Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SUMMER 2014 • VOLUME 21 NUMBER 3

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

DELIVERING PATIENT-CENTRED CARE

Ontario College of Pharmacists

Putting patients first since 1871

MISSION:

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

VISION:

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

VALUES:

Transparency - Accountability - Excellence

STRATEGIC DIRECTIONS:

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

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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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**Marshall Moleschi,
R.Ph., B.Sc. (Pharm), MHA
Registrar**

> "Change will only come by making conscious changes to how we traditionally think and practice."

As most of you know, I attend and often participate in a number of provincial, national and international conferences every year. Although each conference offers its own unique spin, the underlying themes are typically consistent and familiar. How does the profession of pharmacy evolve to better deliver patient-centred care?

This summer, while preparing for one of these speaking engagements I came across a quote from the editor of the *Journal of American Pharmacists Association* that I thought articulated our current state quite well, "As busy as the practicing pharmacist is with his or her daily routine...that ever-whirling wheel of change is upon us... pharmacists must become a part of change or helpless victims of change...the decision remains in our hands". As I read a bit more closely I discovered that this statement was made in 1962!

Has it really been over 50 years? Why is it taking so long for this fundamental idea to take hold?

Perhaps it has something to do with the fact that although we talk about a new role – a clinical pharmacist who is empowered to make decisions in the best interest of the patient – we continue to do things in much the same way as we always have. We might do well to remember Einstein's definition of "insanity: doing the same thing over and over, expecting a different result".

When we look at the recent history of pharmacy there is a lot of evidence to support pharmacists' ability to evolve as the needs of our patients and the healthcare system has required. Initially as chemists and compounders, then dispensers and medication advisors, pharmacists have firmly demonstrated their ability to adapt and be responsible and accountable for ensuring prescriptions are filled accurately. More recently pharmaceutical care became a focus – maximizing the effectiveness of drug therapy through patient counselling and resolving drug related problems.

With today's issues of an aging population and cost pressures on the healthcare system, Canadian governments are following the leads of other countries and shifting the role of the pharmacist to a decision-maker supported through increased scopes of practice. This role is significantly different as it holds pharmacists responsible and accountable for patient outcomes, rather than simply identified tasks that need to be completed. This shift requires an evolution of our current behaviours and processes, the things that have served us well in the past. Like Einstein we must realize that simply continuing to do what we have always done is unlikely to achieve the new results that are required today. Regulatory bodies like OCP and individual practitioners must challenge conventional thinking and find ways to do things differently.

In this issue of *Pharmacy Connection* you will find an article that shares some powerful insights from Dr. Zubin Austin, Professor at the University of Toronto. Dr. Austin is the lead on a mulit-year research project funded by the College designed to identify barriers to practitioners practicing to their full scope and recommend resources to support greater engagement. Recent findings — which were communicated during the Spring District Meetings and summarized in this article — explore the concept of how *who* we are shapes *what* we do.

By understanding how pharmacists — and our colleagues such as family physicians — are intuitively wired, we can consciously shift our behaviours and interactions to more effectively and confidently make the necessary decisions that enhance health outcomes for our patients.

It is clear that healthcare in Canada, like many other countries throughout the world, needs pharmacists to firmly establish themselves as decision-makers. Our challenge, and our opportunity, is to acknowledge and embrace the fact that change will only come by making conscious changes to how we traditionally think and practice.

JUNE 2014 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on June 16th, 2014.

TRANSPARENCY INITIATIVE

In keeping with its objective to enhance the transparency of information, both about pharmacists and the effectiveness of self-regulation, Council agreed to move forward with the presented phased-approach as the next step to this ongoing initiative.

The first phase focuses primarily on enhancing the consistency and clarity of existing information including notices of discipline committee hearings, publicly available criminal findings of guilt, certain bail conditions, and the identity of non-members who are practicing illegally. This will necessitate making amendments to the by-laws which will be drafted this summer and circulated to the membership.

The second phase will focus on the potential provision of information relating to outcomes of the College's Inquiries, Complaints and Reports Committee. Further discussion with committees, legal analysis and evaluation of process changes will need to occur prior to this phase being implemented.

These decisions of Council reflect recognition of the College's mandate of public protection and serving the public interest, and are consistent with decisions made by councils of the other AGRE – Advisory Group on Regulatory Excellence – colleges jointly engaged in leading this initiative.

THREE PRACTICE POLICIES AND ONE GUIDELINE APPROVED

Medical Directives and the Delegation of Controlled Acts (Policy - Revised)

The introduction of an expanded scope of practice has increased the prevalence and opportunity for the use of delegation by members, for example the administration of injections other than through the UIIP or for demonstration and education. Delegation has historically been used in hospital and non-traditional settings (e.g. Family Health Teams), and in recent years there has been heightened awareness of the possible use of delegation in community practice.

Methadone Maintenance Treatment (MMT) and Dispensing (Policy – Revised)

This revised policy outlines a number of changes for the appropriate dispensing of methadone maintenance treatment for opioid addiction and pain, and supports the recent introduction of a manufactured product and provides direction for the exceptions for dispensing a compounded product.

Treating Self and Family Members (Policy – New) / Preventing Sexual Abuse and Harassment (Guideline – Revised)

The new policy on Treating Self and Family Members and the updated guideline on Preventing Sexual Abuse and Harassment support the College's opinion that pharmacists and technicians should not be permitted to routinely treat spouses or other family members. The policy reiterates that it is generally considered to be inappropriate and a conflict of interest to treat self and/or closely related family members. The policy informs members to use their professional judgment on a case-by-case basis and to document the circumstances of the care. The related guideline is meant to be read in conjunction with the policy.

All the above-noted documents can be found on the College website at www.ocpinfo.com.

NEW RESOURCE PUBLICATIONS APPROVED

As required under the *Drug and Pharmacies Regulations Act* (DPRA), Council approved three resources to be included in the College-approved Required Reference Guide for Ontario Pharmacies. The new resources will provide comprehensive, updated, online

Photos by DW Dorken

drug interaction, pharmacotherapy, and patient counselling tools for pharmacists.

COUNCIL APPROVES STRUCTURED PRACTICAL TRAINING (SPT) PROGRAM REDESIGN

Following an evaluation of the SPT Program to determine its relevance and effectiveness, it was established that there were aspects of the program that could be improved to ensure fairness and objectivity. The current structure does not adequately take into consideration the diversity in education, practice experience and background of preceptees (pharmacy student, intern or pharmacy technician applicant) and consequently, the Registration Committee has proposed a redesign of the SPT program. The proposed redesign will streamline the process, allowing for applicants to demonstrate their competence earlier, and with support/guidance of their preceptor and the College, be able to formulate and enact a development plan to address the identified gaps.

The operational details necessary for implementation of the redesign will be developed through engagement with various stakeholders and the new program will be brought back to Council at a future date for final approval.

GOVERNANCE

In early 2013, Council supported the initiative to undertake a governance review, which included producing a Council Policy Manual and a Handbook that would consolidate existing governance documents to help guide Council in fulfilling its role. Since then, with facilitation by Mr. Richard Steinecke, the Task Force on Governance has met regularly and reported its progress at each Council meeting.

The Governance Manual, which gives a comprehensive introduction to governance related issues for new Council members and will serve as an ongoing resource for current Council, committee members and College staff about their roles and recurring issues, was approved.

Flowing from the governance discussions and the preparation of the Manual, a number of proposed changes to the by-laws were identified. Council deferred the approval of these by-laws to their next meeting pending the outcome of a further legal opinion pertaining to one of the proposed provisions in the by-law.

FUTURE COUNCIL MEETING DATE

Monday 15 and Tuesday 16 September 2014

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

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Council Election Results

OCP Council elections were completed on August 6, 2014. The results are as follows:

DISTRICT M


Fayez Kosa


Donald Organ


Laura Weyland

DISTRICT P


Jon MacDonald*


Douglas Stewart*

DISTRICT T

BY-ELECTION


Michelle Tanguay

*won by acclamation

"WHO WE ARE SHAPES WHAT WE DO"

ASSUMING PROFESSIONAL RESPONSIBILITY

By Stuart Foxman

What can early Roman law teach us about professional responsibility?

Ontario pharmacists and pharmacy technicians must understand and adhere to their professional responsibilities in practice to support safe, effective and ethical pharmacy services. Today, people generally associate the word responsibility with authority, reliability and accountability. It's all that, but gets even deeper.

In Roman law, you find the idea of *spondere*. In verbal contracts, legal significance derived from the words used to reach agreements. A party involved would agree to assume an obligation. That word was *spondere* – a solemn promise or undertaking. *Spondere* relates to another Latin word, *responsus*, meaning answer, which is where we get responsible. So what does responsibility really mean to pharmacists?

Zubin Austin thinks about that a lot. Dr. Austin is a Professor at the Leslie Dan Faculty of Pharmacy, University of Toronto. The question of what constitutes responsibility is fundamental to any health care professional. How this particular profession considers it, says Dr. Austin, often hinges on how we see ourselves.

An article in the Spring issue of *Pharmacy Connection* described professional responsibilities in terms of five principles that contribute to patient-focused care. These principles

will guide the development of new or revised programs, policies and guidelines. To Dr. Austin, it's important to take a step back too, to reflect on some mindsets.

In a May 2014 District Meeting, Dr. Austin and College Registrar Marshall Moleschi did a session called "Principles and Personalities: Prescriptions to Patient Care" (view it at http://www.ocpinfo.com/library/news/archived-webcast/). That evening and in a subsequent conversation, Dr. Austin shared his take on the foundations of professional responsibility – and what might be holding some members of the profession back.

PUTTING PATIENT NEEDS FIRST

"The cardinal indication that you are a health care professional is thinking about what the patient needs," says Dr. Austin.

That's the solemn promise – the contract between provider and patient. Historically in pharmacy, he says, responsibility has meant something else. "Responsibility has been interpreted to mean that when we're confronted with a patient who has a problem, the first question we ask is 'What am I allowed to do?'" he says.

Of course, it's vital for every health care professional to be aware of what falls within their scope, what they can and can't do. You can't abandon the rules. The issue is whether you truly place the patient at the centre and explore.

Yes, pharmacists are the medication experts. Remember, however, that in professional responsibility the goal is patient-focused care; drugs are a way to get there, but the end point is that care.

Other health care professionals can always come into play. Yet right at the moment, in the encounter with a patient, you are the health care professional with responsibility.

"When you think about what you're allowed to do," Dr. Austin continues, "maybe you're thinking like someone more interested in operational efficiency. If you start from that perspective, you've reduced your universal options."

As Dr. Austin notes, the profession has been waiting a long time to assume more responsibility – for the government to recognize what we can do, and for patients to come to us for decisions, not just opinions.

What a great time this is, then, for the profession. And what a difficult time, too, for those members of the profession who, as Dr. Austin says, were perhaps a little more comfortable behind the scenes.

The scope of practice is expanding. The profession has changed. The question Dr. Austin poses is whether pharmacy professionals have changed at the same pace.

UNDERSTAND THE FORCES THAT MAKE US

To meet your professional responsibilities, you not only have to be well aware of them, you also have to be self-aware. In other words, says Dr. Austin, understand that *who* we are shapes *what* we do.

So who are the people in this profession?

We're all shaped by a combination of temperament, education and socialization. Start with personality traits. Everyone falls somewhere along a continuum. So are you more inventive (a high need for newness) or consistent (enjoy doing the same thing)? More organized (check and follow the rules) or easy going (do what's necessary)? Are you more outgoing (need others to be at your best) or reserved? More friendly or aloof (i.e. is it important for you to be liked or to be right)? And more sensitive or confident?

No set of traits is better than any other. On the continuum, think of where you fall, where you believe others in this profession fall, and where other health care roles, like the family physician, might fall.

As a group, Dr. Austin suggests that pharmacists tend to be more consistent, organized, reserved, on the border between friendly and aloof, and sensitive. These aren't bad traits, and to a large extent were aligned well with the job. However, are they the traits that are suited to the reality of today's practice?

Likewise, clinical reasoning can emerge from three areas. There are the first principles – the basic propositions to which someone new to any endeavour will return. There's applying the rules. And there's pattern recognition – recognizing what you've seen before, and acting based on your knowledge, experience and self-confidence.

Novice drivers will apply first principles when changing lanes. They'll check and recheck their mirror multiple times, and calculate their speed vs. the speed of drivers

in the next lane. Whereas experienced drivers will just intuitively know when to change lanes, with that pattern recognition looking astonishingly magical, says Dr. Austin. He submits that pharmacy education placed high rewards on applying rules, less so (and less than other health care professions) on recognizing problems.

Then, when people are socialized in the culture of pharmacy, other forces continue to shape a certain way of thinking. Dr. Austin says pharmacists tend to trust others based largely on externalities like degrees and status. They're typically polite, respectful and deferential to authority, and therefore often communicate indirectly. That can come across to other health care professionals as uncertain or unwilling to take responsibility.

> "...in professional responsibility the goal is patient-focused care; drugs are a way to get there, but the end point is that care."

As Dr. Austin noted, pharmacists also think about responsibility in terms of rules and processes. For pharmacists, clinical confidence means certainty in having the right answer. For doctors, clinical confidence might mean that if things go wrong you'll cope and deal with it at the time. Finally, Dr. Austin says that for pharmacists risk is seen as something to avoid, while doctors tend to balance probabilities and

weigh actions accordingly. The idea that if something is risky, do nothing, can actually *introduce* risk.

Temperament, education and socialization can create barriers to becoming more clinically involved and advancing the profession of pharmacy. To do that and meet broader professional responsibilities, says Dr. Austin, pharmacists have to evolve.

IF NOT ME NOW, THEN WHO WHEN?

How do all of these traits play out? The way you carry out your duties depends largely on how you view yourself, your profession and the people you're serving. "Sometimes," says Dr. Austin, "we say something because it's the acceptable rhetoric of the profession. We use the word patient, but we often deal with them as customers."

There's a huge difference. Customer implies a transactional approach, and a relationship where the professional's knowledge, skill and judgment is not necessarily at the forefront: "The customer is always right, and the customer drives the agenda," says Dr. Austin.

In contrast, he says, "The word patient implies a level of responsibility and commitment with follow-up, and a longitudinal relationship."

A challenge in pharmacy is the elastic relationships. Let's says someone is looking for a scopolamine patch because they're going on a cruise. Does that person just need a product and information? Depending on factors like their age or health issues, does the encounter shift from customer mode to patient mode? Or should you always be probing what else that person might need? "Mindfulness," says Dr. Austin, "is the first step."

How do you do that? Besides probing what the patient needs, ask yourself this question: if not me now, then who when? Dr. Austin gives the example of someone coming to the pharmacy to fill a script for an anti-depressant. You tell the person about taking it as prescribed, and ask if there are any questions. "No," the person mutters, ready to head out, "it's probably not going to work anyway."

What do you do now? Let them go? Surely that person is seeing a physician. Maybe a social worker or some sort of counselor is in the picture. Then again, if not me now, then who when? Here's one possible reply to the patient's comment: "I get the sense you're not interested in taking the medication. Do you want to talk about that more?"

"Your professional responsibility says you are in a position – and the only person in the position then – who might be able to do something," says Dr. Austin. "You can ask questions, or look up a referral, or provide positive encouragement. All of that could have an enormous and meaningful impact."

In some cases, he says, making no decision is really making a decision. For instance, if you simply tell a patient "You should see a doctor" – because you don't see something as your job – that might have major consequences for the patient. They may have to take time off work. Or wait a week or more. Patients might not complain about you, because you really haven't done anything. So how else could you have helped?

If you stop and ask what the patient needs, recognize your

> "For some health care professionals, pharmacist equals pharmacy... they're thinking about the place not the professional. We make that worse by playing into that tendency. We say, "It's the pharmacy calling"."

opportunity to assist, and consider the consequences of inaction, "Perhaps we would do things that are more patient-focused, and more beneficial for patients and the health care system," says Dr. Austin.

BEYOND THE COMFORT ZONE

How do other health care professionals see the pharmacist's role? Consider how pharmacists themselves sometimes frame the interprofessional relationship.

"For some health care professionals, pharmacist equals pharmacy," says Dr. Austin. "They're thinking about the place not the professional. We make that worse by playing into that tendency. We say, 'It's the pharmacy calling'."

How can that change? "When other health care professionals know our face, know us personally, we're in a position to collaborate. But pharmacists tend to want to remain anonymous, hidden, and a lot of that goes back to not wanting to take responsibility. It backfires on us, by reinforcing the subordinate position."

That may sound like a harsh evaluation. Dr. Austin knows that many pharmacists will react like this: "You have those other pharmacists pegged, but I'm not like them. I'm the outlier."

"What I'm disappointed in is that everyone is a great armchair quarterback, and doesn't think they need to change," says Dr. Austin. "I'm hoping people take the opportunity for self-reflection. This is what we see in pharmacists in general; am I happy with that?"

Fulfilling your promise and undertaking can often demand change. Dr. Austin says that every member of the College needs to become fully aware, in a meaningful way, of OCP's professional responsibility requirements. "If you read those and internalize them, it gives tremendous responsibility to pharmacists to help patients," he says. "You may go beyond your traditional comfort zone to engage patients and put them first."

Dr. Zubin Austin during a 2014 District Meeting presentation.

Methadone Maintenance Treatment and Dispensing

Updated policy and article on Methadone

PREFACE

Methadone maintenance treatment (MMT) is an effective pharmacological treatment for opioid dependence. Pharmacists are required to have the skills and training necessary to safely dispense methadone in a supportive and professional environment. In response to the introduction of a Health Canada approved manufactured oral solution of methadone for the management of opioid drug dependence, the College has updated the Methadone Maintenance Treatment (MMT) and Dispensing Policy.

The revised policy:

1. *Takes into account the introduction of a manufactured concentrated methadone solution.*

2. *Reminds pharmacists that it is not permissible to compound a commercially available product as per the Health Canada Policy on Manufacturing and Compounding Drug Products in Canada (POL-0051).*

3. *Provides direction for the dispensing of a compounded product in exceptional circumstances.*

4. *Requires methadone doses to be accurately measured using a device that is able to deliver 0.1mL increments to facilitate consistency in dispensing.*

5. *Reinforces the College's commitment to dispensing methadone according to the principles and guidelines established by the Centre for Addiction and Mental Health (CAMH).*

The designated manager (DM) must be trained in methadone via the CAMH Opioid Dependence Treatment (ODT) Core Course within six months of beginning a methadone practice and within one year, at least one staff pharmacist must complete the training requirement. Training must be updated at a minimum of once every five years.

The Ontario Pharmacists Association, in collaboration with the Ministry of Health and Long Term Care, has developed a complimentary online Methadone Education Program which can be accessed at anytime and provides updated and ongoing education in the delivery of care to patients. The online program modules are available to all pharmacists and satisfy the requirement to update training every five years once the initial CAMH training is completed.

