contact the complainant's physician to alert him to the error. The patient later determined that the incorrect medication dispensed to her by Mr. Ellis was Amitriptyline (Elavil®).

Further, during the investigation of the complaint, Mr. Ellis was unable or unwilling to produce any records of the dispensing errors or his apparent efforts to correct these errors.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. The Committee accepted the proposed penalty for the following reasons: Mr. Ellis entered a plea of professional misconduct saving the College the time and expense of a lengthy hearing; he has implemented new policies and procedures to prevent the recurrence of dispensing errors and improve his record keeping; and counsel for Mr. Ellis informed the Committee that Mr. Ellis is committed to completing the remedial courses proposed in the Joint Submission. The Committee also noted that it is appropriate that Mr. Ellis actually serve a period of suspension due to the severity of the conduct in this case. The Committee concluded that proposed penalty was fair and reasonable and made the following Order.

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Ellis' Certificate of Registration, that he complete successfully at his own expense within 12 months of the date of this Order, remedial training in the following courses and evaluations from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
 - i) Basic Professional Practice Laboratories I
 - ii) Advanced Professional Practice Laboratories II
 - iii) Law Lesson 2 – the Regulation of Pharmacy Practice
 - iv) Law Lesson 4 – Complaints and Discipline Procedures of the College
 - v) Law Lesson 6 – Standards of Practice
 - vi) Law Lesson 7 – Professional Liability
3. A suspension of Mr. Ellis' Certificate of Registration for a period of three months, with two months of the suspension to be remitted on condition that he complete the remedial training exercises in accordance with the terms set out in paragraph 2 above
4. Costs to the College in the amount of \$2,000

CASE 5**Dispensing Errors and Recordkeeping**

Member: Peter McElwain, Chesley

Hearing Date: January 22, 2003

Mr. McElwain was found to have:

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act*, or the regulations under those Acts
- Contravened, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs
- Engaged in conduct or performed an act relevant the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to medication dispensing errors and failing to keep records as required

The Discipline Committee accepted Mr. McElwain's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

Facts:

This matter arose from a Complaint from a community healthcare provider received by the College in October 1997 regarding dispensing errors and related documentation issues.

The first instance occurred in July, 1997. Mr. McElwain dispensed 100 Misoprostol 200 mcg when the prescription called for 100mcg. The pharmacy records and the label on the prescription indicated that 100mcg had been dispensed.

In the second instance, which occurred in September

1997, Mr. McElwain dispensed Furosemide 40mg when the prescription called for 20mg. The pharmacy records and the label on the prescription indicated that 20mg had been dispensed.

In both instances, the errors were detected by home care nurses who were providing care to the patients. Mr. McElwain extended his apologies for the mistakes as soon as he was notified.

The complaint investigation demonstrated the following dispensing and recordkeeping errors which had occurred during the period of in or about 1996 to 1997:


- Various medications were dispensed in dosette format resulting in reduced quantities being dispensed on each occasion. The pharmacy was unable to provide any documentation that proper written authorization had been obtained from the patient prior to the dispensing of the reduced quantities. If he testified, Mr. McElwain would have stated that it was his recollection that written authorizations were in the records prior to August 1996. Mr. McElwain and other pharmacists were involved in the dispensing of the medications in question
- Various medications, including Atenolol, Hydrochlorothiazide, Captopril, Ferrous Gluconate and Glyburide were dispensed. The prescribing physician confirmed that prescriptions were provided. However, in response to the College's request to produce records, the pharmacy was unable to locate the written prescriptions, except for the Glyburide
- The pharmacy "piggy-backed" new transactions on old expired prescriptions. The dispensing pharmacists, including Mr. McElwain, failed to properly reference current prescriptions, instead of referencing earlier expired prescriptions in the computer record

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. In considering this submission the Committee noted that this is not Mr. McElwain's first appearance before the Discipline Committee and

considered this to be a serious issue. The Committee was hopeful that the remedial aspects of the Order will assist Mr. McElwain in meeting all standards of practice in the future. Mr. McElwain has himself acknowledged a need and desire to make a fresh start in both his professional and personal life.

