Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

SUMMER 2016 • VOLUME 23 NUMBER 3

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

FIRST IN THE SERIES OF CODE OF ETHICS LEARNING MODULES NOW AVAILABLE

SEE PAGE 7

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Ontario College of Pharmacists
Putting patients first since 1871

Strategic Framework
2015-2018

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

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

Values
Transparency ◆ Accountability ◆ Excellence

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

Strategic Initiatives
Patients First
Effective Communications
Continuous Quality Improvement

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

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

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

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Esmail Merani,
President

Regis Vaillancourt,
Vice President

> "We wish Marshall all the best in his retirement!"

A MESSAGE FROM ESMAIL MERANI, PRESIDENT AND REGIS VAILLANCOURT, VICE PRESIDENT, ONTARIO COLLEGE OF PHARMACISTS

It is with mixed emotion that we announce the retirement of Marshall Moleschi, Registrar of the Ontario College of Pharmacists, effective September 30, 2016.

Over the past 5 years, Marshall has admirably guided the College relentlessly ensuring we stay focused on our vision – to lead the advancement of pharmacy to optimize health and wellness through patient-centred care.

From expanded scope for pharmacists to oversight of hospital pharmacies, Council and College staff have relied heavily and benefitted greatly from Marshall's experience and expertise as a strategist and visionary leader. With quiet confidence and resolve, Marshall has been instrumental in strengthening the public protection mandate of the College and the value of pharmacy professionals to internal and external stakeholders alike, including NAPRA, FHRCO, the Ministry and of course the public.

Marshall was instrumental in introducing the College's fundamental shift in focus from compliance to rules towards coaching and mentoring to the Standards of Practice and Code of Ethics. Introducing new practice-based assessments for pharmacists and pharmacy technicians as well as a new Code of Ethics for the profession are just a few of the many initiatives that have been successfully introduced under Marshall's tenure. He has also significantly enhanced operations, introducing a culture of continuous quality improvement to ensure ongoing efficiencies throughout the organization.

On behalf of Council and staff, we wish to thank Marshall for his dedication over the years and are confident that under his leadership, the College has strengthened its mandate to serve and protect the public interest. Pc

Marshall Moleschi,
Registrar and CEO

JUNE 2016 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on June 13, 2016.

PHYSICIAN-ASSISTED DEATH/ MEDICAL ASSISTANCE IN DYING

The College has been actively collaborating with the Ministry of Health and Long-Term Care, other regulatory bodies and applicable stakeholders on this important and evolving topic. When available, members will be advised of updates made to the Guidance to Pharmacists and Pharmacy Technicians document found on the College website.

COUNCIL APPROVES – FOR SUBMISSION TO GOVERNMENT – PROPOSED AMENDMENTS TO THE PHARMACY ACT REGULATION

(Administration of Vaccinations by Pharmacists)

At its meeting in March, Council approved for circulation for public and member feedback, the amendments to the *Pharmacy Act* regulation which would authorize pharmacists to administer select vaccines.

The proposed changes will allow for the administration of vaccinations for 13 diseases that are preventable by vaccines. This includes vaccinations for Haemophilus Influenzae Type B, Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Japanese Encephalitis, Meningitis, Pneumococcal Disease, Rabies, Tuberculosis, Typhoid Disease, Varicella Virus and Yellow Fever. The proposed amendments will also authorize pharmacy students and interns to administer injections – including those under the Universal Influenza Immunization Program and the selected vaccines – subject to the terms, limits and conditions imposed on their certificate of registration.

In addition to posting the proposed amendments to the regulation on the College website for 60 days, invitations to participate in the consultation were sent vial email and social media. The consultation received 308 responses (280 from pharmacy professionals, 12 from the public and 16 from organizations). Read the responses to the consultation and see page 24 for a summary.

The majority of the feedback indicates overall support for this amendment and no revisions to the proposed regulations were suggested. Council approved the amendment and the next step is for the College to submit the proposed regulation to the Ministry of Health and Long-Term Care for final consideration and ultimate proclamation.

NEW PUBLIC MEMBERS APPOINTED TO COUNCIL

Council welcomed Mr. Ravil Veli and Mr. James MacLaggan who were recently appointed to College Council for a period of three years.

While the addition of two public members on Council and committees is very much welcomed and appreciated, the full compliment of public member representation on Council has still not been met. Given the ongoing challenge of constituting panels for various committees Council agreed to continue to appeal to the Ministry to appoint more public members.

BILL 21, SAFEGUARDING HEALTH CARE INTEGRITY ACT, 2014/ HOSPITAL PHARMACY OVERSIGHT

Bill 21, *Safeguarding Health Care Integrity Act*, 2014, which has been passed in the legislature:




Photos by DW Dorken

- Provides the College with the authority to license and inspect pharmacies within public and private hospitals, in the same manner it currently licenses and inspects community pharmacies
- Provides the College with the ability to enforce licensing requirements with regard to hospital pharmacies
- Allows the College to make regulations to establish the requirements and standards for licensing, operation and inspection of hospital pharmacies
- Provides government with the ability to extend the College's oversight to other institutional pharmacy locations in the future, as appropriate

Although this Bill been passed in the legislature, provisions relating to the College's oversight of hospital pharmacies will not come into effect until the required amendments to the *Drug and Pharmacies Act* (DPRA) regulation have been approved by government.

Minister Hoskins recently wrote a letter advising hospital Presidents and Chief Executive Officers that the proposed amendments to the DPRA, which were approved by Council in June 2015, will shortly be brought forward for approval by Cabinet. The Minister has encouraged hospitals to take the necessary steps to ensure the pharmacies are ready for OCP oversight.

IMPROVING PHARMACY PRACTICE FIVE MINUTES AT A TIME

Dr. David Edwards, Hallman Director, University of Waterloo presented to Council a proposal for the College to partner with the university in an initiative to offer a multimodal teaching tool called "Pharmacy 5in5". The interactive educational tool is designed to help pharmacists and pharmacy technicians develop their skills and acquire a deeper understanding of a variety of clinical and professional topics with a goal of enhancing the delivery of safe, effective and ethical care. Potential topics include changes to the scope of practice, implementation of new services, and clinical management. Pharmacy 5in5 allows users to audit their knowledge and provides them with feedback on their knowledge level compared to their peers.

Given the online delivery of the program, a significant amount of cumulative data will be collected and used by the College to evaluate performance against deliverables identified in the College's Strategic Plan (2015 – 2018). College Council agreed to partner with Waterloo in this multi-year research based, professional development initiative with an investment of $400,000 over three years. Pc

COUNCIL MEETINGS IN 2016:

- Monday 19 and Tuesday 20 September, 2016
- Monday 12 December, 2016

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

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

First in the Series of Code of Ethics Learning Modules Now Available

The College is pleased to launch the first in a series of e-learning modules developed to assist current and future pharmacists and pharmacy technicians understand and apply the new Code of Ethics in everyday practice.

Council approved the new Code at their December 2015 meeting following an extensive development and consultative process. Although practice expectations in the new Code are unchanged, it was updated to more appropriately address current practice and clearly establish the standards of ethical conduct for pharmacy professionals.

The Code is a comprehensive document that outlines the core ethical principles that dictate a healthcare professional's ethical duty to patients and society. The document supports these principles with standards that indicate how a practitioner is expected to fulfill their ethical responsibilities.

In approving the Code Council also established a requirement for all current (and new) pharmacists and pharmacy technicians to declare that they have read and understand the new Code in 2017. To support practitioners in doing this the College is developing a series of e-learning and video modules that use everyday practice scenarios to illustrate the application of the Code in practice.

This introductory module is approximately 20 minutes and features a variety of learning techniques including - true and false questions, whiteboard video and case studies with reflective discussion – to engage learners from all practice settings and emphases key concepts from the Code.

Over the next few months additional e-learning and video modules will be released covering all aspects of the Code and providing practitioners with a library of resources.

All new and current pharmacists and pharmacy technicians are encouraged to view these modules as they are released to ensure they are comfortable with declaring their understanding of and their commitment to the new Code of Ethics in 2017.

AFTER COMPLETING THE INTRODUCTORY MODULE YOU WILL UNDERSTAND:

- The role and purpose of the Code of Ethics;
- Your professional role and commitment as a healthcare professional; and
- The 'social contract' and core ethical principles of healthcare that must guide your everyday practice.

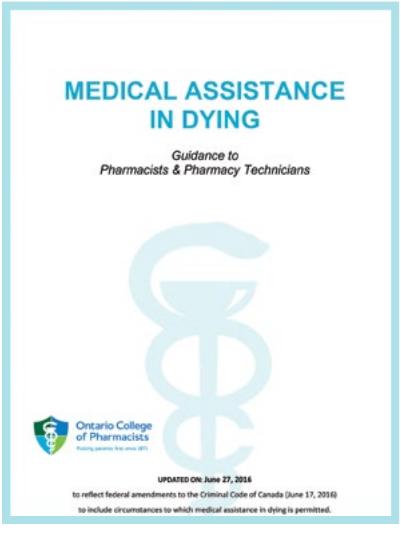
This feature in *Pharmacy Connection* is a place to find information about news stories we're following. Here, you'll read summaries of recent stories relating to pharmacy in Ontario and Canada. For the latest updates, stay tuned to e-Connect and www.ocpinfo.com

MEDICAL ASSISTANCE IN DYING

On Feb. 6, 2015 — through the Carter v. Canada decision — the Supreme Court of Canada (SCC) ruled that all provinces and territories in Canada must permit some form of physician-assisted death. At the time of the Carter decision, the SCC suspended its decision and granted federal and provincial governments time to develop a framework to accommodate medical assistance in dying (referred to as 'physician-assisted death' by the SCC).

On June 17, 2016 the federal government enacted amendments to the Criminal Code of Canada (the "Criminal Code") to include circumstances under which medical assistance in dying is permitted.

On June 27, 2016 the College released Guidance to Pharmacists and Pharmacy Technicians –Medical Assistance in Dying to assist pharmacy professionals to comply with legal obligations and professional expectations with respect to medical assistance in dying (MAiD) as outlined in federal and provincial legislation, the Standards of Practice, Code of Ethics and College policies and guidelines.



Pharmacists and pharmacy technicians are exempted from criminal liability when dispensing a prescription that is written by a medical or nurse practitioner in providing medical assistance in dying.

NALOXONE UPDATE

On June, 24, 2016 the National Association of Pharmacy Regulatory Authorities (NAPRA) review on the scheduling status of naloxone was completed and naloxone, for emergency use for opioid overdose outside a hospital setting, is now listed as Schedule II on the National Drug Schedule (NDS).

Any patient or patient's agent are now permitted to obtain Schedule II naloxone and kit supplies directly from community pharmacists without a prescription. The Ministry of Health and Long-Term Care will provide funding for naloxone for patients according to criteria defined by the Ministry.

The College has released a Guidance document for pharmacy professionals when dispensing or selling naloxone as a Schedule II drug. The intent of this document is to provide guidance to pharmacists and pharmacy technicians regarding their respective responsibilities when dispensing or selling naloxone as a Schedule II drug.

PATCH FOR PATCH RETURN POLICY

The Ministry of Health and Long-Term Care is proposing a regulation to Bill 33 Safeguarding our Communities Act (Patch for Patch Return Policy), 2015 that would assist with the implementation of a regulated Patch4Patch program in Ontario. The program is designed to safeguard patients relating to the use of fentanyl patches by providing a mechanism to address abuse, misuse, and diversion.

The fentanyl Patch4Patch program will require a patient to return all of their used fentanyl patches to the pharmacy before the patient is able to have their next prescription filled.

The Act and proposed regulation sets out requirements for prescribers and pharmacies that dispense fentanyl

patches. Consultation on the proposed regulation closed on June 18, 2016.

It is proposed that the regulation, if approved, come into force on October 1, 2016. In anticipation of the passing of the regulation, the College is currently working with the College of Physicians and Surgeons on joint guidance for physicians and pharmacists.

DRUG AND PHARMACIES REGULATION ACT

At the time of this publication amendments to the *Drug and Pharmacies Regulation Act* (DRPA) were in the final stages of proclamation by government with an anticipated effective date of August 1, 2016. The passing of the amendments extends the College's authority to license and inspect pharmacies within public and private hospitals, as well as future authority over institutional pharmacy locations.

It is important to note that with the exception of the new authority to license and inspect hospital pharmacies, the net result of the proposed DPRA regulation changes with the corresponding supplemental documents is that expectations of practice will not change when the proposed regulations are proclaimed and enacted into law.

Stay tuned to e-connect for ongoing updates about the DPRA.

HEALTH CANADA: PRIOR AUTHORIZATION NO LONGER REQUIRED FOR DESTRUCTION OF NARCOTICS AND CONTROLLED DRUGS

The College has received confirmation from the Office of Controlled Substances that, effective immediately, pharmacies are no longer required to request and receive prior authorization for local destruction of unserviceable narcotics and controlled drugs from Health Canada. All other requirements, including documentation, remain in place.

The College has updated the related Fact Sheet: Destruction of Narcotics, Controlled Drugs, and Targeted Substances, to reflect this change. The Fact Sheet now includes guidance regarding the destruction process previously provided to pharmacies by Health Canada including:

- Options for destruction;
- Record keeping requirements;
- Witnessing destruction;
- Method of destruction; and
- Alteration or denaturing of the controlled substance. Pc

PRACTICE TIP!

If you're not completing a patient assessment before renewing a prescription, how can you be sure you're making the right decision? Learn the steps that should be taken prior to renewing a prescription.
http://www.ocpinfo.com/library/practice-related/download/Expanded%20Scope%20Orientation%20Manual.pdf (pages 8-10)

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

ARE THEY READY FOR PRACTICE?