As pharmacies transition from compounding methadone to the use of a standardized manufactured solution, the DM will need to evaluate pharmacy operations. It is important that individual pharmacies establish policies and procedures that reflect systems, processes and any modifications thereof and make these available to staff.

The revised policy continues to guide members in the provision of optimal methadone therapy, ensuring the highest quality of patient care. For further information related to dispensing methadone, including links to the College's revised policy, reporting form, and many additional resources, please refer to the "Methadone and Buprenorphine" Practice Tools page available on the College website.

METHADONE MAINTENANCE TREATMENT AND DISPENSING

POLICY: Methadone Maintenance Treatment and Dispensing

Approved: September 2010: June 2014

Legislative References: *Drug and Pharmacies Regulation Act* R.S.O. 1990, *c. H.4; Narcotics Safety and Awareness Act, 2010*, SO 2010, c 22; *Controlled Drugs and Substances Act, S.C., 1996, c. 19*.

Additional References: College of Physicians and Surgeons of Ontario: *Methadone Maintenance Treatment (MMT) for Opioid Dependence; and, MMT Program Standards and Clinical Guidelines*. Centre for Addiction and Mental Health: Methadone Maintenance: *A Pharmacist's Guide to Treatment (Current Edition)*.

College Contact: Professional Practice

INTRODUCTION

This policy applies to members participating in methadone maintenance treatment (MMT) programs and who employ any of the models of dispensing methadone for MMT. The policy takes into account the introduction of a manufactured product (2014) indicated for the treatment of opioid dependence. An appendix is attached which addresses methadone dispensing for pain management.

BACKGROUND

The College recognizes MMT as an effective form of treatment for opioid dependence and is committed to ensuring that Ontarians receive this treatment in a safe manner. The best MMT programs are done in partnership recognizing the unique role of the patient, physician, pharmacist and other health care providers in ensuring patient and public safety.

Methadone for the treatment of opioid dependence is regulated by Health Canada in partnership with the Ministry of Health and Long Term Care, the College of Physicians and Surgeons of Ontario (CPSO) and the Ontario College of Pharmacists (OCP).

Physicians who wish to prescribe methadone must apply through Health Canada for exemption under section 56 of the *Controlled Drugs and Substances Act* (CDSA). Exemptions can apply to either methadone maintenance treatment (MMT) for opioid dependence or to the treatment of malignant and chronic non-malignant pain. Physicians who wish to provide methadone for both MMT and pain must obtain separate exemptions. Physicians may also seek authorization through CPSO to delegate the administration component of MMT in a medical office or clinic to qualified health care professionals under a "delegation exemption".

Methadone is dispensed according to the principles and guidelines established by the Centre for Addiction and Mental Health. Pharmacists in an accredited pharmacy are permitted to dispense methadone in individually labeled and fully diluted daily doses for the treatment of opioid dependence pursuant to a written prescription from an exempted physician. In order to enable the administration of methadone in a medical office or clinic, Health Canada has issued an exemption allowing pharmacists in Ontario to transfer custody of such doses, in a secure manner, to a physician or their delegate at the treatment location according to the policies and guidelines developed by both CPSO and OCP.

Pharmacists are reminded that it is not permissible to compound a commercially available product as per the Health Canada *Policy on Manufacturing and Compounding Drug Products in Canada* (POL-0051).

PRINCIPLES

Both OCP and CPSO concur with the following:

1. The ideal model for methadone maintenance treatment is one which supports the integration

of the patient, physician and pharmacist within the community to ensure the availability of local and accessible solutions for patients requiring methadone maintenance treatment for opioid dependence.

2. The pharmacist practices in accordance with the provisions of the *Drug and Pharmacies Regulations Act* (DPRA), *Narcotics Safety and Awareness Act*, Standards of Practice, Code of Ethics, OCP policies and guidelines, and federal legislation, in particular the CDSA and the Narcotic Control Regulations.

3. The physician practices in accordance with CPSO policies and guidelines and meets the requirements of other relevant legislation for the prescribing, dispensing and storage of methadone in Ontario.

4. The pharmacist and the physician play an important and complimentary role in the interdisciplinary model of methadone maintenance treatment. This includes joint development of written policies and procedures to ensure continuity of patient care and secure custody and storage of methadone.

5. According to the Narcotic Control Regulations, the pharmacist, physician and his/her delegate must take all reasonable steps necessary to protect any quantities of methadone on the premises or under their control against loss or theft. When dispensing methadone, pharmacists are responsible for the safety and integrity of the drug until such time as they have dispensed directly to the patient or transferred its custody to an exempted physician or his/her delegate When the provision of methadone has been entrusted to a delegate, the accountability and responsibility for the administration of methadone doses continues to rest with the physician.

6. The role of the pharmacist is to optimize the patient's drug therapy and establish a therapeutic pharmacist-patient relationship with all patients for whom s/he dispenses drugs. The pharmacist must be responsive to prescribed changes in the patient's methadone treatment and able to provide methadone in a timely manner.

7. The Designated Manager (DM) and all pharmacy staff employ the same respectful, professional approaches and attitudes towards MMT patients as they would toward any other patient of the pharmacy.

MODELS FOR DISPENSING METHADONE TO PATIENTS FOR THE TREATMENT OF OPIOID DEPENDENCE

The pharmacist prepares individually labeled doses of methadone using a manufactured product (10 mg/mL solution) pursuant to a prescription and diluted to 100mL of a vehicle which does not lend itself to injection (e.g. Tang®) and then the pharmacist either:

1. Dispenses to patients in a pharmacy accredited by OCP pursuant to the DPRA;

2. Transfers doses in a secure manner to a physician or his/her delegate for custody of and administration to patients; or

3. Takes the doses to the patient at the treatment location and observes the ingestion by the patient.

For the purposes of dispensing methadone in a pharmacy, the pharmacy may be physically located in the treatment location. If the pharmacy is not open seven days a week, pharmacists may open the pharmacy for a restricted time or collaborate with a hospital or another pharmacy to provide weekend access to patients requiring daily doses

COLLABORATION AND SEAMLESS CARE

Collaboration and regular communication between pharmacists and prescribers and other members of the MMT team have an important positive impact on patient care and safety. In order to ensure safe and uninterrupted treatment, pharmacists must communicate and collaborate intra-professionally with other pharmacists during their patients' transitions into or out of institutions and when patients change pharmacies.

PATIENT AGREEMENT

A pharmacy – patient agreement is required for patients treated for MMT. Template agreements may be found in "Methadone Maintenance: A Pharmacist's Guide to Treatment" from the Centre for Addiction and Mental Health (CAMH). Issues to be addressed in agreement may include:

- Expectations of all parties (i.e. pharmacy/clinic hours of operation, consequences of inappropriate behaviour of patient);
- Patient's consent to access and share personal health information with other health professionals involved in their care;

- Notice to the patient that methadone dose will be withheld if the patient appears to be intoxicated or under the influence of other substances;
- Patient's consent to provide identification, if requested, when picking up their medication; and
- Notice to the patient that missed, lost, stolen or wasted doses will not be replaced without a prescription.

The agreement should be in place for the duration of treatment unless circumstances require a re-evaluation of the document. The agreement must be re-signed where a pharmacy makes substantial changes to policies or procedures regarding methadone.

REQUIREMENTS FOR DISPENSING METHADONE IN A PHARMACY

1. Written Prescription for Methadone

A prescription written by an exempted prescriber is required. The CPSO or Office of Controlled Substances (Health Canada) may be contacted to confirm that the prescriber has the appropriate methadone exemption (i.e. MMT or pain).

2. Preparation of Methadone

The methadone is prepared in a manner and form required for dispensing to a patient in accordance with the:

- CAMH guidelines: *Methadone Maintenance: A Pharmacist's Guide to Treatment*;
- Prescriber's instructions;
- Standards of Practice;
- *Drug and Pharmacies Regulations Act and Regulations*; and
- Narcotic Control Regulations.

2.1 Preparation of Final Dosage Form

Daily doses of methadone (drink and carries) must be prepared using a manufactured product (10 mg/mL solution) diluted to 100 mL of a vehicle that does not lend itself to injection such as orange flavoured Tang® or another suitable drink.

Methadone doses must be accurately measured using a device that is able to deliver 0.1mL increments. The reliability of graduated cylinders can vary significantly and such devices are not suitable for accurate dose measurement.

Methadone solution for carries must be dispensed with child-proof safety caps.

2.2 Labeling

Labels on all dispensed methadone must be in accordance with the DPRA, section 156. In addition the label of each unit dose of methadone, i.e. drink or carry, must include:

- The total dose in mg of methadone contained in the bottle;
- A notation: "Drink entire contents of bottle";
- The date for ingestion for carries;
- "Keep refrigerated" auxiliary label for carries; and
- One of the following auxiliary labels must be used:
  - Methadone may cause serious harm to someone other than the intended patient. Not to be used by anyone other than the patient for whom it was intended. MAY BE FATAL TO CHILD OR ADULT.
  - Methadone may cause serious harm to someone other than the intended patient. MAY BE FATAL TO CHILD OR ADULT.

3. Transferring Custody

When pharmacists transfer custody of individually labeled doses of methadone, to a physician or his/her delegate, the physician or delegate must sign the patient manifest on a daily basis to confirm that they have received each correct dose.

Pharmacists must either directly hand the doses of methadone to the physician or his/her delegate, or use a method of transportation that ensures they are aware of and can track who has had custody of the drug at any given time to ensure safekeeping of the methadone while in transit (i.e. a chain-of-signatures and tamper proof boxes). All methadone must be transported in an accountable and secure manner, as described above, and in such a manner as to avoid extremes in temperature or delays in transport which could compromise the drug.

4. Administration of Methadone Dose

Refer to *Methadone Maintenance: A Pharmacist's Guide to Treatment* (CAMH)

In all instances, the patient must be positively identified prior to observing the ingestion of methadone.

After the daily dose of methadone is prepared, the pharmacist does one of the following:

- Observes the ingestion by the patient in the pharmacy;
- Observes the ingestion of the first dose of the maintenance prescription by the patient in the pharmacy and provides authorized carries to the patient;
- Takes the dose to the patient and observes the ingestion of the dose; or
- Takes the doses to the patient and observes the ingestion of the first dose of the maintenance prescription by the patient and provides authorized carries.

5. Documentation

The observation of methadone ingestion is documented daily in the patient record so that it can be determined where each dose of methadone went, for both patient care and auditing purposes. Documentation of methadone ingestion must include the patient's name, daily dose, date, time and place where the administration was observed. When a physician or delegate administers the methadone, the dispensing pharmacist must be provided with copies of such records daily.

All documentation pertaining to methadone must provide an audit trail and be readily retrievable.

6. Changes in Dosing

Any new doses or changes of methadone dose require a new prescription.

7. Unused Doses of Methadone

Unused individually labeled doses of methadone:

- Remain in the pharmacy and are managed in accordance with applicable laws, standards of practice, and OCP policy (where the patient did not attend the pharmacy for his dose, or where the patient was refused the dose because of safety concerns); or
- Are returned to the pharmacy by the physician or his/her delegate, preferably on a daily basis, signed for upon receipt, entered into the appropriate record, and destroyed in the pharmacy in accordance with applicable laws, standards of practice and OCP policy.

8. Daily Reconciliation (pertains to transfer of custody only)

A daily reconciliation of the methadone dispensed to and received from a treatment location is conducted in such a manner that would allow for immediate detection of any losses or diverted quantities.

9. Maintaining Patient Confidentiality and Privacy

Patient administration of methadone in a pharmacy must be done in an area and manner which ensures patient confidentiality and privacy.

EXCEPTIONAL DISPENSING OF A COMPOUNDED PRODUCT

Compounding is permitted in the event of a therapeutic need or lack of product availability and must be completed according to the OCP Guidelines for Compounding Preparations. In the event that, pursuant to a prescription, a patient requires a concentration of methadone that is less than that provided by the manufactured product (10 mg/mL solution) or where a patient is unable to tolerate the commercially manufactured product, the pharmacist is permitted to compound a solution at the required concentration for that patient.

INSTITUTIONAL SERVICES

Institutional deliveries are not considered transfers of custody and should be treated similarly to any narcotic delivery, i.e. auditable and traceable. In those instances where a pharmacy provides methadone services to institutions such as long term care facilities, correctional institutions, or hospitals, specific policies and procedures are to be established by the institution. At a minimum, the pharmacy should be assured that the institution has established policies which outline the secure handing and safe administration of methadone doses.

REPORTING TO THE COLLEGE

The owner/designated manager of a pharmacy that dispenses methadone must provide the College with the following information within seven days using the approved Form:

- Notification of the intention to dispense methadone;

- Whether they are accepting new patients;
- The names of pharmacists who are trained to dispense methadone;
- Hours of operation and days of the week the pharmacy is open, including holidays;
- Whether they are preparing methadone doses for the transfer of custody; and
- Any changes in this status.

EDUCATION AND TRAINING

Pharmacists dispensing methadone must be familiar with the principles and guidelines outlined in both the CAMH publication, *Methadone Maintenance: A Pharmacist's Guide to Treatment and* the CPSO Methadone Maintenance Guidelines. The DM must be trained in methadone via the CAMH Opioid Dependence Treatment (ODT) Core Course or approved course within six months of beginning a methadone practice. In addition to the DM, within one year, at least one staff pharmacist must complete these training requirements. Training must be updated at a minimum of every 5 years. Ideally all pharmacists providing methadone services should participate in educational training in MMT. It is the DM's responsibility to inform all pharmacists working in a pharmacy, including relief and casual pharmacists, if that pharmacy provides methadone services.

REQUIRED REFERENCES

Pharmacies dispensing methadone for MMT must maintain as a required reference the most recent edition of:

- Methadone Maintenance: A Pharmacist's Guide to Treatment (CAMH)
- *Methadone Maintenance Treatment: Program Standards and Clinical Guidelines* (CPSO)
- *Methadone Maintenance Treatment for Opioid Dependence* (CPSO)

OTHER REFERENCES:

- *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*
- OCP: *Methadone and Buprenorphine Practice Tools*
- Fact Sheet: *Key Requirements for Methadone Dispensing*

APPENDIX

METHADONE DISPENSING FOR PAIN MANAGEMENT

Methadone may also be dispensed for pain management in patients. Although, there is no formal training (i.e. CAMH, ODT certification) required for dispensing methadone for pain, pharmacists need to be aware of the requirements regarding methadone. Pharmacists are expected to be familiar with the current Methadone Maintenance Treatment: Program Standards and Clinical Guidelines from CPSO. Pharmacists in all practice settings shall verify whether a prescriber holds an exemption to prescribe methadone for either MMT, Pain, or both.

The owner/designated manager of a pharmacy that dispenses methadone for either MMT or Pain shall inform the College within seven days.

With the exception of the differences outlined below, the same principles and policies apply to the documentation, dispensing, administration and labelling of methadone for both MMT and Pain management.

- Methadone may be dispensed using manufactured products (liquid or tablets) rather than diluted in flavoured drink.
- Observed doses usually will not be necessary and to facilitate self administration, the pharmacist will provide the patient with appropriate measuring device (i.e. oral syringe) with capacity and accuracy to deliver prescribed doses and provide instructions on the use of such devices.
- Labels shall include directions for the frequency of the dosing as prescribed
- In the exceptional cases where a compounded product is dispensed, pharmacist shall label with expiry date and concentration.

REQUIRED REFERENCE

- CPSO Methadone Maintenance Treatment: Program Standards and Clinical Guidelines

OTHER REFERENCES

- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: Part A
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: Part B

METHADOSE® INFORMATION FOR ONTARIO PHARMACISTS

Centre for Addiction and Mental Health (CAMH), Toronto

In Ontario, methadone for treatment of opioid dependence will be prepared using Methadose® Oral Concentrate as the stock solution, and stock solutions will no longer be compounded by pharmacies.

Information in the Methadose® product monograph is not always consistent with the College of Physicians and Surgeons of Ontario (CPSO) Methadone Maintenance Treatment Program: Standards and Clinical Guidelines (February, 2011) and the ***Ontario College of Pharmacists' Methadone Maintenance Treatment (MMT) and Dispensing Policy in Ontario.***

This article will briefly review the topics that can be misunderstood or misinterpreted with the new products:

***METHADOSE Sugar-Free Oral Concentrate (10 mg/mL): DIN 02394618**
Dye-free, sugar-free and unflavoured liquid concentrate

METHADOSE Oral Concentrate (10 mg/mL): DIN 02394596
Red, cherry-flavoured liquid concentrate

**METHADOSE ® Sugar-Free Oral Concentrate (DIN: 02394618) is the recommended product for pharmacies to use as stock solution to prepare methadone maintenance treatment (MMT) doses.*

DOSING GUIDELINES

Dosing of methadone must adhere to the 4th edition of the CPSO's *Methadone Maintenance Treatment Program: Standards and Clinical Guidelines* (February, 2011).

See chart on opposite page.

ACCURACY WHEN MEASURING DOSES

- Special care must be taken in measuring this concentrated formulation (10 mg/mL). Measured doses should be double-checked and double-signed against the original prescription, whenever possible. There have been instances in Ontario in which major life-threatening errors in measurement have been made (e.g. a dose of 190 mg for someone prescribed 19 mg).
- As per OCP policy, Methadose® doses must be accurately measured using devices able to deliver 0.1 mL increments. Even small measurement errors may be clinically significant with methadone's narrow therapeutic range. Graduated cylinders and certain syringes may not be appropriate for this purpose.
- Most pharmacies have previously compounded a different concentration of stock solution (e.g. 5 mg/mL). **Extra caution with measuring is required during this transition period.**
- If using a dispensing pump system, check with the manufacturer for any re-calibration needed for the new products. There may be issues using the cherry flavour product in some systems.

DILUTION WITH FRUIT DRINK STILL REQUIRED WITH METHADOSE®

- Dilution with a vehicle that deters injection or diversion (e.g. orange drink) to 100 mL is still required as per the OCP Methadone Policy **for all observed and carry doses**.
- At this time, both forms of Methadose® Oral Concentrate require dilution as above. Water is not considered a vehicle that deters injection. *For this reason it is recommended to use the unflavoured product diluted with fruit drink.*

CLEAR LABELLING OF THE BOTTLE

The prescription label requirements for methadone doses have not changed. Moving from a compounded product to a commercial product however, requires that the commercial product be clearly identified. Please note, that when the concentration and volume of Methadose® appears on the label for the bottle containing diluted product, this can be misinterpreted. *There have been errors related to labelling where partial*

Dosing discrepancies between Methadose® monograph and CPSO guidelines:

	CPSO GUIDELINES	METHADOSE® MONOGRAPH
Initial dosing	Initial dose of 10-30mg on the first day Maximum total daily dose of 30mg on the first day. Increases should occur only every **3-5** days; decisions within these parameters are based on the clinical situation (see page 40 of Guidelines).	Initial dose of 20–30 mg. An additional 5-10mg may be given on the first day for a total daily dose of 35-40mg on the first day.
Missed doses	Dosage adjustment is required if: **2** consecutive doses are missed during early stabilization or **3** consecutive doses are missed in the maintenance phase	Loss of tolerance should be considered if opioids are not taken for **5** days.

volumes of the diluted product were thought to contain the daily dose. Therefore, labelling must be considered carefully. The label should make the following very clear:

1. The drug product (name, manufacturer) and amount in the bottle.
2. The total dose in milligrams of methadone contained in the bottle.
3. A notation that the drug product has been diluted.
3. A notation: "Drink entire contents of bottle."
4. The date for ingestion for carries.

