Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SPRING 2013 • VOLUME 20 NUMBER 2

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

IMPROVING PATIENT CARE THROUGH COLLABORATIVE PRACTICE

Ontario College of Pharmacists

Putting patients first since 1871

MISSION:

The Ontario College of Pharmacists regulates pharmacy to ensure that the public receives quality services and care.

VISION:

Lead the advancement of pharmacy to optimize health and wellness through patient centred care.

VALUES:

Transparency - Accountability - Excellence

STRATEGIC DIRECTIONS:

1. Optimize the evolving scope of practice of our members for the purpose of achieving positive health outcomes.
2. Promote the use and integration of technology and innovation to improve the quality and safety of patient care, and to achieve operational efficiency.
3. Foster professional collaboration to achieve coordinated patient-centred care and promote health and wellness.
4. Build and enhance relationships with key stakeholders, including the public, the government, our members, and other health care professionals.
5. Apply continuous quality improvement and fiscal responsibility in the fulfilment of our mission.

Ontario College of Pharmacists
483 Huron Street
Toronto, Ontario M5R 2R4

T 416-962-4861
F 416-847-8200
www.ocpinfo.com

COUNCIL MEMBERS

Council Members for Districts are listed below according to District number. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. U of T indicates the Dean of the Leslie Dan Faculty of Pharmacy, University of Toronto. U of W indicates the Hallman Director, School of Pharmacy, University of Waterloo.

H Christine Donaldson
H Regis Vaillancourt
K Mark Scanlon
K Esmail Merani
L Tracy Wiersema
L Farid Wassef
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M TBA
M Tracey Phillips (Vice President)
M Don Organ
N Bonnie Hauser
N Christopher Leung (President)
N Ken Potvin
P Rachelle Rocha
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PM Lewis Lederman
PM Aladdin Mohaghegh
PM Gitu Parikh
PM Shahid Rashdi
PM Joy Sommerfreund
U of T Henry Mann
U of W David Edwards

Statutory Committees

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

Standing Committees

- Communications
- Finance
- Professional Practice

COLLEGE STAFF

Office of the Registrar
x 2243, urajdev@ocpinfo.com

Office of the Deputy Registrar,
Director of Professional Development ,
Pharmacy Connection Editor
x 2241, ltodd@ocpinfo.com

Office of the Director of Professional Practice
x 2241, ltodd@ocpinfo.com

Office of the Director of Finance and Administration
x 2241, ltodd@ocpinfo.com

Registration Programs
x 2250, jsantiago@ocpinfo.com

Structured Practical Training Programs
x 2297, vclayton-jones@ocpinfo.com

Investigations and Resolutions
x 2274, eminich@ocpinfo.com

Continuing Education Programs and
Continuing Competency Programs
x 2264 , ckhun@ocpinfo.com

Pharmacy Openings/Closings, Pharmacy Sales/
Relocation, ocpclientservices@ocpinfo.com

Registration and Membership Information
ocpclientservices@ocpinfo.com

Pharmacy Technician Programs
ocpclientservices@ocpinfo.com

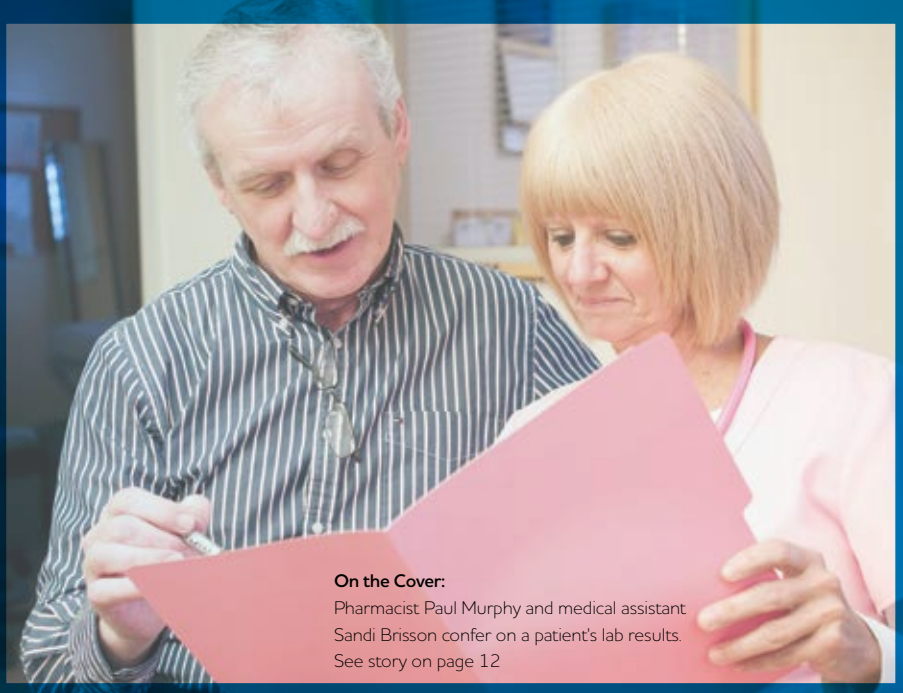
Publications x 2244, rvandoorn@ocpinfo.com

The objectives of Pharmacy Connection are to communicate information about College activities and policies as well as provincial and federal initiatives affecting the profession; to encourage dialogue and discuss issues of interest to pharmacists, pharmacy technicians and applicants; to promote interprofessional collaboration of members with other allied health care professionals; and to communicate our role to members and stakeholders as regulator of the profession in the public interest.

We publish four times a year, in the Fall, Winter, Spring and Summer.

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

ISSN 1198-354X



On the Cover:
Pharmacist Paul Murphy and medical assistant Sandi Brisson confer on a patient's lab results.
See story on page 12

PHARMACY CONNECTION

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

> "This will be my last editorial... as I am retiring from the Ontario College of Pharmacists at the end of June."

This will be my last editorial for Pharmacy Connection, as I am retiring from the Ontario College of Pharmacists at the end of June. May 1 marked my 13th anniversary as Deputy Registrar and as editor of Pharmacy Connection, and I am in my 20th year at the College. It has been a wonderful experience and now it's time to step back and do some of the things I have been saying I am going to do "someday, maybe".

Working at the Ontario College of Pharmacists has been a very rewarding part of my career. I have come to know so many fabulous people here in Ontario, across Canada, and internationally. I have enjoyed the opportunity to contribute to the profession of pharmacy and to its self-regulation status.

We sometimes feel that things move very slowly in our profession, but as I look back over my 20 years at OCP, lots has happened. We have developed structured practical training, a quality assurance program, an IPG program with the Leslie Dan Faculty of Pharmacy, implemented the regulation of pharmacy technicians, seen a new school of pharmacy open at the University of Waterloo, and most recently, implemented the new scope of practice with the last minute addition of immunizations.

The new scope for pharmacists was contained in Bill 179, which advanced the scope of several health professionals, the idea being for us to work together to take better care of the public in Ontario. But working together in a new way and incorporating the new scope into practice takes some time and energy. How do we develop a different relationship with prescribers and work with them in a collaborative way? How will this new scope be useful for our patients and how can it be implemented into our current practice? And how might a regulated pharmacy technician assist us with the technical aspects of dispensing so that the pharmacist is able to turn their attention to making sure that drug therapy is optimized for each patient?

In this edition of Pharmacy Connection, we are sharing some of the principles of interprofessional collaboration that were outlined and developed as several of the regulatory colleges came together to begin working on the new scope. In addition, some pharmacists agreed to speak with us and share some of their learning as they go about developing new relationships and changing their practice. These opportunities are open to everyone and it will be exciting to see how pharmacy practice changes in the next few years. How will our new graduates, soon to all be PharmD's, impact this change?

It has been a privilege to serve as Deputy Registrar of the Ontario College of Pharmacists. I wish to acknowledge all the pharmacists and pharmacy technicians who provide excellent care to their patients every day. I also wish to acknowledge the Council of the Ontario College of Pharmacists as well as those many pharmacists and pharmacy technicians who contribute to College activities and committees as part of our self-regulating responsibilities. Finally, I wish to acknowledge the staff of the College for their dedication, hard work and their friendship throughout my years at the College.

As I said, I will be retiring from the College, but certainly not from the profession or from life! After a nice long summer break with lots of golfing, walking, cycling and catching up with friends and family, I will see you around.

Best wishes, Della

Christopher Leung,
R.Ph., B.Sc.Phm./MBA
President

> "...it is the time for the College to take clear, swift and decisive actions to restore confidence..."

It's not often that circumstances arise where Council feels it necessary to convene a special meeting . . but earlier this month that's exactly what we did. On Friday May 10th, 2013 Council held a special meeting to bring forward proposed regulation and by-law amendments to address concerns regarding the public's confidence in the supply of chemotherapy medications to hospitals in Ontario.

This situation arose following allegations in late March of the under-dosing of chemotherapy drugs supplied by an independent company, neither a manufacturer, licensed by Health Canada nor a pharmacy, accredited by the College, to four hospitals in Ontario and one in New Brunswick.

As the self-regulating body for the profession of pharmacy in Ontario, whose mandate is to serve and protect the public interest, it is appropriate in situations such as this, for the College to be proactive and assume a leadership role. This is not the time to rationalize previous actions, or point fingers towards others. Rather, it is the time for the College to take clear, swift and decisive actions to restore confidence and assure Ontarians that pharmacy products and services are safe in this province.

To this end, the College launched an investigation (which is ongoing) into the conduct of identified members relating to the specific incident and began its support, through participation in the working group, of the government's independent review into Ontario's drug supply, led by Dr. Jake Thiessen.

Additionally, College staff, almost immediately began working with officials at the Ministry of Health and Long-Term Care to draft a proposed regulation and enabling by-laws that ultimately would provide the College with the authority to inspect drug preparation premises where pharmacists and pharmacy technicians practice. This regulation, when combined with the Ministry's regulation change to the *Public Hospital Act*, which ensures hospitals purchase drugs only from accredited, licensed or otherwise approved suppliers, will go a long way in addressing the identified gap in regulatory oversight.

Appreciating the timeliness of the situation, the Ministry granted our request to reduce the circulation period from 60-days to 10-days. The College received just over 50 responses during that period; 45 from individuals and 9 from organizations. Staff acknowledged all feedback received and the comments, which were sincerely appreciated, were carefully considered by Council. The majority were supportive of the proposed regulation and offered valuable feedback, some of which was incorporated into the regulation itself, and others will be referenced by the College as it begins the process of operationalizing this new authority.

Over the coming months College staff will be working diligently to establish the processes and standards required to identify and inspect these facilities as quickly as possible. Meanwhile, Council, who is responsible for setting the strategic direction for the College, will turn our attention to the consideration of whether or not there is even more that we could or should be doing to maintain the public's trust and confidence in the safe and effective delivery of pharmacy services.

More information regarding the regulation and by-laws approved by Council at the May 10, 2013 special meeting can be found throughout this issue of Pharmacy Connection and on the College website at www.ocpinfo.com.

MARCH 2013 COUNCIL MEETING

COUNCIL APPROVES AUDITED STATEMENTS FOR COLLEGE OPERATIONS FOR 2012

	Budget	Actual
Revenues		
Member Fees - Pharmacists	$ 7,766,500	$ 7,779,683
Member Fees – Pharmacy Technicians	280,000	381,650
Pharmacy Fees	3,285,100	3,431,294
Registration Fees and Income	1,375,250	1,498,805
Investment Income	70,000	129,052
Special Project - ORAC	-	93,317
	$ 12,776,850	**$13,313,801**
Expenses		
Council and Committees	2,893,699	2,292,893
Administration	9,599,305	9,122,712
Property	78,020	117,303
Special Project - ORAC	-	93,317
	$ 12,571,024	**$ 11,626,225**
Excess (deficiency) of revenues over expenses from operations for year, before depreciation	205,826	1,687,576
Depreciation	-	319,080
Excess of revenues over expenses for the year	**205,826**	**1,368,496**

Council approved the Audited Financial Statements for the operations of the College for 2012 as prepared by Clarke Henning, LLP, Chartered Accountants. The audit and resulting financial statements were prepared in accordance with Canadian Auditing Standards. The statements reflect the decisions of the Finance (and Audit) Committee including the adoption of the Canadian Accounting Standards for Not-for-Profit Organizations and the establishment of reserve funds for investigations and hearings, contingency and fee stabilization. Council was particularly pleased to note that the auditors did not identify any major issues of concern.

TASK FORCE ON GOVERNANCE ESTABLISHED

Council agreed to the establishment of a Task Force to conduct a review of the College's governance model. The Task Force will be chaired by Vice President, Ms. Tracey Phillips and the review will be facilitated by Mr. Richard Steinecke, who is renowned for his knowledge of both RHPA (Regulated Health Professions Act) Colleges and governance principles. Over the next 12 months it is anticipated that the Task Force will meet regularly to review and develop governance documents. Throughout the process the Task Force will report periodically to Council, solicit feedback on the governance documents and finally, obtain Council approval of these documents prior to their application.

