

# Pharmacy Connection

Official Publication of the Ontario College of Pharmacists

November / December 2004



C O U N C I L 2 0 0 4 / 2 0 0 5



## Council Members

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

- 1 Marie Ogilvie-Stent
- 2 Elaine Akers
- 3 Remi Ojo
- 4 Reza Farmand
- 5 George Phillips
- 6 Philip Emberley
- 7 Leslie Braden
- 8 Iris Krawchenko
- 9 Larry Boggio, *President*
- 10 Gerry Cook
- 11 David Malian
- 12 Peter Gdyczynski
- 13 Donald Stringer
- 14 James Delsaut
- 15 Gurjit Husson
- 16 Albert Chaiet
- 17 Shelley McKinney, *Vice-President*
- PM Thomas Baulke
- PM Morley Bercovitch
- PM Susan Burton-Bowler
- PM Garry Dent
- PM Bob Drummond
- PM Tina Gabriel
- PM Katherine Hollinsworth
- PM Stephen Mangos
- PM Linda Robbins
- PM Michael Schoales
- PM Christina Weylie
- DFP Wayne Hindmarsh

## Statutory Committees

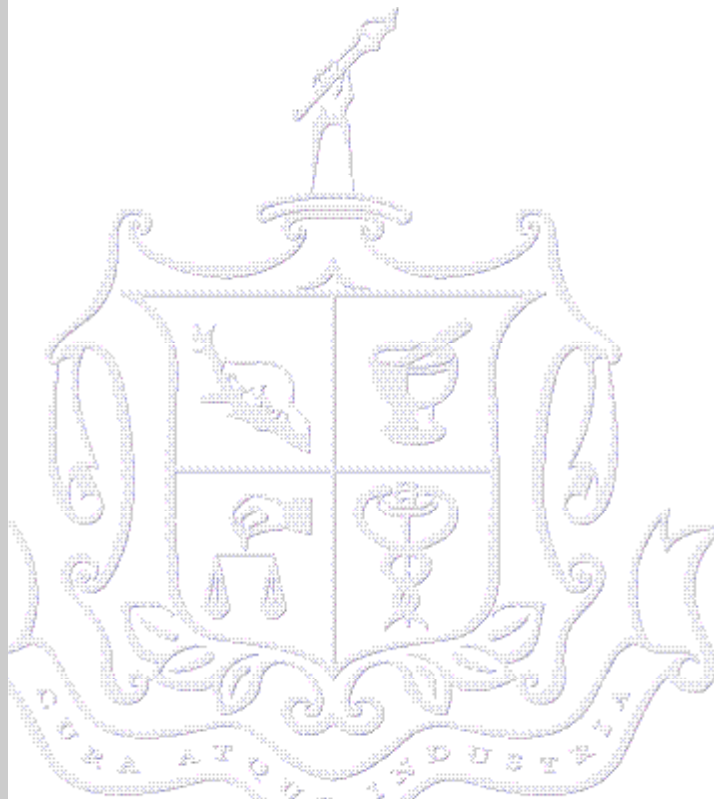
- Executive
- Accreditation
- Complaints
- Discipline
- Fitness to Practice
- Patient Relations
- Quality Assurance
- Registration

## Standing Committees

- Finance
- Professional Practice

## Special Committees

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



## ONTARIO COLLEGE OF PHARMACISTS

### MISSION STATEMENT

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



# WE'RE BACK ON TV!

Airing across Ontario this fall  
on CBC and CTV  
until December 5, 2004



## COUNCIL 2004/2005

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registered with the Ontario College of Pharmacists.

### Pharmacy Connection

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

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

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

# Electoral Districts and Members of Council



District 15, Gurjit Husson  
Thunder Bay



District 14, James Delsaut  
Sudbury

## Hospital Members



District 16, Albert Chaiet  
Toronto



District 17, Shelley McKinney  
Vice President  
Pickering

## Dean, Faculty of Pharmacy

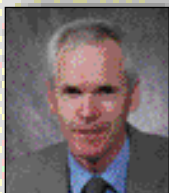


Wayne Hindmarsh, Ph.D., FCSFS  
Dean, Leslie Dan Faculty of Pharmacy  
University of Toronto



District 11, Dave Malian  
Windsor

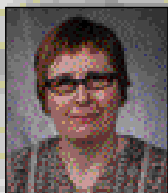
## Public Members



Public Member,  
Thomas Baulke  
Collingwood



Public Member,  
Morley Bercovitch  
Wasaga Beach



Public Member,  
Susan Burton-Bowler  
Toronto



Public Member,  
Garry Dent  
Kapuskasung



Public Member,  
Bob Drummond  
Parry Sound

# Elected Members



District 1, Marie Ogilvie-Stent  
Kemptville



District 7, Leslie Braden  
Barrie



District 2, Elaine Akers  
Peterborough



District 13, Donald (Dan) Stringer  
Goderich



District 3, Remi Ojo  
Scarborough



District 4, Reza Farmand  
Toronto



District 5, George Phillips  
Toronto



District 6, Philip Emberley  
Oakville



District 9, Larry Boggio  
President  
Port Colborne



District 8, Iris Krawchenko  
(Past President)  
Hamilton



District 12, Peter Gdyczynski  
Brantford



District 10, Gerry Cook  
London

Please contact the Ontario  
College of Pharmacists if  
you would like to  
communicate with a  
Member of Council.



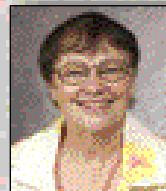
Public Member,  
Tina Gabriel  
Toronto



Public Member,  
Katherine Hollinsworth  
Carp



Public Member,  
Stephen Mangos  
Toronto



Public Member,  
Linda Robbins  
Toronto

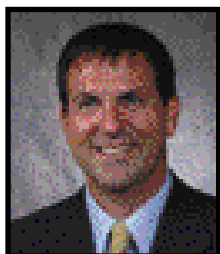


Public Member,  
Michael Schoales  
Toronto



Public Member,  
Christina Weylie  
Kitchener

# P R E S I D E N T ' S M E S S A G E



Larry Boggio, R.Ph., B.Sc.Pharm.  
President

It is my honour to serve as President of the Ontario College of Pharmacists for 2004-2005.

When I graduated from the University of Toronto in 1981, taking on the role of President with the College was probably the last thing I would have

***...the Task Force will be proposing guidelines for medication reviews, for refill authority for chronic therapy, and for monitoring patient therapy and adjusting doses in collaborative practices.***

imagined. But through the years, as I ran my store in Port Colborne, I began to realize that I wanted to contribute more to the profession that provided me with so much personal satisfaction. Like so many before me, I ran for College Council to do just that. I have faced a great learning curve at Council.

For the last four years I have watched, I have listened, I have gotten involved and I have taken on increased responsibilities—all of which has led me to the position of President today.

I have a strong Council of elected pharmacists and publicly appointed members behind me this year. They will provide me with direction and support as we move forward with important steps to advance our profession.

Last year, during our district meetings, we were able to acquire important feedback from pharmacists on what types of support they need to perform better as health care team members. The Task Force on Optimizing the Pharmacist's Role has since reviewed pharmacists' current roles as well as studying a number of published reports of projects in various jurisdictions where pharmacists have expanded roles. The Task Force has also been looking at various collaborative models and exploring where pharmacists could fill gaps in patient care, all with the ultimate goal of benefiting Ontario's public.

I look forward to bringing the Task Force's recommendations to the

Ministry of Health and Long-Term Care to seek their implementation.

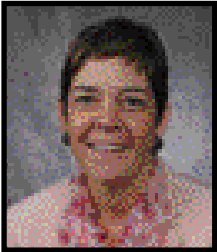
In the meantime, the Task Force will be proposing guidelines for medication reviews, for refill authority for chronic therapy, and for monitoring patient therapy and adjusting doses in collaborative practices.

As we continue with expanding the role of pharmacists, we must look ahead to preparing pharmacy technicians to take on greater responsibilities. This will involve setting higher technician qualifications and establishing standards of practice.

Indeed, regulating technicians will make it possible for pharmacists to take on a greater role in a patient's health care team.

I look forward to meeting many of you this year and getting your views on the issues that we face, both to help me to better represent you and to best serve our public. ■

# REGISTRAR'S MESSAGE



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

**A** few weeks ago, I completed my term as President of the Council on Licensure, Enforcement and Regulation (CLEAR) at its annual conference in Kansas City. CLEAR is an international regulatory association based in Lexington, Kentucky. It has been a tremendous honour to hold this prestigious position and I want to express my gratitude to College Council and all staff, without whose support and encouragement my involvement in CLEAR would not have been possible.

While it has, since its inception, been touted as an international organization, before I was elected onto the Board in 1999, there had only been one non-American Board member — Margaret Risk, the former Registrar of the College of Nurses of Ontario. Since then, CLEAR has taken great strides to become truly international in scope by establishing an office in the UK, by

actively seeking new members from around the world, and most recently, by offering portions of its website in French, Spanish and Cantonese as well as English. CLEAR is an association of individuals, agencies, and organizations which comprises the international community of professional and occupational regulation; it aims to serve as a dynamic forum for improving the quality and understanding of regulation in order to improve public protection.

During my ten years of involvement in CLEAR, I have spoken at a number of international conferences on a variety of topics, including the College's Quality Assurance Program, the mutual recognition agreements that we have with other provinces, and, most recently, our International Pharmacy Graduate Program.

As CLEAR president, I had the opportunity to participate at an international conference on globalization of the professions in Mexico City and was proud to present details of the Mutual Recognition Agreement for Pharmacy in Canada, which was signed in Halifax by all provinces except Quebec in

2000. Ontario is seen as a leader, not only for the work we have done to assure continuing competence, but also for the innovation and leadership shown through the IPG Program, which was developed in partnership with the Ministry of Training, Colleges and Universities and the Leslie Dan Faculty of Pharmacy, University of Toronto.

***We are proud of our Quality Assurance Program, which continues to be cited internationally as a model for assuring continuing competence.***

We are proud of our Quality Assurance Program, which continues to be cited internationally as a model for assuring continuing competence. Indeed, this November, our manager of continuing competency programs will be a speaker at the National Organization for Competency Assurance (NOCA) conference, presenting evidence that our QA Program is indeed having a positive impact on pharmacy practice in Ontario. This evidence, presented to Council at its recent meeting in September, and

# REGISTRAR'S MESSAGE

presented in detail on page 17, is the result of an external evaluation conducted by Harry Cummings and Associates.

As I have so often noted, my involvement in organizations such as CLEAR, NOCA, and the Centre for Quality Assurance in International Education (CQAIE) not only enhances the College's profile but continually confirms that we are very fortunate in Canada and very much "on the right track." In Mexico, participants commended Canada for dealing with mobility issues within its own borders *before* jumping into professional trade and mobility agreements with other countries. It does not make sense, for example, that in some professions in the US, it may be *easier* — because of trade agreements — for a professional from Bolivia or Chile to get licensed in a particular state than it would be if he or she lived in a neighboring state!

Many of you have heard us often observe at district meetings how tremendously privileged we are in Canada to be self-regulating. The Canadian model for self-regulation is both admired and aspired to— not only in the US but around the world.

In the United States for example, the regulation of health professionals very clearly falls under state governments, who receive all collected professional fees and then decide, based on their particular priorities, the size of the budget that will be allocated to a state board for regulating a given profession. In many, though not all instances, a complaint about a specific health care professional will be submitted to, and investigated by, a central agency administrator who oversees many different professions. In some states, one administrator investigates over 40 different regulated health and non-health professions. In cases of

referrals to discipline, the professional member's discipline proceedings generally occur before an administrative law judge, who may or may not have knowledge of the particular profession involved in the hearing.

We are fortunate to enjoy the privilege of self-regulation in its truest form, and must embrace our mandate to put the interest and protection of the public at the forefront of all that we do. So I hope you understand and support our "mantra" that "everything the College undertakes must be grounded in the public interest".

I am proud to have had the opportunity of leading the wonderful organization that is CLEAR this past year, and I am proud to continue as the Registrar of your College 🇨🇦





SEPTEMBER 2004

## COUNCIL APPROVES 2005 CAPITAL AND OPERATING BUDGETS

Council approved capital and operating budgets for 2005. There will be no fee increase in either annual pharmacist fees or renewal fees for pharmacy accreditation.

The operating budget provides for new spending necessary to move forward on a number of objectives of the Strategic Plan 2003. The College will generate revenue to cover the increase in expenses by improving cost recovery for specific activities it undertakes.

Council noted that the College's cash reserves now meet the target set by the Finance Committee; effectively they have been restored after being used to purchase the new property at 186 St. George. Council endorsed the Finance Committee's view that the College's buildings could be viewed as additional reserves, and that money could be raised at any time using these properties as collateral. Given this stable financial situation, Council agreed with the Finance Committee's decision that there was no need to increase renewal fees to cover capital, with Council opting instead to have the capital funded from current cash reserves.