Examples of acceptable labels:

Pharmacy Rx#
Address Date

Jane Doe

Drink entire contents of bottle (METHADONE 80 mg in orange drink) on Friday, June 27, 2014.

80mg Methadone (MAL) DIN02394618

Dr. Smith

Pharmacy Rx#
Address Date

Jane Doe

Drink entire contents of bottle (METHADONE 80 mg in orange drink) on Friday, June 27, 2014.

(8) mL Methadone HCl 10mg/mL (MAL) DIN02394618

Dr. Smith

The following auxiliary labelling should also be included:

- "Keep Refrigerated" for carries
- Methadone may cause serious harm to someone other than the intended patient. MAY BE FATAL TO CHILD OR ADULT.

Additional information required as per OCP Policy (2014) must be included as well: http://www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2

COMMUNICATION WITH PATIENTS

Inform your patients of the change in product and reassure them that they should not notice any difference in the effectiveness of their MMT doses, although there might be a change in taste. Patient information provided by the manufacturer may not be consistent with the guidelines, so distribution of the Ontario Public Programs' "Changes to Methadone Maintenance Frequently Asked Questions" should be considered.

1. College of Physicians and Surgeons of Ontario (CPSO) Methadone Maintenance Treatment Program Standards and Clinical Guidelines (2011): http://www.cpso.on.ca/uploadedFiles/members/MMT-Guidelines.pdf

2. Revised OCP Methadone Maintenance Treatment (MMT)and Dispensing Policy:http://www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2/

3. Ontario Public Programs, Ministry of Health and Long-Term Care: Changes to Methadone Maintenance Treatment Frequently Asked Questions for Patients: http://www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/cmmt_faq_patients_20140620.pdf

Treating Self and Family Members & Preventing Sexual Abuse and Harassment

Updated policy and guidleine

PREFACE

The coming pages feature a policy on Treating Self and Family Members *and a guideline on* Preventing Sexual Abuse and Harassment. *While these topics are different they overlap on the issue of spousal treatment and the notion of professional boundaries.*

In 2013, Bill 70, Regulated Health Professions Amendment Act (Spousal Exception) received Royal Assent. The legislation permitted each health professional Council in Ontario to decide whether to permit a member to treat his or her spouse. While gathering feedback on this issue, on the advice of the Patient Relations Committee, the College submitted that regulated health professionals should not be permitted to routinely treat spouses or other family members, although the Committee recognized that at times it would be appropriate for a member to provide emergency or incidental care to a spouse.

In light of this decision, the Professional Practice Committee considered the more general question of whether a member should provide care or services to his or her self, or other closely related family members. On the advice of the Committee, a policy was developed that indicated it was generally considered to be inappropriate to do so, given the potential for role confusion and conflict of interest.

In taking these decisions, Council has acted to provide clarity on the issue of professional boundaries at a time when members are taking on new patient care roles and collaborating more with other health professionals.

TREATING SELF AND FAMILY MEMBERS

POLICY: Treating Self and Family Members

Approved: June, 2014

Additional References: *Preventing Sexual Abuse and Harassment.*

College Contact: Professional Practice

INTRODUCTION

Providing health care to self and/or closely related family members is generally considered to be inappropriate and a conflict of interest. Treatment in these circumstances could potentially compromise a member's ability to be objective and unbiased in the exercise of his or her professional judgment. In addition to these reservations are concerns that a related person may not feel free to disclose personal information which could have an impact on treatment, a member may not maintain patient confidentiality when treating a related person, and/or, a dual relationship may pose a potential risk of billing fraud.[1] Further, in the event of an error, a family member may be hesitant to exercise his or her right to pursue a complaint.

Regulatory colleges are best equipped to determine standards of practice for respective members, including whether or not to permit a member to provide routine care to his or her self and/or other closely related family members.

DEFINITIONS

Family Member

For the purpose of this policy, a family member means a closely related person including the member's spouse, child, sibling, parent or grandparent, and the spouse's parents and siblings.

Minor condition

A minor condition is one that, in the member's professional judgment, is not urgent or serious and that does not require a physician's intervention.

Emergency

An emergency exists where an individual is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm without immediate care.

Professional Boundary

There is no single all-encompassing definition of what constitutes a professional boundary. Boundaries are based on trust, respect and the appropriate use of power.

POLICY

A member will not provide routine pharmaceutical care to his or her self and/or family members, except incidentally in the case of a minor condition, in an emergency circumstance, or when another appropriate health professional is not readily available.

In determining whether to provide care, the member should consider what a reasonable or prudent practitioner might do in similar circumstances. In those instances where the member decides that it is appropriate to provide care, the member will document the reasons for providing care in addition to the routine documentation and record-keeping associated with delivering pharmaceutical care. If possible, care should be transferred to another pharmacist as soon as it practical/possible.

1. Health Professions Regulatory Advisory Council (2012); The Spousal Patient. P. 15

PREVENTING SEXUAL ABUSE AND HARASSMENT

GUIDELIENE: Preventing Sexual Abuse and Harassment

Approved: 1996; **Revised:** 2011; 2014

Legislative References: *Regulated Health Professions Act, 1991 SO 1991, c18; Pharmacy Act, 1991, SO 1991, c36; Family Law Act, RSO 1990, c F.3; Human Rights Code, RSO 1990, c H.19; Funding for Therapy or Counselling for Patients Sexually Abused by Members, O Reg 59/94*

Additional References: *Funding for Therapy and Counselling*

College Contact: Professional Practice

INTRODUCTION

The following guideline document complies with the requirement of the *Regulated Health Professions Act* (RHPA) that the College take measures to prevent and deal with the sexual abuse of patients.

The purpose of the provisions in the RHPA with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counseling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.

The Ontario College of Pharmacists (OCP) *Code of Ethics* states that members have moral obligations in return for the trust given them by society. A member is required to act in the best interest of and advocate for the patient, observe the law, uphold the dignity and honour of the profession, and practice in accordance with ethical principles and his or her respective standard of practice.

Members are expected to take responsibility for their actions.

OCP PHILOSOPHY

Both pharmacists and pharmacy technicians, as regulated health professionals, are expected to set a high standard of behaviour in the work environment. OCP regards any act of abuse or harassment of a patient, customer, staff person and / or colleague, as unacceptable and such actions are subject to investigation as professional misconduct. Ignoring harassment or abuse is equal to condoning the abuser's actions and further harming the victim, and may be subject to sanction.

DEFINITIONS

Professional Boundary

There is no single all-encompassing definition of what constitutes a professional boundary. Boundaries are based on trust, respect and the appropriate use of power. In the context of this guideline, a boundary is the point at which a relationship changes from professional and therapeutic to unprofessional and personal.

Spouse

According to the *Family Law Act*, a spouse is defined as either of two persons who are married; or, either of two persons who are not married to each other and have cohabited continuously for a period of not less than three years; or, either of two persons who are in a relationship of some permanence, if they are the natural or adoptive parents of a child.

Sexual Abuse

The sexual abuse of a patient by a member is defined as:

- Sexual intercourse or other forms of sexual relations between the member and the patient;
- Touching of a sexual nature, of the patient by the member; or
- Behaviour or remarks of a sexual nature, by the member towards the patient.

Harassment

Harassment means engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome.

Harassment may include bullying, intimidating or offensive jokes or innuendos, displaying or circulating offensive pictures or materials, or offensive or intimidating phone calls.[1]

GUIDELINE

The Member – Patient Relationship

Members have an obligation to establish relationships with patients based on trust, support and mutual respect and further, are responsible for maintaining the professional integrity of the relationships.

A co-existing sexual and patient relationship is considered to be professional misconduct and an act of sexual abuse.[2] OCP does not exempt the treatment of spouses from this rule, and as such, does not permit the provision of routine care to a spouse.

What Is An Appropriate Boundary?

An appropriate boundary of a member-patient relationship would be one that complies with the *Code of Ethics* and OCP's philosophy.

Maintaining Appropriate Professional Boundaries [3]

1. Show sensitivity and respect for the patient's privacy and comfort at all times.
2. Outside of clinical necessity, avoid any physical contact with a patient that could be perceived as inappropriate.
3. Avoid any behaviour or remarks that may be interpreted as sexual by a patient.
4. Endeavour to be aware or mindful of a patient's particular cultural or religious background.
5. Do not make sexualized comments about a patient's body or clothing.
6. Do not criticize or comment unnecessarily on a patient's sexual preference.
7. Do not ask details of sexual history or behaviour unless related to the purpose of the consultation.
8. Be cognizant of social interactions with patients that may lead to romantic involvement.
9. Do not talk with your patients about your own sexual preferences, fantasies, problems, activities or performance.
10. Learn to control the consultation setting and to detect possible erosions in boundaries.

Preventing Sexual Abuse and Harassment

A member must not become sexually involved with his or her patient.

- Under the RHPA, any form of sexual relations between a member and a patient (including a spouse unless the college has adopted a spousal exemption regulation) is considered to be sexual abuse. In the event that a member of a college not exempting spousal treatment is required to provide care to a spouse in an emergency or incidental situation, the member must transfer care as soon as is practical.[4]
- When in doubt as to whether a therapeutic relationship exists/has terminated, members should refrain from any personal relationship.
- Sexual contact with a former patient may be considered professional misconduct even though it is not sexual abuse as defined under the RHPA. A sexual or romantic relationship is inappropriate in cases where the therapeutic relationship has created a vulnerability or dependency on the part of the patient that affects the patient's ability to act freely.
- Sexual relationships between members and caregivers raise concerns about breach of trust and power imbalance. It is advisable that members refrain from sexual or romantic relationships with these individuals.

A member must not harass or otherwise intimidate his or her patient.

Mandatory Reports

A member is required to file a report in writing with the Registrar if he or she has reasonable grounds, obtained in the course of practicing their profession, to believe that a member, of the same or different college has sexually abused a patient. The report must be made within 30 days and may only include the patient's name where written consent has been given by the patient or, if the patient is incapable, the patient's representative. The report must include the name of the member filing the report, the name of the member who is the subject of the report and an explanation of the alleged sexual abuse. Once a report is received, the information will be reviewed by the Registrar to determine the next steps, including appointing an investigator and initiating a formal investigation.

There is a $25,000 fine for failure to report. Members are indemnified for making reports in good faith.

Education Plan

The RHPA requires that Ontario's regulated health professions develop sexual abuse prevention

programs. The College has undertaken to educate members and students about these issues and has provided training to key College staff on how to handle complaints involving topics of a sexual nature.

Funding For Therapy & Counseling

Pursuant to the RHPA, the College has established a fund for therapy and counseling for persons who, as patients, were sexually abused by a member of the College. The maximum amount of funding that may be provided is the amount that the Ontario Health Insurance Plan would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist on the day the person becomes eligible for funding. The Patient Relations Committee administers the fund.

Sexual Relationships with Former Patients:

The member should terminate the therapeutic relationship with a patient prior to initiating a sexual or romantic relationship. The member must consider whether the therapeutic relationship has created a vulnerability or dependency on the part of the patient that may make it inappropriate to engage in a sexual or romantic relationship.

1. Ontario, Ministry of Labour. Workplace Violence and Workplace Harassment.
2. Health Professions Regulatory Advisory Council. The Spousal Patient; p. 11.
3. Adapted from the College of Physicians and Surgeons of Ontario Maintaining Appropriate Boundaries and Preventing Sexual Abuse
4. Incidental care has been defined by the Ontario Court of Appeal as "minor in nature, casual or arising in fortuitous conjunction with a spousal relationship. For example, as cited in V.L. v. College of Chiropractors of Ontario, 2008 CanLII 56709 (ON SCDC)

Coroner's Inquest into Death due to Hyperthermia

B.F was an employee of a small lawn sprinkler company that had been in business for ten years. He suffered from schizophrenia and was prescribed the antipsychotic drug, olanzapine, to control his symptoms. His employer was aware that he had mental health issues but not of his exact diagnosis or medical treatment and any related issues.

On the day of the incident, B.F. was working as usual on the installation of a residential lawn sprinkler system. It was a hot summer day with a maximum temperature in the local area, as measured at Pearson Airport, of 29.2 degrees Celsius. Water and liquids were available and he was seen drinking over the course of the workday. He had voiced no concerns and did not appear to be in any distress, according to his coworkers. However at the end of the day, during clean up, B.F., who was normally a quiet and reserved communicator, stated that he was feeling hot. His coworkers advised him to sit down in an air-conditioned van. Approximately 15 minutes later he exited the van and walked towards another van at the site. He proceeded to collapse and was attended by his coworkers. A passing runner with first aid experience began cardiopulmonary resuscitation. Emergency Medical Services personal found him to have absent vital signs and an initial temperature of 39.9 degrees Celsius.

Resuscitation attempts were initiated and continued en route and in the Emergency Room without success. An autopsy confirmed that B.F. died as a result of environmental hyperthermia and that he had evidence of significantly advanced premature coronary artery disease.

The Coroner's jury made a recommendation to the Ontario College of Pharmacists, Ontario College of Family Physicians, College of Physicians and Surgeons of Ontario, and to the Ontario Medical Association as follows:

RECOMMENDATION:

Increase awareness among Health Care Providers of heat stress and how some medications may impact upon a person's ability to deal with heat stress.

CORONER'S COMMENTS:

Testimony was provided that there are resources presently available to frontline healthcare providers that can effectively facilitate their knowledge of heat stress as it relates to their patients and the medications they prescribe or dispense, and that the providers are unaware of the existence of these resources.

Preventing Heat-Related Illness

Chia Hui Chung, BSc., PharmD Candidate (2016),
University of Toronto Leslie Dan Faculty of Pharmacy

In the summer months, pharmacists are often relied upon to educate patients on matters such as sun protection and sun sensitivity in relation to drug therapy. However, this case teaches us that the effect of drugs on temperature regulation cannot be overlooked. Hyperthermia refers to an increase in core body temperature beyond 38.2 degrees Celsius, thereby producing symptoms that result from the interference of our own heat dissipating mechanisms. Resting, cooling and rehydrating with oral rehydration solution provide the mainstay of treatment for hyperthermia.[1]

RISK FACTORS

Pharmacists need to identify the key risk factors in order to respond to red flag situations that pertain to heat-related illness (as seen in Table 1). Those that are most susceptible to developing hyperthermia include: infants and young children, the elderly, outdoor labourers and the physically active.[2]

Table 1: Risk Factors for Heat-Related Illness[2]

Health Factors	Behavioural/Environmental Factors
∘ Cardiovascular disorders (hypertension, coronary artery disease, peripheral artery disease, heart conduction disorders) ∘ Pulmonary disorders (chronic obstructive pulmonary disease, asthma) ∘ Renal disorders (renal failure) ∘ Psychiatric disorders (dementia, depression, schizophrenia, Alzheimer's) ∘ Skin conditions (scleroderma and miliaria) ∘ Hyperthyroidism ∘ Metabolic conditions (diabetes, obesity) ∘ Alcoholism	∘ Wearing heavy clothing or equipment ∘ Poor physical condition; confined to bed ∘ Hot, humid environment without air conditioning or proper ventilation ∘ Exercising without breaks

HEAT EXHAUSTION VERSUS HEAT STROKE

Heat exhaustion occurs during the first signs of increased core body temperature due to excessive salt and water loss. It can be accompanied with symptoms such as anxiety, headache, nausea and vomiting. The skin becomes red, moist and hot to the touch. The heart rate may increase while blood pressure may drop. Strenuous activity should be avoided for several days.[1]

Heat strokes are the most dangerous and life-threatening forms of hyperthermia, which can occur when heat exhaustion is left untreated. There are two types of heat stroke: classic and exertional. Classic heat strokes primarily affect the elderly with chronic illness, and the skin becomes hot and dry. Exertional heat strokes occur in younger, healthy individuals due to strenuous physical activity and

Table 2: Medications Shown to Decrease Regulation of Body Temperature[3]

Mechanism	Drug Class	Examples
Reduction of perspiration	Anticholinergics	scopolamine
	Antihistamines	brompheniramine
	Antiparkinsonian agents	levodopa, benztropine
	Antipsychotics	olanzapine
	Beta-blockers	atenolol, metoprolol
	Calcium channel blockers	amlodipine
	Diuretics	furosemide
Vasoconstriction of cutaneous vessels	Sympathomimetics	pseudoephedrine
Disruption of centrally-induced thermoregulation	Antidepressants	SSRIs (fluoxetine), TCAs (amitriptyline)
	Amphetamines	Adderall (amphetamine and dextr-amphetamine)
Increased heat production	Excessive thyroid medication	levothyroxine

the skin becomes moist due to profuse sweating. Both types of heat stroke will likely cause changes in mental state (e.g., delirium, coma). Patients should be cooled and be taken to the emergency room immediately.[2]

MEDICATIONS THAT INCREASE RISK FOR HEAT-RELATED ILLNESS

Certain medications can predispose patients to hyperthermia through various mechanisms (examples are illustrated in Table 2). Pharmacists should be able to identify these provoking agents based on a patient's medical history, clinical presentation and timing of symptom onset to mitigate the risk of irreversible sequelae. In light of the Coroner's findings, pharmacists are reminded of the Professional Responsibility Principles, which call on members to assess the appropriateness of therapy by recognizing situations that may cause the patient harm. To facilitate information sharing and professional collaboration within health care teams, proper documentation of patient counseling regarding heat-related illnesses is also advised. Clinical encounters concerning medications that affect body temperature regulation should include the following recommendations:

- Know the signs/symptoms of heat-related illnesses
- Drink at least two cups of cool water every hour during moderate physical activity[4]
- Limit coffee, tea, cola and alcoholic beverages.[2]
- Avoid heavy outdoor activities between 10 a.m. and 3 p.m.[2]
- Schedule frequent rest periods from outdoor activities.[2]
- Wear loose-fitting, light-coloured clothing.[4]

1. Canadian Pharmacists Association. "Thermoregulatory Disorders in Adults." Therapeutic Choices Sixth Edition (2011). Print
2. Canadian Pharmacists Association. "Heat-Related Disorders." Therapeutic Choices for Minor Ailments: The Best Available Evidence for Nonprescription Therapy (2013). Print
3. Health Canada. Acute Care During Extreme Heat: Recommendations and Information for Health Care Workers (2013). Available from: http://www.hc-sc.gc.ca/ewh-semt/alt_formats/hecs-sesc/pdf/pubs/climat/actue_care-soins_actifs/actue_care-soins_sante-eng.pdf
4. United States Department of Labour (Occupational Safety and Health Administration). Protecting Workers from the Effects of Heat [Fact Sheet] (2011). Available from: https://www.osha.gov/OshDoc/

Pharmacy Technician Bridging Program

FACT SHEET: Pharmacy Technician Bridging Program

Published: July 2014

Legislative References: *General Regulation under the Pharmacy Act, 1991.*

Additional References: *Registration Resolutions in respect of Ontario Regulation 202/94*

College Contact: Registration Programs

BACKGROUND

The Pharmacy Technician Bridging Education Program was approved by College Council to allow pharmacy assistants who were already working in the profession sufficient time to upgrade their skills to align with changes in the scope of practice for pharmacy technicians. Those applicants who are in the "in the profession" pathway to registration must successfully complete the Pharmacy Technician Bridging Education Program portion of the registration process prior to January 1, 2015.