A NEW APPROACH TO ASSESSING CANDIDATES AT ENTRY-TO-PRACTICE

One of the College's fundamental responsibilities as the regulator for the profession of pharmacy is to ensure candidates are qualified and have the knowledge, skills and abilities necessary to safely and ethically practice pharmacy in Ontario.

As a requirement to register with the College, every candidate must demonstrate their competence and readiness to practice by successfully completing a structured practical training program.

Earlier in 2016, the College began piloting a new approach to assessing candidates' readiness for practice. PACE — or Practice Assessment of Competence at Entry — is currently being tested with pharmacist candidates and is designed to meet the requirement for structured practical training.

ABOUT PACE

The purpose of PACE is to ensure candidates are qualified to begin practising as pharmacists in Ontario. College-appointed pharmacists – PACE Assessors – assess a candidate's knowledge, skills and abilities to ensure they are competent to become pharmacists.

A diagram of the PACE process can be found on page 13.

ORIENTATION

During orientation, the candidate spends 35 hours over one week to become accustomed to the pharmacy's workflow and processes.

ASSESSMENT

The assessment spans 70 hours over two weeks (full time) or three-weeks (part time). The assessor observes while the candidate engages in the scope of practice of a pharmacist. The assessor avoids providing feedback during the assessment and only intervenes if necessary to ensure patient safety. The candidate's competence is assessed using a tool jointly developed and validated by the University of Toronto, University of Waterloo, the Ontario hospital residency program, and OCP. This ensures that candidates are evaluated on the same criteria whether through University of Waterloo or University of Toronto experiential rotations, or through PACE. The College applies standardized weightings to competency items to determine the final outcome of the assessment in a fair and objective manner.

OUTCOME

Within two weeks of completion of the assessment, the candidate will receive news about whether or not they have been successful in demonstrating competence. If the candidate has demonstrated competence they have met the College's registration requirement for structured practical training and can move forward with the next step(s) of their registration process. If the candidate has not successfully demonstrated competence, he or she will receive a performance profile from the College, indicating areas of competency gaps, as well as feedback and guidance in creating a plan for self-directed development before attempting the assessment again.

DEVELOPMENT

The development phase of PACE is only for candidates who do not demonstrate competence during the assessment. Development will occur for as long as required, but not less than 4 weeks. The purpose of this phase is for candidates to create and implement an action plan to address the practice gaps that were identified during the assessment.

A College registration advisor (RA) will consult with the candidate to review their performance profile and encourage the candidate to reflect on areas where enhancement is needed to meet the standards for practice. The RA will discuss the resources and options that are available to support additional learning in the specific identified areas. With guidance from the RA, the candidate will create their own personalized learning action plan tailored specifically to their development needs.

Candidates will select a practising pharmacist to act as a mentor as they undertake their personalized learning action plan during the development phase. The mentor will supervise the candidate in practice, help the candidate to address areas needing development, and will also provide additional development feedback such as fine-tuning subtle practice points.

The mentor and candidate both acknowledge in writing when the candidate's development has been successfully completed as per the individualized learning action plan, signalling to the College that the candidate is ready for re-assessment.

PACE HIGHLIGHTS

TIME REQUIREMENT – ORIENTATION, ASSESSMENT, DEVELOPMENT

- 35 hours of orientation
- 70 hours of assessment over two or three weeks
- Development (if required) – minimum 4 weeks, may be longer if needed to complete personalized learning action plan

ASSESSMENT PHASE

- Assessment without feedback
- Assessor uses validated and standardized assessment tool

DEVELOPMENT PHASE (IF REQUIRED)

- Occurs separately from assessment
- Self-directed
- Individualized learning action plan supported by OCP and third-party mentor
- Based on performance profile and identified competency gaps

ROLE OF PACE ASSESSOR

- College-appointed volunteer position
- Stringent screening criteria
- Avoids providing feedback – assesses only
- Consistently observes, intervenes only when required to ensure safety

ROLE OF PACE MENTOR

- Volunteer position (not College-appointed)
- Demonstrated capacity to support candidate's development needs
- Observes and develops candidate based on personalized development plan
- Adjusts level of supervision and observation based on performance
- Provides mentorship and feedback
- Determines candidate's readiness for re-assessment

RE-ASSESSMENT

OCP will assign a new assessor in a new location and the candidate will repeat the PACE assessment process, starting from the orientation phase.

WHO CAN BE A PACE ASSESSOR?

The College is currently recruiting PACE Assessors. If you are interested in applying, please review the Assessor Criteria and apply online at http://www.ocpinfo.com/about/key-initiatives/pace/

PACE Assessors should:

- Be experienced community or hospital pharmacists registered and practicing in Ontario, or other Canadian jurisdiction with similar scope of practice, for at least two years providing patient-centred care
- Have an understanding of and commitment to pharmacy regulation, Standards of Practice and the Code of Ethics
- Have a strong sense of professional responsibility demonstrated by a commitment to continuing professional development
- Be experienced in fostering collaborative relationships with excellent verbal, written and listening skills
- Be currently practicing a minimum of 25 hours per week in a community or hospital pharmacy in Ontario that supports a diverse patient population and is engaged in the delivery of a wide-range of pharmacy services
- Be willing to participate as a PACE assessor a minimum of three times per year, which requires direct supervision of candidates for 70 hours over a three week period for each assessment

PACE Assessors should not be:

- New to practice — Assessors must have at least two years experience providing patient-centred care
- Practising with a limited breadth or not practising to full scope
- Practising in an overly specialized pharmacy
- Practising in a pharmacy where management is in transition
- Pharmacy technicians (PACE is currently being piloted for pharmacists only)

APPLYING TO BECOME AN ASSESSOR

Pharmacists can apply, at any time, to the College for consideration as a PACE assessor by completing the application form. The application will be reviewed by the College and successful candidates will be notified of their appointment as a PACE assessor. Assessors will be required to successfully complete assessor training and must continue to meet the criteria outlined in the initial application. Visit http://www.ocpinfo.com/about/key-initiatives/pace/ for more information.

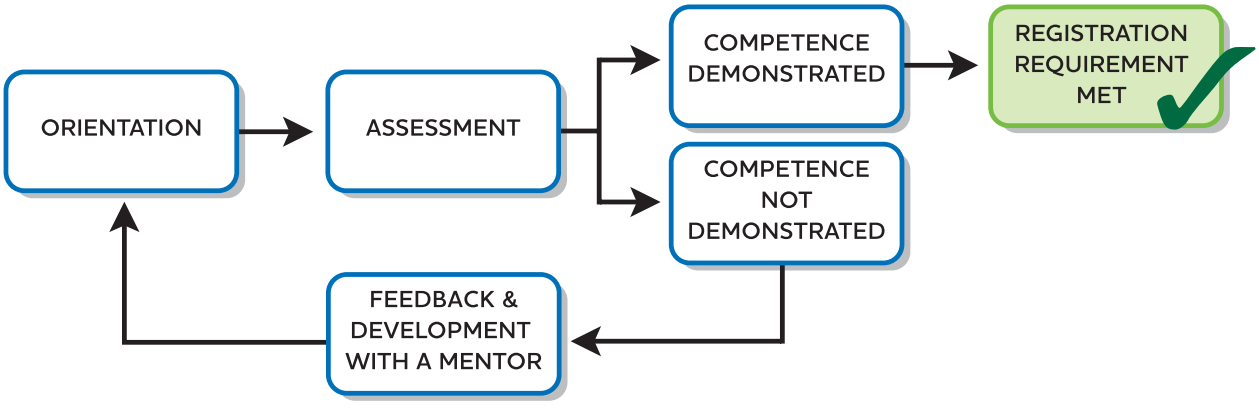
WHO CAN BE A PACE MENTOR

Ideal mentors for PACE candidates will be pharmacists in good standing with the College whose practise site allows for a full scope of practice opportunities. Mentors will support development of the candidate through supervision, feedback, and facilitation of practise opportunities based on an individualized learning action plan created by the candidate, and supported by the College.

NEXT STEPS

The College is currently recruiting and training assessors for the PACE pilot. Stay tuned to the PACE – Key Initiatives page on the College website for more information!

THE PACE PROCESS:



Perspectives of pharmacists and physicians

This article was originally published in the July/August 2016 issue of Canadian Pharmacists Journal (Vol. 149, No. 4), pages 236-245.

Original Article:
Paul A.M. Gregory, BA, MLS;
Zubin Austin, BScPhm, MBA, MISc, PhD

AUTHOR STATEMENT

While physicians are sometimes accused of being benignly ignorant about pharmacists, pharmacists can sometimes appear maliciously well informed about physicians' behaviours. The existence of this asymmetry can make true interprofessional collaboration challenging. We undertook this research to explore the roots of this observation, and as a way of supporting more collaborative patient care.

ABSTRACT

Background: Trust is integral to effective interprofessional collaboration. There has been scant literature characterizing how trust between practitioners is formed, maintained or lost. The objective of this study was to characterize the cognitive model of trust that exists between pharmacists and family physicians working in collaborative primary care settings.

Methods: Pharmacists and family physicians who work collaboratively in primary care were participants in this study. Family health teams were excluded from this study due to the distinct nature of these settings. Through a snowball convenience sampling method, a total of 11 pharmacists and 8 family physicians were recruited. A semi-structured interview guide was used to guide discussion around trust, relationships and collaboration. Constant-comparative coding was used to identify themes emerging from this data.

Results: Pharmacists and family physicians demonstrate different cognitive models of trust in primary care collaboration. For pharmacists, trust appears to be conferred on physicians based on title, degree, status and positional authority. For family physicians, trust appears to be earned based on competency and performance. These differences may lead to interprofessional tension when expectations of reciprocal trust are not met.

Conclusions: Further work in characterizing how trust is developed in interprofessional relationships is needed to support effective team formation and functioning.
Can Pharm J (Ott) 2016;149:xxc-xx.

Trust (noun): firm belief in the reliability, truth, ability or strength of someone or something as in "good relationships are built on trust."

(Oxford English Dictionary)

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KNOWLEDGE INTO PRACTICE

- Effective collaboration between pharmacists and physicians requires trust.
- Different cognitive models of trust produce different behavioural expectations.
- Misalignments between practitioners' cognitive models of trust may produce interprofessional tensions.
- For pharmacists, trust is conferred based upon status, degree, title or positional authority, while for family physicians, trust is earned based on competence and performance.

BACKGROUND

Interpersonal life is lived upon a foundation of trust: without it, our activities of daily living become both impossible and meaningless.[1] Philosophers have long speculated on the centrality of trust to all human relationships, particularly those in which risk, danger or uncertainty exist.[2] Social scientists have defined a variety of frameworks to examine the subtleties associated with trust and the circumstantial nature of its application.[3] Biologists have suggested that humans have a natural predisposition to trust and that the subjective feeling of trusting another can be altered pharmacologically (e.g., by the use of oxytocin).[4] Like the air we breathe, trust is universally relied upon but rarely discussed.

As with any type of human relationship, trust is implicit in the structure and function of health care teams.[5] For example, a physician may rely upon—or trust—the pharmacist who completed an assessment prior to diagnosing or prescribing for a patient. Errors (intentional or accidental) may cause a breach in trust—and the relationship—that may inhibit or prevent collaborative relationships from forming. Biases and stereotypes (known as attribution errors) may inhibit or interfere with an individual's ability to work collegially with others.[6]

As interprofessional collaboration becomes more prevalent, a form of interdependency is required between health care workers.[7] This interdependency manifests itself, for example, in the reliance that nurses place on physicians' trustworthiness to accurately diagnose and prescribe, which in turn is built upon a pharmacist's trustworthiness to accurately and completely undertake a best possible medication history. Without trust in the professional skills and good character of colleagues, true collaboration is not possible.[8]

Anecdotally, there have been reports that this interdependency may not be as deep as it could (or should) be in order to fulfill the


Stock photo

promise of interprofessional collaboration.[9] In particular, it has been reported that within collaborative family practice environments, pharmacists' recommendations may be ignored, or opportunities for pharmacists to contribute to decision-making may be overlooked.[9] The root causes of such behaviours are of course multifactorial and will involve issues of structure, hierarchy, compensation models and power relationships.[10] Rarely, however, is the issue of "trust" itself named as a reason for noncollaborative relationships or as the root cause of interprofessional tension.

OBJECTIVE

The objective of this research was to characterize the construct (or cognitive model) of "trust" in interprofessional collaboration in primary care, from the perspective of community pharmacists and family physicians directly co-involved in patient care.

METHODS

Community pharmacists and family physicians in Ontario working within primary care environments featuring regular periodic contact and communication between one another were the focus of this study. Inclusion criteria for this study were:

1. Licensure as a pharmacist or a physician in Ontario for at least 3 years. Pharmacists must be working in community pharmacy practice a minimum of 20 hours/week. Physicians must be practising as family doctors a minimum of 20 hours/week.
2. Active patient-facing practice involving care of and contact with patients for at least 20 hours/week.
3. Practising within a setting where some form of communication and/or collaboration with the other health care professional (i.e., pharmacist or family physician) occurs regularly (i.e., written, verbal or other communication at least 5 times weekly).

Pharmacists working in family health teams were specifically excluded from this study, as the structure and organization of these teams is qualitatively different than more traditional community pharmacist–family physician relationships.[11] As a result, it was determined that family health team dynamics should be studied separately from this cohort.