As mentioned, there was discussion of appropriate ways to increase cost recovery for specific College services. Among those agreed on were: increases in registration fees to recover 50% of expenses associated with entry to practice; increasing fees for certification of pharmacy technicians, pharmacy openings, and health profession incorporation to recoup 100% of cost, and the introduction of a transaction fee for corporate filings to make changes in shareholding, directorship or names.

Below is a summary of the fee adjustments for 2005:

### Pharmacists:

- Annual fees to *remain* at \$487.92

### Pharmacies:

- Annual Accreditation Renewals to *remain* at \$700
- Sales, relocations, and re-inspections to *remain* at \$500
- New openings to *increase* from \$750 to \$1,000

### Registration:

- Initial filing fees to *remain* at \$112
- Examination fees for the Jurisprudence Examination to *remain* at \$145 and \$290 (for Toronto administrations and those outside Toronto, respectively)

- Registration application fees to *increase* from \$150 to \$175
- Registration training fees to *increase* from \$300 to \$350

### Other:

- Late payment penalties to *remain* at \$100 for late payments received within 30 days and \$150 for late payments received after 30 days
- Health profession corporation renewal fees to *remain* at \$300
- Health profession corporation fees for new openings to *increase* from \$600 to \$1000
- Document evaluation fees for Certification as Pharmacy Technicians to *increase* from \$27.25 to \$31.34
- Examination fees for Certification as Pharmacy Technicians to *increase* from \$220 to \$253
- Renewal fees for Certified Pharmacy Technicians to *increase* from \$54.50 to \$62.68
- A \$75 transaction fee will be *introduced* for shareholding, directorship, and name changes in corporations owning or operating a pharmacy

The above increases provide revenue equal to expenses, before capital, of \$230,000. The reserves at the 2004 year-end will amount to \$1,150,000, which represents the target of two month's operating expenses as outlined in the Finance Policy.

## APPROVED 2005 BUDGET SUMMARY

Pharmacist Fees	\$ 4,859,338
Pharmacy Fees	\$ 2,217,000
Registration Fees	\$ 513,250
Sundry and Investment Income	\$ 255,871
<b>Total Revenue</b>	<b>\$ 7,845,459</b>
<b>Expenses</b>	
Council & Committee	\$ 1,947,940
College Administration	\$ 5,663,191
Property	\$ 202,928
Niagara Apothecary	\$ 31,400
<b>Total Expenses</b>	<b>\$ 7,845,459</b>
Excess of Revenue over Expenses	\$ 0
Capital Expenditures	\$ 230,000
<b>Surplus (Deficit) after Capital</b>	<b>\$ (230,000)</b>

### TASK FORCE ON OPTIMIZING THE PHARMACIST'S ROLE

In the fall of 2003, then President Iris Krawchenko appointed the Task Force on Optimizing the Pharmacist's Role.

In preparing its report to Council, the Task Force considered the pharmacist's current scope and reviewed literature on various projects where pharmacists have an expanded role. Through meetings with government, as well as the CPSO, the Task Force shared its experiences with current collaborative models and explored where pharmacists could fill gaps in patient care. Also used in the preparation of the report were the results of surveys conducted at the 2004 District Meetings. Some 485 pharmacists participated in individual surveys regarding an expanded role,

and 163 breakout groups noted their suggestions for role expansion.

Individually, pharmacists rated *medication reviews*, *monitoring chronic therapy*, and *refill authority for chronic therapy* as preferred areas of future practice. The breakout groups indicated that the areas where they could make the greatest impact on health care were in refill authority, medication reviews and monitoring with lab tests.

Accordingly, the following three recommendations were approved by Council:

- That the Ontario College of Pharmacists develop guidelines for conducting medication reviews
- That the Ontario College of Pharmacists proceed with the development of policies and protocols to enable pharmacists to

accept delegation of authorized acts from other regulated health care professionals

- That the Ontario College of Pharmacists extend the terms of reference of this Task Force as follows: "To propose guidelines, protocols and policies to optimize the role of the pharmacist"

Council noted that consultation with stakeholders (CSHP, CNO, CPSO, MOHLTC, OMA, OPA, and third-party providers) will be required in order to ensure that education programs, protocols, and policy for enabling authority and reimbursement are in place.

Council sees the College working with stakeholders to develop outcome parameters and monitoring systems for medication reviews and to clarify expectations of communications concerning medication reviews. Continued consultation with stakeholders will be necessary to develop a system for sharing of patient data and continuity of care. Council further noted that, while this report identifies primarily short-term goals, it also establishes a framework for expanding the pharmacist's role to optimize patient care in the long term.

### LOYALTY PROGRAMS

Council was pleased that the recent challenge to the College's policy on loyalty programs was dismissed by the courts, with the College being awarded costs in the amount of \$20,000. In his decision, Justice Echlin wrote that "*the College, through its Council, had jurisdiction*

*and was acting within its authority when the policy was issued.”*

As of August, the College had received 349 calls from members and the public, 127 e-mails and one letter respecting this matter. Senior staff members responded to all calls and e-mails as necessary. While the callback initiative has been worthwhile, despite the resources required, the incoming calls and e-mails have effectively ceased and Council agreed that staff time and resources should now be directed to more pressing areas.

### **REVISED POINT OF CARE GRAPHIC STANDARDS**

Council approved the revised Point of Care Graphic Standards 4.0 as presented by the Communications Committee. The Point of Care symbol is used to identify all licensed pharmacists and accredited pharmacies. The revised standards, which are posted on the College’s website, have

been updated to clarify and more precisely describe the conditions under which the symbol can be displayed, including the restriction from using the symbol in any form of advertising.

### **QUALITY ASSURANCE PROGRAM IMPACT STUDY**

The results of an evaluation on the impact of the Practice Review, conducted by Dr. Harry Cummings, were presented to Council.


The following areas were explored to evaluate the impact of the Practice Review on the profession in general, and on pharmacists in particular:

- Activities to improve knowledge
- Attitude and approach toward patients
- Changes in practice
- Feelings toward quality assurance as a whole

The results show that the Quality Assurance Program in general, and

the Peer Review Weekend in particular, are having a positive impact. See page 17 for a detailed summary.

### **2004-2005 COUNCIL DATES**

Council agreed to meet on following dates: December 6 and 7, 2004; March 7 and 8, 2005; June 13 and 14, 2005; and September 12 and 13, 2005. 



# Farewell to Bernie

Staff at the College will be bidding a fond farewell to Dr. Bernie DesRoches as he retires at the end of December. Bernie graduated from the Faculty of Pharmacy, University of Toronto in 1962. Bernie worked at the College while he was a student and officially joined the College staff 38 years ago in August, 1966. Bernie later received his PhD from the University of Wisconsin in 1970.

Over the years, Bernie has served several roles at the College, working in the areas of training and registration, continuing education, and pharmacy technicians. Bernie is well known across Canada, and in fact, worldwide for his contribution to pharmacy continuing education and life-long learning. His expertise in life-long learning led to the development of Ontario's regional CE coordinators, and Bernie was instrumental in the original development of the College's QA program, learning portfolio, and peer support initiative for members requiring remediation and training.

Bernie has also made significant contributions to pharmacy technicians as he developed the College's certified pharmacy technician program, and has, in recent years, dedicated much energy towards the regulation of pharmacy technicians in Ontario.


Throughout all of this, Bernie made numerous College presentations across Ontario, Canada, and internationally. Indeed, Bernie has been a true ambassador of the College, its goals and philosophy.

Bernie sat on various committees of the Pharmacy Examining Board of Canada from 1970 to 1990, and served as president of the Canadian Council on Continuing Education in Pharmacy in 1975-77 and again in 1993-95. Bernie

has been awarded the University of Toronto Pharmacy Alumni Award for Community Service in 1994, the Fellow of Royal Society of Health in 1986, an AH Robbins Award for Outstanding Community Service in 1989 and a 1985 Certificate of Merit for being listed in the International Who's Who in Medicine, First Edition, Cambridge, England.

Over the past four decades, Bernie has also contributed much to our profession; we were pleased to join Bernie at a gala in November where he received the prestigious 2004 Canadian Foundation of Pharmacy Pillar of Pharmacy Award for his significant contribution to the profession.

Despite his professional duties and accomplishments, staff at the College will remember Bernie for his human and personal side. Bernie and Nellie have fostered over 500 children in their home, and we have, over the years, enjoyed meeting these children and hearing about their progress. Bernie and Nellie also have three sons, a daughter, and five grandchildren — all of whom Bernie is very proud.

To us, Bernie is a wonderful, caring man with a fabulous (and often slightly bent) sense of humour which can catch you off guard at the most interesting times. He makes the best homemade soup for our staff potluck parties, has the best decorated office at Christmas time and he remembers everyone's birthday. He is first into the office each morning, and has usually had his daily quota of coffee by the time the rest of us start our day. Bernie has developed many, many friendships among College staff and pharmacists alike, and we all want to give Bernie a great big hug and wish him well in all his future endeavours. 

## THEN & NOW



TOP: Bernie's graduation picture from the University of Toronto in 1962.

BOTTOM: Receiving the Pillar of Pharmacy award in November 2004.

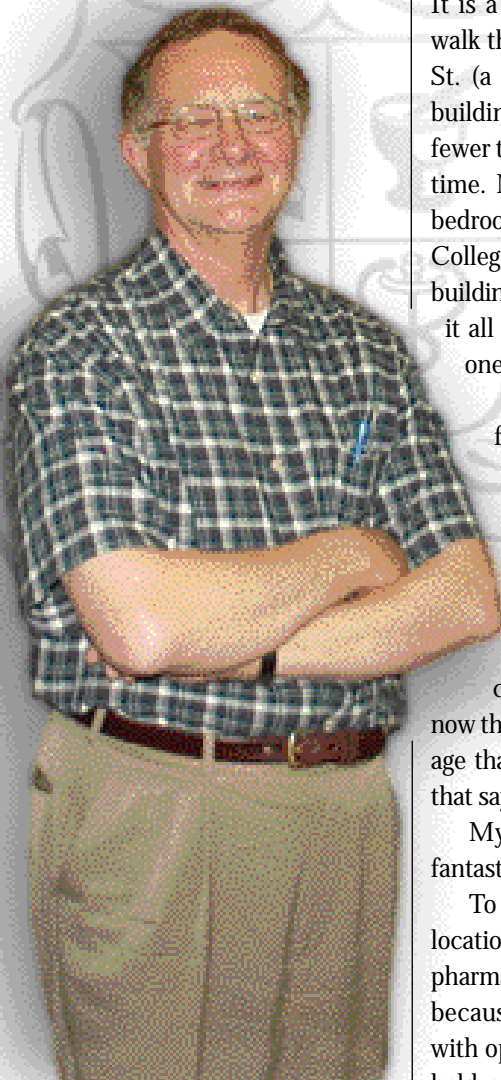
# DesRoches



**WE WILL MISS YOU!**

See Della Connie ~~John~~ Layne Dana  
~~Andrew~~ Augustus Alice Elaine Barb Wendy  
Q Lisa William Jim ~~Adone~~ Suz Whura  
~~Shirley~~ J. Suzanne Jacquin ~~Kim~~ Lu  
Mandy Vicki ~~Shirley~~ Renee Helen F. Deanna  
P. Clayton Bob ~~John~~ Cathy Esther  
~~John~~ Roland Chris Diana Logan  
D. Heather ~~John~~ ~~John~~ Boyd

# Bernie DesRoches



It is a cool day in August, 1966 as I walk through the door into 483 Huron St. (a house converted into an office building) to begin my first day as one of fewer than a dozen College staff at that time. My first office was a converted bedroom with a great view. Today the College has over 50 staff housed in two buildings . . . and I am preparing to leave it all and walk out through that door one last time.

How do I say farewell to all my friends and colleagues who have been part of my College career for 38 years? How do I face the day that I leave a building that has been my home for more waking hours than my personal residence? Can I develop new challenges to keep me stimulated, now that I have reached a chronological age that says “retirement” with a mind that says “not for me”?

My memories of the College are fantastic.

To spend an entire career at one location in the administrative world of pharmacy is a rarity. It happened to me because I was continuously provided with opportunities and challenges that held my interest and blessed with the support of colleagues who helped me achieve results.

With the evolving needs of the College, my responsibilities came to include the areas of registration, practical training, continuing education, journal publication, research, quality assurance, and pharmacy technician programs. Much of my excitement and sense of accomplishment came from being part of the beginnings of many of

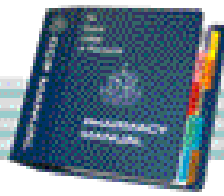
these projects and seeing them evolve into full-fledged programs that today benefit the public and you — members of the College.