The Committee accepted the joint submission and made the following Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. McElwain's Certificate of Registration, that he attends, participates and successfully completes, at his own expense, within 12 months, remedial training as follows:
 - a) The following courses and evaluations from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
 - i) Basic Professional Practice Labs I
 - ii) Law Lesson 2 – The Regulation of Pharmacy Practice
 - iii) Law Lesson 6 – Standards of Practice
 - iv) Law Lesson 7 – Professional Liability
 - b) Workshop modules, "Understanding the Issues and Dealing with Incidents" and "Taking Action to Improve Patient Safety" of the education program "Confronting Medication Errors" offered through the Ontario Pharmacists' Association
2. A suspension of Mr. McElwain's Certificate of Registration for a period of four months, with two months of the suspension to be remitted on condition that he complete the remedial training exercises in accordance with the terms set out in paragraph 2 above
3. Costs to the College in the amount of \$2,000 

Pharmacists' Reporting Obligations to the OCP

Brian Brophy, LL.B
Discipline Case Coordinator

We are frequently asked about the members' obligations to report to the College any information relating to pharmacists who have been involved in unsafe or unethical conduct.

There are two types of scenarios in which there is a mandatory obligation to report a pharmacist to the College. The first scenario involves the mandatory reporting of termination of a pharmacist for professional reasons and the second, mandatory reporting of alleged sexual abuse of a patient by a pharmacist or any other health professional.

MANDATORY REPORTING: TERMINATION OF EMPLOYMENT

It is mandatory to report to the College the facts surrounding the termination of employment of a member if they were terminated for reasons of professional misconduct, incompetence, or incapacity. In the pharmacy setting, this would be the responsibility of the designated manager or the owner of the pharmacy.

The obligation to report the termination of employment for a pharmacist is only required when the termination was for *professional* rather than *employment-related* reasons. That is, if the pharmacist was terminated due to an alleged failure to maintain the standards of practice of the profession or any other type of defined acts of professional misconduct such as theft, insurance or other fraud, dispensing without authorization or serious dispensing errors.

Another prompt for invoking the obligation to report a member's termination to the College is where the termination was due to reasons of alleged "incompetence". Allegations of pharmacist incompetence relate to a member who, in his/her practice, displays a general lack of knowledge, skill, judgment, or disregard for the welfare of patient(s).

Additional reasons for termination that would also require reporting to the College are cases where the member is "incapacitated". Such situations would be when a member is suffering from a physical or mental health disorder that impacts on his/her ability to practice safely. Examples would include untreated and/or uncontrolled psychiatric disorders or substance abuse. (A more detailed discussion of reporting responsibilities associated with a member who is incapacitated will follow in the next edition.)

Conversely, a pharmacist whose employment had been terminated for work-related reasons such as lateness, personal incompatibility or business reasons need not be reported to the College unless these actions were related to underlying issues that affected the member's practice and ability to care for patients.

Pharmacist employers are sometimes unclear about their obligation to report situations where a member voluntarily resigns his/her employment to preempt being dismissed for reasons of professional misconduct. The legislation states that the employer must report a pharmacist who voluntarily resigns to preempt such a dismissal as the member's resignation does not nullify practice concerns and therefore the facts leading to the dismissal remain an issue of public safety that must be reported to the College.

MANDATORY REPORTING OF SEXUAL ABUSE

The second scenario, mandatory reporting of sexual abuse (under the RHPA), is wherever a member has, on reasonable grounds, in the course of practising the profession obtained information that causes him/her to believe that a member of the OCP or another health College has sexually abused a patient. Specifically, if a pharmacist's patient gives him/her reasonable grounds to believe that the patient has

been sexually abused by a member of a health College, the pharmacist is required to report the incident to the member's governing College.

FOLLOW-UP BY THE COLLEGE ON INFORMATION RECEIVED

The College deals with all information related to such reports in a confidential manner. Furthermore, the legislation does not permit the College to share further information regarding the matter, and how it is dealt with by the College, with the reporting member or any other person. (This information may often result in a Registrar's Investigation pursuant to s.75 (a) of the *Health Professions Procedural Code*.) The information relating to the alleged misconduct is only made public if it results in disciplinary proceedings, as all hearings of the Discipline Committee are open to the public.