CHANGE IN POLICY FOR RANDOM SELECTION PROCESS FOR THE PEER REVIEW

Council approved the following changes for the random selection process for the Peer Review (Phase II of the Practice Review) for pharmacists:

- If randomly selected for a second time (after the ten-year exemption), only the Clinical Knowledge Assessment portion of the Peer Review is required;



- Upon successful completion of the Peer Review for the second time (i.e. Clinical Knowledge Assessment only), pharmacists are exempted from the Peer Review for the following 20 years.

Council agreed that those who have successfully completed the Peer Review on two occasions are demonstrating their continuing professional development, and that greater impact could be achieved by having more people who have never done so, participate in the Peer Review. Ideally, it is in the best interest of the public and the College, to have as many pharmacists as possible experience the Peer Review or something similar (such as the PEBC OSCE). Modification of the currently random selection process will maximize the resources used for the Peer Review while at the same time creating increased opportunity for participation for those who have not yet participated.

MEDICAL MARIHUANA

Following the publication of the proposed changes to Health Canada's Marihuana Medical Access Program, as set out in the draft *Marihuana for Medical Purposes Regulations*, this College, together with the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario, has provided comments to Health Canada.

The joint submission focused on two significant concerns: the extent to which the provisions of the draft regulations will align with expectations for safe prescribing/dispensing and professional conduct; and potential negative implications the draft regulations will have for patients and members of our three Colleges. Consequently, the Colleges have requested that Health Canada reconsider the approach articulated in the draft regulations and further, that the response be shared with the Honourable Leona Aglukkaq, Minister of Health.

SCHEDULE F

Consultations are underway with respect to amendments to certain regulations concerning prescription drugs. Schedule F to the *Food and Drug Regulations* lists medicinal ingredients that are required to be sold pursuant to a prescription when sold as a drug in Canada. Currently, adding or removing medicinal ingredients to Schedule F requires approval from the Governor in Council following a well-established scientific review process, and the list of drugs that must be sold pursuant to a prescription is maintained in a regulatory table. The objective of the proposed changes is to gain efficiencies for Health Canada in the maintenance of this list by enabling the Minister of Health to incorporate by reference a list of prescription drugs (Prescription Drug List or PDL) and move towards a less burdensome non-regulatory approach.

TRANSPARENCY PROJECT

Registrar Moleschi reported that this College, together with the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario and College of Nurses of Ontario, are collaborating on a policy review of information available to the public respecting members. Essentially, the four Colleges are looking to ensure that the information provided to the public is easy to understand with clear explanations and context. Although the project is still in the early stages of development, Council was pleased to note that the project will pool our collective research, policy, legal and regulatory expertise to inform recommendations for potential change to the respective College Councils. Council will be kept updated on the work, anticipated to conclude by the end of the year.

Photos by DW Dorken

NATURAL HEALTH PRODUCTS

This College has, since 2006, taken the position that only natural health products that have been reviewed by Health Canada for the product's safety, efficacy and quality, and assigned a Drug Identification Number (DIN) or a Natural Product Number (NPN) or a Drug Identification Number for Homeopathic Medicine (DIN-HM), are authorized to be sold on the Canadian market.

The Natural Health Products (Unprocessed Product Licence Applications) Regulations promulgated by Health Canada in August 2010 have now been repealed eliminating the temporary category of authorized products known as Exempted, having an Exemption Number (EN).

More information regarding the repeal of the NHP-UPLAR, and the list of natural health products, can be found on the Health Canada website.

PHARM D. ENTRY TO PRACTICE RECEIVES GOVERNMENT APPROVAL

Council noted for information that on January 23, 2013, the University of Toronto's application for approval of the entry-to-practice Doctor of Pharmacy (PharmD) program was granted by the government of Ontario. Likewise, the School of Pharmacy at the University of Waterloo also received similar approval and will now offer an entry-to-practice PharmD program resulting in students from both universities graduating with the Doctor of Pharmacy designation.

Both universities are offering bridging programs that will enable current students to complete a PharmD program.

COUNCIL APPOINTMENTS

Following the resignation by Mr. Sherif Guorgui (elected member for District M) on February 19th, the President appointed Ms. Bonnie Hauser to replace him as Past President on the Executive Committee and Mr. Jon MacDonald to replace him as Chair of the Quality Assurance Committee. The resignation has also resulted in the Council directing the Registrar to hold a by-election for the one seat in District M. The timing for this by-election will be in accordance with the by-laws along with the regular summer election schedule.

FUTURE COUNCIL MEETINGS

- June 10 & 11, 2013
- September 9 & 10, 2013

For more information respecting Council meetings, please contact Ms. Ushma Rajdev, *Council and Executive Liaison* at urajdev@ocpinfo.com

EXCITING OPPORTUNITY TO JOIN THE COLLEGE!

Your contributions can help ensure that future pharmacists and technicians are prepared to provide the public with quality services and care.

For more details, visit the College's website and click on 'CAREERS' at the bottom of the page.

MAY 10, 2013
SPECIAL MEETING OF COUNCIL

The President convened a Special Meeting of Council, on May 10th, to discuss two important pieces of business.

REGULATION AND BY-LAW AMENDMENTS RE: DRUG PREPARATION PREMISES

Following the allegations in late March of under-dosing of chemotherapy drugs supplied by an independent company to four hospitals in Ontario and one hospital in New Brunswick, College staff worked with officials at the Ministry of Health and Long-Term Care (MOHLTC) and proposed a regulation and enabling by-laws that will give the College the responsibility to inspect drug preparation premises where pharmacists and pharmacy technicians practice.

The proposed regulation and enabling by-laws were circulated for comment. Modifications were made to reflect feedback received and the amended documents were discussed by College Council. Council voted unanimously to approve, as presented, the regulation (Part IX of Ontario Regulation 202/94 made under the *Pharmacy Act*, Inspection of Drug Preparation Premises) and enabling by-laws. It was noted that this regulation, when combined with the Ministry's proposed regulation change to the *Public Hospital Act*, will go a long way towards addressing the recently identified gap in regulatory oversight.

BY-LAW AMENDMENTS RE: PUBLIC REGISTER OF PHARMACIES

Council unanimously approved by-law amendments, which were circulated for feedback and modified slightly, that permit the College to formalize the creation of a Register of Pharmacies (section 23(2) 14 of the *Health Professions Procedural Code*). The amended by-law includes the posting, on the public register, of the outcome and/or status of inspections of a pharmacy, including the relevant date.

The approved by-laws take effect immediately while the approved proposed regulation was submitted by Council to the Ministry for consideration and will come into effect on the date of government filing.*

** The regulation was filed by government on May 15, 2013*

REMINDER:

UPCOMING COUNCIL ELECTIONS – DISTRICTS K, L, T, TH AND BY-ELECTION FOR 1 SEAT IN DISTRICT M

You will have received or will soon receive your electoral declaration. The workplace we currently have recorded as your Declared Place of Practice (for Elections) will be used for election purposes. **If your information is up to date, you do not need to contact the College.** If the information is incorrect, or you are unclear as to which postal code you will be voting in, please access the College website (www.ocpinfo.com), click on the Member Login icon, login in using your User ID (OCP number) and password, and you will be able to verify and/or change your information for voting purposes (primary workplace).

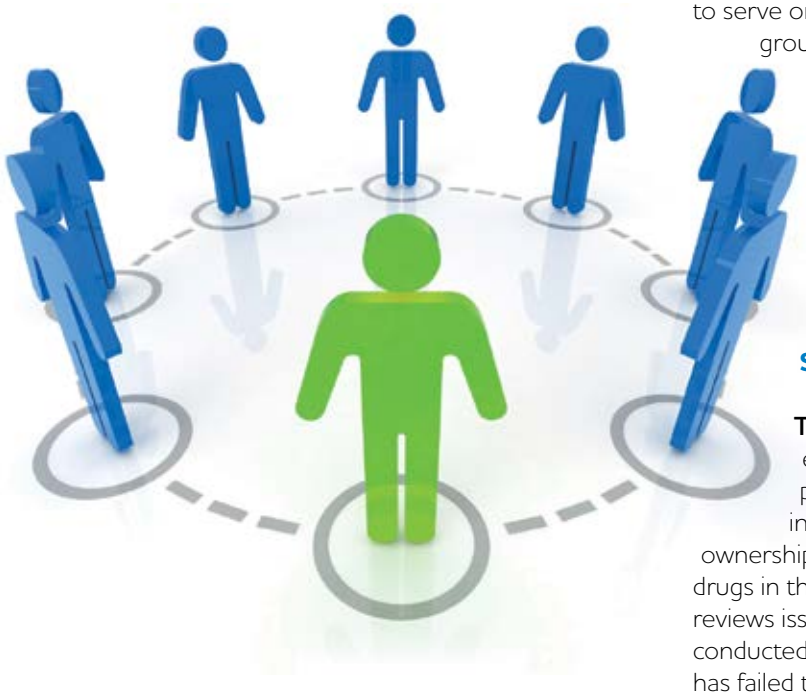
IMPORTANT DATES:

Nominations open: June 1, 2013
Nominations close: June 19, 2013
Voting closes: August 7, 2013

For further information, contact: **Ryan Hosein**
Client Services Representative
416-962-4861 ext. 2350 • email: rhosein@ocpinfo.com

Interested in Serving on a College Committee?

Why not participate as a non-council committee member?



Under the *Regulated Health Professions Act*, the College committee structure requires the appointment of members who are not elected members of Council to its various committees. In addition, members with particular experience or expertise are also required from time-to-time to serve on various special committees, working groups and task forces.

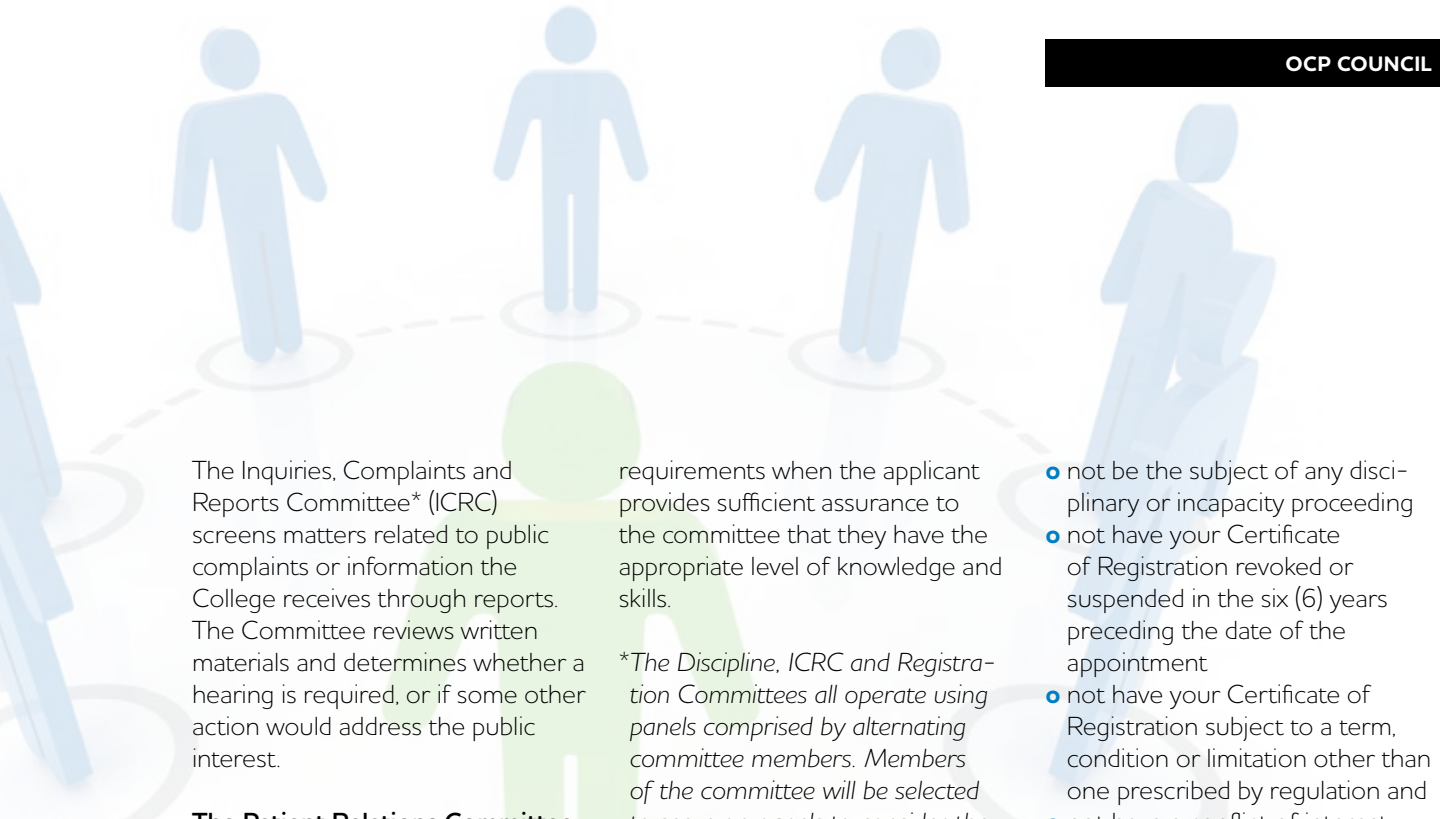
The statutory and standing committees that require participation by a non-council member (NCCM) are listed below, along with a brief description of their terms of reference.