This research was exploratory in nature; consequently, a qualitative research design was selected. A snowballing sampling technique was used, in which community pharmacists who initially participated in this study were invited to nominate family physician colleagues who they thought might be interested in participating. Initial recruitment focused on community pharmacists and was undertaken through recruitment flyers and word of mouth. Upon expressing interest in this study, information was provided to community pharmacists, who then were required to complete informed consent to participate. Upon conclusion of the interview with the community pharmacist, the interviewer asked for

nominations/recommendations for family physicians who might be interested in participating in this study. These family physicians were then contacted directly and invited to participate. Upon expressing interest in the study, information was then provided to the family physician, who was then required to complete informed consent in order to participate. Upon conclusion of the interview with the family physician, the interviewer asked for nominations/recommendations for other family physicians who might be interested in participating in this study.

A semi-structured telephone interview protocol was used to guide interactions with all participants (see Table 1 for sample questions and responses). To facilitate constant-comparative and iterative coding and data interpretation, one interviewer was used for all data gathering and 2 researchers independently reviewed all data and transcripts. Telephone interviews were audio-taped and verbatim transcripts produced. In addition, the interviewer maintained field notes. Transcripts and field notes were managed using NVivo v9. These data were then reviewed and coded by the 2 independent reviewers, who worked together to develop a consensus on themes and priorities emerging from the analysis. A third reviewer was available to address disagreements, but was not used. Each independent reviewer used a constant-comparison method for their analysis, the objective of which was to determine recurring patterns and underlying meanings and themes within the words used by participants, even when the specific phrases, terms or words used by participants was different.[12] The focus of this coding approach was to generate themes that could be confirmed through subsequent interviews. Interviewing was undertaken until saturation of themes was achieved.

Participants who completed the interview received a small gift card to acknowledge their time and contribution. This study was reviewed and approved by the University of Toronto's Research Ethics Board (REB).

RESULTS AND DISCUSSION

Initially, based on recruitment flyers and word of mouth, 20 pharmacists expressed interest in learning more about this study; after a one-on-one information session, a total of 11 pharmacists agreed to participate and completed informed consent procedures. These 11 pharmacists nominated 23 family physicians for participation in this study; in general, these were physicians who the pharmacists felt were collaborative, interprofessional and approachable. Of the 23 family physicians contacted, 11 responded that they were interested in learning more about this study. Following a one-on-one telephone-based information session, 8 family physicians agreed to participate in the interview and completed informed consent procedures. Demographics of study participants are presented in Table 2.

Selected example quotations (based on transcripts and field notes) from the semi-structured telephone interviews are included in Table 1. Three major themes were identified: 1) pharmacists demonstrate implicit trust of physicians based on their professional status/degree/role; 2) physicians do not demonstrate implicit trust of pharmacists simply based on their status/degree/role; 3) differences in psychological construct of trust between pharmacists and physicians may produce or exacerbate interprofessional tensions.

1. Pharmacists' cognitive model of trust

Pharmacists in this study generally expressed satisfaction and pride in working within a collaborative care environment. For most, such an environment represented the "pinnacle" of pharmacy practice, allowing optimal leveraging of knowledge and skills. In their descriptions of the family physicians with whom they worked, pharmacists consistently emphasized specific characteristics that were important in determining the nature/direction of a collaborative relationship: "intelligent/knowledgeable," "busy" and "confident." When describing specific situations or scenarios involving physician colleagues, they very rarely used the physician's first name; instead honorific titles such as "the doctor" or "Dr. XXX" were used in most descriptions.

In discussing the way in which trust was formed in their relationships with family physicians, pharmacists described a process that was characterized as "implicit." Externalities (such as positional authority, status in the health care hierarchy, academic qualification or professional designation) were given significant weighting in determining whether trust could be conferred. The simple fact that a family physician was an MD was (in and of itself) reason enough for most pharmacists in this study to determine that trust in decision-making and judgment should be conferred. As noted by one participant:

> *"Well, of course, why wouldn't you trust them? They're doctors, right, so they've proven themselves already."*

TABLE 1 - Interview guide and sample transcript excerpt responses

QUESTION	PHARMACIST RESPONSE	FAMILY PHYSICIAN RESPONSE
How would you describe the (physicians/pharmacists) you regularly work with?	"Very smart—very intelligent. Knows his stuff cold, which can be a bit intimidating." "Until I started working with them... well, I think it's really hard to understand just how much pressure physicians are under. I don't think I'd ever want to do that job." "It's really great working with Dr. X. He's incredibly knowledgeable—I always feel like I'm learning something new." "A bit intimidating, honestly. When you're working with someone who—well, just so intelligent—makes me always wonder, or question if I'm doing or saying the right thing you know?" "Super confident, actually. I don't know how they do it but they never—I don't know—they never let you seem them sweat anything, right? Always really calm and professional."	"Very nice, helpful." "I don't know what I'd do without (name of pharmacist)! She's great with the details I'm not so good with. Would trust her with my mother!" "Having (name of pharmacist) in the building has made a huge difference in terms of how we manage our patients with diabetes." "A real asset. (Name of pharmacist) keeps me—all of us—on our toes"
Before working with (the physician/pharmacist), what was your general impression of members of that profession?	"Cocky. A bit arrogant. Not really a team player." "Intimidating. Really hard to speak with because they are always too busy." "Top of the heap, I guess? You know, like the leader." "A ton of respect. I can't imagine a harder—or more important—job."	"To tell you the truth I wasn't really ever that impressed with pharmacists. They never really helped—just pointed out mistakes." "Fine. They do their jobs." "Not too much actually—my interactions were pretty limited." "Actually, the only time I ever talked to a pharmacist was when I made a mistake. Not the best way to build a relationship...."
How do you know you can trust (the physician/pharmacist)?	"Well, you just do, right? He's the doctor and—well, he's not god or anything—but still, you need to just trust their judgement or the whole thing falls apart." "Physicians as a whole are pretty reliable people and so you are—I don't know, raised to trust doctors?" "I haven't actually thought about it. I mean, if they're a doctor, well that's pretty tough so they must have proven themselves."	"I like to see how they respond to different situations, then I make up my mind about whether, how, to trust them" "It has to build over time, right? They have to prove themselves." "It can take a while. At the end of the day I have to make sure my patients get the best possible care, so you can't just trust anyone who walks in off the street." "You just know, after a while. You can tell if they're competent, committed, someone you want to rely on. You have to see them in action."
When you disagree with (the the pharmacist's/physician's) opinion or recommendation, how do you manage the disagreement?	"Well, you try to put forward your point of view, the evidence and then, of course it ultimately has to be up to the doctor." "I don't know that we actually ever disagree—maybe different ideas but we always try to discuss it and come to an agreement." "I wouldn't call it a disagreement—like it's not a conflict. More that usually the doctor knows something I may not and when we discuss it and I get all the facts, then it might make more sense."	"Ultimately, it's my responsibility, so while I appreciate an opinion, I have to make the final decision." "It's not a democracy—as the physician I have to be the one to make the decision, so—well, everyone recognizes we don't need to always agree on everything." "I don't say this out of disrespect but with pharmacists—not just pharmacists, but nurses, all the other allied health—they don't have the whole picture. The big picture. That's what physicians have so we need to rely on that."

QUESTION	PHARMACIST RESPONSE	FAMILY PHYSICIAN RESPONSE
How much do you trust the work, the judgment, the opinions of the (physician/ pharmacist)?	"Well, of course you trust them, why wouldn't you? Sometimes they may not know the right answer, but that's not an issue of trust." "They're experts in their areas, right? And we—well, pharmacists know about drugs so they should trust us about that." "You don't have much of a choice but to trust them, do you? How can I second-guess a diagnosis or a lab test result?"	"If it's in their specific area of expertise and I know that and they've proven themselves before, of course I'd trust that." "It's not that you don't trust them—it's just that, well, I need to be responsible and make the decision so give me the information and let me do my job." "In my experience pharmacists are pretty accurate and detailed and can get you the information you want. Many of them do seem hard pressed though to actually ever make a decision —they just want to give you information."
Have you experienced a situation where you feel your judgment or opinion wasn't trusted by (the physician/ pharmacist)? How did that feel to you?	"It's frustrating. You work hard, do the research, plan your approach. And then after 2 seconds the answer is no." "Makes you feel like—well, what's the point? It just seems unfair—I'm a well-qualified professional too. Are they even interested in what I have to say?" "I don't worry too much about it, or take it too personally." "It's sometimes easy to see why physicians get the bad reputation they have. You feel shut down, disrespected sometimes when you don't get the response you think you deserve."	"Um... no, I don't think so" "We haven't always agreed on everything but I don't think that has anything to do with trust." "I know (pharmacist name) doesn't always agree with my decisions and may get a bit upset but at the end of the day we all know it's each of us doing what we need to do for the sake of the patient." "Physicians are like this with other physicians too. I mean, who are the specialists I refer my patients to? People I know, have experience with, know they are competent—I would never refer my patient to a stranger just because that stranger had a certain background or degree or reputation. You need to know them as a person, as a specialist."
How is trust developed between physicians and pharmacists?	"One patient at a time. They need to see us prove ourselves to them before they can trust us." "I guess it takes time—though we seem to be more trusting of them than vice-versa." "When they know you are not out to get them, or prove them wrong, or step on their toes—that's when they will trust you."	"It has to be earned, that's what physicians are taught. It may make us look nasty or like bullies but we have to know—see with our own 2 eyes—what (the pharmacist) is capable of doing for us and our patients first." "I think there's—well, good will. An expectation that the pharmacist will do the best job he or she can. But that's different than trusting someone in a tough or complicated situation. Docs don't even do that with each other, why would we do that with a whole different profession?

Importantly, this implicit, conferred trust did not mean that there was blind faith in all decisions or in the accuracy of all prescriptions; instead, the trust conferred appeared to be focused on activities that were unique to medical practice and distinct from pharmacists' skill sets.

> *"I don't know anything about diagnosis of—oh, let's say R(heumatoid) A(rthritis). So of course if the doctor says it's RA, then it's RA, who am I to question that?"*

However, when the issue of prescribing errors or medication management arose, the construct of trust moved more towards the actual outcome:

> *"Well, it's my job, right? I'm supposed to make sure the doctor doesn't do anything that will harm the patient—or the doctor! I mean they're so busy, they can't know everything... this is my way of, you know, helping? I can keep my eye on the prescribing side so the doctor can manage everything else."*

As illustrated by the excerpt above, the pharmacists in this study still demonstrated implicit, conferred trust in terms of physicians' motives, intentions and competencies and instead framed the notion of error as something understandable, to be expected and something that they could "help" with, rather than representing a breach of competency resulting in reduction in trust.

TABLE 2 - Participant demographics

Demographic characteristic	Pharmacists (n = 11)	Family physicians (n = 8)
Age (mean and range)	33.2 years (27–62 years)	40.2 years (31–59 years)
Years in practice (mean and range)	9.1 years (2–40 years)	11.1 years (7–31 years)
Self-reported estimate of frequency of contact with other professional per week (mean and range)	13 times/week (5–25 times/week)	7 times/week (5–10 times/week)
Frequent reasons for contact	• Prescription clarification\ • Management of prescription error • Recommendation for alternative due to supply shortage issues or lack of insurance coverage	• Prescription clarification • Inventory/supply shortage management issues • Procedural/policy clarification (e.g., insurance coverage)
Frequent modes of contact	• Fax • Telephone • E-mail	• Telephone • Fax
Sex	64% female/36% male	50% female/50% male

Of interest, when asked to describe the reverse situation (i.e., when a pharmacist's recommendation was not valued or trusted by the family physician), pharmacists framed this issue as one of lack of reciprocation:

> *"I trust them to do their job—it's frustrating, okay, sometimes it feels almost like patronizing? —when you know they don't trust your recommendation just because they think, well, you're (air quotes) 'just a pharmacist'."*

This notion of a trust differential, one that is based upon professional designation rather than demonstrated competency, was a source of frustration to most pharmacists in this study, particularly because (based upon professional designation), pharmacists implicitly conferred trust on physicians, a trust that appeared unreciprocated and consequently made most participants feel underappreciated or undervalued.

2. Family physicians' cognitive model of trust

Family physicians in this study also generally expressed satisfaction with their relationships with pharmacists. In their descriptions of pharmacists, they emphasized several key attributes: "nice," "available," "helpful" and "keeps us on our toes." When describing specific situations or scenarios involving pharmacist colleagues they knew, the pharmacist's first name was always used (i.e., no honorific title was ever used to describe the pharmacist). In their descriptions regarding how trusting relationships were formed, physicians indicated the need for evidence, a track record of success or some kind of proof that the pharmacist was indeed trustworthy. Physicians in this study never commented on the role of academic preparation, previous experience or job title as a reason for trusting: instead, there was a strong emphasis on demonstration of competency—and first-hand observation of success—as the vehicle by which trust would be earned (rather than simply conferred due to professional qualification, title or standing).

> *"It's great to know the pharmacist has your back. You spend most of your time as a family doc... well, you know, the buck stops here, the buck stops with you, I mean me. So having someone to help you out, to keep an eye out, matters a lot. To be honest, there are lots of pharmacists I wouldn't ever say this about—a lot of them aren't very good—but XXXX is great."*

Previous experiences with pharmacists who weren't "very good" appeared as a common theme among family physicians in this study. Of interest, no pharmacists in this study ever brought up the issue of working with physicians who were "not very good."

> *"A lot of times, I don't even know what (pharmacists) actually do. But with XXX, it's different. She really knows her stuff and it's really helpful to me. When I*

was in school, or residency, I guess, the pharmacists in the hospital, yeah, they were great, a lot like XXX, really helpful, knowledgeable, always there. Until XXX, I don't think I'd seen that as a family doctor, though."

Physicians seldom framed this as an issue of trust, noting this was not only part of their professional socialization and culture, but similar to the way in which physicians relate to one another.

"I hope that doesn't make me sound... I don't know arrogant? I mean it's just the way we're trained, we don't just trust any random person with our patients. I don't care if it's a nurse, or another doctor or a pharmacist... We're taught, it's our socialization maybe, this is my patient, I'm responsible, you have to prove to me I can trust you with my patient."