DEADLINES

The January 1, 2015 deadline applies only to the date for successful completion of the Pharmacy Technician Bridging Education Program. This deadline is firm and the bridging program will no longer be valid for Ontario applicants wishing to register through the "in the profession" pathway. Individuals who successfully complete the bridging program before the deadline are still able to continue with the other examinations and training requirements for final registration.

EMPLOYER DEADLINES

Many employers have set their own deadlines to support the shift toward regulating pharmacy technicians. Employer deadlines to become fully registered as a pharmacy technician do not relate to the College's deadline to complete the Pharmacy Technician Bridging Education Program.

OPTIONS IF YOU MISSED THE DEADLINE

The deadline to complete the Pharmacy Technician Bridging Education Program by January 1, 2015 is firm. If you missed the deadline, you have two options:

1. Enrol in a pharmacy technician education program accredited by the Canadian Council for the Accreditation of Pharmacy Programs (CCAPP)
   - More information is available at www.ocpinfo.com/registration/register-technician
2. Work as a pharmacy assistant
   - Discuss opportunities with your employer
   - Pharmacy assistants are unregulated
   - You will not be able to call yourself a pharmacy technician or perform any of the related authorized acts
   - Your work responsibilities will not be the same as those of a pharmacy technician

NATIONAL PHARMACY TECHNICIAN BRIDGING EDUCATION PROGRAM

The National Association of Pharmacy Regulatory Authorities (NAPRA) will continue to offer the Pharmacy Technician Bridging Education Program to:

1. Applicants in other provinces that are still developing the regulation process for pharmacy technicians
2. International pharmacy technician applicants

This program is closed for "in the profession" pathway applicants in Ontario.

For questions or further clarification email
ocpclientservices@ocpinfo.com

Canadian HealthcareNetwork

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FEAR FACTOR:

Misguided concerns of some community pharmacists continue to hold techs back

By Albena Ivanov

I have some exciting news! Earlier this year I was hired to work as a full time R.Ph.T. in a retail pharmacy. Clearly, I'm one of the lucky ones. That's because there's a prevailing notion out there that registered techs have few choices as to where to work—it's either in a hospital or long-term care pharmacy.

To a certain degree I understand that sentiment. The retail pharmacy world pays too much lip service to tech regulation, while taking very little action to integrate R.Ph.T.s. Drugstore chains, in general, seem reluctant to hire registered techs for various reasons. I believe the biggest obstacle is that community pharmacists are wary of delegating any responsibilities to us. Who wants to be held accountable for any errors R.Ph.T.s might make if they are allowed to practise to their full scope?

It's true that the Ontario College of Pharmacists still considers any clinical issues to be the responsibility of the pharmacist, while any technical accuracy aspects of the prescription are now our responsibility. However, it seems most pharmacists are still uneasy about co-signing a prescription dispensed by a R.Ph.T.

Come to think of it, everyone in the circle of care, including but not limited to doctors, nurses, pharmacists, or techs, makes a mistake on occasion.

That's why we carry professional liability insurance!

I've had the privilege to work side by side with most excellent pharmacists, assistants and technicians, and I have yet to meet someone who has never made a misstep in their practice. Fortunately, patients are rarely harmed due to errors made in the pharmacy. More often than not, the error is rectified before the medication leaves the store. Or the patient or caregiver suspects something is wrong and returns to the pharmacy with questions.

But while many pharmacists perceive having a R.Ph.T. working to their full scope as risky, there are still a handful of pharmacy managers who appreciate the benefits of having us on board. Call it a leap of faith if you wish. These pharmacists are willing to modify the pharmacy's workflow in order to take full advantage of our superpowers.

As for me, I really enjoy working in retail, as we get to see our patients face to face. I derive a lot of professional satisfaction from having direct contact with the public. While I expected finding a R.Ph.T. position in the community setting to be challenging (especially in a corporate store), I wasn't going to give up hope without trying. It paid off.

You might ask why a retail manager would hire a R.Ph.T. for their dispensary. Of course, each businesses needs are different. I believe it is a good option if a registered tech would contribute to a more efficient workflow, shorter wait times and better patient care. Also, the team must be willing to experiment and adjust until they establish an ideal setup. It takes more than one person to discover what makes sense for a specific workplace.

While tech regulation sounds very good in theory, it won't work until it is carefully implemented into retail pharmacy practice. It takes patience and effort, but it's worth it.

If you doubt that employing a registered tech would be worth it, that's ok. But, please try and see for yourself before judging either way.

This post is not in any way intended to evaluate my abilities or our team effort (after only a few months on the job it would be premature, to say the least). Right now all I can say is this: I am very grateful for the opportunity to practice to our full scope. I am working on a team with very supportive pharmacists and assistants and enjoy coming to work every day.

As I already mentioned above, we don't know it all. We are still figuring out all the details and learn something new in the process every day as we progress in the right direction, which is rewarding.

To those who are looking for work as a R.Ph.T. and like retail as much as I do, do not give up hope. The only way to achieve your desired outcome is to apply yourself. It is up to the hiring manager to consider your application in light of the specific staffing needs. Managers have different approaches to running a business successfully, even when working for the same company.

When given the opportunity to practise as a R.Ph.T. in any pharmacy setting, do a good job and act as a healthcare professional. It is important to take pride in what we do. It makes all the difference.

"PHARMACY TECHNICIAN" A RESTRICTED TITLE

As with all other regulated healthcare professionals, the title "pharmacy technician" is restricted and protected under legislation. It is an offence for anyone other than those who are registered with the Ontario College of Pharmacists as a "pharmacy technician" to call or present themselves as such in Ontario. Non-registered dispensary personnel must use other designations such as dispensary or pharmacy assistants.

The *Pharmacy Act* also protects the use of variations, abbreviations or equivalents of "pharmacy technician" in other languages. The generally accepted abbreviation for pharmacy technician is "R.Ph.T".


Certificate of Accreditation of a Pharmacy
Medical Direct e &/or Delegation Template

Medical Directives and the Delegation of Controlled Acts

Revised Policy and Article on Delegation

PREFACE

The coming pages feature a revised policy on Medical Directives and the Delegation of Controlled Acts *and a new article entitled* Delegation of Controlled Acts — *Direct Orders and Medical Directives. The introduction of an expanded scope of practice has increased the prevalence and opportunity for the use of delegation by members, for example the administration of injections other than through the UIIP or for demonstration and education. Delegation has historically been used in hospital and non-traditional settings (e.g. Family Health Teams), and in recent years there has been heightened awareness of the possible use of delegation in community practice.*

MEDICAL DIRECTIVES AND THE DELEGATION OF CONTROLLED ACTS

POLICY: Medical Directives and the Delegation of Controlled Acts

Approved: October 2007; **Revised:** June 2014

Legislative references: *Regulated Health Professions Act, 1991, Drug and Pharmacies Regulation Act, Health Care Consent Act*

Additional References: **Model Standards of Practice for Pharmacists, Model Standards of Practice for Pharmacy Technicians, Documentation Guidelines, Expanded Scope Orientation Manual**

College Contact: Professional Practice

INTRODUCTION

This policy sets out the College's expectations for members when considering delegation, and provides guidance on a member's responsibility when performing delegated acts. The use of delegation is in accordance with the provisions of the *Regulated Health Professions Act*, and the *Pharmacy Act*.

PRINCIPLES

1. Delegation of a controlled act should only occur if it is clinically appropriate and in the patient's best interests.

2. The use of delegation is only appropriate to advance patient interests, not professional self-interest.

3. Patient safety is paramount and a member should only accept delegation if he or she feels competent to perform the delegated act or procedure.

4. A member is accountable for his or her performance and patient outcomes when accepting delegation.

DEFINITIONS

Controlled Act

Controlled acts are specified in the **Regulated Health Professions Act, 1991 (RHPA)** as acts which may be only performed by authorized regulated health professionals.[1] A controlled act can be delegated by a regulated health professional with the authority to do so.

Delegation

Delegation is a process whereby a regulated health professional authorized to perform a controlled act under a health profession Act (delegator/authorizer) confers that authority to someone (regulated or unregulated) who is not so authorized (delegate/implementer).[2] Any act or procedure can be delegated as long as delegation is not prohibited by legislation or organizational policy (e.g. by regulation, a pharmacy student is not permitted to delegate or accept the delegation of a controlled act).[3]

Order

An order is a prescription for a procedure, treatment, drug or intervention and may take the form of either:[4]

A. Direct Order
A direct order is an order to perform a controlled act for only one patient for a specific intervention. It may be verbal or written and only occurs after a direct assessment of the patient by the authorizer.

or

B. Medical Directive

A medical directive is a written order to perform a controlled act for any patient who meets the criteria set out in the medical directive. A medical directive can order a procedure or series of procedures under specific conditions without a direct assessment of the patient by the authorizer (e.g. authorizing a pharmacist to order INR testing for a patient receiving warfarin therapy). Ideally all health professionals involved in authorizing and implementing procedure(s) under medical directives participate in their development.

POLICY

The regulated health professional conferring delegation will be referred to in this policy as the authorizer, and the person receiving the delegation will be referred to as the implementer. Delegation takes place through either a direct order or a medical directive. Delegation confers the legal authority to perform a controlled act, whereas an order provides instructions on how to perform it.

A member may delegate a controlled act subject to the terms, conditions and limitations of his or her certificate of registration (Appendix A). It is not considered delegation to authorize the initiation of a controlled act that is within the scope of practice of that health professional. It is also not considered delegation to refer a patient to another health professional for care.

A member must only delegate acts that he or she is personally competent to perform and which are a part of his or her regular practice. When delegating an act or procedure, the authorizer is responsible for ensuring that the act is performed competently, and that delegation is in the best interest of the patient. Accountability for the delegated act remains with the authorizer, who must be especially diligent in assessing the performance readiness of an implementer to ensure safe and effective care.

Sub-delegation, where a member delegates an act that was delegated to them, is not permitted.

If a member accepts delegation for an act or procedure in one setting, he or she cannot assume that delegation is transferable to another setting. A change in setting does not affect the competency of the member but does require assessment by both the member and authorizer to ensure the delegated act is appropriate given the conditions of the new setting.

In circumstances where a member is not named in a direct order (e.g. a prescription for a vaccine may include the order "pharmacist to inject") the member should be confident, based on his or her communication with that authorizer, that the order was intended for him or her and that appropriate assessment of the member's performance readiness has occurred.

Medical directives identify the health care professionals authorized by the order (e.g. all pharmacists at the Long River Family Health Team).

The Federation of Health Regulatory Colleges of Ontario (FHRCO) has developed An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario which contains templates for assessing performance readiness, developing a medical directive and education and competence assurance plan, and additional tools to assist with delegation. Members are encouraged to review the FHRCO guide and utilize the templates when developing a medical directive. In addition, FHRCO lists all controlled acts defined under the *RHPA* along with the health professionals authorized to perform each act.

ACCEPTING A DELEGATED ACT OR PROCEDURE

1. Patient Best Interests

Independent of the assessment by the authorizer, a member must use professional judgment when accepting delegation to evaluate the associated risks and determine whether delegation is in the best interest of the patient. Delegation should not occur solely for convenience and should never be accepted on the basis of professional self-interest. A member should have current knowledge of the patient's condition and therapy and only accept delegation in the context of a member-patient relationship unless the patient's best interests dictate otherwise (e.g. if a pharmacist orders lab work under a medical directive in an emergency department).

In accepting a delegated act or procedure, the implementer will:

- Assess the patient to confirm the patient's need for the act or procedure;
- Consider the known risks and benefits to the patient, the predictability of outcomes, and the

safeguards and resources available to safely manage outcomes; and
- Identify any other factors specific to the situation.

2. Assess Personal Competence

In every instance where a member considers accepting delegation the member will ensure that he or she has the appropriate knowledge, skill and judgment to competently perform the act or procedure, as well as safely manage all foreseeable outcomes. In addition, the setting in which the member practices must have appropriate facilities to perform the delegated act or procedure (e.g. there must be a clean, safe, private and comfortable area for administration of injections). A member will provide any information the authorizer may need to assess the member's competence to implement the act or procedure.

3. Accountability

Both the authorizer and implementer are accountable for self-evaluation of:
- Competence and capacity to perform the delegated act or procedure; and
- Ability to manage patient outcomes.

Upon accepting delegation a member is accountable for performing the act or procedure competently and for ensuring that any potential outcomes are managed appropriately.

4. Patient Consent

The implementer is required to provide the patient with appropriate information on the authority under which the act or procedure is being performed, and the patient must give informed consent. As required by the *Health Care Consent Act* the implementer must ensure that the patient understands that the authorizer has delegated the act or procedure to the member.[5] Providing appropriate information to the patient includes the ability to answer questions regarding the risks and benefits of the act or procedure. If a member is unable to provide information that a reasonable person would request, the member should reconsider whether or not acceptance of delegation of the act or procedure is appropriate.

DOCUMENTATION

A member must document that he or she obtained informed consent from the patient to proceed with delegated act or procedure. A member is also required to document details of the delegated act or procedure performed under a direct order. Additionally, under a medical directive a member is required to document the results of the patient assessment as well as the rationale for performing the delegated act.

Members can refer to the Documentation Guidelines for more information.

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1. *RHPA*, s. 27(1)(a,b)
2. Federation of Health Regulatory Colleges of Ontario. An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario. Retrieved on January 31, 2014 from http://www.mdguide.regulatedhealthprofessions.on.ca/orders/what/default.asp
3. *LTCHA*, s. 131(3)
4. College of Nurses of Ontairo. Authorizing Mechanisms (2014). Retrieved on March 21, 2014 from http://www.cno.org/Global/docs/prac/41075_AuthorizingMech.pdf
5. *HCCA*, s.11(1)

Appendix A: Terms, Conditions and Limitations on a Member's Certificate of Registration

	Pharmacist	Student	Intern	Pharmacy Technician
Delegate	Yes	No	No	No
Accept Delegation	Yes	No	Yes	Yes

* **Terms, Conditions and Limitations on a Member's Certificate of Registration are specified under the general regulation of the *Pharmacy Act*.**

Delegation of Controlled Acts – Direct Orders and Medical Directives

The *Regulated Health Professions Act, 1991* (RHPA) identifies thirteen controlled acts that may only be performed by an authorized regulated health professional. Any controlled act can be delegated by a regulated health professional with the authority to do so to someone (regulated or unregulated) who is not authorized, as long as delegation is not prohibited by legislation or organizational policy (for example, a registered pharmacy student may neither delegate a controlled act nor accept the delegation of a controlled act as per Regulation 202/94). The healthcare professional conferring the delegation is the 'authorizer' and the person accepting the delegation is the 'implementer'. Delegation confers the authority to perform that act to the implementer and therefore allows him or her to perform the delegated act as long as proper procedures are followed.

The College's Medical Directives and the Delegation of Controlled Acts Policy was recently revised and reorganized in order to clarify the College's expectation for members when considering delegation. The policy provides guidance on a member's responsibility when, accepting delegation, performing delegated acts, and highlights the need for communication between the authorizer and implementer, particularly the assessment of the implementer's performance readiness. The policy also clarifies that delegation occurs through an order which may take the form of either a direct order or medical directive. The updated policy emphasizes that delegation is a process whereby the authorizer and implementer enter into

> “Appropriate delegation requires open communication between the authorizer and the implementer as communication and documentation are central to good patient care when working in a team environment.”

a *mutually accepted agreement for the provision of services that enhance patient care and that they share accountability for patient outcomes.*

To help illustrate the main components of this revised policy; accepting delegation, direct orders and medical directives, this article will utilize fictional scenarios featuring pharmacist Sandy Smith.

1. ACCEPTING DELEGATION

Independent of the authorizer's assessment, when accepting a delegation, a member is required to apply his or her therapeutic judgment to determine the appropriateness of the delegated act or procedure given individual patient circumstances and his or her competence to safely and effectively perform the delegated act. Any member can accept delegation, but whether or not he or she should accept it is a decision based on his or her skills and the best interest of the patient.

When assessing the best interest of the patient consideration includes:

- *Patient need* - whether the patient's health has been stable or unstable, the risks and benefits of the act or procedure, if the act or procedure is associated with predictable or unpredictable outcomes, potential complications;
- *Context of Practice* – the frequency the member performs the act or procedure, if there is adequate staffing to support the member when performing the act or procedure, the complexity of the act or procedure and the time required to perform;
- *Practitioner Competence* - access to continuing education and clinical experience to acquire and maintain competence.

Both the authorizer and the implementer share accountability to make decisions within the context of delegation that put patient interests first and ensure optimal patient outcomes. When accepting delegation a member assumes accountability for his or her actions when performing the delegated act or procedure, as well as for any patient outcomes that occur as a result of the act or procedure.

Appropriate delegation requires open communication between the authorizer and the implementer as communication and documentation are central to good patient care when working in a team environment. Prior to accepting delegation the member and the authorizer should have discussed the accessibility of the authorizer should the member have a question regarding the implementation of a delegated act or procedure (e.g. the authorizer's office staff is aware of the delegation and will put the member in contact with the authorizer in a timely manner). In addition, the authorizer must have assessed the member's performance readiness prior to issuing the direct order. When reviewing a member's performance readiness it is best practice for the authorizer to consider the member's opportunities to attain and maintain competence, as well as the suitability of the physical environment, whether the member has enough support to devote adequate time to the act or procedure, the risks and benefits of delegation, whether the member has adequate policies, procedures and resources available to support safe practice, and whether the patient will receive the same standard of care as they would from the authorizer.

When performing an act or procedure under delegated authority transparency is of utmost importance. The implementer is required to provide

the patient with appropriate information on the authority under which the act or procedure is being performed and receive informed consent to perform the act or procedure under delegated authority. The informed consent required for performing the act or procedure under delegated authority is distinct from the consent required to physically perform the act or procedure on the patient. Consent for both delegation and for performing the act or procedure should be documented. A member is also required to document relevant details of the delegated act or procedure performed under a direct order, and when performed under a medical directive documentation of the results of the patient assessment as well as rationale for performing the delegated act or procedure is required.

