Ontario College of Pharmacists
Putting patients first since 1871

PHARMACY CONNECTION

WINTER 2017 • VOLUME 24 NUMBER 1

THE OFFICIAL PUBLICATION OF
THE ONTARIO COLLEGE OF PHARMACISTS

IN THIS ISSUE:

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COUNCIL MEMBERS

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

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

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

Ontario College of Pharmacists
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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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PHARMACY CONNECTION

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Nancy Lum-Wilson,
R.Ph., B.Sc.Phm., MBA
Registrar and CEO

OCP WELCOMES NEW REGISTRAR **NANCY LUM-WILSON**

On November 24, 2016, Regis Vaillancourt, President of OCP, announced the appointment of Nancy Lum-Wilson as Registrar and CEO effective January 9, 2017. Read the full announcement here.

As I begin my tenure as Registrar and CEO of the College, I would like to sincerely thank all of those who have extended to me such a warm welcome. I am excited to get started and continue the work of the College in our role to ensure patients are provided the highest quality of care.

It was my pleasure to attend the December meeting of College Council. While listening to the discussion taking place, I witnessed the steadfast commitment from both professional and public Council members to ensuring that all patients are provided with effective and ethical care. The College took a big leap forward at this last meeting, approving a motion to move forward with establishing third party medication incident reporting as the standard. While the details are still being developed, it is the College's firm belief that this step will enable better learnings for practitioners and improved care for patients.

For many years, I have worked in a wide variety of leadership and policy roles within Ontario's healthcare system. It is well known that our healthcare system must transform if it is to be sustainable. An aging population, an increasing complexity of care and shrinking funding are resulting in major structural change. Pharmacists and pharmacy technicians alike must look at better ways of collectively bringing more value to the table as members of the healthcare team. The focus must be on how they can serve the public with their medication knowledge and clinical judgement.

> "How we choose to govern ourselves and practice our profession will chart the course for years to come."

One of the ways in which the College has sought to support the expanded role of the pharmacy professional is through the adoption of the Code of Ethics. The Code was designed to more appropriately address current practice and clearly establish standards of ethical conduct. Upon annual renewal this year, each member will be required to declare that they have read and understood the code. This is a commitment that they will be held accountable to – whether a pharmacist, pharmacy technician, designated manager or director.

From the regulation of pharmacy technicians to expanded scope to vaccines, the role of the pharmacy professional has grown tremendously over the last few years. As we embark on another year, there is opportunity for transformation, for growth, and for a re-commitment to the primary responsibility as a healthcare professional: to serve and protect patients. How we choose to govern ourselves and practise our profession will chart the course for years to come. Ultimately, both the College and each pharmacist and pharmacy technician will need to continue to develop and earn the public trust.

DECEMBER 2016 COUNCIL MEETING

As recorded following Council's regularly scheduled meeting held at the College offices on December 12th, 2016.

COUNCIL DEBATES MEDICATION SAFETY

Following a recent tragic incident linked to a compounded medication error, the College reviewed how medication incident reporting is addressed in practice and what resources are available to improve and strengthen existing measures. This review also included the protocols and reporting requirements of other provincial regulatory authorities, specifically Nova Scotia's SafetyNET-RX and Saskatchewan's COMPASS CQI programs that enable community pharmacies to anonymously report medication incidents to a third party (such as the Institute for Safe Medications Practices [ISMP] Canada). The objective of this approach, which includes analysis of factors contributing to the error, is to ensure that all practitioners learn from these incidents and review and enhance their policies and procedures to reduce the likelihood of recurrence thereby improving patient safety.

In a recent letter to the College, Minister Hoskins stated "Medication safety in Ontario is a priority for my ministry, and given recent tragic events that have been reported in the Ontario media, the proposed work of the ISMP and OCP is timely. I am very supportive of initiatives like this to improve transparency and safety in pharmacies".

Although the College continuously reminds practitioners of their responsibility to appropriately manage medication incidents in their practice through broad communications, and as part of discussions during regular pharmacy practice assessments in hospitals and community pharmacies, it does not currently mandate the reporting of medication errors to an external body.

In discussing this issue, Council was unanimous in its support of requiring such reporting. The expectation is that aggregate analyses of medication incidents will be received by the College for targeted practice improvement initiatives. To this end, a Task Force will be established to fully examine this subject and to develop a model for consultation during January and February 2017. The model will be presented to Council for approval at its meeting in March 2017.

NAPRA'S DRAFT MODEL STANDARDS FOR PHARMACY COMPOUNDING OF NON STERILE PREPARATIONS

NAPRA (National Association of Pharmacy Regulatory Authorities) developed the draft Model Standards for Pharmacy Compounding of Non-Sterile Preparations which the College posted for consultation between October 20 and November 17, 2016. These standards were based on those that are already in place in Quebec, which are in turn based on General Chapter <795> of the United States Pharmacopeia – National Formulary (USP – NF). Responses were received from a number of stakeholder groups including pharmacists, pharmacy technicians and pharmacy organizations, the submissions generally being supportive and providing suggestions to aid clarity. Feedback will be submitted to NAPRA, who will review submissions from across the country and determine what changes to make, if any. When NAPRA has completed work on the standards, Council will consider their adoption as well as timing of implementation.

It is the College's intention that, wherever possible, national standards will be adopted. Most recently, Council approved the implementation by January 2019 of the Model Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations and Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.

LEGISLATIVE INITIATIVES

On December 7, the government introduced the *Medical Assistance in Dying Statute Law Amendment Act, 2016*. The Act consists of a series



of amendments that would provide more clarity on medical assistance in dying for patients, families and health care providers. It would ensure that appropriate coroner oversight of medical assistance in dying situations will continue.

Legislation has also been introduced that would, if passed, further protect patients in Ontario and keep them healthy, including strengthening and reinforcing Ontario's zero tolerance policy on sexual abuse of patients by any regulated health professional. *Bill 87, Protecting Patients Act, 2016* includes legislative amendments that would:

- Clarify the time period after the end of a patient-provider relationship;
- Expand the list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional's license;
- Remove the ability of a regulated health professional to continue to practice on patients of a specific gender after an allegation or finding of sexual abuse;
- Increase access to patient therapy and counselling as soon as a complaint of sexual abuse by a regulated health professional is filed;
- *Ensure that all relevant information about regulated health professionals' current and past conduct is available to the public in an easy-to-access and transparent way;
- Improve colleges' complaints, investigations and discipline processes.

*In anticipation, the College commenced work and has already implemented changes to the public register that support the transparency initiative. More information on these legislative initiatives will be communicated as it becomes available.

NEXT COUNCIL MEETING

Monday March 20, 2017

For more information respecting Council meetings, please contact

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

PRACTICE TIP!

Designated managers are held responsible by the College for the security of drug inventory. Are your narcotic reconciliations conducted to minimize errors? Here are some best practices: https://www.youtube.com/watch?v=1OqHH0J6-ak&list=UUzUJKI3pb-vmaFmwLD5I5Qg

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

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MEMBERSHIP RENEWAL REMINDER

DUE MARCH 10, 2017

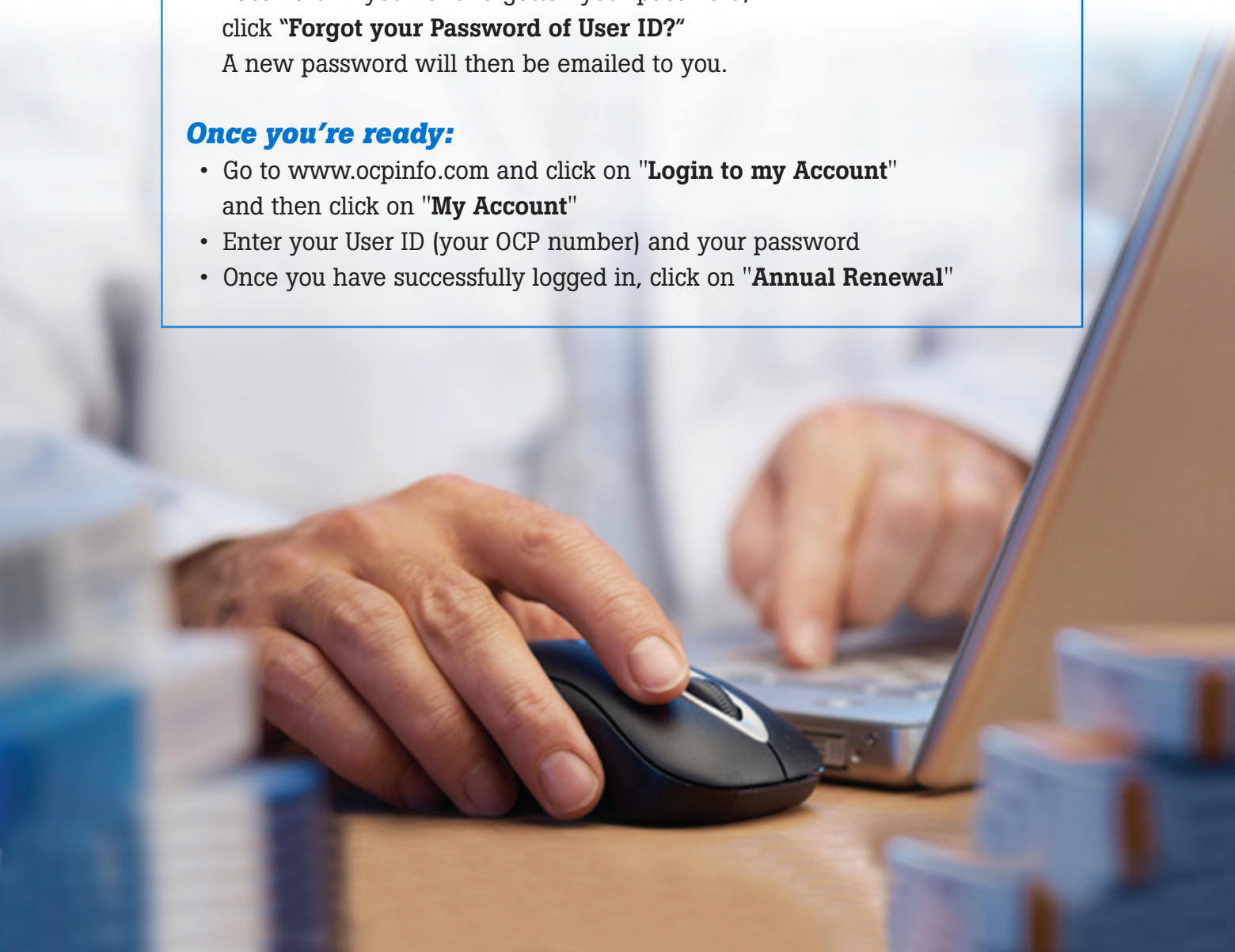
NOTE: No form will be mailed to you, however email reminders will be sent. If you fail to pay your fees by March 10, a penalty will apply.