The notion that a pharmacist may be considered "any random person" was not explored in further detail in this interview.

As illustrated by the excerpts above, the cognitive model of trust for family physicians in this study appears to emphasize evidence and value, with trust being "earned" rather than being "conferred" automatically due to professional designation, academic qualification or any other externality. Previous exposure to pharmacists with widely different skills may also adversely influence family physicians' general opinions of pharmacy as a profession.

3. Implications of differing cognitive models of trust on primary care collaboration

Pharmacists appeared to recognize they have a different cognitive model of trust than physicians, though this recognition did not necessarily mitigate frustration or negative feelings. Pharmacists indicated they entered interprofessional collaborative relationships ready, willing and able to collaborate, trusting physician colleagues implicitly and expecting the same in return. When this implicit trust was not returned—and worse, when it became apparent that for physicians, trust must be earned and is not simply conferred—this produced a range of emotional responses ranging from frustration to aggravation to resentment. Pharmacists noted that, while intellectually, they understood the need to continue to engage, to work diligently to "earn" this trust, the emotional response to this reality led them at times to feel (as noted by one pharmacist in this research) "...it wasn't actually worth the effort." The fundamental asymmetry in expectations of the relationship seemed "unfair" to some pharmacists and posed a short-term threat to the development of a long-term interpersonal or professional relationship. Pharmacists noted that the onus appeared to be on them to make the psychological accommodation to accept the physician model of trust rather than finding any sort of compromise.

The emotional experience of offering implicit/conferred trust to a physician and receiving only earned trust in return created a variety of tensions for pharmacists in the short term. Physicians in this study appeared unaware of this experience, while pharmacists in this study recognized it and noted that, with time, this trust was eventually earned and the relationship evolved into a collegial, collaborative and rewarding experience. For most pharmacists, this experience reinforced the hierarchical nature of health professionals' practice. Importantly, one physician in this study noted that this behaviour was not really an interprofessional issue: physicians "trust" other physicians in a similar earned manner, as evidenced by the referral patterns of family physicians to specialists.

These findings raise important issues with respect to the ideal of interprofessional collaboration in health care. Historically, such collaboration has been assumed to be an unquestioned benefit. In creating interprofessional collaboration in primary care, governments and policy makers have emphasized structural and financial incentives to move family physicians into more collaborative practice settings. The psychological facets of collaboration have been generally overlooked; there has been an implicit assumption that well-intentioned, clever people (like pharmacists and family physicians) could simply figure out how to work with one another in a collaborative setting. The literature has been generally silent on the issue of psychological readiness for collaboration between pharmacists and family physicians. Instead, much of this literature has focused on tools, structures, incentives and processes, rather than the underlying interpersonal dynamics that govern interactions between human beings.

This study has revealed an interesting discrepancy between community pharmacists and family physicians in the cognitive or mental maps governing "trust." As human beings, we recognize that the somewhat amorphous concept of "trust" underlies much of our day-to-day life. Without trust,

interpersonal, family, employment and virtually all other kinds of relationships simply cannot function—or if they do function, they do so in such a laborious and inefficient manner as to become worthless. The complex, high-stakes nature of primary care is an environment where trust must also undergird relationships. If "trust" means different things to different professionals, how is this negotiated and how does it affect the quality and extent of collaboration and teamwork? If pharmacists and family physicians are entering collaborative health care team settings with very different and unarticulated mental models of what trust is and how it is developed, there is a strong likelihood of misunderstanding, hurt feelings and resentments. In general, well-intentioned human beings treat others the way they expect to be treated in return. As the pharmacists in this study noted, the lack of reciprocated implicit/conferred trust can in the short term heighten interprofessional tension and, at its worst, can undermine formation of collaborative relationships.

There is no "right" way to form interprofessional relationships; as with interpersonal relationships, inteprofessional relationships are a function of many different factors starting with simple chemistry. If, however, pharmacists' expectations regarding a fundamental principle such as what "trust" means are not reciprocated, this can lead to internalized resentment, disengagement and frustration. Conversely (and similarly), if physicians' behaviours are labeled as "wrong," "arrogant" or "intimidating," when this is simply their mental model for trust, this can lead to dismissiveness, disengagement and disinterest in further collaboration. There is no one or right way to "trust": instead, it is important that those who are collaborating understand and respect the different ways in which trust is conceptualized and defined by individuals with different professional backgrounds and experiences (Box 1).

It is important to consider the generalizability of these findings to other contexts or jurisdictions. As Sztompka has noted,3 there are unique and important cultural and local factors that are important in understanding trust. Interestingly, there is virtually no published literature that has attempted to characterize trust (as a psychological construct) within interprofessional relationships in primary care or health care generally, despite an abundance of casual or off-handed references to the centrality of trust to effective care provision. There appears to be a tacit assumption that health care professionals have both a common understanding and agreed upon operational definition of what trust actually means and looks like in daily practice. This research provides a useful initial contribution to this literature and does not purport to generalizability beyond its local context and culture. The number of participants was relatively small (though satura-

BOX 1 - Tips for pharmacists to help develop trusting relationships

- Understanding the cognitive model of "trust" for physicians can help you manage expectations for pharmacist-physician collaboration.
- Trust will take time to develop: learning to be patient and allow an interpersonal, rather than interprofessional, relationship to form first is necessary.
- Physicians need to know pharmacists by name, not just by role or location, in order to trust them.
- Do not interpret disagreement with your suggestions as disrespect for your professional autonomy or expertise.
- When the trust you freely confer to physicians isn't immediately reciprocated, don't disconnect and assume it will never happen. Continue to offer your skills and knowledge and allow trust to develop with your successes.

tion of themes was achieved) and the snowballing technique used to identify participants means these participants were not representative of the general population of pharmacists and physicians. For convenience purposes, participants were all from the Greater Toronto Area and therefore not necessarily representative of either Ontario or Canada. While independent double coding of transcripts was used to enhance analytical rigour, no member checking (or verification) with participants themselves was possible due to logistical constraints. The snowballing sampling method used in this research is likely to have resulted in recruitment of participants (particularly physicians) who had already established trusting interpersonal relationships with pharmacists. Methods for recruiting participants who did not have such relationships and examining the issue of trust from the perspective of those practitioners is an important next step in this research project.

Replication of this method in other contexts and jurisdictions would provide a useful way of validating these themes and building the literature in this area. Use of alternative research techniques that blend more observational/ethnographic methods with reflective/interviewing methods could further enhance the rigour of this work, though the logistics associated with such research would be challenging. The importance of trust as a foundation for collaboration, while somewhat self-evident and clear, requires further examination to understand how it is operationalized at the interpersonal and interprofessional level to support and enhance organizational development and quality improvement.

CONCLUSIONS

Interprofessional relationships, like interpersonal ones, are complex and subject to considerable ebbs and flows. Much of the interprofessional literature conceptualizes interprofessional relationships in somewhat bloodless terms, not recognizing the nuances and contradictions that are inherent any time human beings interact with one another. This study has highlighted the different ways in which pharmacists and family physicians may conceive of "trust" and the implications of these differences for collaboration and teamwork. PC

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What we Heard During Consultation

The College recently asked for feedback regarding the proposed changes to the Pharmacy Act (Administration of Vaccines by Pharmacists). The consultation was posted for sixty days and closed on May 29, 2016. We received and considered comments and questions from both practitioners and members of the general public. Below are some of the common questions that we received.

1. ***What is the rationale for the proposed list or need to restrict the scope of vaccination administration?***

The authority proposed in the amendments aligns with the current provincial regulatory approach and framework for developing regulations. The College will work in collaboration with stakeholders and the Ministry to inform an evaluation of the impact realized by expanding pharmacist vaccination administration. The results of this evaluation will be used to guide further discussions regarding the pharmacist's role in vaccinations.

2. ***Will pharmacists be able to prescribe vaccinations?***

The Regulation amendments do not authorize pharmacist prescribing of vaccinations. Patients would still be required to obtain a prescription from an authorized prescriber before a pharmacist could administer a Schedule I vaccination. For Schedule II vaccinations, where a pharmacist determines that the vaccination would be appropriate for a patient, a prescription is not required to administer the vaccination.

3. ***Will students and interns be authorized to administer vaccinations?***

Yes, the proposed regulations allow pharmacy students and interns to administer any vaccination under the supervision of a Part A pharmacist whose responsibility would be to confirm the student or intern has the knowledge, skills and abilities to administer the vaccine.

Students and interns receive training on the administration of injections as part of the pharmacy curriculum, and once training is completed have the same technical skill set and capabilities as a pharmacist. A student or intern is professionally liable for any controlled act he or she performs. Students and interns are required to have professional liability insurance in order to registered with the College and perform controlled acts.

4. ***Will pharmacists require mandatory training to administer specialty travel vaccinations?***

Pharmacists are already required, as a standard of practice, to review prescriptions for appropriateness and educate patients when dispensing a medication, including vaccinations. Pharmacists have the technical skills and training to administer the proposed vaccinations. It is the professional responsibility of the member to ensure they have the appropriate knowledge, skills and abilities to safely and effectively provide the service (e.g. travel vaccinations).

5. ***Many of the vaccinations included will not be routinely stocked in most pharmacies. Will pharmacist administration of vaccinations improve patient access where the vaccination is not available in the pharmacy?***

The Regulation amendments, if passed, would make these vaccinations more convenient and accessible for patients. Increasing the number of vaccinations pharmacists may administer reduces:

- the need for patients to make multiple trips between a physician's office or clinic and a pharmacy; and
- the risks associated with improper medication storage during transport between the pharmacy and physician's office or clinic.

Where a pharmacy does not have a vaccination in stock and the patient is required to make a return trip to the pharmacy for administration, the patient will still benefit from having access to a location with extended hours of operation and weekend availability.

6. ***How can patients ensure that their records will be appropriately updated when receiving a vaccination by a pharmacist?***

The regulations require that pharmacists notify the primary care provider, if any, when a vaccination is administered; therefore concerns about updating patient records are already addressed.

7. ***How will pharmacists be reimbursed for this service and how will this service be integrated into current pharmacy operations?***

Decisions regarding funding and workflow strategies to accommodate a potential increase in the volume of vaccine administration are outside of the scope proposed regulations and the mandate of the College. Any complaints brought forward to the College related to a concern about the safety of vaccine administration in a pharmacy would be investigated.

The Code of Ethics requires that members maintain appropriate human resources to facilitate compliance with Standards of Practice and relevant legislation, policies and guidelines governing the practice of pharmacy. Members also must ensure the operation of pharmacies support professional performance and that the health of others in the work place is not compromised.

NEXT STEPS

College Council approved the proposed regulations at their June 13, 2016 meeting. The regulations have been submitted to government for final consideration and ultimate proclamation.

Members Emeritus

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

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

A MULTI-INCIDENT ANALYSIS BY ISMP CANADA

Insulin Medication Incidents in the Community

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OVERVIEW

Insulin is a life-saving pharmacological therapy used in the management of blood glucose in patients with Type I diabetes (who are insulin deficient) and patients with Type II diabetes whose blood sugar levels are not well-managed with oral anti-hyperglycemic agents alone. There is a multitude of different insulin products available on the market. Insulin may be administered by a syringe, pen, or pump and there are various insulin preparations including rapid-acting, short-acting, long-acting and pre-mixed. Although insulin use is integral to diabetes management, it can be harmful when used incorrectly. Insulin has been identified as a high-alert medication in the community setting.[1] An excessive dose of insulin may cause life-threatening seizures and coma (via hypoglycemia); conversely, an under-dose of insulin may lead to life-threatening ketoacidosis or hyperosmolality (via hyperglycemia). In 2006, ISMP Canada identified insulin as one of the top 10 medications reported as causing harm as a consequence of medication error.[2] ISMP Canada has also identified insulin as one of the top three prescription medication classes involved in medication incident related deaths occurring outside regulated healthcare facilities[3] and furthermore as one of the top five medications involved in medication incidents associated with death occurring in all environments.[4]

This article provides an overview of a multi-incident analysis of medication incidents involving insulin voluntarily reported to the ISMP Canada's Community Pharmacy Incident Reporting (CPhIR) program (http://www.cphir.ca). The following sections contain an overview of the reported medication incidents and highlight the common themes identified through a multi-incident analysis. Specific examples of reported incidents are provided for you to reflect and develop system-based improvements that can be customized to your practice setting.

MULTI-INCIDENT ANALYSIS OF INSULIN MEDICATION INCIDENTS

Reports of medication incidents involving insulin were extracted from the CPhIR program between January and December 2014. A total of 226 incidents were retrieved and 81 met inclusion criteria and were included in this qualitative, multi-incident analysis. The 81 medication incidents were reviewed by an ISMP Canada Analyst and categorized into four main themes (Table 1). (Note: Incident examples provided in Tables 2 to 5 were limited to what was inputted by pharmacy practitioners to the "Incident Description" field of the CPhIR program.)