Notwithstanding, all persons who report information are contacted by College staff and asked if they wish to have their report filed as a "complaint" under s. 25 of the Code, as this report would invoke a complaint investigation. If the reporting member chooses to proceed with a formal complaint, he/she is entitled to be a party to the investigation and will receive the Complaints Committee's decision — as would any complainant who is a member of the public.

MANDATORY REPORTS NEED TO BE MADE TO THE COLLEGE IN WRITING

The legislation requires that mandatory reports be made in writing and addressed to the Registrar. The report must be submitted within 30 days of the incident and must set out the reasons for member termination, and in the case of alleged sexual abuse, the available details pertaining to the allegation. Of course, for patient confidentiality reasons, the patient's name cannot be included in the mandatory report unless he/she has provided their consent in writing.


OTHER REPORTING RESPONSIBILITIES AND SITUATIONS

We are often asked about a member's responsibility to report a pharmacist's conduct to the College when the circumstances do not clearly fall within the parameters that require mandatory reporting (as outlined above). Such a situation may be when a member is being suspended, but not terminated from employment, or a situation where the person wanting to make a report to the College is not the employer

or DM of the pharmacy that employs the pharmacist in question. Another common situation is where the reporter has knowledge of the member's involvement in criminal activity and/or proceedings that are relevant to their suitability to practice, such as theft, drug trafficking or acts of physical aggression.

In these situations, we assist callers by outlining the two instances in which mandatory reports are required while distinguishing the situation at hand as an issue that may impose an ethical, rather than a mandatory, obligation on the pharmacist to report. Indeed, if a pharmacist believes that a colleague's conduct is either unsafe or unethical, reporting this information to somebody who has the ability and authority to intervene for the sake of public protection, is required. The College fits into this category as do many individuals and organizations, depending on the circumstances. Therefore, while not a requirement mandated by the legislation, the College strongly encourages its members to bring information to the attention of the College where it involves conduct that has the potential of negatively impacting public safety and well being. The College responds to all reported information and takes action whenever appropriate.

The information received through mandatory and non-mandatory reports is an important means through which the College fulfills its regulatory duty to protect the public interest and to enforce its standards.

If you are unsure about your reporting obligations, please feel free to contact the Investigations & Resolutions Department for a confidential discussion. 

Other Pharmacist Reporting Obligations to Other Agencies

Pharmacists are required under the *Child and Family Services Act* to report incidents of alleged child abuse to the local Children's Aid Society. This reporting is distinguished from "mandatory reporting" obligations under the *RHPA* which relate to the obligatory requirement for the member or his/her employer to report health professionals to their regulatory College.

HAVE your SAY

*“Have Your Say” submissions should not exceed 500 words and can be directed to the Editor.
The opinions expressed are those of the author and not necessarily representative of a College position or policy.*

DOCUMENTING PATIENT COUNSELLING

Patient counselling has always been an integral part of pharmacy. Counselling has never posed a problem for most pharmacists, but we are now encouraged by the OCP to document counselling that is provided to patients purchasing OTC medications whenever it may be relevant to the patient's health.

Like most pharmacists, I am very busy and find it difficult to find the time to document as often as required. That is why I resolved to not only thoroughly explore the *Standards of Practice*, but also give my patients the best possible care I can.

I looked at a number of suggested ways to document my records, including options to use a hand-held device and/or documenting directly into the computer. While these are good options, one would have to either purchase a hand-held or have more than one available terminal in the pharmacy. These options seemed impractical for my practice but I recently discovered a possible solution when I visited my new dentist's office. The receptionist asked me to fill out a questionnaire, and as I detailed the information requested, I wondered if this procedure could also work in my pharmacy.

After asking for a copy of the dentist's questionnaire and researching various medical self-help books, I developed a questionnaire that contains the typical patient information needed in pharmacy care. This information can then be either added to an existing patient profile, or entered when a patient profile is created.

