Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SPRING 2017 • VOLUME 24 NUMBER 2

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

IN THIS ISSUE:

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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.

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

Standing Committees
- Drug Preparation Premises
- Elections
- Finance & Audit
- Professional Practice

Ontario College of Pharmacists
Putting patients first since 1871

Strategic Framework
2015-2018

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 Priorities
Core Programs Fulfillment of Mandate ♦ Optimize Practice within Scope ♦ Inter & Intra Professional Collaboration

Strategic Initiatives
Patients First
Effective Communications
Continuous Quality Improvement

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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Régis Vaillancourt,
O.M.M., C.D., B. Pharm.,
Pharm. D., R. Ph.
President

As I reflect on our last Council meeting, I am reminded of the incredibly valuable role pharmacy professionals play in patient care and in advancing health system priorities. Most importantly, I am reminded that serving the public is a privilege, no matter whether you are a pharmacist, pharmacy technician, or member of Council or the various College committees. As fiduciaries of the public trust, together we have a collective responsibility to support our patients and to do everything we can to protect them from harm and improve their health outcomes.

As you all know, the government has introduced important legislation intended to help build public confidence in their healthcare system and better protect patients from sexual abuse by healthcare professionals. As a College with a mandate to protect and serve the public interest, we are supportive of the government's objectives as it moves forward with Bill 87 and we have provided constructive feedback to the Minister about how the Bill could be strengthened.

I'm proud to say that through policy set by Council, our College already meets many of the transparency related amendments proposed in the Bill and feel we are well positioned – emboldened by our long-standing commitment to putting patients first – to meet these expectations once the Bill becomes law. This also means looking at ways that we can increase patient engagement and involvement in our work as their perspectives are vitally important within our healthcare system.

Our mandate to protect the public also extends to helping our society overcome public health challenges. We are currently facing an opioid crisis in Ontario and across the country. While federal and provincial governments are undertaking a variety of strategies to combat this crisis, we believe there may be more that we can do, both as a regulator and as a profession.

> "As fiduciaries of the public trust, together we have a collective responsibility to support our patients and to do everything we can to protect them from harm and improve their health outcomes."

For this reason, we have created an Opioid Task Force to support the development of a College opioid strategy that aligns with provincial and national efforts and that considers the role regulators can and should play in response to this crisis. The strategy would address short, medium and long-term initiatives and will be reported to Council regularly. It will also complement the work of the Registrar on the development of a country-wide regulator opioid strategy through the National Association of Pharmacy Regulatory Authorities (NAPRA). More on this will be shared at a future Council meeting.

Patient safety is a tenet of quality healthcare. As health professionals, we must apply principles of patient safety in everything we do, including identifying opportunities to continuously improve the quality of pharmacy practice and the experiences of patients. Council's unanimous approval of a framework for a continuous quality assurance program (CQA) for medication safety in March is a step forward for the College and the profession that, ultimately, will help to maintain public trust in the safety of pharmacy services in the province.

As you will read about later in this issue of *Pharmacy Connection*, the focus on medication safety within pharmacy is part of a larger movement experienced in other jurisdictions, not just in Canada but around the world. In Ontario, we have a real opportunity to work together to reduce the risk of medication incidents and to understand why they happen so that we can identify the steps required to prevent them from happening in the future.

Doing so will help protect patients – a responsibility that we all must share.

MARCH 2017 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on March 20th, 2017.

DR. BELL ADDRESSES COUNCIL

Dr. Robert Bell, Deputy Minister of Health and Long-Term Care, was welcomed to the Council table where he spoke about the modernization of governance of regulated health professionals in light of the *Patients First Action Plan for Health Care* and the health system transformation initiatives underway in Ontario. He spoke about the government's commitment to evolve the health system into one that puts the needs of patients at its centre, the successes to date and the work yet to be done to improve the patient experience in part by making the system more transparent and accountable. He also commented on the need for a single integrated system, rather than the creation of parallel practice systems and funding mechanisms.

The College's mandate of serving and protecting the public, together with the government's commitment to this important initiative, continue to inform all decisions made at the Council table.

BILL 87 – *THE PROTECTING PATIENTS ACT*

At this meeting, Council considered Bill 87, *The Protecting Patients Act*. The Bill is an important piece of legislation that proposes changes to the *Regulated Health Professions Act* (RHPA), the legislation that provides health colleges with the authority to regulate health professions in the public interest. The Bill contains amendments to strengthen the legislative provisions relating to sexual abuse and transparency as well as changes to enhance the complaints, investigation and discipline processes.

Registrar Nancy Lum-Wilson presented to Council a comprehensive overview of the expected changes to the RHPA. It was noted that the intent and overall objectives contained in the Bill align with the College's own values and commitment to transparency and accountability. The College supports actions that provide better patient protection and strengthen its role to serve and protect the public. It was further noted that there are areas that will require further clarity, and that ongoing engagement with the government would be beneficial. The College will participate in the government's consultation process as the Bill moves through the legislature.

CONTINUOUS QUALITY ASSURANCE PROGRAM FOR MEDICATION SAFETY

Medication incident reporting is another significant initiative that is currently underway at the College. As reported in December 2016, there was unanimous support by Council of requiring members to report medication incidents to an external body. A task force was subsequently established to examine this subject and to develop a model for consultation.

At this March meeting, Council received the recommendations of the Medication Safety Task Force which proposed a framework for the development of a standardized continuous quality assurance (CQA) program that will apply to all pharmacies. The standardized CQA program will:

- put the patient first by requiring mandatory reporting to a third party;
- require shared accountability by pharmacies, for the systems they design and how they respond to staff behaviour, and by pharmacy professionals, for the quality of their choices and for reporting their errors;
- emphasize learning and accountability through a culture where individuals are comfortable bringing forward medication incidents without fear of punitive outcomes; and
- enable sharing of lessons learned from medication incidents through reporting, resulting in ongoing process improvements to minimize errors and maximize health outcomes.

Council endorsed the proposed framework and directed the College to move forward with public consultation on the CQA program for a period of 30 days beginning March 31. Following the close of the consultation period, the College will present a final framework for approval at the June 2017 Council meeting, including next steps in its implementation.

TASK FORCE ON OPIOIDS

In November 2016, Federal Health Minister Jane Philpott and Ontario Health Minister Eric Hoskins convened a two-day summit to address the ongoing opioid crisis in Canada. The meeting included other provincial health ministers, addiction experts and affected families. Ontario's commitment was to implement a comprehensive Opioid Strategy that focuses on enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services.

The Registrar is currently serving as a co-lead with the Registrar of the Nova Scotia College of Pharmacists to assist with a national (National Association of Pharmacy Regulatory Authorities) opioid strategy. However, given the importance of this issue, Council considered and fully supported the Executive Committee's recommendation of creating an Opioid Task Force to support the development of a College Opioid Strategy that aligns with provincial and national strategies. The Strategy would address short, medium and long term initiatives and will report to Council through the Executive Committee.

COUNCIL APPROVES AUDITED STATEMENTS FOR COLLEGE OPERATIONS FOR 2016

Council approved the Audited Financial Statements for the operations of the College for 2016 as 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 issues of concern. The summarized financial statements can be found on the College's website.

PHARMACY TECHNICIAN STRATEGY

The College is developing a strategy that will build on existing efforts to achieve integration of pharmacy technicians within practice in order to help maximize the clinical role of pharmacists as medication therapy experts. In addition to the implementation of core College programs such as quality assurance that will impact the integration of pharmacy technicians in practice, the College will engage educators, pharmacy owners, corporations and other stakeholders with aligned objectives to support the strategy. The strategy will be brought forward at the June Council meeting, with further progress reporting through the regular College quarterly reports.

Successful implementation of the strategy will create an environment that better enables the profession to practice to scope.

NEW PUBLIC MEMBERS APPOINTED TO COUNCIL

Council welcomed Ms. Elnora Magboo and Ms. Joan A Pajunen to the table. Ms. Magboo will be serving on the Accreditation, Drug Preparation Premises, Inquiries Complaints and Reports (ICRC) and the Registration Committees of the College, and Ms. Pajunen will be serving on the Discipline and ICRC Committees.

This last quarter also saw the departure of public member, Mr. John Laframboise, and District T elected member, Ms. Michelle Filo. Accordingly, a by-election will be held in District T over the summer.

COUNCIL MEETINGS IN 2017:

- Monday 12 June, 2017
- Monday 18 and Tuesday 19 September, 2017

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

Did you know?

The College provides a listing of ***continuing education resources*** for pharmacists and pharmacy technicians?

Check it out at:
http://www.ocpinfo.com/practice-education/continuing-education/

This feature in *Pharmacy Connection* is a place to find information about news stories we're following. Here, you'll read summaries of recent stories relating to pharmacy in Ontario and Canada. For the latest updates, stay tuned to e-Connect and www.ocpinfo.com

MIFEGYMISO

Health Canada approved the drug Mifegymiso®, a two-drug combination product that provides a non-surgical option for early abortion, in July 2015. Mifegymiso became available to the Canadian public in January 2017.

Details provided by the manufacturer and Health Canada on the prescribing and dispensing of Mifegymiso indicated that physicians be both prescriber and dispenser. OCP and the College of Physicians and Surgeons of Ontario (CPSO) corresponded with Health Canada to seek clarification, as these requirements were outside the normal distribution system for medication in Ontario and would be challenging to operationalize. Based on their response, and collaboration with CPSO, the College subsequently created Guidance for Pharmacy Professionals Who Are Dispensing Mifegymiso.

Many reproductive rights organizations and women's health centres have expressed concerns that Mifegymiso is not accessible to patients under the current Health Canada stipulations and are lobbying for Health Canada to change the approved prescribing and dispensing process so that pharmacists could dispense the medication in alignment with the normal distribution system for medications in Ontario.

On April 28, the provincial government announced that as part of the 2017 budget Mifegymiso would be publicly funded in Ontario.

The College will continue to keep pharmacy professionals informed on any changes to the prescribing and dispensing of Mifegymiso.

MARIJUANA LEGALIZATION

The federal government has tabled legislation to legalize marijuana and begin the regulation of it for recreational use. Additional details around the conditions of sale are expected to be determined by each individual province in the coming months.

The College will be monitoring these developments closely for any implications for pharmacy professionals, pharmacies or patients and will provide guidance or clarification as needed.

ONTARIO CREATING A NEW SERVICE FOR ACCESSING MEDICAL ASSISTANCE IN DYING

The government of Ontario has announced that they are setting up a new service for people seeking medically assisted death. The "care coordination" service will help patients, or their caregivers, connect directly with healthcare navigators who will help handle requests related to medical assistance in dying (MAiD). The service is expected to assist in scenarios where a patient's healthcare setting or healthcare providers are not able to provide MAiD and will also provide additional information to the public about MAiD and palliative options. Similar services exist within Alberta and Manitoba.

The Medical Assistance in Dying Statute Law Amendment Act (previously known as Bill 84), which amended various acts with respect to MAiD and aligned provincial legislation with federal legislation, was passed by the legislature on May 9, 2017.

Pharmacy professionals should be aware of the College's Guidance on Medical Assistance in Dying and the Frequently Asked Questions on MAiD. The College will continue to monitor developments related to MAiD and will adjust guidance as needed.

OPIOID OVERDOSE TRACKING AND NALOXONE AVAILABILITY

A new research report has indicated that two people die every day in Ontario of opioid-related causes, including 734 in 2015. The Ministry of Health and Long Term Care has announced that hospitals will now begin tracking opioid overdoses on a weekly basis. This will contribute to understanding province-wide trends and the data will be accessible to hospital and public health units to better comprehend what is happening in their communities.

At the end of March 2017, more than 28,000 naloxone kits had

been distributed free of charge throughout Ontario, including through 1,000 pharmacies. The Ministry of Health and Long Term Care has created a naloxone webpage that helps the public to understand the role of naloxone and how to use it. It also has a listing of participating pharmacies, community organizations and other facilities where naloxone kits can be obtained. In addition, the Ministry has prepared resources to promote awareness of free naloxone kits, including a video and posters.

Pharmacists can dispense any formulation of naloxone available for sale and distribution in Canada, as long as it is in accordance with all of the requirements outlined in the College's Guidance – Dispensing or Selling Naloxone. It is the professional responsibility of a pharmacist to ensure that he or she has sufficient knowledge, skills and abilities to competently deliver any pharmacy service. The College has included links to external training resources for pharmacists to ensure they are prepared to safely and effectively provide naloxone to a patient or patient's agent.

NEW PHARMACARE PROGRAM FOR CHILDREN AND YOUTH

As part of Budget 2017, the Ontario government has announced the creation of a provincial pharmacare program for children and youth 24 years of age or younger. This program, titled OHIP+, will provide universal drug coverage, regardless of income, with no deductibles or co-payments. It will begin on January 1, 2018.

PRACTICE TIP!

GET A NEW PRACTICE TIP EVERY WEEK ON TWITTER

As you may be aware, the College has an official Twitter account. On a daily basis, we tweet out helpful regulatory news and updates, new practice tools, important member reminders, and much more. Every week we give you a new practice tip (followed by the hashtag #OCPPracticeTip).

Tips are developed from actual observations and encounters in practice and include: record keeping and documentation, methadone dispensing, narcotics reconciliation, clinical decision making, patient counselling, and much more.

Be sure to follow OCP on Twitter so you can see each new tip once it is published!

COUNCIL ELECTIONS

Your knowledge, skills and experience can help protect the public and enhance pharmacy practice throughout the province.

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 publicly appointed.

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 while you are elected by peers to share your perspectives based on your practice type or location, once elected to Council, Council members do not "represent" those who elected them, and those who elected them are not "constituents". Rather, Council has a fiduciary duty of undivided loyalty and good faith to the mandate of the College, which is to serve and protect the public.

Council meetings are held once per quarter and council members may also be appointed to sit on one or more committees. More information about Council can be found on our website.

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 21, 2017.

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.

ELIGIBILITY

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-Law.

LEARN MORE ABOUT THE ELECTION PROCESS AT *www.ocpinfo.com/about/council/election-process*

JOIN COUNCIL AS A **PHARMACY TECHNICIAN**

One seat available on Council to a pharmacy technician practicing (non-hospital setting) in Ontario.

Take part in the College's work to enhance public protection, bringing important insight and experience from your role as a pharmacy technician. You'll also get the opportunity to participate on various College committees.

One of the College's priorities in the coming year is to engage more with pharmacy technicians across the province and in every practice setting. As a Council member, you would have the chance to play an integral role in helping to guide and realize this strategy.

This is a by-election for a term of two years.