Before you begin your renewal you will need:

- Credit Card
- User ID: This is your OCP number
- Password: If you have forgotten your password, click **"Forgot your Password of User ID?"** A new password will then be emailed to you.

Once you're ready:

- Go to www.ocpinfo.com and click on "**Login to my Account**" and then click on "**My Account**"
- Enter your User ID (your OCP number) and your password
- Once you have successfully logged in, click on "**Annual Renewal**"



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

PROTECTING PATIENTS ACT

On December 8, 2016, the Ministry of Health and Long Term Care introduced the *Protecting Patients Act* (also known as Bill 87), which makes legislative amendments around the sexual abuse of patients by regulated health professionals. Amendments include:

- Expanding the list of acts of sexual abuse that will result in a mandatory revocation of a license;
- Increasing fines for health professionals and organizations that fail to report an allegation of patient sexual abuse to a college;
- Establishing a minimum time period after the end of a patient-provider relationship during which sexual relations are prohibited;
- Removing the ability to continue to practise on patients of a specific gender after an allegation or finding of sexual abuse;
- Increasing access to patient therapy and counselling as soon as a complaint is filed; and
- Ensuring that all relevant information about current and past conduct is available to the public in an easy to access and transparent way.

The *Protecting Patients Act* will also increase the ability of the Minister of Health and Long Term Care to play a greater role in the governance of Ontario's health regulatory colleges, such as making regulations around College committees and panels.

The introduction of the Act comes as a result of the findings and recommendations of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act.

SHINGLES VACCINE FREE FOR ONTARIO SENIORS AGED 65-70

As of January 1, 2017, seniors aged 65 to 70 are eligible to receive the shingles, or herpes zoster, vaccine free of charge in Ontario. The vaccine greatly reduces the risk of developing shingles.

The vaccine is available from a primary care provider or a pharmacy. Patients can receive the vaccine directly from their primary care provider at no charge. Patients who wish to receive the vaccine at a pharmacy must get a prescription from their primary care provider and may have to pay the pharmacy a fee for the vaccine. Shingles vaccine should be considered a Schedule I drug at this time, per NAPRA.

Pharmacists are reminded they must have sufficient knowledge, skill and judgement respecting both the vaccine and the condition of the patient, to be able to administer the vaccine safely. The College provides a Guideline – Administering Injections and an Administering Injections practice tool. Also see pages 18-20 for further resources.

DRUG ABUSE STRATEGY

According to data from the coroner's office, at least 165 people in Ontario died as a direct result of the use of fentanyl in 2015, more than double the number of deaths in 2010.

Governments at all levels are taking action to reduce and prevent an increasing number of overdose deaths related to opioids like fentanyl. In the fall, the government of Ontario undertook a number of actions, including delisting high strength formulations of long acting opioids from the Ontario Drug Benefit Formulary, expanding access to naloxone overdose medication, and establishing the Patch for Patch program. See a recent ISMP Safety Bulletin on Opioid Prescribing on page 21.

In December, the federal government introduced the Canadian Drug and Substances Strategy, which focuses on harm reduction as the core pillar of Canada's drug policy. The federal Minister of Health also introduced Bill C-37. The Bill would alter a number of acts to help both health professionals and law

enforcement in their efforts to reduce the harms associated with drug use. Amendments include:

- Streamlining the application process for supervised consumption sites;
- Prohibiting the unregistered import of pill presses;
- Making it a crime to possess or transport anything intended to be used to produce controlled substances; and
- Supporting the faster and safer disposal of seized chemicals and other dangerous substances.

Health Canada will also continue to take actions that align with their Opioid Action Plan, including better informing Canadians about the risks of opioids, supporting better prescribing practices, and reducing easy access to unnecessary opioids.

Many municipal governments have also undertaken strategies to deal with opioid abuse in their individual communities, including ensuring that first responders are equipped with naloxone.

NALOXONE

Public health authorities and governments are strongly encouraging individuals who are at risk of opioid abuse, or who are aware of someone who is, to obtain naloxone kits from their local pharmacy or public health unit. Ontarians with a health card are eligible for a free take home naloxone kit through the Ontario Naloxone Pharmacy Program.

Pharmacists can dispense any formulation of naloxone available for sale and distribution in Canada, as long as it is in accordance with all of the requirements outlined in the College's Guidance – Dispensing or Selling Naloxone. It is the professional responsibility of a pharmacist to ensure that he or she has sufficient knowledge, skills and abilities to competently deliver any pharmacy service. More guidance on naloxone is available on page 14-15.

The College has included links to external training resources for pharmacists to ensure they are prepared to safely and effectively provide naloxone to a patient or patient's agent.

STERILE COMPOUNDING STANDARDS: **IMPLEMENTATION**

As previously reported, Council has approved both the Model Standards of Practice for Pharmacy Compounding of Non-hazardous Sterile Preparations and the Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations for implementation by January 1, 2019.

The standards will apply in all pharmacies where sterile compounding is done, including drug preparation premises, community pharmacies and hospital pharmacies.

Community and hospital practice advisors have developed a joint plan to align expectations for implementation, building on the baseline reviews of hospital pharmacies completed over the last year and the identification of community pharmacies whose practice includes sterile preparations.

It is expected that pharmacies where sterile compounding is done will have started the process of conducting a gap analysis comparing the Model Standards against the pharmacy's own policies, procedures and facilities. Based on this analysis, a plan will be developed leading to compliance before the implementation date.

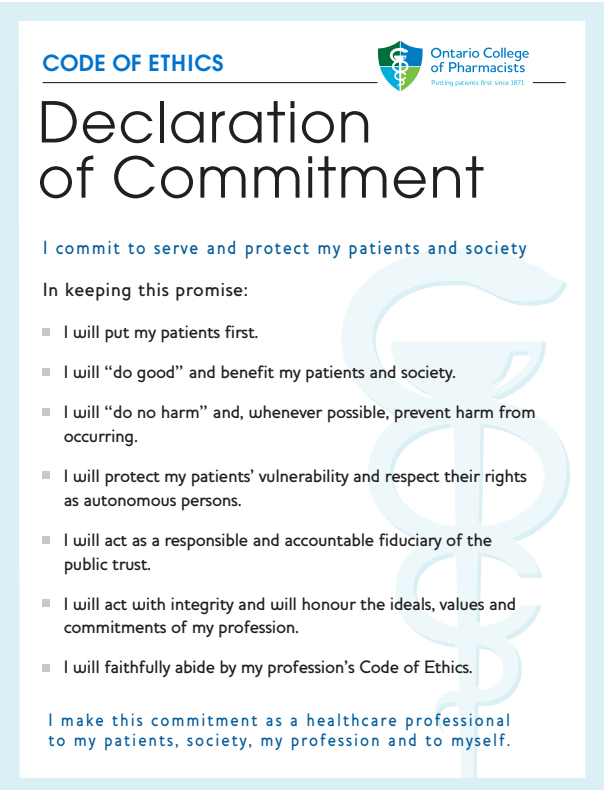
Over the next several months, additional supporting material will be posted to assist pharmacies in moving forward in this area.

BRINGING THE CODE OF ETHICS TO LIFE

In 2016, the College launched a series of e-Learning modules to assist current and future pharmacy professionals in understanding and applying the 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 Code supports these principles with standards that indicate how a practitioner is expected to fulfill their ethical responsibilities.



YOU ARE ACCOUNTABLE TO THE CODE

You are required to make an annual declaration of commitment to the Code of Ethics, starting with this year's renewal. By making this commitment, you are declaring that you have read and understand the Code and your accountability to it.

All pharmacists and pharmacy technicians must apply these ethical principles — not their own beliefs or values — to inform their behaviour and conduct. Your actions and decision-making in practice should support these principles and demonstrate your commitment to serving and protecting patients and society. As a reminder, the four core ethical principles that the Code is founded on are:

1. Beneficence (to benefit)
2. Non maleficence (to do no harm)
3. Respect for Persons/Justice
4. Accountability (Fidelity)

Abiding by these principles is not optional. In fact, understanding and committing to them is part of your overriding role and responsibility as a healthcare professional.

RESOURCES AVAILABLE TO SUPPORT YOUR APPLICATION OF THE CODE

E-LEARNING MODULES

e-Learning modules feature a variety of learning techniques including true and false questions, whiteboard video and case studies with reflective discussion.

AN INTRODUCTION TO THE CODE OF ETHICS

This module explores the role and purpose of the Code of Ethics, outlines the professional role and commitment of healthcare professionals and provides an overview of the core ethical principles of healthcare that must guide your everyday practice.

PRINCIPLE OF BENEFICENCE (TO BENEFIT)

As a healthcare professional, you must actively and positively serve and benefit your patients and society. This module will emphasize how to apply this principle in practice and help you understand that your responsibility extends beyond simply ensuring you have accurately filled the prescription.

PRINCIPLE OF NON MALEFICENCE (DO NO HARM)

In all circumstances, you have an obligation to be diligent in your efforts to do no harm and, whenever possible, to prevent harm from occurring. This module provides examples of the ways that you can help protect patients from harm, including real life examples where a patient was harmed from lack of action.

PRINCIPLE OF RESPECT FOR PERSONS/JUSTICE

You have a dual obligation as a healthcare professional to respect and honour the intrinsic worth and dignity of every patient as a human being, and to treat all patients fairly and equitably. This module will outline components of this principle including recognizing the vulnerability of patients, respecting their autonomy and decisions, and protecting their privacy.