I have also had the opportunity to establish a network of friends in pharmacy that extends around the world. Still my fondest memories remain close to home. I treasure recollections of spontaneous telephone calls and letters from pharmacists who just wanted to thank me for something I had said or done that had a positive impact on their lives. In many cases, they shared stories of challenges that were very personal, so the line between professional interaction and friendship eventually blurred. I like to think that was OK.

I could not have achieved any of this by myself. I am forever grateful to my wife and family, who supported me in my work despite the fact it so often took me away from looking after their needs. I cherish memories of Council members, pharmacists, pharmacy technicians and consultants with whom I have had the pleasure of working over the years. I have special memories and appreciation for my friends on staff who endured my shortcomings and coaxed out my strengths. To them, a simple “thank you” seems inadequate.

I leave the College, on a cold December day, much as it was when I came to it. Important projects are still in progress, significant challenges remain, and wonderful opportunities abound. As it was 38 years ago, our profession is blessed with many who are able to carry on with, and dedicated to, the journey. I am privileged to have been part of it. Thank you all for the memories. ■

“My memories  
of the College are  
fantastic.”



**To save time, please complete this survey online at [www.ocpinfo.com](http://www.ocpinfo.com) or fax, without a cover, to 416-847-8276.**

1. How often per month do you consult the OCP Manual (large blue binder with tabs) for information?

- Never
- Once
- 2–5 times
- 6–10 times

2. How often per month do you consult the Policy Handbook (1/2 inch blue-covered stapled booklet)?

- Never
- Once
- 2–5 times
- 6–10 times

3. When a practice question arises, where are you most likely to go to find an answer?

- OCP website
- Policy Handbook & OCP Manual
- Both equally
- Other \_\_\_\_\_

4. How often do you need to consult a second source if you do not find the information you need in either the Policy Handbook or the OCP Manual?

- Never
- Rarely
- Occasionally
- Often

5. How often per month do you access the [www.ocpinfo.com](http://www.ocpinfo.com) website to obtain the information you need?

- Never
- Once
- 2–5 times
- 6–10 times

6. How often do you update your OCP Manual?

- More than once per year
- Every year
- Every two years
- Every three years

7. Between the OCP Manual and the Policy Handbook, which do you find most useful for your average practice inquiry?

- OCP Manual
- Policy Handbook
- Both equally
- Neither

8. In order to maximize usefulness, how frequently would you want the Policy Handbook to be published:

- Twice a year
- Annually
- Bi-annually

9. In order to maximize usefulness, what would be the best way for you to update the OCP Manual?

- Quarterly insert updates
- Annual insert updates
- Buy entire new manual annually
- Buy entire new manual every 2 years
- Buy entire new manual every 3 years

10. Which of the following items would you like to see added to the Policy Handbook (please check all that apply)

- Highlights indicating all new additions to Handbook
- Summaries of OCP discipline proceedings
- In-depth analyses of current practice topics
- Other \_\_\_\_\_

11. If content, ease of use and currency were improved, would you be willing to pay an annual fee for your OCP Policy Handbook and updates to your Manual?

- Yes
- No
- Depends on Price

12. If prepared to pay an annual fee, what is the most that you would be prepared to pay?

- \$85 to \$100
- \$101 to \$125
- \$126 to \$150

13. Would you pay for an online service for information?

- Yes
- No

**Thank you.**





Reza Farmand, R.Ph., B.Sc.Pharm.

# Thank You QA Evaluation Participants!


**T**he evaluation of the impact of the Practice Review is now complete and has been presented to and accepted by Council. This evaluation was led and performed in strict confidence by Dr. Harry Cummings, an independent consultant.

I am pleased to say that, overall, the outcome of the evaluation was positive. In addition, it provided a very useful perspective on pharmacists' attitudes and concerns about the program.

Many pharmacists were invited to participate in the evaluation and I wanted to ensure everyone has a chance to review the outcome of the evaluation. A copy of the Executive Summary can be found on the College website [www.ocpinfo.com](http://www.ocpinfo.com). If you wish to receive a print copy of the complete evaluation report, please forward your request Shabniz Jaffer at 416-962-4861, x 273 or at [sjaffer@ocpinfo.com](mailto:sjaffer@ocpinfo.com).

Evaluation of the College's Quality Assurance Program is ongoing; presently, we are engaged in understanding how pharmacists use the Learning Portfolio as a tool in planning and achieving their professional development goals. Should you be invited to participate in this evaluation, I encourage you to take the opportunity to help shape the Portfolio's future.

If you have any questions about this or future evaluation initiatives, please contact Nora MacLeod-Glover, Manager, Continuing Competency Programs at 416-847-8269, 1-800-220-1921 x 269, or at [nmacleod@ocpinfo.com](mailto:nmacleod@ocpinfo.com). You may also contact Dr. Harry Cummings at (519) 823-1647.

To those who were able to participate in this evaluation, I would like to express my appreciation for all your candid feedback. 



*Nora MacLeod-Glover, R.Ph., B.Sc.(Pharm)  
Manager, Continuing Competency Programs*

# Evaluation of the Impact of the Practice Review

**T**he College's Quality Assurance Program began in 1997, in response to legislation passed by the Ontario government requiring all self-regulated health professions to develop quality assurance programs.

In 2002, the College decided to evaluate the impact of its quality assurance program to determine the effectiveness of the program and to gain valuable insights into how our members view the program.

The evaluation began with focus group research. Participants were randomly selected from three groups: Practice Review candidates from 2002, Practice Review candidates from 1997 and Self-Assessment Survey participants (who had not completed the Practice Review) from 2002. Focus group input formed the basis for written and phone surveys using the same participant groups. Work was led and performed by an independent consultant so as to reduce bias and ensure participant confidentiality.

The following areas were explored in the focus groups and surveys that evaluated the impact of the Practice Review on the profession and on pharmacists:

- Activities for knowledge improvement
- Attitude and approach toward patients
- Changes in practice
- Feelings towards Quality Assurance on the whole

## FINDINGS

The results show that the Quality Assurance Program, in general, and the Practice Review Weekend, in particular, are having a positive impact. (An executive summary of the main results is available on the College Web site at [www.ocpinfo.com](http://www.ocpinfo.com).)

### STRONG PHARMACIST SUPPORT

Of significance is evidence (that emerged from the groups who participated in the Practice Review weekend) that shows strong pharmacist support for Quality Assurance as a whole. There is also strong support for Quality Assurance among the pharmacists who have only participated in the Self-Assessment Survey. This latter group reported having experienced a positive impact from the Quality Assurance Program, with participants supporting the program overall.

Pharmacists who have participated in the Practice Review weekend agreed with, and validated, the following statements:

- i. "I identified gaps in my general knowledge"
 

2002 Practice Review	66%
1997 Practice Review	63%
- ii. "The Peer Review validated my pharmacy practice"
 

2002	71%
1997	72%
- iii. "I improved my overall communication with patients"
 

2002	63%
1997	54%
- iv. "The Practice Review decreased my self-confidence as a pharmacist"
 

2002	11%
1997	6%
- v. "I identified areas of strength in my practice"
 

2002	74%
1997	69%
- vi. "I was encouraged to seek ways to improve patient care"
 

2002	64%
1997	55%
- vii. "I believe that Quality Assurance as a whole is positive for the profession"
 

2002	92%
1997	95%

Some differences between the two groups of surveyed pharmacists are worth noting.

### 2002 PRACTICE REVIEW GROUP

Pharmacists in the 2002 Practice Review group who were educated outside Canada were more likely than others to feel that the Practice Review influenced them to attend more workshops, conferences, and seminars. Pharmacists in hospital or long-term-care facilities were more likely to have identified strengths in their practice and were more likely to feel the Practice Review improved their approach to patients.

### 1997 PRACTICE REVIEW GROUP

Older pharmacists in the 1997 Practice Review group (defined as those who graduated 25 years ago or longer) were more likely to identify gaps in their knowledge. Pharmacists who work in a retail setting were more likely to have been encouraged to apply their greater knowledge to their practice as a result of Practice Review. Internationally-trained pharmacists were more likely to feel that the Practice Review improved their overall attitude and approach to patients.

### 2002 SELF-ASSESSMENT SURVEY CONTROL GROUP

Pharmacists who completed the Self-Assessment Survey but have not participated in the Practice Review weekend were selected to serve primarily as a control group. However, even this group reported having been influenced by the quality assurance program and the existence of the Practice Review weekend.

- i. "I identified gaps in my general knowledge" - 78%
- ii. "I increased communication and interaction with patients" - 65%
- iii. "I identified areas of strength in my practice" - 77%
- iv. "I believe that Quality Assurance as a whole is positive for the profession" - 82%

Specifically, pharmacists who practice in retail settings felt a greater impact in the area of communicating with patients.

### ADDITIONAL FEEDBACK

Throughout the surveys, participants were given an opportunity to elaborate their views by providing qualitative comments. These comments were then coded to allow us to identify common participant views.

Many pharmacists said they could not credit the Quality Assurance Program (entirely or even at all) with changes they had made in their practices, because they felt they were already doing good things to maintain their competency.

# QUALITY ASSURANCE

Many pharmacists stated that it was the numerous changes in the profession, independent of the College's influence, which were motivating them to seek changes and make improvements to their practice.

Overall, positive comments about the Practice Review outweighed negative comments, with many of the negative comments relating to the stress of the day-long assessment and pharmacists' feelings of fear of and/or intimidation by being assessed.

Findings show that the Practice Review had the greater impact on the 1997 Practice Review group than on the 2002 Practice Review group. The 1997 pharmacists were quite positive about the practice changes they made as a result of participating in the Practice Review. The reason for this variance may be attributed to the number of years that had passed since evaluation. It may be the case that pharmacists become more accepting of the Practice Review after five or more years, eventually realizing the experience is beneficial.

The research also showed that pharmacist profiles are more likely to identify certain types of impact; for example, both internationally-trained and community-based pharmacists experienced greater impact than others.

## IN SUMMARY

It appears that pharmacists who undergo the Practice Review have the greatest overall support for the College's Quality Assurance Program, whereas pharmacists who only participate in the Self-Assessment Survey have less overall support for the process and are more likely to continue to express fear about the Practice Review.

Given the strong underlying education focus of the Quality Assurance Program, it is rewarding to see that the program has a positive effect on pharmacists, including encouragement to identify individual learning needs and areas of practice improvement, and validation of practice experience and strengths. 📌

## STATISTICS

Number of Pharmacists in Part A of the Register: **9,334**

Number of ways a pharmacist can participate in the Practice Review: **3**  
(Random Selection, Referral by Committee, Moving from Part B to Part A)

Number of Years the Practice Review has been running: **7**

Total assessments: **1,617**

Number of Pharmacist candidates that have participated in an initial assessment: **1,447**

Success rate on each component of the Practice Review on initial assessment

Gathering Information:	<b>.92%</b>
Patient Management:	<b>.88%</b>
Communication:	<b>.93%</b>
Clinical Knowledge:	<b>.91%</b>

Practice Review Outcomes on Initial Assessment

Pharmacists demonstrating success in their self-directed professional development:	<b>.1,319 (91%)</b>
Pharmacists requiring peer-guided remediation and reassessment:	<b>.128 (9%)</b>

Pharmacist Reassessment Rates:

Once:	<b>.128</b>
Twice:	<b>.30</b>
Three Times:	<b>.8</b>
Four Times:	<b>.3</b>
Five Times:	<b>.1</b>

Pharmacists who moved to Part B after being assessed: **.12**

Pharmacists who resigned or moved to Member Emeritus after being assessed: **.10**



# Are you interested in participating in the Quality Assurance Development Process?

**W**e are seeking volunteers to join the working groups who help develop clinical cases to be included in the Clinical Knowledge Assessment and the Standardized Patient Interviews. The success of the College's Quality Assurance Program depends on the generous efforts of practising pharmacists who contribute to its development and delivery.

We strive for groups that are representative of our professional population: pharmacists from rural and urban areas; pharmacists from a variety of practice settings, and from all around the province; and pharmacists with varying years of experience in practice and trained both in Canada and internationally.


## WHAT TRAINING IS PROVIDED?

Our education consultant provides training each year to all group members to ensure that we are incorporating the most current educational principles into our question and case development. Templates are provided to assist in the development process, and experienced contributors will help guide you through the writing and reviewing.

## WHO CAN APPLY?

To participate, you must be currently practising and must have successfully completed a Practice Review. Having been through the Practice Review first-hand, you will bring a perspective that will serve to improve the process and make it more relevant to everyday practice.

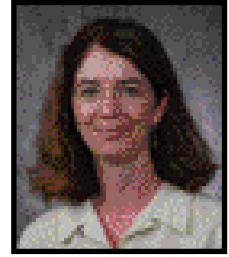
## HOW DO I APPLY?