JOIN COUNCIL AS A **PHARMACIST**

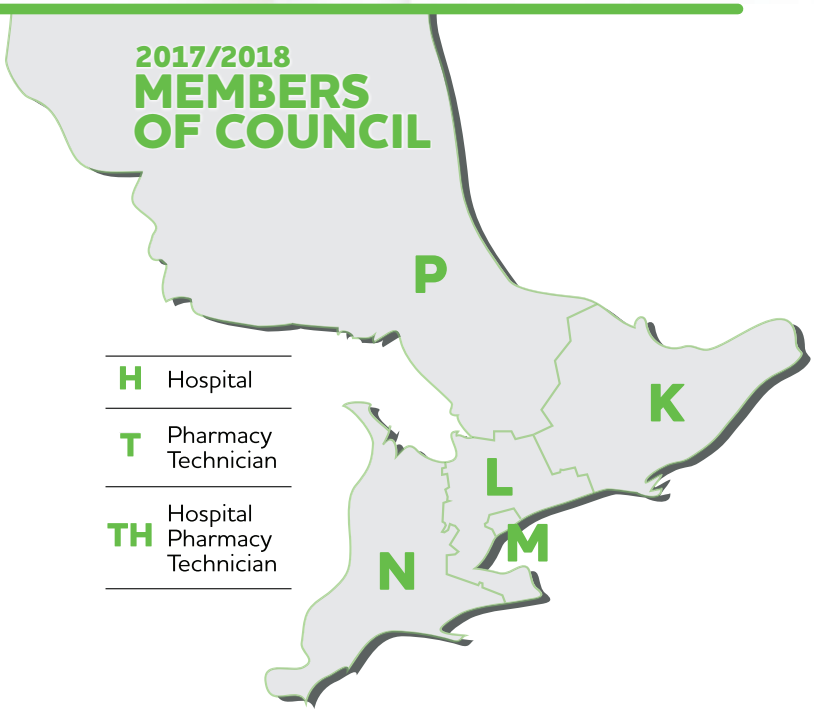
There are a total of six Council seats open to pharmacists in districts M, P and N.

District M
Three seats available for a three year term.

District P
Two seats available for a three year term.

District N (by-election)
One seat available for a one year term.

2017/2018 MEMBERS OF COUNCIL



KEY DATES FOR COUNCIL ELECTIONS

Nominations Open: June 1
Nominations Close: June 21
Voting to commence by: July 10
Voting closes: August 2

Get Involved as a Non-Council Committee Member

Committees require the appointment of pharmacists and pharmacy technicians who are not elected members of Council to serve on various statutory or standing committees. In addition, pharmacists and pharmacy technicians with particular experience or expertise are occasionally needed to serve on various special committees, working groups or task forces.

At the beginning of each Council year (September Council), the statutory and standing committees of the College are established. The Chairs of the Committees are elected on the first day of the Council meeting after which the remaining committee members are appointed.

To be eligible for appointment as a non-council committee member (NCCM), pharmacy professionals must meet the requirements as set out under the By-laws (Article 7.6).

The Role of a Non-Council Committee Member

It is important to note that you have a fiduciary duty of undivided loyalty and good faith to the mandate of the College, which is to serve and protect the public.

Your fiduciary duties also include:

- Being **Diligent** – being prepared for meetings, reviewing materials, arriving on time and participating in discussion.
- Being **Civil** – respecting the process and fellow committee members, paying attention (e.g., no mobile devices during the meetings), genuine listening and consideration and not making up your mind before arriving to the meeting.
- Being **Ethical** – using College resources appropriately, being accurate on the facts (e.g., reading the materials on a particular matter).
- Being aware of **Conflicts of Interest** (e.g. financial, adjudicative, organizational).
- Ensuring **Confidentiality** is maintained. This applies to all information obtained in the course of duties for OCP, unless an exception applies. This is especially important when discussing complaints since you will often be dealing with unsubstantiated allegations and maintaining confidentiality will prevent tainting of processes, facilitate exploration of all options and avoid misinterpretation.

To further understand the role of an NCCM, please review the College Objects (Appendix 4 of the Governance Manual), By-laws, Code of Ethics and Code of Conduct for Council and Committee members.

Term and Date of Appointment: NCCMs serve a one-year term, which starts at the beginning of each Council year (September Council meeting). An orientation will be conducted by the Chair of the Committee to which you are appointed.

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.

If you are interested in being considered for appointment to a committee or have any questions, send an email, by July 31, 2017, to Ms. Ushma Rajdev, Council and Executive Liaison in the Registrar's office at council@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.

Committee Opportunities

The table below provides a brief description of the duties of the Committees, the minimum number of NCCM positions required to be filled and the approximate number of days required for meetings.

Staff will solicit the availability of members well in advance of booking meetings, and will confirm meeting times with participants. For most meetings, material will be made available online and prior to the meeting to allow time for review .

Committee	Frequency of Meetings and Number of NCCMs Required
Accreditation Committee The Accreditation Committee considers matters relating to the operation of community pharmacies in Ontario and also reviews issues relating to pharmacy assessments conducted by College practice advisors where the pharmacy has failed to comply with the requirements.	Six times a year 2 NCCMs
Drug Preparation Premises Committee The Drug Preparation Premises Committee considers all matters relating to the operation of drug preparation premises (DPPs) in Ontario.	One to two times a year (coordinated with Accreditation Committee meetings) 2 NCCMs
Discipline Committee Panels of the Discipline Committee hear allegations of professional or proprietary misconduct.	Approximately twenty-five hearings a year, heard by panels*, plus two meetings of full committee 5 NCCMs
Fitness to Practice Committee The Fitness to Practice Committee considers incapacity matters referred by the Inquiries, Complaints and Reports Committee.	One to two times a year 1 NCCM
Inquiries, Complaints and Reports Committee (ICRC) The Inquiries, Complaints and Reports Committee (ICRC) oversees all investigations into a practitioner's conduct, competence and capacity (this includes pharmacists, pharmacy technicians, students or interns), as well as all complaint investigations, registrar's investigations and health inquiries.	Four panel* meetings a month, plus two meetings of the full committee 7 NCCMs
Patient Relations Committee The Patient Relations Committee advises Council regarding the patient relations program, which enhances relations between practitioners and patients. It also deals with preventing and handling matters relating to sexual abuse of patients by practitioners.	One to three times per year 1 NCCM
Quality Assurance Committee The Quality Assurance Committee develops and maintains the Quality Assurance program. It supports continued competence and encourages continuing professional development of practitioners.	Four times a year 3 NCCMs
Registration Committee The Registration Committee provides guidance to Council on matters concerning registration, examinations and in-service training required prior to registration.	Monthly panel* meetings, plus three to four meetings a year of full committee 1 NCCM
The Discipline, ICRC and Registration Committees all operate using panels comprised by interchanging committee members.* **Note also that for the Discipline Committee, contested hearings may require multiple-day attendance i.e. between 3-5 days at a time.	

Institute for Safe Medication Practices Canada
REPORT MEDICATION INCIDENTS
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 17 • Issue 1 • January 31, 2017

Errors Associated with Hospital Discharge Prescriptions: A Multi-Incident Analysis

- *Communicate with patients and their caregivers when reviewing prescription information during the transition at discharge.*
- *Implement standardized discharge processes to enable the creation of discharge prescriptions that are accurate, unambiguous, appropriate, and understood by all in the patient's circle of care.*
- *Community caregivers and providers are encouraged to review how they process hospital discharge prescriptions to minimize or improve upon error-prone processes and procedures.*

During a hospital stay, a patient's medication regimen may undergo multiple changes. If these changes are not captured accurately on the patient's discharge prescription, these discrepancies can lead to medication errors. A recent study of the medication lists for geriatric patients at the time of discharge from hospital revealed that 56% of patients experienced at least 1 prescribing error.[1] Such errors can result in patient harm, readmission to hospital, and/or an increased workload for care providers, as well as having the potential to undermine patients' confidence in the healthcare system. A multi-incident analysis of medication incidents involving discharge prescriptions was conducted to better understand the challenges around the creation and processing of hospital discharge prescriptions and to share opportunities for system-based improvements.

Methodology and Quantitative Findings

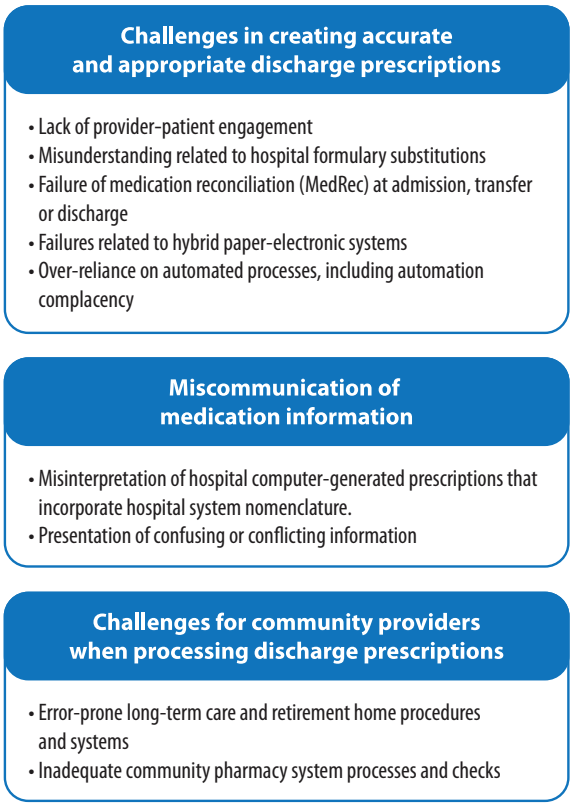
Reports of medication incidents related to discharge prescriptions were extracted from voluntary reports* submitted to 3 ISMP Canada reporting databases (Individual Practitioner Reporting, Community Pharmacy Incident Reporting, and Consumer Reporting) and the National System for Incident Reporting† (NSIR) from April 1, 2010, to November 8, 2016. Key phrases used to search the databases included "discharge prescription", "discharge Rx", "hospital prescription", "hospital Rx". A total of 156 incidents were extracted for review. Reports unrelated to discharge prescriptions, those containing insufficient detail, and duplicate entries were omitted from the dataset. After these exclusions, 134 incidents were included in the final analysis, which was conducted according to the methodology outlined in the Canadian Incident Analysis Framework.[2] About 10% of these cases resulted in harm.

* It is recognized that it is not possible to infer or project the probability of incidents on the basis of voluntary reporting systems.
† 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

Qualitative Analysis

Analysis of the incidents identified 3 main themes and associated subthemes (Figure 1).

Figure 1. Main themes and subthemes from the qualitative analysis



Theme: Challenges in Creating Accurate and Appropriate Discharge Prescriptions

A key component of the patient discharge process is the creation of accurate and appropriate discharge prescriptions. Table 1 highlights the challenges identified within this theme that led to problems with discharge prescriptions.

Factors contributing to the incidents included lack of a systematic discharge medication reconciliation (MedRec) process that incorporates patient engagement, lack of a standardized discharge prescription template across hospitals, and missed opportunities for communication with community pharmacists. The Facilitating Medication Safety at Transitions toolkit and checklist are available for hospitals to help re-examine some of these processes, with the goal of optimizing the transition of patients and their medications at discharge.

- **Recommendation:** Implement standardized discharge processes to enable the creation of discharge prescriptions that are accurate, unambiguous, appropriate, and understood by all in the patient's circle of care.

There is preliminary evidence that electronic MedRec solutions, especially those that incorporate the creation of a discharge prescription, can reduce prescribing discrepancies and errors at discharge.[3] However, with the adoption of new technologies, new sources of error can arise; therefore, hospitals that are designing electronic systems are encouraged to refer to the *Discharge Medication Reconciliation – Clinical Requirements* expert panel workshop proceedings for guidance.[4]

Theme: Miscommunication of Medication Information

Discharge prescriptions are the most common method of communicating changes to medication regimens to the next care providers, which makes the information contained in these documents vital. The multi-incident analysis showed that computer-generated discharge prescriptions included hospital system nomenclature that was misinterpreted by community providers, and led to errors and delays in the dispensing process. Use of ambiguous dose and nonstandard abbreviations were noted. Opportunities exist both to standardize discharge prescriptions and to have community stakeholders involved in testing the clarity of hospitals' computer-generated discharge prescriptions.

Incident Example

A patient recently discharged from hospital was given a computer-generated discharge prescription that read "warfarin 4mg WRF". The

Table 1. Subthemes for challenges related to creating accurate and appropriate discharge prescriptions

Subtheme	Discharge Prescription Problem and Example
Lack of provider–patient engagement	**Incorrect patient or inappropriate agent/formulation** – Failure to correctly identify a patient led to the patient receiving another patient's discharge prescriptions. Lack of consideration of patient-specific factors led to prescribing of a less-than-desirable agent/formulation (e.g., medication not covered by insurance, devices requiring manual dexterity).
Misunderstanding related to hospital formulary drug substitutions	**Therapeutic duplication** – Hospital formulary drug was substituted for patient's at-home medication during inpatient stay and was subsequently prescribed at discharge; patient resumed preadmission medication at home along with newly prescribed formulary drug, which resulted in therapeutic duplication.
Failure of medication reconciliation (MedRec) at admission, transfer or discharge	**Medication omissions** – Home medications not identified during admission MedRec (whether or not they were to be continued in hospital) resulted in omissions from discharge prescriptions and led to confusion on the part of patient and community providers.
Failures related to hybrid paper–electronic systems	**Incomplete information** – Paper-based systems not communicating with electronic systems within the same organization resulted in information being omitted from the discharge prescription.
Over-reliance on automated processes, including automation complacency	**Inappropriate medications** – Prescribers signed the computer-generated discharge prescriptions without assessing each medication for appropriateness for continuation at home (e.g., analgesia, routine post-operative bowel regimen).

community pharmacist interpreted "WRF" as "Wed, Thurs, Fri". Upon checking with the hospital, however, the pharmacist discovered that "WRF" was a short form for "WaRFarin" used by that particular hospital to indicate its usual warfarin daily dose administration time.

Effectively communicating key medication information, including changes in therapy, to the patient and family is integral to the success of the discharge medication plan. This analysis identified many gaps and discrepancies in the information provided to patients, including provision of information that conflicted with the directions on the prescription, which resulted in the patient using medication(s) in a different way than intended. ISMP Canada has **previously recommended** that prescriptions be written in a manner that patients can read and understand (e.g., without unnecessary abbreviations).[5]

Hospital staff can engage patients and caregivers by using the "5 Questions to Ask about your Medications" to foster discussions about medication changes during this critical time and by using teach-back techniques to enhance uptake. There is also evidence that a post-discharge follow-up phone call to certain high-risk patients can help to prevent readmissions.[6]

- **Recommendation:** Engage patients and their caregivers at or before discharge to communicate changes in the medication regimen and to support an independent check of the discharge prescriptions.