TABLE 1: Main Themes and Subthemes from the Multi-Incident Analysis of Insulin Medication Incidents

MAIN THEMES	SUBTHEMES
Product Selection (related to unique insulin properties)	Prescribing Order Entry Dispensing
Therapeutic Regimen Change	
Dosage Calculations	
Storage Requirements	

TABLE 2: Theme 1 - Product Selection (related to unique insulin properties)

Incident Example	Possible Contributing Factors	Commentary
Subtheme 1: Prescribing		
A number of weeks back, she went to the doctor who asked her what insulin she was on and she told her the new one that starts with an L. The doctor assumed Lantus®, but it was Levemir®	• Multiple formulations of same insulin type • Look-alike, sound-alike drug names • Knowledge deficit on drug names • Confirmation bias	• Physicians should consider asking patients for a current and comprehensive medication list before prescribing new medication(s) or re-ordering refill of current medication(s).
Subtheme 2: Order Entry		
Upon checking to see if [the] patient required any further prescriptions filled, [the pharmacist] noticed that the dose of the Humulin® N had "changed" to what the directions of the Humulin® R used to be. Upon further inspection, pharmacist noticed that no dose change was supposed to occur and the person who entered inadvertently entered the wrong type of insulin into the prescription.	• Look-alike, sound-alike drug names • Patient concurrently using multiple insulin products • Lack of independent double checks • Confirmation bias	• Incorporate warning flags in pharmacy software to alert for potential mix-up during insulin selection at pharmacy order entry. [5, 7] • Perform independent double checks throughout the entire pharmacy workflow. This may include verification with the patient regarding the current insulin product(s) being used at drop off. [5, 8] • Highlight information related to look-alike/sound-alike insulin products as a part of pharmacy staff training. [5, 9]
Subtheme 3: Dispensing		
The patient noticed his insulin box was different than what he had before. He should have received Novolin® ge NPH and had been given Novolin® ge 30/70 in error.	• Look-alike, sound-alike packaging • Proximity of storage of look-alike/sound-alike insulin products • Lack of independent double checks • Environmental distractions • Confirmation bias	• Implement auxiliary alerts (e.g. labels or stickers) regarding look-alike/sound-alike drug pairs on insulin storage bins. [5] • Perform independent double checks throughout the entire pharmacy workflow. When a patient picks up his/her insulin, include a physical review (i.e. packages, labels, insulin product) as they are provided to the patient. [5, 8, 10] • Organize the pharmacy environment to create a safe and efficient working area. For instance, segregate insulin products by storing them according to their onset of action (i.e. rapid-acting, short-acting, intermediate-acting, long-acting), rather than by brand, in well-differentiated areas of the refrigerator (e.g. on different shelves) [5, 9, 10] • Instruct patients and their family members to ask questions if they notice any unexpected changes in either the insulin packaging or product at the time of receiving the medication or at any other time. [10]

TABLE 3: Theme 2 - Therapeutic Regimen Change

Incident Example	Possible Contributing Factors	Commentary
Prescription had specific instructions for use and was copied over by an old one with just "use as directed" on it. Direction was kept as before but there was a change in directions on the prescription, from 48 to 44 units.	• Copying previous prescriptions • Lack of independent double checks • Confirmation bias	• Consider programming the pharmacy software or developing policies to restrict the process of copying from previous prescriptions for all insulin prescriptions (or high-alert medications) to prevent confirmation bias at order entry. [5] • Perform independent double checks throughout the entire pharmacy workflow. For example, during order entry or pick-up, verify with patient the most current prescription orders and directions from the prescriber. • Encourage patients to actively participate in a dialogues with the pharmacist when providing medication counselling (i.e. confirm appearance of medication, directions for use and appropriate technique for administration). [5, 6, 8]
Instructions were to stop Lantus®, and glyburide, and to start NovoMix® 30. The drugs were inactivated on the client's profile but the change to [the glyburide] prescription was not given to the blister pack department.	• Lack of communication between pharmacy staff members • Lack of independent double checks	• Develop a system for communication with respect to patient medication therapy changes/updates within the pharmacy (e.g. when a patient's regimen changes or if patient is admitted to hospital, etc.) for multi-medication compliance aids. • Perform independent double checks throughout the entire pharmacy workflow. [5, 6, 8] For example, when filling compliance packs, verify printed prescription labels with patient's most current prescription orders. • Consider performing a comprehensive diabetes-focused medication review when a patient has a significant change in insulin therapy (e.g. addition of insulin, switching to a new insulin formulation) to ensure adequate communication of patient's regimen between the patient and pharmacist. Pharmacist should also communicate and update the patient profile accordingly, so that other pharmacy staff members are aware of the changes.

TABLE 4: Theme 3 - Dosage Calculations

Incident Example	Possible Contributing Factors	Commentary
Poor physician handwriting. Entered as "Use 4 mLs before supper." Should be "Use 4 UNITS before supper. Prescription for 4-10 units of insulin a day x 90 days [was] entered as 45 mLs [as the total quantity dispensed]. Only 15 mLs were required.	• Knowledge deficit on insulin dosing units • Illegible handwriting on prescription	• Physicians should consider using standardized pre-printed order forms to avoid insulin unit related dosing and calculation errors. [5, 6] • Prescribers are encouraged to write all insulin orders in units instead of millilitres (mL) and to spell out "units" rather than writing "U". [11, 12]
Refill came up as early refill. Wrong days' supply was put on original [prescription].	• Knowledge deficit on conversion from insulin units to millilitres and total number of days' supply	• Develop policies for pharmacy staff to document handwritten calculations for insulin quantity during order entry and again by a different staff member during the dispensing process as an independent double check to enhance accuracy. [13] • Highlight information related to insulin dosing calculations (e.g. conversion from insulin units to millilitres) as a part of pharmacy staff training.
Doctor ordered insulin syringes for up to 100 units, [but] we filled for 1/2 cc (up to 50 units) [syringes].	• Variety of syringe sizes available	• Highlight information related to insulin syringe sizes as a part of pharmacy staff training.

TABLE 5: Theme 4 - Storage Requirements

Incident Example	Possible Contributing Factors	Commentary
The prescription was entered early morning, [the] pharmacist [saw the] patient walking in assuming [the] patient was in to pick up prescription. Patient walked around the store, said she would return, and [the] insulin was put in the drawer instead of the fridge.	• Environmental distractions • Confirmation bias	• Develop or reinforce existing policies and procedures with regards to dispensing refrigerated products. Refrigerated products should always be returned to the fridge immediately after filling (i.e. even if the patient says they are returning soon).

CONCLUSION

Medication incidents involving insulin in the community setting are common and have the potential to cause detrimental harm. Due to the unique characteristics of insulin, there are distinctive insulin-related medication incidents that occur in community pharmacy practice. The results of this multi-incident analysis are intended to educate health care professionals on the vulnerabilities that contribute to these insulin-specific medication incidents. Key points of focus include correct insulin product selection, limiting errors when insulin regimens are changed, proper calculation of insulin doses and adequate storage of insulin products. Pc

ACKNOWLEDGEMENT

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Delivering pharmacy services is a complex, human process. Communication and transparency are essential as pharmacy compensation mechanisms adapt to support the provision of professional services that are not directly linked to dispensing a prescribed medication. "Close-Up on Complaints" presents some of the challenges that can arise when charging a fee for professional services so that practitioners can use them as learning opportunities.

Ideally, pharmacists and pharmacy technicians will be able to identify areas of potential concern within their own practice, and plan and implement measures to help avoid similar incidents from occurring in the future.

Ethical Consideration and Clear and Transparent Communication Key when Offering Professional Pharmacy Services

Have a Complaint?

Anyone who is not satisfied with the care of services provided by a pharmacy, pharmacist, pharmacy technician, student or intern can file a formal complaint with the College. Complaints must be received in writing and include as much detail as possible. The College investigates all written complaints.

SUMMARY OF THE INCIDENT

This incident occurred when a patient from a retirement residence tried to have his prescriptions transferred. The pharmacist from the new pharmacy called to have the prescriptions transferred on behalf of the patient. He was told by the transferring pharmacy that they would have to check with the nurse at the retirement residence and speak to the patient themselves before they could do anything.

The patient then called the pharmacy himself and asked the pharmacist to transfer his medications. Initially he was told the transfer would be completed immediately, but when he checked with the new pharmacy an hour so later they had still not received the transfer.

The pharmacist from the new pharmacy then made a second call to the transferring pharmacy and was told that no one had requested a transfer for the patient. Frustrated and confused by this response the patient again intervened with a call to the pharmacy and was now told that he had to pay a $100 fee before the transfer could be completed. The patient refused to agree to the charge, claiming he was unaware that such a fee was required, and insisted that the pharmacy transfer his prescription immediately.

Later in the day the patient placed a third call to the transferring pharmacy to inquire about the status

of transfer. The transfer had still not been done and the patient was now informed that he had to submit a signed request, including proof of his identity, in order for his prescriptions to be transferred. The patient complied with the request and was subsequently asked to fax his Social Insurance Number as additional proof of identity.

After many hours, and multiple phone calls, an incomplete profile of the patient's prescriptions was transferred to the new pharmacy. Eventually, the patient's physician had to intervene with a telephone call to the transferring pharmacy on the patient's behalf in order to finally get the transfer completed.

WHY DID THIS HAPPEN?

In reading the summary of this incident it is obvious that the pharmacist and his staff at the transferring pharmacy did not respond to the patient's request for a transfer in a professional and collaborative manner. Their lack of cooperation resulted in both the patient and new pharmacist having to make multiple phone calls to the pharmacy before the transfer was completed. The pharmacy also requested information from the patient at multiple stages of the process further frustrating and confusing the patient and ultimately delaying the transfer.

COMPLAINT OUTCOME

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

ADVICE/ RECOMMENDATION

Advice/recommendations allow an opportunity for practitioners to improve conduct or care.

Advice/Recommendation is issued as a remedial measure for matters which are not serious in nature and are considered to pose low risk of harm to the public.

In considering this case the Committee noted that pharmacists and pharmacy technicians have specific obligations under the Code of Ethics and Standards of Practice to respect a patient's choice of pharmacy and transfer prescriptions in a timely manner.

The Committee found that in this case the pharmacist did not have firmly established and communicated professional and ethical processes in place to ensure the safe and timely transfer of prescriptions requested by patients.

The Committee issued advice and recommendations to the pharmacist to enhance adherence to established practice and conduct expectations relating to prescription transfers.

LEARNING FOR PRACTITIONERS

Reflecting on this complaint provides practitioners a number of learning opportunities to help improve the delivery of patient-centred care.

This incident could have been avoided (or at least de-escalated) by improved transparency to patients regarding the cost for pharmacy services and clearly establishing and communicating a professional and ethical process for transferring prescriptions.

Ethical Consideration

Pharmacy professionals are responsible for demonstrating professionalism and applying ethical principles in their daily work. The primary focus at all times during patient care must be the well-being and best interests of the patient.

One of the fundamental principles of healthcare ethics outlined in the Code of Ethics is Respect for Persons. This principle refers to our obligation, as healthcare professionals, to honour the intrinsic worth and dignity of every patient. There are many ways that practitioners demonstrate their commitment to this principle including respecting patient's autonomy to make their own informed decisions about their healthcare.

As clearly outlined in standard 3.9 of the Code pharmacists and pharmacy technicians must – respect the patient's right to choose a pharmacy and/or pharmacy professional and facilitate the patient's wish to change or transfer pharmacy care and services as requested.

Timely transfers are a matter of courtesy and respect for a patient's choice of pharmacy. In this case, the pharmacy took many hours to provide

an incomplete transfer of the patient's prescriptions and requested that the patient provide information at multiple points during the process. Pharmacy professionals should ensure that any personal information they request from a patient is required to provide the professional service.

Clear and Transparent Communication

With respect to clear and transparent communication the first issue in this case occurred when the patient initially brought a prescription to his original pharmacy and was not informed in a clear and transparent manner about the fees required for prescription transfers. Although pharmacies have the right to charge for professional services, as outlined in the Code (standard 4.23), any fees charged must be transparent.

Additional guidance is provided in the College's Policy – Fees for Professional Pharmacy Services – which states that all fees must be communicated to patients in advance of the provision of the service or product, readily accessible to patients and fair and reasonable. In addition, the patient's consent to payment must be received prior to the service being delivered.

Pharmacy professionals must respect the patient's right to choose a pharmacy and/or pharmacy professional.

The pharmacist or pharmacy technician in this case should have informed the patient about the prescription transfer fee so that the patient could make an informed decision about whether to receive services from that pharmacy before the first time dispensing.

The transferring pharmacy should have also clearly communicated the requirements and process for transferring a prescription during the initial phone call with the patient. The patient also should have been informed of the time required to complete the transfer. This would have avoided the need for multiple phone calls and requests for additional information, and the patient would not have been concerned about the status of the transfer.

Appropriate Policies and Procedures

A final contributing factor to this incident was the absence of appropriate policies and procedures for providing prescription transfers. In all community pharmacies the designated manager is responsible for ensuring that the pharmacy has appropriate policies and procedures in place to support pharmacy professionals in practicing to the Standards.

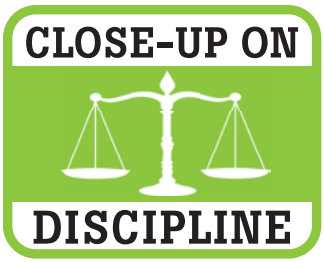
For example, procedures to ensure that all staff engages in appropriate processes for reviewing a patient's medication history to determine what prescriptions need to be transferred, recognizing pertinent information that should be communicated to the receiving pharmacy, and providing transfers in a courteous and timely manner. The policies should clearly outline what information is required from the patient to provide a transfer.

In the end however, all practitioners are individually responsible and held accountable to practice to the Standards of Practice and the Code of Ethics to ensure the safe, effective and ethical delivery of pharmacy services.. Pc

PRACTICE TIP!

When thinking about narcotics reconciliation, manual and computer records are not error proof – while helpful, they can provide incomplete or incorrect data.
http://www.ocpinfo.com/practice-education/practice-tools/fact-sheets/recon-security/

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



One of the tasks of the Discipline Committee is to hear allegations of professional misconduct that have been referred by the Inquiries, Complaints or Reports Committee. Sexual abuse of a patient is one of the types of alleged professional misconduct that the Discipline Committee deals with.