PRINCIPLE OF ACCOUNTABILITY/FIDELITY

This principle requires you to be a responsible and faithful custodian of the public trust, accountable not just for your own actions and behaviours, but for those of your colleagues as well. This module explores the professional promise that all health professionals share – to always and invariably act in the best interest of your patient, not your own.

PROFESSIONAL BOUNDARIES

Woven throughout the Code is the expectation that you will assume the responsibility, at all times, for maintaining appropriate professional boundaries with patients. This module discusses these responsibilities and explores them in practice.

VIDEO PRACTICE EXAMPLES

The video practice examples provide you with the opportunity to participate in an interactive learning tool that focuses on a specific ethical dilemma that you may encounter in everyday practice.

CONFIDENTIALITY

A neighbour comes to you for information about her fourteen year old daughter as she is concerned about her recent behaviour. What do you do?

CONTINUITY OF CARE

It's Friday night and a regular patient of your pharmacy has recently been discharged from hospital. His prescriptions from the hospital do not include a regular medication that he has been taking. You can't reach his physician; what do you do?

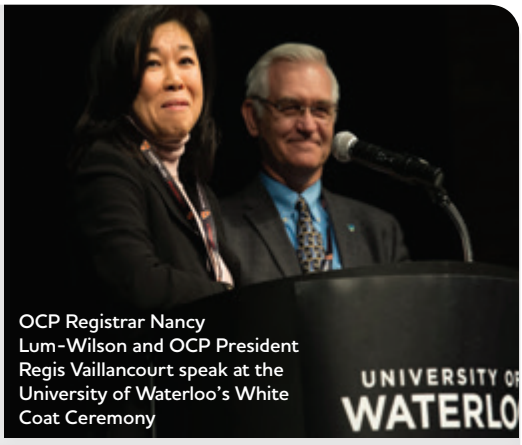
APPLYING PROFESSIONAL JUDGMENT

It's a busy night at the pharmacy and a father is picking up an antibiotic for his four year old daughter. You question the dose and duration; the doctor's office is closed. What do you do?

White Coat Ceremonies at UNIVERSITY OF TORONTO and UNIVERSITY OF WATERLOO

The University of Toronto and University of Waterloo recently hosted ceremonies to formally mark the beginning of incoming pharmacy students' professional journey. During the ceremonies, students make their commitment to ethics and integrity and are welcomed into the professional community. College Registrar and CEO Nancy Lum-Wilson attended both ceremonies.

University of Toronto's Pharmacy Class of 2020



OCP Registrar Nancy Lum-Wilson and OCP President Regis Vaillancourt speak at the University of Waterloo's White Coat Ceremony

University of Waterloo's Pharmacy Class of 2020

NALOXONE:
5 Things Pharmacists Need to Know

Maria Zhang, RPh, BScPhm, PharmD, MSc and Beth Sproule, RPh, BScPhm, PharmD
Centre for Addiction and Mental Health (CAMH)
Leslie Dan Faculty of Pharmacy, University of Toronto

1. NALOXONE IS NOW A SCHEDULE II DRUG

On March 22, 2016, Health Canada delisted naloxone as a prescription drug.[1] The National Association of Pharmacy Regulatory Authorities (NAPRA) then reclassified naloxone as a Schedule II medication when used in an emergency opioid overdose situation outside of hospital settings.

While most take-home naloxone kits currently contain intramuscular formulations of naloxone, there is an Interim Order, issued by the Minister of Health that allows the importation and sale of NARCAN® nasal spray for the emergency treatment of known or suspected opioid overdoses.[2] Like the parenteral formulations, intranasal naloxone is also available without a prescription.

2. ONTARIANS WITH A HEALTH CARD ARE ELIGIBLE FOR A FREE TAKE-HOME NALOXONE KIT THROUGH THE ONTARIO NALOXONE PHARMACY PROGRAM

Pharmacies are provided up to $70.00 for each naloxone kit they dispense and provide training on. Eligibility criteria for the program include anyone who is:

- Currently using opioids,
- A past opioid user who is at risk of returning to opioid use, or
- A family member, friend, or other person in a position to assist a person at risk of opioid overdose.[3]

Essentially, any Ontarian with a health card should be provided with a naloxone kit and training, upon request. Pharmacists' main role in this program is to provide education to naloxone kit recipients and minimize barriers to access. Those who do not have health cards can be directed to local public health units. Intranasal naloxone is available for free for recently released at-risk inmates[4].

3. PATIENTS ON CHRONIC OPIOID THERAPY SHOULD BE OFFERED A TAKE-HOME NALOXONE KIT

While there are known factors that increase the risk of opioid overdose, including concurrent use of other sedating agents (e.g., alcohol, benzodiazepines) and concomitant medical conditions such as chronic obstructive pulmonary disease (COPD), it is clear that there is a link between daily doses and overdose death. The risk of opioid-related mortality is increased even at doses of 50 mg of morphine equivalents per day.[5] Therefore, take-home naloxone kits should be proactively offered to anyone on chronic opioid therapy, regardless of dose.

Given the profound stigma around people living with substance use disorders, pharmacists may encounter patients on opioids who do not wish to receive a naloxone kit. Pharmacists can highlight that having a naloxone kit around the house is a way to protect the person using opioids, and anyone who may inadvertently consume them, and describe it as similar to having a first-aid kit.

4. PRE-ASSEMBLED TAKE-HOME NALOXONE KITS ARE AVAILABLE

Pharmacies no longer have to self-assemble take-home naloxone kits as pre-assembled ones are available for ordering. Pharmacies are encouraged to check with their usual pharmaceutical distribution channels.

5. RESOURCES EXIST TO SUPPORT PHARMACISTS IN PROVIDING NALOXONE KIT TRAINING

Centre for Addiction and Mental Health:

- Pharmacists' Checklist (vial or ampoule)
- "5 Steps to Save a Life" kit insert for naloxone kit recipients
- Poster for dispensing area
- Portico clinical tools for opioid misuse and addiction, including specific naloxone resources

University of Waterloo

- Naloxone at pharmacies: what you need to know to combat the opioid crisis
- Video: How to administer naloxone (ampoule)
  **Note: do not need to open (or use) an alcohol wipe to open an ampoule*

Ontario College of Pharmacists

- Guidance for Pharmacists on Dispensing or Selling Naloxone

Ontario Pharmacists Association

- Take home naloxone in community pharmacies: online module

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Ready, SET, PACE

COLLEGE LAUNCHES NEW APPROACH TO ASSESSING APPLICANTS' READINESS FOR PRACTICE

All registered pharmacy students beginning the registration process in Ontario must now go through the new Practice Assessment of Competence at Entry (PACE), unless they are actively engaged in the University of Waterloo or University of Toronto PharmD programs. The existing Structured Practical Training (SPT) program will continue for interns and students who started the SPT process before January 18, 2017.

In PACE, a candidates' ability to demonstrate entry-to-practice competence in a practice setting is assessed by College-appointed pharmacists - PACE Assessors. Candidates demonstrate their knowledge, skills and abilities while engaged in on-site practice opportunities. Following assessment, guidance will be offered to candidates with identified practice performance gaps to support appropriate individualized development prior to re-assessment. The practice-based registration requirement is met when a candidate demonstrates entry-to-practice competence to the validated standard.

THE PACE PROCESS

STEP 1

ORIENTATION (ONE WEEK)

The candidate has an orientation to the practice site and gets familiar with the workflow and processes before engaging in practice.

STEP 2

ASSESSMENT (TWO OR THREE WEEKS)

The candidate engages in the scope of practice of the profession over 70 hours on either a two-week full time or three-week part-time basis to demonstrate their competence. The PACE Assessor observes their practice and assesses it against the PACE Assessment Criteria. The candidate will also document examples and situations of their practice experience in an online portal.

STEP 3

OUTCOME (UP TO TWO WEEKS)

The candidate is notified of the outcome of the assessment: Competence Demonstrated or Development Required.

STEP 4

FEEDBACK & PLAN DEVELOPMENT (FOR CANDIDATES REQUIRING DEVELOPMENT)

The candidate creates a self-directed learning action plan to address gaps in their competence. College staff provide support to the candidate in the development of their learning action plan. The candidate works with a coaching pharmacist to implement their plan.

BE A PACE ASSESSOR: SUPPORT THE FUTURE OF THE PROFESSION

The Role of a PACE Assessor

PACE assessors supervise candidates to help the College determine if that candidate has met the practice-based registration requirement.

Assessors directly observe the candidate over a specified period of time. Once this period is over, they use the validated Ontario Pharmacy Patient Care Assessment Tool (OPPCAT) to rate the candidate's ability to demonstrate the entry-to-practice competencies outlined in the PACE Assessment Criteria, and then submit their completed assessment to the College.

The College applies a standardized scoring rubric to the assessor's ratings to determine if the candidate has successfully demonstrated their competence at entry-to-practice or if additional development is required.

The Benefits

PACE assessors:

- Receive specialized training and have opportunities for ongoing skills development;
- Develop skills and experience that will be valuable for future roles with the College;
- Ensure that future pharmacists are competent to deliver patient care;
- Are publicly recognized as practice leaders in *Pharmacy Connection; and*
- Receive an official Certificate of Appointment from the College.

The Qualifications

The College looks for the following when selecting assessors:

- Experience providing patient care as a pharmacist in Canada for at least two years;
- Currently practicing a minimum of 24 hours per week in a community or hospital pharmacy in Ontario that supports a diverse patient population and delivers a wide range of pharmacy services;
- Understanding of and commitment to the Standards of Practice and the Code of Ethics;
- Strong advocate of outstanding patient care and public protection;
- Willing to engage and maintain competence in using the assessment tool;
- Experience in fostering collaborative relationships; and
- Excellent verbal, written and listening skills.

To learn more and explore whether you could be a PACE Assessor, please visit the PACE Assessor page under Key Initiatives on the College website or contact regprograms@ocpinfo.com

PACE will allow for support from the profession in roles beyond being an assessor. If you have enjoyed being a SPT preceptor for students and interns in the past, please contact us to find out how you can continue to positively influence and share your expertise with new practitioners within the PACE model.