Theme: Challenges for Community Providers when Processing Discharge Prescriptions

The analysis identified unique challenges faced by community providers in dealing with hospitals' discharge prescriptions. For example, some community pharmacies that service retirement or long-term care facilities use a system that requires the facilities to transcribe information from the hospital discharge prescription onto a digital MedRec form. This form is then sent to the community pharmacy for dispensing. The additional process of interpretation and transcription led to errors, including omission of medications, ordering of incorrect drugs, and dosing errors. When a resident is discharged to a long-term care facility, the hospital's original discharge prescriptions and/or discharge plan should be shared with the dispensing pharmacy to support accurate dispensing and thorough MedRec processes.

> ***Incident example***
>
> A long-term care resident who had been in hospital was given a prescription for a beta-blocker at the time of discharge back to the care facility. The nurse transcribed the discharge prescription onto the partner pharmacy's order form, but misinterpreted the instructions. Fortunately, the mistake resulted in a subtherapeutic dose of the medication, which was questioned by the pharmacist. After the pharmacist requested a copy of the hospital's discharge prescription form, the discrepancy was resolved.

- **Recommendation:** Long-term care and retirement facilities should forward to their partner community pharmacies, the hospital's discharge prescriptions along with the electronic order forms containing the transcribed information, to support an independent check process.

Patients are often discharged home with prescriptions for a large number of medications, including both new therapies started in hospital as well as preadmission medication to be continued. These latter prescriptions are handled in various ways by the community pharmacy. New prescriptions for existing and unchanged therapies are often logged as inactive or "for future use" in the computer, meaning that they will be activated and dispensed when the current prescription runs out. Prescriptions with changes are processed by copying and modifying existing orders in the computer, while also discontinuing the original order. This helps with pharmacy workflow and saves time in processing the prescriptions. However, the copying process is error-prone.

- **Recommendation:** Community pharmacies processing hospital discharge prescriptions should minimize "electronic copying" when entering changes into pharmacy dispensing systems.

Conclusion

The creation of a complete, accurate, and unambiguous hospital discharge prescription is a vulnerable point in the process of transferring medication information. Findings from this multi-incident analysis concurred with the findings of an observational study that reported omissions and incomplete, conflicting, or unclear information in many discharge prescriptions.[7] The analysis findings also led to recommendations. Opportunities exist for hospitals to implement a standardized discharge process that includes clarifying discrepancies, validating the accuracy, completeness, and clinical appropriateness of the prescriptions, and a review of the discharge regimen with patients and caregivers.[1,8] Additionally, it is important to capture incidents related to discharge prescriptions in hospital incident reporting systems so vulnerable processes and systems can be identified. Community partners can likewise review how they handle hospital discharge prescriptions in the context of the error-prone processes identified in this analysis to minimize errors.

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Diabetic Ketoacidosis with SGLT2 Inhibitors

Diabetic ketoacidosis (DKA) is a rare medical emergency resulting from insulin deficiency, making it difficult for the body to use glucose for energy. In this situation, complex metabolic changes occur that result in a dangerous build-up of ketones in the body, leading to ketoacidosis. Hyperglycemia is a typical finding of DKA, resulting from the unused glucose. Symptoms of DKA include thirst, excessive urination, nausea, vomiting, abdominal pain, confusion, fever, a fruity odour on the breath, and a sense of air hunger.

The sodium-glucose cotransporter 2 (SGLT2) inhibitors (canagliflozin, dapagliflozin, and empagliflozin) are a new class of hypoglycemic medications (for patients with type 2 diabetes mellitus) that have been associated with an atypical presentation of DKA. Affected patients may present with euglycemia or only a slight increase in blood glucose level, rather than the high blood glucose levels typical of DKA. Although, SGLT2 inhibitor-induced DKA in patients with type 2 diabetes is considered rare (≤0.1%), its atypical presentation may delay diagnosis and treatment. A recently published review provides practical recommendations for prevention and diagnosis of SGLT2 inhibitor-induced DKA.[1]

Selected Key Learning

- All patients with diabetes who are being treated with an SGLT2 inhibitor should be advised to withhold their SGLT2 inhibitor therapy during any situation that might precipitate DKA (e.g., acute illness, surgery, dehydration, missed insulin doses).
- Any patient who is taking an SGLT2 inhibitor and who experiences symptoms of DKA should go to the emergency department for evaluation, even if initial blood glucose testing shows euglycemia. If DKA is diagnosed, the SGLT2 inhibitor should be stopped.

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This segment of the bulletin describes a recent SafeMedicationUse.ca publication from ISMP Canada's Consumer Program.

January 2017 Newsletter

What to Expect if the Pharmacy Makes a Mistake

Although pharmacists aim to give their patients the best care, errors sometimes happen at the pharmacy. How pharmacists handle the situation when a medication error occurs is critical to continuing their trusted relationship with patients. The most recent SafeMedicationUse.ca newsletter shares with patients what they should expect from the pharmacist, should they discover a medication error.

In general, the following steps should be taken by the pharmacist if a medication error is discovered:

- When a patient reports a medication error, acknowledge and listen to the patient's concern in a private area of the pharmacy.
- Conduct an investigation to confirm whether an error has occurred. If there was an error, acknowledge it and offer the patient a sincere apology.
- Inform the prescribing physician of the error. If the patient is experiencing adverse effects, or there is a risk of adverse effects, send the patient to the doctor or the emergency department.
- Develop an action plan to prevent similar errors in the future. Involve the pharmacy team, and possibly the patient, in the processes of developing and implementing the action plan.
- Follow up with the patient to describe the action plan and to thank the patient for identifying and reporting the incident.
- Consider reporting the medication error to a third party (e.g., ISMP Canada) if the learning can help to prevent errors in other pharmacies and/or inform standards of practice.

Consumers Can Help Prevent Harmful Medication Incidents

SafeMedicationUse.ca

College Developing **New Pharmacy Technician Strategy**

At our recent Council meeting, engagement with pharmacy technicians was identified as an important priority and focus of Council. The College is currently developing a strategy that will focus on the integration of pharmacy technicians in practice, as well as their engagement with the College. This will involve looking at both the core programs of the College, and how we communicate to stakeholders, including pharmacy technicians, pharmacists, Designated Managers, owners, corporations, educators and associations.

INTEGRATION OF PHARMACY TECHNICIANS FOR ENHANCED PATIENT CARE

In December 2010, Ontario became the first province in Canada with registered pharmacy technicians.

Pharmacy technicians play a vital role in both community and hospital pharmacy settings, supporting the pharmacist in providing more comprehensive patient care services. By taking responsibility for certain technical components within the pharmacy, pharmacy technicians allow pharmacists to expand their services and scope of practice, such as counselling, monitoring and injections, to improve patient care. As regulated healthcare professionals, pharmacy technicians are accountable and responsible for the technical aspects of both new and refill prescriptions, (i.e. the correct patient, drug dosage form/route, dose, prescriber) and the final release of the product to the patient.

> "Fifty nine percent of pharmacy technicians are working in hospital or other healthcare facilities"

There are a number of ways that pharmacy technicians have been incorporated into workflows at various community and hospital settings. The College has a video on Integrating Technicians into Community Practice and other resources available on our website.

THE CURRENT LANDSCAPE

In the more than six years since pharmacy technicians were regulated, they have been significantly integrated into the hospital system. Fifty nine percent of pharmacy technicians (or 2,178) are working in hospital or other healthcare facilities. This is a 100% increase in the hospital sector over three years.

However, this same growth and integration has not been seen in community practice, where there has only been a 50% increase in the last three years (from 926 to 1,403). Eighty-one percent of the community pharmacies where the College has done pharmacy assessments in the last three years report they do not have pharmacy technicians working to scope on an average day.

Registration of pharmacy technicians with the College is stabilizing after steady growth since regulation, with 4,286 currently registered. It is anticipated that growth in the coming years will reflect registration of new graduates.

DON'T FORGET TO VOTE!

Only 10% of pharmacy technicians voted in the last Council election. One seat is available for a pharmacy technician in non-hospital practice.

Learn more about Council Elections on page **10**

WHAT'S ***NEXT?***

The College is committed to the full engagement and integration of pharmacy technicians in Ontario and is currently finalizing a Pharmacy Technician Strategy, to be presented to Council in June.

In addition to internal College activities, the Pharmacy Technician Strategy will engage with stakeholders to address how business practices and educational preparation can enhance the ability of pharmacy technicians to fully engage and work to their full scope. It will also engage pharmacists to work collaboratively with pharmacy technicians, utilizing their support to maximize their own clinical role. Measures of engagement and integration will be used to track progress over time and inform decisions about ongoing activities within the strategy.

RESOURCES TO HELP PATIENTS **MANAGE THEIR MEDICATIONS DURING RAMADAN FASTING**

The University of Waterloo has developed a number of resources to support pharmacy professionals in helping patients manage their medications – and health – during Ramadan. Ramadan is marked by a month of fasting for practicing Muslims, who refrain from eating, drinking, and taking oral medications from dawn to sunset. This year the holy month begins on the evening of May 26 and ends in the evening on June 24.

The resources below were created as part of Pharmacy 5in5, an interactive learning platform to help pharmacy professionals self-audit their knowledge and acquire a deeper understanding of a variety of clinical and professional topics. Pharmacy 5in5 is supported and funded, in part, by OCP. We will provide more information on this platform in an upcoming issue of *Pharmacy Connection*.

Video: 5 Things Healthcare Providers Should Know About Ramadan

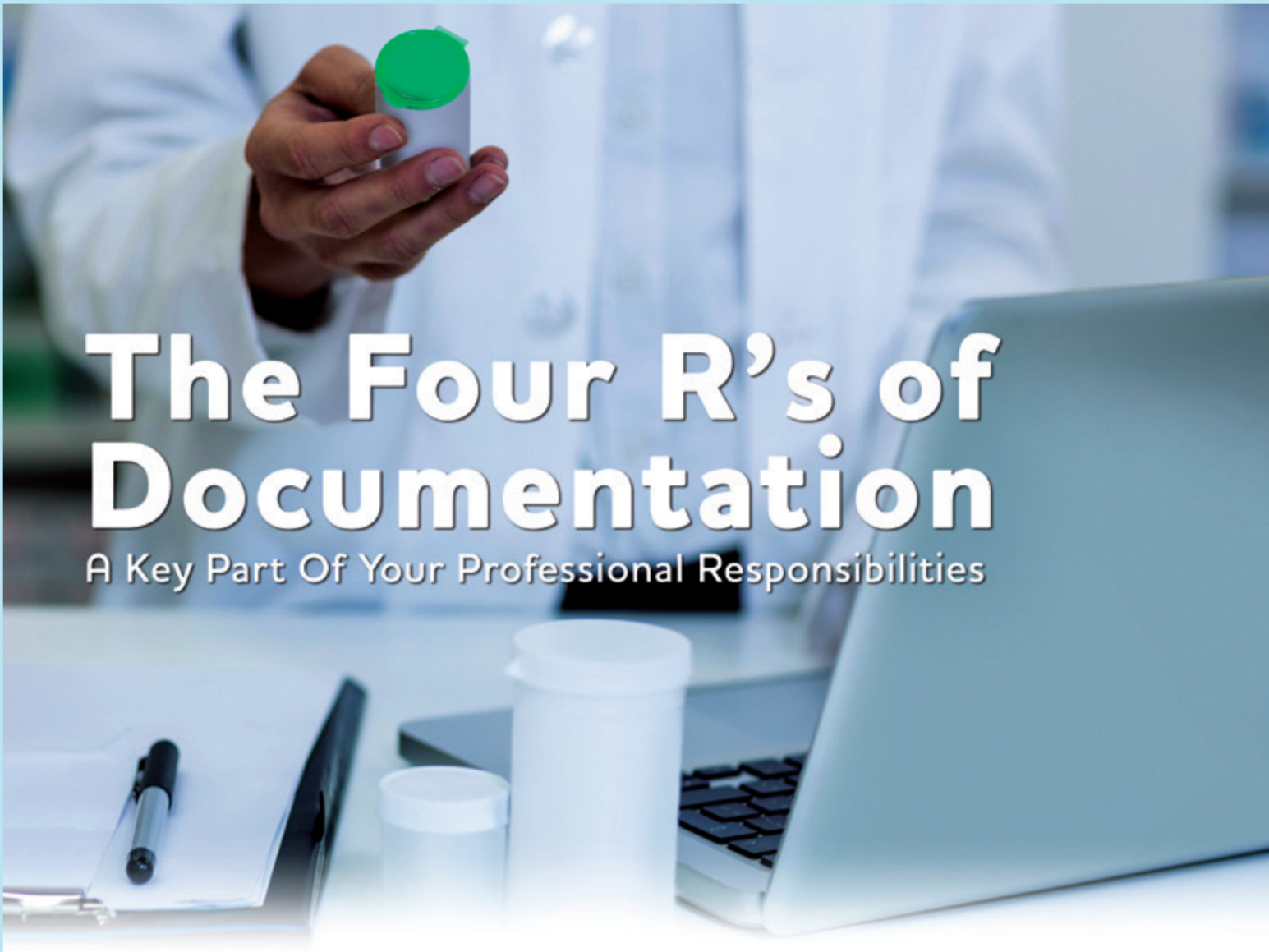
Learn five ways you can help patients during Ramadan fasting in this motion-graphics style video narrated by University of Waterloo assistant professor Wasem Alsabbagh.

Article: Managing Medications During Ramadan Fasting

In this article, University of Waterloo assistant professors, Kelly Grindrod and Wasem Alsabbagh, offer an inside look into Ramadan and what you can do to help patients manage their health during the fasting period.

Infographic : Ramadan Fasting and Medication

This infographic, which can be easily displayed in your practice for pharmacy staff to review, walks you through key facts about safe medication management during Ramadan.



The Four R's of Documentation

A Key Part Of Your Professional Responsibilities

RELIABLE

Documentation is a fundamental component of a pharmacy professional's responsibilities. Pharmacists and pharmacy technicians must know and understand when and how to document their actions related to dispensing and therapeutic activities.

For new prescriptions, documentation should reliably demonstrate that each prescription has been reviewed for both technical and clinical aspects before it is dispensed to the patient. Each completed prescription record must contain the signature, or some other identifying mechanism, from the pharmacy professional(s) involved in the dispensing process. Where a technician and pharmacist are working collaboratively, the documentation must reflect each professional's responsibilities.

There is no set manner for how this must be achieved, as workflow may vary depending on the nature of the practice. Designated Managers are encouraged to emphasize consistency by establishing operational processes for documentation on both the patient record and the prescription hardcopy.