Please apply in writing, stating your name, OCP number and the group you would be interested in joining, as well as giving a brief summary of your practice experience, including any clinical focus or specialty you have developed. Address your correspondence to Shabniz Jaffer, either by mail or by e-mail at [sjaffer@ocpinfo.com](mailto:sjaffer@ocpinfo.com). 

## THESE QA WORKING GROUPS NEED YOUR HELP:

- 1. Clinical Knowledge Assessment – Writers:** These pharmacists write cases and multiple choice questions, based on their clinical practice experience, prior to each meeting. You will need to be available for three day-long meetings per year at the College, plus do some home writing on your own to develop cases prior to each meeting.
- 2. Clinical Knowledge Assessment – Reviewers:** These pharmacists review the cases and questions drafted by the writing working group to ensure the accuracy of case information, content of questions, and relevance to current practice. Members of this working group must be comfortable checking references for accuracy of answers. You will need to be available for three day-long meetings per year at the College. Currently, this group meets on Sundays.
- 3. Standardized Patient Cases – Writers:** These pharmacists write cases and multiple choice questions that can be acted out by a standardized patient, based on their clinical practice experience, prior to each meeting. Standardized Patients also assist in the case development and you will need to be willing to role-play the cases in front of the group. You will need to be available for three day-long meetings per year at the College, plus do some writing at home to develop cases prior to each meeting.
- 4. Standardized Patient Case – Reviewers:** These pharmacists review the cases and questions drafted by the writing working group to ensure the accuracy of case information, content of questions, and relevance to current practice. Members of this working group must be comfortable checking references for accuracy of answers. You will need to be available for three day-long meetings per year at the College.

# QUALITY ASSURANCE



*Nora MacLeod-Glover, R.Ph., B.Sc.(Pharm)  
Manager, Continuing Competency Programs*

## **PART A & B**

On a regular basis the Continuing Competency Department receives calls and emails from pharmacists who need clarification about Part A and Part B. Most of the requests for information are to assist the pharmacist in determining into which part of the Register they should elect.

**Q I have recently moved to Ontario from another province and am unfamiliar with the different parts of the Register. Can you tell me what it means to be in either Part A or Part B?**

The two-part register came into effect with the start of the Quality Assurance Program. While all pharmacists, whether in Part A or Part B, are required to maintain a record of the ongoing learning activities, only those pharmacists in Part A are included in the pool of pharmacists who can be randomly selected to participate in the Self-Assessment Survey (Phase I) or the Practice Review (Phase II).

In the regulation, "Part A" means the "direct patient care" part of the Register. This means that only pharmacists in Part A will be able to provide pharmacy services directly to patients or their agents, give information related to drug use in the course of providing direct patient care, and be the designated manager of an accredited pharmacy.

A pharmacist choosing Part B is declaring that she or he will not be providing direct patient care. This means that a pharmacist in Part B cannot:

- Work in a pharmacy as pharmacist
- "Fill in" as a pharmacist on an occasional basis

- Provide information related to drug use to patients, or their agents or health care providers in the course of providing direct patient care as a pharmacist
- Be the designated manager of an accredited pharmacy

Although a pharmacist electing to Part B cannot be the designated manager of an accredited pharmacy, he or she can, as a registered pharmacist in Ontario, be an owner of a pharmacy, or a director of a corporation owning a pharmacy in Ontario.

**Q I am currently working as a drug information pharmacist and I frequently get questions from patients as well as health care professionals regarding oral contraceptives, hormone therapy, antibiotic dosing, etc., and I do counsel them on what to do. I am not sure if speaking on the phone, as opposed to face to face, qualifies as direct contact or not. Does working as a drug information pharmacist qualify me for Part A or Part B?**

Direct patient care can take the form of information given via telephone or even e-mail, it is not important that you are not dealing face to face with the patient. Therefore, as a drug information pharmacist, you need to be in Part A of the Register and your hours of work would contribute to the 600 hours required every three years to maintain your Part A license.

*continued on following page*

## PRACTICE REVIEW

We often receive questions from pharmacists following the receipt of their Practice Review reports. As nearly 1,600 pharmacists have participated in the Practice Review, the following questions may be of interest.

**Q** In my Practice Review results package, you included a statement about communications skills that says: “As pharmacists, we may become too focused on the facts of a situation and miss important patient cues as to how patients are feeling and what really matters to them.” Please illustrate the meaning of this sentence with one or two examples of what a pharmacist should know and demonstrate in the patient interviews.

Patients are often unable to verbalize their concerns or confusion about discussions of their conditions of health or use of medication so it becomes the pharmacist’s responsibility to watch for non-verbal cues (e.g., body language) that signal to the pharmacist a need to address the patient’s feelings or seek additional information. It may be that the patient requires clarification or a chance to ask questions about what has been discussed. A pharmacist who is too focused on providing information may not pick up on a patient’s subtle cues.

Consider, for example, when a patient has just been diagnosed with a chronic condition, such as hypertension or diabetes. It may be that the pharmacist is providing proper and effective care to the patient, but has failed to acknowledge the patient’s feelings about this new development in their state of health or about the new necessity for long-term medication. This can be especially important if the patient has never had to take chronic medication. In this situation, acknowledging the patient’s feelings is the first step in building the rapport necessary for the patient to effectively learn about their condition and medication(s). Without such acknowledgement, your patient may listen but not hear what is being said, or may be less willing to accept the long-term implications of his or her diagnosis and treatment.

**Q** On my performance summary in my Practice Review results package, it shows that I had a score of 56 on the Clinical Knowledge Written Assessment. However, I see that I had only two errors (one on case 1 and one on case 15); should my score not be 58 (out of 60)?

Your Clinical Knowledge Written Assessment was scored initially out of 60 but it was also analyzed by our education consultant who conducts a complete psychometrical review of all questions and answers before results are finalized. During this process, we can identify questions which may not have been answered according to expectation. We review any such questions to see why this should have occurred and if we find any ambiguity, or the possibility of two correct answers, we discard the question and rescore all assessments.

Therefore, your final score is now 56 out of 58.

This analysis serves as a final quality assurance check in the process and helps to ensure that the assessment is as fair as possible. At any rate, the outcome is always in the candidate’s favour. 📌

# Learning Portfolio Evaluation

We are evaluating our Learning Portfolio resources, including the electronic Learning Portfolio on our website. We believe that this tool, created in 1997 to assist pharmacists in maintaining a record of their ongoing learning, needs to be revised and updated.

## **WHY IS THE LEARNING PORTFOLIO BEING EVALUATED?**

The College is performing an evaluation to better understand how you use the Portfolio materials, how effectively the materials assist you, and how they can be updated to better serve you. In addition, we hope to understand more clearly the issues you face when using the Learning Portfolio so that we can more effectively address those issues for all pharmacists.

## **WHO IS CONDUCTING THE EVALUATION?**

These surveys are being conducted through an independent evaluation specialist, Harry Cummings & Associates (HCA). Dr. Cummings has an extensive background in program evaluation.

## **HOW CAN I PARTICIPATE?**

HCA will be holding regional focus groups with pharmacists throughout Ontario this fall. We will provide HCA with a list and invitations will be mailed to pharmacists in these areas.

Focus group locations:

Toronto: November 12

Ottawa: November 30

Thunder Bay: December 1

Sudbury: December 2

Windsor: December 6

Should you wish to participate but not live near one of these cities, please contact Shabniz Jaffer at 416-962-4861 or 1-800-220-1921 x 273, or at sjaffer@ocpinfo.com.

Your participation is *optional*, but your input is valuable in further refining the Learning Portfolio resources.

## **WHAT INFORMATION WILL THE COLLEGE RECEIVE?**

Individual responses will be kept confidential, as the College will be provided only with a summary of responses. Should you have any questions about any aspect of the evaluation, please contact Nora MacLeod-Glover at 416-847-8269 or 1-800-220-1921 x 269, or at nmacleod@ocpinfo.com.

**Thank you for your participation!**

# FOCUS ON Error Prevention



Ian Stewart, B.Sc.Pharm.

As pharmacists, we aim to provide the best care possible to our patients. To do so, we must take all the necessary steps to ensure that the right patient receives the right drug, at the right dose, via the right route at the right time.

Despite our best intentions and efforts, however, the potential for error exists. Should an error occur, we must ensure the situation is handled appropriately and promptly.

The following case was reported by the mother of a five-month-old child. The woman was upset and concerned, not only because her child received the incorrect drug, but also because she felt the pharmacy downplayed the situation.

## CASE

A five-month-old girl was due to receive a Menjugate® vaccination on May 10th, 2004 at 4:00 p.m. The mother phoned ahead to the pharmacy and requested that the Menjugate® vaccine be set aside for pickup prior to 4:00 p.m. The pharmacy staff member who spoke to the mother indicated that a Prevnar® vaccine for her daughter was in the refrigerator and ready for pickup. The mother explained that a Prevnar® vaccine had been picked up and administered to her daughter the previous month and that the Prevnar® currently in the refrigerator would be picked up and administered the following month (at a two-month interval from the first dose). The mother emphasized that on this occasion, she needed the Menjugate® vaccine.

The child's father later arrived at the pharmacy and requested the Menjugate® vaccine. However, he was given

the Prevnar® vaccine in error, and he took it to a nurse practitioner for administration. The nurse practitioner, assuming that it was the correct vaccine, administered the Prevnar® to the child.

On returning home from the appointment, the parents received a call from the pharmacist who indicated that the father had been given the wrong vaccine. The mother, was understandably, alarmed and extremely upset.

## RECOMMENDATIONS:

- When dispensing vaccines, review the vaccination schedule with the patient or the patient's agent
- Remind all staff of the importance of documentation to ensure continuity of care
- Ensure that there is a written protocol in place for the handling of medication errors
- All staff must receive a copy of the protocol, which should be reviewed regularly (including at staff meetings)

## HANDLING A MEDICATION ERROR\*

- Acknowledge the error
- Apologize
- Acknowledge the patient's or agent's emotional state; these may include fear, concern, anxiety, anger, etc.
- Be empathetic
- Inform the patient/agent that you, too, are concerned that an error has occurred and that you will investigate what went wrong
- If the patient has ingested the medication, ensure they are safe and refer to the physician if you're concerned
- Reassure the patient/agent that you will take steps to ensure that this error will not recur
- Apologize again
- Document all details of the error, including your actions and your discussions with the patient/agent

\*Author's note: This article highlights only some of key points in handling medication errors. Please consult additional references for a in-depth discussion.

# HEALTH CANADA

## Advisories & Notices

DATE	TYPE
01 Oct, 2004	<p>Health Canada Informs Canadians Of VIOXX® Withdrawal By Merck &amp; Co. Merck &amp; Co., Inc. announced on October 1, 2004 at a press conference in the U.S. that they are voluntarily withdrawing their drug Vioxx® globally</p> <p><i>Please refer to the Notices on our website for further information on this item</i></p>
27 Sept, 2004	<p>Important safety information for patients taking the antiepileptic, LAMICTAL (lamotrigine) - GlaxoSmithKline Inc., Health Canada</p>
01 Sept, 2004	<p>Important Safety Information on Euro-K and Riva-K Sustained Release Potassium Supplements – Health Canada notice to the Public and to Health Care Professionals</p> <p>All lots of Euro-K and Riva-K are being recalled with the exception of Euro-K lots EKT 404 and EKT 405. These two lots are currently being assessed and the results will be provided to pharmacists via a separate communication</p> <p>As a precaution, Health Canada is advising consumers to return these products to their pharmacists for a suitable alternative if necessary</p> <p>Those individuals, with heart, liver or kidney conditions, taking any of these potassium supplements on the advice of a physician should consult their physician to assess the adequacy of their potassium replacement. The following lots release potassium at levels less than specified, Euro-K 8 SR capsules Lot EKE302 Exp 2005 OC; Riva-K 8 SR capsules Lot KERK 804A Exp 2005 MR and Riva-K 8 SR Lots KJRK 805A and KJRK 805B Exp 2005 AL</p>
20 August, 2004	<p>PUBLIC ADVISORY Health Canada Endorsed Important Safety Information on TracheoSoft XLT</p>
16 August, 2004	<p>Health Canada - URGENT RECALL NOTICE - Immediate Action Required TAXUSTM Express<sup>2</sup>™ Paclitaxel-Eluting Coronary Stent Systems and Express<sup>2</sup>™ Coronary Stent Systems - Boston Scientific</p>
09 August, 2004	<p>PUBLIC ADVISORY - Health Canada advises of potential adverse effects of SSRIs and other anti-depressants on newborns</p>

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

## REGISTRATION

# Q&A



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

**Q**I've heard something about a legislative change to the Pharmacy Act to assist labour mobility. Could you tell me what change was made?

The recent change in the Pharmacy Act was made to allow pharmacists on the non-active part of a register in another province to make application to go directly into Part B of the Ontario Register.