"Close Up on Discipline" presents some of the issues that arise in hearings before the Discipline Committee. Ideally, pharmacists and pharmacy technicians will review the learnings that flow from the decisions of the Discipline Committee and incorporate those learnings into their own practice.

It can be helpful to understand the legislation that underpins the allegations made in a particular case, as well as the decision of the Discipline Committee regarding the allegations made.

THE LEGISLATION

Sexual abuse of a patient is defined as professional misconduct in section 51(1)(b.1) of the *Health Professions Procedural Code*, which is Schedule 2 of the *Regulated Health Professions Act, 1991*. Section 51(5) of the Code sets out that if a Panel finds that a member has committed sexual abuse of a patient, the Panel shall do the following (in addition to anything else it may do under subsection 51(2)):

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
   - i. sexual intercourse,
   - ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
   - iii. masturbation of the member by, or in the presence of, the patient,
   - iv. masturbation of the patient by the member,
   - v. encouragement of the patient by the member to masturbate in the presence of the member.

THE DECISION OF THE DISCIPLINE COMMITTEE

In a case before the Panel of the Discipline Committee, the College alleged that a Member engaged in the following acts with the patient:

- sexual intercourse and/or
- other forms of physical sexual relations and/or
- touching of a sexual nature and/or
- behavior or remarks of a sexual nature

In a hearing before a Panel of the Discipline Committee, the sexual relationship was admitted, but whether the sexual relationship and the pharmacist-patient relationship happened at the same time was contested. In the end, the Panel decided that this crucial connection had not been proven. The Panel made no finding of professional misconduct against the Member.

In its decision, the Panel also commented that the relationship, while not amounting to sexual abuse of a patient, was inappropriate, if not unprofessional. The Panel further expressed its view that knowledge of the prohibition of sexual relationships with patients is something that ought to be known to pharmacists, and that such knowledge is, in fact, an obligation for pharmacists.

COMMENTARY AND LEARNING FOR PRACTITIONERS

In a therapeutic relationship, it is the pharmacist's responsibility to establish and maintain appropriate boundaries. Pharmacists have a fiduciary duty to their patients to protect the elements of the therapeutic relationship, and to not exploit or violate the trust a patient places on the pharmacist. Members of the College must be knowledgeable about the law, the ethical principles guiding their conduct, and any applicable policies or guidelines, to ensure that therapeutic relationships are both appropriate and professional.

The College has communicated the relevant legislation and guidelines regarding sexual abuse and sexual harassment to the membership. This information is available on the College's website at http://www.ocpinfo.com/regulations-standards/policies-guidelines/boundaries/.

Members of the College must ensure that they understand the boundaries that apply to relationships with patients and take proactive steps to maintain those boundaries. Crossing boundaries or inappropriate/unprofessional behaviour towards a patient by a member of the College may result in the College taking appropriate action to protect the public. Pc

Gaps in Transition: Management of Intravenous Vancomycin Therapy in the Home and Community Settings

- *All patients needing continuation of parenteral medications (via infusion or injection) outside the hospital must have an assessment prior to discharge that includes the following elements:*
  - *reviewing the prescribed treatment to confirm that oral alternatives (or alternatives that do not require laboratory monitoring) are NOT available/appropriate*
  - *determining the feasibility/safety of carrying out the treatment and care plans*
  - *communicating the treatment and care plans to community providers and patients/caregivers*
  - *scheduling all necessary follow-up tests and appointments*
  - *educating the patients/caregivers on the signs, symptoms, and concerns to report and/or act on*
- *Together, hospitals and regional health authorities should create appropriate infrastructure to support safe medication management plans in the home and community settings.*

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As a result of changes in healthcare delivery, patients are increasingly receiving medical treatment in the home and community setting, instead of as inpatients in a hospital. Patients receiving prolonged parenteral antibiotic therapy are among potential suitable candidates to continue treatment outside the hospital setting. However, outpatient management of these individuals, particularly those receiving antibiotics that require therapeutic drug and adverse effect monitoring (e.g., aminoglycosides, vancomycin) can pose serious safety concerns. As part of an ongoing collaboration with a provincial death investigation service, ISMP Canada received a report of the death of an individual who was being treated at home with parenteral vancomycin. This safety bulletin focuses on the potential for serious harm to patients, as well as the challenges faced by practitioners, when antimicrobial therapy requiring therapeutic drug monitoring (TDM) is delivered in the community at home.

MEDICATION INCIDENT

An adult with type 2 diabetes mellitus was admitted to hospital for treatment of a persistent diabetic foot infection. Treatment was initiated with intravenous (IV) vancomycin, oral ciprofloxacin, and metronidazole. The patient remained in hospital for more than 1 week, during which time his serum creatinine was stable and serum trough levels of vancomycin were monitored to achieve a target level of 15–20 mg/L. Upon discharge, the patient's serum creatinine was within the normal range, and the serum trough level of vancomycin was 20 mg/L. Medications to be continued at home included ramipril and hydrochlorothiazide. Weekly monitoring of serum vancomycin was ordered, beginning 3 days after discharge. However, no blood samples for vancomycin monitoring were drawn after he returned home, mainly because of an incomplete laboratory requisition.

By the fourth day after discharge, the patient noticed a rash on his body, which prompted him to go to

the emergency department. Laboratory testing showed significantly increased serum creatinine, thrombocytopenia, and random (not trough) vancomycin level almost 4 times the level at discharge. It is unknown when the most recent vancomycin dose had been administered. The vancomycin was held, as were ramipril and hydrochlorothiazide. The patient was admitted and was given IV fluids and platelet transfusions, but there was no improvement in serum creatinine or platelet count. Two days after the readmission, the patient became hypertensive, and an episode of epistaxis occurred, along with mental status changes that progressed to obtundation. Urgent computed tomography of the brain revealed acute intracerebral hemorrhage, and the patient was transferred to intensive care. In light of his condition and prognosis, care was withdrawn, and the patient died.

BACKGROUND

Diabetic foot infections represent a common clinical problem that ranges in severity from mild infection of the skin and subcutaneous tissue, through more serious infection of deeper structures causing osteomyelitis, to severe infection leading to sepsis.[1] Antibiotics are invariably part of the treatment regimen for these infections, and long-term therapy may require administration of these drugs outside the acute care setting.[1,2]

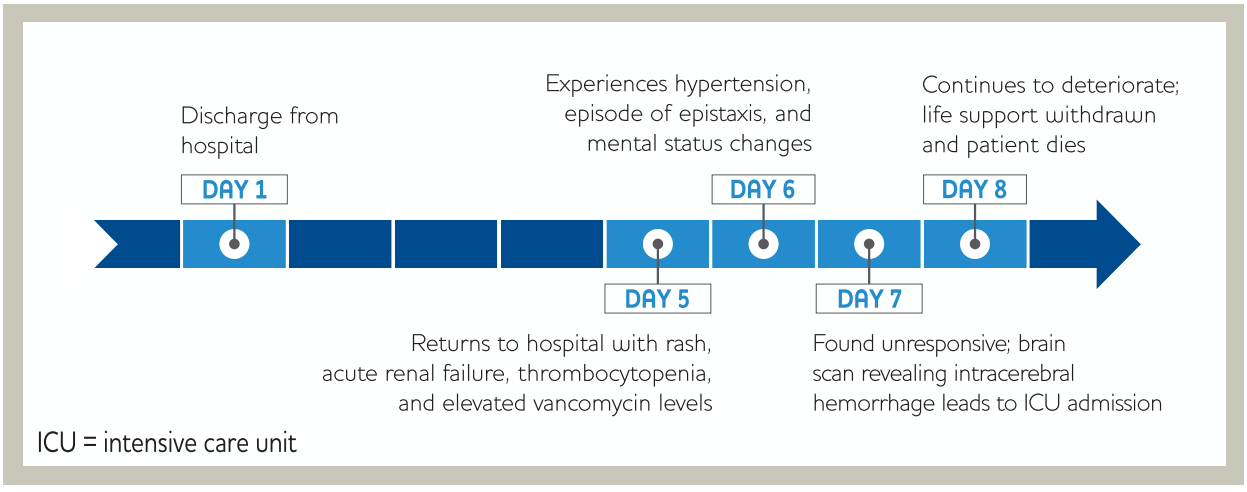
Vancomycin is one of many parenteral antibiotics prescribed in the home and community settings to manage diabetic foot infections. For complicated infections, high serum trough levels of vancomycin (i.e., 15–20 mg/L) are recommended to improve penetration into the infected tissues and to achieve optimal concentrations and clinical outcomes.[3,4] However, higher daily doses and elevated target trough levels increase the risk of vancomycin-induced kidney injury, especially if concomitant nephrotoxins (such as aminoglycosides) are being administered.[5,6] As a result, timely TDM is important, both to ensure adequate concentrations for therapeutic intent and to prevent adverse drug events such as nephrotoxicity.

Perhaps less well appreciated is that vancomycin may cause substantial thrombocytopenia via vancomycin-dependent platelet-reactive antibodies.[7] This adverse effect, which can be severe and refractory to platelet transfusion, often resolves after drug cessation, although recovery can take longer for patients with renal failure.[7]

DISCUSSION

This case highlights the potential for harm associated with delivery of IV antimicrobial therapy in the home and community settings to patients who require TDM. Safe administration of IV vancomycin outside the hospital can be complicated. The timing of drawing blood samples is critical. Accurate interpretation of trough levels may necessitate additional bloodwork (e.g., potassium and creatinine levels), and urgent admission to acute care may be required. Planning for outpatient testing of serum vancomycin levels alone is insufficient. Follow-up must be assigned to monitor test results and to develop an appropriate action plan based on the findings. In the case described here, the patient experienced acute kidney injury within a few days of discharge, despite stable creatinine levels during the initial hospital stay. Monitoring of vancomycin levels might not have prevented this injury; however, earlier detection of elevated levels might have mitigated the

FIGURE 1: Timeline of events from the patient's initial hospital discharge to his death. ICU = intensive care unit.



harm. Whether earlier detection would have prevented the severe thrombocytopenia that led to fatal intracranial bleeding is unknown. ISMP Canada has received reports of other incidents in which poor infrastructure for outpatient monitoring of drug levels and subsequent management of test results have placed patients at risk.

RECOMMENDATIONS

The following recommendations are offered for the safe administration of IV vancomycin in the home and community settings; these recommendations are generally applicable for other parenteral medications requiring TDM.

Regional Health Authorities and Home and Community Organizations

- Review existing systems for management of IV medications in the home and community settings.
- For patients discharged on home infusion therapy, provide a nursing assessment within 24 hours after discharge from hospital, including a review of all discharge orders (e.g., medications and any required monitoring).
- Provide appropriate supports and processes (agreed upon by all care providers) to ensure:
  - o blood samples will be drawn at appropriate times/frequency following discharge and drug levels will be reported to, interpreted by, and acted upon (in a timely fashion) by individuals on the healthcare team with clearly assigned responsibilities for follow-up; and
  - o medication administration schedules can be altered appropriately, according to clinical and/or laboratory evidence.

Hospitals and Discharge Planners

- Ensure that, before leaving the hospital, every patient who is to be cared for in the home and community settings has bloodwork scheduled, understands the importance of this bloodwork, and is able to have it done. The Hospital to Home: Facilitating Medication Safety at Transitions Toolkit and Checklist identifies this requirement and can be used to support the transition process.
- Enlist hospital pharmacists, particularly those involved in TDM, to support the transition and to relay information to the next care provider (e.g., infusion pharmacy provider, family physician). The hospital pharmacist should link the infusion pharmacy provider and the patient's community pharmacist to strengthen the communication between these partners.
- Educate and inform patients about situations that require prompt medical attention, such as infusion reactions and adverse effects.

Prescribers

- Review the discharge treatment plan to determine whether oral alternatives (or IV alternatives that do not require TDM) can be prescribed.
- Determine that outpatient therapy is safe and feasible for both the patient and the care team. For patients residing in areas with limited services, the prescriber should confirm that the community and home sector is able to support TDM. This includes addressing scenarios that will require prompt action, such as abnormal serum levels and severe adverse reactions. IV administration of vancomycin carries unique risks, such as infusion intolerance (e.g., "red man" syndrome), acute kidney injury (particularly with higher doses and prolonged therapy), and thrombocytopenia.
- Liaise with the most responsible health care provider who will be responsible for ongoing monitoring and assessment of the patient in the community prior to the patient's discharge, and provide copies of any laboratory requisitions and special instructions. If a care plan cannot be implemented right away (e.g., due to timing on the weekend or lack of a primary care provider), consider referring to an outpatient clinic for follow-up, scheduling bloodwork in the hospital, or admitting/keeping the patient.
- Include most recent laboratory results and scheduled bloodwork in prescriptions written for IV medications that require TDM. Ensure lab requisitions are completed and sent to the most appropriate care provider. If possible, avoid scheduling bloodwork on Fridays, because weekends or holidays may delay the interpretation of test results.
- Review the patient's concomitant medications to identify those with nephrotoxic potential (e.g., diuretics, nonsteroidal anti-inflammatory agents, angiotensin-converting enzyme inhibitors) and to evaluate whether any of these medications should be held for the duration of antimicrobial treatment.

Home and Community Care Nurses

- Review the treatment plan and TDM requirements with the patient/caregivers.
- Reinforce and educate and inform patients about situations that require prompt medical attention, such as infusion reactions and adverse effects.
- Monitor and report any signs or symptoms of

adverse effects or other concerns to the prescriber or practitioner assigned for follow-up. Drug-specific monitoring parameters can be found in monographs (available at http://www.ismp-canada.org/SafeHomeInfusion/) developed for the most commonly administered IV medications in this setting.
- Review that blood work is ordered with the patient/substitute decision maker and scheduled appropriately. Review the importance of the laboratory testing as required.
- Before administering each dose, review the latest bloodwork.
- Educate patients about what symptoms and concerns they should report and how to contact their healthcare team.