PHARMACISTS NOW AUTHORIZED TO ADMINISTER ADDITIONAL VACCINES

Amended regulations under the *Pharmacy Act* expand pharmacist authority relating to the administration of vaccines. Building on the success of pharmacists' participation in the administration of flu shots through the province's Universal Influenza Immunization Program (UIIP), these recent changes provide patients with more convenient access to many routine vaccines, particularly related to travel. Additionally, patient safety will be improved because temperature sensitive vaccines can now be administered on-site at the pharmacy, instead of having to be transported to another location for administration by a different healthcare provider.

CHANGES TO THE REGULATIONS

Pharmacists, pharmacy students and interns who have registered their injection training with the College are now permitted to administer vaccines to any patient five years of age or older for 13 vaccine preventable diseases in the following circumstances:

- The patient is prescribed a Schedule I vaccine specified in the regulations; and/or
- The patient requires a Schedule II vaccine specified in the regulations.

Where a patient meets eligibility criteria for publicly funded vaccines (e.g., routine childhood immunization, HPV for grade 7 or 8 students, pneumococcal for seniors aged 65+, etc.), pharmacists must inform the patient of their option to have the vaccine administered by their primary health care provider free of charge prior to administering the vaccine at a cost to the patient.

Authority includes vaccinations for:

1. Bacille Calmette-Guérin (BCG)
2. Haemophilus influenzae type b (Hib)
3. Hepatitis A
4. Hepatitis B
5. Herpes Zoster (Shingles)
6. Human Papillomavirus (HPV)
7. Japanese Encephalitis
8. Meningococcal disease
9. Pneumococcal disease
10. Rabies
11. Typhoid
12. Varicella
13. Yellow Fever

Additionally, the authority to administer the influenza vaccine in accordance with the Universal Influenza Immunization Program (UIIP) has been extended to pharmacy students and interns.

REQUIREMENTS FOR THE ADMINISTRATION OF VACCINES

The requirements for the administration of these new vaccines align with the requirements already established for the administration of any substance by injection or inhalation.

These include:

- All injections are administered in an appropriate environment that is safe and clean;
- The appropriate infection control procedures are in place;
- A practitioner may only administer a substance by injection after receiving informed consent from the patient, or his or her authorized agent;
- A practitioner has sufficient knowledge, skill and judgement respecting both the vaccine and the condition of the patient, to be able to administer the vaccine safely;
- A vaccine is only administered when it is in the best interest of the patient, given the known risks and benefits and the safeguards and resources available to safely manage any outcomes after administration, including any adverse events;
- Documentation requirements are met; and
- The patient's primary care provider (if any) is notified within a reasonable time after administration.

The College has developed an Administering a Substance by Injection or Inhalation Guideline to provide further guidance to pharmacy professionals when administering a vaccine.

INJECTION TRAINING AND REGISTRATION WITH THE COLLEGE

Injection training requirements and courses are the same for administration of any injection. Pharmacists must successfully complete OCP approved pharmacist injection training, maintain certification in CPR and First Aid, and register their training with the College.

Pharmacy students and interns are permitted to administer vaccines subject to the terms, limits and conditions imposed on their certificate of registration. Students and interns who attend the University of Waterloo (2012 and onward) and graduates of the University of Toronto (2013 onward) receive the injection training as part of their curriculum. Prior to administering an injection, the supervising pharmacist must confirm that the student or intern has completed all necessary training.

Pharmacy professionals are reminded that they are accountable for practising within their scope of practice, the terms, conditions and limitations on their certificate of registration, if any, and in accordance with their knowledge, skill, and judgment. A pharmacy professional is expected to assess his or her continuing education needs prior to administering a vaccine.

! MESSAGE FROM NAPRA: *IMPORTANT INFORMATION FOR ONTARIO PHARMACISTS ON VACCINE SCHEDULING*

Pharmacists may have questions regarding the schedule of certain vaccines. Of the 13 additional vaccines now permitted, 11 are specifically listed in the National Drug Schedules (NDS). However, human papillomavirus (HPV) vaccine and herpes zoster (shingles) vaccine are not listed.

The NDS states that vaccines are Schedule I unless they are "part of a routine immunization program in most/all provinces and territories," in which case they are Schedule II. It is permissible to apply the criteria to other vaccines that are not specifically listed in the NDS.

- HPV vaccine is part of routine immunization programs in all provinces and territories and would therefore be considered Schedule II.
- Shingles vaccine is currently part of the routine program only in Ontario and would therefore not meet the criteria for Schedule II. Shingles vaccine should be considered a Schedule I drug at this time.

Information on routine immunization schedules across Canada can be found at healthycanadians.gc.ca

5 Things to Know About Administering Vaccines

Pharmacy professionals have an ethical and professional responsibility to recognize and practice within the limits of their competence and with the patient's best interest in mind.

1. Identify Learning Opportunities

Pharmacists, interns, and students must possess sufficient knowledge of the vaccines and associated conditions to administer them safely. This includes assessing the patient to determine the clinical appropriateness of a vaccine, whether prescribed, requested by the patient or recommended by the pharmacist.

Pharmacists are expected to engage in routine self-assessment and to pursue continuing education when gaps are identified. OCP provides a number of tools to assist practitioners with ongoing learning and professional development, including a listing of CE resources available on the OCP website.

2. Use Proper Technique

Pharmacists, interns, and students must possess sufficient skills to perform a vaccine injection properly. This is essential to minimize the potential for adverse reactions and ensure effective levels of immunity are attained.

Prior to giving an injection to a patient, the practitioner must use aseptic technique, properly landmark the appropriate injection site, select the appropriate needle length and volume, and decide if a bunching or flattening technique should be used[1]. Other learned skills include inserting the needle at the correct angle and depth, the rate of administration, and managing the patient's pain perception.

As with any learned skill, practice is important to be comfortable and confident when performing injections. When not part of routine practice, it may be challenging to gain hands-on experience. Consider taking a refresher course or enlisting the support of a peer who has mastered the technique to help you brush up on your injection skills.

3. Store Vaccines Appropriately

Designated managers are responsible for overseeing inventory management in the pharmacy. Policies and procedures must be in place to handle and store vaccines appropriately and address any deviations. This includes managing the cold-chain from procurement to administration, regular monitoring of the ambient pharmacy temperature, and temperature control of the refrigerators and/or freezers used. In addition to having adequate storage facilities, pharmacy staff must be familiar with and adhere to OCP's Policy — Protecting the Cold Chain.

4. Maintain Effective Documentation

Documentation on the patient record should include relevant details, such as:

- Information on the pharmacist who performed the injection (and the supervisor, if applicable);
- The clinical assessment and information gathered from the patient;
- Confirmation that an informed consent was given by the patient or his or her authorized agent;
- The date and location the act was performed;
- Details on the vaccine administered (e.g., name, strength, volume, site of administration, lot number, DIN, expiration date);
- Circumstances relating to any adverse reaction experienced by the patient, and treatment recommended or administered as a result;
- Notification to the patient's primary care provider; and
- Provision of proof of vaccination to the patient for their vaccine administration record.

Refer to the College's Documentation Guidelines for additional guidance.

5. Know the Limits of Independent Authority

Situations may arise where a pharmacist is asked to administer an injection that falls outside of the vaccines or circumstances included in Regulations. In these instances, delegation of authority from another healthcare professional with this authority would be required, such as a Medical Directive or a Direct Order.

Prior to accepting delegation, members should be familiar with OCP's Policy of Medical Directives and Delegation of Controlled Act and understand their professional responsibilities in doing so. Collaboration and communication with the prescriber in both delegation scenarios is important to ensure the best possible patient outcomes.

[1] http://healthycanadians.gc.ca/publications/healthy-living-vie-saine/1-canadian-immunization-guide-canadien-immunisation/index-eng.php?page=8#p1c7a3b

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

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

ISMP Canada Safety Bulletin

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Safer Decisions Save Lives: Key Opioid Prescribing Messages for Community Practitioners

- *Do not prescribe potent opioids for minor pain.*
- *Chronic opioid therapy should be reserved for chronic pain that impairs daily function and has not responded to non-opioid treatments.*
- *If opioid therapy is chosen, it should be treated as a therapeutic trial. Prepare patients for the possibility that therapy will be discontinued if it is ineffective or there is evidence of harm.*
- *Educate patients about opioid-associated harm and prevention of overdose.*
- *Understand how to recognize opioid use disorder and how to initiate or refer a patient for treatment.*

In fall 2015, ISMP Canada brought together a panel of opioid experts from across Canada to identify prescribing and management practices likely to result in better opioid prescribing in the community, especially for treatment of chronic noncancer pain. The panel identified a number of themes on opioid prescribing and management, which were further refined into key opioid prescribing messages.* Although the practices described in these messages will be particularly helpful to community prescribers, their relevance extends to all healthcare providers in the community, as well as regulatory colleges, legislators, and the general public.

Selection of Patients for Opioid Therapy

Do not prescribe potent opioids for patients with minor pain.

Potent opioids (e.g., morphine, oxycodone, hydromorphone) are not needed for treatment of minor pain (e.g., pain resulting from musculoskeletal injuries, minor surgery, or dental work), and their use in this context can delay a patient's return to work. These drugs are suitable for pain associated with major trauma (e.g., fractures, major surgery), but should not be prescribed for longer than the expected recovery time (usually less than 1-2 weeks). Emergency, urgent care, and walk-in clinic physicians should prescribe quantities that will last only a few days, until patients can be seen by their regular physician.

Reserve opioids for patients with severe, chronic noncancer pain that impairs daily function.

Opioids should be considered only after adequate trials of all non-opioid treatments that are appropriate for the underlying condition. Do not prescribe opioids

* This bulletin is not intended to be comprehensive and must be evaluated in the context of professional standards, regulations, and expectations. Not all evidence, knowledge, or advice may have been available or taken into account when this document was prepared, and not all possible practices informing opioid prescribing may have been considered or presented. The opinions, principles, guidelines, practices, and advice outlined in this document are not necessarily those of the project participants, the partnering organizations, or Health Canada, which funded the project.

for fibromyalgia, headache, or low back pain. There is no compelling evidence of effectiveness in these situations, the pain relief will be minimal, and any benefits are typically outweighed by side effects and risk of harm.

Prescribe opioids with caution for patients at high risk of addiction.