STATUTORY COMMITTEES:

The Accreditation Committee considers matters relating to the operation of pharmacies in Ontario. These matters include operational requirements, ownership, supervision and the distribution of drugs in the pharmacy. The Committee also reviews issues relating to pharmacy inspections conducted by field staff where the pharmacy has failed to comply with the requirements for maintenance, record keeping and ownership.

The Discipline Committee*, through selected panels, hears allegations of professional misconduct against members as referred by various Committees of the College. Upon finding the member guilty of professional misconduct, the panel has the authority to revoke, suspend or limit a member's registration, impose a fine, or reprimand the member.

The Fitness to Practice Committee considers incapacity matters referred by the Inquiries, Complaints and Reports Committee.



The Inquiries, Complaints and Reports Committee* (ICRC) screens matters related to public complaints or information the College receives through reports. The Committee reviews written materials and determines whether a hearing is required, or if some other action would address the public interest.

The Patient Relations Committee has a legislative requirement to develop and monitor a Sexual Abuse Prevention Plan as well as to monitor the College's Patient Relations Program and make recommendations to Council on ways to enhance relations between members and patients.

The Quality Assurance Committee is responsible for developing and maintaining the College's Quality Assurance Program, which includes such components as continuing education, a two-part register, minimum practice requirements and a practice review process. The goal of the Quality Assurance Program is to support continued competence and to encourage continuing professional development of registered pharmacists and pharmacy technicians.

The Registration Committee* establishes the conditions and qualifications for registration. The Committee reviews, through panels, the eligibility of applicants when the registrar has doubts about their ability to meet the requirements. A panel of the Registration Committee may exempt an applicant from a portion of the entry-to-practice requirements when the applicant provides sufficient assurance to the committee that they have the appropriate level of knowledge and skills.

**The Discipline, ICRC and Registration Committees all operate using panels comprised by alternating committee members. Members of the committee will be selected to serve on panels to consider the matters presented and panels are convened approximately one a month.*

STANDING COMMITTEES:

The Communications Committee is charged with dealing with matters supporting public education and outreach, including, but not limited to, raising awareness of the value of both the profession and the College.

The Professional Practice Committee reviews issues relating to pharmacy practice and makes recommendations to Council on ways to improve member adherence to practice standards.

TO BE ELIGIBLE FOR CONSIDERATION FOR APPOINTMENT, YOU MUST:

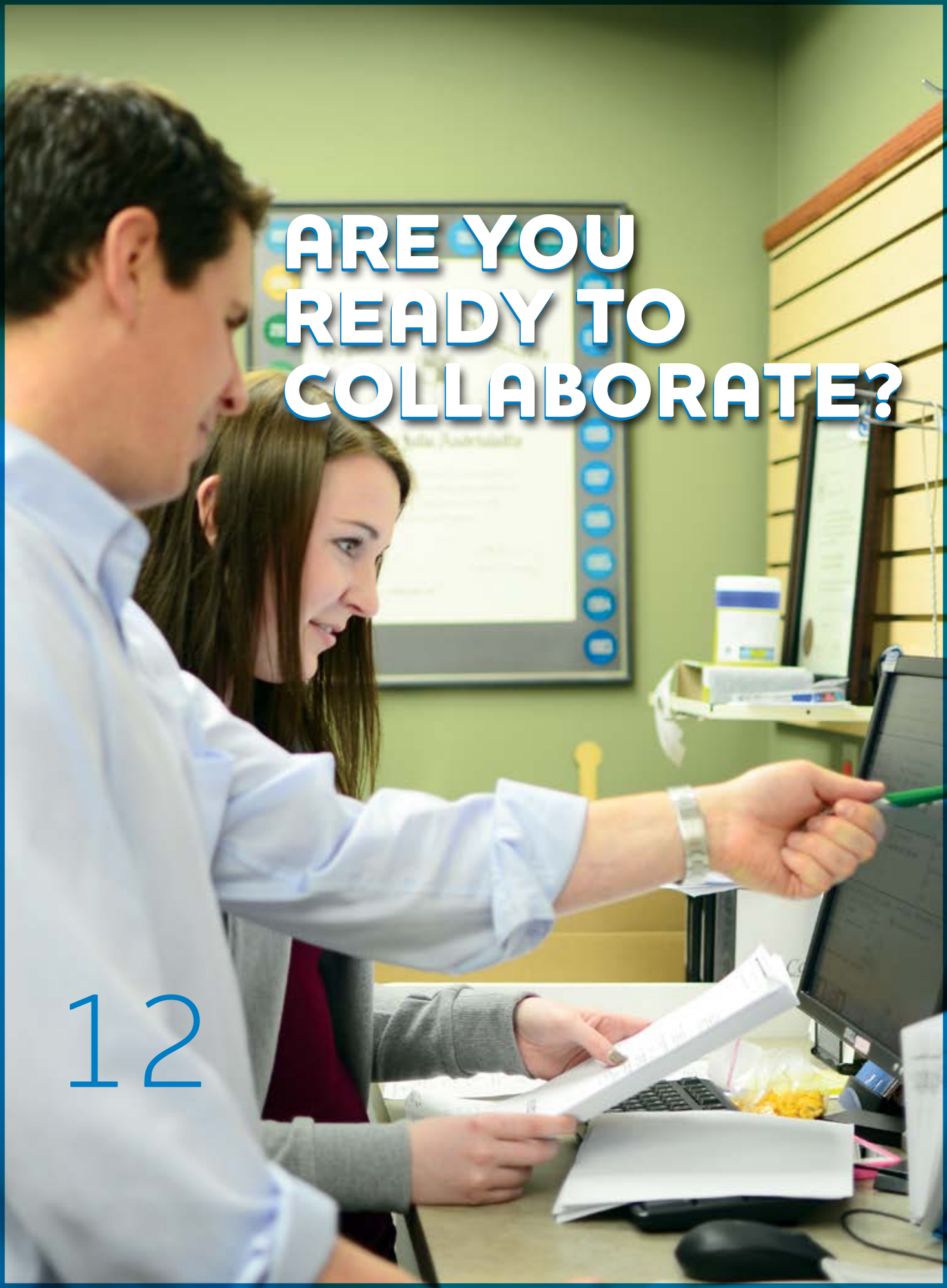
- hold a valid Certificate of Registration as a pharmacist or as a pharmacy technician
- either practice or reside in Ontario
- not be in default of payment of any fees prescribed in the by-laws
- not be the subject of any disciplinary or incapacity proceeding
- not have your Certificate of Registration revoked or suspended in the six (6) years preceding the date of the appointment
- not have your Certificate of Registration subject to a term, condition or limitation other than one prescribed by regulation and
- not have a conflict of interest in respect of the Committee to which you are to be appointed

You will need to submit a letter of interest stating the committee(s) on which you would like to serve, along with a brief resume and any other information you deem useful.

The number of days required by members to serve on each committee varies according to the frequency of meetings and agenda.

Non-council committee members are required to serve a one-year term and the President, in conjunction with the chairs of the committees, makes committee appointments at the beginning of each Council year. You will be contacted after the Council meeting has taken place (September 9 and 10, 2013) if you have been appointed to serve on a Committee.

If you are interested in being considered for an appointment to a committee, or for more information on non-council committee representation, contact Ms. Ushma Rajdev, Council Liaison, at 416-962-4861, ext. 243; email urajdev@ocpinfo.com.


ARE YOU
READY TO
COLLABORATE?

7 STEPS TO MORE EFFECTIVE PARTNERSHIPS WITH OTHER HEALTH CARE PROFESSIONALS

By Stuart Foxman

LEFT: Pharmacist Sean Simpson with pharmacy assistant Sydney Brown.

How do you get from co-operation to collaboration? That question preoccupies Kelly Haggerty, RPh. She runs an anti-coagulation clinic at her Bright's Grove Family Pharmacy in Sarnia, working with 40 doctors. As she notes, pharmacists regularly exchange information with various health care professionals. Yet those are mainly routine interactions. True collaboration is different.

"Collaboration means respecting each other's contribution, knowledge and ability to solve a problem," says Haggerty. The ultimate outcome – "Patients can be managed more effectively."

Four pharmacists who've had success collaborating with other professionals share their thoughts on how to do it effectively.

1. GET YOUR CREDENTIALS READY

When Haggerty opened her independent pharmacy in 2009, she wanted to broaden her scope of practice and introduce new clinical programs. One of her ideas was to perform blood tests with a point-of-care machine, and manage dosages for patients on warfarin.

"I needed to collaborate with physicians to work under their medical directive," she says. "If you're going to ask a doctor for that, they have to see that your expertise is valid."

She enrolled in a University of Waterloo program in anti-coagulation management. "I spent a lot of time preparing, enhancing my knowledge to the point where I could show I was academically prepared. I needed to prove that my skills were strong enough."

> “Collaboration means respecting each other’s contribution, knowledge and ability to solve a problem.”
>
> Pharmacist Kelly Haggerty

2. BE PROACTIVE IN MAKING CONTACT

In Haggerty’s immediate area, the nearest health professionals are a veterinarian and a dentist. She had to design an education and marketing plan to reach out to at least 60 medical doctors who she didn’t know professionally. She also wanted the doctors to learn about and support the program before she began promoting it to patients.

Haggerty created a brochure targeted to doctors, and made appointments to meet with them, much like a drug rep. She also arranged to distribute her brochure to the physicians’ mailboxes at the local hospital.

At the outset of the clinic’s life, Haggerty ran print and radio ads, and patients came to her directly. She would then contact their doctor – with the patient’s consent – to discuss taking them on. Her earlier efforts laid the groundwork to gain the physicians’ approval. “They didn’t have to worry about assigning responsibility,” says Haggerty.

3. SHOW HOW TEAMWORK SUPPORTS THE PATIENT

Whenever she sees a patient, Haggerty sends the doctor a progress note. It covers the test results, relevant discussions from the appointment, and her dosage suggestions.

“Warfarin patients don’t get their blood done in a lab as often as they should, and there can also be a lag in getting those results,” says Haggerty. “The doctors love that I get results instantly. We can monitor and manage the patients so much faster.”

Haggerty also visits patients in their home if they lack the mobility to come to the pharmacy. As needed, she’ll alert doctors to other issues. Haggerty recalls visiting one patient at home, a woman whose husband was in hospital at the time. She noticed that the patient was having problems administering her medication from her blister packs. This woman was clearly missing doses, and didn’t have her husband around to help her monitor her usage. So Haggerty shared her concern with the patient’s doctor.

The doctors appreciate that their mutual patients have easy access to a clinic, and that she adds to their care. By showing that value, “I’ve earned the respect of the doctors in town,” she says. Now, 80-90% of her new patients are referrals from the doctors.

4. RAISE YOUR PROFILE IN THE HEALTH CARE COMMUNITY

To gain respect and encounter possible interprofessional opportunities, it helps to get involved in broader health care initiatives. For instance, in 2010 Rob Parsons,

CONTINUED ON PAGE 16

UNDERSTANDING YOUR PARTNER IN CARE

What do other health care professionals think about collaborating with pharmacists? Here's some insight from a doctor and a nurse practitioner.

- **Focus squarely on the patient.** "I look at collaboration like this: Here's what I can provide for you, now what can you provide for me for a better or different service for my patients?" says Shelly Redman, NP, Clinical Administrator and Lead NP at the Ingersoll Nurse Practitioner-Led Clinic. Any business benefits are secondary.

- **Take ownership.** Consulting with pharmacists may be valuable, but collaboration is about something more, says Dr. Brenda Copps of the Hamilton Family Health Team. "It's about being willing to take ownership of a problem, and make yourself available beyond the initial encounter," she says. Dr. Copps says she's happy to relinquish some control; when a pharmacist shares responsibility for challenging patients, for example, that takes some weight off her, and frees her time to serve other patients.

- **Be respectful.** "I like to see excitement from another professional about what they're doing, but get turned off by someone who's pushy," says Redman. Having new ideas is great, but don't imply that you have all the answers, she says: "It can get people's backs up."

- **Pick up the phone.** Electronic communications has "lowered the bar", Dr. Copps says. If a pharmacist wants to collaborate in some way, a call speaks volumes. "With less personal contact, there's less of an opportunity to get a sense of the relationship," she says.

- **Remember your value.** Are pharmacists seen as junior partners in care? Not to Dr. Copps. "Within my setting, it has been a huge pleasure to see the scope of what the pharmacist has brought to our team," she says. It's easy to talk yourself out of potential opportunities because you worry you'll be rejected. "Start with the assumption that other professionals are open to you," Redman says.