Infusion Pharmacy Providers

- Drug information support should be available to help identify the need for bloodwork and monitoring of adverse effects. The infusion pharmacy provider is a resource for home and community care nurses. Pharmacists and nurses can also consult a drug information centre or access monographs (including one for vancomycin) for the most commonly administered IV medications in the home and the community settings found on the ISMP Canada website at: http://ismp-canada.org/SafeHomeInfusion/. This information is intended for front-line care providers to ensure appropriate ordering, administration, and monitoring of these medications in the home environment.
- Liaise with the patient's community pharmacist to identify potential drug interactions between IV medications and oral home medications.
- If practical, dispense only enough medication to last the patient until TDM results are available. Ideally, release of the next set of doses should be contingent on the TDM results, in case dose adjustment or reassessment is required.

CONCLUSION

Complicated treatment plans to be carried out by home and community care services, such as those for IV antibiotics requiring TDM, require standardized processes in which patients, caregivers, and the health-care team understand their respective roles. In addition, these stakeholders must recognize the protocols, systems and partners that exist to support them. ISMP Canada has received reports of incidents showing evidence of a complex, non-integrated system which was developed without a clear strategy to evaluate the potential for errors, and which resulted in patient harm. Without concrete changes to the current approach, situations like the one described in this bulletin will continue to recur, leading to patient harm or death. Pc

Acknowledgements

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THE *Niagara Apothecary*

EXPERIENCE AN 1869 PHARMACY

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

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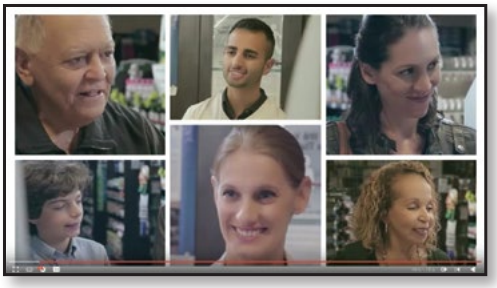
PROVIDING VALUE AND ENHANCING TRANSPARENCY THROUGH VIDEO

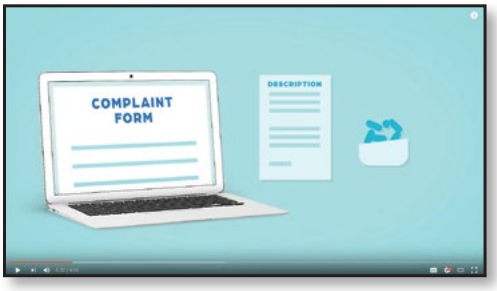
As part of the College's mandate to serve and protect the public and ensure that patients receive quality pharmacy services and care, OCP has been producing a number of public-facing videos. These videos are valuable to patients, many of whom visit their pharmacy every week, and support the College's continued commitment to transparency. Here are the public-facing videos the College has produced so far.

TRUST IN THE CARE YOUR PHARMACIST PROVIDES:



"Trust in the Care Your Pharmacist Provides" gives patients an overview of the many services pharmacists and pharmacy technicians are qualified and authorized to deliver. From the video, patients learn that a pharmacy isn't just a place to go to pick up their prescriptions – it's much more than that.

HOW TO FILE A COMPLAINT:



"How to File a Complaint" gives patients an overview of how to file a complaint about the care they or a loved one has received from a pharmacist or pharmacy technician in Ontario. In the video, they learn about the steps they need to take to file a complaint and how the complaints process works, including what happens once the complaint is filed and the action(s) that can be taken.

THE ROLE OF THE ONTARIO COLLEGE OF PHARMACISTS

"The Role of the Ontario College of Pharmacists" explains the College's mandate to serve and protect the public's interest by holding pharmacists and pharmacy technicians accountable for the safe, effective and ethical delivery of pharmacy services.

In addition to these three public-facing videos, the College is also committed to producing member-facing videos designed to help pharmacists and pharmacy technicians enhance their practice. These videos include:

- Integrating Pharmacy Technicians into Community Practice
- Narcotics Reconciliation
- Documentation in the World of Expanded Scope (created in conjunction with the University of Toronto), and more.

You can find all of the College's videos on our YouTube channel. To be notified via email when the College puts out a new video, click the red "Subscribe" button at the top right of our YouTube channel.

DISCIPLINE DECISIONS

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Member: Dilip Jain (OCP # 204400)

At a hearing on April 5, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Jain with respect to the following incidents:

- That he dispensed Suboxone to patient [Patient] in advance of the interval specified by the prescriber for dispensing, and without observing [Patient] ingest the medication (i.e. he dispensed "observed doses" as "carry doses"), contrary to the directions of the prescriber

- That he dispensed Suboxone to patient [Patient] without valid authorization and/or without keeping a record of a valid authorization and/or without recording on the prescription the information required by s. 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4

- That he dispensed Suboxone to patient [Patient] pursuant to authorizations containing erroneous dates, without taking and/or documenting any steps to verify the dates and/or authorizations with the prescriber

- That he created false and/or misleading pharmacy records, which recorded that patient [Patient] was dispensed Suboxone on certain dates, when he was not

- That he signed prescription hardcopies recording that he dispensed Suboxone to patient [Patient] on certain dates, when he did not dispense Suboxone to [Patient] on those dates

- That he created pharmacy records containing false and/or misleading statements by processing prescriptions that were not in fact dispensed, and/or were dispensed on a later date than indicated on the pharmacy records

- That he submitted accounts containing false and/or misleading statements by billing for prescriptions that were not in fact dispensed, and/or were dispensed on a later date than indicated on the accounts

- That he signed prescription hardcopies for prescriptions that he did not in fact dispense, and/or that he dispensed on a later date than the date the hardcopy was signed

In particular, the Panel found that he

- failed to maintain a standard of practice of the profession

- failed to keep records as required respecting his patients

- 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 Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and/or 156 of the Drug and Pharmacies Regulation Act , R.S.O. 1990, c. H-4, as amended

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

The Panel imposed an Order which included as follows:

1. A reprimand

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

   (a) that the Member complete successfully, at his own expense, within 12 months of the date of this Order, the following courses and evaluations:

      i. CPS II Module 3 (Professional Practice & Pharmacy Management II) offered by the Leslie Dan Faculty of Pharmacy;

      ii. Medication safety for pharmacy practice: Incident analysis and prospective risk assessment offered by the Institute for Safe Medication Practices;

   (b) that the Member shall be prohibited from having any proprietary interest in, or acting as a Designated Manager in, any pharmacy, for 2 years from May 2, 2016 (i.e. until May 2, 2018);

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 5 months, with 1 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in subparagraph 2(a) above.

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

In its reprimand, the Panel noted that integrity, trust, and adherence to the standards of practice are paramount to the profession. The Panel observed that 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 noted that the Member acknowledged responsibility for his actions. The Panel expressed its expectation that the Member will learn from this experience and will make necessary changes in his practice that will maintain the public trust and protection. Although this was the Member's first appearance in front of a panel of the Discipline Committee, the Panel expects it will be his last.

Member: Nashat Ramzy (OCP #106801)

At a hearing on April 19, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ramzy with respect to the following incidents:

- That he was found guilty on December 13, 2013 for breach of trust contrary to the Criminal Code, R.S.C. 1985, c. C-46, section 122
- That he submitted false or unsubstantiated claims to the Ontario Drug Benefit Program totalling approximately $155,000 in relation to 13 different drugs and/or other health products in or about September 2009-September 2011
- That he created false records of billing and/or dispensing transactions in relation to the false or unsubstantiated claims submitted to the Ontario Drug Benefit Program in or about September 2009-September 2011

In particular, the Panel found that Mr. Ramzy

- was found guilty of an offence that is relevant to his suitability to practice
- 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, 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, the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, sections 5, 6 and/or 15
- engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration, including:

   (a) That the Member shall complete successfully, at his own expense and within twelve (12) months of the date of this Order, the ProBE Program on Professional/Problem Based Ethics for Health-care Professionals, with an unconditional pass;

   (b) That the Member shall be prohibited from:

      (i) having any proprietary interest of any kind in a pharmacy, or

      (ii) receiving remuneration for his work as a pharmacist other than remuneration based on hourly, weekly or monthly rates only,

   provided that the terms, conditions or limitations as set out in sub-paragraphs 2(b)(i) and (ii) above may be removed by an Order of a panel of the Discipline Committee, upon application by the Member, with such application not to be made sooner than five (5) years from the date of this Order; and

   (c) That the Member shall be prohibited from acting as the Designated Manager at any pharmacy for

a period of five (5) years from the date of this Order.

3. Directing the Registrar to suspend the Member's certificate of registration for a period of eighteen (18) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2 (a) above.

4. Costs to the College in the amount of $15,000

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy. The Panel expressed disappointment with the Member's conduct. The Panel pointed to the nature of the fraudulent activities, both with respect to monetary value and persistence over time, and observe that this demonstrated the egregiousness of the Member's behaviour and his complete disregard for the trust that is placed on the profession of Pharmacy to self regulate and exercise good judgment in regards to delivering patient care. The Panel found the Member's actions to be dishonourable, disgraceful, and conduct unbecoming of a pharmacist. The Panel pointed out that pharmacists are entrusted as custodians of the taxpayers' dollars and, in this regard, the Member has failed them. The Panel expressed its hope that the Member will not appear before a panel of the Discipline Committee again.

Member: Daniel Yung (OCP #49956)

At a hearing on April 27, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Yung with respect to the following incidents:

- That he dispensed prescription narcotics without verifying with the prescribers that the prescriptions were valid in relation to:

  i. Rx #N36484, Rx #N36488 and/or Rx #N36500 (change of prescriber, previous supply not exhausted, and prescriptions forged); and/or

  ii. Rx #N36470 and/or Rx #N36471 (prescription unsigned, two strong narcotics prescribed and prescription forged);

- That he dispensed narcotics and other controlled drugs without complying with the prescriber's directions regarding blister pack compliance packaging, and without consulting with the prescriber regarding alternative packaging, in relation to Rx #N37116, Rx #N37117, Rx #N36626 and/or Rx #N37084;

- That he dispensed controlled drugs in a weekly supply rather than dispensing daily as directed by the prescriber, and without consulting with the prescriber, in relation to Rx #N37239 and/or Rx #N37240;

- That he dispensed a controlled drug pursuant to a refill prescription when a more recent new prescription for the same drug had just been dispensed, without consulting with the prescriber, in relation to Rx #349329 and/or Rx #348896;

- That he sold Schedule II narcotics to customers without making inquiries or assessing the customers before approving the sale of the narcotics, on or about August 12, 2014 and/or February 6, 2015;

- That he committed various prescription discrepancies, including labelling errors in relation to Rx #345270, Rx #349356, Rx #N36481, Rx #N36500, and/or Rx #N37701; compounding errors in relation to Rx #345287; and incorrect prescriber information recorded in relation to Rx #N36517 and/or Rx #N37171; and/or

- That he failed to maintain the pharmacy in a clear and orderly fashion, and in a good state of repair, in relation to cluttered shelves and storage areas, dirty carpets and floor areas, burnt out light bulbs, and/or inadequate monitoring of fridge temperatures.

In particular, the Panel found that Mr. Yung

- Failed to maintain a standard of practice of the profession

- Failed to keep records as required respecting his patients

- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, sections 155 and/or 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4, as amended, and/or sections 4, 5, 24, and 40 of O.Reg. 58/11, R.S.O. 1990, c.H.4

- Contravened any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section C.01.041 of the Food and

Drug Regulations, C.R.C., c. 870, as amended, to the Food and Drugs Act, R.S.C. 1985, c.F-27, as amended, and/or section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended, under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended

- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

2. Directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration, including:

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

   b. That the Member shall be prohibited from acting as the Designated Manager at any pharmacy for a period of three (3) years commencing on June 1, 2016;

   c. That the Member:

      i. retain, at the Member's expense, a practice mentor acceptable to the College, within three (3) months of the date of this Order;

      ii. meet at least three (3) times with the practice mentor, at the mentor's place of practice, for the purpose of reviewing the Member's practice with respect to detecting forged prescriptions and conducting narcotic inventory reconciliations, and identifying areas in the Member's practice with respect to these issues that require remediation; to this end, the Member shall provide the practice mentor with the following documents related to this proceeding:

         1. a copy of the Notice of Hearing;

         2. a copy of the Agreed Statement of Facts;

         3. a copy of the Joint Submission on Order;

         4. a copy of the Report of Investigation dated March 11, 2015; and

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

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

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

      v. require the practice mentor to report the results of the mentorship meetings to the Manager, Investigations and Resolutions at the College, after their completion, which shall be no later than twelve (12) months from the date of this Order.

3. Directing the Registrar to suspend the Member's certificate of registration for a period of four (4) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2 (a) above.

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

In its reprimand, the Panel reminded the Member that the practice of pharmacy is a privilege and not a right, and indicated its disappointment that the Member was appearing before them for a second time on the same issues. The Panel remarked that the Member was failing to take into account the safety of patients and the public in general, failing the profession by not maintaining the standards of the profession, and failing himself by not performing up to his potential as a health care professional. The Panel indicated that the Member betrayed the public trust, and expressed its hope that the Member will fulfill his commitment to make the necessary improvements and will not appear before the Discipline Committee again.

Member: Vartan Manoukian

Mr. Vartan Manoukian applied to the Discipline Committee for reinstatement of his Certificate of Registration. At a hearing on April 14 and 15, 2015, a Panel of the Discipline Committee heard this application. By way of a decision dated January 25, 2016, the application was dismissed.

This decision is under appeal.