When the Pharmacy Act was originally written, there was only one part to the Register. Over time, Ontario developed a two-part register: Part A, for pharmacists who provide direct patient care, and Part B for pharmacists who *do not* provide direct patient care.


Some other provinces have developed similar two-part registers although they may not precisely correspond to Parts A and B of the Ontario Register. Therefore, previously, a pharmacist coming to Ontario from another province was expected to meet the entry-to-practice requirements to be admitted to Part A of the Register.

This change is now in effect.

**Q**I have an internationally trained pharmacist working in my pharmacy as a student. The OCP inspector checked the College's database and informed me that my employee was not a student. Why did my employee receive a student number?

Your employee did not receive a student number; she received a *file number* that will eventually become her student number.

Student status is only granted to those applicants who are enrolled in the University of Toronto's undergraduate pharmacy program or the IPG Program. (Rarely, in unique circumstances, some applicants are allowed to start directly in studentship resulting from a decision by a panel of the Registration Committee.)

For candidates who have achieved student status for credit or non-credit purposes, a student card is provided. It is essential that you check with the College or ask your employee to produce his/her student card to ensure that he/she has student status. Otherwise, your employee can only work as a technician and his/her name badge must reflect that status. Furthermore, while technicians can dispense under the supervision of a pharmacist, they absolutely may not counsel patients. 

## PRACTICE

# Q&A



*Greg Ujiye, R.Ph., B.Sc.Pharm.  
Manager, Pharmacy Practice Programs*

### **Q** Can any nurse prescribe or renew drugs for patients?

No. Not all nurses have been given the authority to prescribe or refill drugs for patients. Only the Registered Nurse in the Extended Class, RN(EC), has the education and is given authority to prescribe or refill drugs from an accepted list outlined in legislation. This class of nurses is sometimes referred to as Primary Health Care Nurse Practitioners.

### **Q** I have the new drug list for the RN(EC). Can RN(EC)s prescribe drugs that are not on the list but fall into the same therapeutic category?

No. The authority for RN(EC)s to prescribe is drug-specific and, in some cases, use, route (dosage form) or client-condition specific. Specific drugs RN(EC)s can prescribe and renew are listed in the Nursing Act – Schedule 2 and 3.

### **Q** Where can I find Schedule 2 and Schedule 3 of the Nursing Act?

Schedule 2 and Schedule 3 are found in the regulations to the Nursing Act 1991 under Ontario Regulation 275/94; Amended to O. Reg. 264/04. The RN(EC) lists are also posted on the College of Nurses website at [www.cno.org](http://www.cno.org) under “Publications” / “Resources” / “Document List.”

### **Q** What is meant by a refill?

When refilling a drug identified in Schedule 3, an RN(EC) is expected to write the prescription as previously prescribed by the physician without changing the dose, the route, or the frequency.

### **Q** RN(EC)s can now authorize some refills. How would I know if a medication prescribed by the nurse practitioner or RN(EC) is a refill?

Pharmacists are not expected to verify or question every prescription by an RN(EC) or another practitioner unless there is some doubt or question about that prescription. However, pharmacists, like RN(EC)s, practise according to professional standards of practice and, if during counselling or dialogue with a patient, the pharmacist has doubts about the validity of the prescription, the RN(EC) should be contacted.

RN(EC)s are regulated by their college under the authority of the RHPA. RN(EC)s practice according to their standards of practice and know and understand their scope and limitations. Only the drugs identified for renewal in the Nursing Schedule 3 (Nursing Act 1991, O. Reg. 275/94 amended to O.Reg.264/04) can be authorized for renewal by an RN(EC). Some of these drugs have further restrictions, such as route of administration or the purpose for use.

If concerns arise about the practice of a particular RN(EC), these should be reported to the College of Nurses by phone at 416-928-0900 or by mail at 101 Davenport Road, Toronto, Ontario, M5R 3P1.

### **Q** An RN(EC) has refilled a prescription for atenolol for an ODB-eligible patient. Can I fill this prescription?

An RN(EC) can refill prescriptions for atenolol, and such prescriptions are legal. However, at time of printing of this article, the additional drugs that an RN(EC) can prescribe are not listed in the ODB Formulary (Part XI) and are not eligible for reimbursement by ODB. In this situation, pharmacists are advised to contact the RN(EC) to have the original physician authorize the refill; otherwise, the pharmacy may not be reimbursed by ODB. 📌

## NOTICE TO PHARMACISTS

Faxed to all Pharmacies on September 24, 2004

### **CHANGES TO SCHEDULE OF DRUGS THAT MAY BE PRESCRIBED BY PRIMARY HEALTH CARE NURSE PRACTITIONERS [RN(EC)]**

The proposed changes to the schedules of drugs that may be prescribed by registered nurses in the extended class [RN(EC)] received government approval on September 10, 2004. The changes to Schedules 2 and 3 of the *Nursing Act*, O.R. 275/94 will update the pharmaceutical options available, ensuring patients receive appropriate and timely care without unnecessary referral or duplication of services.

Schedules 2 and 3 of the *Nursing Act*, O.R. 275/94 are now in effect and RN(EC)s can prescribe from this list. **The complete list is available on the OCP website: [www.ocpinfo.com](http://www.ocpinfo.com) under Practice Guidelines; the complete list will also be published in the Nov/Dec 2004 issue of Pharmacy Connection.**

The changes to the list are identified in bold. Please note that some of the drugs, for renewal only, have route, purpose and/or prescribing circumstances identified. Although these drugs may have additional routes or uses, the authority of RN(EC)'s to prescribe extends only to the routes or purposes identified. These limitations reflect the scope for prescribing of primary health care nurse practitioner practice. The RN(EC) is accountable for knowing and prescribing within the limitations included in the schedules of drugs.

**Please note that Part XI of the Ontario Drug Benefit (ODB) Formulary lists the products that are eligible for reimbursement under the ODB program when prescribed by an RN(EC). Part XI is a list of eligible ODB products that an RN(EC) may prescribe for claims adjudication purposes only. Products not listed are not eligible for reimbursement by ODB. Any addition to this list will be reviewed by ODB. An RN(EC) must have a physician authorize any drug not listed in this section for patients eligible for coverage under the ODB program.**

### **PRESCRIBING BY NURSE PRACTITIONERS - RN(EC)**

**Additions have been made to the list of drugs that the Registered Nurse in the Extended Class [RN(EC)] may prescribe. (Ontario Gazette, September 11, 2004)**

**\*\*Revised additions as of August 2004 noted in red/bold print**

Nurse practitioners are registered nurses (RN) in the extended class (EC). They will identify themselves with the designation RN (EC).

As well as the controlled acts available to registered nurses, those registered in the extended class have the authority to perform three additional controlled acts:

1. communicating a diagnosis of a disease or disorder,
2. ordering diagnostic ultrasound, and
3. prescribing a defined range of drugs.

In addition, changes to other acts authorize RNs in the extended class to order specific x-rays and laboratory tests, and to certify death in specific circumstances.

Pharmacists will be most interested in prescribing by the nurse practitioner. Please note that a prescription written by a nurse practitioner must show the RN(EC) credentials of the prescriber. A list of drugs that nurse practitioners

may prescribe and their restrictions follows (the list starts with Schedule 2 as there is no Schedule 1 at this time). For those medications that can only be prescribed for certain disease states, the pharmacist may assume that the nurse practitioner is prescribing appropriately and therefore it is not required that you verify that diagnosis with the patient or nurse practitioner. Ontario Drug Benefit will not require a disease state code for adjudication. If you are concerned that medications are being prescribed for disease states other than those listed, you should contact the nurse practitioner or the College of Nurses of Ontario, rather than challenging the patient.

The College of Nurses of Ontario will provide a list of nurse practitioners to Ontario Drug Benefit who will assign billing numbers.

### **RN(EC) Current drug List (2004-09-11) - Nursing Regulation 275**

Drugs that may be prescribed by Registered Nurses in the Extended Class (Amended August, 2004)

#### **Schedule 2**

Diphtheria and tetanus toxoids (**DT**)

Diphtheria and tetanus toxoids and pertussis vaccine (**DPT**)

Diphtheria and tetanus toxoids and polio vaccine (**DT** — polio)

Diphtheria and tetanus toxoids and pertussis and polio vaccines (**DPT** — polio)

Diphtheria and tetanus toxoids and pertussis and haemophilus b vaccines (**DPT** — Hib)

Diphtheria and tetanus toxoids and pertussis, polio and haemophilus b vaccines (**DPT** — polio + Hib)

Haemophilus b vaccine (**Hib**)

Hepatitis **A** vaccine (inactivated)

Hepatitis **B** immune globulin

Hepatitis **B** vaccine

Inactivated polio vaccine

Influenza vaccine

Measles, mumps and rubella vaccine (**MMR**)

Measles vaccine

Meningococcal vaccine

Mumps vaccine

Pertussis vaccine

Pneumococcal vaccine

Rh (**D**) immune globulin

Rubella vaccine

Tetanus toxoid

Tetanus and diphtheria toxoids (**Td**)

Tetanus and diphtheria toxoids and polio vaccine (**Td** — polio)

Tetanus Immune Globulin

Varicella virus vaccine

#### **Schedule 3**

When circumstances are set out for a drug in Schedule 3, an RN(EC) shall only prescribe the drug in those circumstances. Until now, routes and/or purposes are the two circumstances identified for certain drugs. The August 2004 amendments to Schedule 3 also include the condition “for renewal only” when prescribing certain drugs.

An RN(EC) who prescribes a drug that is authorized “for renewal only” is accountable for all of the following:

- Knowing that the drug has been prescribed for the client on an ongoing basis for a period of time;
- Knowing that the client’s ongoing response to the drug is predictable, typical, and well-established;
- Determining that the client’s condition has not destabilized or deteriorated and that the established drug regimen remains appropriate for the client;
- Writing the prescription as previously prescribed by the physician without changes to dose, route, frequency;
- Consulting with a physician to discuss any question or concern regarding continued use of the drug as originally prescribed.

#### **Acarbose – for renewal only**

Acetic acid/benzethonium chloride/hydrocortisone compound

Acyclovir (oral)

Acyclovir (topical preparation)

#### **Alendronate sodium – for renewal only**

#### **Amantadine hydrochloride**

#### **Amlodipine besylate – for renewal only**

Amoxicillin

Amoxicillin and clavulanate

Aqueous procaine penicillin G — for the purpose of treating sexually transmitted diseases

#### **Atenolol – for renewal only**

Azithromycin

**Beclomethasone dipropionate (inhalation) – for renewal only**

Benzathine penicillin G — for the purpose of treating sexually transmitted diseases

Benzoyl peroxide

Betamethasone sodium phosphate and gentamicin sulfate otic solution

Betamethasone valerate

**Budesonide – for renewal only**

Cefixime — for the purpose of treating sexually transmitted diseases

**Cefprozil**

Ceftriaxone sodium — for the purpose of treating sexually transmitted diseases

**Cefuroxime axetil (oral)**

**Celecoxib – for renewal only**

Cephalexin

**Ciprofloxacin HC (otic)**

Ciprofloxacin HCl

Clarithromycin (oral)

Clindamycin (oral)

Clindamycin (topical preparation)

Clindamycin phosphate (vaginal cream)

Cloxacillin (oral preparation)

**Collagenase**

Condylline

**Conjugated Estrogens**

**Conjugated Estrogens and medroxyprogesterone acetate**

**Cyanocobalamin (Vitamin B12)**

Desogesterol and ethinyl estradiol

Dextrose 50 per cent (injectable preparation) — in an emergency

Diazepam (injectable preparation) — in an emergency

Diclofenac sodium and misoprostol

Dienestrol

**Diltiazem – for renewal only**

Diphenhydramine hydrochloride (injectable preparation) — in an emergency

Doxycycline hyclate

Doxylamine succinate and pyridoxine hydrochloride

Econazole

**Enalapril maleate – for renewal only**

Epinephrine

Epinephrine hydrochloride (injectable preparation) — in an emergency

Erythromycin and benzoyl peroxide

Erythromycin and tretinoin

Erythromycin base

Erythromycin estolate

Erythromycin ethylsuccinate

**Erythromycin ethylsuccinate/sulfisoxazole acetyl**

Erythromycin stearate

Erythromycin with ethyl alcohol lotion

**Estradiol-17 beta (micronized)**

**Estradiol-17 beta (Silastic ring)**

**Estradiol-17 beta (transdermal)**

**Estradiol-17 beta hemihydrate**

**Estradiol-17 beta norethindrone acetate**

**Estrone (cone or cream)**

**Estropipate (piperazine estrone sulfate)**

Ethinyl estradiol and cyproterone acetate

Ethinyl estradiol and ethynodiol diacetate

Ethinyl estradiol and levonorgestrel

Ethinyl estradiol and norethindrone

Ethinyl estradiol and norethindrone acetate

Ethinyl estradiol and norgestimate

Ethinyl estradiol and norgestrel

**Etidronate disodium/ calcium carbonate – for renewal only**

Famciclovir

**Fluconazole (oral) – for renewal only**

Flumethasone pivalate/clioquinol compound

Flunisolide

Fluocinolone acetonide

**Fluticasone propionate (inhalation) – for renewal only**

**Fluticasone propionate (nasal)**

Folic acid

**Formoterol fumarate dihydrate –for renewal only**

Framycetin sulphate

Framycetin sulphate/gramicidin/dexamethasone compound otic solution

**Furosemide – for renewal only**

Fusidic acid (topical preparation)

