PHARMACY CONNECTION

SPRING 2015 • VOLUME 22 NUMBER 2

Ontario College of Pharmacists
Putting patients first since 1871

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

Putting Patients First

WHAT'S ETHICS GOT TO DO WITH IT?

See page 14

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.

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COUNCIL MEMBERS

Elected Council Members are listed below according to District. 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 Esmail Merani (Vice President)
K Mark Scanlon (President)
L Jillian Grocholsky
L Michael Nashat
L Farid Wassef
M Fayez Kosa
M Don Organ
M Laura Weyland
N Bonnie Hauser
N Christopher Leung
N Ken Potvin
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T Michelle Filo
TH Goran Petrovic

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PM David Hoff
PM Javaid Khan
PM John Laframboise
PM Lewis Lederman
PM Katie Mahoney
PM Aladdin Mohaghegh
PM Sylvia Moustacalis
PM Shahid Rashdi
PM Joy Sommerfreund
U of T Heather Boon
U of W David Edwards

Statutory Committees

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

Standing Committees

- Communications
- Drug Preparation Premises
- Elections
- Finance & Audit
- Professional Practice

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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.

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PHARMACY CONNECTION

SPRING 2015 • VOLUME 22 NUMBER 2

CONTENTS

**Mark F. Scanlon,
R.Ph., B.Sc.Phm.
President**

> "... when we chose this vocation, we committed ourselves to a unique set of obligations and expectations."

Recently, Ontario's Minister of Health and Long-Term Care, Dr. Eric Hoskins, has been talking a lot about getting back to the roots of what it means to be a healthcare professional. Minister Hoskins — a physician himself — has been reminding us to put patients first, focus on improving people's lives, and remember why we chose to become healthcare professionals in the first place.

As a third generation pharmacist, following in the footsteps of my father and grandfather, I find myself drawn to his message. Pharmacy has become a family profession for the Scanlons, and one that we take great pride in. For decades, we have been committed to using our medication expertise to enhance our patients' lives and improve their health outcomes.

Why did we become pharmacists? I think it's just what we were meant to do — a calling.

The English word *vocation* is from the Latin *vocacio* — meaning a call or summons. The Minister has also referenced it in his *Patients First Action Plan for Healthcare*. I quite like this concept and think it's at the heart of what it means to be a healthcare professional. It's true – it's not *just a job*. It's a vocation – a life's work that is challenging, rewarding, and important. However, I think it's essential that we remember and understand that when we chose this vocation, we committed ourselves to a unique set of obligations and expectations.

Late last year, OCP Council began a project that will result in more clarity around these obligations and expectations. We are making some significant changes to the College's Code of Ethics to better outline the professional role and commitment of pharmacists and pharmacy technicians. This is a significant project that will help us all to better understand our role as healthcare professionals.

As you flip through this issue, I encourage you to spend a few minutes reading the article on page 15 entitled "What's ethics got to do with it?" It's a great piece that asks us to take a moment to consider why we became healthcare professionals, and what it means to put someone else's interests and well-being ahead of our own. The article explains what a Code of Ethics is, where it comes from, why it is important, and more.

As you'll read in the article, Codes have been around for thousands of years, and while they have continued to evolve, they remain founded on the same core ethical principles of healthcare that were first seen in the Hippocratic Oath back in 400BC.

Recently, I was going through some of my father's and grandfather's old pharmacy belongings and found a 1967 Code of Ethics from the Ontario Pharmacists Association. As I was reading through, I noticed that many of the same concepts – serving others, putting patients first, doing no harm, shunning actions based solely on financial gain – are all there. It was a great reminder to me of the roots of our profession, and the unique obligations and expectations that we, as healthcare professionals, have committed ourselves to.

I'm really excited and honoured to be working with Council's task force on the revision of our profession's Code of Ethics. Codes are so often overlooked, or seen as less important, than Standards of Practice or government legislation. However, I think it's so important that these three work together in harmony - they each have an integral role to play in forming the framework that supports our ability to deliver safe, effective and ethical care to the patients we serve.

Stay tuned for more information on the Code project in coming issues of *Pharmacy Connection*.

Thanks for reading,

Mark F. Scanlon, President

THE *Niagara Apothecary*

EXPERIENCE AN 1869 PHARMACY

The Niagara Apothecary, located in Niagara-on-the-Lake, is a replica of a typical 1869 pharmacy. Visit this beautiful mid-Victorian national historic site and learn about pharmacy practice in the 19th century confederation period. Once there, you'll have the opportunity to speak with retired pharmacists and learn about the building and its artifacts.

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

Visit this summer!

For more information, go to *www.niagaraapothecary.ca*

MARCH 2015 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on March 10, 2015.

PROPOSED CHANGES TO THE DPRA REGULATIONS

The passing of Bill 21: *Safeguarding Health Care Integrity Act, 2014* extends the College's authority to license and inspect pharmacies within public and private hospitals, as well as future authority over institutional pharmacy locations. As a result, the current *Drug and Pharmacies Regulations Act* (DPRA) regulations, which only address community pharmacy practice, needed to be revised. In drafting these revisions, consideration was given to the following principles:

1. Regulations will be performance-based
2. Regulations will focus on high risk practices, those that impact patient safety
3. The approach to drafting regulations will be high-level rather than specific. Standards, policies and guidelines will be utilized to address issues wherever possible
4. The regulations will support practice evolution and change
5. The regulations will be drafted without specificity to permit the contemplation of multiple classes of certificates of accreditation

The proposed regulation sets out the performance expectations of pharmacy practice sites, but excludes details which may become irrelevant over time. Council, however, was assured that policies, guidelines and processes will be developed with appropriate consultation that will ensure that the expectations of the regulation are clearly articulated and met.

Accordingly, Council approved the recommendation that the proposed regulation be circulated for public and member feedback. Comments and input – due by May 10, 2015 – will be considered by Council at its meeting in June.

STRATEGIC PLANNING

Council participated in a facilitated session to review the current Strategic Priorities, mission and vision statements and core values.

The focus at the session was on the governance principle that Council leads and directs the College to achieve its public interest mandate, and the Registrar is given the authority and responsibility to operationalize Council's public interest mandate and strategic plan. While the current Strategic Directions were considered to still be valid and appropriate, there was consensus that each direction should be reviewed with a **"patients first"** lens to ensure that patients continue to remain front-and-centre in all our activities. Council also directed that the College review the means by which it engages public/patients and members to inform decision making.

Over the next few months, College staff will develop an operational plan to support the Strategic Directions, ensuring that the values of transparency, accountability and excellence are applied throughout. The plan will be brought forward to Council for approval at its June 2015 Meeting.

The operational plan will be monitored and each quarter Council will receive an update regarding progress on the Strategic Directions.

Photos by DW Dorken

COUNCIL APPROVES AUDITED STATEMENTS FOR COLLEGE OPERATIONS FOR 2014

Council approved the Audited Financial Statements for the operations of the College for 2014 as prepared by management and audited by Clarke Henning, LLP, Chartered Accountants. The audit and resulting financial statements were prepared in accordance with Canadian Auditing Standards. Council was pleased to note that the auditors did not identify any major issues of concern. The summarized financial statements will be published in the 2014 Annual Report in late March.

BY-LAWS DEALING WITH INFORMATION ON THE PUBLIC REGISTER — APPROVED

The College has committed to enhancing transparency and ensuring that Ontarians have access to information that is relevant, timely, useful and accurate. Over the last two years, we have been collaborating with five other healthcare regulators on the topic of transparency. This Advisory Group for Regulatory Excellence (AGRE) has recommended certain categories of information be made available on the Colleges' public registers to allow members of the public to make more informed choices about their healthcare.

At this Council meeting, feedback on the proposed changes that deal specifically with additional member information to be placed on the public register was reviewed and considered. Some of this information is related to the work of the Inquiries, Complaints and Reports Committee (ICRC), and some is information that is generated through other processes (criminal charges) or regulatory authorities (findings in other jurisdictions). Of the 49 responses received (45 from members, 3 from public and 1 from an organization), there was some opposition based on the perception that this would have a personal impact. There was also some misunderstanding of the categories of complaint outcomes that will become public information.

Council approved the changes to the by-law, noting that the College is not proposing to provide any information regarding federal and provincial charges that is not already publicly available and that criteria and processes for some of the other information (e.g. determining relevance to suitability to practice) is currently being developed. The processes and criteria will be communicated once they have been established.

CODE OF ETHICS TASK FORCE – UPDATE

The Code of Ethics Task Force was established in December 2014 with a mandate to review and update the current Code of Ethics so that it more appropriately addresses current practice, and to enable pharmacists and pharmacy technicians to apply it in practice. Mr. Scanlon, who is the Chair of this task force, reported to Council that an ethicist has now been contracted to assist with the project and it is anticipated that further updates on progress will be provided to Council at its meeting in June. Pc

NEXT COUNCIL MEETINGS:

- Monday 15 June, 2015
- Thursday 17 and Friday 18 September 2015

Council meetings are open to the public, and are held at the College: 483 Huron Street, Toronto, ON M5R 2R4. If you plan to attend, or for more information, please contact

Ms. Ushma Rajdev, *Council and Executive Liaison* at urajdev@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.

To be eligible for consideration for appointment, you must:

- Hold a valid Certificate of Registration as a pharmacist or as a pharmacy technician
- Either practise 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
- Not be disqualified from serving on Council or a committee within the six years immediately preceding the appointment
- Not have a conflict of interest in respect to the Committee to which you are to be appointed

- Not be the owner or designated manager of a pharmacy that, within the six years immediately preceding the appointment, has undergone a re-inspection, as a result of deficiencies noted in an initial inspection, for a third time or more after the initial inspection, and
- Not be an employee or an elected or appointed member of the governing body of any local, regional, provincial or national professional association of pharmacists or pharmacy technicians

Term and Date of Appointment: A non-council committee member (NCCM) is required to serve a one-year term. The President, in conjunction with the chairs of the committees, will make the appointments at the beginning of the Council year (i.e. September 17, 2015).

Location of Meetings: Meetings will be held at the College. The College is equipped for video and voice conferencing so participation by teleconference at most committee meetings is possible.

Remuneration: The College recognizes that although members' time is volunteered and is therefore unpaid, members choosing to serve committees should not be out of pocket for costs incurred. For more details on the remuneration and expenses, refer to Article VI of the by-laws.

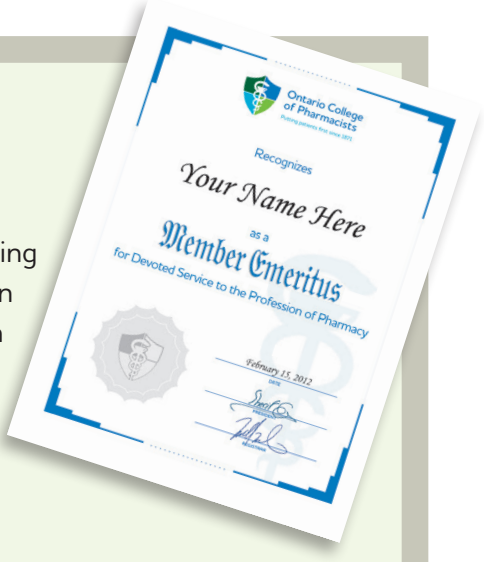
Frequency of Meetings: The number of days required by members to serve on each committee will vary (see table on page 12). For more information regarding the committees, refer to committees on the College website.

For more information on the role of an NCCM, please review the Governance Manual. If you are interested in being considered for appointment to a committee or have any questions, send an email, **by August 7, 2015,** to Ms. Ushma Rajdev, Council and Executive Liaison, at urajdev@ocpinfo.com. In your email, state the committee(s) on which you would like to serve and provide a resume together with any other information you deem useful.

You will be contacted after Council's September meeting has taken place *if you have been appointed* to serve on a committee.

Members Emeritus

Any pharmacist who has practiced continually in good standing in Ontario and/or other jurisdictions for at least 25 years can voluntarily resign from the Register and make an application for the Member Emeritus designation. Members Emeritus are not permitted to practice pharmacy in Ontario but will get a certificate, receive Pharmacy Connection at no charge, and be recognized as Member Emeritus.



For more information, contact Client Services at 416-962-4861 ext 3300 or email ocpclientservices@ocpinfo.com

COUNCIL ELECTIONS

It's Election time again!

Your skills, knowledge and experience are needed at the College.

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This year, the College is holding Council Elections for two seats in District H (hospital) and three seats in District N.*

THE ROLE OF A COUNCIL MEMBER:

The College operates under the leadership and stewardship of its Council. Council's primary role is to ensure that the interests of the public are protected and maintained.

Members of Council include 15 elected pharmacists (two from hospital), two elected pharmacy technicians (one from hospital), two deans from the faculties of pharmacy at University of Toronto and University of Waterloo and nine to 16 members of the public who are appointed by government.

Council is the policy-making group and board of directors for the College. The College's administrative staff is responsible for carrying out these policies and administering the *Regulated Health Professions Act, the Pharmacy Act* and the *Drug and Pharmacies Regulation Act* and associated regulations. The College is required to fulfill the role of a regulatory college established in this legislation. All Council decisions must be consistent with this legislation.

It is important to note that once elected to Council, Council members do not "represent" those who elected them. Rather, Council has a fiduciary duty of undivided loyalty and good faith to the mandate of the College, which is to regulate the pharmacy sector in the public interest. For more information about the role of a Council member, please review the Governance Manual.

ELIGIBILITY TO RUN FOR COUNCIL:

In order to run for election and hold a seat at the Council table, you must meet the eligibility criteria contained in Article 4 (Section 4.9) of the by-laws.

THE NOMINATION PROCESS:

To stand for election, you must be nominated by three members of the College who are eligible to vote in the electoral District for which you are nominated.

Your nomination paper must be accompanied by your signature which affirms your commitment to the Objects of the College and that you undertake to comply with the College's policies, the By-Laws, Code of Ethics and Code of Conduct and procedures for Council and committee members, all of which can be found on the College website.

The nominations must be filed with the Registrar's Office no later than 5:00 p.m. on Wednesday, June 17, 2015.

As part of the election process, the College will provide information about each candidate to the members in the relevant district. This information along with a photo for each candidate will be posted on the College website. The biography and campaign material help voters learn more about each candidate.

WHAT IS THE TIME COMMITMENT INVOLVED IN SERVING AS A COUNCIL MEMBER:

Council meetings are held four times per year at the College – September, December, March and June. Each meeting is about one day in length (except September, which may be about a day and a half). The meetings are open to the public.

COMMITTEE MEETINGS:

Council members may also be appointed to sit on one or more committees. These appointments are approved by Council each September, which is the beginning of the Council year for this College. Committees meet anywhere from three days a year to once a month, depending on the committee. The table below

*N corresponds to the first letter of the postal code for your primary place of practice.

KEY DATES FOR COUNCIL ELECTIONS:

- **NOMINATIONS OPEN:** Monday, June 1, 2015
- **NOMINATIONS CLOSE:** Wednesday, June 17, 2015
- **LAST DAY FOR CANDIDATES TO WITHDRAW:** Tuesday, June 30, 2015
- **VOTING TO COMMENCE ON OR BY** Friday, July 10, 2015
- **VOTING CLOSES:** Wednesday, August .5, 2015

gives an approximate overview of the time commitments of each committee.

TERM AND EFFECTIVE DATE ON COUNCIL:

The term of office for elected members is three years with a maximum of nine consecutive years. The first Council meeting following the election is Thursday, September 17 and Friday, September 18, 2015.

REMUNERATION AND EXPENSES:

The College recognizes that although the Council members' time is volunteered and is therefore unpaid, members choosing to serve on Council should not be out of pocket for costs incurred. For more details on remuneration and expenses, refer to Article 6 of the by-laws.