RPh, of Ingersoll Pharmasave, was serving on the Oxford County Drug Task Force. Opioid abuse had become a huge issue in the county, and Parsons was giving a talk to prescribers about opioid prescribing habits.

"It's not about networking, but engaging in the community and trying to make it a better place to live and work," says Parsons. "Through that, you end up coming across like-minded people."

At his talk, Parsons met Shelly Redman, a Nurse Practitioner (NP) at a community health centre. When Redman was looking to launch an NP-led health clinic, Parsons supported her bid to the Ministry of Health and Long-Term Care. Later, after Redman was successful, she moved into the building where Parsons had his pharmacy.

Now, Parsons collaborates with her team in a clinical way. Redman says that Parsons' role in the drug task force opened her eyes to him being a potential partner in collaboration.

"You want to see someone who is committed to and connected with the community, beyond what they're doing in their pharmacy," she says.

5. SEE THE FOREST

Parsons regularly answers questions from the NP-led clinic about drug therapies. He feels that those conversations, while important, are about putting out little fires. You've saved a tree, but haven't necessarily protected the forest. He says collaboration comes from seeing the big picture of how the pharmacist can help to complete a clinical effort.

That happened when the NP-led clinic was working with several patients who were coming in with chronic pain. Parsons promoted a pain management algorithm, and now works in tandem with the NPs. As part of a primary intake visit, Parsons does a medication history and the nurses do a diagnostic history.

"We see where in the algorithm the patient has been for pain treatment, and we come up with a suggestion for the NP," says Parsons.

Parsons mentions one patient who bought opioids on the secondary market, then took copious amounts of Tylenol 1. The patient was in a methadone program. Parsons helped devise a treatment plan, and reports that the patient no longer uses opioids. By working together, Parsons and the clinic are providing more responsive care. The benefits can extend beyond the individual patient.

"If opioids aren't prescribed, they can't make it onto the secondary market," says Parsons, "so that's about community safety."

6. FIND A NICHE AND FILL A GAP

Even in settings where pharmacists work in close proximity to other professionals, genuine collaboration isn't automatic.

Paul Murphy, RPh, is part of the Hamilton Family Health Team, the largest in Ontario with 130 doctors and 12 clinical pharmacists among other professionals. Murphy works with 12 physicians in six practices, rotating every week. When he started in 2008, "The physicians weren't quite sure what they would do with a pharmacist," he says. "Yes, we knew about drugs, but on an everyday basis what did we bring to the equation?"

Murphy is a certified diabetes educator – "my ace card", he says. "So the doctors felt comfortable sending me diabetes patients. As you work in practice and they assess your competence, the trust relationship grows."

Pharmacist Rob Parsons, above, consults with Nurse Practitioner Shelly Redman, Clinical Administrator of the Ingersoll Nurse Practitioner-led Clinic, in one of the the exam rooms located above the Pharmasave Parson's co-owns with colleague Dom Ricciuto, seen at left during a patient consultation.

> “You want to see someone who is committed to and connected with the community, beyond what they’re doing in their pharmacy.”
>
> Nurse Practitioner Shelly Redman

Before joining a FHT, Murphy did try to collaborate with doctors. While in a community practice, he remembers a patient with diabetes. This patient was reluctant to go back to his endocrinologist; he was doing badly, and worried about what the doctor might say.

"I called the doctor and got an appointment," says Murphy. "I explained that I'd seen his patient. The doctor said, 'I never had a pharmacist make a house call to me before.' I asked if he would be comfortable with me working with the patient. I wanted to be an add-on, not replace what the doctor was doing."

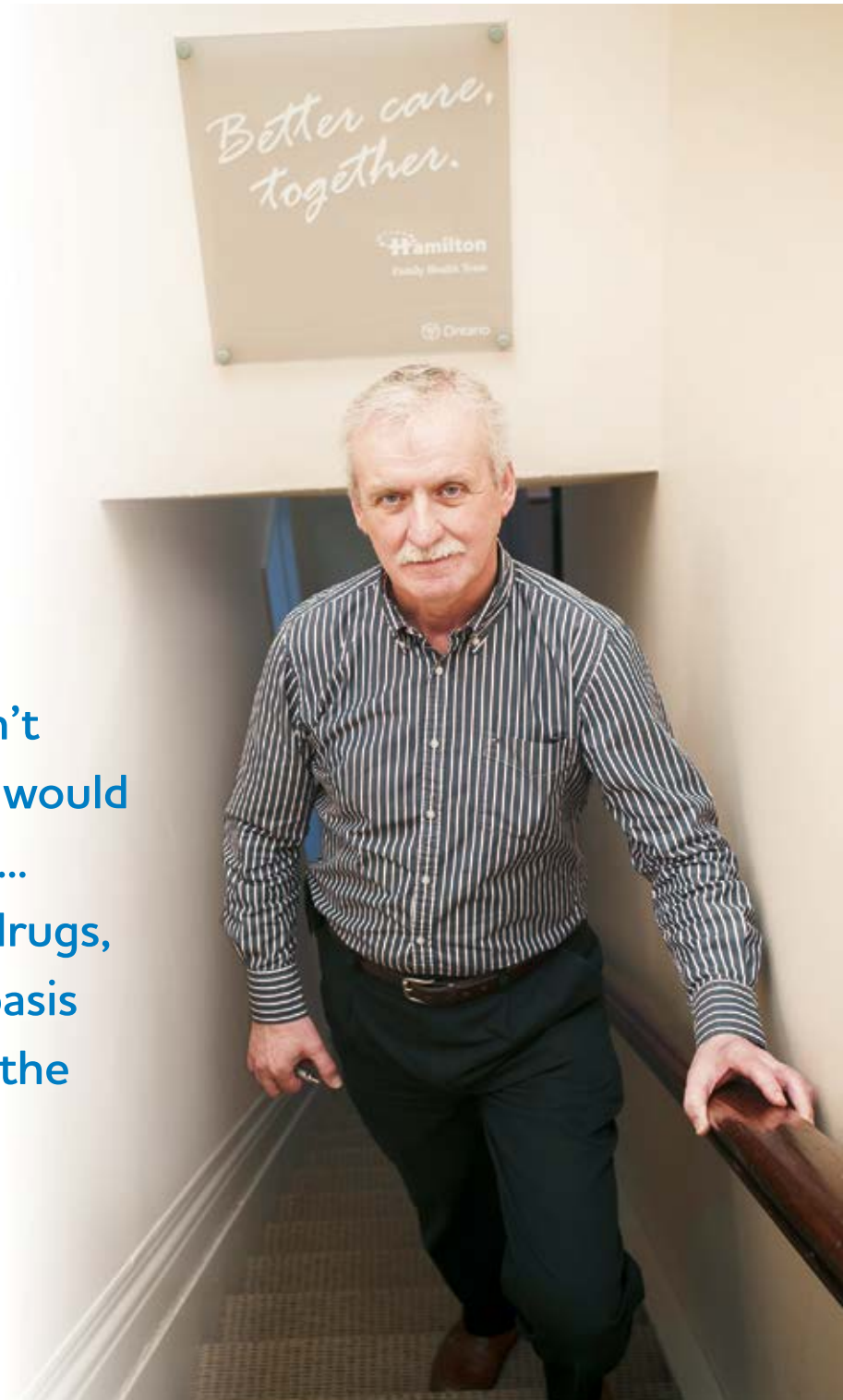
Typically, there were long gaps between the patient's endocrinologist appointments. In between Murphy saw him monthly. He worked on motivating the patient to manage the condition and make lifestyle changes, and adjusted his insulin if necessary. Murphy gave progress reports to the doctor if there were any changes. Within 12 months, he helped the patient get his A1C levels down to target.

For Murphy, the key to collaboration is identifying and meeting a need without infringing on another professional's turf: "We have to become complementary." He urges fellow pharmacists to get the courage to suggest ways to collaborate.

"Most doctors are pleased to have the extra assistance," says Murphy. "The reception may surprise you."

7. START IN YOUR OWN BACKYARD

Pharmacists often talk about collaboration solely in relation to specific programs or clinics. "We pigeon hole it," says Sean



> "The physicians weren't quite sure what they would do with a pharmacist... Yes, we knew about drugs, but on an everyday basis what did we bring to the equation?"
>
> Pharmacist Paul Murphy

> You have to understand what you both can get out of the relationship and work together towards the ultimate goal of enhancing patient care and improving patient outcomes.
>
> Pharmacist Sean Simpson

Pharmacist Sean Simpson with pharmacy assistants Ainslie Beaton (left) and Kim Montgomery (right)

Simpson RPh, who runs Simpson's Pharmasave in Virgil and Simpson's Apothecary Pharmasave in Niagara on the Lake. To Simpson, pharmacists who yearn to collaborate with doctors and other health care professionals should get in the habit by collaborating within their own pharmacy.

For instance, in talking to his pharmacy technicians about record keeping, he has two routes. Either tell them what to do, or talk about what has to be done and then explore ways to best do it. "It's about soliciting feedback from the people we work with, sharing objectives and coaching – that's collaboration" says Simpson.

Simpson started to set aside time each Friday afternoon for team meetings, which look at everything from scheduling to product knowledge to waiting times to fill scripts. "We're trying to provide more patient-centred service, and this creates a forum for discussion, not just a one-way transfer of information," he says.

Collaborating with other professionals on your own team can provide a foundation, a mindset, to foster other sorts of collaborations. Simpson reminds his team that this attitude of partnership should extend to working with patients. "It's understanding why, for instance, they might not want to take a drug because of the side effects, or explaining the risks and benefits of a drug. Maybe that's my most important form of collaboration."

With anybody – colleagues in the workplace, patients and outside health care professionals – here's what defines collaboration for Simpson as a pharmacist. "You have to understand what you both can get out of the relationship and work together towards the ultimate goal of enhancing patient care and improving patient outcomes."

Common Principles for Interprofessional Care

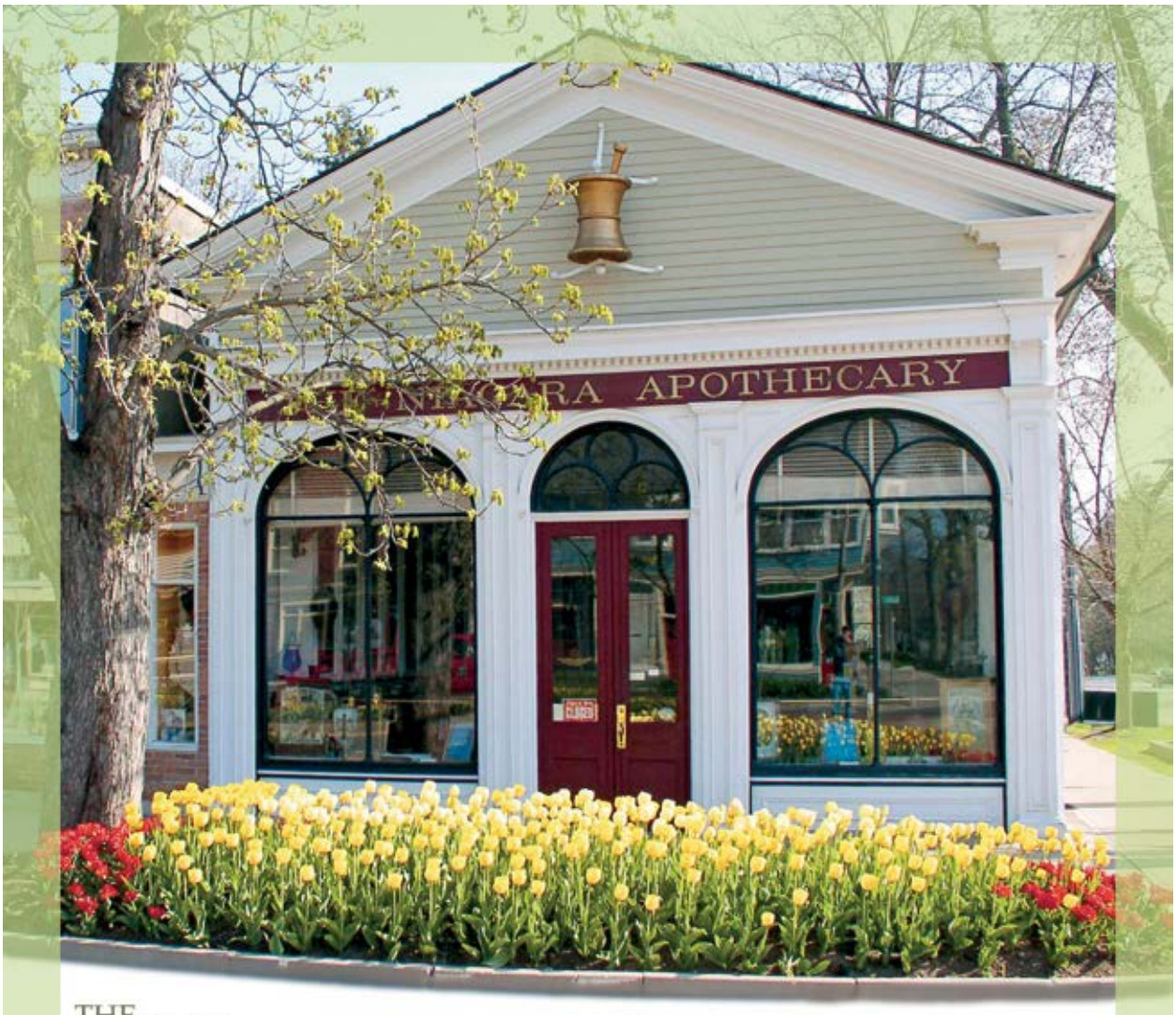
The common principles for interprofessional care presented here were reached through consensus, several years ago, by an ad-hoc working group of representatives from over fifteen regulatory colleges. The working group was chaired by the Ontario College of Pharmacists and included the College of Physicians and Surgeons, the Royal College of Dental Surgeons and the College of Nurses of Ontario.