RETRIEVABLE AND USEABLE

Continuity of care is extremely important for patient safety, whether between different health care settings, or between different pharmacy professionals within the same pharmacy. In order to enable effective and efficient communication, documentation must be clear and available.

Pharmacy professionals should document information in a manner that is timely, readily retrievable and easily accessible by staff. Pharmacies are encouraged to have a standardized process in place to maintain patient-specific, and not only transaction-specific, records

The ease of retrieval for patient records, including those that may be stored off-site or with a third party, must be balanced with the need to maintain confidentiality. The pharmacy's record keeping system must be secure enough to protect personal health information against theft, loss, and unauthorized use or disclosure.

ROBUST

A thorough and complete patient record will demonstrate accountability for a pharmacy professional's decisions and actions.

Pharmacists should exercise professional judgment when determining the appropriate amount of documentation. There should be sufficient information to effectively manage a patient's drug therapy, monitor their progress, and ensure continuity of care. The exact content and level of detail will vary depending on the situation; thus, the lists below are provided as a guideline only.

Effective documentation on the patient record should include:

- ☑ Patient information gathered, such as allergies, medical conditions, medications, changes in health, monitoring information and relevant patient characteristics or circumstances;
- ☑ Indication for medication, where relevant, to facilitate monitoring and future assessment and continuity of care; and
- ☑ Collaboration with other healthcare providers, if relevant.

For adaptations, renewals and medication reviews, documentation should include the following (if applicable) in addition to the above list:

- ☑ Consent;
- ☑ Patient assessment;
- ☑ Decisions made and rationale;
- ☑ Follow up; and
- ☑ Communication with patient/agent.

Documentation without these important details is at risk of being misinterpreted, not accurately reflecting the actual care provided, and impeding collaboration or follow-up.[1]

RETAINED

Documentation may be maintained electronically, as scanned originals. Once scanned, the decision to destroy paper based records is left to the discretion of the Designated Manager, who should evaluate the systems and backup processes in place.

Patient records must be kept for at least 10 years from the last recorded professional pharmacy service provided, or 10 years after the day on which the patient reached (or would have reached) 18 years or age, if longer. As long as a patient continues to use a pharmacy, their entire record would need to be retained indefinitely. When a pharmacy is sold or closed, the Designated Manager is responsible for transferring complete custody and control of the records to another pharmacy.

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RESOURCES

- OCP Documentation Guideline
- OCP Record Retention, Disclosure and Disposal Guideline
- Documentation Practice Tool

STERILE **COMPOUNDING** STANDARDS: *GAP ANALYSIS*

As previously reported, Council has approved both the *Model Standards of Practice for Pharmacy Compounding of Non-hazardous Sterile Preparations* and the *Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations* for implementation by *January 1, 2019*. The standards will apply in all pharmacies where sterile compounding is performed, including community pharmacies, drug preparation premises and hospital pharmacies.

The College has produced two gap analysis documents based on the Community and Hospital Assessment Criteria. Criteria have been taken from the relevant legislation, policies, guidelines or standards of practice. These gap analysis documents have been provided as tools to assist pharmacy professionals in assessing gaps in their sterile compounding practice and determining next steps required to meet the *Model Standards of Pharmacy Compounding for Non-Hazardous Sterile Preparations* and *Hazardous Sterile Preparations*. They can also be used to track and monitor progress. The documents are not meant to replace the standards.

If you have a practice assessment coming up, we encourage you to fill out the document ahead of time for discussion with your practice advisor. While the College does not require you to fill out or submit this analysis, and you are welcome to use other resources that might be available, we believe it will be very helpful in ensuring that your pharmacy is prepared for upcoming deadlines.

During the implementation timeline, your practice advisor will be monitoring your progress to ensure compliance with the standards by January 1, 2019

Some elements of the standards, such as infrastructure or equipment, may take some time to put in place. However, you should start by concentrating on the people and the processes in your pharmacy. For example, you could begin by focusing on orientation, training, policies and procedures, guidelines, documentation, and quality assurance.

The College will continue to identify opportunities for the development of additional supporting material and guidance to assist pharmacies in meeting these standards.

Access the Gap Analysis for Hazardous Sterile Preparations and the Gap Analysis for Non-hazardous Sterile Preparations.

Antimicrobial Stewardship in Ontario:

What's Your Role?

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The Challenge

Antimicrobial Resistance (AMR) is an increasing problem globally. The combined impact of increasing prevalence of antibiotic resistance with very few novel antimicrobials on the horizon has the potential to be overwhelming – a recent global review estimates that by the year 2050, global deaths due to antibiotic resistance infections will surpass deaths due to cancer.[1] For this reason, the Government of Canada has committed to working with the provinces to address the threat of AMR.[2]

What is antimicrobial stewardship?

Antimicrobial stewardship, which refers to a set of coordinated interventions which promote the optimal selection, dosing and duration of antimicrobial therapy, is one part of this overall strategy required to address AMR.[3] In other words, it means ensuring those who need antibiotics get the right drug, at the right time, using the right dose and for the right duration.

The emerging role of pharmacists in out-patient antimicrobial stewardship

In 2013, antimicrobial stewardship became an Accreditation Canada Required Organizational Practice (ROP) for hospitals and as a result, almost all hospitals in Ontario now have formal antimicrobial stewardship programs (ASPs) in place.[4] Pharmacists play a prominent role in these hospital ASPs.[5]

In non-acute care settings, coordinated approaches to antimicrobial stewardship are in early stages of development. Despite the fact that about 80 per cent of all antimicrobials are prescribed in the community,[6] there are currently very few formal programs in community or long-term care. This may be due in part to the lack of Canadian accreditation requirements in these sectors. As easily accessible healthcare providers with drug expertise, pharmacists working in non-acute care settings have an opportunity to help shape antimicrobial stewardship initiatives in these settings.

Community pharmacists in Ontario already play a key role in infection prevention by providing immunizations so it is a natural next step for pharmacists to become engaged in antimicrobial stewardship as recently articulated

Ways pharmacists can impact out-patient antimicrobial stewardship:

- Reinforce when antibiotics do not help (e.g. viral infections) and educate on the risks of antibiotic use (e.g. adverse reactions, *C.difficle* infection);
- Collaborate on stewardship interventions such as delayed prescribing and audit and feedback;
- Discourage the use of prolonged antibiotic durations for common bacterial infections (e.g. cystitis, pneumonia, skin and soft tissue infections);
- Track and evaluate antibiotic utilization.

by the Canadian Pharmacists Association,[7] Ontario Pharmacists Association[8] and CDC Core Elements of Stewardship for Outpatient Settings.[9] While pharmacists should continue to educate patients on the judicious use of antibiotics and antibiotic-related harms, they should also look for ways to actively collaborate with prescribers in more targeted stewardship strategies such as delayed prescribing. This approach is used for infections such as sinusitis where patients are provided a prescription and instructed to initiate antibiotics only if symptoms do not improve after a specified period of time. In this instance, pharmacists can support prescribers that wish to use delayed prescribing by reinforcing symptom management and when to follow-up when counselling patients.[10]

Pharmacists working in primary care collaborative practice environments such as Family Health Teams are uniquely positioned to help promote and implement effective antibiotic audit and feedback strategies, which are gaining momentum. Similar to the use of prospective audit with intervention and feedback in acute care settings, individualized feedback to clinicians and peer comparison of antibiotic prescribing practices are strategies that have been shown to increase guideline adherence and reduce unnecessary prescribing.[11,12]

Pharmacists practicing in the long-term care sector can also have a significant impact. The CDC's Core Elements of Stewardship for Nursing Homes calls for pharmacists to be partners and leaders in antimicrobial stewardship.[13] It is also encouraging to see that support from consultant pharmacists with training in stewardship contributes to reducing antibiotic use and negative consequences of antibiotic harms in long-term care homes (LTCH).[14] Antibiotic overuse such as prolonged treatment durations for common bacterial infections is a significant problem in Ontario's LTCHs.[15,16] Research shows that residents in Ontario homes with higher antibiotic use are at an increased risk of antibiotic-related harm.[17] To help address this, pharmacists practicing in the long-term care setting can lead a number of activities such as implementing mechanisms to reduce unnecessary antibiotic prescriptions, discourage the use of prolonged antibiotic durations and systematically track antibiotic utilization, all of which contribute to a robust stewardship program.[13]

Antimicrobial stewardship is a shared responsibility which requires the active participation of pharmacists. With pharmacists already playing a leadership role in acute care programs, the timing is right for community pharmacists and those working in long-term care to rise to the challenge of moving antimicrobial stewardship forward in those sectors.

PHO Antimicrobial Stewardship Resources

Public Health Ontario (PHO) has developed several resources intended to help build or enhance ASPs.

Antimicrobial stewardship strategies that can be used to optimize antimicrobial use in health care institutions.

Hospital profiles that provide examples of ASPs in community hospitals.

ASP posters to promote appropriate prescribing in hospitals.

Infographic that describes antibiotic overuse and impact in Ontario's long-term care homes.

Urinary Tract Infection (UTI) Program to help support long-term care homes adopt and sustain best practices for managing and treating UTIs.

PHO aims to help advance antimicrobial stewardship in Ontario by providing scientific and technical guidance, resources and expertise to support stakeholders to implement and strengthen their individual ASPs. PHO is also leading research and evaluation of antimicrobial stewardship interventions and programs. For more information about ASP at PHO, please visit publichealthontario.ca or email asp@oahpp.ca.

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"Close-Up on Complaints" presents issues that occur in practice so that pharmacists and pharmacy technicians can use them as learning opportunities. Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

AVOIDING ACTUAL OR PERCEIVED CONFLICT OF INTEREST IN BUSINESS DEALINGS

SUMMARY OF THE ISSUE

This issue occurred when a pharmacist placed an advertisement for physicians to work in the medical clinic adjacent to the pharmacy in a building owned by the pharmacist. The advertisement offered "zero overhead" for the physician and payment of expenses by the pharmacy.

A physician sought more information from the pharmacist who informed the physician that the unoccupied space did not have existing expenses, but clarified that any new costs incurred by the clinic would not be covered by the pharmacy. The pharmacist expressed that there was no obligation or expectation of the physician occupying the clinic to encourage patients to fill their prescriptions at the pharmacy, and that the pharmacist believed that nothing prohibited a pharmacy from receiving payment from a physician based on a percentage of earnings. The physician felt that this agreement would contravene conflict of interest regulations for both pharmacists and physicians.

WHY DID THIS HAPPEN

The main concern here is conflict of interest, whether actual or perceived. It could be perceived that offering clinic space owned by a pharmacist at no cost would be an inducement to prescribers, regardless of whether the prescriber is actually referring patients or suggesting they have their prescriptions filled at the pharmacy. It could be perceived that such an arrangement would encourage a prescriber to engage in such activity.

It could also be perceived that a pharmacist's professional judgment might be compromised in situations in which a pharmacist was receiving increased business from a prescriber. This may affect their ability to be impartial and unbiased in decision-making, as they may fear that questioning a prescription by the prescriber could negatively impact the prescriber-pharmacist relationship and thus the pharmacy's business.

Pharmacy professionals must avoid situations that are, or may reasonably be perceived to be, a conflict of interest. It is also expected that pharmacy professionals will avoid dual relationships and other situations which may present a conflict of interest and potentially affect their ability to be impartial and unbiased in decision-making.

COMPLAINT OUTCOME

The College's Inquiries, Complaints & Reports Committee (ICRC) oversees investigations of each complaint or report the College receives. The Committee considers a pharmacy professional's conduct, competence and capacity by assessing the facts of each case, reviewing submissions from both the complainant and the pharmacy professional, and evaluating the available records and documents related to the case.

The Panel noted that the primary issue raised by the facts before it is the conflict of interest provisions under both the Professional Misconduct Regulations and the *Drug and Pharmacies Regulation Act*. Provisions under the Professional Misconduct Regulations state that it is professional misconduct for a member to practice the profession while in a conflict of interest, while provisions under the *Drug and Pharmacies Regulation Act* state that it is proprietary misconduct to carry on business as a pharmacy while in a conflict of interest as defined in the regulation.

The Panel concluded that these provisions prohibit pharmacies and pharmacy professionals from offering prescribers inducements in the nature of free or below market value rent for premises. Such arrangements give at least the appearance of an inducement to encourage prescribers to maximize patient attendance at a pharmacy, regardless of whether or not this is actually occurring. In the decision, the Panel noted that it would be prudent for pharmacy professionals to rent out premises to physicians or other healthcare professionals at market value.

> "The Panel noted that it would be prudent for pharmacy professionals to rent out premises to physicians or other healthcare professionals at market value."

The Panel issued advice and recommendations to assist the pharmacist in how he may be more thoughtful in his practice when engaging in business relationships.

LEARNINGS FOR PHARMACY PROFESSIONALS, DESIGNATED MANAGERS, DIRECTORS AND CORPORATIONS

Reflecting on this complaint provides pharmacy professionals, Designated Managers, directors and corporations with learning opportunities to recognize and avoid conflicts of interest in business dealings. There is a joint responsibility for all involved in the provision of pharmacy services to ensure that the primary focus is on the well-being and best interest of the patient and that professionalism and ethics are being applied in all areas related to practice.

A perceived conflict of interest can erode public trust just as much as an actual conflict of interest. Patients trust that as healthcare professionals, pharmacists and pharmacy technicians will use their knowledge, skills and abilities to make decisions that enhance their health and well being; conflict of interest breaches heathcare professionals' core obligation to act as fiduciaries of the public trust.

Pharmacy professionals must recognize that other healthcare professionals also have a responsibility to avoid conflicts of interest in their own practice. **In this case, the physician is governed by conflict of interest regulations under the *Medicine Act* that specifically indicate that it is a conflict of interest to rent premises from a supplier, except where rent is normal for the area and the amount of rent is not related to the volume of business.** Directors, Designated Managers, pharmacists and pharmacy technicians should understand and respect the role that they and all healthcare practitioners have to uphold the basic ethical principles of healthcare, including accountability, and maintain patient trust in the system as a whole.

PHARMACY PROFESSIONALS

The Code of Ethics and Standards of Practice clearly outline that patient need, and not monetary gain, must be what a pharmacy professional considers when prioritizing care. Pharmacy professionals must only provide pharmacy care and services that are of good quality and intended to optimize the patient's health outcomes and should never compromise patient care to further corporate or business interests.

If there are concerns that human resources, policies, procedures, working conditions or the actions, professional performance or health of others may compromise patient care or public safety, pharmacy professionals must raise concerns to the appropriate authority. Pharmacy professionals must also report unethical behavior or professional incompetence by colleagues or other healthcare professionals to the appropriate regulatory authority. Ultimately, if you think there is something wrong, you have a professional responsibility to take action to protect your patients.