SUBMISSION OF NOMINATIONS:

BY MAIL: Attention: Ms. Ushma Rajdev
c/o Registrar's Office Ontario College of Pharmacists
483 Huron Street
Toronto, Ontario M5R 2R4

BY EMAIL: urajdev@ocpinfo.com

FOR INFORMATION REGARDING YOUR VOTING DISTRICT AND ELIGIBILITY, CONTACT:

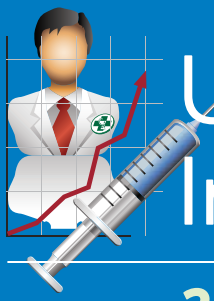
Ms. Jessie D'Souza,
Client Services Representative
416-962-4861 ext. 6231
jdsouza@ocpinfo.com

FOR INFORMATION REGARDING THE ELECTIONS PROCESS, CONTACT:

Ms. Ushma Rajdev,
Council and Executive Liaison
urajdev@ocpinfo.com

COMMITTEE	FREQUENCY OF MEETINGS
Accreditation	Approx. 6 times a year
Drug Preparation Premises (DPP)	DPP members sit on Accreditation – meetings are coordinated with Accreditation when possible or via conference call when required
Communications	Approx. 2-3 times a year
Discipline*	25 hearings a year, heard by panels of the Discipline committee (panels are appointed by the Chair from among individuals who are available to sit on dates set for hearings and pre-hearing conferences); plus 2 meetings of the full committee (orientation at the beginning of the term and one mid-year meeting)
Fitness to Practise	One orientation meeting at the beginning of the Council year (this committee held no hearings last year).
Inquiries, Complaints and Reports (ICRC)*	4 panel meetings a month; plus 2 meetings of the full committee; orientation at the beginning of the term and one mid-year meeting
Patient Relations	Approx. 2-3 times a year
Professional Practice	Approx. 2-3 times a year
Quality Assurance	Approx. 4 times a year
Registration*	Approx. 3-4 meetings a year; plus 4-6 panel meetings

** The Discipline, ICRC and Registration Committees all operate using panels comprised by alternating committee members.*



Universal Influenza Immunization Program

2014-2015 FLU SEASON RECAP

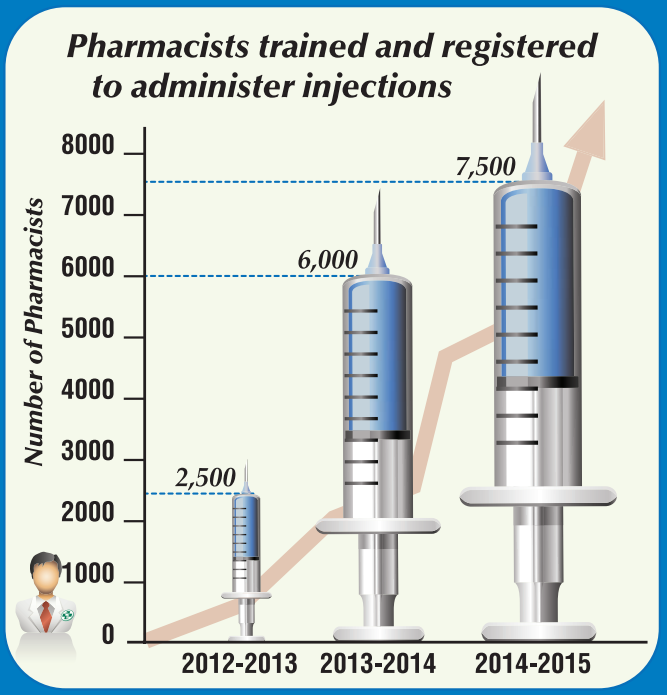
This year marked the third season that pharmacists were involved in the province's Universal Influenza Immunization Program (UIIP).

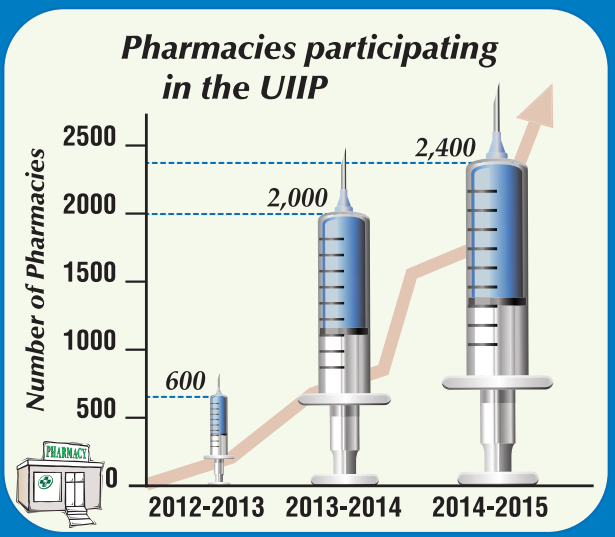
More than 900,000 Ontarians visited a community pharmacy and received their flu shot from a trained pharmacist during the 2014-2015 flu season.

(*As of March 31, 2015*)

As per the *Pharmacy Act*, pharmacists may only administer the influenza vaccine within the context of Ontario's UIIP. In order to participate in the UIIP pharmacists must complete an OCP-approved injection training course and register their training with the College.

Applications to participate in the 2015-2016 immunization program are due June 30, 2015. Information and application materials for next season's UIIP are available at www.ontario.ca/influenza.






CODE OF
ETHICS

WHAT'S ETHICS GOT TO DO WITH IT?

Part 1 of 4

Think back for a second – can you remember the moment you knew you were meant to be a healthcare professional? Can you recall when or how you knew you wanted to spend your life helping others? Was it a conscious decision or did you just *know* that it was what you were meant to do?

Being a healthcare professional isn't just a job – it's a vocation, a calling. The foundation of that calling is about putting another person's interests ahead of your own. At the most basic level, it's about putting patients first.

In his 2015 Action Plan for Healthcare, Ontario's Minister of Health and Long-Term Care, Dr. Eric Hoskins, communicated this point so effectively. He said, "Caring for people is what motivates everyone in the healthcare sector...The desire to improve people's lives is at the core of why we chose this vocation and it must be at the core of every decision we make..."

There are a unique set of obligations and expectations that come with being a healthcare professional. You must be conscientious and act with integrity at all times. You must do the right thing because it's the right thing to do, act with diligence and fidelity, work honourably, and keep the promises you make.

While this all seems simple, sometimes the simplest things are the hardest to understand and consistently commit to. So how do we make sure that healthcare professionals truly understand their commitment? How do we ensure that they put patients first?

The answer? We have a Code of Ethics.

WHAT IS A CODE OF ETHICS FOR?

A Code of Ethics can take many different forms, but its basic purpose is to outline the ethical principles and standards that healthcare professionals are guided by and held accountable to. It's the document that outlines your professional role and commitment.

The Code of Ethics helps bridge the gap between *what*, *how* and *why* healthcare professionals practice. The *what* and *how* are captured in legislation and Standards of Practice. The *why* — the professional role and commitment — is where the Code of Ethics comes in.

Codes help you to understand what it means to be a healthcare professional, and why you must meet these unique obligations and expectations — first and foremost, to put the best interest of your patients first.

WHAT IS MY PROFESSIONAL ROLE AND COMMITMENT?

As a healthcare professional, you must understand that your vocation is distinguished by a few criteria that are different than other jobs, and even other professions. Being a *healthcare* professional means you are part of a special group of people who are:

1. Experts with complex knowledge and training
2. Granted autonomy to regulate themselves
3. Accountable to society
4. Committed first and foremost to directly benefiting patients

While these first three points apply to many other professionals, the last one is what primarily distinguishes a healthcare professional from others. The patient must be first — this is also the key to the social contract.

WHAT IS THE SOCIAL CONTRACT?

All healthcare professions and professionals have entered into a social contract with society. By virtue of choosing to enter the profession, you agree to serve and protect the well-being and best interests of your patients, first and foremost. In return, society agrees to provide the profession with the autonomy to govern itself and the privileges and status afforded to regulated healthcare professionals.

The key to the social contract is about putting the patient's best interests ahead of all others — including your own, your business, or otherwise.

WHERE DID CODES OF ETHICS COME FROM?

Codes of Ethics have been around for centuries.

In the 5th century BC, the ancient Greek physician Hippocrates — whose oath laid the foundation for Codes of Ethics in healthcare — talked about "prescribing regimens for the good of my patients according to my ability and my judgment, and never do harm to anyone". This statement is still an integral piece of modern day Codes of Ethics.

In the 12th century, Jewish Philosopher Maimonides developed the concept further, focusing on the idea of serving others as a vocation. In addition to your commitment to do good and not harm others, he believed that being a healthcare professional was part of "who you are" – individuals dedicated to putting their patients interests ahead of their own.

Thomas Percival, an English physician, was the author of the first modern day Code in the late 1700s. The concepts in his Code were derived and tailored from Codes of the past and include many of the basic concepts from Hippocrates and Maimonides. It was Percival's Code that went on to form the first Code used by the American Medical Association and Canadian Medical Association in the mid 1800s.

Although Codes have continued to evolve since then, they are all founded on the same core ethical principles of healthcare.

WHAT ARE THE ETHICAL PRINCIPLES?

All healthcare professionals are bound by the same set of ethical principles – and they've been unchanged for centuries. The principles guide and inform every decision you, as a healthcare professional, make. They inform behaviour and conduct, and serve as a compass for your actions.

It's crucial to remember that as a healthcare professional, your own personal beliefs or values do not guide your professional decision making. Instead, the established ethical principles of healthcare must be your guide. Abiding by these principles is not optional and is not unique for pharmacists and pharmacy technicians. These principles apply to all healthcare professionals.

While there are more than just the following ethical principles, these four summarize your commitment to the social contract – ensuring that patients' interests are put first. It is essential for you to understand and embody these principles:

1. **Beneficence** – you use your knowledge, skills and abilities to actively 'benefit' the health and well-being of patients
2. **Non-maleficence** – you do your best to 'do no harm' and actively prevent harm from occurring, whenever possible
3. **Respect for persons** (autonomy) – you recognize and honour the inherent worth and dignity of all human beings, and respect patients' vulnerability and autonomy as self-governing decision-makers in their own healthcare
4. **Accountability** (fidelity) – you understand your responsibility as the custodian of public trust and always act in the best interest of your patients and society, not your own

WHY IS A CODE OF ETHICS IMPORTANT?

All healthcare professionals need to realize why a Code of Ethics is important. As a foundational document, a Code helps you understand the *why* of your practice. Codes explain the significance of the professional role and commitment that you made when you signed up to become a healthcare professional.

WHAT ELSE DOES A CODE DO?

Besides setting out the ethical principles and standards for healthcare professionals, a Code also:

- Serves as a resource for education, self-evaluation and peer review
- Provides a benchmark for monitoring and addressing the conduct of healthcare professionals
- Helps educate the public about the ethical obligations of the profession

WHY SHOULD I CARE ABOUT THIS NOW?

In September 2014, College Council established a task force to review and update the College's Code of Ethics. Council engaged the expertise of an ethicist and, after engaging with several stakeholder groups, the task force is currently working on drafting a new Code and supplementary documents for the profession.

It is anticipated that early this fall, the College will host a public consultation on our website that will provide an opportunity for all members, other stakeholders, and the public to provide comments on a draft version of the new Code.

More information will be available in coming issues of *Pharmacy Connection* and all members will eventually be required to participate in some learning and ethics education.

Stay tuned for more updates about the Code of Ethics project.

REVISED PROFESSIONAL MISCONDUCT REGULATION EXPECTED SOON

In order to ensure that the laws that govern the profession remain relevant to current practice and the expectations of society, changes to legislation are required from time-to-time. This process, however, can often take some time as it requires stakeholder feedback and consultation during the drafting process, committee and/or Council approvals, and ultimately acceptance and enactment into law by the Ontario government.

In 2013, the College initiated a revision of the *Professional Misconduct Regulation*, which outlines the profession's legal expectations regarding the professional behaviour of pharmacists and pharmacy technicians. The regulation required amendments to reflect practice changes, including the addition of a new class of registrants (pharmacy technicians), the expanded scope of practice for the profession, and clarification of the expectations for practitioners exercising their professional judgment in choosing to deliver services and/or referring patients to another healthcare professional.

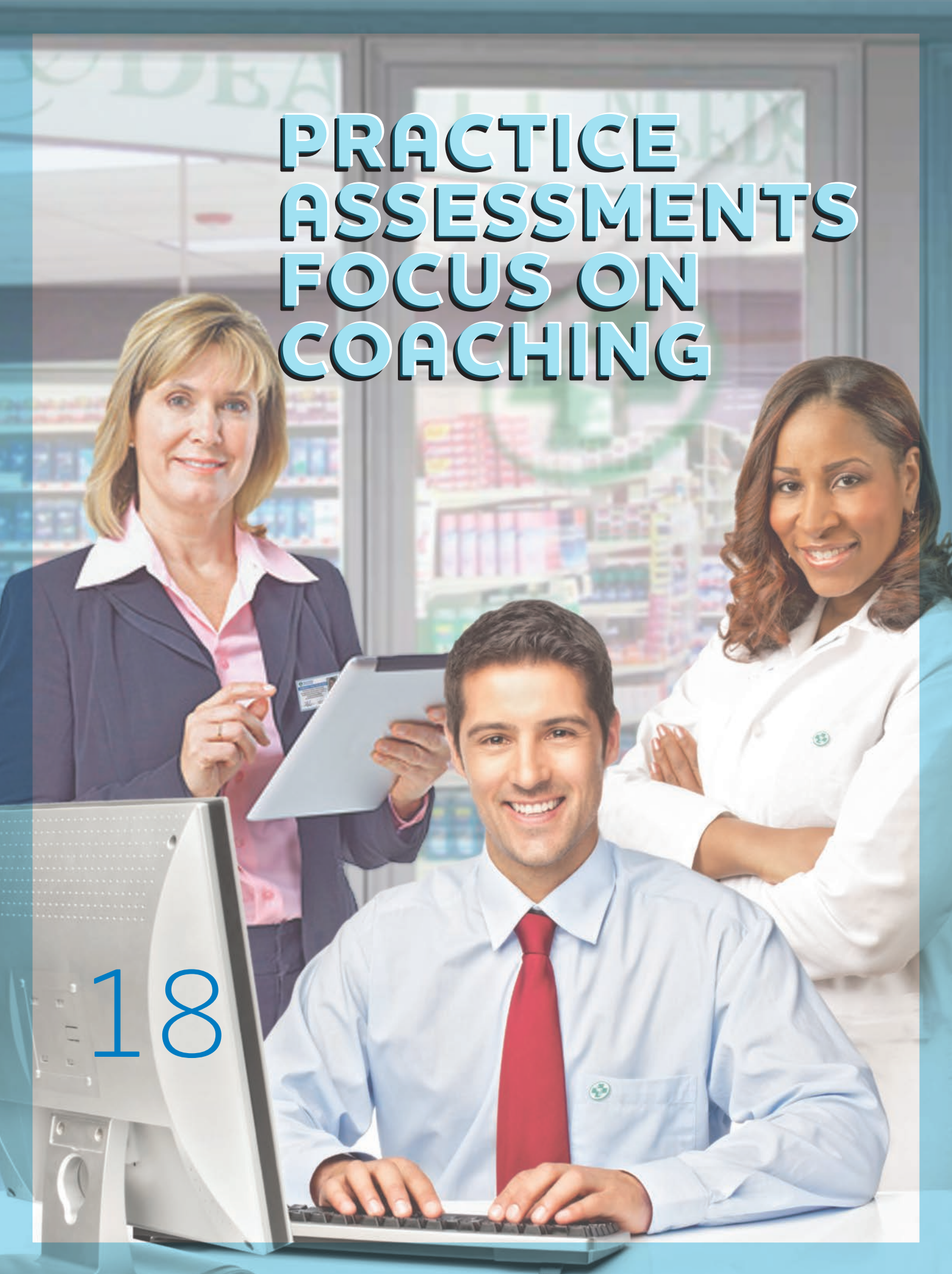
The proposed regulation aligns with those of other healthcare professions and with the College's *Proprietary Misconduct Regulation* under the *Drug and Pharmacies Regulation Act (DPRA)*, which outlines legal expectations regarding owning and operating a pharmacy. It also takes into account current College policies and guidelines and the *Model Standards of Practice for Canadian Pharmacists and Pharmacy Technicians*.