**Gentamicin sulphate (otic, ophthalmic and topical)**

**Gliclazide – for renewal only**

**Glyburide –for renewal only**

**Haloperidol – for chronic nausea in palliation**

**Hydrochlorothiazide – for renewal only**

**Hydrocortisone-17-valerate**

Hydrocortisone (topical preparation)

Hydroxyzine hydrochloride (oral preparation)

Ibuprofen

**Imiquimod**

**Ipratropium bromide – for renewal only**

**Ipratropium bromide/salbutamol sulfate – for renewal only**

Ipratropium bromide (inhaler or nebulizer solution) — in an emergency

**Ketoconazole (topical)**

Ketoprofen

Levocabastine HCl

Levonorgestrel

**Levonorgestrel releasing intrauterine system**

**Levothyroxine sodium – for renewal only**

Lidocaine hydrochloride 1 per cent and 2 per cent, with or without epinephrine (local anaesthetic)

Lorazepam (injectable preparation and **oral**) — in an emergency (**Oral route is new**)

Mebendazole

Medroxyprogesterone acetate (injectable preparation and **oral**) (**Oral route is new**)

Mefenamic acid

**Meloxicam – for renewal only**

Mestranol and norethindrone

**Metformin hydrochloride – for renewal only**

Metronidazole (oral and topical preparations)

**Minocycline hydrochloride**

**Misoprostol**

**Mometasone furoate monohydrate**

Mupirocin

Naproxen

Nicotine patch

**Nifedipine – for renewal only**

Nitrofurantoin

Nitroglycerin SL or spray — in an emergency

Norethindrone

**Norethindrone acetate/ethinyl estradiol**

Nystatin (oral)

**Oseltamavir phosphate**

Penicillin V

Phenazopyridine HCl

Pivampicillin

Podophyllum resin

PPD-B (Mantoux)

**Progesterone**

**Raloxifene HCL – for renewal only**

**Ramipril – for renewal only**

**Ranitidine HCL (oral)**

**Risedronate sodium hemi-pentahydrate – for renewal only**

**Rofecoxib – for renewal only**

Salbutamol (inhaler or nebulizer solution) — in an emergency or **for renewal (for renewal is new)**

**Salmeterol xinafoate –for renewal only**

**Salmeterol xinafoate/fluticasone propionate – for renewal only**

Silver sulfadiazine

Sodium cromoglycate (ophthalmic and nasal preparations)

Sulfacetamide sodium

Terbinafine (topical preparation)

**Terbutaline sulfate – for renewal only**

Terconazole

Tetracycline hydrochloride (oral preparation)

**Tretinoin (topical)**

**Triamcinolone acetonide**

**Trichloroacetic acid 50-80% , Bichloroacetic acid 50-80%**

Trimethoprim

Trimethoprim and sulfamethoxazole (oral preparation)

Valacyclovir hydrachloride

**Zanamivir**

**C A S E :****Discontinuation of Service Without Reasonable Cause****Member:** Safwat Milad, Mississauga**Hearing Date:** January 22, 2003

Mr. Milad was found to have committed an act of professional misconduct in that he discontinued needed professional services, without reasonable cause and without arranging for alternate services or providing a reasonable opportunity to his patient(s) to do so.

The member pled not guilty to the allegation of professional misconduct relating to his involvement in the discontinuation of professional services. However, based on the evidence presented, the Panel made a finding of professional misconduct.

**FACTS**

In a complaint filed with the College, a patient explained that, on July 22, 2000, he attempted to obtain a refill of a medication on file at the pharmacy. The patient stated that he was advised that the drug was not in stock and was asked to come back the following week. When the patient returned to the pharmacy on July 30, 2000 he found the store locked. However, there was an attendant in the store, who, at the same time, let an optician enter. The optician appeared to operate out of the store. The patient asked for his prescription back, only to be told again that the drug was not in stock. The patient was told that the pharmacy would be closed for the next two days but was not told why.

The patient then tried to get his prescription refilled at another pharmacy. He could not because there was no one to contact at the pharmacy at which his prescription was on file. At the time of filing his letter of complaint with the

College, the patient believed that his only option was to secure another prescription from his physician.

The College's investigation revealed that the pharmacy had been evicted from the premises and that the pharmacy had not operated "for some time". Furthermore, the pharmacy's Certificate of Accreditation was cancelled by the College on August 14, 2000 for non-payment of fees.


While Mr. Milad denied that he was the designated manager of the pharmacy during the period in question, he admitted that he was the owner of the pharmacy during this same time and that he was aware that it was closing.

**JOINT SUBMISSION ON PENALTY**

The Panel was presented with a Joint Submission on Penalty and found the penalty to be reasonable in these circumstances, for the following reasons:

- This was Mr. Milad's second appearance before the Discipline Committee
- The remedial elements set out in the Joint Submission would assist Mr. Milad in meeting the standards of practice of the profession in the future, as well as serving to protect the public

**ORDER**

- A reprimand
- A condition on Mr. Milad's Certificate of Registration that, within one year, he shall, at his own expense, take and successfully complete the appropriate examinations for the following courses offered by correspondence through the Canadian Pharmacy Skills Program of the Leslie Dan Faculty of Pharmacy, University of Toronto: "Complaints and Discipline Procedures"; "Standards of Practice"; and "Professional Liability"
- Costs in the amount of \$1,000 

## NEW PART-TIME DISTANCE DOCTOR OF PHARMACY PROGRAM

The Doctor of Pharmacy Program at the University of Toronto admitted its first class to the new Part-Time Distance Education Program in September 2004.

This means that our Pharm.D. Program is now offered in two formats: the traditional two-year full-time program and, now, the part-time distance education program which students can complete within four years. Both programs lead to post-baccalaureate degrees, and are academically rigorous.

The new part-time format is divided into two phases: the first consists of online courses, delivered through web-based interactive courseware, and the second consists of eleven



one-month rotations which can be scheduled over a one- to two-year period.

The use of web-based interactive courseware permits flexibility of time and space; students are able to combine their professional work with their studies and are able to participate in courses at times and locations convenient to them. Our dedicated faculty members are committed to the part-time format and to ensuring that all educational standards are maintained.

Visit the Pharm.D. website: [www.utoronto.ca/pharmacy](http://www.utoronto.ca/pharmacy), click on "Programs and Admissions" and follow the links to "Pharm.D.". For an admissions package, call 416-978-0603. 📧

# Ontario Court Decision Respecting Loyalty Programs

## *The College May Make Interpretations Related to Professional Misconduct*

Last spring, a pharmacy chain made an application to the Ontario Superior Court of Justice for a declaration that the College, through its Council, did not have the jurisdiction to make and issue its new Policy Respecting Loyalty Programs, which was to take effect on July 1, 2004. The chain sought an injunction to prevent the College from implementing the new policy.

In late June, after reviewing written submissions and hearing oral arguments from both parties, Justice R. Echlin of the Ontario Superior Court of Justice dismissed the chain's application.

Justice Echlin found that the College "had jurisdiction and was acting within its authority when the policy was issued." Echlin further stated that "it is notable that the Ontario Court of Appeal has previously confirmed that the Ontario College of Pharmacy [sic] is authorized to issue interpretations regarding professional misconduct..."

Echlin noted that only the College's Discipline Committee could make actual findings of professional misconduct, and that members had a right to appeal such findings made against them. In such cases, a reviewing Court would have concrete facts before it, and could evaluate whether the Discipline Committee's findings should stand or not. (In particular, whether the interpretation issued by the College was valid.) Echlin, therefore identified going to the Discipline Committee as the appropriate route to challenge a College policy — not seeking a court or judge to generally declare that the College did not have the right to pass such a policy. 📧

**International  
Pharmacy  
Graduate  
Program**



# IPG Program Goes West

*Marie Rocchi Dean, IPG Program Coordinator*

**S**ince its inception in 2001, the International Pharmacy Graduate Program has been through seven complete cycles, with over 300 internationally trained graduates having attended the program (one or both parts) and are enjoying great success in meeting the entry-to-practice requirements in Ontario.

Despite its success, a drawback to the IPG Program is that it is only offered in Toronto. As Canada's largest city, Toronto is the destination of choice for most immigrants (including internationally trained pharmacists). However, the demand for pharmacists is also significant outside our large cities. Consequently, there has been growing interest in establishing satellite IPG sites.

This past summer, a pilot IPG program was run in partnership with the University of British Columbia's Faculty of Pharmaceutical Sciences, in Vancouver. (Vancouver is another major destination for international pharmacy graduates.)

The IPG Vancouver satellite campus model was organized and administered by U of T program faculty while staff from both universities were involved in teaching and assessment. The core curriculum was the same as that of U of T's; however, sections on pharmacy law were modified to reflect British Columbia's regulatory environment.

These differences created challenges for the Toronto program staff who developed program materials, and adjustments needed to be made in marking and assessment to accommodate differences in practices.

The centrepiece of this model involved using distance technologies for certain therapeutics and pharmacy practice courses. Since, for scheduling reasons, the UBC pilot start was about two weeks behind the IPG Program session, we decided to use CD and DVD technology to aid course delivery. Lectures were recorded in Toronto, produced in a CD/DVD format and then sent by courier (along with handouts and other course materials) to the UBC co-coordinator.

Muhammad Zuberi, a pharmacist at the University Health Network with an interest in distance learning and technology, developed an interface that allowed learners in BC to enjoy a replicated lecture experience. Students at UBC viewed the lectures in groups and then undertook facilitated discussions, questions, and case simulations with the co-coordinator and other locally-hired experts. Though this format did not allow for direct interaction between the Toronto-based lecturer and the Vancouver-based students, the local co-coordinator acted as an important intermediary for the video presentations. In addition, students were able to readily communicate with the Toronto-based lecturer through e-mail and other web technologies.

There were 34 students in British Columbia and 33 in Ontario participating in the program. All of the Vancouver IPG students were corporately sponsored and the Vancouver schedule was more compressed, as classes had to conclude by the end of August (Toronto classes, meanwhile, ran well into September).


“Our goal is to help international pharmacy graduates achieve their dream of meaningful employment in Canada by offering unique bridging education that helps them adapt their skills to the Canadian context. More than 90 per cent of those who’ve completed the IPG program in Toronto have passed their licensure requirements and gained employment as pharmacists. We believe this success can be replicated outside Ontario so it made sense to share this established curriculum with our colleagues at UBC.” -


*Wayne Hindmarsh, Dean of the Leslie Dan Faculty of Pharmacy*

Although the final results and marks have not been tabulated, it appears that the Toronto class fared slightly better, possibly due to the advantage of seamless curriculum delivery. However, at a reception, hosted by the BC College of Pharmacists in late August, Toronto program staff were overwhelmed by the gratitude expressed by the Vancouver students for the opportunity to participate in the program.

Due to the overall success of the Vancouver pilot, the IPG Program is well positioned to continue its expansion and bring bridging education to other Canadian cities.

We continue to discuss with Alberta and BC the possibility of additional satellite campuses and, in Ontario, we are exploring the feasibility of satellite campuses in other parts of the province. Indeed, our goal is to engage the active pharmacy communities in these cities to help us create viable, sustainable IPG programs.

For more information, visit us at our new website, [www.ipgcanada.ca](http://www.ipgcanada.ca). 



# Personal Health Information Protection Act, 2004

**P**HIPA came into effect November 1, 2004. This Act governs the collection, use and disclosure of personal health information in the health sector. Please familiarize yourself with the information provided in the following sources:

1. *A Guide to the Personal Health Information Protection Act*. A copy of this manual has been recently mailed to every pharmacy in Ontario.
2. *PHIPA* Article, September/October 2004 issue, *Pharmacy Connection*
3. Information and Privacy Commission of Ontario's website, [www.ipc.on.ca](http://www.ipc.on.ca).

**THE FOLLOWING ADDITIONAL FAQs HAVE BEEN RE-PRINTED FROM THE THE IPC WEBSITE.**

## FREQUENTLY ASKED QUESTIONS, PART 2

(Please see September/October Issue for FAQ's Part 1)

### RIGHTS AND RESPONSIBILITIES

#### **Q** How does *PHIPA* protect personal health information?

The ability of an individual to control how his/her own personal information is collected, used and disclosed is key to his/her privacy rights. *PHIPA* gives patients control over their own personal health information by requiring health information custodians to obtain consent for the collection, use or disclosure of personal health information, with limited exceptions.