DESIGNATED MANAGERS, DIRECTORS AND CORPORATIONS

Designated Managers, directors and corporations are responsible for ensuring that the practice environment supports practice in alignment with the Standards of Practice and Code of Ethics. They should support and require pharmacy professionals to practice with professional integrity and use their professional judgment to advocate for patients when necessary and appropriate.

All pharmacies are also required to ensure that policies and procedures in the pharmacy respect and support the patient's right to choose a pharmacy and/or pharmacy professional – business decisions cannot hinder patient choice of where to receive services.

While it did not apply in this specific case, pharmacy professionals, Designated Managers, directors and corporations are reminded that members cannot accept gifts, inducements or referrals that may effect, or be perceived to effect, their professional judgment. They must also ensure that they are not participating in any referral program with other pharmacy professionals or with members of other healthcare professions for the express purpose of benefiting financially.

A conflict of interest does not arise as a result of normal and customary rent.

CONCLUSION

All pharmacy professionals must recognize that their patient's best interests must always override their own interests, or the interests of the business which the member owns, has a financial interest in or is employed by. If a pharmacy professional feels that they have been placed in a conflict of interest, they must demonstrate personal and professional integrity by ensuring they inform an appropriate person with oversight of pharmacy operations.

Pharmacy professionals and those operating a pharmacy must recognize that self-regulation of the profession is a privilege. Every pharmacist and pharmacy technician has a professional responsibility to uphold this privilege by maintaining public trust and confidence in each member individually and the profession as a whole.

CODE OF ETHICS ACCOUNTABILITY MODULE

The Principle of Accountability (Fidelity) requires you to be a responsible and faithful custodian of the public trust, accountable not just for your own actions and behaviours, but for those of your colleagues as well. Watch the module now!

NEW PROFESSIONAL MISCONDUCT REGULATIONS

New regulations under the *Pharmacy Act* speak specifically to conflict of interest in relation to this type of case.

Part II, 6(d) of the regulations indicates that a member is in a conflict of interest when he or she *"enters into any agreement or arrangement that influences or encourages, or appears to influence or encourage, a prescriber to promote the services of the member or of any pharmacy in which the member is employed, with which the member is associated or in which the member has a financial interest;"*

These changes to the regulations have been approved by government and are awaiting a date of proclamation. The College will let members know as soon as they become law.

Reminder on **Designated Manager Responsibilities When Using Technology** to Deliver Pharmacy Services

Advancements in technology have made it possible to deliver pharmacy services in new ways, including online and through specialty apps. Regardless of the mechanism used to receive and dispense prescriptions, Designated Managers are reminded that they are responsible for the privacy and security of personal health information and that all services offered should be adhering to standards of practice, legislation, policies and guidelines. Due diligence is needed to ensure that the software being used has encryption and security in place that is satisfactory.

Additionally, the pharmacist dispensing the medication must ensure that they have the original prescription prior to the release of the product to the patient. It is the responsibility of the pharmacy to maintain proper documentation in this regard.

Review the policy on Faxed Transmission of Prescriptions on the OCP website and the fact sheets available from the Office of the Information and Privacy Commissioner of Ontario on safeguarding personal health information.

PRACTICE TIPS!

NO KNOWN ALLERGIES

Pharmacists should document any allergies on the patient's record. If the patient has no allergies, a notation of that fact should be made.

NAPRA DRUG SCHEDULING

If you're unsure about which schedule a specific drug falls into, familiarize yourself with the NAPRA website and their "Search National Drug Schedule" page. http://napra.ca/pages/schedules/search.aspx

Follow @OCPinfo on Twitter and get a helpful practice tip each week. #OCPPracticeTip

College Moves Forward with a **Continuous Quality Assurance Program** for Medication Safety

As part of its mandate to serve and protect the public, the College is introducing a Continuous Quality Assurance (CQA) Program for Medication Safety and evolving its expectations around how pharmacy professionals and pharmacies respond when a medication incident occurs.

The proposed CQA program will support ongoing continuous quality improvement and put in place a mandatory consistent standard for all pharmacies in the province. CQA is an essential component of patient/medication safety advancement and the implementation of a standardized program (as supported by evidence from SafetyNET-Rx in Nova Scotia and COMPASS™ in Saskatchewan) is a crucial step in achieving the mission of error reduction and mitigation of patient harm. In fact, our work in this area is consistent with a general overall worldwide trend toward improving medication safety and, particularly in Canada, acknowledging the important role of pharmacy in helping to reduce the risk of medication incidents.

CQA programs enable practitioners to learn from medication incidents, and better understand why they happen and how they can be prevented. Utilizing both a preventative approach through proactive reviews of work processes to identify areas of risk and retrospective reviews of specific medication incidents, pharmacy professionals can identify learnings that will help prevent incidents and enhance patient safety.

Anonymous medication error reporting to an independent third party is a critical component of CQA as it provides data to support improvements within pharmacies as well as aggregate reviews of national trends. This reporting is distinct from existing College processes having to do with the handling of complaints. The College will receive high-level aggregate data, which will identify trends in medication incidents and support shared learnings through informed College activities focused on educational opportunities.

The development of the CQA program follows the work of the Medication Safety Task Force – comprised of public, patient advocate and community and hospital pharmacy members – which presented its recommendations at the March 20, 2017 Council meeting. Council unanimously supported the recommendations and authorized the College to move forward with open consultation on the proposed model.

The College is committed to patient safety and to enhancing the safe, effective and ethical delivery of pharmacy services in Ontario. Moving forward with a formal quality assurance program will lead to standardized, accurate and complete tracking of medication incident information across the province and help provide a better understanding of errors and how they can be prevented to better protect patients.

KEY *MILESTONES*

- December 2016: Council assigns a task force to develop a program
- March 2017: Recommendations from task force presented to Council and unanimously approved
- March 31 – May 1: Public consultation
- June 2017: College reports back to Council on the consultation and next steps

NEXT STEPS

The public consultation period has closed and the College is currently reviewing the comments that were received. We are also consulting with additional key stakeholders.

The College will report back to Council at their June 12 meeting on the results of the consultation and the next steps.

CALL FOR VOLUNTEERS

The College has proposed a multi-phased approach for implementation. The first phase would involve volunteer pharmacies that are representative of pharmacy practice across Ontario and would provide an opportunity to provide feedback on the program requirements and support ongoing improvements to both the proposed program and implementation processes in preparation for full implementation.

We are currently looking for pharmacies and pharmacy professionals who would be interested in participating in either this first phase or a subsequent phase of the implementation. As a participant, you would be requested to provide feedback on the program and be willing to provide peer network support for other pharmacies in your area.

If you are interested, please email communications@ocpinfo.com.

RESOURCES RELATED TO MEDICATION SAFETY

While the College finalizes and implements the CQA program, there are other resources available to assist pharmacies and pharmacy professionals in engaging in continuous quality improvement in their place of practice.

- Medication Incidents Practice Tool
- CQI: An Essential Component of Patient/Medication Safety (*Pharmacy Connection*, Winter 2017)
- CQI Benefits Patients in Community Pharmacies (*Pharmacy Connection*, Winter 2015)
- Focus on Error Prevention (Pharmacy Connection articles)

For more information, see the Continuous Quality Assurance for Medication Safety Key Initiative on the OCP website.

PRACTICE TIP!

Do you conduct appropriate medication reconciliations? Ensure that medications are suitable for the patient and follow-up on any discrepancies. Learn why these duties can be so essential, especially in transfer of care!
http://www.ocpinfo.com/library/practice-related/download/CloseUpOnComplaintsSpring2016.pdf

Follow @OCPinfo on Twitter and get a helpful practice tip each week.
#OCPPracticeTip

A **Framework** for **Ethical Decision-Making**

Ethical issues and dilemmas are a reality of everyday practice. The ability to make sound ethical decisions is a fundamental responsibility of pharmacists and pharmacy technicians as healthcare professionals.

Designed to enhance objectivity and consistency, the Framework for Ethical Decision-Making provides a systematic thought-provoking process to guide decision-making and document decisions made in practice that support our commitment to serve and protect our patients' best interests.

When confronted with an ethical issue or dilemma, pharmacists and pharmacy technicians should systematically work through the steps outlined in the Framework.

The Framework

Identify the Issue & Examine the Facts
1

- Is this a clear ethical issue of 'right and wrong'?
- What is the ethical issue or dilemma?
- Is the ethical dilemma complicated by a 'conflict of values'?
- What are the key facts?
- If related to a patient issue or dilemma, what are the patient's wishes? Does the patient have sufficient information to make an informed decision?
- Are there any unique situational factors that you need to consider?

Apply Guidelines and Standards
2

- What does our Code of Ethics say about this situation?
- What does our Standards of Practice say about this situation?
- Are there any applicable legislation, policies or guidelines you need to consider?
- Is there any applicable research or literature available to inform and support you?
- Is there anyone you should consult such as a colleague and/or the College?

Evaluate Possible Resolutions
3

- Determine and critically reflect on at least 3 alternative courses of action. Consider the strengths and limitations of each.
- In considering potential resolutions, ask yourself: Would this course of action:
  - Put your patient first and respect his/her right as an autonomous person?
  - Bear public scrutiny, i.e., if your decision and conduct were made public, would it be considered ethical and appropriate?
  - Be considered acceptable as a precedent for future behaviour, i.e., would it be appropriate for all pharmacists or pharmacy technicians to now do this?
  - Support our commitment to serve and protect the best interests of our patients?

Implement & Document Your Decision-Making
4

- Choose the most appropriate course of action and implement your decision.
- Document the rationale for your decision, including an explanation of how it supports the best possible health outcome for the patient.

Review and Reflect
5

- Review and reflect on the outcome of your decision:
  - What did I learn from it?
  - What might I have done differently to produce a better outcome for my patient?
- Share learning with colleagues and other healthcare professionals if applicable.

Ethical Decision-Making *IN PRACTICE*

AN EXAMPLE OF AN ETHICAL DILEMMA

After the narcotic order is received and reconciled at a community pharmacy, the pharmacist asks the pharmacy technician who is working that day to put away the order because the technician who usually manages the order is away sick. As the pharmacy technician is putting away the checked order, she looks at the previous orders for the month. She notices that quite a few of the previous orders include OxyNEO®, which she does not recall seeing in the pharmacy stock. On the previous order specifically she notes that four bottles of OxyNEO® 20 mg were ordered. However, she recently had a patient with a prescription for that strength and the pharmacy didn't have any in stock and the patient ended up taking his prescription to another pharmacy. The only staff employed by the pharmacy are herself, the other technician and the owner. She suspects that the other pharmacy technician is diverting the OxyNEO®.

When presented with any ethical issue, pharmacy professionals should consider and apply the ethical principles of healthcare to determine the most appropriate ethical decision. If you are presented with a more complex situation, such as the one above involving a personal conflict of interest, it may be beneficial to take a more structured approach to decision-making to ensure that only the established ethical principles of healthcare, not your own personal values or beliefs, guide your decision-making.

The Ethical Decision-Making Framework can be used to assist pharmacy professionals in assessing a situation that poses a more complex ethical dilemma.

1. IDENTIFY THE ISSUE AND EXAMINE THE FACTS

The first step in assessing a complex ethical dilemma is to identify the key ethical issue(s) and then the facts of the situation. It is important to keep in mind that the facts surrounding the ethical issue include information that is known to exist or to have happened and are not influenced by the ethical issue itself.

In the above case, the pharmacy technician has noted that a quantity of narcotic drugs (OxyNEO®) is unaccounted for in the pharmacy. Of the three people on staff at the pharmacy, only one pharmacy technician routinely manages drug orders for the pharmacy. The pharmacy technician that has identified the discrepancy has strong evidence that the other pharmacy technician on staff has engaged in unethical behaviour.

If the pharmacy technician suspects that her colleague is diverting narcotic drugs, she has an ethical duty to report this to the Designated Manager for further investigation. There is also a professional duty of the pharmacy technician to report unethical behaviour by colleagues to the appropriate regulatory authority.

Unlike many other work places, if an issue is identified in a pharmacy, simply reporting the employee within the organization or terminating employment is not enough. As a healthcare professional, you have a duty to act in society's best interest. If a Designated Manager releases an individual from employment at the pharmacy and they are not reported (by either yourself or the Designated Manager) to the appropriate regulatory body, you could be putting patients at other pharmacies and the public at risk if they are simply hired at another pharmacy.

2. APPLY GUIDELINES AND STANDARDS

The Ethical Principles and Standards in the Code of Ethics provide guidance on expectations of conduct and behaviour. Standards of Practice set out minimal expectations of practice and provide guidance about the

Principle: Accountability

Related Standard: 4.10

Members report professional incompetence or unethical behaviour by colleagues or other healthcare professionals to the appropriate regulatory authority.

knowledge, skills, judgment and attitudes that members should apply to their practice to provide patients with safe and ethical care. College policies, guidelines and other supporting resources provide additional clarification on certain areas of practice. Legislation and regulations set out rules or requirements for the operation of a pharmacy and for individual practice. All of these can be applied when considering an ethical dilemma.

In relation to this specific case example, pharmacy professionals are required to keep records of narcotic purchases and losses in accordance with relevant policies, guidelines and legislation. The Standards of Practice, legislation and College policies also outline requirements for narcotic inventory management. Review of the processes and narcotic records in the pharmacy against the requirements outlined in relevant resources would provide information regarding whether appropriate narcotic management is occurring in the pharmacy.

Examples of resources that should be considered with this case are:

- Code of Ethics – Standards under Principle of Accountability
- Standards of Practice for Pharmacy Technicians – Standards under Standard 1: Expertise in drug distribution systems and Standard 4: Professionalism and Ethics
- Narcotic Control Regulations under the Controlled Drugs and Substances Act
- Medication Procurement and Inventory Management Policy
- Resources under the Narcotics Practice Tool that include Fact Sheets on Narcotic Purchases, Narcotic Purchase Records, Narcotic Reconciliation and Security and Narcotic Reporting of Loss.

3. EVALUATE POSSIBLE RESOLUTIONS

The resources identified, including relevant ethical standards, should be used to determine possible resolutions to an ethical dilemma. Here are three options for this case, putting you in the role of the pharmacy technician:

Option A: Discuss the situation with the other pharmacy technician and determine if he has an explanation as to why the OxyNEO® is not in the pharmacy stock in the safe. Since you are good friends and you have been working with him for a long time and don't want to upset him, you tell him that if any additional issues arise you will have to bring it to the attention of the Designated Manager.

Option B: Inform the Designated Manager of the information that you have discovered and allow her to have a discussion with the other pharmacy technician. Since you feel you have done what you needed to and this is no longer your issue, you remove yourself from the situation after this point and leave any further decisions to the Designated Manager.