The draft regulation was circulated for public consultation in summer 2013 and following consideration of the feedback received, the draft regulation was approved by Council at their December meeting and submitted to the Ministry of Health and Long-Term Care early in 2014. Following ongoing discussions between the College and the Ministry — which resulted in only minor edits — a final draft of the regulation was approved by the Ministry earlier this year. The final step in the process – which is expected at any time – is for the regulation to be enacted into law by Cabinet.

The revised regulation applies to all pharmacists and pharmacy technicians regardless of practice setting and will provide a valuable tool to both practitioners and the College. In addition to giving practitioners further clarity regarding the expectations related to ethical practice and professional boundaries, the regulation also outlines specific activities that are precluded. Council, committees and staff will be provided with a valuable screening mechanism to support and guide decisions around professional misconduct.

Once the regulation is enacted by Cabinet, the regulation becomes law and is published on the Government of Ontario's e-Laws website. Practitioners will be advised of this final step via e-Connect, once it has occurred. Until then, the current *Professional Misconduct Regulation* remains in effect. Pc

PRACTICE ASSESSMENTS FOCUS ON COACHING



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New model helps practitioners appreciate reasons behind standards

By Stuart Foxman

All healthcare professionals work under Standards of Practice and a Code of Ethics (guidance on activities that benefit patients), as well as legislation around preventing harm. It's not enough to know the rules, says Samer Mikhail, RPh. He has a theory on what makes practitioners actually abide by them.

"If you understand and appreciate standards, and what could happen if they aren't there, then you'll follow them consistently," says Mikhail, who has practiced since 2002. "That will lead to a more professional practice, and more confidence in the pharmacist."

Mikhail, who owns Woolwich Total Health Pharmacy in Elmira, was reminded of that recently when he participated in the College's new practice assessment.

The practice assessments, which are now part of the full pharmacy assessment (formerly called inspections), are being piloted as part of the College's commitment to continuous quality improvement. Practice advisors, who are experienced pharmacists themselves, have always inspected pharmacies to assess operations and processes. The new practice assessments add an observation of a practitioner's performance in their practice site.

The practice advisors look at how practitioners handle four areas: patient assessment, decision making, documentation and communication. The advisor assesses these four areas by observing and discussing the processes for new and refill prescriptions, adaptations/renewals and medication reviews.

With an emphasis on educating, the goal of the practice assessments is to increase adherence to practice standards, help practitioners use their full scope, and ultimately support optimal health outcomes.

How have the pharmacists who've taken part reacted to the new model? Sometimes, they agree, the old process could seem daunting. Just the word "inspection" caused some apprehension, says Sandra Cox, RPh, who runs a Pharmasave in Huntsville with her pharmacist husband Troy.

In the past, she says, "We would get the letter informing us of an inspection and start checking off items that were current and ordering books that had lapsed in editions."

In contrast, the new focus on practice standards made the experience educational and very thought provoking. "It was a chance for self-reflection and positive reinforcement of everything we are doing well," says Cox, who has been practicing since 1990.

"It was a two-way conversation with another pharmacist/educator who had great ideas and insight into the reasons why we do things and how to improve on them."

BETTER AND MORE CONSISTENT PRACTICES EMERGE

The sessions centre around coaching and mentoring. The advisors probe the thinking behind certain practices and decisions through observation and conversations about previously filled prescriptions, and help the pharmacists to adopt best practices.

Cox mentions how the advisor reviewed her prescription files and documentation. It was an in-depth conversation about the thought processes, and the counselling that occurred (or could have) when filling prescriptions. This included proper dosing, drug interactions, late refills, and always explaining the reasons for documenting everything to ensure continuity of care.

Another topic discussed was prescription errors and documenting them. The advisor explained the importance of keeping medication incident files on even the tiniest mistakes, and created fictional scenarios to emphasize that need.

"Nothing was new and foreign, just a gentle reminder of why we need to always document, says Cox. "The entire experience was very positive and will translate to even better patient care."

Mark McNamara, RPh, concurs with Cox that when preparing for past inspections he would run through a checklist. He says it's easy to get into a day-to-day routine and not step back to think about why you're doing what you're doing.

"I like the spirit of this practice assessment," says McNamara, who has been a pharmacist for 10 years and runs a pharmacy in Guelph. "We're being asked to reflect on and talk through our processes. For instance, I had to show a medication review, and the advisor asked me about my rationale for the steps I took."

McNamara says he started to think more deeply about the intent behind the standards of practice for the profession, and view them from the patient's perspective. Following the rules "to a T" should be a given, he says. What's just as important is embracing why those rules exist.

"You have to think about what patients need and how you're a conduit in meeting those needs," McNamara says. "What's best for the patient, and what procedures do you have in place to ensure that they receive the best care?"

Mikhail appreciated the chance to delve into issues with his practice advisor – no discussions of mistakes and actions plans, just sound suggestions from a peer.

For example, the advisor asked Mikhail about his inventory of narcotics. He had an actual count, but was reminded of the importance of periodic reconciliation. Mikhail was eager to learn more, so he and the advisor went deeper. They talked over the whys and hows of creating a perpetual inventory on the computer. The advisor explained scenarios where misuse could occur, and how the reconciliations can catch it.

To Mikhail, those sorts of conversations were instructive. He says shortcuts can happen when people either aren't aware of a rule or fail to recognize its importance. The open and supportive tone of the assessments, he says, can "change the way you practice".

SHARING THE LESSONS

How will pharmacists try to preserve what they gained from their practice assessments and extend those lessons?

Cox says the session helped her to look at the big picture, and reinforce the need to do more – put better systems in place, do additional patient counselling, improve service, and contemplate how to better apply the standards in practice.

For instance, since the assessment Cox has become more alert to having proper documentation. When she advises patients on interactions or adjusting doses, she's likelier to write it all down. "That will lead to more continuity of care," says Cox.

It's not that she or the pharmacy were deficient, she says. But post-assessment she has talked with her

> "If you understand and appreciate standards, and what could happen if they aren't there, then you'll follow them consistently."
>
> Pharmacist, Samer Mikhail

> "It was a chance for self-reflection and positive reinforcement of everything we are doing well."
>
> Pharmacist, Sandra Cox

team about how she envisions the pharmacy evolving into an even more therapeutic role.

"Do we want to be a factory or be people who can educate and do patient care?" Cox poses. "I want to do more diabetes, nutrition and weight care management, and practice above the standards to provide the best care we can possibly give."

For his part, McNamara was made more aware of educational tools available via the College, like e-Learning modules and videos. He also briefed his pharmacists, technicians and pharmacy assistants on what he heard from the practice advisor. He'll follow up one-on-one with the four staff pharmacists. Drawing on the assessment, McNamara's message is clear: "Here's what we're doing well, and here's where we can do even better."

He says the assessment model is a critical foundation for enhancing practice. Traditionally, healthcare professionals are continually increasing their knowledge by learning more. "But there's not always a lot of self-reflecting, beyond the new educational learning, on how you can improve in your daily practice," McNamara says.

"Pharmacists become accustomed to doing the same things every day," he continues. "You get in the habit of just doing something a certain way. When you start understanding the 'why' of what you're doing, it takes hold and you can be more insightful. When you boil it all down, the reason we're here is to improve patient outcomes."

The College's new practice assessments are designed to support pharmacists and pharmacy technicians to do just that.

Find out more about the practice assessments at http://www.ocpinfo.com/about/key-initiatives/practice-assessments/.

To access the videos visit: http://cpd.pharmacy.utoronto.ca/opc.html . Pc

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>
> Pharmacist, Mark McNamara

TRANSPARENCY:

Reviewing our Commitment & Recent Initiatives

While transparency has been a core value of this College for many years, we've recently made a number of changes that increase transparency, boost public confidence and provide information that helps patients make more informed healthcare decisions.

Many of these changes came as a result of our work with the Advisory Group for Regulatory Excellence (AGRE), a working group of health regulators that is leading a province-wide project examining transparency. Representatives from medicine, nursing, dentistry, optometry, pharmacy and physiotherapy have been working together on a multi-staged initiative to examine information-sharing practices and determine what additional information regulators should share publicly. Changes we've made as a result of our work with AGRE, along with other initiatives, are reflected below.

ENHANCING INFORMATION FOUND IN "FIND A PHARMACY OR PHARMACIST"

A good number of the changes we've made are related to the type, clarity and depth of the information we share about the people and places we oversee. Specific information about pharmacists, pharmacy technicians and pharmacies is available on our public register — also known as "Find a Pharmacy or Pharmacist".

NEW INFORMATION ABOUT PEOPLE

Council recently passed several by-laws that allow us to share more information about people on "Find a Pharmacy or Pharmacist". With these changes, patients will be able to easily access information that will help them make more informed decisions about their healthcare.

Although we've always disclosed general information about a practitioner's training and registration history, practice location and discipline history, the new by-laws will allow us to share even more.

We will now disclose if a pharmacist, pharmacy technician, student or intern:

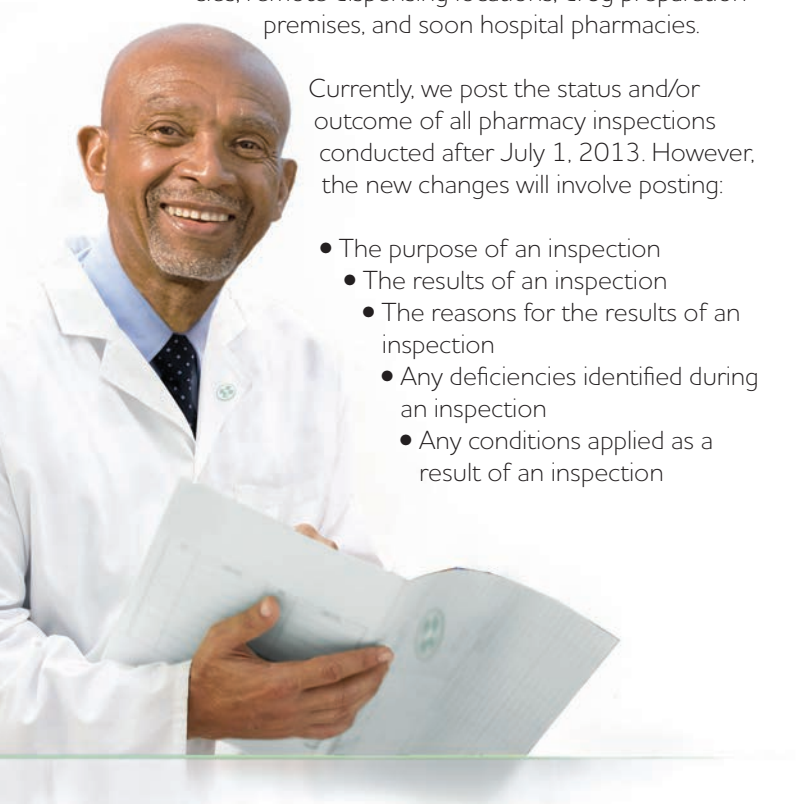
- Has criminal charges, criminal findings of guilt or bail conditions that are relevant to their suitability to practice, if known, after April 1, 2015
- Receives a "caution" or is directed to complete remedial learning (a SCERP) as a result of a complaint filed after April 1, 2015
- Previously had their license revoked and applies for re-instatement
- Has licenses to practice pharmacy in other jurisdictions
- Is currently under investigation by the College (in some circumstances)

We will also post a full "notice of hearing" for any discipline hearing regarding professional or proprietary misconduct. The notice includes the allegations, information about the hearing and other important details.

Many of these changes have already been implemented on "Find a Pharmacy or Pharmacist". For specific details about each of these by-law changes please visit: http://www.ocpinfo.com/about/key-initiatives/transparency/

NEW INFORMATION ABOUT PLACES

We are also in the process of making changes to the information we post about the places we oversee. These places include community pharmacies, remote dispensing locations, drug preparation premises, and soon hospital pharmacies.



Currently, we post the status and/or outcome of all pharmacy inspections conducted after July 1, 2013. However, the new changes will involve posting:

- The purpose of an inspection
- The results of an inspection
- The reasons for the results of an inspection
- Any deficiencies identified during an inspection
- Any conditions applied as a result of an inspection

CHANGES TO INCREASE SIMPLICITY AND CLARITY

In addition to posting more information about the people and places we oversee, we will also be making changes to the design and navigation of "Find a Pharmacy or Pharmacist". We believe that transparency is not just about making additional information public, it's also about making the information we do share clear, accessible and easy to understand.

At the core of the re-design will be revisions to better assist the public with completing basic tasks – such as improvements to how easily they access information about the pharmacies in their neighbourhood, or the practitioners that work there.

Stay tuned for more information about the "Find a Pharmacy or Pharmacist" re-design project.

ENHANCING INFORMATION FOUND ON WWW.OCPINFO.COM

In 2012 we undertook a comprehensive website re-design project to completely revamp and update our most public-facing communications vehicle. The re-design project was rooted in the College's core values – but most notably in transparency. The purpose of the re-design was to enable visitors to quickly access and understand the information they want in a clear, concise and transparent manner.

Although all content currently available on the website is accessible by anyone, the re-design created a tailored experience for each of the identified user groups: the general public, applicants and members. Each group has their own homepage that provides the information our research results identified as the most important for them.

Since the launch of the new website in January 2014, we have added a few new features that continue to enhance transparency. Most notably, we created an online consultations system. This feature works alongside our process of asking for feedback as we develop regulations, by-laws, policies or guidelines (or other). We generally ask for feedback from the public, other organizations, practitioners and anyone else who might be interested. With this new feature we are now able to post all of the feedback we receive to ensure transparency and encourage open dialogue.

Moving forward we will continue to evaluate the website, conduct research and enhance our content and navigation to keep pace with the evolving needs of users, especially the public.

NEXT STEPS

Transparency is not something to be achieved but rather a foundational value that must be consciously considered and diligently applied to all of the work that we do. At the strategic planning session in March 2015, Council once again solidified transparency as a core value and identified it as a key priority in the 2015 to 2018 Strategic Plan, and beyond.

We are committed to continuously and collaboratively working to identify and implement measures to enhance transparency, and ensure the public has access to the information needed to make informed choices about their healthcare. Pc

New Online Learning Modules Help Pharmacists Practise to Their Full Scope

Shortly after the Ontario government announced new regulations expanding the scope of practice for pharmacy, the College and the Leslie Dan Faculty of Pharmacy at the University of Toronto established a program to support pharmacists practicing to their new scope. The program, now in its third year, is part of a five year research initiative by the university and is supported and funded by OCP.

The program – called Optimizing Patient Care – started with a variety of research initiatives, designed to identify barriers to pharmacists embracing their new expanded scope responsibilities. Some of the research findings were addressed during the OCP district meeting last year.

The research suggested a need to enhance the resources available to pharmacy professionals to help them address key knowledge gaps. As a result, the university began developing new learning modules, which cover topics such as documentation and clinical decision-making.

Dr. Jamie Kellar, a Pharmacy Clinician Educator with the Leslie Dan Faculty of Pharmacy and the Centre for Addiction and Mental Health, is the education lead for this program and is heading the development and implementation of the learning modules.