As I began to use this questionnaire (see form at right), I encountered some resistance from patients who expected immediate service. However whenever I explained that such pertinent information is valuable in making sound patient care decisions, patients agreed and completed the form. I soon realized how important it is to take this additional time with new patients — one individual had not checked asthma as an existing condition but indicated he was regularly using Ventolin®.

I have also found that having patients complete the questionnaire raises awareness and a greater appreciation for the pharmacist's role.

While this may not be accepted by all my patients, I believe it will assist those patients who agree to participate, *particularly* when incorrect information could result in patient harm.

To date, we have seen an overall increase in new patients and these patients see that we are truly concerned with their well being.

The following questionnaire is by no means perfect and can be modified to suit your needs. There are also times when the patient provides information about symptoms that need to be assessed by a physician. This tool has also helped me to appropriately triage patients or follow-up with them on other issues.

Larry Hallok, B.Sc.Pharm.
— Toronto

PRE-CONSULTATION QUESTIONNAIRE FOR OVER-THE-COUNTER PATIENT COUNSELLING

To give you, our customer, the best quality of service, we ask that you fill out the following questionnaire. The information will be held in the strictest confidence and if you choose, can be recorded in your patient history for future reference.

What do you wish to consult the pharmacist about?

Please indicate:

- Ear ache
- Cough
- Diarrhea
- Eye problems
- Minor burn
- Scrapes and/or abrasions
- Sore throat
- Stomach flu
- Sinus pain
- Headache
- Constipation
- Sunburn
- Bee sting or insect bite
- Other (please specify)

Name: _____

Address: _____

City: _____

Home Phone: _____

Sex: M F

Birth date: _____ / _____ / _____
Day Month Year

Physician: _____

Do you have (or suffer from) any of the following?

Please indicate:

- Anemia
- Angina
- Arthritis
- Asthma
- Breast feeding
- Bronchitis
- Cardiac arrhythmia
- Cardiovascular disease
- Depression
- Diabetes
- Epilepsy
- Gall bladder
- Gastrointestinal problems
- Glaucoma
- Gout
- High blood pressure
- Jaundice
- Kidney problems
- Lupus
- Migraine
- Pregnancy
- Recent trauma
- Smoking
- Thyroid
- Vision problems
- Other

Allergies (please specify):

What medications are you currently taking:

Please check applicable symptom(s):

- Hot and cold spells
- Hallucinating or confused
- Difficult to swallow or breathe
- Brown or bloody sputum
- Green sputum or nasal discharge
- Swelling of mouth, throat or tongue
- New skin rash
- Enlarged glands
- Discharge or drainage from ear
- Suspected poisoning
- Severe pain or headache on moving neck
- Severe abdominal pain
- Dehydration
- Vomiting
- Blood or dark brown in vomit or stools
- Shortness of breath
- Dizziness
- Tight chest
- Food sticks on way down
- Pain in eye
- Severe swelling or redness around the eye
- Trouble seeing
- Recent eye surgery
- Bright light hurts eye
- Pupils different size
- Severe sore throat without cough or cold symptoms

If you feel feverish, what is it?

I would like counselling and for this information to be put on my patient profile.

Signature

Recommendation

Pharmacist's Signature

Date

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.

April (TBA), Newmarket
Breast Cancer, York North
 Pharmacists' Association
 Carolyn Bornstein
 tel (905) 895-4521, ext. 2128
 e-mail: bornstein@sympatico.ca

Apr. 3-4: Sudbury
Respiratory Care across the Lifespan, Ontario Respiratory Care Society, Northern Region,
 Howard Johnson Hotel
 Sheila Gordon-Dillane
 tel (416) 864-9911, ext. 236
 fax (416) 864-9916
 e-mail: orcs@on.lung.ca

Apr. 4-5: Kingston
4th Annual Diabetes Workshop,
 Options for Diabetes, Holiday Inn
 Margaret Little
 tel (613) 547-3438
 Joan Ferguson
 tel (416) 239-0551
 Anne Belton
 e-mail: ibelton@ca.inter.net