The group was brought together following the Ontario government's passing of Bill 179, the *Regulated Health Professions Statute Law Amendment Act, 2009*. The legislation expanded the scopes of practice of several regulated health professions, including our own, and required health colleges to work together to develop common standards of knowledge, skill, and judgment in areas where professions may provide the same or similar services.

These principles guide our College and others as we development resources to support interprofessional collaboration. You may also find them of value as you enhance your own collaborative relationships.

PRINCIPLES:

1. Professional relationships, based on trust and respect, exist between patients and health professionals.
2. Patients are partners in their care.
3. Health professionals are accountable for practicing within their scopes of practice and in accordance with their knowledge, skill, and judgment.
4. Health professionals obtain consent prior to providing care.
5. Health professionals maintain patient confidentiality and privacy in the provision of care.
6. Health professionals are responsible for their own continuing professional development and for interprofessional development.
7. Health professionals understand and respect each other's role and expertise and work together in the best interests of the patient.
8. Health professionals communicate with other health providers where appropriate, communication being central to good patient care.



THE

Niagara Apothecary

A PHARMACY MUSEUM

Located in Niagara-on-the-Lake, this mid-Victorian national historic site replicates a typical 1864 pharmacy. Visit the Apothecary and learn about pharmacy practice during the Confederation period. Retired pharmacists are available to answer questions about the building and its artifacts. A fun day for all ages!

Admission is free.

Open daily from Mother's Day to Labour Day
Open weekends from Labour Day to Thanksgiving

Visit this summer!

For more information visit the Apothecary's website at

www.niagaraapothecary.ca

Introducing . . . the Interprofessional Collaboration (IPC) eTool for healthcare professionals

When working as part of healthcare team have you ever wondered where your role ends and where another healthcare professional's role begins? Now, there's a tool that can confidently help you answer that question.

IPC eTOOL

HEALTHCARE PROFESSIONALS

The new Interprofessional Collaboration (IPC) eTool lets health professionals coordinate care and take into account expanding and overlapping scopes and authorities among professions. The eTool provides a framework that outlines roles, responsibilities and scopes of practice for every regulated healthcare professional in Ontario. It can help you build stronger, more efficient and effective collaborative care teams. The tool gives you the option to plan, identify risks, streamline workflow, encourage discussions, facilitate problem solving and empower team members to take on new roles.

HOW THE ETOOL CAME TO BE

The Federation of Health Regulatory Colleges of Ontario (FHRCO) brought together the Colleges to create a resource to address the growing need for multi-disciplinary teams to work together in hospitals, long-term care facilities and other healthcare settings to provide safe, quality patient-centred care. Interprofessional collaboration isn't just a lofty goal, it is a government expectation as part of the drive to reduce costs and improve levels of patient care. Changes to the *Regulated Health Professions Act (RHPA)* have made collaboration between professions part of the language of regulation.

PUTTING THE TOOL TO WORK FOR YOU

With three useful features, the web-based tool has customizable checklists, a Frequently Asked Questions section and a comprehensive table of all of the scopes of practice and controlled acts with links to relevant College policies and standards. It assists but does not direct team members in their decision making, by providing them with the information necessary to make informed decisions in one handy place.

CHECKLISTS

The checklists help to lay out workflow and are built on common patient-centred milestones, with drop down menus that allow you to add personalized milestones to suit your teams' specific needs. It prompts teams to work through all of the critical checkpoints they might encounter and plan ahead on how to manage these transitions safely and efficiently.

A team could use the tool to plan how to approach caring for a particular patient type in their practice setting – take for example patients with congestive heart failure admitted to a long-term care facility.

Or to create checklists to plan a public health initiative, like administering community flu shots or creating medical directives in a hospital setting or managing hip replacement patients after hospital discharge. The options are endless and the eTool is flexible enough to adapt to meet your needs.

FREQUENTLY ASKED QUESTIONS

The FAQ section covers a broad range of topics — practical things such as consent, privacy, documentation and communication – and apply across the board. The extensive FAQ is a great place to start when looking for answers or as a learning tool for new and student healthcare professionals.

SCOPES OF PRACTICE AND CONTROLLED ACTS CHARTS

These comprehensive charts allow any healthcare professional to see at a glance who is authorized to provide what level of care. The charts help answer questions like "Who can suction in an ER?" or "Who on this health team has the authority to communicate a diagnosis in this case?" It gives teams the information they need to systematically work through scenarios working across the continuum of care.

GUIDE TO MEDICAL DIRECTIVES AND DELEGATION

Another excellent resource that too few people know about is the Guide to Medical Directives and Delegation. Members of multi-disciplinary teams are often unsure as to who can delegate what activity to whom. Go here to quickly get this crucial information. It allows for efficient, effective and safe collaboration within any practice setting.

WORKING COLLABORATIVELY TOGETHER

Healthcare teams have always worked together to deliver the best for their patients. The new eTool helps build stronger, more effective teams by making sure every player knows their roles and responsibilities. The tool plays an important role in risk mitigation as the team will start their work together with a full understanding of where each player's accountabilities begin and end. Access the eTool at http://ipc.fhrco.org.

GUIDANCE TO MINIMIZE THE LOSS AND THEFT OF CONTROLLED SUBSTANCES WITHIN PHARMACIES

The purpose of this letter from Health Canada is to provide guidance to pharmacists and their staff on the essential steps that should be taken to minimize the loss and theft of controlled substances within pharmacies. The recommendations below are based on information obtained by Health Canada regional Inspectors during recent onsite inspections at licensed dealer and pharmacy sites across Ontario.

For additional information on this important topic members should reference the College's Fact Sheet – Narcotics Reconciliation and Security found on the website www.ocpinfo.com under Professional Practice > Practice Advisory > Fact Sheets.

Health Canada Santé Canada

Dear Pharmacist:

Regulations within the Controlled Drugs and Substances Act (CDSA) require that you, as a pharmacist, take all reasonable steps that are necessary to mitigate the risk of diversion of controlled substances and precursors on your premises or under your control. Pharmacists are expected to comply with these regulatory requirements by conducting regular physical inventory counts and reconciliations of controlled substances, maintaining accurate sales reports and adhering to good record-keeping practices, etc. However, even with the above measures in place, Health Canada continues to receive a large number of controlled substances loss and theft reports from Ontario pharmacies each month.

In the majority of the loss and theft reports received from licensed dealers (e.g., narcotic drug manufacturers and wholesalers) and pharmacies, the root cause of the loss and theft is unexplained. After further follow-up through a Health Canada inspection, there are many cases where the pharmacy determined the root cause to be a suspected loss in transit or shortage from their supplier. In most cases, the pharmacist could not demonstrate that these losses did not occur while the narcotics were under their control because pharmacy staff did not verify or reconcile the contents of the shipment upon receipt from the transportation company.

It is extremely important for pharmacists to be aware that when a narcotic shipment is received and accepted by the pharmacy, the narcotics are considered to be under the control of the pharmacist. Therefore, the pharmacist is responsible for ensuring that shipment contents are verified, reconciled and any discrepancies are immediately identified, documented and reported to the required entities.

In addition to pharmacists performing regular narcotic and controlled drug reconciliations, Health Canada is recommending that the following steps should also be taken by pharmacists to minimize loss and thefts and facilitate the timely identification and reporting of any discrepancies.

1) Immediately upon receipt from the transportation company examine the shipping container for any anomalies (e.g., box not properly sealed, evidence of tampering, shipping container looks different, etc.). Document any anomalies noted.

2) Immediately verify and reconcile the quantities listed on the invoice/shipping documentation with the contents in the container. Document any discrepancies.

3) While reconciling the shipment contents, quickly perform a physical inspection of the bottles and document anything unusual (e.g., outer safety seal missing, bottle appears lighter than normal, etc.). In the case where suspected shortages have been identified, it may be necessary to determine the exact quantity of narcotic drugs in the affected bottles.

4) Ensure that the narcotic shipment contents (date of receipt, name and quantity of narcotic, name and address of the person from whom the narcotic was received) are properly recorded in the register and are physically placed into the secure narcotic pharmacy inventory as soon as operationally possible.

5) If any discrepancies are noted, document this information on the Health Canada Loss and Theft form (Health Canada website link below) and fax to (613) 957-0110 within 10 days. http://www.hc-sc.gc.ca/hc-ps/substancontrol/substan/compli-conform/loss-perte/loss_rep-rap_perte-eng.php

6) It is highly recommended that you also report this information to your provincial pharmacy college, your local police and the wholesaler/distributor you ordered the products from. This will allow for a proper investigation to determine the root cause of the loss.

7) Continue to conduct regular physical inventory counts and reconciliations at a minimum of every 6 months to facilitate the timely identification and reporting of any discrepancies.

It is your responsibility to ensure that the controlled substances within your custody are accounted for at all times. By following the above steps, you can objectively demonstrate that all reasonable steps have been taken to minimize the loss and theft of narcotics and controlled substances under your control. A failure to effectively identify discrepancies and report losses and thefts may lead to an investigation by Health Canada and your provincial college. This could have an impact on your professional privileges related to the handling of controlled substances.

Health Canada expects that all Canadian pharmacists do their part to not only meet their regulatory obligations under the CDSA, but more importantly, maximize their important role in minimizing narcotic diversion at the pharmacy level.

Controlled Substances Inspectors

The regional controlled substances Inspectors are the compliance and enforcement arm of the Office of Controlled Substances. We have a mandate to ensure that drugs and controlled substances are available for legitimate use and remain in legal distribution channels.

We help achieve this mandate by conducting compliance and monitoring activities to enforce the Controlled Drugs and Substances Act and its Regulations, including but not limited to the Precursor Control Regulations and the Narcotic Control Regulations. Inspectors conduct onsite inspections of licensed dealers authorized by Health Canada to conduct regulated activities such as the importation, manufacturing and distribution of narcotics, controlled drugs and precursors. We also have a capacity to conduct pharmacy inspections to address areas of risk and to ensure compliance with the Controlled Drugs and Substances Act and its associated regulations.

We work closely with our partners within Health Canada and external partners including the RCMP, local law enforcement, the Canada Border Services Agency and provincial licensing bodies through joint training initiatives and other collaborative efforts.

Canada

APPLY NOW TO PROVIDE FLU SHOTS THIS FALL!

As outlined in the expanded scope regulation, pharmacists who have completed and registered their training (see below), are able to administer the flu vaccine only through a pharmacy participating in the Ministry's Universal Influenza Immunization Program (UIIP). Last flu season was the inaugural year of pharmacies participating in the UIIP and pharmacists really stepped up to make a difference. Nearly 600 pharmacies participated in the program, providing over 250,000 flu shots to patients across Ontario.

Applications for pharmacy participation in this year's (2013/2014) UIIP are currently being accepted, with a **deadline for submission of July 2, 2013.** This year every effort will be made by Ontario's public health system to integrate all interested pharmacies into the program. Should the number of applications exceed local capacity for cold chain inspections, the inspections will be done on a first come first served basis. Therefore, it is important for your pharmacy to apply as early as possible.

The User Agreement application form, along with a number of support materials, are now available on the Ministry's website at www.ontario.ca/flu >Health Care Professionals > For Pharmacies with Trained Pharmacists. A number of improvements have been made to help streamline the process this year:

- The User Agreement application is now an online, paperless process
- A valid store insurance policy, covering September 1, 2013 to August 31, 2014, remains a requirement however including the actual certificate is no longer necessary, rather a self-declaration to this effect has been incorporated into the online User Agreement application
- Program timelines have been extended:
  - Application Period: May 16, 2013 to July 2, 2013
  - Cold Chain Inspection Period: June 2013 to September 2013

Following the submission of your User Agreement application pharmacies are asked to wait for their local public health unit to contact them to arrange for a cold chain inspection of the refrigerator that will be storing publicly-funded influenza vaccine.

Public health units will likely have only one opportunity to conduct the required cold chain inspection for your pharmacy, so it is very important that you do everything you can to be ready for inspection the first time. To help prepare for this inspection, please carefully review and assess your pharmacy's adherence to the provincial Vaccine Storage and Handling Guidelines (found on the College website).