The first three modules are now published, with six more in the production or planning stages. Dr. Kellar notes that they will be instrumental in helping pharmacists and pharmacy technicians break through key barriers they're facing or may encounter, optimize the care they provide to patients, and practise to their full scope. The videos will also give practitioners practical tips and ideas on how to rethink and reflect on their own practice.

With the profession of pharmacy changing and pharmacists assuming greater responsibility, practitioners need to adapt to these changes accordingly.

Dr. Zubin Austin, the research lead for this program and the Murray B. Koffler Chair in Pharmacy Management at the Leslie Dan Faculty of Pharmacy, has studied and written about this topic extensively. In particular, the role pharmacists play, how they see themselves, barriers to practice change, and important personality traits needed for today's pharmacist to excel in their profession.

In the Summer 2014 issue of *Pharmacy Connection*, Dr. Austin discussed key obstacles that may be preventing pharmacists from practising to their full scope and suggested that an understanding of personality traits and thought processes are essential. Through interviews with pharmacists, Dr. Austin and his team discovered common themes holding practitioners back from developing greater responsibility and confidence.

Dr. Austin and Dr. Keller worked closely together to ensure the educational videos produced as part of this program address many of the barriers Dr. Austin discovered during his research.

"Through a combination of online surveys, focus groups and interviews, the perspectives and experiences of pharmacists were used as a foundation for understanding learning needs and designing educational modules to address these needs in an effective and enjoyable way," said Dr. Austin.

The videos are about 15-20 minutes each, and are informative and interesting – not just because they're filled with valuable and highly relevant

insights – but because they portray real life scenarios or "What would you do?" cases and the steps a practitioner could take to address them.

Practising pharmacists are featured in the modules, providing the introduction and conclusion, key learning lessons and takeaways, and acting out simulated, real-life practice scenarios. Professional actors from the University of Toronto's Standardized Patient Program play the role of the patients. These actors are highly trained in accurately depicting the personal history, physical symptoms, emotions, and everyday concerns of an actual patient.

The first video, *A Difference of Opinion – Managing Issues Due to Expanded Scope*, focuses on how pharmacists can confidently make clinical decisions. The video examines how and why a difference in clinical opinion is not an error, navigating the "grey" of the pharmacy world, how to make clinical choices that are in the best interest of the patient, and the development of strategies to reduce the risk of errors when providing expanded services.

The second video, *Clinical Decision Making*, starts with an overview of Clinical Decision Making in Pharmacy Practice, and then transitions into the factors that impact clinical decision making, the responsibilities involved in direct patient care, key steps in the patient care process, and more.

The final video being released at the end of May, *Documentation in the World of Expanded Scope*, gives pharmacists insights into effective documentation in daily practice, why it's crucial to document decision making, including rationale, and how to properly use strategies to routinely integrate documentation.

The next three videos are expected to be available in September 2015 and the remaining three in January 2016. They will cover topics such as managing workflow, successfully dealing with physicians, handling relationships with patients, communications, and patient assessment.

The modules are available to all practitioners and can be accessed through the Continuing Education section of the College's website. Each video is accompanied with a short description and useful resources.

The videos will be leveraged in a variety of other ways, too. OCP's practice advisors may recommend certain modules to pharmacists identified during practice assessment who could benefit from the learning material. The modules will also be referenced in publications, guides, and other materials produced by the university and OCP.

Since ongoing professional development is crucial to maintaining competence, the videos are particularly important with assisting pharmacy professionals in navigating the changing landscape in pharmacy practice today.

The program is very much in-line with OCP's vision to "Lead the advancement of pharmacy to optimize health and wellness through patient-centered care."

The videos promote continued competency among pharmacists and pharmacy technicians and help practitioners better utilize their knowledge, skills and abilities, ultimately benefiting their patients and their working relationships with other members of the healthcare team. They also provide pharmacy professionals with the tools needed to flourish in their role (including the mindset they need to adopt) and practise to the standards of the day.

Both the university and OCP are confident that this program will be tremendously valuable to practitioners for many years to come, helping make a bigger impact in the care they deliver to patients. Pc

cancer care ontario | action cancer ontario

Supporting Continuity of Care for Cancer Patients

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INTRODUCTION

John is a 69-year-old male patient who regularly comes to your community pharmacy to fill his prescriptions and to seek advice on self-management issues. Today he presents with a prescription for two new medications:

Apart from this information, the prescription contains no further information. The patient's profile reveals a non-significant medical and medication history. John tells you that he was recently diagnosed with colon cancer but remembers little else, including how to take these medications.

This likely represents the scenario that the pharmacy team working in the community may typically witness when patients present with prescriptions for oral chemotherapy agents. As patients now receive cancer care beyond the cancer centre or hospital, including in the community, the role of community pharmacy will grow as oral chemotherapy becomes an increasingly important part of care.

This article will describe a number of initiatives led by Cancer Care Ontario (CCO) to support this transition between hospital and community, relevant guidelines and safety initiatives now underway, and how you can become involved to improve the care of cancer patients in Ontario.

BACKGROUND

The incidence of cancer continues to rise as the population ages, with 45 percent of men and 41 percent of women expected to have a cancer diagnosis in their lifetimes.[1] Once diagnosed, many patients will proceed to have chemotherapy as part of their treatment plan. Oral chemotherapy is now commonly used as part of cancer treatment and can be used as monotherapy

(e.g., imatinib) or in combination with intravenous chemotherapy (e.g., capecitabine). It is estimated that 44 per cent of new therapies under development are oral cancer medications. [2]

Patients who receive oral chemotherapy as part of their treatment face new challenges as the responsibilities associated with dispensing, administration and patient education shift, in part, from the cancer hospital to the community and home. In order to ensure a seamless transition for patients from the cancer clinic to community and back to clinic, collaboration is essential between cancer specialists and community partners. The primary goals are to prevent unnecessary visits to the emergency departments and to prevent hospitalization due to toxicities from treatment.

INFORMATION FOR PATIENTS AND PRACTITIONERS

Oncology is a highly specialized area of practice using drugs that have a narrow therapeutic index. Ensuring that the right drug is given at the right dose, frequency, and interval is critical to minimize side effects and maximize therapeutic outcomes. Unfortunately, the information required is not always readily available to the community pharmacist, as illustrated in the example above.

A number of provincial initiatives are underway to ensure that the prescriptions leaving the cancer clinics contain the necessary information to enable community pharmacists to perform clinical verification and provide appropriate counselling to patients.

1. **Prescriptions for cytotoxic drugs will be computer-generated**
   Cancer Care Ontario (CCO) has set a provincial goal that by June 30, 2015, there will be no handwritten or verbal orders for oral chemotherapy. This will ensure the legibility and accuracy of the prescription. Currently over 90 percent of hospital visits for intravenous chemotherapy are supported by computerized physician order entry (CPOE) systems.

2. **Defining the recommended components of a prescription**
   A list of recommended components that should appear on a prescription was developed with the aim of standardizing the information on an oral chemotherapy prescription. Additional information such as diagnosis/indication, weight, body surface area, dosage modification factors and reasons will help the community pharmacist perform the cognitive verification and provide appropriate counselling. CCO is working to ensure that prescriptions generated by its own CPOE system, (Oncology Patient Information System or OPIS), will contain these recommended components and also work with facilities using other CPOE systems to identify similar opportunities. A list of the recommended components is available at the CCO Drug Formulary website (www.cancercare.on.ca/drugformulary).

3. **Pre-printed physician orders where CPOE is not in place**
   Pre-printed physician orders (PPO) have been developed for all evidence-informed regimens that contain oral chemotherapy (approximately 150 PPOs). These include cytotoxic, targeted and hormonal therapies. The PPOs are available at the CCO Drug Formulary website above.

4. **Clinical checklist**
   Based on the checklist models used in surgery, emergency medicine and the aviation industry, work is currently underway to develop a clinical checklist to assist with the cognitive verification of a chemotherapy prescription. An opportunity exists to participate as a pilot site to evaluate the checklists prior to provincial roll-out.

In addition to having the necessary information on a prescription, pharmacists may require additional information about the drug(s) and regimen in order to perform the cognitive verification and to provide counselling to patients. The CCO Drug Formulary is available online and also as a mobile app (www.cancercare.on.ca/applibrary). Professional and patient information about indications, dosing schedules, management of adverse effects and more is provided through the app. Symptom management guides can also be found on the CCO website www.cancercare.on.ca/toolbox/symptools/ or on the app.

> As patients now receive cancer care beyond the cancer centre or hospital, including in the community, the role of community pharmacy will grow as oral chemotherapy becomes an increasingly important part of care.

SAFE HANDLING OF CYTOTOXIC DRUGS

Once a prescription has been verified for clinical appropriateness, it must then be dispensed with accuracy and in a manner that is safe for both providers and patients/caregivers. In the example above, capecitabine must first be recognized as an antineoplastic agent by the pharmacy technician/assistant to ensure proper handling to minimize exposure in the immediate setting to the technician/assistant and pharmacist and further down the road, to other patients through potential cross-contamination. Challenges exist where policies and procedures are not in place to identify chemotherapy drugs and their proper handling requirements.

A number of guidelines are available related to the safe handling of chemotherapy agents. CCO released a set of recommendations in December 2013, *A Quality Initiative of the Program in Evidence-Based Care, Cancer Care Ontario: Safe Handling of Cytotoxics*[3,4], (https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=293473). Although the document focuses on intravenous chemotherapy in the hospital setting, there are helpful recommendations pertaining to oral agents. Key recommendations include:

- Identifying a responsible party to develop and review policy and procedures
- Providing initial and ongoing training to staff around the safe handling of cytotoxic drugs
- Maintaining a list of cytotoxic drugs. Each drug and their waste should be properly identified on the container with the symbol capital "C" and under it, the words "CYTOTOXIC/CYTOTOXIQUE"
- Using gloves that meet standards defined in the document, to handle cytotoxic drugs
  - o 1 pair for the handling of solid oral dosage forms
  - o 2 pairs for handling/preparing creams, ointments and oral solutions
- Using safe handling and administration techniques and providing this information to patients/caregivers to minimize possible exposure to individuals and the environment when administering cytotoxic drugs in the home
- Providing education to patients and caregivers on the proper disposal of cytotoxic drugs
  - o Dispose of all cytotoxic waste in cytotoxic waste receptacle
  - o Use appropriate personal protective equipment to handle bodily-fluid waste
- Ensuring proper handling of biological fluids, excreta, contaminated bedding and soiled equipment of patients who have received cytotoxic drugs

Other resources that may be useful to community pharmacists include the Canadian Association of Pharmacy in Oncology's Standards of Practice for Oncology Pharmacy[5], Australia's SHPA Standards of Practice for the Provision of Oral Chemotherapy for the Treatment of Cancer[6] and the Quebec's Prevention Guide: Safe Handling of Hazardous Drugs[7].

Guidelines published by CCO and the Program in Evidence-Based Care, including safe administration, CPOE best practices and safe labelling, can be found at https://www.cancercare.on.ca/toolbox/qualityguidelines/clin-program/systemic-ebs/.

CONTINUING PROFESSIONAL DEVELOPMENT

Canadian pharmacists have reported a discomfort with the cognitive services associated with the dispensing of chemotherapy drugs. This is in part due to the lack of information available regarding the patient and disease but a significant factor is the lack of undergraduate and continuing education pertaining to oncology practice. Abbott et. al.[8] conducted a survey to assess oncology knowledge of community pharmacists across Canada. They found that only 13.6 percent of pharmacists felt that undergraduate oncology training was adequate, 19 percent attended an oncology continuing education (CE) session in the past two years, 24 percent were familiar with common doses, and 9 percent were comfortable counselling cancer patients. A positive correlation was noted between the number of CE

sessions attended and comfort in dispensing chemotherapy. This study highlights the increasing need for community pharmacists to receive additional training in oncology practice.

Through a collaborative effort with the Ontario Pharmacists Association (OPA), an online educational program for community pharmacists with a specific focus on oral chemotherapy, "Principles of Oncology Treatments and Pharmaceutical Care" was developed to support pharmacists in this important area of clinical care. The program is currently being reviewed for accreditation. Please contact OPA if you are interested in taking this course.

PAVING THE ROAD FOR THE NEXT FIVE YEARS

High-quality care for cancer patients, whether provided in hospital or in the community, requires planning. In December 2014, CCO released the Quality Person-Centred Systemic Treatment in Ontario: Systemic Treatment Provincial Plan 2014 – 2019[9] (http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=325326). The plan sets out a roadmap for the delivery of systemic treatment across the province for the next five years and aligns with the Ontario Cancer Plan[10] (http://ocp.cancercare.on.ca/). The plan details nine strategic priorities including Oral Chemotherapy, Toxicity Management and Community Pharmacy. Recommendations within those priorities include:

- By 2019, patients will receive oral chemotherapy medications that have been reviewed for clinical appropriateness and dispensing accuracy by registered pharmacists
- By 2019, patients will be able to access high-quality and standardized care when filling prescriptions at cancer centre and community pharmacies
- By 2019, patients will receive coordinated care between a cancer clinic and their partnering community pharmacy

Returning to John in the example above, a patient-centred approach would result in the patient receiving standardized, high-quality care starting with a prescription that was not handwritten and that contained the necessary information for the community pharmacist to perform the cognitive verification and provide patient education that complemented and reinforced the information provided by the cancer centre. There would be clear communication on the safe handling and disposal of the chemotherapy agents for both providers and patients/caregivers. Finally, the patient's care would be coordinated and supported by good communication between the cancer clinic and his partnering community pharmacy.

To achieve these goals it is critical that community pharmacists and pharmacy technicians/assistants are involved. If you would like to learn more about provincial and local initiatives, be heard and contribute in any way please contact Kathy Vu (kathy.vu@cancercare.on.ca). Pc

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Medication Incidents Associated with Hospital Discharge:

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

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INTRODUCTION

Case Example: The patient was hospitalized for 2 weeks. Nitro-dur® was not included on the discharge order brought to the community pharmacy. Patient's wife inquired the next day and upon calling the hospital, it was realized that Nitro-dur® was missed. Patient had suffered angina since coming home from the hospital.

Transitional Care is defined by The American Geriatric Society (AGS) as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location".[1] The World Health Organization recognizes medication incidents at transition of care to be a major concern for patient safety globally.[2]

This multi-incident analysis focuses on the transition of hospitalized patients back to their home following discharge. Patients are especially vulnerable to medication incidents during this time due to a shift from an institutional system back into the community and a potential discontinuity of care. Up to 23% of hospital discharged patients experience at least one adverse event; with 72% being adverse drug events.[3] In addition, patients with one or more medication discrepancy have a higher rate of rehospitalization than patients without.[4] Therefore, adverse medication events, hospital readmission, and death can be a result of suboptimal discharge.[3]

Medication incidents from community pharmacies can offer insights into what happens on the receiving end of hospital discharge and the impact on patient safety when something goes wrong. The purpose of this analysis is to examine these incidents to identify vulnerabilities and areas of improvement associated with the discharge process.

METHODS

The Community Pharmacy Incident Reporting (CPhIR) Program (available at http://www.cphir.ca) is designed for community pharmacies to report near misses or medication incidents anonymously to ISMP Canada for further analysis and dissemination of shared learning from incidents.[5] CPhIR has allowed the collection of invaluable information to help identify system-based vulnerable areas in community pharmacy practice in order to prevent medication incidents.[5]

A qualitative, multi-incident analysis[6,7] was conducted using anonymous reports submitted to the Institute for Safe Medication Practices Canada (ISMP Canada) Community Pharmacy Incident Reporting (CPhIR) Program. Medication incidents involving the keywords "Discharge", "Hospital", "Release", "Transfer", "fax"or incidents from hospital prescriptions were extracted from the CPhIR Program from April 2010 to December 2014. Incidents with insufficient narrative information or unrelated to the pre-defined hospital discharge context were excluded. A total of 221 incidents were extracted with 83 incidents included in the analysis. Two independent analysts reviewed the medication incidents to determine the themes and trends.