Member: Thi Kim Tien Nguyen (OCP #205136)

On May 5 and 6, 2016, the College brought a motion before a Panel of the Discipline Committee to stay allegations of professional misconduct against Ms. Nguyen. The allegations are as follows:

- That she submitted accounts or charges for services that she knew were false or misleading to the Ontario Drug Benefit program for one or more drugs and/or products from on or about January 1, 2008 to on or about April 30, 2009; and/or
- That she falsified pharmacy records relating to her practice in relation to claims made to the Ontario Drug Benefit program for one or more of drugs and/or products from on or about January 1, 2008 to on or about April 30, 2009; and/or
- That she failed to keep records of monthly Ontario Drug Benefit eligibility cards or a copy of the cards with respect to each person for whom a drug was dispensed, as required by section 29 of Ontario Regulation 201/96, under the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended, from on or about September 1, 2008 to on or about April 30, 2009.

In particular, it is alleged that she

- Failed to maintain a standard of practice of the profession;
- Failed to keep records as required respecting her patients;
- Falsified records relating to her practice;
- Submitted accounts or charges for services that she knew to be false or misleading;
- 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 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, as well as section 29 of Ontario Regulation 201/96, under the Ontario Drug Benefit Act, R.S.O. 1990, c. O.10, as amended;
- 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 College brought the motion before the Discipline Committee in light of the fact Ms. Nguyen entered into an Undertaking, Agreement and Acknowledgment with the College whereby she resigned permanently as a member of the College, irrevocably surrendered her Certificate of Registration, and will no longer work or be employed in a pharmacy, in any capacity whatsoever, in Ontario, effective September 5, 2016.

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

Member: Joshua Ramsammy (OCP #613037)

At a hearing on June 6, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Ramsammy with respect to the following:

- That he failed to provide to the Registrar the details of the criminal charges against him, including the status of the proceedings relating to those charges
- That he misappropriated and/or obtained from the Pharmacy narcotics and other controlled and prescription drugs that had not been prescribed for him and/or refilling a prescription for Ratio-Oxycocet without proper authorization to do so, in or about October 4, 2010 to February 3, 2014
- That he inaccurately indicated on his 2014 Annual Renewal that he was not the subject of a current proceeding in respect of any offence in any jurisdiction.

In particular, the Panel found that Mr. Ramsammy

- Contravened a term, condition or limitation imposed on his certificate of registration
- Failed to maintain a standard of practice of the profession
- Dispensed or sold drugs for an improper purpose

- Falsified records relating to his practice

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

- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4, as amended

- Contravened a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, sections C.01.041 and/or G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, as amended; section 4 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended; section 31 of the Narcotic Control Regulations, C.R.C., c.1041, as amended; and/or section 51 of the Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000-217, as amended

- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

2. An Order directing the Registrar to suspend the Member's certificate of registration for a period of six (6) months, with one (1) month of the suspension to be remitted on the condition that the Member completes the remedial training specified in paragraph 3(i) below.

3. an Order directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:

   i. the Member must successfully complete with an unconditional pass, at his own expense and within twelve (12) months of the date when this Order is imposed, the ProBE Program on Professional / Problem-Based Ethics for healthcare professionals offered by the Center for Personalized Education for Physicians;

   ii. for a period of five (5) years from the date when this Order is imposed, the Member shall be prohibited from acting as a Designated Manager or narcotic signer at any pharmacy;

   iii. ffor a period of three (3) years from the date when this Order is imposed:

      a) the Member shall only engage in the practice of pharmacy if he has notified the College in writing of any employment in any pharmacy, which notification shall include the name, address, and telephone number of the employer and the date on which he is to begin employment, within seven (7) days of commencing such employment; and

      b) the Member shall only engage in the practice of pharmacy for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of that pharmacy (and any subsequent Designated Manager, if there is a change in the Designated Manager at the same pharmacy during the Member's tenure) to the College, within seven (7) days of the Member's commencement of employment at the pharmacy (and within seven (7) days of a change in Designated Manager), that the Designated Manager received and reviewed a copy of this Order and the Decision and Reasons of the Discipline Committee in this matter before the Member commenced his employment;

4. Costs to the College in the amount of $3,000.

In its reprimand, the Panel observed that pharmacy is a self-regulated profession, and that there is a responsibility to ensure that the trust of the members and the public is maintained. The Panel noted that the practice of pharmacy is a privilege that carries obligations to the public, the profession, and oneself. The Panel observed that the Member acknowledged responsibility for his actions. The Panel expressed its view that the Member's conduct was disgraceful, dishonourable, and unprofessional.

Member: Said Attalla (OCP #209632)

At a hearing on June 20, 2016 a Panel of the Discipline Committee made findings of professional misconduct against Mr. Attalla with respect to two referrals of specified allegations of professional misconduct made by the Inquiries, Complaints and Reports Committee.

Regarding the first referral of specified allegations of professional misconduct, the Panel made findings against Mr. Attalla with respect to the following:

- That he submitted accounts or charges for services that he knew were false or misleading to the Ontario Drug Benefit program for one or more drugs and/or products;
- That he falsified pharmacy records relating to his practice in relation to claims made to the Ontario Drug Benefit program for one or more drugs and/or products;
- That he dispensed Schedule 1 and/or Schedule F drugs, controlled drugs, narcotics, and/or targeted substances without a prescription and/or proper authorization;
- That he recorded authorizations for prescriptions and/or refills of prescriptions where no such authorization was given;
- That he dispensed and/or billed for drugs not prescribed or otherwise authorized, and/or not actually dispensed, and/or failed to keep accurate records regarding prescriptions and dispensing transactions.

In particular, the Panel found that he:

- Failed to maintain a standard of practice of the profession;
- Failed to keep records as required respecting his patients;
- Falsified records relating to his practice;
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement;
- Submitted accounts or charges for services that he knew to be false or misleading;
- Contravened the Pharmacy Act, 1991, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular sections 155 and 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, and/or s. 2.1 of Ontario Regulation 297/96 made thereunder;
- 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 and 15(1)(b) of the Ontario Drug Benefits Act, R.S.O. 1990, c. O.10, as amended, and/or Ontario Regulation 201/96 made thereunder, and/or sections C.01.041 and G.03.002 of the Food and Drug Regulations C.R.C., c. 870, as amended, to the Food and Drugs Act, R.S.C. 1985, c. F-27, as amended, and/or section 31 of the Narcotic Control Regulations, C.R.C., c. 1041, as amended, and/or s. 51 of the Benzodiazepines and Other Targeted Substances Regulations, S.O.R/2000-271 under the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended;
- 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.

Regarding the second referral of specified allegations of professional misconduct, the Panel found that Mr. Attalla:

- Failed to maintain a standard of practice of the profession;
- Permitted, consented to or approved, either expressly or by implication, the commission of an offence against s. 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 relating to the practice of pharmacy or to the sale of drugs by a corporation of which he was a director, in respect of certain drugs; and
- Engaged in conduct or performed an act or acts relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

The Panel imposed an Order which included as follows:

1. A reprimand
2. A 30 month suspension of the Member's certificate of registration, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training specified in paragraph 3(a) below.
3. an Order directing the Registrar to impose specified terms, conditions or limitations on the Member's certificate of registration as follows:

a. the Member must successfully complete with an unconditional pass, at his own expense and within 12 months of the date the Order is imposed, the ProBE Program on professional / problem-based ethics for health care professionals offered by the Centre for Personalized Education for Physicians;

b. for a period of two years the Member shall be prohibited from having a proprietary interest of any kind in a pharmacy, and the Member shall have 60 days from the date of this Order to divest himself of any such proprietary interests, at which time the two year period shall commence;

c. the Member's practice and all activities at any pharmacies in which the Member has a proprietary interest of any kind shall be monitored by the College by means of practice assessments 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 three years, beginning two years from the date of this order and continuing until five years from the date of this order. The practice assessments may be in addition to any of the routine inspections conducted by the College pursuant to the authority of section 148 of the Drug and Pharmacies Regulation Act. The Member shall cooperate with the College during the practice assessments and, further, shall pay to the College in respect of the cost of monitoring, the amount of $650.00 per assessment, such amount to be paid immediately after completion of each of the assessments, with the total amount paid by the member not to exceed $10,000.00, regardless of the number of assessments;

d. for a period of five years from the date the Order is imposed, the Member shall be prohibited from:

   i. acting as a Designated Manager in any pharmacy; and,

   ii. receiving any remuneration for his work as a pharmacist other than remuneration based on hourly or weekly rates only or (subject to paragraph (b) above) by reason of having a proprietary interest in a pharmacy;

e. for a period of five years from the date the Order is imposed, the Member shall be required to notify the College in writing of the name(s), address(es) and telephone number(s) of all pharmacy employer(s) within fourteen days of commencing employment in a pharmacy;

f. for a period of five years from the date the Order is imposed, the Member shall provide his pharmacy employer with a copy of the Discipline Committee Panel's decision in this matter and its Order; and

g. for a period of five years from the date the Order is imposed, the Member shall only engage in the practice of pharmacy for an employer who agrees to write to the College within fourteen days of the Member's commencing employment, confirming that it has received a copy of the required documents identified above, and confirming the nature of the Member's remuneration.

4. Costs in the amount of $20,000.

In its reprimand, the Panel noted that the Member stole from the people of Ontario and from the trusted reputation of the profession. The Panel pointed out that the Member undermined the public confidence in pharmacy, put his own needs ahead of the trust of patients, and took advantage of his position in society. The Panel expressed its view that some of the fraud to which the Member admitted was unfathomable. The Panel observed that the Member's actions exemplified disgraceful, dishonourable, and unprofessional conduct. The Panel expressed its anticipation that the discipline proceeding has impressed upon the Member the seriousness of his misconduct. Pc

The full text of these decisions is available at www.canlii.org
CanLii is a non-profit organization managed by the Federation of Law Societies of Canada. CanLii's goal is to make Canadian law accessible for free on the Internet.

FOCUS ON ERROR PREVENTION

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

DETERMINING THE CLINICAL PURPOSE OF A PRESCRIPTION

When dispensing medications, pharmacists must review each prescription for a medication that a patient is taking for the first time to ensure that the medication is the most appropriate for the specific patient and the dose and instructions for use are correct.

In a large number of cases, this cannot be accomplished unless the pharmacist is aware of the indication for use. The optimal dosage regimen will often be determined by the clinical purpose of the drug.

CASE 1:

Rx
Medication: Dukoral® Oral Vaccine
Sig: Use as directed
Quantity: Two doses

The above medication was prescribed for a five year old child. The prescription was taken by the child's mother to a local community pharmacy for processing. The vaccine was prepared and dispensed by the pharmacist.

While counselling the parent on the use of the vaccine, the pharmacist asked the appropriate questions including,

1. When will the child be travelling?
2. Has the child taken Dukoral® previously and if so when?
3. What did the doctor tell you about the purpose for taking Dukoral®?

The pharmacist learnt that the child was travelling to Africa in approximately one month and had not taken Dukoral® previously. The parent also indicated that the physician had prescribed Dukoral® because of cholera concern.

Based on the information received, the pharmacist determined that the patient must take three doses of Dukoral® (not two) at least one week apart[1]. The pharmacist therefore contacted the prescriber to change the prescription accordingly. The parent was also advised to start the vaccine immediately as protection against cholera will start approximately one week after the third dose is given.

CASE 2:

Rx
Medication: Valacyclovir
Sig: 1000mg every 12 hours
Quantity: Six doses

The above prescription was processed at a local community pharmacy. Six valacyclovir 1000mg tablets were dispensed with the instructions to take one tablet every twelve hours until finished.

While patient counselling, the pharmacist noticed that the patient was developing a cold sore. The pharmacist confirmed that the valacyclovir was indeed being taken to treat the cold sore.

The pharmacist contacted the prescriber to discuss the recommended dosage regimen for treating cold sores (Herpes Labialis) was valacyclovir 2000mg (not 1000mg) every twelve hours for one day only[2]. The physician acknowledged the 2000mg dosage and indicated that he had provided six doses to treat future outbreaks and not to be used continuously.

The prescription was therefore changed to valacyclovir 2000mg every twelve hours for two doses only, plus two refills.

RECOMMENDATIONS:

- To ensure the patient receives the most appropriate drug therapy, always gather the indication for use

from the prescriber or patient whenever possible. If this information cannot be obtained prior to the dispensing of the drug, use open ended questions to gather this information from the patient during patient counselling.

- Always contact the prescriber to clarify ambiguous information. This includes unusual prescribed quantities based on the indication for use.

- Remember that pharmacists may adapt prescriptions by changing the dose as per the expanded scope of practice[3]. Pc

Please continue to send reports of medication errors in confidence to Ian Stewart at: ian.stewart2@rogers.com .

Please ensure that all identifying information (e.g. patient name, pharmacy name, healthcare provider name, etc.) are removed before submitting.

REFERENCES

1. Dukoral® product monograph available at: https://www.dukoralcanada.com/download/consumer-info-en.pdf Accessed June 29th, 2016.

2. Valtrex® product monograph available at: http://ca.gsk.com/media/593038/valtrex.pdf Accessed June 29th, 2016

3. Expanded Scope of Practice orientation manual available at: http://www.ocpinfo.com/library/practice-related/download/Expanded%20Scope%20Orientation%20Manual.pdf Accessed June 29th, 2016.

PRACTICE TIP!

GET A NEW PRACTICE TIP EVERY WEEK ON TWITTER

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

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

You may have noticed practice tips scattered throughout this issue of *Pharmacy Connection*. These are tips that we've previously tweeted out as part of this new initiative. Enjoy!

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

CHECK OUT OUR NEW ONLINE TOOL FOR A LIST OF CE ACTIVITIES

http://www.ocpinfo.com/practice-education/continuing-education/

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