Scenario 1 – Accepting Delegation

A patient comes into the pharmacy with a prescription from the travel medicine clinic next to the pharmacy for hepatitis A and B vaccination. Sandy (fictional pharmacist) assesses the patient using criteria in the medical directive ABC pharmacy developed with the travel clinic and determines that the patient meets all criteria in the directive. In addition, Sandy assesses that it is in the patient's best interest to administer the vaccination. Sandy explains that she is authorized by the physician to administer the vaccination under delegation. She reviews the risks and benefits of receiving the vaccination, potential adverse events and side effects, as well as how to identify and manage an adverse event or side effect that is experienced. Before proceeding with the injection she asks if the patient has any questions about either the delegation of the act or about the vaccination. Sandy documents that informed consent was received to administer the injection under delegation and that the patient consented to receive the injection, as well as other relevant details of administering the vaccination.

Did Sandy properly inform the patient about her authority to administer the injection?
Yes. Sandy informed the patient that she was administering the injection under delegated authority and asked the patient if he had any questions regarding the delegation.

Did Sandy receive proper consent to administer the injection?
Yes. Sandy received and documented that the patient provided consent to administer the vaccination.

2. DIRECT ORDER

A direct order is an order to perform a controlled act for only one patient for a specific intervention, for example injecting Mr. Brown's travel vaccination. Direct orders may only be made after a direct assessment of the patient by the authorizer. Direct orders may be written or verbal; however members are encouraged to use written direct orders unless a verbal order is in the patient's best interest due to emergency circumstances. Where a verbal order is given the order should be documented in a timely manner.

Scenario 2A – Direct Order

Sandy is working a relief shift when a regular patient of the pharmacy presents a prescription for a travel vaccination that includes the order "pharmacist to inject". Sandy has completed her injection training and has knowledge of travel medicine, but has no relationship with the physician. Although she is confident in her ability to safely administer the medication and manage any potential outcomes, she is not confident that the order from the physician was intended for her as they have had no previous communication regarding the topic of injections. Sandy informs the patient that either she would have to call the physician to discuss administering the vaccination since she does not know this physician or the patient could return the next morning when the pharmacist who regularly works shifts and has an established relationship with the physician is available.

Would it have been best practice for Sandy to have accepted delegation in this scenario?
No. Where a member is not named in the direct order they must be confident, based on prior communication with the authorizer, that the order was intended for him or her and that an appropriate assessment of his or her practice readiness has been done.

Scenario 2B – Direct Order

Sandy is working a shift at her regular pharmacy, ABC pharmacy, and receives a prescription for a travel vaccination for a patient which includes the order "pharmacist to inject" on the prescription. Sandy has an established relationship with the prescribing physician and they routinely communicate regarding patients. During a previous conversation Sandy mentioned to the physician that she had received her injection certification. The physician contacted Sandy to discuss her injection training and certification as well as her

> Direct orders may be written or verbal; however members are encouraged to use written direct orders unless a verbal order is in the patient's best interest due to emergency circumstances.

additional education and training in the area of travel medicine and agreed to have her patients get their travel vaccinations injected by Sandy at the pharmacy. Sandy is confident in her ability to safely administer the medication and manage any potential outcomes, and that the order from the physician was intended for her. Sandy dispenses the medication to the patient, who is a regular patient at her pharmacy and assesses that administering the vaccination is in the patient's best interest. Sandy explains that the prescribing physician has delegated the task of injecting the vaccination to her and that the physician has reviewed her training and determined that she is competent to carry out the order. Sandy obtains consent from the patient, injects the vaccination and appropriately documents all required information.

Was it appropriate for Sandy to accept delegation in this scenario?
Yes. Sandy is confident based on her prior communication with the physician, that the physician assessed her performance readiness and that the order was intended for her. Sandy also assessed her own personal competence and received appropriate patient consent before implementing the delegated act.

3. MEDICAL DIRECTIVE

A medical directive is an order authorizing those identified in the directive to perform a controlled act or a series of controlled acts under specific conditions for any patient who meets the criteria set out in the directive, for example all pharmacists at the ABC pharmacy are authorized to order INR testing for any patient receiving warfarin therapy. A medical directive is always written and may permit the implementer to perform the act or procedure without the requirement for a direct assessment by the authorizer. The implementer is accountable for ensuring that all the specified criteria within the directive have been met prior to performing the authorized act or procedure and completing documentation. All affected regulated professionals and relevant administrators must participate in the development of a medical directive.

Scenario 3 – Medical Directive

ABC pharmacy operates beside a travel medicine clinic and employs three pharmacists. All three staff pharmacists have completed a certified injection course, are educated regarding travel vaccinations and are confident in their competence to safely administer the vaccinations and manage all potential outcomes. Sandy approaches the lead physician at the travel medicine clinic to discuss developing a medical directive to allow for injection of prescribed vaccinations at the pharmacy as Sandy and her staff have been accepting delegation through numerous direct orders from the travel clinic. The lead physician and Sandy set up a meeting for all the physicians from the clinic and pharmacists from ABC pharmacy to discuss the pharmacists' training and education.

The physicians and pharmacists agree to move forward with a medical directive and use the Federation of Health Regulatory Colleges of Ontario (FHRCO) medical directive template and guide to assist with the development. The medical directive:

- *Names all of the pharmacists at the pharmacy as authorized implementers;*
- *Provides details regarding the delegated order;*
- *Describes the recipient patients;*
- *Directs when and under what conditions the directive applies;*
- *Includes guidelines for implementing the order;*
- *Identifies documentation and communication required;*
- *Includes review and quality monitoring guidelines; and*
- *Contains the signature of all authorizers and implementers*

Can any pharmacist working at ABC pharmacy now perform injections under the medical directive?
No. Only those pharmacists specifically named in the medical directive are authorized to administer injections.

Can a pharmacist authorized by the medical directive inject any vaccination to any patient from the travel medicine clinic?
No. Pharmacists may only inject those medications authorized by the medical directive and only to those patients who meet the criteria set out in the medical directive. When determining if it is appropriate to perform an act or procedure authorized by a medical directive, the pharmacist must assess and document whether the patient meets all criteria within the directive.

Are the pharmacists authorized by the medical directive able to inject vaccinations prescribed from other travel medicine clinics?
No. Pharmacists are only authorized to inject vaccinations for patients under the care of physicians listed under the medical directive according to the criteria set out in the directive.

Whether you are a pharmacist, pharmacy technician, student or intern, the concepts outlined in both the Medical Directives and the Delegation of Controlled Acts Policy and the Professional Responsibility Principles – recently introduced by College Council – should be considered when contemplating delegation. (Note members may only delegate or accept delegation according to the terms, conditions and limitations on a member's certificate of registration as described in the Medical Directives and the Delegation of Controlled Acts Policy.)
Members are encouraged to use the resources developed for all healthcare professionals by the Federation of Health Regulatory Colleges of Ontario (FHRCO). FHRCO's *An Interprofessional Guide on the Use of Orders, Directives and Delegation* for Regulated Health Professionals in Ontario provides information on delegation and medical directives, and also contains templates for developing medical directives.

All of these resources and more can be found on the College website in the Practice Tool – Interprofessional Collaboration and Teamwork found under the Practice and Education tab.

IPC ETOOL FOR HEALTHCARE PROFESSIONALS

FHRCO launched the new Interprofessional Collaboration (IPC) eTool for healthcare professionals in early 2013. The tool supports regulated healthcare professionals to coordinate care and take into account expanding and overlapping scopes and authorities among professions.

The web-based tool has three useful features to assist practitioners:

1. CHECKLISTS

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

2. FREQUENTLY ASKED QUESTIONS

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

3. SCOPES OF PRACTICE & CONTROLLED ACTS

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

The new eTool helps build stronger, more effective teams by making sure every player knows their roles and responsibilities. The tool plays an important role in risk mitigation as the team will start their work together with a full understanding of where each player's accountabilities begin and end.

Access the eTool at http://ipc.fhrco.org

Sale of Non-Approved Marketed Health Products

In meeting the ongoing mandate to serve and protect the public; the College reminds members that only products that have received a market authorization or a product license from Health Canada are approved for sale in Canada. As communicated by and outlined on the National Association of Pharmacy Regulatory Authorities' (NAPRA) website - http://napra.ca/pages/Schedules/Schedules_Products.aspx

SALE OF NON-APPROVED MARKETED HEALTH PRODUCTS

Once a marketed health product is approved for sale, approval follows a review by Health Canada for the product's safety, efficacy and quality, and a number is provided to identify the product.

Only products that have received a market authorization or product licence from Health Canada are approved for sale in Canada. Authorized products will bear a Drug Identification Number (DIN) or a Natural Product Number (NPN) or a Drug Identification Number for Homeopathic Medicine (DIN-HM). These numbers serve as a means for the public and healthcare professionals to know that the product is authorized to be sold on the Canadian market.

The Natural Health Products (Unprocessed Product Licence Applications) Regulations promulgated by Health Canada in August 2010 have now been repealed, eliminating the temporary category of authorized products known as Exempted, having an Exemption Number (EN). More information regarding the repeal of the NHP-UPLAR can be found on the Health Canada website.

To assist in confirming if a particular product is licensed by Health Canada members may wish to:

1) Search Health Canada's Drug Product Database (DPD) or the Licensed Natural Health Products Database.
   a. Drug Product Database - http://webprod5.hc-sc.gc.ca/dpd-bdpp/index-eng.jsp.
   b. Licensed Natural Health Products Database - http://webprod5.hc-sc.gc.ca/lnhpd-bdpsnh/index-eng.jsp

2) Visually inspect the product package. All authorized products will bear a Drug Identification Number (DIN) or a Natural Product Number (NPN) or a Drug Identification Number for Homeopathic Medicine (DIN-HM).[1] These numbers serve as a means for the public and health care professionals to know that the product is authorized to be sold on the Canadian market.

3) Contact Health Canada at 1-800-622-6232 to obtain clarification.

Foreign health products are subject to the same Canadian market authorization process, as well as requirements related to the importation of health products as defined by the *Food and Drugs Act* and its Regulations.[2] Products with Canadian market authorization or a product license have been assessed by Health Canada and found to be safe, effective and of high quality under their recommended conditions of use. Unapproved health products of foreign and domestic source offer no guarantee of product integrity, efficacy, or safety.

In the event that a non-approved health product is discovered for sale by any Canadian retailer, members of the College and public alike are encouraged to report the retailer and product to Health Canada using the Health Product Complaint Form (FRM-0317) available on the Health Canada website - http://www.hc-sc.gc.ca/dhp-mps/compli-conform/prob-report-rapport/frm-0317-eng.php.

Reflecting back to the Code of Ethics[3] - *In holding the patient's well-being at the center of one's professional and/or business practices*; members are advised to neither sell, recommend, nor dispense any unauthorized or unlicensed health product. Additionally, members, as retailers, should remain cognizant of any further legislation governing the sale of products from their place of business.

1. Health Canada POL-0044. Retrieved at: http://www.hc-sc.gc.ca/dhp-mps/compli-conform/info-prod/prodnatur/lett-complian-conform-pol-eng.php#a2
2. Health Canada POL 0060. Retrieved at: http://www.hc-sc.gc.ca/dhp-mps/compli-conform/import-export/pol-0060_biu-uif-eng.php#a51
3. OCP Code of Ethics. Retrieved at: http://www.ocpinfo.com/regulations-standards/code-ethics/

DEFINITIONS

"Health product" includes products regulated under the *Food and Drugs Regulations* ("drugs") and the *Natural Health Products Regulations* ("natural health products").

"Drug" as defined in the *Food and Drugs Act* includes any substance or mixture of substances manufactured, sold or represented for use in:

a. the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state, or its symptoms, in human beings or animals;
b. restoring, correcting or modifying organic functions in human beings or animals; or
c. disinfection in premises in which food is manufactured, prepared or kept.

"Natural health product" as defined in the *Natural Health Products Regulations* is a substance set out in Schedule 1 of the *Natural Health Products Regulations* or a combination of substances in which all the medicinal ingredients are substances set out in Schedule 1 of the *Natural Health Products Regulations*, a homeopathic medicine or a traditional medicine, that is manufactured, sold or represented for use in:

a. the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state or its symptoms in humans;
b. restoring or correcting organic functions in humans; or
c. modifying organic functions in humans, such as modifying those functions in a manner that maintains or promotes health.

Medication Incidents Reported to and Reviewed by the ICRC:

A TREND ANALYSIS BY ISMP CANADA

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Analyst, ISMP Canada

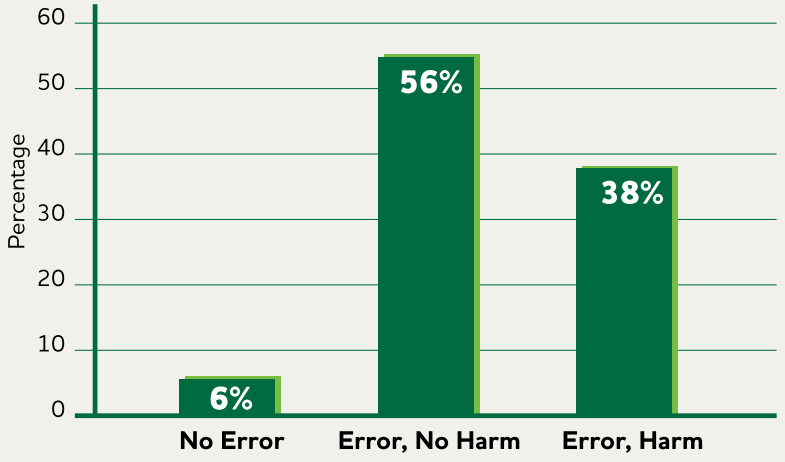
Certina Ho, RPh, BScPhm, MISt, MEd
Project Manager, ISMP Canada

In a collaborative effort to promote safe medication practices in community pharmacy, the Institute for Safe Medication Practices Canada (ISMP Canada) reviews medication incidents reported to the Inquiries, Complaints, and Reports Committee (ICRC) at the Ontario College of Pharmacists on a regular basis. ISMP Canada reviewed 100 medication incidents reported to the ICRC between January 1 2009 and December 31, 2010. A previous analysis reviewed 78 medication incidents reported to the ICRC between January 1, 2007 and December 31, 2008.[1] The purpose of this review is to search for trend information that may help in recognizing potential flaws in the medication-use system, highlight areas of interests and concerns in community pharmacy, and develop recommendations for enhancing medication safety. The information gathered from these incidents provides ISMP Canada and OCP with deeper understanding towards the development of patient safety strategies in order to prevent future occurrences of medication incidents in community pharmacy practice.

This report highlights the most significant findings from a quantitative analysis of 100 medication incidents (reported to the ICRC between 2009 and 2010) with a main focus on:

- Degree of harm to patient due to incident
- Type of medication incidents
- Common medications reported
- Medication system stages involved in the incident
- Possible contributing factors
- Areas of concern in community pharmacy practice

FIGURE 1. **DEGREE OF HARM TO PATIENT DUE TO INCIDENT**



No Error	Near misses
Error, No Harm	Medication was dispensed to the patient, but no symptoms were detected and no treatment was required
Error, Harm	Mild, moderate or severe harm

A similar result was observed from the previous report[1] with 42.3% of the errors causing "harm" to patients. Although most of the medication incidents from the two recent reviews were not associated with patient harm or death, the proportion of events associated with harm does illustrate the importance of implementing system-based safeguards and consequently preventing similar incidents from happening in the future. Furthermore, it is possible that extra healthcare recourses associated with the "harm" events would have been required, in particular, the grief and suffering caused to patients and their family members.

TYPE OF MEDICATION INCIDENTS

The three most common types of incidents reported were:

1. Incorrect dose/frequency/strength/concentration (26%)
2. Incorrect drug (26%)
3. Omitted medication/dose (11%)
4. Expired medication (7%)

Compared with the previous analysis[1], similar types of incidents were noticed with the exception of incidents related to "omitted medication/dose" and "expired medication". The increasing number of errors associated with "omitted medication/dose" and "expired medication" could be due to inadequate education for patients and healthcare providers as well as lack of quality control or independent double checks. Additionally, other factors could have contributed to the medication incidents listed above, including look-alike/sound-alike drug names, use of dangerous abbreviations and crowded storage spaces in the pharmacy.

ISMP Canada has conducted incident analyses which suggest medication system improvement strategies for enhancing patient safety through the Safety Bulletin (available at http://www.ismp-canada.org/ISMPCSafetyBulletins.htm). For example, "Aggregate Analysis of Dose Omission Incidents Reported as Causing Harm" can be retrieved from http://ismp-canada.org/download/safetyBulletins/2013/ISMPCSB2013-02_Dose_Omission_Incidents.pdf.

COMMON MEDICATIONS REPORTED

The medications most frequently involved in reported events were different between these two analyses.[1] The medications below are commonly prescribed and/or dispensed within a community pharmacy setting. Due to the small sample size of these two analyses, we were unable to determine if these medications are truly high-risk or red flags to community pharmacy practice. Further analysis with a larger sample size of medication incidents is required in order to provide a better understanding of high-risk medications in community pharmacy. However, it is important to know that warfarin, methadone, and oxycodone have been recognized as high-alert medications in community or ambulatory care settings.[2]

MEDICATION SYSTEM STAGES INVOLVED IN THE INCIDENT

Within this analysis, the majority of medication incidents occurred during the prescription order entry stage and prescription preparation/dispensing stage. A similar trend was noticed from the previous analysis on medication incidents reported to the ICRC from 2007 to 2008.[1] One possible explanation for this pattern is that these stages are the two most common processes within the medication-use system in community pharmacy practice. Since most of these incidents were discovered and reported to the ICRC by patients and/or their caregivers, other stages within the medication use system, such as prescribing, administration, and monitoring might not be as easily recognized.

POSSIBLE CONTRIBUTING FACTORS

The most common causes associated with these medication incidents were:

- Drug name, label or packaging problems (35%);
- Environmental factors (i.e. poor lighting, cluttered work spaces, and distractions in the pharmacy), staffing or workflow problems (23%);
- Staff education problems (18%); and
- Lack of quality control or independent check system (12%).