RESULTS:

TABLE 1 – Theme 1 – Error on the Discharge Prescription – Incidents in which there was an error occurring when the discharge prescription was being prepared in the hospital.

SUBTHEMES	INCIDENT EXAMPLES	COMMENTARY
Medication Inappropriately Ordered	Patient was prescribed Fragmin® (Dalteparin), from a hospital hematology clinic, to temporarily replace warfarin for a procedure. Patient has pork allergy, which is a contraindication for Fragmin®. The hospital was aware of the allergy but the community pharmacy does not have the allergy information on file. It was the patient who noticed this while reading the Kroll monograph. The community pharmacy then contacted the prescriber who decided not to use Fragmin® as patient is low risk for bleeds.	Community pharmacists may not have access to the patient's chart (with patient allergy information, in this case) in the hospital and potential errors may not be identified. This example emphasizes the importance of medication reconciliation at discharge (or transition of care). Allergy information should be included on discharge prescriptions and discharge plan, if possible.
Medication Omitted	The community pharmacist was counselling a patient discharged from the hospital. Patient inquired about INR paperwork and thought he was supposed to be on warfarin, which was not included in the discharge prescription. Hospital was contacted and warfarin 5 mg was supposed to be started at night and then adjusted depending on INR results.	Home and hospital medications may be omitted during discharge. Medication reconciliation at admission and discharge should be implemented to gather a complete home medication list. This incident also highlights the importance of patient education at discharge and patients as an important source of information.
Dosing Error	Patient's parent presented with a pre-printed (fill-in-the-blanks) asthma discharge form. Prescription was written for "Flovent® 125 [mcg] II [puffs] bid". Pharmacist questioned the dose as it seemed high for the patient's age. The physician was contacted. Physician thought patient had been on "Flovent® 100 [mcg] II [puffs] bid". When physician was informed the previous dose was "Flovent® 50 [mcg] II [puffs] bid", she reordered that strength as she had not intended to change therapy.	Medication reconciliation during hospital discharge can rectify common dosing errors which may arise due to incomplete or erroneous pre-admission medication list.
Wrong Patient	Patient's daughter-in-law dropped off a discharge prescription with no name. The prescription was for Tecta® (which patient was on) and Plavix® (a new medication). The nurse also explained that patient had some clotting problems so the daughter-in-law and the community pharmacist did not question the prescription. Three weeks later, the patient experienced mild bleeding and it was discovered when he arrived for dialysis that the prescription was given to the wrong patient.	In the community, primary care prescribers often write prescriptions while the patient is present in the clinic or the prescriber's office. Discharge prescriptions are generally printed using the patient's chart or electronic profile rather than having the patient physically present (or next to the prescriber), hence a potential omission of identity verification. Confirmation bias may play a role in this type of incident. Recognizing this vulnerability, community pharmacists should be vigilant and verify patients' identity for hospital discharges (and any other new prescriptions if in doubt). For example, confirm the patient's name, address, and date of birth when receiving the prescription at the prescription drop-off counter. This can serve as an independent double check. This incident also illustrates the importance of

SUBTHEMES	INCIDENT EXAMPLES	COMMENTARY
		medication reconciliation at discharge where medications that the patient has been taking prior to admission, those initiated during the patient's hospital stay, and medications that patient should be taking upon discharge are all being reviewed, reconciled and resolved (if there are discrepancies), and well explained to the patient (or the patient caregiver).[9]
Wrong Duration of Therapy	The discharge prescription has 30-day supply with five refills for all medications. The community pharmacist double-checked with the hospital cardiologist, clopidogrel should have been prescribed for 16 days.	Less emphasis may be placed on quantity and refills for hospital orders, as prescribers may be used to adjusting the medication order during daily rounds. Medication reconciliation during hospital discharge can serve as an independent double check to avoid these errors.

TABLE 2 – Theme 2 – Communication Issues – Incidents in which the discharge prescriptions were correct but due to miscommunication, errors occurred.

SUBTHEMES	INCIDENT EXAMPLES	COMMENTARY
Illegible Fax/ Prescription	Lipitor® 10 mg was dispensed instead of 40 mg. Discharge prescription was faxed to the community pharmacy but a thin white line cut off the part of the "4" making it look like a "1". Lipitor® was a new medication for the patient hence the dose was not questioned.	The process of faxing prescriptions to community pharmacies runs the risk of the fax being lost in transmission or appearing illegible on the receiving end . What can be done at the hospital end? If using a fax machine, ensure that only original prescriptions are transmitted; do not transmit NCR (i.e., no-carbon-required) copies of prescriptions. [8] What can be done at the community pharmacy end? Educate all pharmacy staff members about potential errors that can occur with faxes, and how to identify such errors. Schedule regular maintenance and cleaning of fax machines to ensure optimal transmission of medication-related information. [8] It is important to engage and educate patients throughout the medication-use process, and in this case, during hospital discharge e.g. providing patients with a list of their medications, including dose, frequency, and other information. Patients can help identify any medication discrepancies and prevent potential errors that may occur at transition of care. [8]
Complex Medication Order	The discharge prescription contained an order for Coversyl® 4mg once daily and another order for Coversyl® 2mg once daily on the next line. Patient was told to take the lower dose if the blood pressure remains low. This was a near-miss event where both Coversyl® strengths were filled and the patient asked the community pharmacist if both strengths should be taken.	For inpatients, all medications are administered by nurses who understand the required clinical conditions (for administration) on the prescription. During discharge, prescribers should simplify medication orders and avoid discharging patients on the same drug with multiple strengths, when possible, as patients may be confused as to when to use which strength of the drug.

TABLE 3 – Theme 3 – Community Integration – The discontinuities between the hospital systems and community practices create vulnerabilities leading to medication errors.

SUBTHEMES	INCIDENT EXAMPLES	COMMENTARY
Different Preparations Used in Hospitals	Patient was taught, in hospital, how to inject a syringe using the multi-dose Fragmin®. The pre-filled syringe Fragmin® was dispensed in the community pharmacy and the patient told the pharmacist the training was done in the hospital. When the patient had to give the dose the next day, several doses were damaged before the pharmacy was contacted for help. Mother of baby came to the community pharmacy to get a measure to give 1 mL for Vitamin D drops. The mother had already given the child 1 mL by removing the stopper on the bottle. The correct dosage for the selected product was supposed to be 1 drop only. The hospital discharge prescription says give 1 ml as the hospital used a different concentration to give 400 units. The hospital pharmacy did counsel the mother that the concentration may be different at the community pharmacy.	Multiple preparations of the same medication may be present in the market. Depending on the hospital formulary, the preparation used may not be the same as what is available in the community pharmacy. Patients may assume that there is only one preparation for the medication they are given. This type of incident emphasizes the importance of patient education.
Duplication in Medication Therapy	The discharge prescription was faxed to the pharmacy but the [patient] brought in another hard copy which was entered into the computer again.	During hospital discharges, prescriptions may be faxed to the pharmacy and the patient might be given the original in case the fax did not go through. To prevent duplication of therapy, indicate on the original prescription which pharmacy it was faxed to, once it has been sent, before giving a copy to the patient.
Multi-medication Compliance Aids	Amlodipine was prescribed as a new medication upon hospital discharge. Patient normally gets medications in a blister pack [or multi-medication compliance aids] but amlodipine was given in a vial to "catch-up" to the blister pack schedule. Hence, it was not flagged as part of the blister pack and amlodipine was not included when the packs were prepared.	Interruptions in blister pack schedules and changes to the patient's medications during hospital stay require community pharmacies to either make another blister pack or give the new medication in a vial until the next blister-pack cycle.

MEDICATION RECONCILIATION

The above incident examples highlighted some of the vulnerabilities that are associated with the hospital discharge process. Many of the incidents are results of miscommunication or prescription errors. Medication reconciliation plays an important role in mitigating these errors with pharmacists being an indispensable member in the process.

Medication reconciliation "is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care".[9] It involves gathering all the information (for example, what has been added, changed, or discontinued) about a patient's medications to enable appropriate prescribing decisions.

According to the 2014 Canadian Health Accreditation Report, the national compliance rate for medication reconciliation at transfer or discharge was at 61%, an increase from 50% in 2011.[10] Therefore, this represents an area of patient safety which deserves more focus.

Figure 1 outlines the optimal patient transition through

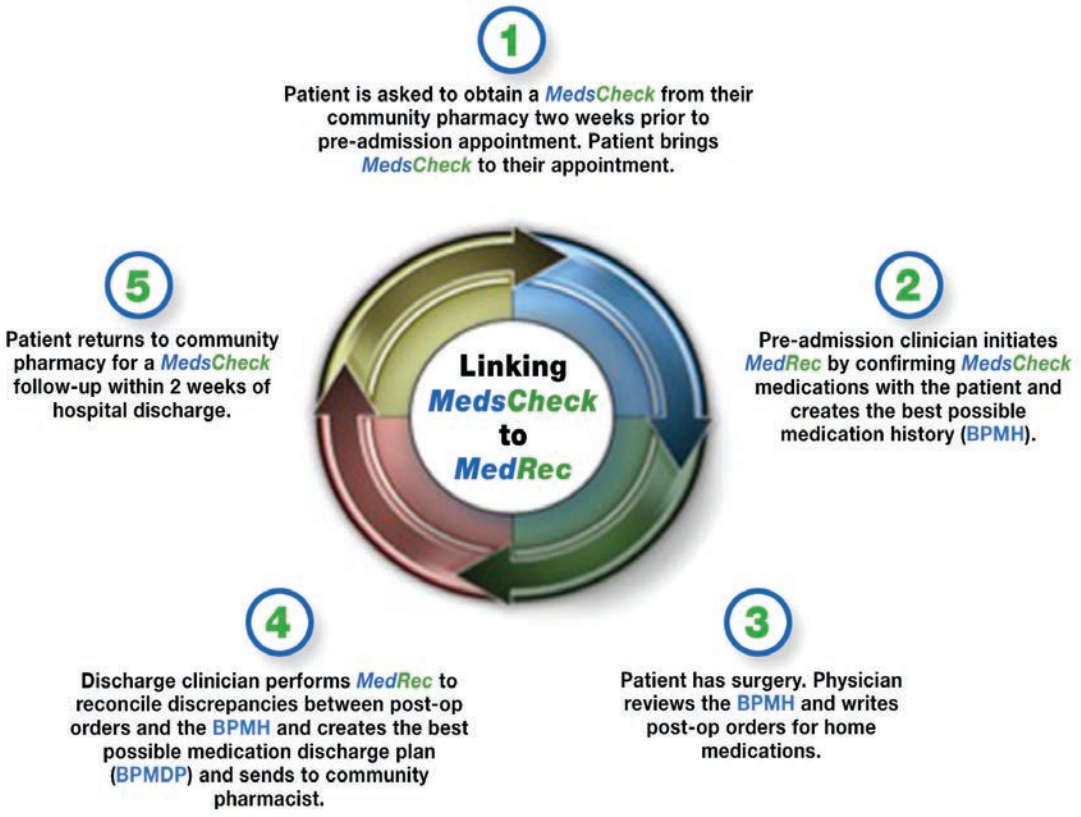
hospital admission to discharge. MedsCheck[11] is a medication review program available in Ontario but the idea is similar to other medication review programs across Canada. Before admission, community pharmacies should conduct a medication review with the patient using the Best Possible Medication History (or BPMH)[12] process and have the patient bring the BPMH into the hospital. Upon admission, medication reconciliation should be completed using the BPMH process again. During discharge, clinicians should reconcile discrepancies between hospital orders and the patient's BPMH to create a Best Possible Medication Discharge Plan.[12] Within two weeks of discharge (i.e. when the patient returns to the community pharmacy) a follow-up medication review (e.g. MedsCheck Follow-Up in Ontario)[11], again using the BPMH process, should be completed.

This ensures continuity of care and allows the opportunity for identification and resolution of medication discrepancies due to communication issues.

OTHER POSSIBLE INTERVENTIONS

1. Inform patient of changes to their medications and what to expect upon discharge. Patients should be counselled that medications used in the hospital may have different formulations in the community and always check with the pharmacist before using the same directions as in hospital.[14-15]
2. Inform primary health care professionals about the discharge plan – clear understanding of the reason for admission, changes made in hospital and discharge plan can eliminate errors from communication issues.[1,14-15]
3. Indicate on the original discharge prescription which community pharmacy it was faxed to once it has been sent before giving a copy to the patient to prevent duplication of therapy.
4. Develop a hospital helpline for patients and other primary health care providers. Inability to contact hospital prescribers was noted as a problem in some of the incidents. Bi-directional communication between health care professionals can encourage collaboration and improve the transition of care for patients.[1,14]
5. Prepare (or re-pack, if possible) blister packs or multi-medication compliance aids to incorporate changes of medication therapy rather than giving the new medications to patients in a separate vial until the next scheduled cycle.
6. Conduct independent double checks whenever possible in the pharmacy workflow.[13]

FIGURE 1: The process of coordinating MedsCheck and medication reconciliation to ensure continuity of care during a patient's transition through hospital stay.[9] (ISMP Canada)



7. Provide follow-up and monitoring support by the community pharmacy to enhance patient adherence and therapeutic effectiveness.[15]

LIMITATIONS:

The results of this analysis were limited to the voluntary nature of medication incident reporting and what was actually inputted by the reporter to the Incident Description field of the CPhIR database. As well, follow-up with reporters of the medication incidents was not possible due to the nature of the database.

CONCLUSION

This qualitative, multi-incident analysis highlighted the importance of learning from medication incidents. It provided valuable insight into vulnerabilities and areas of improvement in the hospital discharge process. It also presented opportunities where community pharmacists can have an impact on the continuity of care for hospital discharge patients through the MedsCheck program in Ontario.

SUGGESTED RESOURCES:

- Ontario Ministry of Health and Long-Term Care: MedsCheck Program: http://www.Medscheck.ca
- Health Quality Ontario's Quality Compass: http://qualitycompass.hqontario.ca/portal/transitions/Transitions
- Medication Reconciliation (ISMP Canada): https://www.ismp-canada.org/medrec/
- Safer Health Care Now!: http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/default.aspx

ACKNOWLEDGEMENT

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ISMP Canada would like to acknowledge support from the Ontario Ministry of Health and Long-Term Care for the development of the Community Pharmacy Incident Reporting (CPhIR) Program (http://www.cphir.ca). The CPhIR Program also contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (http://www.ismpcanada.org/cmirps.htm). A goal of CMIRPS is to analyze medication incident reports and develop recommendations for enhancing medication safety in all healthcare settings. The incidents anonymously reported by community pharmacy practitioners to CPhIR were extremely helpful in the preparation of this article. Pc

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5 Things to Know about Prescriptions for Buprenorphine /Naloxone

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Centre for Addiction and Mental Health
Leslie Dan Faculty of Pharmacy

Community pharmacists are seeing increasing numbers of patients who are prescribed buprenorphine/naloxone sublingual tablets. Recently generic products considered as interchangeable with Suboxone®, have become available.

Many communities still do not have easy access to physicians who are exempted to prescribe methadone. The increased availability of buprenorphine/naloxone has improved access to opioid dependence treatment across Ontario. Additionally, buprenorphine/naloxone may provide an alternative for patients with concerns surrounding the stigma associated with methadone. Although increased access is important, there have been reports of errors during the dispensing process as a result of pharmacy teams not understanding the many unique elements in dispensing this drug.