There are 2 major risk factors for opioid addiction:
- current or past history of alcohol or substance use disorder
- current or past history of a psychiatric disorder (including anxiety, depression, and post-traumatic stress disorder)

Do not prescribe potent opioids for high-risk patients unless they have a pain condition that interferes with daily life and has not responded to a full trial of all major pain treatments (e.g., nonsteroidal anti-inflammatory agents, antidepressants, anticonvulsants, physiotherapy and other nonpharmacologic therapies). In cases where opioids are to be prescribed for high-risk patients, avoid hydromorphone, fentanyl, and oxycodone; dispense small quantities at frequent intervals (rather than larger amounts at extended intervals); order regular urine drug screens to identify use of nonprescribed opioids, benzodiazepines, or other drugs; and educate patients and families about overdose and harm prevention.

Opioid Selection and Dosage

Treat all opioid prescribing as a therapeutic trial.

There have been no long-term (> 1 year) controlled trials of the effectiveness of opioids, and cohort studies have indicated that patients receiving long-term opioid therapy have worse pain and function outcomes than patients with similar pain conditions who are not taking opioids. Therefore, the opioid should be tapered and discontinued if it does not significantly improve pain and function at a dose of 50 mg MED† or if the patient experiences fatigue, sedation, or other side effects.

Start with weak opioids first.

Weak opioids include codeine, tramadol products, and transdermal buprenorphine. Switch to a potent opioid only if the weak opioid is ineffective. If a potent opioid is needed, use low doses of a short-acting formulation for initial titration. Avoid fentanyl. Do not prescribe benzodiazepines concurrently with opioids.

Recommend the lowest possible dose for the shortest possible time.

Low doses and slow dose titration are appropriate for all patients, but are especially important for those at risk for opioid-induced falls, sedation, and other harms. Risk factors for opioid-induced falls, sedation, and other harms include advanced age, concomitant benzodiazepine or other sedating medications, alcohol use, sleep apnea, and impairment of renal, hepatic, or respiratory function. Do not prescribe opioids for nighttime use by elderly patients who are at high risk for falls.

Advise patients about opioid-related harms and prevention of overdose.

Use patient-specific handouts, such as Opioid Pain Medicines–Information for Patients and Families, to support discussion of the following issues of concern:
- impairment of ability to drive or operate machinery, especially after initiation of an opioid or after an increase in dose
- avoidance of the combination of opioids with alcohol, benzodiazepines, or illicit drugs
- the need to alert family members and friends to the initiation of opioid treatment, as well as the symptoms and signs of opioid toxicity
- the requirement for secure storage of opioids, especially if children or young adults live in the same house as the patient
- the requirement to not share opioids with others or take opioids from others
- the method for obtaining naloxone from community naloxone programs or pharmacies, where available

† MED = morphine equivalents/day, also known as morphine milligram equivalents (MME)/day. This is the total amount of opioid consumed in a 24-hour period, converted to the morphine-equivalent daily dose in milligrams. Potency ratios: morphine = 1, oxycodone = 1.5, hydromorphone = 5 (available from http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html).[1]

Keep the dose below 50 mg MED.

Most patients respond well to doses of 50 mg MED or less. For patients receiving opioid doses above 90-120 mg MED, strongly consider requesting a second opinion from another healthcare provider, and advise these patients to get a naloxone kit from the pharmacy, where available. The risk of overdose and the inherent risk of addiction increase steeply at higher doses.

Tapering Opioids

Taper the opioid dose when necessary.

Taper the dose in the following situations:
- patient has experienced no improvement in function with opioid therapy
- patient is experiencing opioid-induced sedation, depression, fatigue, sleep disturbance, or other harm
- there is a concern that the patient is experiencing opioid-induced hyperalgesia
- there is a concern that the patient may have an opioid use disorder

Consider tapering for any patients who are receiving doses above 50 MED, particularly those whose doses are over 200 MED. Many patients on higher doses will actually experience improvements in their pain, mood, and function when their dose is lowered.

Taper doses by no more than 10% of the total daily dose every 1-4 weeks. Whenever possible, use scheduled rather than as needed (PRN) doses. Dispense small quantities frequently (as often as daily), depending on the patient's adherence to the tapering schedule.

For patients who are taking high doses, do not stop the opioids suddenly.

Abrupt cessation may cause patients who are taking high doses to go into severe withdrawal. This may lead them to seek other sources of opioids, which puts them at risk of overdose and other harms.

Opioid Use Disorder: Diagnosis and Management

Know how to diagnose opioid use disorder.

The clinical features of opioid use disorder include requirement for higher doses than expected for an underlying pain condition, resistance to tapering despite poor analgesic response, alarming behaviours (e.g., patient frequently runs out early; patient accesses opioids from other sources; patient snorts, crushes, or injects oral opioids), poor psychosocial function and mood, and binge use with frequent withdrawal symptoms.

If the diagnosis is unclear, prescribers should:
- closely monitor the patient with frequent visits and urine drug screens (at least every 2 weeks)
- dispense opioids frequently (1-7 times weekly) in small quantities
- closely monitor the patient's pain and function
- refer patients to and/or seek a consult (by phone or email) with an addiction physician

If the patient has an opioid use disorder, develop and discuss the treatment plan with the patient.

Include the following messaging in your discussion of the treatment plan:
- options for initiation of buprenorphine or referral to an addiction specialist
- anticipated benefits of the treatment plan, including reduction of pain, prevention of overdose, and improvement in mood, energy level, and function

For most patients with opioid use disorder, initiate buprenorphine or refer the patient to an addiction physician for buprenorphine or methadone treatment.

Both buprenorphine and methadone have been shown to dramatically reduce opioid use, crime, and overdose. Buprenorphine can be safely prescribed and managed by family physicians.

If the patient refuses the treatment plan, and will not attend an addiction clinic, then taper the dose over 1-3 months, with frequent dispensing (as often as

daily). Continue to offer primary care, unless the patient has been abusive to office staff or other patients.

Educate patients with opioid use disorder about overdose and harm prevention.

All patients on opioids should be educated about overdose and harm prevention, in particular those with opioid use disorder. Several key points should be addressed:

For all patients taking illicit opioids or high doses of prescription opioids:

- Obtain a take-home naloxone kit. In many regions of the country, these kits are available at no cost and without a prescription, through naloxone programs or pharmacies.
- Avoid taking benzodiazepines or alcohol at the same time as the opioid.
- Use a lower dose if the opioid has not been taken for several days or more. Patients on prescribed opioids should contact their doctor for guidance.

For patients who misuse opioids (e.g., inject, crush or snort opioids, or acquire opioids from non-medical sources):

- Never use opioids alone and avoid taking benzodiazepines or alcohol at the same time as an opioid. If available, use opioids at a safe injection site.
- Give naloxone if a friend may have overdosed on opioids and call 911. Never leave the friend alone to "sleep it off".
- Use pharmaceutical opioids obtained by prescription rather than illicit opioids obtained from other sources. Caution patients that opioids obtained from other sources may contain fentanyl and that other dangerous adulterants are often added to heroin, morphine, oxycodone, and even to cocaine or crystal methamphetamine. This further increases the risk for overdose and death, even for heavy and experienced users.

Conclusion

Opioid prescribing and management in the community are complex issues. This report summarizes key prescribing messages that aim to minimize the use of opioids and reverse their associated harm, as well as to support community prescribers in the treatment of opioid use disorder.

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Reference

1. Appendix B-8-1: Oral opioid analgesic conversion table. In: Canadian guideline for safe and effective use of opioids for chronic non-cancer pain. Hamilton (ON): National Opioid Use Guideline Group (NOUGG); 2010 [cited 2016 Nov 9]. Available from: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b08.html

Eliminate Dangerous Dose Designations—Use a Leading Zero Before a Decimal

CBC.ca recently reported a medication incident that resulted in immediate harm and potential long-term complications to a young boy because he ingested a 10-fold overdose of risperidone daily over several months. The intended dose was 0.3 mL daily of risperidone solution but the dose on the prescription was written as ".3 mL daily". The prescription was dispensed with instructions to give 3 mLs (10 times the intended dose) every day.

ISMP Canada considers lack of a leading zero to be a dangerous dose designation. Use of a trailing zero *after* a decimal can also lead to 10-fold errors. We urge all healthcare providers and electronic prescribing and dispensing system designers to avoid using dangerous dose designations to prevent errors.

See ISMP Canada's Do Not Use List of Dangerous Abbreviations, Symbols and Dose Designations; available from: www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

Dose Designation	Example	Potential Problem	Correction
Trailing zero	x.0 mg	Decimal point is overlooked resulting in 10-fold dose error.	Never use a zero by itself after a decimal point. Use "x mg".
Lack of leading zero	.x mg	Decimal point is overlooked resulting in 10-fold dose error.	Always use a zero before a decimal point. Use "0.x mg".

Figure 1. Dangerous dose designations from ISMP Canada's *DO NOT USE Dangerous Abbreviations, Symbols and Dose Designations*

This "Close Up on Complaints" will follow a slightly different format than previous issues of *Pharmacy Connection*. In this issue, the case under review will be used to highlight a more systematic issue concerning the dual responsibilities of the individual professional (pharmacists and pharmacy technicians) and the corporation (including designated managers, owners and directors) when providing pharmacy services. The following discussion will examine the role and responsibility of each when providing pharmacy services to ensure optimal health outcomes for the patient.

PHARMACISTS, PHARMACY TECHNICIANS, DESIGNATED MANAGERS, DIRECTORS AND CORPORATIONS:

A SHARED RESPONSIBILITY FOR ETHICAL AND EFFECTIVE PHARMACY SERVICES

SUMMARY OF THE INCIDENT

This incident occurred when a pharmacist at Pharmacy A conducted a MedsCheck review for a regular patient who had multiple medical conditions and received weekly compliance aids from the pharmacy. When the pharmacist submitted the MedsCheck claim, it was rejected by the Ontario Drug Benefit (ODB) program for the reason that a MedsCheck had already been billed for this patient at another pharmacy, Pharmacy X, a few months before.