Similar types of contributing factors were noticed from the previous review with slightly different frequencies.[1] It is important to know that a medication incident

TABLE 1: **COMPARISON BETWEEN COMMON MEDICATIONS REPORTED TO THE ICRC FROM 2007-2008[1] AND FROM 2009-2010**

Common medications reported to the ICRC from 2007-2008[1]		Common medications reported to the ICRC from 2009-2010	
Synthroid®	(8 of 78 cases)	Methadone	(5 of 100 cases)
Amlodipine	(5 of 78 cases)	Oxycodone	(4 of 100 cases)
Clindamycin	(3 of 78 cases)	Lipitor®	(2 of 100 cases)
Warfarin	(3 of 78 cases)	Sertraline	(2 of 100 cases)

may have multiple contributing factors. Therefore, it is not possible to conclude that the contributing factors mentioned above are the only ones causing medication incidents. However, analysis of medication incidents does provide us a good indication for potential areas of focus to enhance medication safety.

AREAS OF CONCERN IN COMMUNITY PHARMACY PRACTICE

Look-alike/Sound-alike:

A 19-month-old child was given Chloral Hydrate instead of the prescribed Lactulose. As a result of this error, the child was hospitalized and monitored for 24 hours. According to the patient's mother, the child continued to experience night terrors and has had ongoing visits to her physician's office. It was noted by the pharmacist that the two bottles were stored closely together on the shelves. The bottles look similar in appearance, and both labels start with the prefix "PMS".

Look-alike/sound-alike medication incidents accounted for 12% of the incidents reviewed. ISMP Canada has received other reports regarding look-alike/sound-alike drug names and conducted an analysis on these medication incidents.[3] In community pharmacy practice, these errors can occur at any point in the medication-use system, including prescribing, order entry, dispensing, administration and/or monitoring. Alerts should be incorporated into the pharmacy computer systems to flag potential mix-up during drug selection processes.[3]

Wrong Patient:

Patient was prescribed clarithromycin 250 mg for a 10-day course of treatment. However, she was dispensed a medication vial labelled and intended for a different patient, which contained lorazepam 2 mg. Patient did not notice the error until she took her second dose. She was experiencing dizziness and vomiting during the first dose already. Patient took the medication back to the pharmacy. The dispensing pharmacist recalled that the correct prescription vial was in the basket at that time, but somehow during the checkout procedure another patient's prescription was bagged and dispensed to the patient.

Errors involving incorrect patients accounted for 11% of incidents reviewed. Medication errors related to incorrect patients can occur for a variety of reasons at any point in the patient encounter. Thus, a patient verification process using at least two identifiers (e.g., birth date, address) is needed throughout the medication-use process.[4]

Expired Medication:

The patient attended the pharmacy to fill a prescription for Elocom® cream. When she returned home, she removed the prescription label and noticed that the medication would expire in the same month. Three days later she returned to the pharmacy to notify them of the error. The pharmacist apologized and gave her a new tube with a better expiration date. The patient has lost trust in the pharmacy and is worried about the expiration of all the other medications that are not dispensed in their original vials.

Errors involving expired medication accounted for 7% of incidents reviewed. All products in a community pharmacy should be properly stored under the conditions specified by the manufacturer. The expiry date of each product should be checked on a regular basis; the product with near expiry date must be flagged and identified properly. All expired drugs and medical products must be collected, labeled clearly as expired items, and kept in a separate place for proper management or disposal. Furthermore, all pharmacy staff should practice independent double checks of the expiry date of the product prior to dispensing.

METHADONE:

A relief pharmacist dispensed the wrong dose (10-fold overdose) of methadone to six patients. The pharmacist dispensed methadone to several patients that day using stock solution already made in the pharmacy. However, additional stock solution was required and prepared by the relief pharmacist. The relief pharmacist consulted the compounding log and recalled reading 25 g of methadone powder required to compound the stock solution. However, the correct dose was 2.5 g of methadone powder.

Errors associated with methadone accounted for 5% of the incidents reviewed. Pharmacies are encouraged to adopt a workflow that allows independent double checks to verify proper order entry, dispensing, and administration (in the case of methadone).[5] The ideal model for methadone maintenance treatment (MMT) is one which allows a 3-way integration of patient, pharmacist, and physician within the community to ensure availability and accessibility of MMT for patients requiring such care.[5]

LIMITATIONS OF ANALYSIS

The findings in this analysis are based on medication incidents submitted to the ICRC by patients or their caregivers. Therefore, it cannot be used to obtain a true estimate of high-alert medications or the probability of specific

incidents in a typical community pharmacy. However, it does suggest that there is a potential to reduce preventable patient harm by focusing on several or specific high-risk medication-use areas. Some of the limitations of this analysis include:

- Under-reporting of incidents in community pharmacy is a considerable concern, and in most cases patients would not report incidents if they were not likely to complain.
- Due to the small sample size of this analysis, it is impossible to conclude that the results would truly reflect current community pharmacy practice. Since no statistical analyses were done within this review, it is impossible to completely rule out "chance" from our explanations.
- Similarly, due to the small sample size and the fact that the most frequently reported medications are commonly prescribed or dispensed medications, it is impossible to determine if those medications are truly high-risk to community pharmacy practice. Therefore, a qualitative data analysis of the incidents' description and the investigation reports will be beneficial for further verifications.

RECOMMENDATIONS

1. All healthcare practitioners are encouraged to report medication incidents and near misses or good catches to ISMP Canada Medication Incident and Near Miss Reporting Programs (available at https://www.ismp-canada.org/err_index.htm) to identify early opportunities for enhancing medication safety.
2. Community pharmacists are encouraged to adopt ISMP Canada Community Pharmacy Incident Reporting Program (available at http://www.cphir.ca) which facilitates community pharmacies for continuous quality improvement.
3. Patients are also encouraged to report medication incidents via the ISMP Canada Consumer Reporting portal at http://www.safemedicationuse.ca/report/.
4. Other ISMP Canada medication safety initiatives and continuous quality assurance (CQA) programs for community pharmacies include:
   - Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy™ (available at http://www.ismp-canada.org/amssa/), which helps identify system improvement opportunities proactively within your own pharmacy.
   - Root Cause Analysis (RCA) (available at http://www.ismp-canada.org/rca.htm) which provides a standardized approach to the retrospective analysis of critical incidents and near-miss events in health care.
   - Failure Mode and Effects Analysis (FMEA) (available at http://www.ismp-canada.org/fmea.htm) which is a proactive assessment of work environment, equipment, and procedures to identify, improve or correct system-based problems.

CONCLUSION

Continuous quality improvement in community pharmacy practice is motivated by lessons learned from past mistakes. Collaboration with ISMP Canada would assist in identifying high-risk medications and analyzing possible contributing factors that may lead to errors in the medication-use system.[6] Through the analysis of incidents and sharing of findings, healthcare practitioners can learn from reported incidents and implement system-based safeguards. Ultimately we can create a culture of patient safety and prevent similar medication incidents from occurring in the future.

ACKNOWLEDGMENT

The authors would like to acknowledge Roger Cheng, Project Leader, ISMP Canada for his assistance in conducting the incident analysis of this report.

1. Petrov E, Ho C. Medication Incidents Reported to and Reviewed by the ICRC: An Analysis by ISMP Canada. Pharmacy Connection 2012; Summer: 36-38.
2. ISMP. ISMP List of High-Alert Medications in Community/Ambulatory Healthcare. Horsham (PA): ISMP; [updated 2011 Jan 30] Available at: https://www.ismp.org/communityRx/tools/highAlert-community.pdf
3. Kawano A, Li Q, Ho C. Preventable Medication Errors – Look-alike/Sound-alike Drug Names. Pharmacy Connection 2014; Spring: 28-33.
4. ISMP. Oops, sorry, wrong Patient! A patient verification process is needed everywhere, not just the bedside. ISMP Medication Safety Alert! Nurse Advise-ERR 2011; 9(8): 1-4. Available at: http://www.ismp.org/Newsletters/nursing/Issues/NurseAdviseERR201108.pdf
5. Kawano A, Kong JH, Ho C. Methadone Medication Incidents: A multi-incident analysis by ISMP Canada. Pharmacy Connection 2013; Summer: 38-41.
6. Ho C, Hung P, Lee G, Kadija M. Community pharmacy incident reporting: A new tool for community pharmacies in Canada. Healthcare Quarterly 2010; 13: 16-24. Available at: http://www.ismp-canada.org/download/HealthcareQuarterly/HQ2010V13SP16.pdf

College shifts focus to practice site-based assessments

As the regulatory body for the profession of pharmacy in Ontario, the College's mandate is to protect the public interest. One of the fundamental ways this is achieved is through a series of quality assurance measures established by the College. These measures ensure that at entry-to-practice — and throughout their careers — pharmacists and pharmacy technicians are competent to deliver safe, effective and ethical pharmacy services. Each practitioner's competence is evaluated against the established legislation, Standards of Practice and code of ethics relevant to pharmacy practice in Ontario.

Council recently endorsed five new professional responsibility principles that reinforce the College's practice expectations. The principles are applicable to all pharmacists and pharmacy technicians regardless of role or practice setting, and are reflective of the reality that the healthcare environment and pharmacy practice is continuously evolving.

The principles remind practitioners of their overriding responsibility as regulated healthcare professionals, to uphold their ethical duty to put the best interests of patients first and foremost. Patients trust that their pharmacy practitioners — as the holders of power in the patient-practitioner relationship — will use their knowledge, skills and abilities to make decisions that positively enhance patient health outcomes.

Practicing these professional responsibilities — which reflect practice today and are

NEW TERMINOLOGY

COLLEGE "INSPECTORS" ARE NOW CALLED "PRACTICE ADVISORS"

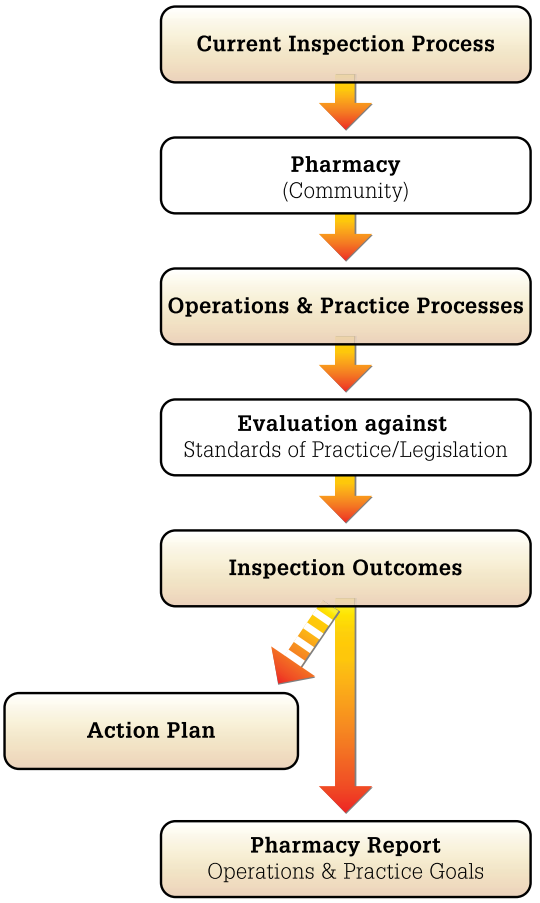
AND "INSPECTIONS" ARE NOW CALLED "ASSESSMENTS"

supported by the Standards of Practice — requires a conscious shift in a practitioner's focus from the individual task at hand to the bigger picture of patient-focused care. Members must assert professional judgment to act in the best interest of the patient and balance professional versus organizational responsibilities to ensure the best patient outcomes and safety.

In order to appropriately evaluate and support pharmacists and pharmacy technicians' efforts in practicing these responsibilities and Standards of Practice, the College also needs to shift its focus.

As part of its current quality assurance measures, the College conducts routine inspections of community pharmacies (diagram 1) – approximately 1,500 per year. These inspections have traditionally focused on assessing pharmacy operations and practice processes and have only indirectly touched on an individual practitioner's practice. Practice advisors (formerly known as inspectors) evaluate what they observe against relevant legislation, policies and standards, and outline operational and practice goals for the pharmacy and its practitioners in a "Pharmacy Report". If there are any issues identified, the designated manager will be required to submit an Action Plan to the practice advisor who may revisit the pharmacy at a later date to follow up.

DIAGRAM 1



Over the past several months the College has been developing a new assessment model — the practice site-based assessment — which is an enhancement of the College's current routine pharmacy inspections and includes an evaluation of an individual practitioner's performance in their practice site. The new model will allow the College to better evaluate, coach and mentor individual pharmacists and pharmacy technicians to adhere to their professional responsibilities and Standards of Practice.

In the new practice assessment model (diagram 2), the assessment is broken into two pieces — the first is similar to the College's current inspection process and focuses on the operations and practice processes of the pharmacy. The second — and new piece — focuses on the individual practitioner(s) and assesses his or her everyday practice. Practice advisors will focus on identifying and understanding the processes that are in place that shape and support the practitioner's clinical decision-making. In addition to the "Pharmacy Report" that outlines the operational and practice goals for the pharmacy, each practitioner who has been assessed will receive an "Individual Report" outlining observations made by the practice advisor.

Since it would be impossible to focus on all areas of an individual's practice during an assessment, an important component in the development of the new practice assessment has been identifying the key areas of focus. Practice advisors will visit the pharmacy and evaluate the process for new prescriptions, refills, adaptations/prescribing and medication reviews. This will allow the practice advisor to assess the practitioner(s) in the following areas:

1. Patient assessment
2. Decision making
3. Documentation
4. Communication

In determining these focus areas, the College considered which practice activities have the greatest impact on patient and public safety (diagram 3).

DIAGRAM 2

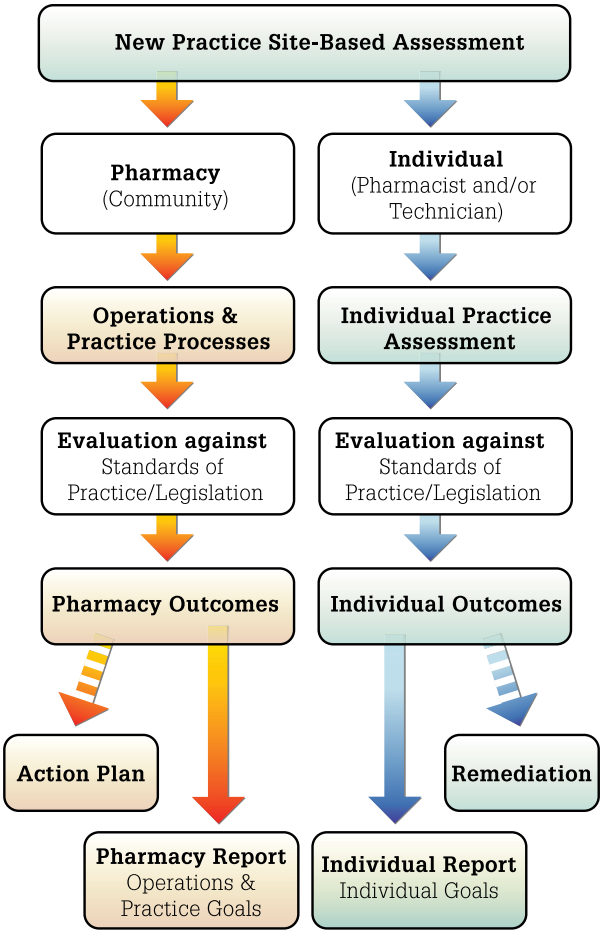
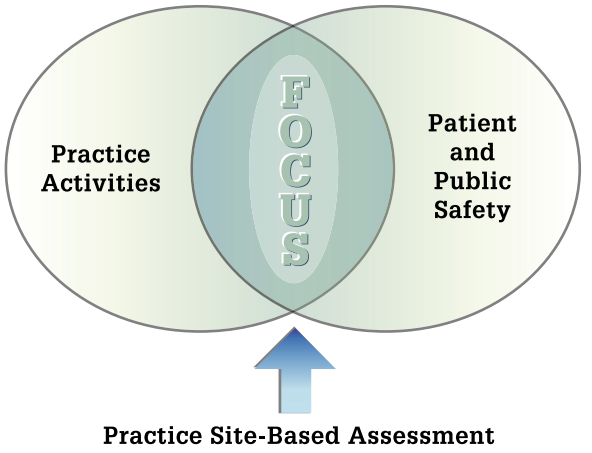


DIAGRAM 3



The new practice assessment does not replace any of the College's formal Quality Assurance Program such as the Peer Review, but does offer a chance for more practitioners to be involved in a quality assurance activity throughout their career. While the Peer Review uses standardized patient interviews with sample cases in a controlled environment, the new practice assessment reviews the practitioner's actual practice. Assessing practice in this way will provide the College with a relevant and practical means to evaluate practice and — more importantly — coach, and mentor pharmacists and pharmacy technicians to enhance their practice and embrace their professional responsibilities.

Although a significant amount of work has already been done on the development of the new practice site-based assessment model, there is still much more to do before its anticipated launch in early 2015. This fall, newly hired and current practice advisors will receive extensive training to ensure that their understanding and subsequent application of the assessment tool is applied fairly and consistently amongst the pharmacies and pharmacists and/or pharmacy technicians assessed. Before the end of 2014, the College will test the new practice assessment and learnings will be incorporated into the final assessment model.

It is not revolutionary but rather evolutionary that the College is moving toward a practice site-based assessment as a primary tool for evaluating pharmacists' and pharmacy technicians' competence in delivering safe, effective and ethical pharmacy services. The shift supports the role of pharmacists as medication experts and clinical decision-makers and is consistent with other primary healthcare practitioners such as doctors and nurses. A number of other provincial pharmacy regulators across the country have already or are in the process of moving to a more practice-focused assessment or inspection.

It is anticipated that the new assessment model — by providing the College with opportunities to evaluate and mentor actual practice — will increase adherence to practice standards, support practitioners as they practice to their full scope and ultimately assist in the delivery of greater health outcomes to patients.

When might connecting to a College practice consultant be beneficial to you?

Access to a practice consultant (formerly practice advisors) is one of many services offered to Ontario's pharmacists and pharmacy technicians by the College's Pharmacy Practice department. Members are welcome to take advantage of this service but must understand what practice consultants can do — and what they cannot do.

Many members believe that College staff — practice consultants in particular — have the ability to make the decision or approve a particular practice that a practitioner is contemplating. This is simply not the case. As regulated healthcare professionals pharmacists and pharmacy technicians are responsible and accountable for their own decision-making.

The role of the practice consultant is to respond to general practice questions, assist members with meeting the Standards of Practice and provide advice, guidance and clarification that support a member's decision making. Advice is limited to the information provided by the member and is intended to assist members in identifying and interpreting relevant legislation, standards and best practices. Practitioners are expected to use their own professional judgment to make decisions that support their patient's best interests.

Practice consultants cannot provide legal advice or legal opinions, and they can not tell a member what course of action to take, or not take. However, practice consultants may assist in identifying and evaluating the options and risks involved in taking various courses of action.

It is important to note that the practice consultant service is not intended to operate as an emergency call centre and therefore immediate access and response should not be expected. Between 30 and 50 calls and emails are received daily and many inquiries require consideration and research before a complete and accurate response can be provided.