Although physicians are required to be knowledgeable about treatment with buprenorphine, no exemption is required in order to prescribe buprenorphine/naloxone and pharmacists are not required to inform OCP that they are dispensing this medication.

Nevertheless, pharmacists need to be familiar with the use of this drug and to be aware of required processes, guidelines and standards of practice if they agree to provide pharmacy care and dispensing services with this unique opioid agonist. Buprenorphine / naloxone has many similarities with methadone. It is approved in Canada for the treatment of opioid use disorder. Although it may be safer in overdose and dissolved under the tongue (vs. swallowing methadone diluted in a vehicle that does not lend itself to injection – such as orange flavored Tang® or other suitable drink), much of the framework for prescribing and dispensing is very similar.

Some selected points pharmacists must know in order to provide buprenorphine treatment safely to their patients are:

1 INDICATION

Opioid dependence treatment is the most frequent, and the only approved, indication for buprenorphine/naloxone. It is being used in some settings for the treatment of opioid withdrawal (unapproved indication). There may also be some patients who are prescribed this medication "off-label" for combined chronic pain and opioid use disorder, as well as some who are receiving it for the sole treatment of chronic pain when other options have been ineffective. When it is used in the treatment of pain in those patients with a history of substance use, it is prescribed and dispensed in a framework similar to that used in the provision of methadone for opioid dependence.

Buprenorphine (without naloxone) is also available in a patch formulation, (BuTrans®), which is approved for the treatment of chronic pain (not approved for use in addiction).

2 PAY ATTENTION TO START AND STOP DATES

Start and stop dates for dispensing are usually (and preferably) used instead of the total numerical quantity of doses needed. Pharmacists are required to **strictly adhere to these dates** which form part of the prescription and authorize the dispensing of the quantity of buprenorphine/naloxone required for the treatment period indicated on the prescription.

As is the case for any narcotic prescription, where no total quantity is indicated, the quantity must be able to be clearly and exactly calculated. If the narcotic quantity cannot be accurately calculated or the prescriber's intent is unclear, it would be important to obtain clarification from the prescriber.

Increasingly, structured opioid therapy with other narcotics is being used in the context of chronic pain, and start and stop dates are being prescribed for medications like hydromorphone, morphine etc.

3 MISSED DOSES ARE NOT "OWING DOSES"

If a patient misses buprenorphine/naloxone doses on days during the interval indicated by the start and stop dates, these doses are not considered as "owing "to the patient. As for methadone, when an "observed dose" is missed, the next dose dispensed should be observed. **Under no circumstances should doses be dispensed after the stop date on the prescription or for previous dates on which the client has not picked up doses.** Pharmacists need to ensure that all pharmacy staff members involved in the dispensing of buprenorphine/naloxone are aware of this.

4 OBSERVED AND TAKE-HOME DOSES

Supervised dosing by the pharmacist is an important clinical component. This involves carefully, respectfully and discretely witnessing a patient placing the tablet(s) under the tongue and observing dissolution. This is best done in a private area, if possible. There are reports that some pharmacists are not adhering to this practice and patients are able to spit out doses and/or divert easily. This has negative impact on treatment outcomes.

Carry doses are doses which may be taken home for later self-administration. They must be dispensed in a childproof container. A take home agreement can be completed with the patient.

There may be some special notes on the prescription requiring pharmacist attention, for example, notes about what to do if the pharmacy is closed on Sunday or a statutory holiday. Such notes should be considered to form part of the prescription, and if unclear, may warrant clarification with the prescriber directly.

In any case, the prescription should clearly indicate which doses, including which days of the week, are to be observed in the pharmacy and which doses may be taken home. Pharmacists need to adhere to these directions.

5 TRACKING MISSED DOSES AND COMMUNICATING WITH THE PRESCRIBER.

Information about missed doses is essential for the prescriber in making clinical decisions regarding buprenorphine therapy and for the pharmacist to medicate their patients safely. This information needs to be accurate and easily retrievable.

As with methadone, it is good practice to inform the prescriber of each missed dose. Prescribers should be contacted for direction after 3 missed doses of buprenorphine/naloxone, since this may indicate a considerable loss in patient stability. After more than 5 doses have been missed, the prescription should be cancelled since the dose will, in most cases, need to be decreased as per this table in the Buprenorphine/Naloxone Guidelines (1):

Buprenorphine Dose	Number of Consecutive Days Missed	New Starting Dose
> 8 mg	> 7 days	4 mg
> 8 mg	6-7 days	8 mg
6-8 mg	6 or more days	4 mg
2-4 mg	6 or more days	2-4 mg

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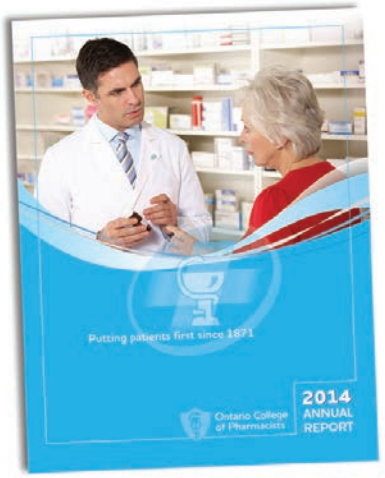
2014 Annual Report

The College published our 2014 Annual Report in March. The report features highlights and trends from the calendar year, including:

- Messages from the Registrar and President
- Statistics on pharmacists, pharmacy technicians and pharmacies
- Information and statistics on College programs
- Audited financial statements
- Special features about transparency, professional responsibilities, practice assessments, hospital inspections, and more

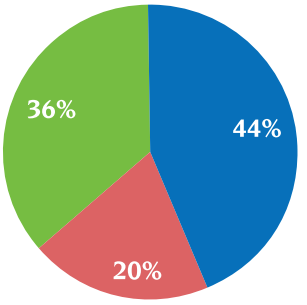


For the full report go to
http://www.ocpinfo.com/library/annual-reports/

BY THE NUMBERS

14,431 pharmacists in Ontario **4% increase** since 2013	2,927 technicians in Ontario **60% increase** since 2013
42% of pharmacists in Ontario are male	94% of technicians in Ontario are female
45 the average age of a pharmacist in Ontario	40 the average age of a technician in Ontario
36% of pharmacists were educated internationally	83% of technicians took the bridging program to become registered
14% of pharmacists are 60+ and are approacing retirement age	35% of pharmacists graduated more than 25 years ago

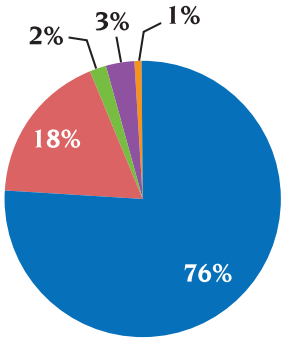
Pharmacists: Place of Education



Ontario	6,360
North America (outside Ontario)	2,876
International	5,195

Pharmacists by Practice Type

As of Dec. 31, 2014



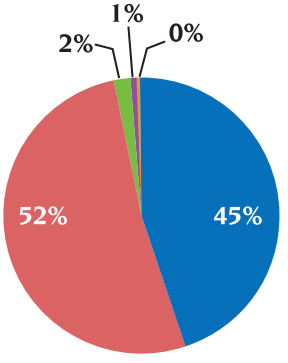
Community pharmacy	9,721
Hospital or other healthcare facilities	2,265
Association, academia or government	243
Industry or other	424
Pharmacy corporate office, professional practice or clinic	100

76% of pharmacists work in community practice.

52% of pharmacy technicians work in hospitals or other healthcare facilities.

Pharmacy Technicians by Practice Type

As of Dec. 31, 2014

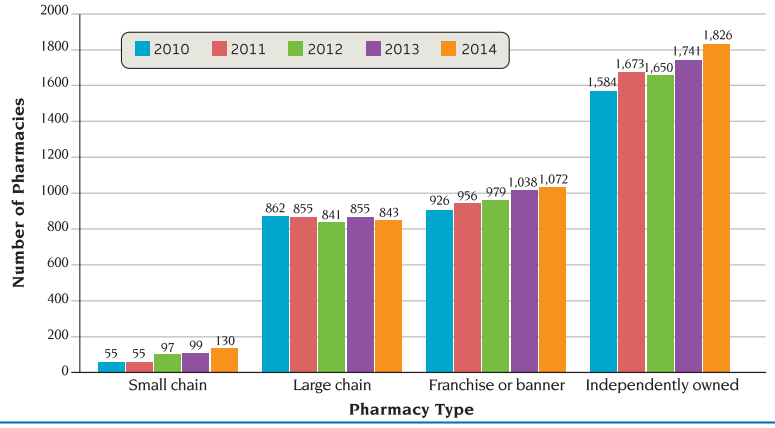


Community pharmacy	926
Hospital or other healthcare facilities	1,073
Association, academia or government	38
Industry or other	14
Pharmacy corporate office, professional practice or clinic	6

All practitioners are required to declare their primary place of practice each year upon annual renewal.
These graphs do not include practitioners who failed to record a place of practice.

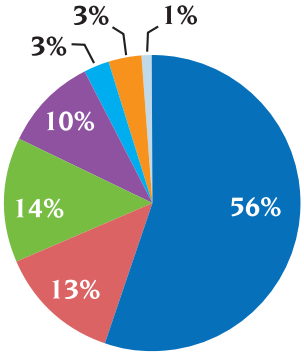
2014 Annual Report

Community Pharmacies by Type — Trends



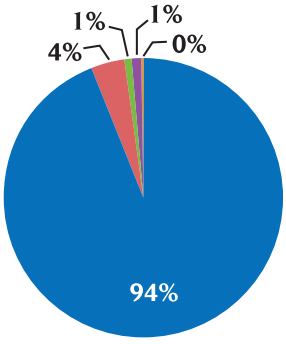
47% of Ontario pharmacies are independently owned.

Types of Inspections in 2014



Routine inspections	811
New openings (first visit)	192
New openings (call back after six months)	199
Change in ownership	150
Change in location	43
Re-inspections ordered by the practice advisor	50
Re-inspections ordered by the Accreditation Committee	16

Inspection Outcomes in 2014

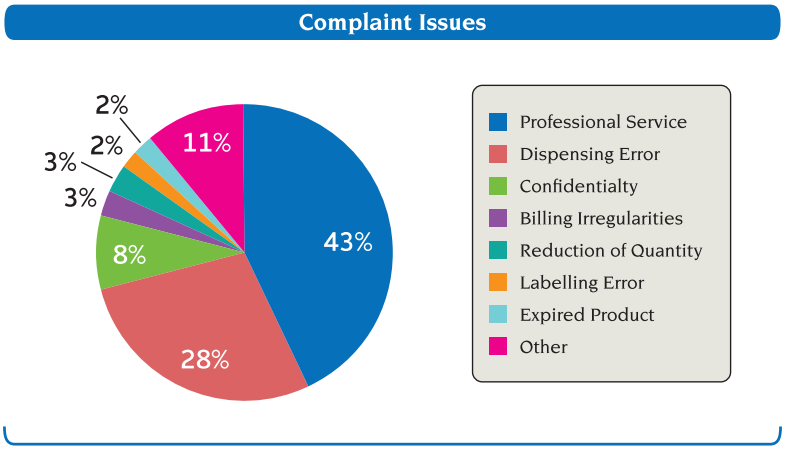


Satisfactory or minor issues identified	1,375
Re-inspections	58
Referrals to Accreditation Committee	12
Reports to Accreditation Committee	16
Referrals to Discipline Committee	2

94% of inspections were satisfactory or had minor issues identified

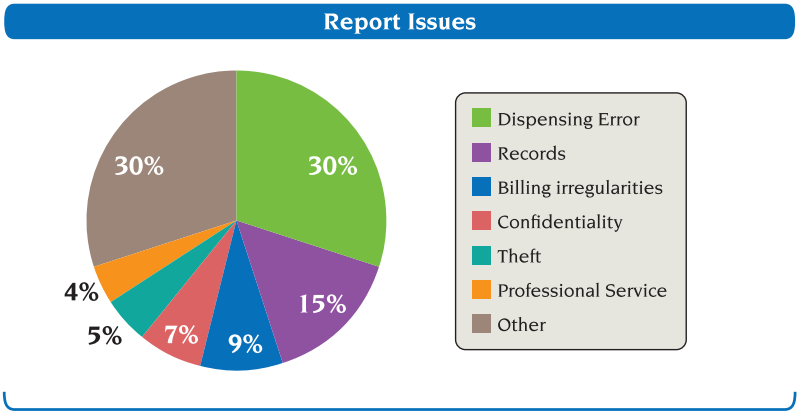
COMPLAINT ISSUES

43% of the complaints received in 2014 were related to professional service problems. This included problems with communication or issues concerning counselling a patient, performing MedsChecks, or ending the pharmacist-patient relationship.
The "other" category includes various problems such as excessive charges, forgery, fraud, product selection/substitution, unauthorized prescriptions and other miscellaneous issues.



REPORT ISSUES

The following pie chart shows the issues identified for the 62 reports received in 2014.
The "other" category includes various problems such as not meeting the responsibilities of a designated manager, failing to report criminal charges, selling unapproved products and treating family members.



Institute for Safe Medication Practices Canada
REPORT MEDICATION INCI DENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

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

ISMP Canada Safety Bulletin

Volume 15 • Issue 4 • April 22, 2015

Analysis of Incidents Involving Oral Chemotherapy Agents

The past few years have seen the introduction of many oral chemotherapy agents.[1,2] These agents can be self-administered at home, allowing for increased convenience relative to parenteral therapy administered in a specialized oncology setting. However, home therapy also transfers responsibility for the management and monitoring of chemotherapy regimens to patients, their caregivers, and healthcare professionals who may not have the appropriate training to take on these new tasks.[1,3] A multi-incident analysis of medication incidents involving oral chemotherapy agents was performed to better understand the challenges encountered by healthcare professionals who care for patients taking these medications. This bulletin shares the findings of the analysis and, by highlighting the major findings, identifies opportunities for system-based improvements.

Methodology

Reports of incidents involving oral chemotherapy were extracted from the ISMP Canada medication incident database and the National System for Incident Reporting (NSIR)* database.[4,5] The data reviewed for this analysis spanned the periods from July 2002 to April 2014 for the ISMP Canada database and from April 2009 to April 2014 for the NSIR database. A total of 516 incidents were analyzed using the multi-incident analysis technique outlined in the Canadian Incident Analysis Framework.[6] Table 1 breaks down the incidents by severity of harm.