REGISTER YOUR TRAINING WITH THE COLLEGE

As per regulation, prior to administering an injection for any purpose (i.e. education, demonstration or influenza immunization within the UIIP), pharmacists must successfully complete OCP-approved training and register this training with the College.

The College's required training includes:
- valid certification in CPR and First Aid (the equivalent of the Red Cross Standard First Aid with CPR "C" + AED Course level
- successful completion of an OCP-approved course for Pharmacists' Injection Training

Note: More information on OCP-approved courses, including registration information, is available under Continuing Education (CE).

Pharmacists can register their training by:
- Login to OCP's Online Services
- Click on My Profile – Practice
- Scroll to OCP Approved Injection Training and click Update
- Acknowledge completion of required CPR / First Aid training
- Select the appropriate Injection Training Course and the year completed

Note: Once you have completed this process, the College public register will reflect that you have the required injection training. As of May 2013 more than 3,100 pharmacists have registered their training.

NEW REGULATION GIVES COLLEGE AUTHORITY TO INSPECT DRUG PREPARATION PREMISES WHERE PHARMACISTS AND PHARMACY TECHNICIANS WORK

Following unanimous approval by Council at their special meeting on May 10, 2013, and subsequent filing by government on May 15th, the new regulation *(Part IX of Ontario Regulation 202/94 made under the Pharmacy Act, Inspection of Drug Preparation Premises)* and enabling by-laws, which provide the College with the authority to inspect Drug Preparation Premises (DPP) where pharmacists and pharmacy technicians work, are now in effect.

The regulations and by-laws outline the parameters, including timelines, of how a member is to notify the College if they are currently or intending to be employed in a Drug Preparation Premise and how the College is to conduct and report on inspections of a DPP. Over the coming months College staff will be working diligently to establish the processes and standards required to operationalize this new authority. It is anticipated that inspections will begin in late summer/early fall.

Members currently working in DPP's are encouraged to watch their emails and make frequent visits to the College website (www.ocpinfo.com) for updates. The new regulation and enabling by-laws can be accessed from the homepage under Advisory Notice – Drug Preparation Premises.

BACKGROUND:

The new regulation and by-laws were drafted in an effort to address the gap in regulatory oversight that was identified as a result of allegations in late March of the under-dosing of chemotherapy drugs supplied by an independent company to four hospitals in Ontario and one in New Brunswick. The proposed regulation and by-law amendments were circulated for comment, and modifications were made to reflect feedback received.

This regulation, when combined with the Ministry's regulation change to the Public Hospitals Act, which ensures that hospitals purchase drugs only from accredited, licensed or otherwise approved suppliers, goes a long way in addressing the identified gap in regulatory oversight.

NEW PUBLIC REGISTER OF PHARMACIES WILL INCLUDE OUTCOME AND/OR STATUS OF INSPECTIONS

At the special meeting of Council on May 10, 2013, Council unanimously approved a proposed by-law amendment that permits the College to formalize the creation of a Register of Pharmacies under the authority provided in section 23(2) 14 of the *Health Professions Procedural Code (Code).*

The amended by-law will provide further transparency to the public register, as it will include the posting of the outcome and/or status of inspections of a pharmacy, including the relevant date. This applies to the most current outcome and/or status of any inspection conducted after July 1, 2013 and the outcome and/or status of every inspection conducted thereafter.

The particulars of the by-law amendment relating to the posting of inspection outcomes and/or status has been modeled after the College of Physicians and Surgeons of Ontario's recently approved by-law regarding Out-of-Hospital Premises.

The new by-laws can be accessed from the homepage of the College website: www.ocpinfo.com under News Feed - Public Register of Pharmacies.

BACKGROUND

In September 2012, Council directed that a Special Committee of Council be appointed to conduct an overall review of the College's Operating By-law; By-law No 2. The full recommendations stemming from the Review are scheduled to be presented to Council at its regular meeting on June 10, 2013.

Recent attention drawn to the issue of public reporting of the outcome and/or status of pharmacy inspections however, resulted in the decision to separate this amendment from the rest of the proposed by-law revisions and bring it forward to the May 10, 2013 special meeting of Council.

BULLETIN BOARD

OPA CONFERENCE 2013 – EXPANDED SCOPE, EXPANDED IMPACT

Hundreds of pharmacy professionals will gather at the Metro Toronto Convention Centre on June 20-22, 2013 for the Ontario Pharmacists' Association's annual conference.

College Registrar Marshall Moleschi will be speaking on Saturday afternoon from 2:45 – 3:45pm. During his presentation, Marshall will talk about how shifting focus from what we do to how we do it, is key in the delivery of quality patient care. Building on his previous "Navigating the Grey" and "Expanded Scope of Practice" presentations, Marshall will examine how finding opportunities to support and enhance the quality of how patient care is delivered will become a key focus for the College in the coming years.

June 20-22, 2013
Metro Toronto Convention Centre
Visit www.opatoday.com to register

ATTENTION CLASS OF 7T8!

Plans are underway for the 35th year reunion. Organizers are currently gauging interest and seeking suggestions for locations/venues and dates in September/October 2013.

Please send your comments and contact information to Doris Kalamut at doris.kalamut@utoronto.ca.

Thank you!

Office of the Chief Coroner
26 Grenville Street
Toronto, ON M7A 2G9
Telephone: (416) 314-4000
Facsimile: (416) 314-4030

Bureau du coroner en chef
26 rue Grenville
Toronto, ON M7A 2G9
Téléphone: (416) 314-4000
Télécopieur: (416) 314-4030

Interim Chief Coroner's Alert to Ontario Physicians and Pharmacists

To: Members of CCFP, CPSO, OMA, and OCP

From: Dr. Dan Cass, Interim Chief Coroner for Ontario

Subject: Lethal consequences from the recreational use of the antidepressant bupropion (Wellbutrin®; Zyban®) through inhalation and/or injection

Dr. Dan Cass is alerting Ontario physicians, particularly family physicians, emergency physicians, psychiatrists, as well as pharmacists, of the potential lethal consequences of the recreational use of bupropion through atypical routes.

The Office of the Chief Coroner is aware of at least six cases in which the recreational use of bupropion by inhalation or injection was a causative factor in the death. In these cases, bupropion was injected or inhaled alone or in combination with other illicit or prescribed drugs. Injection use may be associated with significant tissue necrosis at the injection site, leading to death in some cases.

A public safety risk appears to be emerging. Physicians and pharmacists should be aware of the potential for recreational use of bupropion via inhalation or injection when considering prescribing and/or dispensing this medication, and when treating patients presenting with complications of use via these atypical routes.

Office of the Chief Coroner for Ontario
26 Grenville Street
Toronto, Ontario
M7A 2G9
416-314-4000

Date: May 7, 2013

FOCUS ON ERROR PREVENTION

Ian Stewart B.Sc.Phm., R.Ph.

DISPENSING OF VACCINES

With the expanded scope of practice regulation in effect, pharmacists will become more actively involved in the administration of vaccines. (Currently in Ontario, only the administration of the influenza vaccine is permissible in the context of the Universal Influenza Immunization Program). Pharmacists should therefore be aware of the potential for error when dispensing or administering vaccines.

CASE:

A prescription for Menveo® was presented to a pharmacy assistant for processing for a pediatric patient. The prescription was entered correctly into the computer. The pharmacy assistant then retrieved the Menveo® vaccine from the refrigerator.

Menveo® vaccine is available as a two vial combination for each dose. One vial containing lyophilized MenA conjugate component and one vial containing liquid MenCWY conjugate component. Each package contains ten vials or five doses.

On retrieving the vaccine from the refrigerator, the pharmacy assistant retrieved only one vial containing the liquid MenCWY conjugate component and in error left the second vial containing the lyophilized MenA conjugate component. The single vial was placed into a prescription vial surrounded by cotton balls and labeled. The pharmacist checked the prescription, but did not identify the dispensing error. The product was then placed into the refrigerator for pick up.

A few days later, the parent returned to pick up the vaccine. On this occasion, a second pharmacist retrieved the vaccine from the refrigerator, opened the prescription vial and noticed that the second vial was missing. Fortunately, the pharmacist was aware of the need for two vials for each dose of Menveo®.

POSSIBLE CONTRIBUTING FACTORS:

- The pharmacy assistant and dispensing pharmacist were likely unfamiliar with Menveo® vaccine and the need for two vials per dose.
- Menveo® vaccine is available in packages of ten vials or five doses. Therefore, without reading the fine print, it is relatively easy for someone unfamiliar with Menveo® vaccine to assume that only one vial is required.

RECOMMENDATIONS:

- The packaging of Menveo® should be improved to include one dose only, consisting of one vial containing lyophilized MenA conjugate component and one vial containing liquid MenCWY conjugate component. The packaging should state clearly that both vials are required for reconstitution before vaccine administration.
- Become familiar with vaccines which require a second vial for reconstitution before administration.
- When checking prescriptions for vaccine products, open all packaging to check the contents carefully as some packaging can obscure key information.
- Ensure that all pharmacy staff receives the appropriate training on the dispensing and administration of vaccines. Helpful websites/links include:
  1. http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/guide_vaccine_storage.pdf
  2. http://publications.gc.ca/site/eng/75290/publication.html
  3. http://www.phac-aspc.gc.ca/naci-ccni/
  4. http://www.phac-aspc.gc.ca/publicat/cig-gci/index.html
  5. http://www.cdc.gov/vaccines

Please continue to send reports of medication errors in confidence to:
Ian Stewart at: ian.stewart2@rogers.com
Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

Community Pharmacy Incident Reporting (CPhIR)
Volume 3, Special Issue 2013

CMIRPS SCDPIM
Canadian Medication Incident Reporting and Prevention System
Système canadien de déclaration et de prévention des incidents médicamenteux

TransPhIR from CPhIR

Connecting you to safe medication practices

Safety Alerts: Preventable Drug-Drug Interactions

- Challenges in preventing drug-drug interactions
- Evaluating the clinical significance of drug-drug interactions
- Selected pharmacoepidemiological studies on drug-drug interactions with increased risk of hospitalization

Did you know ...

Some drug-drug interactions, based on pharmacoepidemiological studies, have shown an increased risk of potential hospitalization in the geriatric population.

Summary of selected pharmacoepidemiological studies on drug-drug interactions can be found in Table 1.

Introduction

Drug interactions are pharmacokinetic or pharmacodynamic influences of drugs on each other, which can result, beside desired effects, in reduced effectiveness or increased toxicity. [1] It is estimated that drug interactions cause up to 2.8% of hospital admissions [2] and they can lead to serious adverse patient outcomes. The following tragic incident is an example:

> *A 46-year-old patient was provided with a "starter" medication kit for HIV PEP, containing Kaletra (lopinavir and ritonavir) and Combivir (zidovudine and lamivudine), by a hospital emergency department. The patient's regular medications were noted as venlafaxine, amitriptyline, bupropion, hormone replacement therapy, and fentanyl patch 100 mcg/h. Approximately 4 days after initiation of PEP, the patient was noted to be very drowsy and needed to be frequently wakened. The patient went to lie down and some time later that evening was found unresponsive. Resuscitation attempts were not successful. Based on post-mortem examination and serum drug levels, the cause of death was determined to be fentanyl toxicity due to an interaction with Kaletra.* [3]

Challenges in Preventing Drug-Drug Interactions

Drug-drug interactions are, in theory, largely preventable. In most cases there are a number of therapeutic alternatives available so that a significant drug-drug interaction can be avoided. In practice, however, recognition and detection of drug-drug interactions by clinicians is not optimal. For instance, a study of 263 physicians who practiced at a large southern California Veterans Affairs health care system, only 54 percent of contraindicated drug-drug interactions was recognized. [4] A potential cause for this situation is the continually increasing number of drug interactions, making it virtually impossible for the health care practitioners to keep up with new knowledge.

A solution to the over reliance on human memory in drug interaction detection is the development of computerized drug interaction detection systems; however, studies evaluating pharmacy computerized drug interaction detection systems identify opportunities for improvement. For example, a study evaluating pharmacy computerized drug interaction systems found that such systems may fail to detect up to a third of drug-drug interactions while frequently alerting pharmacists to trivial issues. [5]

What's New

ISMP Canada has developed a one-page documentation form for pharmacists to communicate with the prescriber regarding these drug-drug interactions. We are currently looking for pharmacies to pilot test this new intervention tool; if you are interested, please contact ISMP Canada at cphir@ismp-canada.org

Evaluating the Clinical Significance of Drug-Drug Interactions

One of the fundamental reasons for the lack of sensitivity and specificity of computerized drug interaction systems is the lack of high quality evidence evaluating the clinical significance of drug interactions. An exciting development in this field had been the growing body of research studies filling this gap. By utilizing pharmacoepidemiologic methods and the linkage of several databases (such as the Ontario Drug Benefit prescription claims database), these studies clearly demonstrated a significant association between specific drug-drug interactions and hospitalization with adverse event such as digoxin toxicity, hypoglycemia, hyperkalemia and recurrent myocardial infarctions. [6, 7] It is very important that health care practitioners be aware of these studies and systematically incorporate them in practice so that these serious drug interactions can be prevented.