Apr. 7-8: Toronto; Apr. 28-29: Boston MA;

May 5-6: San Francisco CA; May 15-16: Philadelphia PA; May 19-20: San Juan PR
PLC, SCADA and DCS: cGMP Qualification for Automated Process Control Systems
 PTi International
 tel (941) 951-7885 or 1-866-647-0921
 fax (941) 365-2507
 web: www.pti-international.com

Apr. 12: Toronto
Current Topics, the Sunnybrook & Women's College Health Sciences Centre
 Sunnybrook site
 Jeffrey Steer
 tel (416) 480-4498
 fax (416) 480-5887
 e-mail: jeffrey.steer@sw.ca

Apr. 26: London
Technicians in Action, London Health Sciences Centre, Best Western Lamplighter Inn & Conference Center
 Sharon Hartman
 e-mail: s.hartman@lhsc.on.ca

May (tba), Newmarket
Mother Risk/Poison Control Presentation, York North Pharmacists' Association
 Carolyn Bornstein
 tel (905) 895-4521, ext. 2128
 e-mail: bornstein@sympatico.ca

May 1: Toronto
10th Annual Pain Management Conference for Healthcare Professionals: Changing the Face of Pain, Sunnybrook and Women's College Health Sciences Centre, Vaughan Estate at the Sunnybrook Campus
 Kathy Ross
 tel (416) 480-6100, voicemail 83022
 e-mail: kathy.ross@sw.ca

May 2-3, Markham
Conference 2003: Opening Doors, Ontario Pharmacists' Association, Hilton Suites Hotel
 Karen Cameron
 tel (416) 441-0788, ext. 4235
 e-mail: kcameron@ontpharmacists.on.ca
 web: www.opatoday.com

May 8: Toronto
Professional Practice Conference: Building Capacity for Quality Care, St. Joseph's Health Centre Toronto, Islington Golf & Country Club
 Karen Patterson
 tel (416) 530-67000, ext. 3716
 e-mail: pattek@stjoe.on.ca

May 23-24: Toronto
Integrated Health Expo 2003
 Metro Toronto Convention Centre
 tel (416) 203-7900, ext. 107
 fax (416) 703-6392

Free CE for Technicians!

A new national bilingual CE correspondence program has been launched for pharmacy technicians. *Pharmacy Practice* magazine will publish six free CE lessons for techs annually. The lessons are sponsored by Novopharm and are inserted in *Tech Talk*, the bimonthly newsletter for pharmacy technicians (published in *Pharmacy Practice*). For more information call Karen Welds at (416) 596-3465 or check out the technician section of the *Pharmacy Practice* web site: www.pharmacyconnects.com

Points of Care

IN ONTARIO



Carepharma Drugmart, KEMPTVILLE



Boggio Pharmacy, PORT COLBORNE



Guardian Pharmacy, KANATA



Lovell Drugs, OSHAWA



Marina Pharmacy, OTTAWA



If you are interested in including the *Point of Care* symbol into your permanent pharmacy signage, please contact the Communications Department for an electronic copy of the artwork. You may also go online to ocpinfo.com and select "*Point of Care*" to view the graphic usage standards.

For information contact:
Layne Verbeek
Communications Manager
at 416-962-4861 ext. 294
or lverbeek@ocpinfo.com

Let the public know you are

Worth Knowing!

Are you displaying the *Point of Care* Symbol?

All pharmacies are asked to participate in the *Point of Care* public education program by displaying the *Point of Care* symbol in their pharmacy window/main entrance and by displaying the Worth Knowing education materials.

- Please send me a complete kit: \$80.25 (\$75 plus \$5.25 GST)
- Please send me a plexi-sign and chains only: \$48.15 (\$45 plus \$3.15 GST)

Name:

(Mr., Mrs., Ms)

(First Name)

(Surname)

Address:

(Pharmacy Name)

(#)

(Street)

(City)

(Province)

(Postal Code)

Telephone Number: () -

To order, please complete the form above and send along with a cheque payable to:

Ontario College of Pharmacists - Office Services
483 Huron Street, Toronto, ON M5R 2R4

BULLETIN BOARD

Class of 7T8 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.