*PHIPA* establishes certain privacy rights for individuals and imposes specific obligations on health information custodians in protecting personal health information.

## Q What rights do individuals have?

Individuals can expect to be well informed about how their personal health information will be collected, used and disclosed by health information custodians. Individuals can also expect the administrative, technical and physical safeguards relating to their personal health information to continue to be in place.

*PHIPA* gives individuals the right to:

- Understand the purposes for the collection, use and disclosure of personal health information;
- Refuse or give consent to the collection, use or disclosure of personal health information, except in circumstances specified in *PHIPA*;
- Withdraw consent by providing notice to the health information custodian;
- Request access to one's own personal health information;
- Request corrections to be made to one's own personal health information;
- Complain to the IPC about a custodian's refusal to give access to all or part of a health record; and
- Complain to the IPC about any breach of *PHIPA* in the manner in which personal health information has been collected, used, disclosed or handled.

*PHIPA* establishes a formal process for individuals to access and correct their own personal health information with time frames and rights of complaint and appeal if an access or correction request is denied.

## Q What responsibilities do health information custodians have?

*PHIPA* requires health information custodians who have custody or control of personal health information to establish and implement information practices that comply with its provisions. This does not mean that custodians are expected to completely set aside their existing policies and practices. In fact, *PHIPA* builds upon existing policies and guidelines for health care professionals and provides enforceable rules relating to the collection, use or disclosure of personal health information.

*PHIPA* will require health information custodians to:

- Obtain an individual's consent when collecting, using and disclosing personal health information, except in limited circumstances as specified under *PHIPA*;
- Collect personal health information appropriately (by

lawful means and for lawful purposes) and no more than is reasonably necessary;

- Take reasonable precautions to safeguard personal health information, even when it is used and disclosed outside of Ontario, including:
  - Protection against theft or loss;
  - Protection against unauthorized use, disclosure, copying, modification or destruction; and
  - Notification to an individual at the first reasonable opportunity if the information is stolen, lost or accessed by an unauthorized person.
- Ensure health records are as accurate, up-to-date and complete as necessary for the purposes which they use or disclose personal health information;
- Ensure health records are stored, transferred and disposed of in a secure manner;
- Designate or take on the role of a contact person who is responsible for:
  - Responding to access/correction requests;
  - Responding to inquiries about the custodian's information practices;
  - Receiving complaints regarding any alleged breaches of *PHIPA*; and
  - Ensuring overall compliance with *PHIPA*.
- Provide a written statement that is readily available to the public and describes:
  - A custodian's information practices;
  - How to reach the contact person; and
  - How an individual may obtain access, request a correction or make a complaint regarding his/her personal health information.
- Inform an individual of any uses and disclosures of personal health information without the individual's consent that occurred outside the custodian's information practices; and
- Ensure that all agents of the custodian are appropriately informed of their duties under *PHIPA*.

## CONSENT REQUIREMENTS

### Q What is consent under *PHIPA*?

The general rule is that a health information custodian needs to obtain an individual's *knowledgeable* consent to collect, use and disclose personal health information unless *PHIPA* allows the collection, use or disclosure without consent. An individual's consent may be express or implied.

# Personal Health Information Protection Act, 2004

*Knowledgeable* consent means that an individual must know why a health information custodian collects, uses or discloses his/her personal health information and that he/she may withhold or withdraw this consent.

## Q What is the difference between express and implied consent?

Where consent is required under *PHIPA*, consent may be either express or implied.

*Express consent* to the collection, use or disclosure of personal health information by a health information custodian is explicit and direct. It may be given verbally, in writing or by electronic means.

*Implied consent* permits a health care custodian to infer from the surrounding circumstances that an individual would reasonably agree to the collection, use or disclosure of his/her personal health information.

For example, when an individual discloses his/her personal health information for the purposes of filling out a prescription, a pharmacist can reasonably infer consent to the collection of that information.

## Q What are the requirements for consent?

Under *PHIPA*, a health information custodian may consider to be valid if it is:

- Knowledgeable;
- Voluntary (not obtained through deception or coercion);
- Related to the information in question; and
- Given by the individual.

Administratively, a health information custodian may ensure that consent is knowledgeable by posting a conspicuous notice or distributing brochures that are readily available to the public describing the purposes for the collection, use and disclosure of personal health information.

## Q When is implied consent sufficient?

In practice, a health information custodian is not required to obtain an individual's written or verbal consent every time personal health information is collected, used or

disclosed. *PHIPA* permits a custodian to assume implied consent where information is exchanged between custodians within the circle of care for the purpose of providing direct health care — unless a custodian is aware that an individual has expressly withheld or withdrawn his/her consent. Consent may never be implied for an individual who specifies that his/her personal health information may not be collected, used or disclosed.

Implied consent is also permitted if a health information custodian collects, uses or discloses names or addresses for the purposes of fundraising.

In addition, if an individual has provided information about his/her religious affiliation to a health care facility, the facility may rely on implied consent to disclose the individual's name and location within the facility to a person representing his/her religious organization. Before making this disclosure, the facility must provide the individual with an opportunity to withhold or withdraw the consent.

## Q When is express consent required?

In certain circumstances express consent will always be required:

- Express consent is required for a disclosure of personal health information to an individual or organization that is not a health information custodian and is outside the circle of care:
  - o For example, a pharmacist is not able to reasonably infer that an individual would consent to have his/her personal health information disclosed to a third party, such as an insurance provider, who is considered to be outside the circle of care. The pharmacist would be required to obtain the express consent of the individual in order to disclose personal health information to the insurance provider.
- Express consent is required where information is disclosed by one custodian to another for a purpose other than providing or assisting in providing health care.
- Express consent is also required where a custodian:
  - o Collects, uses or discloses personal health informa-

tion other than an individual's name and mailing address for fundraising purposes;

- o Collects personal information for marketing research or activities; and
- o Collects, uses or discloses personal information for research purposes, unless certain conditions and restrictions are met.

### **Q** Is express consent required to disclose personal health information to an insurance company?

Yes. *PHIPA* prohibits a health information custodian from disclosing an individual's personal health information to an insurance company, an entity outside the circle of care, without the express consent of that individual.

### **Q** Can an individual withdraw his/her consent?

Yes. An individual may withdraw his/her consent at any time for the collection, use, or disclosure of his/her personal health information by providing notice to the health information custodian. This applies to implied as well as express consent.

A withdrawal of consent is not retroactive. This means that where a disclosure has been made on the basis of a consent, the custodian is not required to retrieve the information that has already been disclosed.

### **Q** Can an individual place a condition or restriction on his/her consent?

Yes. Where consent is required, an individual may restrict a health information custodian from sharing all or any part of his/her personal information with another custodian. In doing so, an individual can be said to have placed his/her personal health information into a "lock-box."

However, an individual's restriction may not impede the collection, use or disclosure of personal health information that is required by law, professional or institutional practice.

### **Q** What is a "lock-box?"

The "lock-box" is not a defined term under *PHIPA*. It is a term of reference used to describe the right of an individual to instruct a health information custodian not to disclose specified personal health information to another custodian.

### **Q** How does the lock-box work?

When an individual requests a health information custodian not to use or disclose his/her personal health information to another custodian, the custodian is obliged to inform the recipient custodian that some personal health information is inaccessible as a result of it having been "locked" by the individual. The custodian who receives "locked" personal health information may choose to explore this matter with the individual. The custodian would need to obtain the express consent of that individual to access and use that information.


However, a custodian is permitted to disclose the information to a recipient custodian in certain circumstances, including where in his/her professional opinion, the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to an individual or a group of persons.

### **Q** When does the lock-box provision take effect?

The lock-box provision takes effect on November 1, 2004, when *PHIPA* comes into force. However, *PHIPA* specifies that hospitals may begin to comply as of November 1, 2005, in order to provide sufficient time for hospitals to implement this provision.

### **Q** What happens when an individual is incapable of providing consent?

*PHIPA* generally presumes that individuals are capable of making their own decisions regarding the collection, use or disclosure of their personal health information if they are able to understand and appreciate the consequences of providing, withholding or withdrawing their consent.

If a health information custodian believes that an individual is incapable of providing consent, *PHIPA* permits a substitute decision maker (such as a relative, spouse, child's parent, or the Public Guardian and Trustee) to make a decision on an individual's behalf. For example, a substitute decision maker is authorized to provide personal health information on behalf of a child under the age of 16 who is unable to provide an answer to a medical question. 



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

# Alternative Dispute Resolution


## Accomplishes College Regulatory Objectives

The College has, over the past few years, been using alternative dispute resolution (ADR) mechanisms where appropriate as a way of achieving compliance with College policies and applicable legislation without sending a member or pharmacy to the Discipline Committee.

ADR is used whenever a member both acknowledges accountability for a practice violation and reaches agreement with the College on a joint resolution that obviates the need for any resolution to be ordered by the Discipline Committee.

Specifically, after the College's investigation, a member's case is considered by the Executive Committee, which has the authority to refer specified allegations of professional misconduct to the Discipline Committee (The Accreditation Committee in turn, has the authority to refer the pharmacy to





***ADR mechanisms  
provide the College  
with meaningful and  
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the Discipline Committee). When appropriate, however, the Executive Committee has used this review process to invite the member to undertake certain professional or educational commitments — instead of submitting to disciplinary proceedings.

ADR mechanisms provide the College with meaningful and effective ways of attaining continuing competence while assuring public safety without costly hearings. In some instances, the College is able to accomplish more through ADR than through a disciplinary hearing; for example, when the transgressing party is not a member of the College, and therefore, is not subject to the same level of accountability as members of College.


A recent situation of this kind involved inappropriate conduct of six members who had, as designated managers of pharmacies belonging to a chain, and further to the chain's promotional program, offered bonus/loyalty points to their patients. It was the College's position that their involvement in the promotion amounted to "offering or distributing directly or indirectly, a gift, rebate, bonus or other inducement with respect to a prescription or prescription services" and therefore, that they committed professional misconduct.

As part of the resolution of this matter, and in lieu of disciplinary proceedings, the Executive Committee

accepted from each of the six members a signed document acknowledging prior knowledge of the College's position respecting promotional programs, and undertaking to comply in the future with "all aspects of the College's policies, the standards of practice, and the laws that regulate the practice of pharmacy, the operation of pharmacies, and the advertising of pharmacy and pharmaceutical services." The six members specifically undertook not to participate in any future programs (such as the chain's promotional program) which were not in compliance with College policies.

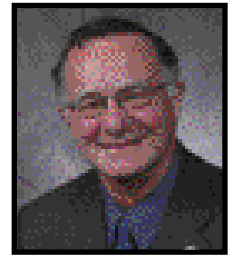
A further component of the resolution required the dissemination of a letter from the chain's corporate offices to all of its pharmacists stating that it would not institute any program which breached College policies or standards, and that it would not require its pharmacists to participate in any activity that breached College policies.

Having achieved this commitment from the corporation the Executive Committee was satisfied that no further breach of the College's policy relating to promotional programs would occur.

Considering that the College regulates only pharmacists and pharmacies, the resolution reached through ADR had far-reaching effects that could not have been accomplished through the College's disciplinary process alone. 

## TECHNICIAN

# Q & A



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

**A**s you know, I have overseen the College's work with pharmacy technicians for the past 30 years, and I will be retiring at the end of this year.

I am proud of the work that has been done in advancing the profession of pharmacy technicians. We began in the early 1970s with a survey of the profession to determine the number of pharmacy technicians in Ontario and subsequent establishment of the first community college programs for pharmacy technicians.

At Council's request in 1995, I helped launch the College's voluntary certification process. The first exams were offered in 1996, and over 2,500 C.Ph.T.s have since successfully met the certification requirements. I am proud of the high standards established for this certification as well as the solid recognition it has earned among pharmacists and pharmacy technicians across Ontario.

In 1998, Council set a new priority to create a separate class of registration for pharmacy technicians who would be capable of an expanded role. Through several working groups, countless meetings, and the preparation of an equal number of equally countless documents, this initiative has evolved to its current status.

During this process, I have collaborated with many pharmacy technicians in the working groups and have met with many more stakeholders and interested parties from Ontario, Canada and internationally. As a result, I have gained an immense appreciation and respect for the dedication, energy, and wisdom of pharmacy technicians eager to fulfill and expand their role. I am grateful for the privilege.

Through this Q & A column, I have answered many questions and done my best to keep you up to date on the College's initiatives related to pharmacy technicians. I am indeed grateful to all you who have submitted questions and comments to this column.