Table 1 summarizes the pharmacoepidemiological studies in Ontario with drug-drug interaction pairs that have been shown to increase the rate of hospitalizations in the elderly population.

Conclusion

Drug-drug interactions (DDIs) represent a potentially serious problem for patients that can result in preventable adverse drug events and consumption of scarce healthcare resources. There has been a growing body of high quality studies demonstrating an increase in hospitalization with specific drug-drug interaction pairs. Healthcare practitioners are encouraged to familiarize themselves with these drug-drug interaction pairs so that these clinically significant drug interactions can be prevented.

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ISMP Canada Community Pharmacy Incident Reporting (CPhIR) Program is a national, voluntary medication incident and 'near miss' reporting program founded for the purpose of sharing the learning and experiences from medication incidents. ISMP Canada guarantees confidentiality and security of information received. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

Table 1. Drug-drug Interactions in the Geriatric Population – Summary of Selected Pharmacoepidemiological Studies in Ontario (Nested Case-Control, Retrospective Cohort and Case Cross-Over Studies).*

DRUG-INTERACTION PAIR		Study Population	Drug Toxicity/ Adverse Event	Possible mechanism of action	Comments
Continuous Medication	Added Medication				
Glyburide[1]	Trimethoprim-sulfamethoxazole (TMP-SMX)	Older than 66 years treated with glyburide. A total of 909 cases.	Hypoglycemia	Sulfamethoxazole can directly cause pancreatic insulin release (at higher doses due to structural similarity to sulfonylurea) in patients with renal impairment. Sulfonamide antibiotics inhibit CYP 2C9. Glyburide is metabolized by CYP 2C9.	The concomitant use of TMP-SMX with glyburide was associated with increased risk of hospitalization due to hypoglycemia in the elderly. Juurlink et al. estimated that patients who were hospitalized due to hypoglycemia while using glyburide were around 6 times more likely to have been treated with TMP-SMX within 1 week.
Digoxin[1]	Clarithromycin	Older than 66 years treated with digoxin. A total of 1051 cases. A total of 51896 controls.	Digoxin toxicity	Clarithromycin inhibits P-glycoprotein which leads to decreased renal clearance of digoxin.	The concomitant use of clarithromycin and digoxin was associated with increased risk of hospitalization due to digoxin toxicity in the elderly. Juurlink et al. estimated that patients who were hosipitalized due to digoxin toxicities while using digoxin were around 12 times more likely to have been treated with clarithromycin.
Angiotensin-Converting Enzyme Inhibitors (ACEIs)[1]	Potassium-sparing diuretics (amiloride, triamterene, or spironolactone)	Older than 66 years treated with an ACEI. A total of 523 cases. A total of 25807 controls.	Hyperkalemia	ACEIs and potassium sparing diuretics both increase serum potassium levels. When used together they may precipitate hyperkalemia.	The concomitant use of ACEIs and potassium sparring diuretics was associated with an increased risk of hospitalization due to hyperkalemia in the elderly. Juurlink et al. estimated that patients who were hospitalized due to hyperkalemia while using ACEIs are 20 times more likely to have been treated by potassium sparring diuretics.
Lithium[2]	ACEIs or loop diuretics	Older than 66 years treated with lithium. A total of 413 cases and 1651 controls.	Lithium toxicity	ACEIs reduce glomerular perfusion via inhibition of angiotensin II.	Concomitant use of lithium and ACEIs or loop diuretics was associated with increased risk of hospitalization due to lithium toxicities in the elderly. Juurlink et al. estimated that patients who were hospitalized due to lithium toxicity while using lithium are 2 times more likely to have been treated by ACEIs or loop diuretics.

DRUG-INTERACTION PAIR		Study Population	Drug Toxicity/ Adverse Event	Possible mechanism of action	Comments
Continuous Medication	Added Medication				
Warfarin[3]	NSAIDs [(nonselective NSAIDs) or COX-2 Inhibitors (celecoxib and rofecoxib)]	Older than 66 years treated with warfarin. A total of 361 cases. A total of 1437 controls.	Upper GI hemorrhage	S-warfarin (active enantiomer) and NSAIDs are substrates for CYP 2C9. Both NSAIDs and warfarin can increase risk of GI bleeding.	Concomitant use of warfarin and NSAID or COX-2 inhibitor was associated with increased risk of upper GI hemorrhage in the elderly. Battistella et al. estimated that patients who were hospitalized due to an upper GI bleed while using warfarin were around 2 times more likely to have used an NSAID or COX-2 inhibitor within 90 days.
Digoxin[4]	Macrolide antibiotics	Over the age of 66 treated with digoxin. A total of 1659 cases. A total of 6439 control cases.	Digoxin toxicity	Macrolide antibiotics can reduce re-circulation of Digoxin by reducing *E. lentum* in the gut. Clarithromycin may inhibit P-glycoprotein-mediated tubular secretion of digoxin.	Concomitant use of digoxin and macrolide antibiotics may lead to increased risk of hospitalization in the elderly. Gomes et al. estimated that in patients who are hospitalized due to digoxin toxicity, are 15 times more likely to be taking clarithromycin and 4 times more likely to be taking azithromycin or erythromycin.
Clopidogrel[5]	Proton pump inhibitors (PPIs)	Over the age of 66 years treated with clopidogrel. A total of 734 cases. A total of 2057 controls.	Re-infarction	Clopidogrel is a pro-drug requiring activation by CYP 2C19. Omeprazole, lansoprazole and rabeprazole inhibit CYP 2C19 which leads to reduced anti-platelet action.	Concomitant use of clopideogrel and PPIs (except pantoprazole) is associated with increased risk of re-infarction in the elderly. Juurlink et al. report in patients who are hospitalized for a re-infarct and using clopidogrel are more likely to be using a PPI within 30 days. Pantoprazole was not associated with increased hospitalization.
ACEIs/Angiotensin Receptor Blockers (ARBs)[6]	TMP-SMX	Over the age of 66 years treated with ACEI or ARBs. A total of 369 cases. A total of 1417 controls.	Hyperkalemia	ACEIs and ARBs impair urinary potassium excretion. TMP reduces urinary potassium excretion.	Concomitant use of TMP-SMX and ACEIs or ARBs is associated with increased risk of hospitalization due to hyperkalemia in the elderly. Antoniou et al. estimated in patients who are hospitalized for hyperkalemia and using ACEIs or ARBs are about 7 times more likely to have received TMP-SMX.

DRUG-INTERACTION PAIR		Study Population	Drug Toxicity/ Adverse Event	Possible mechanism of action	Comments
Continuous Medication	Added Medication				
Warfarin[7]	TMP-SMX, ciprofloxacin	Over the age of 66 years treated with warfarin. A total of 2151 cases. A total of 10201 controls.	Hemorrhagic complications	TMP-SMX inhibits CYP 2C9. S-warfarin (active enantiomer) metabolized predominantly by CYP 2C9.	Concomitant use of TMP-SMX or ciprofloxacin with warfarin increases the risk of hospitalization due to hemorrhagic complications. Fischer et al. estimated patients, who were hospitalized with hemorrhagic complications while using warfarin, are 3 times more likely to have been exposed to TMP-SMX and 2 times more likely to have been using ciprofloxacin.
Tamoxifen[8]	Paroxetine	2430 women over the age of 66 years treated with tamoxifen for breast cancer on concurrent treatment with a single SSRI.	Breast cancer mortality	Tamoxifen is a pro-drug metabolized by CYP 2D6 to the active endoxifen. Paroxetine is a potent CYP 2D6 inhibitor and may reduce the activation of tamoxifen.	Kelly et al. report paroxetine use during tamoxifen treatment increases breast cancer mortality. The median overlap time of tamoxifen and paroxetine treatment in this study was 41%. It is estimated that this level of overlap would result in one additional breast cancer death at 5 years for every 20 women treated. This is a retrospective cohort study.
Calcium channel blockers (CCBs) (verapamil, diltiazem, nifedipine, amlodipine, or felodipine)[9]	Macrolide antibiotics (erythromycin, clarithromycin, and azithromycin)	Over the age of 66 years treated with CCBs. A total of 7100 in cohort. A total of 176 cases.	Hypotension	Two macrolides, erythromycin and clarithromycin, inhibit CYP 3A4. Azithromycin does not inhibit CYP 3A4. Calcium channel blockers are CYP 3A4 substrates.	Concomitant use of CCBs and macrolide antibiotics are associated with increased risk of hospitalization due to hypotension. Wright et al. found in patients who are admitted to hospital due to hypotension while using a CCB are more likely to have received clarithromycin or erythromycin prior to hospitalization. Azithromycin was not associated with hypotension. This is a case cross-over study.
Theophylline[10]	Ciprofloxacin	Over the age of 66 treated with theophylline. A total of 180 cases. A total of 9000 controls.	Theophylline toxicity	Theophylline is metabolized by CYP 1A2. Ciprofloxacin is a potent inhibitor of CYP 1A2. Ciprofloxacin is a commonly used antibiotic given to COPD patients.	Concomitant use of theophylline and ciprofloxacin may lead to an increased risk of hospitalization due to theophylline toxicity. Antoniou et al. estimated that patients hospitalized due to theophylline toxicity were 2 times more likely to have been treated with ciprofloxacin.

DRUG-INTERACTION PAIR		Study Population	Drug Toxicity/ Adverse Event	Possible mechanism of action	Comments
Continuous Medication	Added Medication				
Phenytoin[11]	TMP-SMX	Over the age of 66 years treated with phenytoin. A total of 796 cases. A total of 3148 controls.	Phenytoin toxicity	Phenytoin is metabolized by CYP 2C8. TMP-SMX is a potent CYP 2C8 inhibitor and may lead to increase in phenytoin level.	Concomitant use of phenytoin and TMP-SMX increases the risk of hospitalization due to phenytoin toxicity. Antoniou et al. estimated patients who are hospitalized due to phenytoin toxicity are 2 times more likely to have received TMP-SMX within 30 days.
Spironolactone[12]	TMP-SMX, Nitrofurantoin	Over the age of 66 years treated with spironolactone. A total of 248 cases (median age, 82 years). A total of 783 controls (median age, 81 years).	Hyperkalemia	Spironolactone and TMP-SMX both decrease urinary excretion of potassium.	Concomitant use of TMP-SMX or nitrofurantoin with spironolactone has been associated with increased risk of hospitalization due to hyperkalemia. Antoniou et al. estimated that patients hospitalized due to hyperkalemia while using spironolactone are 12 times more likely to have been using TMP-SMX and 2 times more likely to have been using nitrofurantoin.

***The information in Table 1 was taken from the individual drug interaction studies and does not necessarily represent the opinion of ISMP Canada. Health care organizations are encouraged to critically appraise these studies to determine the applicability to their specific practice settings.** (Updated April 24, 2013)

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DISCIPLINE DECISIONS

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Member: Thi Pham Buu

At a motion on February 11, 2013, a Panel of the Discipline Committee considered allegations of professional misconduct against Ms. Buu which concerned falsifying records relating to her practice, signing or issuing documents that she knew contained false and misleading statements, and submitting accounts or charges for services that she knew were false and misleading, as well as failing to exercise appropriate professional judgment in dispensing duplicate drugs.

In resolution of the matter, Ms. Buu entered into an Undertaking, Agreement and Acknowledgment with the College whereby she resigned permanently as a member of the College, irrevocably surrendered her Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario.

Accordingly, the parties made a joint submission to the Discipline Committee to issue an Order for a stay of the allegations of professional misconduct against Ms. Buu. On the basis of the Undertaking, Agreement and Acknowledgment Ms. Buu entered into with the College, the Discipline Committee accepted the joint submission of the parties and issued an Order staying the allegations of professional misconduct against Ms. Buu.

Member: Godwin Ogowa

At a hearing on April 4, 2013, a Panel of the Discipline Committee found Mr. Ogowa guilty of professional misconduct. The allegations of professional misconduct against Mr. Ogowa arose as a result of his failure to comply with a prior Order of the Discipline Committee dated June 9, 2008 and failing to comply with the terms of an Acknowledgement and Undertaking the Member entered into with the College dated January 26, 2011. The hearing proceeded in the absence of Mr. Ogowa.

The Panel ordered that the Member's Certificate of Registration be suspended immediately, until September 30, 2013. The Panel further ordered that if the Member has not successfully completed the College's Jurisprudence Examination by September 30, 2013, the Registrar shall revoke the Member's Certificate of Registration.

Member: To Ha

At a hearing on April 25, 2013, a Panel of the Discipline Committee found Mr. Ha guilty of professional misconduct. The allegations of professional misconduct against Mr. Ha related to the falsification of pharmacy records regarding claims made in 2009 to the Ontario Public Drug Program for nine prescription drug products.