Information provided remains confidential and will not be shared or used by other programs or departments within the College except in the following situations:

- where action is taken against the College in relation to the information/consultation provided
- where the College has a legal obligation to release the information (e.g. discovery purposes at Discipline)
- where it is necessary in the interest of public safety (duty to warn)
- where the caller has requested and therefore consented to the release

Before contacting a practice consultant visit www.ocpinfo.com and use the search function to find more information on your question. Practitioners should also keep up-to-date on official College communications including *Pharmacy Connection* and e-Connect.

The College encourages you to contact a practice consultant whenever appropriate. Please ensure your message includes: your name, phone number, OCP registration number and a brief description of your question or reason for the call.

Practice consultants Lilly Ing and Andrew Tolmie can be reached via email at pharmacypractice@ocpinfo.com or a phone message may be left at 416 962-4861 x 2236.

DIRECT YOUR QUESTIONS TO THE APPROPRIATE SOURCE

1. Drug Scheduling
All drug scheduling questions should be directed to the National Association of Pharmacy Regulatory Authorities (NAPRA). More information at www.napra.ca

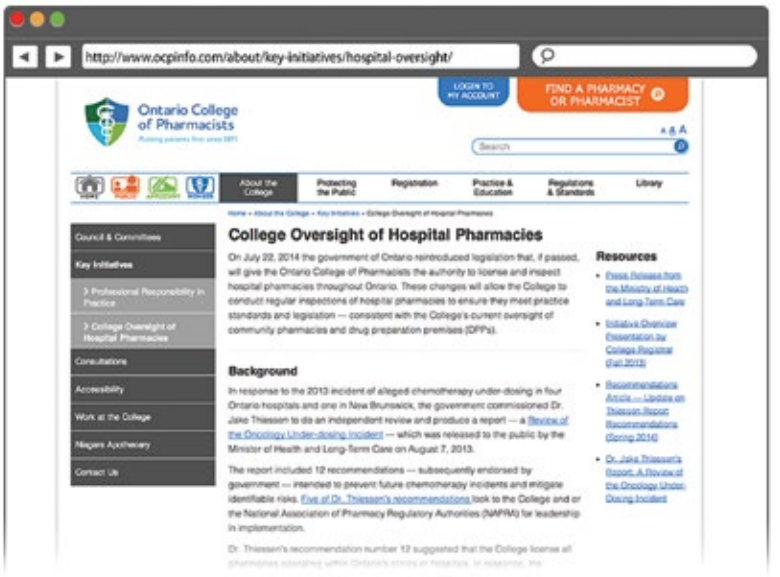
2. Other Regulated Health Professionals
For questions about other regulated health professionals, contact the appropriate regulatory college. OCP cannot answer questions or interpret scopes of practice for other health professionals. Contact information for all health regulatory colleges can be found at www.regulatedhealthprofessions.on.ca

NEW SECTION ON COLLEGE WEBSITE FEATURES KEY INITIATIVES

As the regulatory body for the profession of pharmacy in Ontario, the College is actively involved in initiatives that further support our mandate of protecting the public by ensuring the safe, effective and ethical delivery of pharmacy services.

To bring greater attention to these important topics – which all pharmacists and pharmacy technicians should familiarize themselves with – the College has created a new section on the website, titled Key Initiatives. This section – arranged by topic – includes a general overview of the initiative, provides regular updates and links to relevant resources.

There are currently three key initiatives available on the website:



COLLEGE OVERSIGHT OF HOSPITAL PHARMACIES

On July 22, 2014 the government of Ontario reintroduced legislation that, if passed, will give the Ontario College of Pharmacists the authority to license and inspect hospital pharmacies throughout Ontario. These changes will allow the College to conduct regular inspections of hospital pharmacies to ensure they meet practice standards and legislation — consistent with the College's current oversight of community pharmacies and drug preparation premises (DPPs).

More information on the legislation — the *Safeguarding Health Care Integrity Act* — and details on the College's initial steps toward developing the accreditation process and draft inspection criteria for hospital pharmacies is available by visiting this key initiative page on the website.

PROFESSIONAL RESPONSIBILITY IN PRACTICE

This key initiative introduces the newly developed Professional Responsibility Principles. The principles were developed by Council in response to the March 2013 incident of alleged chemotherapy under-dosing and were the featured topic of the College's Spring 2014 District Meetings.

These principles articulate our professional responsibility as regulated healthcare professionals and are applicable to all pharmacists and pharmacy technicians, regardless of role or practice setting. The principles will be used for years to come, to guide the development of new or revised College programs, policies and guidelines.

TRANSPARENCY PROJECT

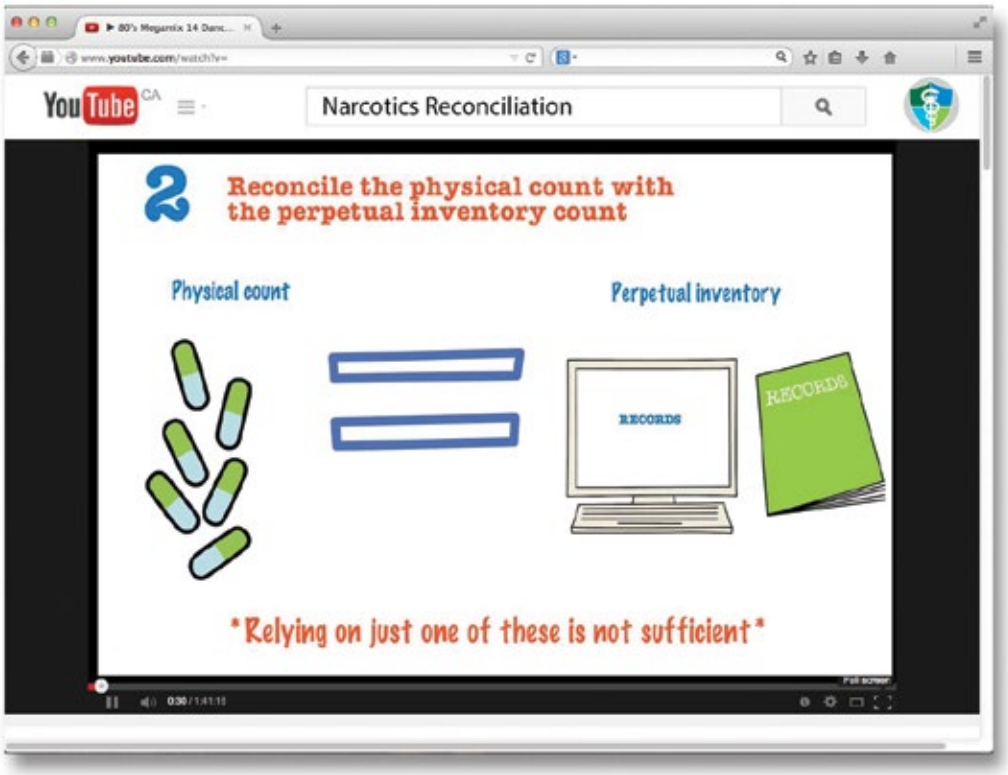
The public's growing call for organizations — particularly those with a public interest mandate — to be more open with their decisions and processes has initiated a province-wide project around the transparency practices of health regulatory colleges in Ontario.

The Ontario College of Pharmacists is part of a working group of health regulators — the Advisory Group of Regulatory Excellence (AGRE) — that is leading the project examining transparency. This multi-staged initiative is designed to examine how information-sharing practices determine how regulators might make more member-specific information regarding decisions and processes available to the public.

Visit http://www.ocpinfo.com/about/key-initiatives/ for more information.

Video: Helpful Resource for Accurate Narcotics Reconciliations

As healthcare professionals, one of our fundamental responsibilities is to ensure the security of drug inventory in pharmacies.



Regulatory requirements outlined in the *Food and Drugs Act and Regulations, Controlled Drugs and Substances Act, the Narcotic Control Regulations*, and the *Benzodiazepines and Other Targeted Substances Regulations*, hold members accountable for the safe storage and distribution of drugs from the moment they are received, to the time they are dispensed to patients or otherwise removed from inventory.

Periodic reconciliation is the primary mechanism used to effectively monitor the drugs in a pharmacy. However, during routine College inspections it has been discovered that reconciliations, although conducted with the best of intentions, aren't always completed in a way that ensures accurate results.

To better support members in completing accurate reconciliations, the College has developed a quick, easy-to-follow video – ***Narcotics Reconciliation*** – which illustrates the general process for completing accurate reconciliations, highlights best practices to minimize errors and provides insights on how to reconcile discrepancies.

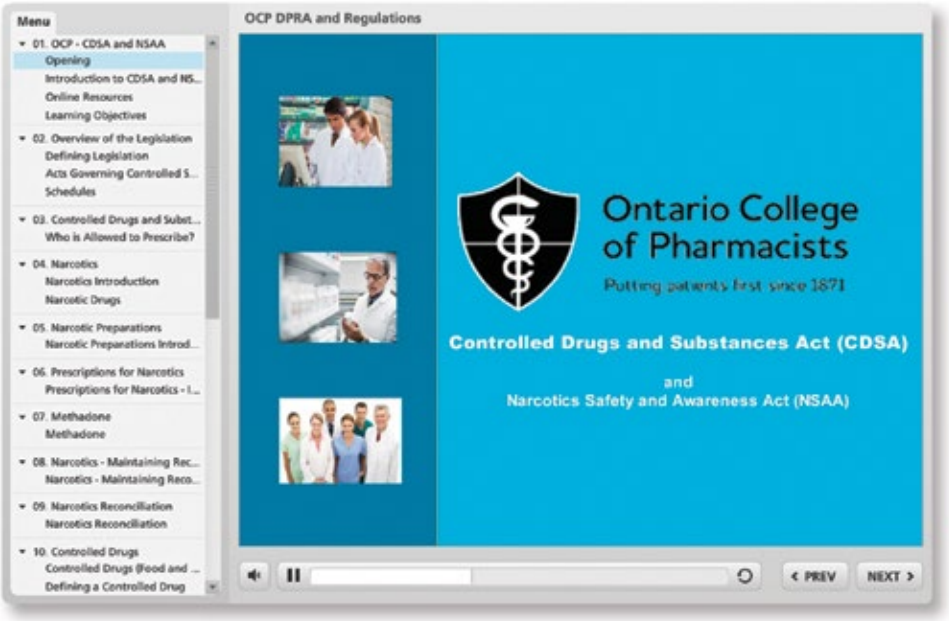
All members are encouraged to take a few moments to view the video to ensure that their current narcotics reconciliation process is effectively achieving its objective of safeguarding their drug inventory. Members can easily pause and resume the video to focus in on areas they would like to better understand and review more carefully.

For more information visit the Fact Sheet on Narcotic Reconciliation and Security on the College website.

Find the video at www.ocpinfo.com/library/videos

College launches second e-Learning module for Jurisprudence

Over the past year, the College has been engaged in the development of a number of online learning tools that provide support for learning and understanding Jurisprudence. The resources support candidates who are preparing to write the Jurisprudence Exam, students who are learning the legislation and practitioners who may be interested in updating their jurisprudence knowledge or are looking for a continuing education opportunity.



A new e-learning module focusing on the *Controlled Drugs and Substances Act* (CDSA) and the *Narcotics Safety and Awareness Act* (NSAA) launched in August 2014. The estimated running time is approximately two hours but depends on your individual pace.

The modules are self-directed and review topics of legislation but are not intended as stand-alone courses or substitutes for reading the legislation and OCP practice policies and guidelines.

There are currently two e-Learning modules available on the College's website. The first focuses on the *Drug and Pharmacies Regulation Act* (DPRA) and the second focuses on the *Controlled Drugs and Substances Act* (CDSA) and the *Narcotics Safety and Awareness Act* (NSAA).

To access the e-Learning Modules go to www.ocpinfo.com/registration/training-exams/jp-exam and click on "Resources".

Disclaimer: *The e-Learning modules are tools to support learning the legislation and are not comprehensive study resources. It is important to refer to the official legislation for more detailed and current information.*

DISCIPLINE DECISIONS

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Member: Armia Fahmy

At a hearing on May 14, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Fahmy in that he

- on or about October 14, 2011, purported to authorize the refill of a prescription for patient J.B. without complying with all of the conditions set out in s. 42 of Ontario Regulation 58/11 made under the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, thereby contravening that section of that regulation;
- on or about December 21, 2011, entered a new prescription for patient D.B., when this was in fact a refill of a prescription dated November 16, 2011, without properly documenting this fact;
- on or about November 6, 2011, dispensed drugs to patient R.S. pursuant to a verbal authorization from a prescriber, without complying with all of the conditions set out in s. 40 of Ontario Regulation 58/11 made under the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, thereby contravening that section of that regulation;
- dispensed drugs pursuant to a prescription without ensuring the information prescribed by s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, was recorded on the prescription;
- failed to take all reasonable steps necessary to protect narcotics and controlled substances at the pharmacy against loss or theft and, in particular, failed to maintain accurate inventories and other records of narcotics and controlled substances purchased by and dispensed at the pharmacy and/or failed to report loss or theft of narcotics and controlled substances and/or to otherwise account for inventory discrepancies, for the period from April 1, 2011 to May 1, 2012;
- failed to obtain confirmation of a patient's prior dose of methadone before dispensing methadone to that patient, and/or failed to keep a record of that confirmation;
- created a misleading and/or inaccurate dispensing record by backdating dispensing records to a date different than the date on which the records were created, without appropriately documenting that fact;
- dispensed drugs pursuant to a prescription without ensuring the information prescribed by s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, was recorded on the container on which the drugs were dispensed;
- inaccurately recorded the identity of the prescriber in patient and pharmacy records;
- dispensed drugs pursuant to a prescription while inaccurately recording the identity of the prescriber on prescription hardcopies, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- created a misleading and/or inaccurate dispensing record by dispensing drugs pursuant to prescription hardcopies containing the notation "reprint" and/or "modified reprint," without documenting that there was no original hardcopy and/or without documenting the changes from the original hardcopy;
- dispensed narcotics pursuant to prescriptions that were not signed by the prescribers, contrary to s. 40 of Ontario Regulation 58/11 made under the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and s. 155 of that Act, and to s. 31 of the Narcotic Control Regulations, C.R.C. c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- dispensed drugs pursuant to a prescription while inaccurately and/or unclearly recording directions for use compared with those intended by the prescriber, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed different drugs than those authorized by the prescriber, contrary to s. 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and/or to s. C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, made under the Food and Drugs Act, R.S.C. 1985, c. F-27, and/or to s. 31 of the Narcotic Control Regulations, C.R.C. c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- dispensed drugs pursuant to a prescription as dispensing pharmacist without recording his signature on the prescription, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed drugs pursuant to a prescription while incorrectly recording the quantity of drug authorized

by the prescriber, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed drugs pursuant to a prescription while incorrectly recording the quantity and/or strength of the drug dispensed, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed drugs pursuant to a prescription while incorrectly recording the date on which the drug was dispensed to the patient, contrary to s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4;
- dispensed narcotics without authorization from a prescriber and/or on a date not authorized by the prescriber, contrary to s. 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and s. 31 of the Narcotic Control Regulations, C.R.C. c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- dispensed narcotics to patients on days not authorized by a prescriber, contrary to s. 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, and s. 31 of the Narcotic Control Regulations, C.R.C. c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19;
- dispensed drugs pursuant to a prescription in a quantity less than the entire quantity authorized by the prescriber, contrary to s. 9 of the Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c. P.23;

and/or

- dispensed a narcotic to patient D.H. pursuant to a prescription after the quantity of the narcotic specified in the prescription had already been dispensed, contrary to s. 37 of the Narcotic Control Regulations, C.R.C., c. 1041, made under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, on or about February 7, 2012.

In particular, he was found to have

- failed to maintain a standard of practice 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;
- 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;
- 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 the following:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   (a) that the Member complete successfully, at his own expense, within 12 months of the date of the Order, the following course and evaluation:
      (i) CPS I Module 5 (Professional Practice & Pharmacy Management 1) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto;
   (b) that the Member shall be prohibited from acting as a Designated Manager in any pharmacy until the later of:
      (i) a period of 12 months from the date of the Order, and
      (ii) the date the College is notified that the Member has successfully completed:
         A. the course and evaluation set out in paragraph 2(a)(i) above; and
         B. the following additional courses and evaluations: CPS II Module 5 (Professional Practice & Pharmacy Management 2) from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto; and Root Cause Analysis from the Institute for Safe Medication Practices Canada;
   (c) 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 12 months beginning 12 months from the date of the Order and continuing until 24 months from the date of the Order. 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 $600.00 per inspection to a maximum of 4 inspections, such amount to be paid immediately after completion of each of the inspections.

3. A suspension of three months, with one month of the suspension to be remitted on condition that the Member completes the remedial training. The suspension shall commence on May 14, 2014 and shall continue until July 13, 2014, inclusive.

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

In its reprimand, the Panel reminded the Member that he is a member of the profession of pharmacy where integrity and trust are paramount, and further that pharmacists are held in high regard in the provision of health care. The Panel acknowledged that this was the Member's first appearance before the Discipline Committee, however the Panel noted that the broad range and frequency of the Member's errors were of concern to the Panel, and that the errors represented a significant lapse in the maintenance of the Standards of Practice of the profession. The Panel reminded the Member that all health care professionals are expected to conduct themselves in a manner that maintains public confidence and safety. The Panel stated it was confident the Member would make the necessary adjustments to his practice.

Member: Charles Rak

At a hearing on June 18, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Rak in that he was found guilty by Justice Polowin of the Ontario Superior Court of Justice of the following offences:

- using a computer to communicate with a person who was or was believed to be under the age of 14 years for the purpose of facilitating the commission of an offence under section 151 (sexual interference) or 152 (invitation to sexual touching) of the Criminal Code of Canada, contrary to section 172.1 of the Criminal Code of Canada (computer luring);
- touching, for a sexual purpose, with a part of his body, the body of a person under the age of 16 years, contrary to section 151 of the Criminal Code of Canada (sexual interference);
- without lawful authority and knowing that another person was harassed or recklessly as to whether that person was harassed, engaged in repeatedly communicating with, either directly or indirectly, that person, and caused that person to reasonably fear for his personal safety, contrary to section 264 of the Criminal Code (criminal harassment);
- eight (8) counts of failing, without lawful excuse, to comply with a condition in a recognizance, while being at large on a recognizance entered into before a Justice and being bound to comply with conditions thereof, contrary to section 145(3) of the Criminal Code (failure to comply with recognizance).