Our work toward establishing registered pharmacy technicians is well underway and I am confident that those

who will carry on will have the determination and dedication to bring this to a successful outcome.

I now "turn the reigns" of this column over to the very capable hands of my colleague, Chris Schillemore, Manager of Registration. For more information, please contact Deborah Byer, Administrative Assistant, Registration Programs, at 416-962-4861 x 250 or at dbyer@ocpinfo.com.

### SOME INTERESTING STATISTICS ABOUT THE C.PH.T. PROGRAM

When the College started the certification process for pharmacy technicians, about half of the candidates sitting the examination were trained on the job. In the early years, there were 11 community colleges and three private vocational schools, with a total of 12 campuses, offering formal pharmacy assistant/technician programs.

There are now 10 community colleges offering programs; however, the private career college sector has seen a significant increase in numbers; there are now nine colleges, with a total of 27 campuses across the province, with more private colleges seeking accreditation by the Ministry of Training, Colleges, and Universities.

Many more candidates now sitting the exam have studied in formal training programs, as shown in the following statistics:

<b>Training Site</b>	<b>1996</b>	<b>2004</b>
Community college	190	188
Private career college	24	92
On-the-job trained	204	158
Other	0	5
	<b>418</b>	<b>443</b>

In the fall of 2000, a number of the community colleges initiated a four-semester pharmacy technician program in response to a direction from the Ministry that, as of 2002, all community colleges must follow suit. Meanwhile, private career colleges continue to offer a two-semester program. ■

# 2004-2005

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**NCCM:** Non-Council Committee Member

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Christine Vanderspiegel

## NOTICE TO PHARMACISTS

September 17, 2004

### **METHADONE DISPENSING**

It has come to the attention of the College that some pharmacists have involved their pharmacies in special arrangements with some methadone clinics. Under these arrangements, the preparation and dispensing of methadone doses for patients is done as usual, but the methadone is subsequently delivered to the clinic for storage and administration by staff at the clinic. It is the position of the Ontario College of Pharmacists that this practice falls below the *Standards of Practice* as well as falling outside the guidelines for dispensing methadone published by the Centre for Addiction and Mental Health (CAMH).

**Therefore, pharmacists are hereby notified to cease and desist from this practice.**

In order to ensure continuity of care and access to methadone for patients the Ontario College of Pharmacists have advised the College of Physicians and Surgeons that OCP expects this practice to be eliminated no later than three months from the date of this notice. Therefore, be advised that participation in such arrangements after December 31st, 2004 may be subject to disciplinary proceedings.

If you have any questions, please contact Mr. Greg Ujiye, Manager of Pharmacy Practice Programs at 416-962-4861 x 235 or email [gujiye@ocpinfo.com](mailto:gujiye@ocpinfo.com).

# Canadian Foundation for Pharmacy Survey

## **Ipsos-Reid survey on Pharmacy Students' and Recent Graduates' Perceptions of Pharmacy**

If you are currently enrolled in a pharmacy program, or are a pharmacist who has graduated within the last five years, the CFP wants to hear about your expectations and your experiences.

Your participation in this important Canadian study will ensure that the profession continues to provide fulfilling opportunities for you and for future generations of pharmacy graduates.

Those who complete the survey will be eligible to win 1 of 9 PharmaPalms, or an all-expenses-paid trip to CPhA in Quebec City in May, 2005.

**Influence the future of pharmacy. Take the Ipsos-Reid survey now:**

<http://www.unified.ca/survey/cfpreport.html>

# CEVENTS

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

**Dec - Mar: Toronto/Ottawa  
Personal Health Information  
Protection Act (PHIPA) Training,  
National Privacy Services Inc  
and ClinCoach**

Health Care Stream:

**Toronto: Jan 5 & Mar 2**

**Ottawa: Dec 2, Jan 12 & Mar 9**

Clinical Research Stream

**Toronto: Jan 6 & Mar 3**

**Ottawa: Dec 1, Jan 13 & Mar 10**

tel (902) 464-4497; (902) 466-7889

or 1-877-774-8529

fax (902) 466-6889

info@privlaw.com

www.privlaw.com

or

tel (902) 425-3038

fax (902) 425-6879

info@clincoach.com

www.clincoach.com

**Jan 18: Newmarket**

**Emergency Contraception, York  
North Pharmacists' Association  
and Ontario Pharmacists'  
Association**

Janet Shore

jshore@pathcom.com

Sandra Winkelbauer

tel (416) 441-0788 x 4235

fax (416) 441-0791

swinkelbauer@opatoday.com

www.opatoday.com

**Jan 28-30 & Feb 25-27: Toronto  
Certified Geriatric Pharmacist  
Preparation Course, Ontario  
Pharmacists' Association**

Sandra Winkelbauer

tel (416) 441-0788 x 4235

fax (416) 441-0791

swinkelbauer@opatoday.com

www.opatoday.com

**Feb 3-5: Toronto  
Better Breathing 2005, Ontario  
Respiratory Care Society**

Sheila Gordon-Dillane

tel (416) 864-9911 x 236

fax (416) 864-9916

orcs@on.lung.ca

www.on.lung.ca

**Feb 5-9: Toronto  
Professional Practice  
Conference (PPC), Canadian  
Society of Hospital Pharmacists**

Desarae Davidson

tel (613) 736-9733 x 229

www.cshp.ca

**Feb 8: Aurora/King City  
Update on Atopic Dermatitis,  
York North Pharmacists'  
Association and Fujisawa**

Janet Shore

tel (905) 853-0855

fax (905) 853-0571

jshore@pathcom.com

**Mar 5-6: Toronto  
23rd Annual Pharmacy  
Technician Conference, Humber  
College**

Cindy Abela

tel (416) 675-6622 x 4020

fax (416) 675-0135

cindy.abela@humber.ca

**Apr 3-5: Toronto  
15th Annual Provincial  
Conference on Palliative and  
End-of-Life Care, Humber  
College**

Cindy Abela

tel (416) 675-6622 x 4020

fax (416) 675-0135

cindy.abela@humber.ca

www.palliativecare.humber.ca

## CANADA

**Mar 4-6: Banff AB  
31st Annual Banff Seminar,  
Canadian Society of Hospital  
Pharmacists, Western Branches**  
Christine Morris  
christine.morris@calgaryhealthregion.ca

## INTERNATIONAL

**Dec 12-15: Orlando FL  
National Forum on Quality  
Improvement in Health Care:  
"But ... How?", Institute for  
Healthcare Improvement (also  
available by satellite throughout the  
US, Canada, Mexico, and Europe)**  
tel 1-888-320-6937  
info@ihi.org  
www.ihi.org  
For site information:  
satellite@ihi.org

**Feb 2-4: New Orleans LA  
International Stroke Conference  
2005, American Stroke Association**  
tel (214) 706-1543  
fax (214) 706-5262  
strokeconference@heart.org  
strokeconference.org

**Apr 10-17: Eastern Caribbean  
Cruise  
Another Notch: Taking your  
Practice to the Next Level,**  
Dalhousie Division of Continuing  
Pharmacy Education  
Cruise info: Catherine Kellough  
tel (902) 422-1773 or  
1-866-344-8344  
fax (902) 421-1297  
ckellough@maritimetravel.ca  
CE info: Beverley Zwicker  
tel (902) 494-3460  
ce.division@dal.ca

# Use the OCPinfo.com site to stay up-to-date on College Notices and to learn about upcoming CE Events/Resources

If you cannot find a particular event, search by keyword using the website's search engine



CE Section Contains CE Events, Resources and Links for Pharmacists. Items are organized by type and location

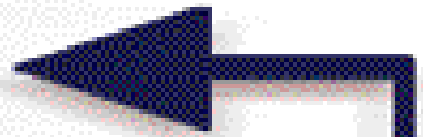
CE for Technicians: Look for technician events here

Click on the "OCP CONNECTS" banner to pay your fees with a credit card or to update information

Notices to Pharmacists: Displays OCP and Health Canada Notices

Click on title bar for full listing

CE Listings: Lists next three upcoming CE events



# O C P M A N U A L - February 2005



Each issue of *Pharmacy Connection* includes an up-to-date summary of all current *OCP Manual* items in the table shown. These items are available and can be printed off from our website: [www.ocpinfo.com](http://www.ocpinfo.com). 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).

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

Amended 2004  
Regulations to the DPRA:  
DPRA R.R.O. 1990, Regulation 545 – Child Resistant Packages  
DPRA R.R.O. 1990, Regulation 547 Amended to O.Reg. 548/93 – Dentistry  
DPRA Ontario Regulation 297/96 Amended to O.Reg. 180/99 – General  
DPRA R.R.O. 1990, Regulation 551 Amended to O.Reg. 179/99 – General  
DPRA R.R.O. 1990, Regulation 548 Amended to O.Reg. 705/93 – Medicine  
DPRA R.R.O. 1990, Regulation 550 Amended to O.Reg 550/93 – Optometry

## Drug Schedules \*\*

Summary of Laws Governing Prescription Drug Ordering, Records, Prescription Requirements and Refills - January 2001 OCP  
Canada's National Drug Scheduling System - July 1st, 2004 NAPRA (or later)

## Regulated Health Professions Act (RHPA) \*

Amended 2004  
Regulations to the RHPA:  
Ontario Regulation 39/02 -Certificates of Authorization  
Ontario Regulation 107/96 – Controlled Acts Amended to O.Reg. 296/04  
Ontario Regulation 59/94 – Funding for Therapy or Counseling for Patients Sexually Abused by Members

## Pharmacy Act (PA) & Regulations \*

Amended 1998  
Regulations to the PA:  
Ontario Regulation 202/94 Amended to O.Reg. 270/04 – General  
Ontario Regulation 681/93 Amended to O.Reg. 122/97 – Professional Misconduct

## Standards of Practice ▲

New Standards of Practice, January 1, 2003 OCP

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

Amended 2004  
Regulations to the DIDFA:  
R.R.O. 1990 Regulation 935 Amended to O.Reg. 358/04 – General  
R.R.O. 1990 Regulation 936 Amended to O.Reg. 205/96 – Notice to Patients

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

Amended 2004  
Regulations to the ODBA:  
Ontario Regulation 201/96 Amended to O.Reg. 359/04 – General

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

Updated Health Canada Version as of Dec. 31, 2003  
Amendment 1329 - Schedule F - 19 May, 2004; Registration: SOR/2004-108, Canada Gazette II

## Updated NAPRA Version as of October 25, 2000

Regulations to the Controlled Drugs and Substances Act (CDSA) \*\*  
Benzodiazepines & Other Targeted Substances Regulations-Can. Gazette; updated Jan. 30, 2003

Marihuana Medical Access Regulations July 2001, NAPRA  
Precursor Control Regulations – Can.Gazette October 9/02; updated July 2003, NAPRA

Regulations Exempting Certain Precursors and Controlled Substances from the Application of the Controlled Drugs and Substances Act; NAPRA update July 2003

## Narcotic Control Regulations \*\*

Updated NAPRA Version as of October 25, 2000

## OCP By-Laws By-Law No. 1 – June 2004 ▲

Schedule A - Code of Ethics, May 1996  
Schedule B - Conflict of Interest Guidelines for Members of Council and Committees - Oct 1994  
Schedule C - Member Fees - Jan 1, 2003  
Schedule D - Pharmacy Fees - Jan. 1, 2003  
Schedule E – Certificate of Authorization – Jan. 2003  
Schedule F - Privacy Code - Dec. 2003

## Reference ▲

Handling Dispensing Errors, Pharmacy Connection Mar/Apr 1995  
Revenue Canada Customs and Excise Circular ED 207.1  
Revenue Canada Customs and Excise Circular ED 207.2  
District Excise Duty Offices - Oct. 10/96  
Guidelines for the Pharmacists on "The Role of the Pharmacy Technician"  
OCP Required Reference Guide for Pharmacies in Ontario, May 2004  
Structure and Function of Pharmacy in Ontario

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

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

☺ Information available at **Federal Publications Inc.** Ottawa: 1-888-4FEDPUB (1-888-433-3782)  
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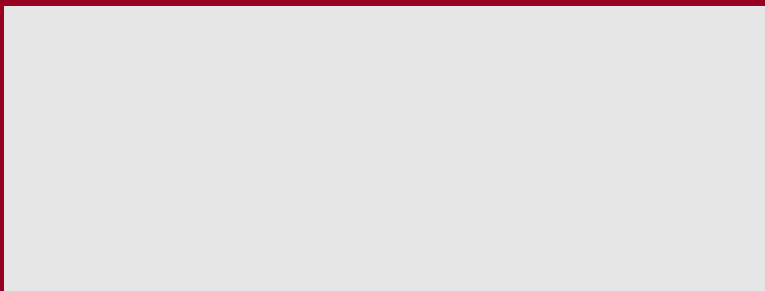
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2004/2005

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