Option C: Although this is your friend and colleague you realize you have a professional responsibility to inform the Designated Manager of the information that you have discovered and allow her to have a discussion, with or without you, with the other pharmacy technician. You also ask that you are updated on the outcome and if unethical behaviour is identified fulfil your professional duty to ensure that the information is reported to the College and the loss to Health Canada (either by yourself or the Designated Manager).

4. IMPLEMENT AND DOCUMENT YOUR DECISION-MAKING

Select an option from the possible resolutions you identified. Ensure that you document the specifics of the information you identified and why it concerned you, including dates and details regarding subsequent conversations on the particular issue. Information like this might be required if you make any kind of report.

In this specific case Option C is the most appropriate option. The pharmacy technician has a professional duty to look past personal conflicts of interest to ensure that the unethical behaviour is reported to the appropriate authorities. Pharmacy professionals are reminded that dual relationships, such as a friendship with a professional colleague, often place the healthcare professional's needs - whether these are emotional, financial or social - in conflict with the needs, or best interests, of the patient and should be avoided.

5. REVIEW AND REFLECT

Consider the outcome of your decision and reflect on what the outcome may have been if you had chosen a different option. Review the outcome in relation to the standards in the Code of Ethics, Standards of Practice and other applicable resources and reflect on whether the outcome meets the requirements outlined in these resources. Use this opportunity to consider what you may do differently if presented with a similar situation in the future.

A Multi-Incident Analysis on Fentanyl Transdermal System in the Community

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INTRODUCTION

Fentanyl is a highly potent long-acting opioid and is listed as a high-alert medication in community and ambulatory healthcare settings.[1] In particular, the fentanyl transdermal system (i.e. fentanyl patch) has been a long-standing concern worldwide due to its prescribing and dispensing without proper consideration of patient selection criteria, proper dose adjustments, and safe administration procedures.[2] Failure to acknowledge these considerations may result in fentanyl overdoses, which can have fatal consequences, especially for opioid naïve users.[3] In recent years, there have been a growing number of reported overdoses and deaths in Canada related to misuse and abuse of fentanyl patches; it is becoming a more alarming safety crisis nationwide. Between 2009 and 2014, at least 655 deaths in Canada were associated with fentanyl or fentanyl analogues.[4] Many stakeholders, including healthcare professionals, regulators, law enforcement, and all levels of government are working closely together to address this concerning issue.[5, 6] Although the Institute for Safe Medication Practices (ISMP) in both the United States and Canada have released several alerts and safety newsletters to address the misuse of fentanyl patches and their potential for serious consequences, fentanyl transdermal system remains an issue of priority with respect to patient/medication safety.[7, 8, 9, 10]

The Community Pharmacy Incident Reporting (CPhIR) program (available at http://www.cphir.ca) is designed for community pharmacies to anonymously report near misses or medication incidents to ISMP Canada for further analysis and dissemination of shared learning from the reported incidents. 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. This article provides an overview of a multi-incident analysis of fentanyl patch related medication incidents reported to the CPhIR program.

METHODS

A total of 111 reported medication incidents involving "fentanyl" or "fentanyl patch" or "fentanyl transderm*" or "Duragesic" were extracted from the CPhIR program from January 2010 to January 2016. Fifty-one incidents were excluded from the analysis due to: (1) inadequate information provided in the "Incident Description" field to determine the cause of the incident; (2) other dosage forms that are not related to the transdermal system; and (3) medication errors that are not related to properties pertaining to fentanyl transdermal system. Two ISMP Canada analysts independently reviewed the medication incidents that met the inclusion criteria to determine the themes and subthemes derived from this multi-incident analysis (Table 1).

MULTI-INCIDENT ANALYSIS ON FENTANYL TRANSDERMAL SYSTEM

Based on the analysis, three main themes were identified: (1) pharmacological properties of fentanyl; (2) opioid-dose conversion and considerations; and (3) product design of fentanyl. These three main themes were further divided into sub-themes (Table 1). Subthemes are elaborated by providing incident examples and a discussion of corresponding potential contributing factors (Tables 2, 3, and 4). Note: The "Incident Examples" provided in Tables 2, 3, and 4 were limited by what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.

Table 1: Themes and subthemes derived from multi-incident analysis on fentanyl transdermal system

Main Themes	Sub-themes
1) Pharmacological Properties of Fentanyl	Dosing interval
	Drug-drug interaction
	Rate of absorption
	Opioid-naïve
2) Opioid-Dose Conversion and Considerations	
3) Product Design of Fentanyl	Supplied in a box of 5 patches
	Dosage availability per patch

Table 2 – Main Theme 1: Pharmacological Properties of Fentanyl

Sub-themes	Incident Example	Commentary
Dosing interval	A resident is prescribed a fentanyl 100 mcg patch to be applied every 48 hours. A medication administration record was received from the pharmacy and checked by three nurses. The next patch should be due on Jan 02/10. On Jan 01/10, medications were received and the fentanyl patch was applied by the registered nurse practitioner. [The nurses were confused about the dosing of fentanyl for this patient.]	There was unclear communication and lack of understanding among patients/caregivers/ other health care professionals in regards to patient-specific dosing interval (e.g. every 72 hours versus every 48 hours) for fentanyl transdermal administration. Although most patients would be adequately maintained with fentanyl patch administered every 72 hours, a small number of patients may require fentanyl patches to be applied every 48 hours instead of every 72 hours in order to achieve adequate pain control. [11]
	During checking, the pharmacist discovered an error in the prescription directions. She contacted the prescriber who refused to alter prescription because it was suggested by a pain specialist. The specialist indicated that the patch should be applied every day in a consultation note. The pharmacist contacted the specialist who would not alter another prescriber's prescription. After a lengthy explanation, the specialist read his note to the prescriber and realized his error. The specialist agreed that the directions should be every 3 days and not every day.	Complexity of dosing for fentanyl transdermal administration. Lack of knowledge or awareness of the unique dosing interval of fentanyl transdermal patch in pain management. Lack of standardized fentanyl guidelines for prescribers to clearly specify the correct quantity (i.e. number of patches), strength, and dosing interval and to assess patient's opioid-tolerability and contraindications including any concurrent use of other maintenance and/or breakthrough pain medications.[12]
Drug-drug interaction (DDI)	The doctor prescribed Biaxin® 500 mg twice a day to a patient who is on fentanyl; pharmacist called the doctor and suggested to switch it to Zithromax®.	Concomitant use of the fentanyl patch with any cytochrome P450 3A4 inhibitors may result in an increase in fentanyl plasma concentrations, which may cause potentially fatal respiratory depression. Thus, carefully monitor patients who are concomitantly taking CYP 3A4 inhibitors with fentanyl patches for an extended period of time. Adjust the fentanyl dose if necessary.[11] Lack of a DDI alert system in place to remind the prescriber for potential DDI and/or other contraindications.[12]
Rate of absorption	Prescription directions entered as 1-2 patches when it was supposed to be just 1 patch.	Fentanyl patch is a controlled delivery system designed to release a steady amount of medication at a constant rate of mcg/hour.[11] It should not be up to the patient to decide whether to apply 1 or 2 patches. Unlike other "as needed" medications, fentanyl transdermal patch has a strict dosing regimen and direction of use.
Opioid-naïve	The doctor prescribed fentanyl to an opioid-naïve patient. The patient was only taking acetaminophen 650 mg extended release. Administering fentanyl to this patient may have serious effects.	Lack of knowledge or awareness of the indication for the use of fentanyl patches. Contraindicated in the management of postoperative pain, mild pain, or intermittent pain (e.g. use on a "as needed" basis) because of the risk for serious or life-threatening respiratory depression.[13] Only prescribe a fentanyl patch of 25 mcg/hour if the patient has been receiving the equivalent of at least 60 mg of oral morphine per day for an extended period.[10]

Table 3 – Main Theme 2: Opioid-Dose Conversion and Considerations

Incident Example	Commentary
The patient's guardian arrived at the pharmacy to pick-up fentanyl patch expecting a dose increase from 75 mcg to 100 mcg. This dose increase was confirmed by the pharmacy student and dispensed. However, the patient had been using 75 mcg along with ~36 mg morphine equivalents per day for breakthrough. This level of breakthrough use usually only warrants increase in dose by 12 mcg. The doctor should have written for 12 mcg instead of 25 mcg increase. The prescription was processed and prepared without a therapeutic check. As a result, it was released to the patient without having addressed the above issues first. One 100 mcg patch was applied to the patient before this error was discovered.	Incorrect calculation of "morphine equivalents" total daily dose. Over-estimating the dose when doing fentanyl dose adjustment or converting from another opioid analgesic may result in a fatal overdose.[13] Lack of standardized prescribing fentanyl guidelines to include an equianalgesic conversion table as reference for prescribers.[12]

Table 4 – Main Theme 3: Product Design of Fentanyl

Sub-themes	Incident Example	Commentary
Supplied in a box of 5 patches	Two patches were short when trying to fill a fentanyl patch prescription. When checking, the pharmacist discovered that two prescriptions were supposed to be filled for 8 patches but the patient actually received 10.	Confirmation bias with number of boxes versus number of patches.
Dosage availability per patch	Directions for the fentanyl patch was entered as apply 25 mcg along with 100 mcg, but it should have been 25 mcg along with a 50 mcg and 100 mcg.	Requiring multiple patches from the same and/or various strengths to be dispensed at once to meet the total daily dose prescribed. Specify the total dose of fentanyl in the direction of use to ensure all the strengths of fentanyl patches that were prescribed are dispensed appropriately.

RECOMMENDATIONS

The unique properties of fentanyl transdermal patches present many vulnerabilities for medication incidents to occur. It is critical for healthcare professionals to be fully aware of these characteristics in order to successfully incorporate safety measures into their practices. Different harm reduction strategies have been initiated at local, provincial, and national levels (e.g. mandatory patch-for-patch programs, and delisting of high-dose opioids from formularies).[4, 14] However, currently, there is no consistent or standardized approach at the national level. Nonetheless, the following are some suggested recommendations targeting different medication system stages to encourage safer fentanyl patch use in the community (Figure 1).

1. Prescribing

- Standardized fentanyl prescribing guidelines [4,12,15]
  - o Specify the quantity*, strength, dosing interval, and day supply
  - o Include an equianalgesic conversion table (e.g. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html) when making dose adjustments or switching from other opioid medication(s)

* Recommend that no more than 10 fentanyl patches to be dispensed at one time (i.e. one patch every 72 hours x 10 patches = 30 days)

2. Prescription Order Entry

- Adhere to the specific instructions written by the physician in the best interest of the patient [4]
- Directions of use:
  - o Include comment "*Apply with ___ mcg fentanyl patch (Total fentanyl ___ mcg)*" when dispensing multiple strength patches
  - o Include comment "*Return used patch(es) to pharmacy*" at the end of the directions [4]

3. Therapeutic Check

- Assess the following:
  - o Contraindications including comorbid medical conditions, drug-drug interactions, and additive effects from other central nervous system medications
  - o Opioid-naïve (i.e. patient has no history of opioid use)
  - o Other opioid concomitant use (e.g. for breakthrough pain relief) including total equivalent doses in morphine
  - o Appropriate indication and dose (e.g. initiating, switching, or discontinuing)

4. Medication Dispensing

- Apply a visible prescription label, with proper brand name, generic name, and specified delivery rate of the fentanyl patches dispensed
- Conduct independent double check on the total number of patches to be dispensed
- Ensure all strengths of fentanyl patches dispensed add up to the total prescribed dose

5. Patient Counselling

- Ensure patients have a comprehensive understanding of the following:
  - o Indication of fentanyl patch
  - o Administration of fentanyl patch
  - o Signs and symptoms of opioid overdose / toxicity
  - o Administration of naloxone in case of opioid-associated overdose emergency

6. Monitor / Follow-up

- Initiate a fentanyl patch-for-patch partnership between the physician, pharmacist, and patient to develop a transparent monitoring plan. [4] The College of Physicians and Surgeons of Ontario (CPSO) and the Ontario College of Pharmacists (OCP) strongly support this; as of October 1st, 2016, the Patch-For-Patch Fentanyl Return Program has been mandatory in Ontario (http://www.ocpinfo.com/regulations-standards/policies-guidelines/Patch_For_Patch_Fentanyl_Return_Fact_Sheet/).
- Provide patients with opioid exchange disposal sheets to help them return used fentanyl patches for safe disposal at the pharmacy [4]
- Initiate provision of naloxone kits to patients and/or family/friends of patients with the following risk factors: [16]
  - o Concomitant use of benzodiazepine and/or other sedatives
  - o Alcohol use
  - o High-dose opioid therapy

Figure 1 - *Recommendations for the safe use of fentanyl patch in community pharmacy practice* [4,12,15,16]

CONCLUSION

The fentanyl patch, when used appropriately, is highly effective in chronic pain management due to its potency. However, it is because of its high potency that fentanyl patch incidents may result in severe harm. Moreover, these incidents occur due to individuals not being familiar with the unique characteristics of the fentanyl transdermal system, and lack of consistent standardization in the medication-use process. Recognizing this, effective March 22nd 2016, naloxone has been removed from Canada's Prescription Drug List (PDL).[17, 18] Increasing accessibility to naloxone (without a prescription) can offer a harm reduction option not only for illicit-drug users, but also for high-dose opioid prescription drug users for emergency use in opioid overdose.[14, 18] Widespread safety concerns continue to arise but it is hoped that the insights from this multi-incident analysis can act as safeguards to help reduce the medication incidents of fentanyl patches in the community.

ACKNOWLEDGEMENTS

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New Video Resources

Alternative Dispute Resolution

This recently released video for the public helps potential complainants understand why the College's Alternative Dispute Resolution program could be a good option for them.

The College's voluntary and confidential Alternative Dispute Resolution (ADR) program is ideal for resolving certain types of complaints. ADR is a form of mediation that is an alternative to the College's formal complaints process. This informative whiteboard video explains the benefits of ADR for both parties involved in a complaint.

A Practical Approach to Patient Assessment

"A Practical Approach to Patient Assessment" is the latest and final video module in the "Optimizing Patient Care" series, a program developed by the Leslie Dan Faculty of Pharmacy and supported and funded by OCP. The program consists of 10 video modules to support pharmacists practicing to their full scope.

This educational video module, presented by clinician educator and assistant professor Dr. Natalie Crown, was developed to equip pharmacists with the tools and knowledge to help enhance the quality of care and service delivered to patients. The video supports pharmacists in identifying patients' four drug related needs, gathering essential information from them to conduct a medication assessment, and following a systematic approach to assess their medication therapy. It combines both motion graphics and a simulated practice scenario played out in a community pharmacy.