In particular, he was found to have

- been found guilty of offences that are relevant to his suitability to practise;
- engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regarding 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 the following:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   a. that the Member is prohibited from dispensing to, consulting with, advising, counselling, or performing any controlled act on any person under the age of 18 years, except where another pharmacist registered in Part A of the College's register or a Pharmacy Technician registered with the College is present to supervise any communication or interaction between the Member and any person under 18 years of age. The supervisor or supervisors must be approved by the Registrar;
   b. that in using a computer, cellphone, tablet, electronic device, or handheld electronic device while working as a pharmacist, the Member may only use the device for purposes of his employment as a pharmacist, and not for personal purposes;
   c. that the Member participate in any treatment, therapy or counselling recommended by Dr. Julian Gojer or Dr. Gojer's designate, to be paid for by the Member if it is not covered by an insurance plan;
   d. the Member is prohibited from acting as a Designated Manager of a pharmacy;
   e. that the Member is prohibited from being an owner, director or shareholder of a corporation that owns a pharmacy, or otherwise having any proprietary interest in a pharmacy;

3. The Member may apply to the Registrar to remove or vary the terms, conditions and limitations set out in paragraph 2 above as follows:

   a. the Member may apply to the Registrar to remove or vary the terms, conditions or limitations set out in paragraphs 2(a) to 2(e) above after two years;
   b. in considering whether to allow a request to remove or vary the terms, conditions or limitations on the Member's certificate of registration, the Registrar may require that Mr. Rak undergo a further sexual behaviours assessment, to be

conducted by a psychiatrist acceptable to the College, and provide a report of the assessment to the Registrar. The Registrar may also require Mr. Rak to provide any other information necessary for the Registrar to assess whether it is in the public interest to remove or vary the terms, conditions or limitations.

4. Costs to the College in the amount of $5,000.

In its reprimand to the Member, the Panel reminded the Member that integrity, trust and professional conduct are at the core of the practice of pharmacy. The Panel also reminded the Member that pharmacy is a self regulated profession, and as such, the profession bears the responsibility to ensure that it maintains the trust of its members and the public. The Panel stated that it found the Member's actions to have been dishonourable, disgraceful and conduct unbecoming of a Pharmacist. The Panel recognized the Member's remorse and commended him on being proactive in changing his behaviour and providing evidence of treatment.

Member: Joseph Salek

On July 24, 2014, the College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Mr. Salek. The allegations are as follows:

- he falsified pharmacy records relating to his practice in connection with claims made for drugs in 2009 and 2010;
- he signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement in connection with claims made for drugs in 2009 and 2010;
- he submitted an account or charge for services that he knew was false or misleading in connection with claims made for drugs in 2009 and 2010; and/or
- he 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.

In particular, it is alleged that he:

- failed to maintain a standard of practice of the profession;
- falsified a record relating to his practice;
- signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement;
- submitted an account or charge for services that he knew was false or misleading;
- contravened the Pharmacy Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155, 156 and 166 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, sections 5, 6 and 15(1) of the Ontario Drug Benefit Act, R.S.O. 1990, c 0.10, and sections 25 and 27 of Regulation 201/96 under the Ontario Drug Benefit Act;
- 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 Discipline Committee in light of the fact Mr. Salek entered into an Undertaking, Agreement and Acknowledgment with the College whereby he resigned permanently as a member of the College, irrevocably surrendered his Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario.

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

Member: Jamil Rashid

At hearing on July 28, 2014, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Rashid in that, from on or about May 1, 2008 to on or about June 30, 2010, he

- submitted false claims to third party payors including the Ontario Drug Benefit program, for products that were not prescribed and/or not received by patients,

for one or more products; and/or
- recorded that products had been dispensed to patients pursuant to a prescription when the products were not received by the patients, for one or more products.

In particular, he was found to have

- failed to maintain a standard of practice of the profession;
- falsified records relating to his practice;
- submitted accounts or charges for services that he knew to be 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)(b) of the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder;
- engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regarding to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

At the hearing on July 28th, Mr. Rashid acknowledged that he submitted false and misleading claims for payment to the Ontario Drug Benefit Program in the amount of approximately $104,138.72 for diabetic test strips that were never obtained from suppliers or dispensed to patients.

The Panel imposed an Order which included the following:

1. A reprimand;

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's Certificate of Registration, and in particular:
   a. that the Member complete successfully, at his own expense, within 12 months of the date of the Panel's Order, the ProBE Program – Professional/Problem Based Ethics, offered by the Centre for Personalized Education for Physicians, or an equivalent program acceptable to the College;
   b. that the Member shall be prohibited, for a period of 3 years deemed to have commenced April 16, 2013, from:
      i. Having any proprietary interest in a pharmacy of any kind;
      ii. Acting as a Designated Manager in any pharmacy;
      iii. Receiving any remuneration for his work as a pharmacist other than remuneration based only on hourly or weekly rates, and not on the basis of any incentive or bonus for prescription sales;
   c. that the Member shall be required, for a period of three years deemed to have commenced April 16, 2013, to notify the College in writing of any employment in a pharmacy;
   d. that the Member, for a period of three years deemed to have commenced April 16, 2013, shall ensure that his employer has confirmed in writing to the College that they have received and reviewed a copy of the Discipline Committee Panel's decision in this matter and their Order, and confirming the nature of the Member's remuneration. This term is only applicable where the Member is employed by a pharmacy, in the pharmaceutical industry, or otherwise employed as a pharmacist;

3. A suspension of eight months, with one month of the suspension to be remitted on condition that the Member completes the remedial training. The suspension shall commence on September 1, 2014 and shall continue until March 31, 2014, inclusive.

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

In its reprimand to the Member, the Panel emphasized the fact that integrity and trust is paramount to the profession as pharmacists provide care to the public and in return are held in high regard for the role they play in the provision of healthcare in Ontario. The Panel stated that it was extremely disappointed with the Member's actions resulted in knowingly submitting false claims, committing an act of professional misconduct and making inappropriate billings to the Ontario Drug Benefit Program for reimbursement of medications that were not dispensed. The Panel found the Member's actions to be dishonourable, disgraceful and conduct unbecoming of a pharmacist. The Panel noted that it expected that the Member would learn from this process to ensure that he improve his practice and regains the trust of others that has been diminished through his actions.

The full text of these decisions is available at http://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.

2014 OPA CONFERENCE

The College hosted an information booth at the annual Ontario Pharmacists Association Conference held in Niagara Falls on June 19-21. With hundreds of pharmacists, pharmacy technicians and industry representatives in attendance it was a great opportunity for College staff to remind practitioners about their professional responsibilities and discuss how to apply the professional responsibility principles to every day practice.

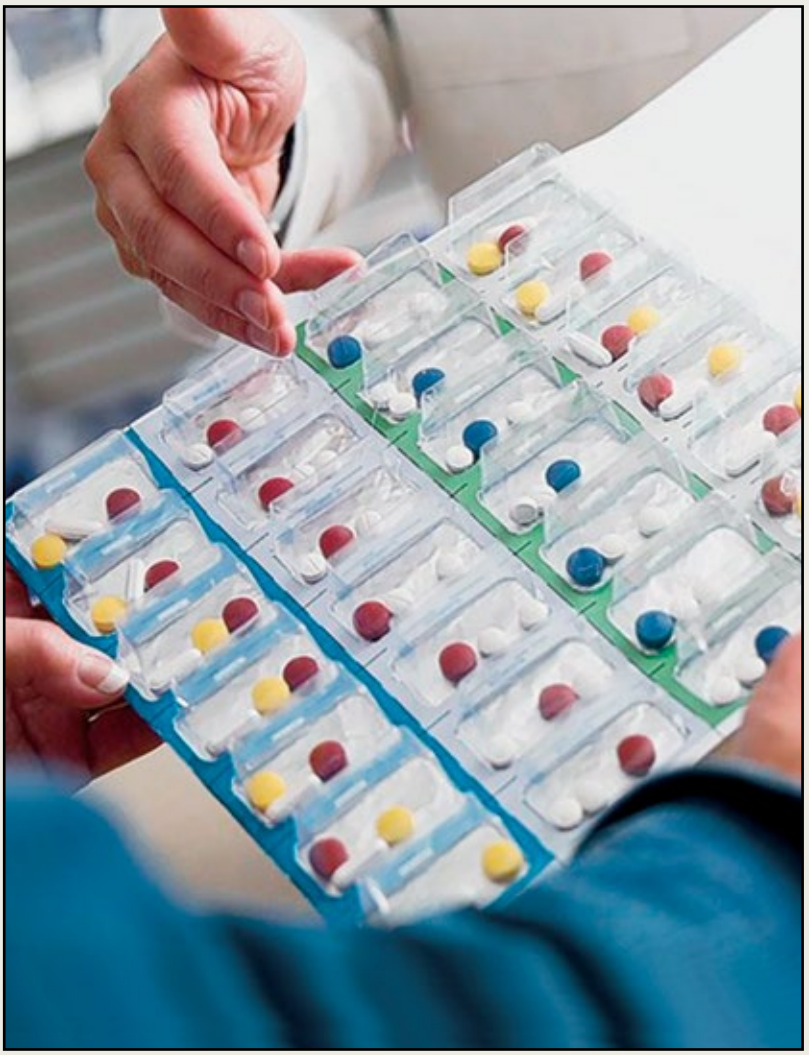
Vice-president Mark Scanlon (right) at the OCP booth beside council member Rachelle Rocha (centre) and College staff Jasmine Graham.

Registrar Marshall Moleschi (left) pictured here with College staff members Jasmine Graham, Tara Breckenridge and Betty Hsu (right).

FOCUS ON ERROR PREVENTION

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

COMPLIANCE PACKAGING



The number of Canadians aged sixty-five years or older has grown steadily over the years. As a result, an increasing number of patients are taking multiple medications with complex regimens. Compliance packaging is one tool which can be used to ensure patients are taking the correct drug at the correct time.

However, pharmacists must be aware of the types of errors possible when preparing and dispensing compliance packaging. One type of error that has been reported is: duplication of drug therapy.

CASE:

An eighty-eight year old patient living in a retirement residence receives her medication via compliance packaging from her local pharmacy on a bi-weekly basis. One of her regular medication is amiodarone 100mg taken once daily.

On one occasion, after dispensing the patient's compliance package, the pharmacist noticed that the refills for amiodarone had been exhausted. The pharmacist therefore contacted her physician by fax for a prescription for three months' supply of amiodarone to be logged for future dispensing.

A few days later, the physician returned the authority to dispense three months' supply of amiodarone by fax. A pharmacy assistant retrieved the faxed authority, then processed and prepared the full three months' supply. A second pharmacist checked the prescription but failed to notice that the patient receives her medications by compliance packaging. The full three months' supply of amiodarone was therefore dispensed and delivered to the patient. The patient received the amiodarone and did not question why this medication was being dispensed separate from her compliance packaging.

Approximately ten days later, the initial pharmacist began to process another two week supply

of compliance packaging for the patient and noticed that a three month supply of amiodarone had been dispensed. She immediately contacted the patient to inquire if they had taken any of the amiodarone tablets in addition to the amiodarone in her compliance packaging. The patient indicated that she did indeed take the additional amiodarone for a few days. However, fortunately the patient did not experience any ill effects.

POSSIBLE CONTRIBUTING FACTORS:

- When processing the prescription for three months' supply of amiodarone, the pharmacy assistant was alerted by the computer that the patient does receive medication by compliance packaging. However, there are some medications that are not included in the compliance packaging such as PRN medications. The pharmacy assistant therefore assumed that this case was also a valid exception.
- Though the computer hard copy did indicate that the patient is a "blister pack patient", the pharmacist missed the note and was unaware of the patient's history.

RECOMMENDATIONS:

- Create a documentation system for all patients receiving compliance packaging. Documentation should include details of current medication, changes to drug therapy over time, etc.
- Pharmacy staff must consult the patient's file before dispensing any medication for patients receiving compliance packaging.
- Ensure that patients receiving compliance packaging are easily identifiable. Speak with your software vendor to ensure patient notes are readily seen and not easily missed.
- When faxing reauthorization requests to physicians, write in bold letters that the patient is receiving compliance packaging.
- Educate all pharmacy staff the importance of identifying compliance packaging patients to the pharmacist when processing their prescriptions.
- Check the patient's medication history to identify changes in drug therapy and to prevent medication errors.
- Encourage the patient and/or their agent to ask questions if something does not seem correct. Patients can play a key role in error prevention.
- All pharmacy staff should be familiar with the College's practice policies and guidelines regarding multi-medication compliance aids[1].

1. Multi-medication Compliance Aids Guideline. Available at: www.ocpinfo.com/regulations-standards/policies-guidelines/compliance-aids/ (Accessed August 2014).

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.

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 Client Services at 416-962-4861 ext 3300 or email ocpclientservices@ocpinfo.com

CONTINUING EDUCATION (CE)

This list of continuing education activities is provided as a courtesy to members. The Ontario College of Pharmacists does not necessarily endorse the CE activities on this list.
For information on local live CE events in your area you may wish to contact your Regional CE coordinator (list available on the OCP website).

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

LIVE EVENTS AND CONFERENCES

August 24 – October 26, 2014 (Multiple Dates and Locations)
Flu Season and Pharmacy Services: An Injection Refresher Workshop
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

September 10, 2014 (Toronto, ON)
Multi-Incident Analysis Workshop
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 11, 2014 (Toronto, ON)
Closing the Loop on Medication Incident Reporting:
The Importance of Safety Culture
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 14, 2014 (Montreal, ON)
Biologic Treatments in Patient Care Certificate Program
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

September 24-25, 2014 (Toronto, ON)
Medication Safety for Pharmacy Practice:
Incident Analysis and Prospective Risk Assessment
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

September 27, 2014 (Toronto, ON)
The 10th Annual Infectious Diseases - Critical Care Pharmacotherapy Conference
University of Toronto, Faculty of Pharmacy
Contact: http://www.pharmacy.utoronto.ca/cpd/id

September 28 – 29, 2014 (Toronto, ON)
Pharmacogenetics in Mental Health and Addictions Training
Centre for Addiction and Mental Health
Contact: htttp://www.camh.ca/en/education/about/AZCourses/Pages/Pharmaco.aspx

October 2, 2014 (Toronto, ON)
BPMH Training for Pharmacy Technicians
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

October 3, 2014 (Toronto, ON)
Incident Analysis Framework: Train-the-Trainer Workshop
Institute for Safe Medication Practices Canada
Contact: http://www.ismp-canada.org/index.htm

October 4, 2014 (Toronto, ON)
Humber Pharmacy Technicians Conference
Healthmark
Contact: http://www.healthmark.ca/18-95-EVENTS/Humber-Pharmacy-Technicians-Conference_en.html

October 4-5, 2014 or October 18-19, 2014 (Toronto, ON)
Asthma and COPD: Supporting Patient Treatment and Control
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

October 16-18, 2014 (Ottawa, ON)
XXIV Annual Meeting & Scientific Conference 2014
Canadian Society of Addiction Medicine
Contact: http://www.csam-smca.org/events/csam-xxiv-annual-meeting-scientific-conference-2014/

October 25, 2014 (Toronto, ON)
Medication Therapy Management for Older Adults – CGP

Preparation Course
Ontario Pharmacists Association
Contact: https://www.opatoday.com/224009

November 1, 2014 (Toronto, ON)
Cardiovascular Patient Care Certificate Program
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

November 1, 2014 (Mississauga, ON)
Trillium Pharmacy Technician Conference
Healthmark
Contact: http://www.healthmark.ca/18-96-EVENTS/Trillium-Pharmacy-Technician-Conference_en.html

November 18-19, 2014 (Toronto, ON)
TB: Rising to the Challenges
The Lung Association
Contact: http://www.on.lung.ca/tbconf

November 24, 2014 (Toronto, ON)
Paediatrics for Pharmacy Professionals Conference
The Hospital for Sick Children
Contact: http://www.cvent.com/events/paediatrics-for-pharmacy-professionals/event-summary-19116a661d3e44909b627a05715813f6.aspx

December 6, 2014 (Toronto, ON)
Psychiatric Patient Care – Level II
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

December 13, 2014 (Toronto, ON)
Infectious Disease Management Certificate Program
Ontario Pharmacists Association
Contact: http://www.opatoday.com/professional/live-courses

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

ONLINE LEARNING/ WEBINARS/ BLENDED CE

Centre for Addiction and Mental Health (CAMH)
Online courses with live workshops in subjects including: The TEACH Project (Training Enhancement in Applied Cessation Counselling and Heath); Core Specialty and Certificate courses in Tobacco Intervention and Cessation; and TEACH specialty Integrated Chronic Disease Prevention; Motivational Interviewing Introduction Course; Motivational Interviewing (MI for Opioids and Other Forms of Substance Dependence; Basic Pharmacology in Mental Health and Substance Use; Youth Drugs and Mental Health; Concurrent Disorders Core; Concurrent Disorders in Primary Care; Fundamentals of Addiction; Fundamentals of Mental Health; Interactions Between Psychiatric Medications and Drugs of Abuse; Interactions Between Psychiatric Medications and Drugs of Abuse; Medications and Drugs of Abuse Interactions in ODT Clients; Safe and Effective Use of Opioids for Chronic Non-Cancer Pain; Youth, Drugs and Mental Health; Youth, Opioid Use Disorders and Treatment Options,
Contact: http://www.camh.ca/en/education/about/AZCourses/Pages/default.aspx

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

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

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

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

Complimentary from OCP and University of Toronto, Leslie Dan Faculty of Pharmacy: Collaborative Care: Conflict In Inter-Professional Collaboration; Pain: Chronic Non-Cancer Pain; Pharmacists Role: Who Do We Think We Are? The '10 Minute Patient Interview' webcast; Physical Assessment for Pharmacists; There is no "I" in "Team".
Contact: http://www.ocpinfo.com/practice-education/continuing-education/listings/pharmacists/

Ontario Pharmacists Association (OPA)
On-line courses with live workshops in subjects including; Lab Tests, ADAPT: Patient Care Skills Development, De-prescribing, Infant Care and Nutrition, Infectious Disease – Foundations for Pharmacy, Interpretation of Lab Values, Introduction to Geriatrics and an Overview of the Beers Criteria, Multi-Sesssion Package, Natural Health Products, New Anticoagulants, QUIT Smoking Cessation Program, Serving Travel Medicine Needs in the Pharmacy, The Transition from Hospital to Community.

Complimentary online courses include: Managing Menopause and it's Associated Disorders, Head Start in Migraine Management , Methadone Education Program, Methadone and Buprenorphine, Ontario Drug Benefit blood glucose test strip reimbursement policy: Support tools for pharmacists, Practical Management of Cough an Cold, Smoking Cessation, Ulcerative Colitis, Vitamin D in Osteoporosis, Why the Common Cold and Flu Matter: A Look at Prevention,
Contact: http://www.opatoday.com/professional/online-learning

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

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

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

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

OCP is looking for additional regional CE coordinators and associate coordinators in regions 4 (Pembroke and area), 9 (Lindsay area), 10 (North Bay area), 11A (Markham area) 17 (Brantford area), 25 (Sault Ste. Marie area), 27 (Timmins area). A complete list of CE coordinators and regions by town/city is available on our website.

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

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