The Panel imposed a penalty which included:

- A reprimand;
- Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
- that he complete successfully, at his own expense, within 12 months of the date of the Order, the ProBE Program on Professional/Problem Based Ethics for health care professionals;
- for a period of three years from the date of the Order, that he shall:
  - o be prohibited from having any proprietary interest in a pharmacy of any kind;
  - o be prohibited from acting as a Designated Manager in any pharmacy;
  - o be prohibited from receiving any remuneration for his work as a pharmacist other than remuneration based only on hourly or weekly rates, and not on the basis of any incentive or bonus for prescription sales;
  - o notify the College in writing of any employment in a pharmacy; and
  - o ensure that his employers confirm in writing to the College that they have received and reviewed a copy of the Discipline Committee Panel's decision in this matter and their Order, and confirming the nature of the Member's remuneration.
- A suspension of ten months, with one month of the suspension to be remitted on condition that the Member complete the remedial training;
- Costs to the College in the amount of $12,000.

The full text of these decisions is available at www.canlii.org

CanLii is a non-profit organization managed by the Federation of Law Societies of Canada. CanLii's goal is to make Canadian law accessible for free on the Internet.

Maintaining Public Trust

One of the fundamental responsibilities of any regulatory body is to continuously monitor and take steps to maintain the reputation and trust of the profession.

The recent **Grey Areas** *article, reprinted here, illustrates an example of where the College pursued legal action against a company. In this case, a call and processing centre operating in Ontario, but claiming to be operating out of Belize, was positioning itself online as a 'pharmacy', but was not accredited by the College.*

After careful consideration of all the evidence presented, the court had no difficulty finding that the Ontario call and processing centre was selling and dispensing drugs and operating a pharmacy illegally. The court granted the injunction and declarations sought by the College.*

* *The decision is currently being appealed.*

GREY AREAS

Steinecke Maciura LeBlanc
April 2013
No. 175

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

FINALLY, SOME GUIDANCE ON TELEPRACTICE

It is difficult to believe that it has taken until 2013 for the Canadian courts to provide its first major decision on the telepractice of a profession (excluding some interesting securities cases). It has taken so long that even the term, telepractice, is now obsolete, since what we are really talking about now is practising a profession over the internet. And the guidance only addresses the easier side of the equation: the jurisdiction of regulators where the provider is in one jurisdiction and the client is in another jurisdiction.

In *Ontario College of Pharmacists v. 1724665 Ontario Inc.*, 2013 CanLII 13655 (ON SC) (*Global Pharmacy*) the regulatory College sought an injunction against a call centre (which was also the processing centre) in Ontario that organized the shipment of drugs from India to the United States and elsewhere. None of the staff in the Ontario call and processing centre were registered pharmacists and the call centre was not a regulated pharmacy. None of the drugs were, in the company's recent operating history, sent to Canadians.

The actual company operating the business was located in Belize and the Canadian call centre notionally only acted as a contractual clerical service provider to the Belize corporation. However, the website for the operation emphasized its Canadian character (complete with the Canadian maple leaf), used an Ontario address for receiving orders and operated an Ontario bank account to receive funds. The Court found that the enterprise was exploiting the trust that consumers placed in the highly regulated pharmacy sector in

Canada (particularly in Ontario) to promote its business. Yet, the enterprise had avoided any accountability to the Ontario regulatory College.

Two of the regulatory requirements that the enterprise did not comply with were a requirement for a physician's prescription (a photograph of a pill bottle was sufficient) to support the sale and the fact that the enterprise provided automatic refills every three months without further authority for dispensing. The regulatory College viewed these as examples of the safety risks associated with the enterprise.

The Court first dealt with the issue of whether the regulatory College had jurisdiction over the activities of the Ontario call centre. Not every entity with a glancing connection to Ontario is subject to the requirements of an Ontario regulator. The Court found that there were two ways in which the Ontario regulator could have jurisdiction:

1. Where the entity had a sufficient connection to Ontario in terms of its operation of the regulated profession or industry. This requires an analysis of both the enabling legislation (as to what it is intending to protect) and the substance of the activities of the entity.

2. Where the entity was an agent of another entity that was, in fact, practising the profession or operating the industry in Ontario.

The Court found that both tests were met in this case. In substance the call (and processing) centre was not simply providing clerical services; it was operating a pharmacy in Ontario in conjunction with the Belize company. In addition, the call centre was acting as an agent for the Belize company in its attempt to remotely operate a pharmacy in Ontario. In making those findings the court was quite prepared to look behind the official contractual documentation between the two corporate legal entities (in Belize and in Ontario) to view the substance of the relationship between them. It did not help the respondents that they undertook a series of restructurings that appeared to be obvious attempts to avoid regulatory accountability, although the Court did not place heavy emphasis on this aspect of the evidence.

The Court also had to examine whether the regulatory body had any business protecting consumers outside of Ontario (and, indeed, Canada) since the enterprise had taken steps to ensure that Canadian consumers did not receive any of their drugs. The Court concluded that public protection legislation can and often is intended to protect the public outside of Ontario as well as Ontario residents. A number of arguments were referenced including the inappropriateness of failing to regulate misleading, fraudulent or unsafe practices that occur within the province, the hope for reciprocal enforcement elsewhere for Ontario consumers, and the disrepute that comes to the profession in Ontario if such conduct is not regulated.

The Court then looked at the "core" issue of whether the sale of drugs occurred in Ontario. The Court concluded, after a very detailed review of the law and evidence, that the sales did occur in Ontario. The Court found this both on the traditional contract law notions of "offer and acceptance", and under a purposeful, intent-of-the-legislation understanding of transactions. It is not clear if only one of those approaches would be sufficient to establish accountability for the telepractitioners, although the answer is probably yes.

Having reached this conclusion, the Court had no difficulty finding that the Ontario call and processing centre was selling and dispensing drugs and operating a pharmacy illegally. It granted the injunction and declarations sought.

The Court did not deal with the mirror image of *Global Pharmacy*, that being the jurisdiction of regulators over out-of- province / territory practitioners providing goods and services to clients in the province / territory. It did cite a recent patent case in the Supreme Court of Canada that suggested that courts would take a liberal view of Canadian regulators in those circumstances: *Celgene Corp v. Canada (Attorney General),* 2011 SCC 1. Of course there are significant practical challenges in regulating such providers even if the Canadian regulator has jurisdiction. However, one can expect clarification of those issues as well in the coming years.

The *Global Pharmacy* decision is being appealed to the Ontario Court of Appeal which is expected to hear the case soon.

The *Global Pharmacy* case can be found at www.canlii.org.

Originally published on Grey Areas
by Steinecke Maciura LeBlanc
401 Bay Street, Suite 2308
Toronto, Ontario M5H 2Y4
Telephone: 416-626-6897 • Facsimile: 416-593-7867
E-Mail: rsteinecke@sml-law.com

CONTINUING EDUCATION (CE)

This CE list is provided as a courtesy to members and is by no means exhaustive. Inclusion of a CE on this list does not imply endorsement by the Ontario College of Pharmacists (OCP). For information on local live CE events in your area you may wish to contact your Regional CE coordinator (list available on the OCP website).

Updates available on the OCP website, www.ocpinfo.com under Fast Track > Continuing Education (CE)

LIVE

May 30 - 31, 2013 (Toronto)
TEACH Specialty Course: Tobacco Interventions for Patients with Mental Health and/or Addictive Diseases
Centre for Addiction and Mental Health (CAMH)
Contact: http://www.camh.ca/en/education/

May 30, 31, 2013 (Toronto)
TEACH Specialty Course: Integrated Chronic Disease Prevention - Addressing the Risks
Centre for Addiction and Mental Health
Contact: http://www.camh.ca/en/education/

June 1 – 4 (Charlottetown, PEI)
Canadian Pharmacists Association Conference 2013
Canadian Pharmacists Association (CPhA)
Contact: http://www.pharmacists.ca/index.cfm/news-events/events/conference/

June 9 – 12 (Ottawa)
Canadian Public Health Association Conference 2013
Canadian Public Health Association (CPHA)
Contact: http://www.cpha.ca/en/default.aspx

June 11, 2013 or September 18, 2013 (Toronto)
BPMH Training for Pharmacy Technicians: Understanding the hospital pharmacy technician's role in medication reconciliation
Institute for Safe Medication Practices (ISMP Canada)
Contact: http://www.ismp-canada.org/education/

June 13 - 15, 2013 (Toronto)
Antimicrobial Stewardship Educational Program
University of Toronto
Contact: www.antimicrobialstewardship.com

June 20, 2013 (Toronto)
Patient Assessment and Screening Tools for Enhanced Care Management
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

June 20, 21, 22, 2013 (Toronto)
Ontario Pharmacists Association (OPA) Conference 2013
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

August 10-13, 2013 (Calgary, AB)
Summer Educational Sessions 2013
Canadian Society of Hospital Pharmacists (CSHP)
Contact: http://www.cshp.ca/events/ses/2013/index_e.asp

August 21, 2013 (Toronto)
Confronting Medication Incidents
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

September 21, 2013 (Toronto)
Nutrition for Pharmacists Certificate Program
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

September 26, 2013 (Toronto)
Root Cause Analysis (RCA) Workshop for Pharmacists
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

September 27, 2013 (Toronto)
Failure Mode and Effects Analysis (FMEA)
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/education/

October 3 - 5, 2013 (Toronto)
Cardiovascular Patient Care
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

October 19, 2013 (London)
Contraceptives in Women's Health
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

October 20, 2013 (Toronto)
New and Expectant Mothers
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

October 24 – 26, 2013 (Toronto)
November 21 – 23, 2013 (Toronto)
Certified Geriatric Pharmacist Preparation Course
Ontario Pharmacists Association
Contact: http://www.opatoday.com/index.php/education.html

Multiple dates and locations – contact course providers
Immunizations and Injections training courses
Ontario Pharmacists Association:
http://www.opatoday.com/
Pear Health:
http://www.pearhealthcare.com/training-injection-training.php
RxBriefcase, CPS and PHAC:
http://www.advancingpractice.com/

ON-LINE/ WEBINARS/ BLENDED CE

NEW – SOCIAL MEDIA – e-Learning module
"Pause Before You Post"
Social Media Awareness for Regulated Healthcare Professionals

This new e-learning module, which contains numerous examples and case-based scenarios designed to illustrate social media use in health care, was produced in collaboration with six other health regulatory Colleges.

The module does not replace practitioners' professional obligation to review and understand relevant professional standards of practice and legislation. Rather, it encourages individuals to apply these standards, legislation and principles to the social media environment, thereby establishing risk management strategies to help maintain professional reputations and appropriate professional relationships in practice.

On-line Learning (Social Media – eLearning Module)
www.ocpinfo.com under Fast Track > Continuing Education (CE) > CE for Pharmacists

Centre for Addiction and Mental Health (CAMH)
On-line courses with live workshops in subjects including mental health, safe and effective use of opioids, opioid dependence treatment core course (with additional elective courses), motivational interviewing, interactions between psychiatric medications and substances of abuse.
Contact: http://www.camh.ca/en/education/

Canadian Pharmacists Association
Home Study Online accredited education programs including the ADAPT Patient Skills Development certificate program, Diabetes Strategy for Pharmacists, Micronutrients, QUIT: Quit Using & Inhaling Tobacco and Respiratory care
http://www.pharmacists.ca/index.cfm/education-practice-resources/

Canadian Society of Hospital Pharmacists (CSHP)
Online education programs accredited by CCCEP
www.cshp.ca

Canadian Healthcare Network
On-line CE Lessons
www.canadianhealthcarenetwork.ca

Communimed
A Practical Guide to Successful Therapeutic Drug Monitoring and Management (TDM & M) in Community Pharmacy: Focus on Levothyroxine
www.tdm-levothyroxine.ca

Continuous Professional Development - Leslie Dan Faculty of Pharmacy, University of Toronto
Infectious Diseases Online Video Lectures and Slides, Influenza DVD
http://www.pharmacy.utoronto.ca/cpd/

Ontario Pharmacists Association (OPA)
Complimentary online programs in therapeutic areas including the Common cold and Flu, Methadone, Smoking Cessation, Ulcerative colitis and Vitamin D in osteoporosis.
http://www.opatoday.com/index.php/education/
Contact: onlinelearning@opatoday.com

RxBriefcase
On-line CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).
www.rxbriefcase.com

Ontario is fortunate to have a dedicated team of regional CE Coordinators, who volunteer their time and effort to facilitate CE events around the province.

***OCP extends its sincere appreciation and thanks** to each and every member of these teams for their commitment and dedication in giving back to the profession.*

ADDITIONAL CE COORDINATORS NEEDED:

For members interested in expanding their network and giving back to the profession, OCP is looking for regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 11 (Markham area), 17 (Brantford area), 25 (Sault Ste Marie area), 27 (Timmins area). A complete list of CE coordinators and regions by town/city is available on our website. To apply, please submit their resume to ckhun@ocpinfo.com

REMINDER

UPCOMING COUNCIL ELECTIONS: DISTRICTS K, L, T, TH AND BY-ELECTION FOR 1 SEAT IN DISTRICT M

SEE PAGE 9 FOR DETAILS

CANADA POST #40069798

Ontario College of Pharmacists
Putting patients first since 1871