The patient did not currently attend Pharmacy X and had visited the pharmacy to purchase a blood glucose meter. The pharmacist at Pharmacy X conducted the MedsCheck without first reviewing the patient record and therefore was not aware that the patient had not filled a prescription at the pharmacy for over a year. The pharmacist did not request the patient's prescription history from his current pharmacy, Pharmacy A.

In addition, the patient did not recall participating in a MedsCheck from Pharmacy X. The patient remembered discussing his medical conditions but was unaware he was being provided a specific pharmacy service as opposed to the counselling he normally received from the pharmacist.

WHY DID THIS HAPPEN

The pharmacist working at Pharmacy X did not conduct the patient's MedsCheck in accordance with the Standards of Practice and Code of Ethics. The pharmacist did not consult the patient record or request the patient's medication history from Pharmacy A, and therefore did not have the appropriate information to complete a thorough review of the patient's medication.

Pharmacy X used computer software to identify potential patients that would qualify for a MedsCheck. Owners, directors, designated managers, and pharmacists and pharmacy technicians are reminded that while software and other methods can be used to encourage the provision of pharmacy services and identify potential opportunities to provide services, the service should only be delivered where the pharmacist reviews the specific patient circumstances and determines that the service is in the patient's best interest. Only those services that would benefit the patient and optimize care should be provided. In this case, it was apparent that there had been a communication breakdown between those responsible for

setting organizational expectations around pharmacy services and the front line pharmacists and pharmacy technicians who deliver them.

COMPLAINT OUTCOME

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

> "Your commitment to your professional role requires that you make decisions based on the needs and best interest of the patient and not your personal or business interests."

In considering this case, the Committee noted that while the pharmacist felt he was facing corporate pressure to complete pharmacy services, pharmacists and pharmacy technicians are accountable for their practice as a member of a regulated health profession and must ensure they are acting ethically and within the parameters of the Standards of Practice.

The Committee found that the pharmacist had not completed some of the fundamental steps involved in a MedsCheck, such as gathering a best possible medication history. The Committee issued advice and recommendations to the pharmacist to assist him in being more thoughtful in practice and ensuring he act in an ethical manner at all times, regardless of the corporate pressure he might be facing or his own personal or business interests.

The Committee also acknowledged that corporations, designated managers or directors on behalf of a corporation have a responsibility to ensure that pharmacy services are provided in a professional manner. The best interest of the patient must be the primary consideration and provision of any service must allow for the pharmacist or pharmacy technician to apply his or her professional judgement. Designated managers have the same practice obligations as registered pharmacists, in addition to being accountable for the operation of the pharmacy to ensure it supports pharmacists and pharmacy technicians in their cognitive and patient care functions.

LEARNING FOR PHARMACISTS, PHARMACY TECHNICIANS, DESIGNATED MANAGERS, DIRECTORS AND CORPORATIONS

Reflecting on this complaint provides pharmacists and pharmacy technicians and their employers with a number of learning opportunities to help improve the delivery of any pharmacy service. As noted above, while this example specifically refers to MedsChecks, the purpose of this *Close Up on Complaints* is to illustrate the importance of equal partnership between pharmacists and pharmacy technicians, and designated managers, directors and owners to ensure that all pharmacy services are provided appropriately with the goal of optimizing the health of patients. Healthcare providers must never forget that the most important characteristic of a healthcare professional is that they are committed, first and foremost, to the direct benefit of their patients and only secondarily to making a profit.

LEARNING FOR PHARMACISTS AND PHARMACY TECHNICIANS

The Standards of Practice and Code of Ethics clearly outline the responsibility of every individual pharmacist and pharmacy technician to maintain the patient's best interest as the core of all activities and to demonstrate personal and professional integrity when providing patient care. Regardless of a practitioner's position or practice environment, when a pharmacist or pharmacy technician performs a specific role, they must perform it to the level specified in the Standards of Practice and meet the standards associated with that role.

As a pharmacist or pharmacy technician, your commitment to your professional role requires that you make decisions based on the needs and best interest of the patient and not your personal

or business interests. Patients trust that healthcare professionals will use their specialized knowledge, skills and judgement to make decisions that enhance their health and well-being based on each patient's individual needs and circumstances.

This may not always be as simple as it sounds, and pharmacists and pharmacy technicians, will, at times, be required to evaluate whether providing a pharmacy service is professionally and ethically appropriate for the patient. Pharmacists and pharmacy technicians are accountable for any decision or action taken while providing patient care, including whether or not to provide a specific pharmacy service.

It is a practical reality that time constraints and limited resources will impact the provision of pharmacy services. This does not mean that the most appropriate option is to not provide any pharmacy services. Pharmacists must prioritize the provision of pharmacy services and use their professional judgment to determine which patients will most benefit from receiving a service.

To determine where to most appropriately allocate these services, pharmacists must consider the patient's medical history and other relevant factors, and where necessary seek information and ask questions of the patient to ascertain if the current or proposed medication provides the most appropriate therapy. By using professional judgment to determine the appropriateness of a pharmacy service, pharmacists and pharmacy technicians can ensure that services provided are of good quality and in accordance with the Standards of Practice.

Lastly, pharmacists and pharmacy technicians must be clear and transparent regarding any pharmacy services provided. Prior to providing a service, the pharmacist or pharmacy technician must inform the patient about what service they are providing so that the patient can make an informed decision about whether to receive the service from that pharmacy.

LEARNINGS FOR DESIGNATED MANAGERS, DIRECTORS AND CORPORATIONS

The Standards of Practice outline the responsibilities of a pharmacist when managing a pharmacy and the Standards of Accreditation (under the *Drug and Pharmacies Regulation Act*) outline the responsibilities of the designated manager, owner and directors when operating a pharmacy.

The Standards of Practice require designated managers to develop and implement policies and procedures that support continuous quality improvement and to ensure that staffing and workflow enable pharmacists and pharmacy technicians to fulfil standards of practice and optimize patient care.

> "There is an overarching obligation on designated managers, directors and corporations to support the provision of quality services."

The Standards of Accreditation require the provision of the necessary equipment, systems and staffing needed to allow members practicing in the pharmacy to meet the standards of practice of the profession.

The standards, taken together, create an overarching obligation on designated managers, directors and corporations to support the provision of quality services. This expectation applies to any service provided by pharmacists and pharmacy technicians.

RECOGNIZING SHARED RESPONSIBILITIES TO PROVIDE PATIENT CENTERED CARE

The College holds pharmacists, pharmacy technicians, designated managers, and directors (on behalf of corporations) accountable where professional obligations, expectations and responsibilities are not met – and equally enforces the clearly outlined responsibilities accorded to each role.

If a complaint comes to the College, a pharmacist or pharmacy technician cannot say that they had to do something (e.g. perform a medication review) that was not in the patient's best interest. A designated manager or director cannot say that they didn't know the appropriate environment, staffing or resources were not in place to support pharmacists and pharmacy technicians in providing quality patient care. It is the professional responsibility of pharmacists,

pharmacy technicians, designated managers and directors of corporations to ensure that each work-place environment supports the delivery of ethical and quality pharmacy services.

Pharmacists and pharmacy technicians need to ensure that they inform an appropriate person with oversight of pharmacy operations (e.g. pharmacy manager, designated manager, district manager) if they do not have the support required to practice to the Standards of Practice or if they reasonably believe human resources, policies, procedures, working conditions or the actions, professional performance or health of others may compromise patient care or public safety.

Designated managers and directors are required to ensure that each pharmacy – and corporation – maintains appropriate human resources to support pharmacists and pharmacy technicians in meeting the Standards of Practice.

Frequent and clear communication between pharmacists and pharmacy technicians, designated managers, owners and directors is essential to ensure that the pharmacy environment is sufficiently supported to provide services that are appropriate and of good quality. While it is acknowledged that business needs will be a consideration in the design and implementation of pharmacy services, the primary consideration must always be the patient's best interest.

CONTINUOUS QUALITY IMPROVEMENT (CQI):

An Essential Constituent of Patient/Medication Safety

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INTRODUCTION:

CURRENT LANDSCAPE OF CQI IN ONTARIO

In 2015, the Ontario College of Pharmacists (OCP) published an article entitled "CQI Benefits Patients in Community Pharmacies" in *Pharmacy Connection*,[1] highlighting the need for continuous quality improvement (CQI) and expecting CQI program adoption by community pharmacies in Ontario.[1] Furthermore, as per the standards of practice for the pharmacy profession, all pharmacists and pharmacy technicians have the responsibility and obligation to manage medication incidents and address unsafe practices.[1] Despite the potential significant benefits associated with CQI programs, to-date, the only Canadian province that has successfully implemented a mandatory standardized community pharmacy CQI program and reporting of medication errors is Nova Scotia.

In September 2016, the Institute for Safe Medication Practices Canada (ISMP Canada) and the Leslie Dan Faculty of Pharmacy at the University of Toronto collaboratively conducted a research survey, in an effort to explore and gain better insight into the current perceptions and implementation of CQI programs in Ontario community pharmacies. A 28-item online questionnaire was sent to Ontario community pharmacists and pharmacy technicians who provided consent to OCP to be contacted for research purposes during their annual registration. The questionnaire aimed to identify pharmacy professionals' perceptions about CQI and the current extent of CQI implementation, as well as perceived enablers and barriers to implementing a CQI program.

A total of 299 responses were collected and analyzed. Overall, pharmacy professionals have positive perceptions of CQI programs and the associated benefits to patient care and safety. However, the dominant concern with discussing and reporting medication incidents is associated with a perceived blame-and-shame culture in community pharmacy. With respect to CQI program implementation, time is considered to be the greatest challenge. In

addition, responses suggested that there is currently a large variance in the stage of implementation of CQI programs across community pharmacies. For pharmacies that have not implemented a CQI program, or have partially implemented one, the barriers to implementation cited included challenges in allocating adequate human resources to facilitate a CQI program and incorporation of CQI requirements into daily operations. The great variation in these responses implied that community pharmacies are currently at different stages with respect to implementation of a CQI program, which may be interpreted as a lack of standardization in CQI implementation and processes.

WHY DO WE NEED CQI? WHAT IS A STANDARDIZED CQI PROGRAM?