Ontario College of Pharmacists

Putting patients first since 1871

HIGHLIGHTS FROM THE COLLEGE'S 2016 ANNUAL REPORT

The College published its 2016 Annual Report in March. The report features highlights and trends from the calendar year, including:

- Messages from the Registrar and President;
- Data and trends on pharmacists, pharmacy technicians and pharmacies;
- Information and statistics on College programs and initiatives;
- Audited financial statements; and
- Special features about transparency and our updated public register, the new Code of Ethics, our communications channels, and more.

The report also shares some of the ways our work will expand and develop in 2017.

The following selections from the report feature key statistics from our major program areas.

In keeping with our environmental initiatives, this report was only produced electronically and is available at http://www.ocpinfo.com/extra/ocp_annual_report_2016/

PICTURE OF THE PROFESSION

BY THE NUMBERS

As of Dec. 31, 2016

15,715 pharmacists registered in Ontario

4% increase since 2015

58% of pharmacists in Ontario are female

44 average age of a pharmacist in the province

38% of Ontario's pharmacists were educated internationally

1% increase since 2015

14% of pharmacists are 60+

59% of pharmacists are registered to administer injections

4,286 pharmacy technicians registered in Ontario

11% increase since 2015

9% of pharmacy technicians in Ontario are male

39 average age of a pharmacy technician in the province

2% of pharmacy technicians are 60+

37% of pharmacists graduated more than 25 years ago

1% higher than 2015

REGISTERING QUALIFIED PHARMACY PROFESSIONALS

All pharmacists and pharmacy technicians in Ontario must be registered with the Ontario College of Pharmacists. To become registered, applicants must demonstrate that they possess the required knowledge, skills and abilities to practise pharmacy in the province.

One of the primary ways that we protect the public is by verifying that only those applicants who have successfully met the registration requirements are granted the right to practise in Ontario.

BY THE NUMBERS

962 new pharmacists registered in 2016
4% decrease compared to 2015

487 new pharmacy technicians registered in 2016
48% decrease compared to 2015

52% of new pharmacists were educated internationally
2% increase compared to 2015

1,658 pharmacy students and interns were training in Ontario in 2016

39% of new pharmacists were educated in Ontario
2% decrease compared to 2015

182 applications considered by panels of the Registration Committee in 2016

240 applicants registered in Ontario by way of the Agreement on Internal Trade (AIT), after first becoming licensed in another Canadian province

ASSESSING PHARMACIES

The College assesses and accredits all community pharmacies and hospital pharmacies in Ontario. We check that all facilities are operating safely. Only those pharmacies that have been assessed and have met the accreditation criteria are authorized to operate in the province. We routinely visit these facilities to assess compliance with established standards and legislation.

BY THE NUMBERS

4,150 accredited community pharmacies

An increase of **3%** since 2015

81% of community pharmacies recieved a pass (no action plan required) on their first assessment

226 accredited hospital pharmacies

59 routine hospital pharmacy assessments performed*

2,350 community pharmacy assessments performed

36% increase since 2015

1,063 community pharmacies provided methadone maintenance treatment in 2016

435 community pharmacies provided compounding services in 2016

138 hospital pharmacies provided high risk services (e.g. chemotherapy, sterile compounding)

*Since August 1, 2016, when the College gained the authority to accredit and assess hospital pharmacies

INVESTIGATING AND RESOLVING CONCERNS

One of the primary ways we protect the public is through our investigation process. When we receive information that raises concerns about public safety in relation to the practice or behaviour of a pharmacist, pharmacy technician, intern, or student we will investigate.

Any member of the public who is dissatisfied with the care or services provided by a pharmacy professional or pharmacy may file a formal complaint or report the information to the College. We investigate and resolve every complaint we receive.

There are other ways we might be informed about a potential issue with a pharmacy professional or pharmacy. For example, employers, facility owners or other regulated health professionals have a mandatory obligation to report certain concerns, including information about sexual abuse of a patient, misconduct, incapacity, or incompetence.

Additionally, pharmacy professionals are required to inform the College if they have been charged with or found guilty of an offense, or are the subject of a proceeding in Ontario or any other jurisdiction within Canada. Regardless of how information comes to the College, the seriousness of the allegations are assessed in relation to the potential for harm to the public and appropriate action is taken to address them in the interest of serving and protecting the public.

BY THE NUMBERS

276 complaints opened in 2016

4% increase since 2015

94 reports opened in 2016

7% increase since 2015

12 complaints resolved through the alternative dispute resolution process in 2016

63 pharmacy professionals required to complete a specified continuing education or remediation program (SCERP) in 2016

38% of complaints dealt with in 2016 were related to dispensing issues

15% of reports dealt with in 2016 were related to billing issues

41 pharmacy professionals had allegations of professional misconduct referred to the Discipline Committee in 2016

54 pharmacy professionals issued an oral caution in 2016

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 to Labour Day.
Open every weekend to Thanksgiving.

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

DISCIPLINE DECISIONS

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Anne Matsumoto-O'Brien (OCP #67342)

At a hearing on April 13, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Matsumoto-O'Brien with respect to the following incidents:

- That she practised at and/or operated a pharmacy for which a certificate of accreditation had not been issued by the College;
- That she used the protected designations "drug" or "drugs" in connection with a retail business that was not an accredited pharmacy;
- That she sold prescription drugs by retail to customers in the U.S. without valid prescription or other authorization recognized by law in Ontario;
- That she permitted unregulated staff to perform controlled acts associated with the practice of pharmacy, including dispensing or selling drugs, and/or supervising the part of a pharmacy where drugs were kept;
- That she practised at and/or operated a pharmacy internet site in contravention of the Policy for Ontario Pharmacies Operating Internet Sites, issued by the College in June 2001, and/or the Policy for Prescriptions - Out of Country, issued by the College in January/February 2003.

In particular, the Panel found that she

- 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, and in particular, sections 139, 147, 149, 155 and/or 156 of the Drug and Pharmacies Regulation Act , R.S.O. 1990, c. H.4, as amended; sections 56, 58, 59, 61 and/or 62 of Ontario Regulation 551, R.R.O. 1990, as amended; section 2.1 of Ontario Regulation 297/96, as amended; and/or sections 4, 40 and/or 43 of Ontario Regulation 58/11, as amended
- Contravened, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, sections C.01.041 and/or C.01.042 of the Food and Drug Regulations, C.R.C., c. 870, as amended
- Knowingly permitted the premises in which a pharmacy is located to be used for unlawful purposes
- Permitted, consented to or approved, either expressly or by implication, the commission of an offence against any Act relating to the practice of pharmacy or to the sale of drugs by a corporation of which she was a director
- 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 impose specified terms, conditions or limitations on the Member's certificate of registration, including:

   a. That the Member shall complete successfully, at her own expense and within twelve (12) months of the date of this Order, the ProBE program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass, and within a further twelve (12) months, the ProBE Plus Program;

   b. That the Member shall be prohibited from:

      i. having any proprietary interest of any kind in a pharmacy (with the Member to divest herself of any current proprietary interest(s) no later than three (3) months from the date of this Order), or

      ii. receiving remuneration for her work as a pharmacist other than remuneration based on hourly, weekly or monthly rates only,

provided that this term, condition or limitation as set out in subparagraphs (i) and (ii), above, may be removed by an Order of a panel of the Discipline Committee, upon application by the Member, such application not to be made sooner than three (3) years from the date of this Order;

   c. That the Member shall be prohibited from being the Designated Manager at any pharmacy for a period of three (3) years commencing May 1, 2016;

   d. That the Member's practice will be monitored

by the College for a period of twenty-four (24) months from the date of this Order, on the following terms:

i. the monitoring will be by means of inspections conducted by a representative of the College at such times as the College may determine;

ii. the monitoring inspections may be in addition to any routine inspections conducted by the College pursuant to the Drug and Pharmacies Regulation Act, s. 148;

iii. the Member shall cooperate fully during such monitoring inspections;

iv. the Member shall pay to the College in respect of such monitoring inspections the amount of $600.00 per inspection, after each inspection, with the total number of inspections for which the Member must pay not to exceed a total of four (4); and

v. the College may choose to conduct additional inspections within the monitoring period at no further cost to the Member; and

e. That the Member shall provide notification to all her employers in pharmacy regarding the disposition of this discipline proceeding, for a period of three (3) years from the date of this Order, on the following terms:

i. the Member shall notify the College in writing of the name, address and telephone number of any current or future employer, within fourteen (14) days of resuming any current employment or commencing any future employment in pharmacy;

ii. the Member shall provide her employer(s) in pharmacy with a copy of the Decision and Reasons of the Discipline Committee in this matter, including this Order, prior to resuming any current employment or commencing any future employment in pharmacy; and

iii. the Member shall only engage in the practice of pharmacy for an employer who agrees to advise the College in writing, within fourteen (14) days of the Member resuming any current employment with the employer or commencing any new employment, confirming that the Designated Manager of the employer's pharmacy has received a copy of the Decision and Reasons of the panel of the Discipline Committee in this matter, including this Order, and confirming the nature of the Member's remuneration.

3. Directing the Registrar to suspend the Member's certificate of registration for a period of twelve (12) months, with two (2) months of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2(a) above

4. Costs in the amount of $7,500.

In its reprimand, the Panel noted that it was deeply disturbed by the events that brought the Member before the Discipline Committee. The Panel observed that the practice of pharmacy carries significant obligations to the public, the profession, and oneself. The Panel expressed its view that the Member, as a result of her professional misconduct, eroded the public trust in the pharmacy profession and cast a shadow over her own integrity. The Panel indicated that the Member's actions demonstrated poor judgment and exposed the public to unnecessary risk. The Panel found the Member's conduct to be unprofessional, disgraceful, and dishonourable, and expressed its hope that the Member will not appear before a panel of the Discipline Committee again.

Ovietobore (Felix) Aygbe (OCP #204476)

The College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Mr. Ayigbe. The allegations are that he:

- Failed to ensure that prescriptions at Sunshine Pharmacy were appropriately transferred to patients, another pharmacy or the College when the Pharmacy was closed;

- Failed to ensure that other pharmacy records at Sunshine Pharmacy were appropriately stored or transferred to another pharmacy when the Pharmacy was closed;

- Failed to protect personal health information in pharmacy records left on the Sunshine Pharmacy premises from unauthorized disclosure when the Pharmacy was closed;

- Failed to ensure that narcotics at Sunshine Pharmacy were returned to a licenced dealer,

transferred to another pharmacy or destroyed, as permitted, when the Pharmacy was closed;

- Failed to ensure that other prescription and non-prescription drugs at Sunshine Pharmacy were appropriately transferred to a wholesaler, another pharmacy or destroyed when the Pharmacy was closed; and/or

- Failed to provide an accurate and timely Pharmacy Closing Statement to the College regarding the disposition of prescription and other pharmacy records, signs and symbols relating to the practice of pharmacy, and drugs in stock in the Pharmacy when the Pharmacy was closed

In particular, it is alleged that he

- Failed to maintain a standard of practice of the profession

- Failed to keep records as required respecting his patients

- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement

- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 141 and/or 157(2) of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, and/or section 56 of O.Reg. 58/11, as amended

- 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, and in particular, sections 31, 43 and/or 45 of the Narcotic Control Regulations, C.R.C., c1041, as amended

- 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 College brought the motion before the Discipline Committee in light of the fact that Mr. Ayigbe's Certificate of Registration was revoked by a previous Panel of the Discipline Committee.

Accordingly, the parties made a joint submission to the Discipline Committee to issue an Order for a stay of the allegations of professional misconduct against Mr. Ayigbe. The Discipline Committee accepted the joint submission of the parties and issued an Order staying the allegations of professional misconduct against Mr. Ayigbe. The stay remains in effect unless and until Mr. Ayigbe applies for reinstatement of his Certificate of Registration.

Robert Brown (OCP #62499)

The College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Mr. Brown. The allegations are as follows:

- That on or about July 9, 2012, while listed in Part B of the register, he provided care to patients and/or dispensed drugs at Health-Care Pharmacy in Sudbury, Ontario, contrary to the terms, conditions and limitations imposed on his certificate of registration;

- That in or about June 2013 and August 2013, while listed in Part B of the register, he provided care to patients and dispensed drugs at MMT Centre Pharmacy in Oakville, Ontario, contrary to the terms, conditions and limitations imposed on his certificate of registration, whereas he had been specifically reminded by staff of the College, in or about August 2012, that as a pharmacist registered in Part B, he was prohibited from doing so;

- That on or about July 9, 2012, in dispensing drugs pursuant to prescriptions at Health-Care Pharmacy in Sudbury, Ontario, for various prescriptions he:

  i. failed to sign the hardcopy;

  ii. failed to document dialogue with the patient;

  iii. failed to document the original authorization, or to attach the original authorization to the hardcopy;

  iv. failed to ensure that the correct prescriber, or the correct name and contact information of the prescriber, was entered;

  v. failed to ensure that correct repeats were entered;

  vi. reduced the quantity of the drug without authorization;

vii. dispensed the incorrect drug; and/or

viii. dispensed a narcotic prior to the interval due date.

In particular, it is alleged that he:

- Contravened a term, condition or limitation imposed on his certificate of registration, and specifically the terms set out in s. 9(1), paragraphs 1 and 2 of Ontario Regulation 202/94;
- Failed to maintain the standards of the profession;
- Contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts, and specifically, s. 156 of the Drug and Pharmacies Regulation Act;
- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be disregarded by members of the profession as disgraceful, dishonourable and/or unprofessional.

The College brought the motion before a Panel of the Discipline Committee (the "Panel") in light of the fact Mr. Brown has not practised pharmacy for a significant period of time, and also in light of the fact that the his Certificate of Registration has been cancelled.

Accordingly, the College made a motion to the Panel to issue an Order for a stay of the allegations of professional misconduct against Mr. Brown. The Panel issued an Order dated December 9, 2016, staying the allegations of professional misconduct against Mr. Brown. The Panel issued this Order on the basis of the reasons set out above, and because continuation of the matter by way of a formal hearing would not be in the interest of the public, the profession or Mr. Brown, and because the primary objective of the College, public protection, is served as a result of fact that Mr. Brown is no longer practising pharmacy and no longer holds a Certificate of Registration from the College.