11th Annual Ontario Pharmacists' Charity Hockey Tournament

The 11th annual tournament will be held March 27 - 29, 2003 in Peterborough. Cost of \$100 per player. Welcoming Reception Thursday, March 27, 7:00pm at the Holiday Inn and the games will be held at the The Evinrude Centre Twin Pads on Friday March 28 and Saturday March 29.

Dinner Friday Evening will be held at the Holiday Inn. Accommodations can be booked at the Holiday Inn Peterborough, 1-705-743-1144, book under "Pharmacists' Hockey Tournament" by Feb. 28.

For more information, please contact:

Mark F. Scanlon, B.Sc.Pharm., The Clinic Pharmacy, 327 Charlotte Street, Peterborough, K9J 7C3
tel: 705-748-5859, fax: 705-743-4392 or email to clinpharm@on.aibn.com or ontpharmhockey@yahoo.com.

The College Warmly Welcomes...


Tara Conboy who joined us in February as our SPT Secretary in the Registration Department Tara came

to us from the Drug Trading Company where she worked as an Enterprise Coordinator to the VP, Pharmacy Services. Her administrative experience and pharmacy-related background will serve her well in her new role.

Remy Pearson also joined us in February in a contract position as Investigations and Resolutions Program Secretary. Remy comes to us from Westminster Education Service in London, England where she was the Executive Assistant to the Director of Curriculum and Quality. Remy's background includes counselling in the area of women's health, marketing and sales and administrative work.

The College Bids Farewell to...

Kim Ruthig After over 11 years at the College, Kim has decided to move on to new challenges. Kim has played a significant role as the College's Investigator. He has worked with diligence and passion and is recognized as a first rate professional. The staff would like to express its sincere best wishes to Kim and his wife Jean as they look forward to new challenges ahead.

Please note: the **Preceptor Advanced Workshop** for Sunday, April 13 has been **rescheduled to Monday, April 14, 2003**. Please contact the SPT secretary, Tara Conboy at Ext 297 tconboy@ocpinfoc.com for more information. 

**International
Pharmacy
Graduate
Program**



ASSESSORS NEEDED

The International Pharmacy Graduate Program is looking for pharmacists to act as assessors for the Prior Learning Assessment (PLA) Component of the Program.

You Can Help!!!

If you are interested in participating or would like more details, please contact Artemis Diamantouros at 416-946-5779 or e-mail artemis2@sympatico.ca.

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
urajdev@ocpinfo.com

Deputy Registrar/Director of Programs' Office x 241
ltodd@ocpinfo.com

Director of Finance and Administration's Office x 263
lbaker@ocpinfo.com

Registration Programs x 250
dbyer@ocpinfo.com

Registration Information Surnames A-L: x 228
jsantiago@ocpinfo.com

Registration Information Surnames M-Z: x 232
jmckee@ocpinfo.com

Structured Practical Training Programs x 297
bchurch@ocpinfo.com

Pharmacy Practice Programs x 236
emaloney@ocpinfo.com

Pharmacy Openings/Closings x 227
jsandhu@ocpinfo.com

Pharmacy Sales/Relocation x 227
jsandhu@ocpinfo.com

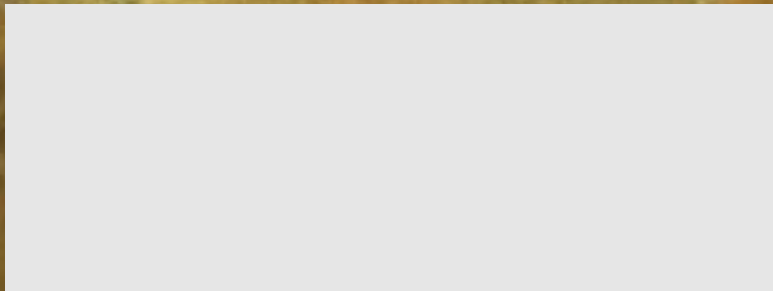
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