Table 1: Reported Severity of Outcomes of Oral Chemotherapy-Related Medication Incidents

	ISMP Canada	NSIR
No error†	181	14
No harm	256	46
Harm	15	0
Death	4	0
Total	**456**	**60**

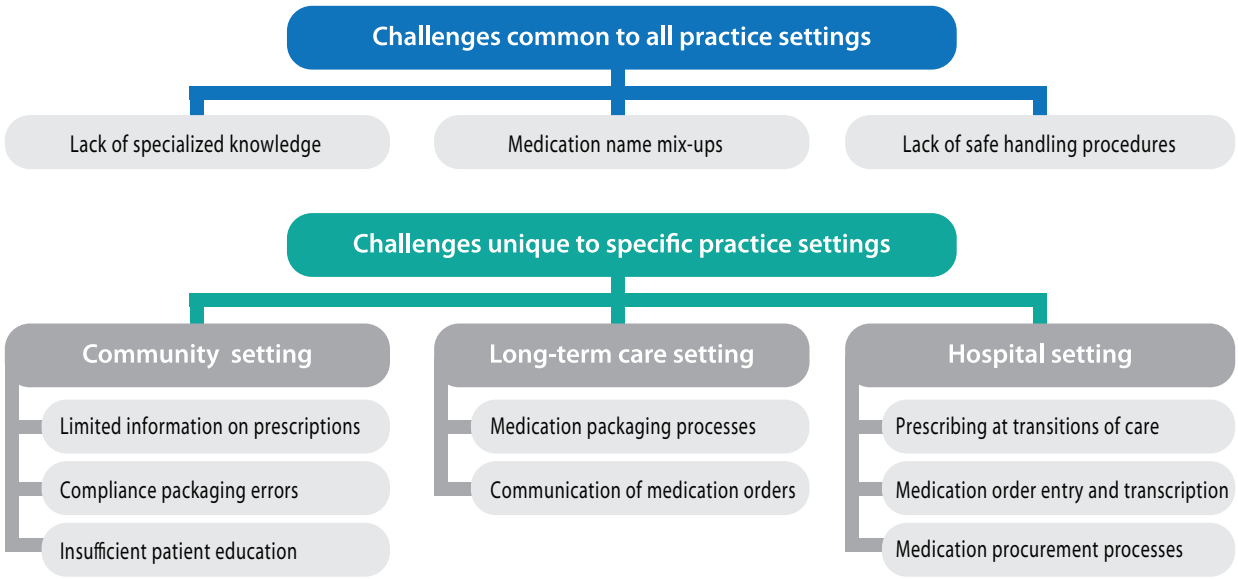
† "No error" is defined as a circumstance or event that has the capacity to cause harm for ISMP Canada data[7] and as a reportable circumstance or near miss for the NSIR.[8] "No error" incidents do not reach the patient, which differs from "No harm" incidents which do reach the patient.[7,8]

Findings of the Multi-Incident Analysis

Analysis of the incidents identified a number of challenges faced by healthcare professionals (see Figure 1). Details about 3 themes especially relevant to the management of oral chemotherapy agents in all practice settings, including potential contributing factors, are described below. Some challenges unique to specific practice settings are highlighted in the discussion of these 3 themes. Selected examples from the ISMP Canada database are provided.

* The NSIR, provided by the Canadian Institute for Health Information, is a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) program. More information about the NSIR is available from: http://www.cmirps-scdpim.ca/?p=12

Figure 1: Challenges Related to Medication Incidents, Grouped by Practice Setting



Theme: Lack of Specialized Knowledge

Reported incidents demonstrated that a lack of specialized knowledge and/or oncology expertise among healthcare providers contributed to an increased risk of medication errors. Similarly, a recent survey found that many Canadian community pharmacists lack the appropriate expertise, including an understanding of chemotherapy cycles and side-effect profiles, to provide sufficient education to patients about correct administration and monitoring for adverse effects.[1] If such education is not provided by other members of the healthcare team, the patient may be unable to carry out the care plan or to recognize early signs of toxicity.

Subtheme for the Community Setting: Limited Information on Prescriptions

Limited information on prescriptions was a key factor contributing to errors in community pharmacies. Healthcare professionals without the appropriate expertise may not recognize that critical information, such as the diagnosis, the patient's height and weight, and the duration of the chemotherapy cycle, is necessary to verify indication-specific dose ranges and schedules.[2]

Incident example:

A patient was receiving capecitabine according to a cyclical dosing regimen, as per a defined protocol. When the patient was admitted to hospital, the capecitabine was mistakenly ordered to be given daily. After the hospital stay, the discharge prescription also specified that the capecitabine be taken daily. The error was discovered by the oncologist 1 week after discharge. The care team's lack of familiarity with the oral chemotherapy regimen may have contributed to this error.

Theme: Medication Name Mix-Ups

Confusion between drug names resulted in a number of incidents that were included in the analysis; look-alike or sound-alike drug names were a key contributing factor (see Table 2). Duplication of therapy secondary to lack of familiarity with brand and generic names for oral chemotherapy agents played a role in other incidents.

ISMP Canada is currently reviewing confusable drug name pairs, including many pairs involving oral chemotherapeutic agents, for potential application of TALLman lettering as a strategy to aid in

differentiation. This work builds upon a previous collaboration on TALLman lettering between ISMP Canada and the Canadian Association of Provincial Cancer Agencies (CAPCA).[9]

Table 2: Examples of Common Medication Name Mix-Ups

Between brand names
Androcur (cyproterone) and Andriol (testosterone)
Casodex (bicalutamide) and Cozaar (losartan)
Nexavar (sorafenib) and Nexium (esomeprazole)
Between brand and generic names
tamoxifen and Tamiflu (oseltamivir)
tamoxifen and Tecta (pantoprazole)
Temodal (temozolomide) and tramadol
Between generic names
cyclophosphamide and cyclosporine
flutamide and fluticasone
hydroxyurea and hydroxyzine
procarbazine and carbamazepine

Contributing factors to errors with look-alike names included limited information on prescriptions and limited use of extra checks. ISMP Canada has recommended stating the indication for the drug on all prescriptions. Including both the generic and brand names can help to prevent medication errors involving look-alike names. Use of barcoding technology can also provide an extra safety check.

Theme: Lack of Safe Handling Procedures

Oral and parenteral chemotherapy agents are hazardous substances. The use of standardized handling processes and appropriate warning labels can help to minimize the risk of harm. Such processes include the use of designated devices and personal protective equipment during medication preparation, dispensing, and administration, to protect both healthcare providers and patients from inadvertent exposure to these hazardous medications. However, practitioners and patients are often unfamiliar with the handling safeguards required for these medications.

Incident example:

A pharmacist dispensed Diclectin (a combination of pyridoxine and doxylamine used to treat nausea and vomiting in pregnancy) using the same counting tray that had been used earlier to fill a prescription for hydroxyurea, without properly cleaning the tray between prescriptions. The pharmacist contacted the patient with instructions to replace the Diclectin before any doses were taken.

Subtheme for the Long-Term Care Setting: Medication Packaging Processes

The use of packaging technology, particularly in the institutional setting, increases dispensing efficiency and accuracy. However, staff involved in the packaging process must be made aware that oral chemotherapy agents are not to be packaged with these machines, as doing so will result in equipment contamination.[10] In addition, errors related to filling a drug canister with the incorrect medication can be very difficult to detect and may potentially affect a large number of patients.

Incident example:

A resident received hydroxyurea 500 mg instead of hydroxyzine 25 mg because the wrong drug had been stocked in an automated strip-packaging machine. This error resulted in mislabelling of the medication, an error that was not caught during the dispensing process.

Subtheme for the Hospital Setting: Medication Procurement Processes

Despite established processes to safely manage oral chemotherapeutic agents in facilities, the use of a patient's own supply can potentially bypass many key safeguards (e.g., product verification, use of warning labels, monitoring for drug interactions).

Incident example:

A patient's own supply of dasatinib was used during a hospital admission. Staff members caring for the patient were not notified to take the necessary precautions for handling the medication safely.

Conclusion

Attention to the safe management of oral chemotherapy agents must increase as their use grows.[11] Properties such as narrow therapeutic index, the serious and potentially fatal consequences that can result from adverse effects or dosing errors, and inadvertent environmental exposure mean that the use of these agents is associated with a higher inherent risk of harm than the use of most other oral medications. This multi-incident analysis identified many challenges related to the use of oral chemotherapy agents in various healthcare settings. Organizations and practitioners are encouraged to use these findings to build and share system safeguards aimed at reducing the risk of medication errors related to oral chemotherapy. ISMP Canada has been working with CAPCA to develop oral chemotherapy guidelines. This collaborative is supported by every provincial cancer agency and program in Canada. The new document will provide guidance for the physicians, pharmacists, and nurses who care for patients receiving oral chemotherapy agents.

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DISCIPLINE DECISIONS

46

Member: Sameh Guirguis, R.Ph.

At a hearing held on March 3, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Guirguis with respect to the following incidents:

- That on or about the dates identified below, he dispensed methadone to the patients identified below without obtaining and/or documenting confirmation of their prior doses:
  i. C.E., December 20, 2013;
  ii. M.H., December 20, 2013;
  iii. R.R., December 20, 2013;
  iv. D.W., December 20, 2013;
  v. L.D., December 24, 2013;

- That on or about the dates identified below, he dispensed methadone to the patients identified below without obtaining and/or documenting a valid prescription for those instances of dispensing:
  i. C.E., December 20, 2013;
  ii. M.H., December 20, 2013;
  iii. R.R., December 20, 2013;
  iv. D.W., December 20, 2013.

In particular, the Panel found that Mr. Guirguis

- failed to maintain a standard of practice of the profession;
- contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, namely, s. 155 and/or s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, namely, s. 31 of the Narcotic Control Regulations, C.R.C. c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   (a) that the Member complete successfully, at his own expense, within 12 months of the date of this Order, the following course and evaluation:
      (i) Opioid Dependence Treatment Core Course, offered by the Centre for Addiction and Mental Health; if the College so directs, the Member may successfully complete the Methadone, Buprenorphine and the Community course offered by the Ontario Pharmacists Association in lieu of the Opioid Dependence Treatment Core Course;
   (b) that the Member shall be prohibited from acting as a Designated Manager in any pharmacy until the date the College is notified that the Member has successfully completed the course and evaluation set out in paragraph 2(a)(i) above;

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 3 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training specified in subparagraph 2(a) above. The suspension shall commence on March 3, 2015;

4. Costs to the College in the amount of $2,000.00.

In its reprimand, the Panel pointed out that the practice of pharmacy is a privilege which carries significant obligations to the public, the profession, and oneself. The Panel indicated that the Member failed in his obligation

to adhere to the standards of practice when dispensing methadone. The Panel stated that methadone is highly regulated due to its pharmacological actions and the risk to the public if it is misused. The Panel agreed that the Member's actions were disgraceful, dishonourable, and unprofessional. The Panel expressed its expectation that the Order will motivate the Member to modify his behavior and professional practice.

Member: Armia Fahmy, R.Ph.

At a hearing on March 16, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Fahmy with respect to the following incidents:

- between about December 17, 2013, and December 20, 2013, he failed to take reasonable steps to ensure continuity of care for patients of the Pharmacy while the Pharmacy was unexpectedly closed for 2 days; and
- between about April 11, 2011, and February 5, 2014, he failed to maintain appropriate care and control of narcotic, controlled substances, and/or targeted substances inventory at the Pharmacy, and/or failed to report a loss or theft of narcotics, controlled substances, and/or targeted substances as required.

In particular, the Panel found that Mr. Fahmy:

- failed to maintain a standard of practice of the profession;
- contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, namely, s. 7(1) of the Benzodiazepines and Other Targeted Substances Regulations, SOR/2000-217, and ss. 42 and 43 of the Narcotic Control Regulations, C.R.C. c. 1041, both made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:

   a. that the Member:
      i. retain, at the Member's expense, a practice mentor acceptable to the College, on or before May 16, 2015;
      ii. meet at least twice with the practice mentor for the purpose of reviewing the Member's practice and identifying areas in the Member's practice that require remediation; to this end, the Member shall provide the practice mentor with the following documents related to this proceeding:
         1. a copy of the Notice of Hearing;
         2. a copy of the Agreed Statement of Facts;
         3. a copy of the Joint Submission on Order;
         4. a copy of the Decision and Reasons, when available; and
         5. a copy of the Order, if applicable and when available;
      iii. develop a learning plan to address the areas requiring remediation;
      iv. demonstrate to the practice mentor that the Member has achieved progress in meeting the goals established in the learning plan;
      v. require the practice mentor to report the results of the mentorship meetings to the Manager, Investigations and Resolutions at the College, after their completion, which shall be no later than March 16, 2016;

   b. that the Member shall be prohibited from acting as a Designated Manager in any pharmacy until the later of:
      i. May 14, 2016, and
      ii. the date the College is notified that the Member has successfully completed the mentoring program set out in paragraph 2(a) above;

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 2 months. The suspension shall commence on March 16, 2015; and

4. Costs to the College in the amount of $2,000.00.

In its reprimand, the Panel expressed concern that this was the second time that the Member had appeared before a panel of the Discipline Committee within 12 months. The Panel noted that integrity and trust are paramount to the profession of pharmacy and expressed disappointment with the Member's actions.

The Panel identified the potential impact of the member's actions on public safety as disturbing and his lack of control of the narcotics in his responsibility as shocking. The Panel suggested that the consistent lack of appropriate record keeping demonstrated disturbing and cavalier behaviour, which was unprofessional. The Panel indicated that the Member showed a complete lack of professionalism and commitment in carrying out the duties of a pharmacist, and showed a lack of commitment to patients, other members of this college, and other health care professionals in general. The Panel expressed its expectation that all health care professionals are to conduct themselves in a manner that maintains public confidence and safety.

Member: Vaughn Osgan, R.Ph.

At a hearing on March 27, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Vaughn Osgan with respect to the following incidents:

- The Member was found guilty on October 2, 2013, of criminal offences relevant to his suitability to practise; namely, conspiracy to traffic a controlled substance and conspiracy to produce a controlled substance (anabolic steroids) contrary to section 465(1)(c) of the Criminal Code of Canada; and
- The Member used a controlled drug (anabolic steroids) and failed to notify his Addiction Medicine Physician, PHP Monitor and PHP Case Manager or the Medical Director, in contravention of Terms 13 and 18 of his Professionals Health Program (PHP) contract dated June 18, 2009.

In particular, it is alleged that he

- was found guilty of criminal offences relevant to his suitability to practice;
- contravened a term, condition or limitation imposed on his certificate of registration; and
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A Reprimand

2. Directing the Registrar to suspend the Member's Certificate of Registration for a period of six months, commencing July 1, 2015.

3. That the Member be prohibited, until the terms of suspension prescribed in (2), above, is served in its entirety:
   (i) from acting as a Designated Manager for any pharmacy; and
   (ii) from having any proprietary interest in a pharmacy as a sole proprietor or partner, or director or shareholder in a corporation that owns a pharmacy (excepting only that he may be permitted to own shares in a publicly traded corporation that has an interest in a pharmacy), or in any other capacity, or receiving any remuneration for his work as a pharmacist, or related in any way to the operation of a pharmacy, other than remuneration based on hourly or weekly rates or salary and in particular, not on the basis of any incentive or bonus for prescription sales.

4. The Member is required to comply with the following treatment plan for 24 months from the date of this Order:
   (a) remain under the care of physician Dr. K. (or his designate approved in writing by the College);
   (b) attend for a follow-up visit with Dr. K. or his designate at least once every six months or more frequently if so directed by Dr. K. or his designate;
   (c) comply with all treatment recommendations of Dr. K. or his designate;
   (d) attend for a follow-up visit with psychiatrist Dr. U. (or his designate approved in writing by the College) within 12 months of the date of this order, and again within 24 months from the date of this order;
   (e) continue to take all medication as prescribed by Dr. U. or his designate;
   (f) comply with all treatment recommendations of Dr. U. or his designate.

5. The Member is to provide a written authorization and direction to Dr. K. or his designate to:
   (a) immediately advise the College is the member is not compliant with any portion of his treatment program;
   (b) provide a written report to the College 12 months after this order, and 24 months after this order, reporting on the member's mental health and compliance with his treatment program.

6. The Member is to provide written authorizations to the College and Dr. K. (or his designate) that

authorizes Dr. K. (or his designate) to speak with the College about all aspects of the member's health and treatment program.

7. The Member is to provide written authorizations to the College and Dr. U. (or his designate) that authorizes Dr. U. (or his designate) to speak with the College about all aspects of the member's health and treatment program.

8. The Member is to continue attending counselling sessions at Community Addiction Services of Niagara at a rate of at least once every six weeks and provide proof thereof to the College upon request.

9. For a period of two years from the date of this order, the Member shall only work for an employer who confirms to the College in writing that the employer has been provided with a copy of:
   (i) the Notice of Hearing in this matter;
   (ii) this Order; and
   (iii) the panel's reasons for decision in this matter, if available.