Nancy Wu (OCP #51632)

The College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Ms. Wu. The allegations are that she:

- Falsified pharmacy records relating to her practice in connection with certain identified claims made for drugs and/or other products;
- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement in connection with certain identified claims made for drugs and/or other products;
- Submitted an account or charge for services that she knew was false or misleading in connection with certain identified claims made for drugs and/or other products;
- Failed to ensure that the Pharmacy complied with all legal requirements, including but not limited to, requirements regarding record keeping, documentation, and billing the Ontario Drug Benefit Plan; and/or
- Failed to actively and effectively participate in the day-to-day management of the pharmacy, including, but not limited to drug procurement and inventory management, record keeping and documentation, and billing

In particular, it is alleged that she

- Failed to maintain the standards of practice of the profession
- Falsified pharmacy records relating to her practice
- Signed or issued, in her professional capacity, a document that she knew contained a false or misleading statement
- Submitted an account or charge for services that she knew was false or misleading
- 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, and in particular, sections 5, and 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended
- 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 College brought the motion before the a Panel

of Discipline Committee (the "Panel") in light of the fact Ms. Wu entered into an Undertaking, Agreement and Acknowledgment with the College whereby she resigned permanently as a member of the College, irrevocably surrendered her Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario.

Accordingly, the parties made a joint submission to the Panel to issue an Order for a stay of the allegations of professional misconduct against Ms. Wu. On the basis of the Undertaking, Agreement and Acknowledgment Ms. Wu entered into with the College, the Panel accepted the joint submission of the parties. On January 4, 2017, the Panel issued an Order staying the allegations of professional misconduct against Ms. Wu, with the stay to remain in effect unless and until Ms. Wu applies for reinstatement of her Certificate of Registration.

Andrew Ng (OCP #75035)

At a hearing on January 31, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ng with respect to the following incidents:

- That he failed to keep records as required with respect to 13 identified MedsCheck reviews, in or about December 2010 – August 2015
- That he failed to conduct inventory reconciliations for narcotics and other controlled substances and/or to report any losses to Health Canada as required, in or about June 2015 – September 2015

In particular, it the Panel found that he

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required
- 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 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 requiring the Member:

   a. to review specific College policies, procedures, guidelines and recommendations regarding inventory reconciliations for narcotics and other controlled substances, as identified by the College;

   b. to complete, after review of the publications, two comprehensive inventory reconciliations for all narcotics and other controlled substances in his current pharmacy, with the first inventory reconciliation to be completed and submitted to the College no later than two months from the date of this Order (i.e., by March 31, 2017) and the second inventory reconciliation to be performed and submitted to the College six months after the first (i.e., by September 30, 2017), with the inventory reconciliations to cover the six-month period preceding each inventory reconciliation.

3. Directing the Registrar to suspend the Member's certificate of registration for a period of one (1) month, with the suspension to be fully remitted on condition the Member complete the remedial exercise specified in paragraph 2 above. If the Member is required to serve the suspension, the suspension shall commence on December 1, 2017 and continue without interruption until December 31, 2017

4. Costs to the College in the amount of $2,000.

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of Pharmacy, and that pharmacists are held in high regard for the role they play in the provision of health care in Ontario. The Panel expressed its disappointment in the Member's actions. The Panel suggested that the Member's disregard for proper narcotics control was shocking. The Panel expressed its dissatisfaction with the Member's continued lack of adherence to the standards of the profession, especially after these issues were brought to his attention and in light of narcotic diversion concerns in Ontario. The Panel related it expectation that the remediation ordered will assist the Member to improve his conduct and that he will not appear before the Discipline Committee again.

Trevor Scott Sweazey, R.Ph. (OCP #104914)

At a hearing on March 7, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Sweazey with respect to the

following incidents:

- In or about the period from January 1, 2012, to January 1, 2014, he failed to keep records as required by the College's Medication Procurement and Inventory Management Policy with respect to the inventory of narcotics and controlled drugs

- He failed to take all reasonable steps necessary to protect narcotics on premises or under his control against loss or theft

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession

- Contravened section 43 of the Narcotics Control Regulations, C.R.C., c. 1041

- 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 unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

2. That the Registrar is directed 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, within three (3) months of the date of this Order;

      ii. meet at least two (2) times with the practice mentor, at the mentor's place of practice, for the purpose of reviewing the Member's practice with respect to protecting against narcotics loss and theft, and identifying areas in the Member's practice with respect to these issues 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 this Joint Submission on Order;

4. a copy of the Report of Investigation; and

5. a copy of the Decision and Reasons, when available.

      iii. develop a learning plan to address the areas requiring remediation;

      iv. demonstrate to the practice mentor that the Member has achieved success in meeting the goals established in the learning plan; and

      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 twelve (12) months from the date of this Order.

3. That the Registrar will be directed to suspend the Member's certificate of registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2 (a) above. The suspension shall commence on March 8, 2017 and shall continue until May 7, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraph 2(a) above, the balance of the suspension shall commence on March 9, 2018 and continue until April 8, 2018, inclusive.

4. That the Registrar is empowered, in her discretion, to grant a request for an extension of time or a change of mentor in relation to the administration of this Order, if she is of the view that it is in the interests of fairness to do so and that is it not contrary to the College's mandate to serve and protect the public interest.

5. Costs to the College in the amount of $3,500.00

In its reprimand, the Panel observed that the Member is part of the highly respected profession of pharmacy and that practice standards require the safe and secure management of narcotics and controlled substances. The Panel indicated that it was troubled by the inadequacies in the Member's policies and procedures, which permitted a scale of theft that went unnoticed for a sustained period of time. The Panel acknowledged the Member's efforts to remedy the problem, but noted that it was the thefts that highlighted the lack of management regarding the required policies and procedures for appropriate

narcotic reconciliation. The Panel expressed its expectation that this has been a learning experience and that the Member will continue to take the necessary steps to improve his practice and ensure that this type of loss will not reoccur.

James Ying (OCP #609598)

At a hearing on March 17, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ying with respect to the following incidents:

- That he failed to maintain the professional boundaries of the pharmacist-patient relationship when he developed a non-professional, personal relationship with the patient or former patient, [the Patient] in or about January 2013 to June 2013, and continued to pursue that relationship thereafter, until in or about June 2014; and/or

- That he engaged in sexual abuse of the patient, [the Patient], on one or more occasions, in or about January 2013 to June 2013.

In particular, the Panel found that he

- sexually abused a patient

- failed to maintain a standard of practice of the profession

- abused a patient, verbally or physically

- 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 and unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

2. an Order directing the Registrar to revoke the Member's certificate of registration; and

3. Costs to the College in the amount of $15,000.00

In its reprimand, the Panel observed that Mr. Ying admitted to an appalling breach of the standards of practice of the profession, and to conduct that members of the profession would view as disgraceful, dishonourable, and unprofessional. The Panel noted that Mr. Ying failed in his moral obligation to conduct himself in a manner that is professional and maintains public confidence.

The Panel noted that pharmacists are expected to demonstrate personal and professional integrity and to maintain professional boundaries at all times; these boundaries are based on trust, respect and the appropriate use of power. The Panel expressed its view that Mr. Ying's conduct undermined the foundation of the trust that exists between pharmacy professionals and their patients.

The Panel noted that it has an obligation to ensure that the penalty is appropriate to the findings. The Panel expressed its view that Mr. Ying's actions constitute one of the most serious manifestations of professional misconduct and therefore the legislated mandatory revocation is warranted.

Emad Abdel Sayed (OCP #610270)

At a hearing on March 27, 2017, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Abdel Sayed in that:

- Between about March 3, 2014 and September 21, 2015, he dispensed narcotics pursuant to invalid prescriptions, without taking and/or documenting adequate steps to verify the validity of the prescriptions;

- He dispensed drugs in doses, quantities, and/or frequencies that were unsafe and/or inappropriate;

- He failed to adequately document the steps taken and/or the clinical reasoning that justified dispensing drugs in exceptionally high doses, quantities, and/or frequencies;

- In the two-year period preceding approximately December 23, 2015, he failed to perform, and/or maintain a record of, adequate narcotic inventory counts and/or reconciliations;

- He failed to ensure that a patient identifying number was recorded on the prescription and/or failed to keep a record of that patient identifying number as recorded on the prescription before dispensing the prescription;

- He dispensed narcotics in advance of the interval specified by the prescriber for dispensing, without

taking adequate steps to communicate with the prescriber and/or documenting the communication or the reasons for early dispensing;

- He dispensed narcotics to a single patient pursuant to prescriptions from two different prescribers without taking adequate steps and/or documenting those steps taken to verify the legitimacy of the prescriptions

In particular, it is alleged that he

- 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, and in particular, section 155 of the Drug and Pharmacies Regulation Act , R.S.O. 1990, c. H-4, as amended

- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular:

  - He contravened section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended, under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended, when between about March 3, 2014 and September 21, 2015, he dispensed narcotics pursuant to invalid prescriptions, without taking and/or documenting adequate steps to verify the validity of the prescriptions;

  - He contravened section 11 of the Narcotic Safety and Awareness Act, 2010, S.O. 2010, c. 22, when he failed to ensure that a patient identifying number was recorded on the prescription and/or failed to keep a record of that patient identifying number as recorded on the prescription before dispensing the prescription;

- 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 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, requiring:

   a. that the Member complete successfully with an unconditional pass, at his own expense, within 12 months of the date of this Order, the ProBE course and any related evaluations offered by the Centre for Personalized Education for Physicians;

   b. that the Member's practice shall be monitored by the College by means of inspection(s) by a representative or representatives of the College in such number and at such time or times as the College may determine, for a period of 36 months from the date of this order. The 36-month period shall be suspended during any period of time during which the Member is not actively practising pharmacy and shall resume when the Member resumes the practice of pharmacy. The Member shall cooperate with the College during the inspections and, further, shall pay to the College in respect of the cost of monitoring, the amount of $1,000.00 per inspection to a maximum of 3 inspections, such amount to be paid immediately after completion of each of the inspections.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 5 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2(a) above. The suspension shall commence on March 27, 2017 and continue until June 26, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in paragraph 2(a) above, the balance of the suspension shall commence on March 27, 2018, and continue until May 26, 2018, inclusive.

4. Clarity Note: The requirement to complete the remedial training specified above in paragraph 2(a) as terms, conditions or limitations on the Member's Certificate of Registration cannot be relieved by serving the remitted portion of the suspension referred to in paragraph 3 above.

5. The Registrar is empowered, in her discretion, to grant a request for an extension of time to complete the remedial steps set out in paragraphs 2(a) and 2(b) and/or to make any related necessary adjustments to the dates upon which the Member

is to serve his suspension set out in paragraph 3, if the Registrar is of the view that it is in the interests of fairness to do so and that it is not contrary to the College's mandate to serve and protect the public interest.

6. Costs to the College in the amount of $3,500.

In its reprimand, the Panel noted that practice standards require the safe and secure management of narcotics and controlled substances. The Panel pointed out that these practice standards are designed to prevent the abuse, misuse, and diversion of substances that are regulated due to their high potential for addiction and toxicity.

The Panel acknowledged the Member's cooperation and efforts to correct any deficiencies, but observed that, as Designated Manager, the Member's lack of adherence to standards of practice and procedures for appropriate narcotic reconciliation could not be ignored. The Panel pointed out that the Member's failure to follow College guidelines related to the identification of forgeries and fraudulent prescriptions was particularly alarming. The Panel expressed its expectation that the Member will continue to improve his practice.

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.

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 be added to the roll of persons so designated, receive a certificate and continue to receive *Pharmacy Connection* at no charge.

For more information, contact Member Applications & Renewals at 416-962-4861 ext 3400 or email memberapplications@ocpinfo.com

FOCUS ON ERROR PREVENTION

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

INDICATIONS FOR ANTIPLATELET THERAPY

When reviewing prescriptions for appropriateness, pharmacists must consider the indication for use of the drug. It is difficult to confirm that the right patient is receiving the right drug at the right dose at the right time via the right route for the correct duration if the purpose of the medication is not known. Unfortunately this key piece of information is often missing.

A common indication for clopidogrel bisulfate is for the secondary prevention of atherothrombotic events (myocardial infarction, stroke and vascular death) in patients with atherosclerosis documented by stroke, myocardial infarction, or established peripheral arterial disease[1].

Patients taking clopidogrel bisulfate may be asked to stop taking the medication for five to seven days before any planned surgery to minimize bleeding[1].

However, for patients undergoing stent implantation surgery, antiplatelet therapy has been shown to reduce the risk of major adverse cardiac events including myocardial infarction, and the risk of death[2].

Though excessive bleeding is a concern during stent implantation surgery, clotting or stent thrombosis is a more serious and potentially fatal problem.

Therefore, patients scheduled for diagnostic coronary angiography with the intent to perform percutaneous coronary interventions if the lesions are amenable to angioplasty will often be asked to begin antiplatelet therapy such as clopidogrel before the procedure to prevent major adverse cardiac events.

CASE:

A sixty-two year-old patient with a strong family history of coronary artery disease has additional risk factors including diabetes and hypertension. The patient has experienced typical chest pain, but is still very active and an avid cyclist. He recently had a positive stress echocardiogram indicating ischemia in the mid to distal anterior and apical region, with the possibility of a left anterior descending coronary artery lesion.

The patient was referred for an angiogram to assess coronary anatomy and possible angioplasty if needed. His cardiologist prescribed a 300mg loading dose of clopidogrel, then 75mg by mouth once daily to begin immediately. The prescription was taken to his community pharmacy for processing.

During patient counselling, the patient was told by the pharmacist not to take the clopidogrel since he will be having surgery and there is an increased risk of bleeding. The patient therefore did not take the much needed clopidogrel. Fortunately, during questioning by the nurse at the catheterization laboratory, the error was caught.

The patient's angiogram showed significant mid left anterior descending artery plaque. He was therefore given a loading dose of clopidogrel and one drug-eluting stent was deployed.

The patient was discharged home later the same day without issue.

RECOMMENDATIONS:

- When checking prescriptions for appropriateness, always consider the drug's indication for use. The purpose of the medication would not only help in determining the appropriateness of the drug therapy and dosage, it can also help in preventing errors associated with look-alike and sound-alike drug names.
- If the purpose of the medication is not included on the prescription, ask the patient using open ended questions.
- Ensure that the patient receives appropriate patient counselling depending on the drug's indication for use.
- If faced with ambiguous information during patient counselling, always contact the prescriber for clarification.

REFERENCES:

1. Plavix product monograph available at: http://products.sanofi.ca/en/plavix.pdf. Accessed April 10th, 2017.
2. Francois Schiele, Nicolas Meneveau, and Jean-Pierre Bassand. Routine pre-treatment with clopidogrel before diagnostic coronary angiography: the question is right, but what about the answer? European Heart J 2008; 29:1475–1477

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.

PRACTICE TIP!

As members of a self-regulated profession, pharmacists must be able to rationalize the clinical decisions that they make, to their peers and to any person or organization which may be affected by their actions, including individual patients, the public, their employers, and other health care professionals.
http://www.ocpinfo.com/library/practice-related/download/Professional%20Judgment.pdf

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