Continuous quality improvement (CQI) involves an ongoing and systematic examination of an organization's work processes and the employment of scientific methods to identify and address the root causes of quality issues and implement corresponding changes.[2] The benefits of CQI can be enormous – from an organizational management point of view, by regularly and systemically examining, monitoring, and improving core pharmacy workflow and processes, we can potentially eliminate sources of inefficiencies, suboptimal quality of care and services to patients, and enhance the overall system performance.[2]

We learned from responses to our recently administered CQI questionnaire (see above) that Ontario community pharmacies do not currently seem to have a standardized CQI approach or program in place. Compared to informal structures, standardized CQI programs offer unique advantages, such as:[2]

- Prompt communication and sharing of medication incident details (including contributing factors and immediate action plan towards the incident) among pharmacy team members;
- Trending and/or identification of common medication incidents occurring in pharmacy practice and corresponding recommendations of changes for prevention of incident reoccurrence; and
- Potential increase in staff engagement with a no-blame-no-shame culture of patient safety.

The typical components of a standardized or formal CQI program include (but are not limited to) the following:[3]

- Anonymous reporting of medication incidents to an independent, objective third-party organization that has the relevant expertise in medication incident analyses and commitment to sharing learning that is derived from trends and patterns of medication incidents reported by pharmacy professionals. An example of this resource is the ISMP Canada Community Pharmacy Incident Reporting (CPhIR) program, available at http://www.cphir.ca.[4]
- An open discussion on medication incidents and their associated root causes among pharmacy team members, followed by formal documentation of quality improvements made as a result of regular incident reviews during CQI or staff meetings at the pharmacy.
- Completion of a medication safety self® assessment on a regular basis (e.g. annually) for proactively identifying areas of improvement and monitoring progress of the resulting enhancement or action plans at regular CQI or staff meetings at the pharmacy. An example of this resource is the ISMP Canada Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy™, available at https://www.ismp-canada.org/amssa/.[5]

WHAT IS A MEDICATION INCIDENT?

A medication incident is "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer."[6] Medication incidents can occur at any stage of the medication-use process (e.g. prescribing, order entry, prescription preparation / dispensing, administration, and monitoring). Common types of medication incidents include incorrect drug, incorrect dose, incorrect frequency of administration, improper storage of medication, incorrect quantity, etc. These also include near misses (i.e. "an event that could have resulted in unwanted consequences, but did not because either by chance or through timely intervention [that] the event did not reach the patient")[6] and no harm events (i.e. an incident occurs and reaches the patient, but results in no harm to the patient, for example, events where the medication has been dispensed and may have been consumed by the patient, but the patient presents no symptoms or does not require treatment).[6]

On the other hand, an adverse drug event includes adverse drug reactions and harm from medication incidents.[6] According to the Canadian Adverse

Events Study, 7.5% of patients admitted to acute care hospitals in Canada experienced one or more adverse events, of which 36.9% were deemed to be preventable.[7] Therefore, sharing the learning from medication incidents (including near misses and no harm events) and having an ongoing strategy to review or prevent medication incidents can have significant implications and contribution to advancing patient/medication safety.

CONCLUSION:

CURRENT LANDSCAPE OF CQI IN CANADA – NOVA SCOTIA AND SASKATCHEWAN

Nova Scotia – SafetyNET-Rx

Looking at what is happening across Canada with respect to CQI program implementation – Nova Scotia is the only province that has successfully implemented a mandatory standardized community pharmacy CQI program and medication incident reporting – SafetyNET-Rx (http://safetynetrx.ca/) – since 2011.[3,8] SafetyNET-Rx encourages an open dialogue on medication errors and near misses among pharmacy professionals within community practice settings; it offers community pharmacies (in Nova Scotia) a one-stop access for evidence-based research findings on CQI, tools and resources pertaining to reporting and learning from medication incidents with an ultimate goal to improve workflow and processes for quality patient care.[9]

Saskatchewan – COMPASS™

Modelled after SafetyNET-Rx, COMPASS™ (Community Pharmacists Advancing Safety in Saskatchewan - http://saskpharm.ca/site/cqa_pp?nav=03) is a provincial quality assurance program (in Saskatchewan) designed to help pharmacies recognize, resolve, and learn from medication errors; it aims to provide community pharmacy professionals with the tools needed to better report and learn from medication incidents and to implement system-based changes in order to reduce the likelihood of similar incidents from recurring.[10] COMPASS™ has undergone three phases of pilot between 2013 and 2016, involving a total of 119 community pharmacies in Saskatchewan. It has demonstrated the following benefits with respect to CQI:[11]

- Increased pharmacy staff awareness of safety issues;
- Reduction of blame-and-shame with open discussion of medication incidents and near misses;
- Perceived reduction in the number of medication incidents occurring at the pharmacy; and
- Increased scrutiny of workflow processes resulting in formal changes for quality improvement.

In conclusion, both SafetyNET-Rx and COMPASS™ are standardized CQI programs, which include the following key components:[8,11]

- Reporting of medication incidents anonymously to an independent, objective third-party organization for the purpose of generating a national aggregate incident database;
- Completion of a medication safety self-assessment (MSSA) regularly (e.g. annually or bi-annually);

- Scheduling of regular (e.g. annually or as frequent as quarterly) CQI or staff meetings in order to educate pharmacy team members on patient/medication safety, discuss medication incidents, complete the MSSA, or develop and monitor quality improvement plans, etc.;

- Development, monitoring, and documentation of quality improvement plans at regular CQI or staff meetings; and

- Designation of an individual team member to be the Quality Assurance coordinator at each pharmacy.

In Ontario, as shown by the CQI survey analysis findings (see above), although pharmacy practitioners recognize the benefits of CQI programs, there is not a standardized CQI program implemented in community pharmacies and therefore, there is marked variation in the stage of implementation of a CQI program across pharmacies surveyed. Our findings are consistent with a previous study by Boyle et al[3] in Nova Scotia where the uptake of CQI standards of practice by community pharmacies varied, depending on the pharmacy characteristics, pharmacy location, prescription volume, etc. CQI is an essential component of patient/medication safety advancement and the implementation of a standardized CQI program (as supported by evidence from SafetyNET-Rx in Nova Scotia and COMPASS™ in Saskatchewan) is a crucial step in going forward to achieve the mission of error reduction and mitigation of patient harm. At the same time, a critical yet complementary element in safe medication practices is that we should always share our learning from medication incidents and medication error reporting, and make sustainable changes in practice.

OTHER RESOURCES

For further examples of how CQI programs support medication incident learning and help improve medication safety, case studies have been documented in the following reference texts:

- Boyle TA, Ho C. Chapter 28: Medication incidents and quality improvement. In: Hindmarsh KW, ed. *Pharmacy management in Canada*. Mississauga, ON: The Canadian Foundation for Pharmacy, 2015; 249-260.

- Hincapie AL, MacKinnon NJ, Nau DP, Warholak TL. Chapter 117: Assessing pharmacy-related quality of care. In: Allen LV, Jr, ed. *Remington: The science and practice of pharmacy*, 22nd ed. Philadelphia, PA: Pharmaceutical Press, 2012; 2685-2693.

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11. Saskatchewan College of Pharmacy Professionals. COMPASS™ to become a standardized CQA program in all Saskatchewan community pharmacies. In: *SCOPe newsletter: Quality pharmacy care in Saskatchewan* 2016 December; 8(6): 5-6. Available from: http://scp.in1touch.org/uploaded/web/SCOPe_Newsletter_December2016.pdf (accessed January 5, 2017).

Thank you, PRECEPTORS & EVALUATORS!

Pharmacists and pharmacy technicians have consistently demonstrated commitment to their students, interns and pharmacy technician applicants – and to the profession – by fulfilling roles as preceptors in the SPT Program. The tremendous dedication our preceptors put forward in supporting future colleagues is pivotal to its success. Thank you preceptors.

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AMHERSTBURG

MacDonald, Christopher ..... Rexall Pharma Plus
Schiefer, Joshua ..... Emrose Medical Pharmacy

AMHERSTVIEW

Gellert, Chantell ..... Hunt's Pharmacy

ANCASTER

MacKinnon, Jesse ..... Costco Pharmacy

ANGUS

McLeish, Natalie ..... Angus Borden Guardian Pharmacy

AURORA

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Pang, Vincent ..... Remedy's Rx
Shenouda, John ..... Hollandview Pharmacy
Tam, Rosannawai ..... Remedy's Rx
Yong, Pei ..... Summit Veterinary Pharmacy Inc

BARRIE

Albach, Abdulkader ..... Shoppers Drug Mart
Bomenhalli Krishne, Gowda ..... Pharma Plus
Chang, Nathan ..... Rexall Pharma Plus
Chen, Guo ..... Pharma Plus
Conlin, Jacquelyne ..... Medisystem Pharmacy
D'Souza, Stanley ..... Loblaw Pharmacy
Dube, Betty ..... Shoppers Drug Mart
Francis, Karim ..... Shoppers Drug Mart
Kaloti, Amandeep Kaur ..... Shoppers Drug Mart
MacCarthy, Kevin ..... Royal Medical Pharmasave
Malik, Sajjad ..... Kempenfelt Pharmacy
Mankarious, Maged ..... Shoppers Drug Mart
Miller, Marie ..... Wal-Mart Pharmacy
Momberg, Margaret ..... Sobeys Pharmacy
Ogundipe, Boluwaji ..... Costco Pharmacy
Pojmaj, Jolanta ..... Loblaw Pharmacy
Zarate, Priscilla Anne ..... Loblaw Pharmacy

BEAMSVILLE

Menon, Seema ..... Rexall
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BELLEVILLE

Vieira, Leanne ..... Quinte Health Care

BLENHEIM

Roberts, Nicholas ..... Mcintyre Pharmacy Ltd

BOLTON

Awad, Medhat ..... Total Health Pharmacy
Cvancic, Sara ..... Total Health Pharmacy
Gobran, Nabil ..... Total Health Pharmacy