10. Costs to the College in the amount of $5000.

In its reprimand, the Panel pointed out that the member is part of an honourable profession and that integrity, trust, and professional conduct are at the core of the practice of pharmacy. The Panel noted that the Member admitted responsibility for his action and agreed that his conduct was disgraceful, dishonourable, and unprofessional. The Panel indicated that the Member's actions were unacceptable and expressed the expectation that he will not appear before the Discipline Committee of the Ontario College of Pharmacists again.

Member: Phillip Ku

After a hearing held on December 16 – 17, 2014, and April 1 and 9, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ku with respect to the following incidents:

- that between about September 27, 2013, and February 5, 2014, the member failed to maintain current contact information with the College and/or failed to respond in a timely way to communications from the College and/or evaded attempts by the College to contact him;
- that on or about September 13, 2013, the member misappropriated drugs from Peoples Choice Remedy's Rx pharmacy in Toronto, Ontario;

In particular, the Panel found that Mr. Ku:

- failed to maintain a standard of practice of the profession;
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. That the Member appear before the Panel to be reprimanded on or before July 9, 2015;

2. That the Registrar immediately revoke the Member's certificate of registration;

3. Costs to the College in the amount of $25,000.00 payable within 30 days of the date of the Order. Pc

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.

FOCUS ON ERROR PREVENTION

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

DRUG ALLERGIES

Pharmacy computer systems play a key role in identifying potential drug related problems such as the dispensing of an incorrect dose, an inappropriate change in drug therapy, potential drug interactions and contraindications due to patient allergies.

However, an incorrect input by the computer operator can result in the failure of this important safety system.

CASE:

Following dental surgery, a patient was prescribed Amoxicillin 500mg to be taken three times daily for one week. The written prescription was taken to a local community pharmacy for processing.

Upon accepting the prescription from the patient, the pharmacy assistant gathered the usual information including possible allergies to medications. The patient indicated that he was severely allergic to penicillin. In response, the pharmacy assistant entered into the patient profile that he was allergic to "Pen". The prescription was then put aside while the pharmacy assistant served another patient.

A few minutes later, the pharmacy assistant entered the prescription into the computer and failed to identify that Amoxicillin would be contraindicated for a patient who is severely allergy to penicillin. Amoxicillin was therefore prepared to be checked by the pharmacist. The computer alert system did not detect the contra-indication because the system did not recognize "Pen" as penicillin. The pharmacist checked the prescription, but did not notice "Pen" listed as an allergy on the patient's profile.

While counselling the patient, the pharmacist mentioned, "This is Amoxicillin, a penicillin antibiotic". The patient interrupted the pharmacist and stated that he was severely allergic to penicillin and he had informed the staff when he handed in the prescription.

The patient was not happy that though he informed both the dental office and the pharmacy that he was severely allergic to penicillin, he was still being given penicillin.

POSSIBLE CONTRIBUTING FACTORS:

- The pharmacy assistant used an abbreviated form of the word penicillin which the computer alert system failed to recognize.
- The delay between the prescription being accepted and later entered into the computer may have played a role in the pharmacy assistant's failure to identify the contraindication.
- The pharmacist failed to notice "Pen" listed as an allergy in the patient profile and therefore did not investigate its meaning.

RECOMMENDATIONS:

- Do not use abbreviations when entering allergy information into patients' profiles.
- Double check the spelling of the information entered. In another error reported, the computer system failed to detect a patient's contraindication to taking erythromycin because erythromycin was misspelled when the patient's allergies were entered into the computer.
- Whenever possible, select the specific drug allergen from a list in the computer. Entering the information in freeform can introduce errors.
- Be careful when selecting the specific allergen. Remember that sulfur is not the same as sulfon-amide. Therefore, if **sulfur** is entered into the patient's profile as an allergen, the computer system will not prevent the dispensing of **sulfa** drugs such as sulfamethoxazole. Pc

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.

CONTINUING EDUCATION (CE)

This list of continuing education activities is provided as a courtesy to members. The Ontario College of Pharmacists does not necessarily endorse the CE activities on this list.
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).

Visit www.ocpinfo.com for an up-to-date list of Continuing Education.

LIVE EVENTS AND CONFERENCES

May 22 or October 1, 2015 (Toronto, ON)
Incident Analysis Framework: Train the Trainer Workshop
(for PSEP-Canada Trainers)
The Institute for Safe Medication Practices Canada
Contact: http://www.ismpcanada.ca/education/

May 24-28, 2015 (Quebec, QC)
The 14th Conference of the International Society of Travel Medicine
International Society of Travel Medicine
Contact: http://www.istm.org/

May 26, 2015 or June 26, 2015 (Toronto, ON)
Reviews and Disclosures of Incidents: Improving Quality of Care for Patients
Ontario Hospital Association
Contact: http://www.oha.com/EDUCATION/Pages/education.aspx

May 28, 2015 (Toronto, ON)
Education Program for Immunization Competencies - 2015
The Canadian Paediatric Society
Contact: http://www.cps.ca/en/epic-pfci

May 28-31, 2015 (Ottawa, ON)
Canadian Pharmacists Conference 2015
Co-hosted by the Canadian Pharmacists Association and the Ontario Pharmacists Association Contact: http://www.pharmacists.ca/index.cfm/news-events/events/calendar-of-events/canadian-pharmacists-conference-015/?month=5&year=2015&categoryID=&relatedID\

May 31-June3, 2015 (Toronto, ON)
E-Health Conference
E-Health
Contact: http://www.e-healthconference.com/

June 1, 2015 (Mississauga, ON)
Canadian Society for Epidemiology and Biostatistics (CSEB 2015 Conference)
Canadian Society of Epidemiology and Biostatistics
Contact http://csebca.ipage.com/wordpress/conferences-events/biennial-conference/

June 2-3, 2015 (Richmond Hill, ON)
Shift the Conversation Community Health and Wellbeing
Association of Ontario Health Centres
Contact: http://aohc.org/conference2015

June 3, 2015 (Toronto, ON)
Going beyond the numbers: Using incident reports to assess medication safety culture A Novel Approach to Understanding Patient Safety Culture from Medication Incidents
The Institute for Safe Medication Practices Canada
Contact: http://www.ismpcanada.ca/education/

June 10 or 18, 2015 (Toronto, ON)
Resolving Drug-Drug Interactions: A Guide for Community Pharmacies to Reduce Potential Hospitalizations
The Institute for Safe Medication Practices Canada
Contact: http://www.ismpcanada.ca/education/

June 11-12, November 5-6, 2015 (Toronto, ON)
Medication Safety for Pharmacy Practice: Incident analysis and prospective risk assessment
The Institute for Safe Medication Practices Canada
Contact: http://www.ismpcanada.ca/education/

June 14-17, 2015 (Victoria, BC)
IPAC Canada 2015 National Education Conference: "Surfing Waves of Change"
Infection Prevention and Control Canada
Contact: http://www.ipac-canada.org/conf_registration.php

June 21-December 5, 2015 (Multiple Dates and Locations)
Injections and Immunizations Supplemental Program –
Difficult Situations, Best Practices and Injection Skills Refresher Workshop
Ontario Pharmacists Association
Contact: https://www.opatoday.com/professional/live-courses

August 31-September 2, 2015 (Toronto, ON)
International Conference on Alzheimer Disease & Dementia
OMICS Group Inc.
Contact: http://10times.com/alzheimer-disease-Toronto

September 16-18, 2015 (Ottawa, ON)
Community Health Centres: Agents of Care, Agents of Change Conference
Canadian Association of Community Health Centres
Contact: http://www.cachc.ca/acac2015

September 19, November 14, 2015 (Toronto, ON)
Immunization and Injections for Pharmacists
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/injections.html

October 3, 2015 (Toronto, ON)
Infectious Diseases/Critical Care Conference
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/categories/practice-development.html

October 16-18, 2015 (Niagara Falls, ON)
Lifelong Learning in Paediatrics
Canadian Paediatric Society
Contact: http://www.cps.ca/en/llp

October 23-25, 2015 (Calgary, AB)
CAG 2015 Conference: From Possibility to Practice in Aging: Shaping a Future for All
Canadian Association on Gerontology
Contact: http://cag2015.ca/

October 24, 2015 (Toronto, ON)
Minor Ailments
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/categories/practice-development.html

October 29 – November 1, 2015 (Ottawa, ON)
Canadian Hospice Palliative Care Conference
Canadian Hospice Palliative Care Association
Contact: http://conference.chpca.net/

November 2-4, 2015 (Toronto, ON)
Health Achieve 2015 Conference
Health Achieve
Contact: http://www.healthachieve.com/about

November 8, 2015 (Toronto, ON)
Self Care Symposium Conference
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/categories/practice-development.html

November 12-14, 2015 (Vancouver, BC)
2nd International Conference: Where's the Patient's Voice in Health Professional Education 10 Years On?
The University of British Columbia
Contact: http://interprofessional.ubc.ca/patientsvoice/

November 25 - 27, 2015 (Toronto, ON)
Thrombosis Management
University of Toronto
Contact: http://cpd.pharmacy.utoronto.ca/programs/thrombosis.html

November 16-18, 2015 (Montreal, QC)
Issues of Substance Conference 2015
Canadian Centre on Substance Abuse
Contact: http://www.ccsa.ca/Eng/newsevents/Issues-of-Substance-Conference/Pages/default.aspx

November 30-December 4, 2015 (Vancouver, BC)
IDF 2015: World Diabetes Congress
International Diabetes Federation
Contact: http://www.idf.org/worlddiabetescongress

January 30-February 3, 2016 (Toronto, ON)
CSHP Professional Practice Conference
Canadian Society of Hospital Pharmacists
Contact: http://www.cshp.ca/events/ppc/index_e.asp

Multiple dates and locations – contact course providers

Immunizations and Injections training courses:
Ontario Pharmacists Association: https://www.opatoday.com/223957
RxBriefcase, CPS and PHAC http://www.advancingpractice.com/p-68-immunization-competencies-education-program.aspx
Canadian Health Network: http://www.canadianhealthcarenetwork.ca/pharmacists/
Pear Health http://www.pearhealthcare.com/training-injection-training.php
University of Toronto: http://cpd.pharmacy.utoronto.ca/programs/injections.html
Dalhousie University: http://www.dal.ca/faculty/healthprofessions/cpe/programs/live-programs/immunization-andinjectionadministrationtrainingprogram.html

ONLINE LEARNING/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)
On-line courses with live workshops in subjects including: TEACH: Certificate Program In Intensive Tobacco Cessation Counselling, TEACH Core Course: A Comprehensive Course on Smoking Cessation , ADAT, Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians, Collaborating with Families Affected by Concurrent Disorders, Concurrent Disorders Core, Concurrent Disorders in Primary Care, Fundamentals of Addiction, Fundamentals of Mental Health, Interactions Between Psychiatric Medications and Drugs of Abuse, Legal Issues in Mental Health Care in Ontario, Medications and Drugs of Abuse Interactions in ODT Clients, Motivational Interviewing introduction Course, Recovery-Oriented Approach, Safe and Effective Use of Opioids for Chronic Non-cancer Pain, Youth, Drugs and Mental Health.
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/default.aspx

Canadian Pharmacists Association (CPhA)
Home Study Online accredited education programs including: ADAPT Patient Care Skills Development. Lab Tests, Medication Review Services, QUIT: Smoking Cessation Program, Diabetes: CANRISK CE.
Contact: http://www.pharmacists.ca/index.cfm/education-practice-resources/professional-development/

Canadian Society of Hospital Pharmacists (CSHP)
Online education programs, including Medication Reconciliation, Minimizing the Risk of Contamination in the Oncology Pharmacy Setting and Immunization Competencies Education Program (ICEP).
Contact: http://www.cshp.ca/programs/onlineeducation/index_e.asp
Complimentary from Canadian Society of Hospital Pharmacists (CSHP)
Minimizing the Risk of Contamination in the Oncology Pharmacy Setting, Immunization Competencies Education Program (ICEP)
Contact: http://www.cshp.ca/programs/onlineeducation/index_e.asp

Canadian Healthcare Network
On-line CE Lessons for pharmacists and pharmacy technicians.
Contact : http://www.canadianhealthcarenetwork.ca/pharmacists/

Continuous Professional Development – University of Toronto, Leslie Dan Faculty of Pharmacy:
Infectious Diseases Online Video Lectures and Slides, Influenza DVD, Canadian Health Care System, Culture and Context, Canadian Pharmacist Skills 1 (CPS1)
Contact: http://cpd.pharmacy.utoronto.ca/
Complimentary from OCP and University of Toronto, Leslie Dan Faculty of Pharmacy: Collaborative Care: Conflict In Inter-Professional Collaboration; Pain: Chronic Non-Cancer Pain; Pharmacists Role: Who Do We Think We Are? The '10 Minute Patient Interview' webcast; Physical Assessment for Pharmacists; There is no "I" in "Team", The Why and How Of Deprescribing.
Contact: http://www.ocpinfo.com/practice-education/continuing-education/listings/pharmacists/

Institute for Safe Medication Practices Canada (ISMP)
On-line webinars including: BPMH Training for Pharmacy Technicians Workshop, Failure Mode and Effects Analysis (FMEA), Root Cause Analysis.
Contact: https://www.ismp-canada.org/education/

Ontario Pharmacists Association (OPA)
On-line courses with live workshops in subjects including; Implementing Smoking Cessation Services in the Pharmacy, Medical Directives, Pharmacist Health Coaching – Cardiovascular Program Training Course, Orientation to Pharmacy in Long-Term and Residential Care Facilities
Complimentary online courses include: Ontario Drug Benefit Blood Glucose Test Strip Reimbursement Policy: Support Tools for Pharmacists, Methadone and

Buprenorphine/Naloxone Online Modules.
Contact: http://www.opatoday.com/professional/online-learning

rxBriefcase
On-line CE Lessons (Clinical and Collaborative Care series) and the Immunization Competencies Education Program (ICEP).
Contact : http://www.rxbriefcase.com/

Optimizing Patient Care Series: Clinical Decision Making in Pharmacy Practice
This module focuses on the many ways a pharmacist can apply the pharmaceutical care process to a variety of clinical situations to provide patients with individualized care plans that will optimize their medication experience.
http://cpd.pharmacy.utoronto.ca/opc/modules/modules.html

Optimizing Patient Care Series: Managing Issues Due to Expanded Scope
This module identifies how pharmacists, as part of the healthcare team, can prepare themselves to make clinical decisions with confidence.
http://cpd.pharmacy.utoronto.ca/opc/modules/modules.html

Optimizing Patient Care Series: Documentation in the World of Expanded Scope
This module focuses on how pharmacists can effectively integrate documentation of patient care services into daily practice.
http://cpd.pharmacy.utoronto.ca/opc/modules/modules.html

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.*

Interested in expanding your network and giving back to the profession?

Additional regional CE coordinators and associate coordinators are needed in regions 4 (Pembroke and area), 6 (Kingston area), 7 (Trenton area), 9 (Lindsay area), 10 (North Bay area), 12 (Toronto area) 16 (Niagara area) 17 (Brantford area), 18 (London area), 19 (Guelph area) 21 (Kitchener), 22 (Owen Sound area) 23 (Chatham area, 24 (Windsor area, 25 (Sault Ste. Marie area), 26 (Thunder Bay area) 27 (Timmins area) and 29 (Sarnia area). A complete list of CE coordinators and regions by town/city is available on our website.

To apply, submit your resume to ckuhn@ocpinfo.com

BULLETIN BOARD

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40TH REUNION CELEBRATION

UofT Pharmacy Class of 7T5 is celebrating their 40th reunion on Sept 26th in Toronto with a faculty tour, reception and dinner. For further information and to get on the mailing list please contact Muriel (Barber) Heska at mheska@hotmail.com.

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