BOWMANVILLE

Rice, Patricia ..... Bowmanville Clinic Pharmacy Limited

BRACEBRIDGE

Krahn, Leo ..... Rexall Pharma Plus

BRADFORD

Perrotta, Enrico ..... Rexall

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Azer, Maria ..... Logos Pharmacy
Bajaj, Jaspreet ..... Father Tobin Pharmacy
Bansal, Viney ..... Shoppers Drug Mart
Bassi, Navjot ..... Loblaw Pharmacy
Bhardwaj, Arun ..... Healthplex Pharmacy
Bhatti, Balpreet ..... Shoppers Drug Mart
Brar, Navraj ..... Pharmasave
Camarillo, Mildred ..... Shoppers Drug Mart
Ceci, Ada ..... Rexall
Chaudhry, Mukesh ..... Vital RX Pharmacy
Chauhan, Kalpesh ..... Shoppers Drug Mart
Chauhan, Tejal ..... Castlemore Remedy's RX Pharmacy
Darji, Dharmegn ..... Pharma Plus
De Torres, Eva ..... Cumberland Pharmacy
Desai, Bhavin ..... Allwell Pharmacy Inc.
Dhillon, Manveer ..... Pharmasave Bramcity Pharmacy
D'Souza, Sandra ..... Shoppers Drug Mart
Elbadri, Dina ..... Shoppers Drug Mart
Georgy, Eveline ..... Northview Pharmacy
Ghattas, Salwa ..... Cornerstone Pharmacy
Gill, Harmanpreet ..... Bramcentre Pharmacy
Guirgis, Yvonne ..... Rexall
Gupta, Chakshu ..... Costco Pharmacy
Hanna, Rania ..... Shoppers Drug Mart
Hernane, James ..... Shoppers Drug Mart
Kaushik, Ram ..... Rexall
Khachh, Sharanjit ..... Shoppers Drug Mart
Khaira, Hiteshwar ..... Shoppers Drug Mart
Kondoor, Sunitha ..... Shoppers Drug Mart
Lucasan, Rosabella ..... Shoppers Drug Mart
Mahmood, Saima ..... Shoppers Drug Mart
Matalia, Hardikkumar ..... Allwell Pharmacy Inc.
Messiha, Samuel ..... Shoppers Drug Mart
Nanji, Alisha ..... Kensington Pharmacy
Nejat, Jinous ..... Shoppers Drug Mart
Nguyen, Ellie ..... Shoppers Drug Mart
Parikh, Nishant ..... Westbram Pharmacy
Patel, Sangeeta ..... Charolais Pharmacy
Pleta, Jo Ann ..... Shoppers Drug Mart
Ramaswamy, Manisha ..... Shoppers Drug Mart
Rampartab, Natasha ..... Pharma Plus
Rathi, Satyajeet ..... Loblaw Pharmacy
Rattia, Gurpreet ..... Castle Oaks Pharmacy
Riar, Nina ..... Bramalea BestCare Pharmacy
Rizarri, Ethel ..... Shoppers Drug Mart
Rizvi, Kehkashan ..... Rexall
Rygailo, Kelly ..... Hoopers Pharmacy
Saad, Neven ..... Greencross Drugs
Sehdev, Naresh ..... Shoppers Drug Mart
Shah, Dushyant ..... Mayfield Pharmacare
Sharma, Shamah ..... Pharma Plus
Shenouda, Baher ..... Pan Drugs
Singh, Parvinder ..... BramNorth Pharmacy
Smilsky, Diane ..... Shoppers Drug Mart
Suliman, Fady ..... Cornerstone Pharmacy
Tatla, Sukhjeev ..... Brisdale Pharmacy
Varghese, Zacheriah ..... Drugstore Pharmacy
Wang, Sharon ..... Shoppers Drug Mart

BRANTFORD

Gambacort, Ashley ..... Avenue Pharmacy
Mimar, Rana ..... Remedy's Rx
Morgan, John ..... Brantford Life Care Pharmacy
Rana, Rashda ..... Fairview Remedy's Inc.
Thapar, Atul ..... Wincare Drug Mart

BRIGHTS GROVE

Denesyk, Katherine ..... Shoppers Drug Mart

BROCKVILLE

Groves, Leslie ..... Rexall

BURLINGTON

Abdelmalak, Vivian ..... Next Door Pharmacy
Alveza, Ma. Berta ..... Maple I.D.A. Pharmacy
Balac, Mirjana ..... Joseph Brant Hospital
Cousins, Marilyn ..... Classic Care Pharmacy
Desai, Manisha ..... Smartmeds Pharmacy
El Kabbani, Mayada ..... Aldershot Village Pharmacy
Elia, Abeer ..... Plains Medical Pharmacy
Feret, Sandra ..... Innomar Specialty Pharmacy
Georges, Nabil ..... Aldershot Guardian Pharmacy
Handa, Jason ..... Smartmeds Pharmacy
Killeny, Raief ..... Total Health Pharmacy
Mansour, Dianne ..... Innomar Specialty Pharmacy
Moloughney, Adora ..... Classic Care Pharmacy
Salama, Heba ..... Shoppers Drug Mart
Sharma, Rohit ..... MedProHealth Pharmacy
Stojanovic-Kojic, Jelena ..... Pharma Plus
Yasseen, Baseer ..... Shoppers Drug Mart

CAMBRIDGE

Amr, Mona ..... Langs Medical Pharmacy
Butt, Shahzad ..... Shoppers Drug Mart
Digiovanni, Matthew ..... Hespeler Pharmacy
Matta, Tamer ..... Casey's Pharmacy
Olayemi, Funmilayo ..... Loblaw Pharmacy
Papalambropoulos, Haralambos ..... Rexall

CHATHAM

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White, Albert ..... Rexall

CHELMSFORD

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COLLINGWOOD

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CORNWALL

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Froats, Jessica ..... Cornwall Community Hospital - McConnell Site
Gobran, Samy ..... Shoppers Drug Mart
Greis, Younan ..... Pitt Street Pharmacy
Hamed, Eslam ..... Shoppers Drug Mart
Hanna, Andrew ..... Cotton Mill Pharmacy
Pilon, Suzie ..... Medical Arts Phcy Cornwall Ltd

DOWNSVIEW

Ismail, Fatima ..... Nor-Arm Pharmacy
Joseph, Josee ..... Jane Centre Pharmacy
Kherani, Alym ..... Shoppers Drug Mart
Mostaan, Mahsa ..... Shoppers Drug Mart
Samuel, Refat ..... Jane Centre Pharmacy

DUNDAS

Grace, Mourad ..... Right Care Pharmacy

EAST GWILLIMBURY

Saifi, Parinaz ..... Costco Pharmacy

ELLIOT LAKE

Venter, Martinette ..... Shoppers Drug Mart

ERIN

Ugbosu-Maya, Lois ..... Pharma Plus

ESPANOLA

Lalonde, Karen ..... Remedy'sRx

ETOBICOKE

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Ali, Kareem ..... Shoppers Drug Mart
Ashraf, Muhammad ..... Woodbine Pharmacy Pharmachoice
Baslious, George ..... Renforth Pharmacy
Boctor, Julie ..... Islington Medical Pharmacy
Chan, Christopher ..... Shoppers Drug Mart
Der-sahakian, Sylvia ..... Shoppers Drug Mart
Eskandar, Wael Alfy Kirllos ..... Renforth Pharmacy
Fraser, Minglin ..... Rexall
Hafez, Sherine ..... Trust Care LTC Services
Hassan, Farhana ..... Woodbine Pharmacy Pharmachoice
Milanovic, Christopher ..... Costco Pharmacy
Patel, Pratik ..... One Eva Pharmacy
Pileggi, Giuseppe ..... Shoppers Drug Mart
Raheem, Arif ..... Wal-Mart Pharmacy
Rakov, Gennadiy ..... Shoppers Drug Mart
Soor, Anmol ..... Shoppers Drug Mart
Sourial, Ramy ..... Sav-On Drug Mart
Sundaramoorthy, Ragavan ..... Shoppers Drug Mart
Takhar, Harvinder ..... Rexdale Medical Pharmacy
Trat, Daniel ..... Costco Pharmacy
Wajid, Abdul ..... Loblaw Pharmacy
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FOREST

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FORT ERIE

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Hanna, Peter ..... Young's Pharmacy And Homecare
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GRAND BEND

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GRAVENHURST

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GRIMSBY

Costa, Despina ..... Shoppers Drug Mart

GUELPH

Abdelmalak, Medhat ..... Royal City Pharmacy
Husain, Diary ..... Costco Pharmacy
Manson, Kenneth ..... Rexall
McNamara, Mark ..... Shoppers Drug Mart
Meleka, Malak ..... Campus Drugmart

HAGERSVILLE

Gandhi, Vinod ..... Cavanagh IDA Pharmacy

HAMILTON

Abd El Hadi, Ahmed ..... Samy's Drug Mart
Ahmad, Muhammad Basil ..... Shoppers Drug Mart
Aziz, Tamer ..... Upper James Clinic Pharmacy
Bernard, Sandra ..... Loblaw Pharmacy
Cassavia, Orlando ..... MT Cross Pharmacy
Elia, Abeer ..... Guardian Hamilton Care Pharmacy
Enyinniah, Brendan ..... Shoppers Drug Mart
Giudice, Giuseppe ..... Shoppers Drug Mart
Houneini, Wassim ..... Shoppers Drug Mart
Kajan, Stephanie ..... Limeridge Medical Pharmacy
Kurian, Betty ..... People's Pharma Choice
Kurian, Prabha ..... Shoppers Drug Mart
LaPalme, Monique ..... Juravinski Hospital
Lavji, Shemin ..... Remedy's Rx Healthcare Plus Pharmacy
Le, Angie ..... Hamilton Health Sciences Corp
Matache, Daniel ..... Shoppers Drug Mart
Nagra, Bhupinder ..... Shoppers Drug Mart
Parihar, Kavita ..... McMaster University Medical Centre & Children's Hospital
Pidar, Bhoj ..... Rexall
Ramsbottom, Katrina ..... Rexall
Rana, Ayesha ..... Shoppers Drug Mart
Ross, Ivan ..... McMaster University Medical Centre
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KANATA

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MacDonald, Russell ..... Shoppers Drug Mart
Pappin, Janet ..... Kanata Pharmasave

KESWICK

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KINCARDINE

Luk, David ..... Rexall Pharma Plus

KINGSTON

Akinwumi, Olumide ..... Rexall
Ho, Mary ..... Correctional Service of Canada
Hussein, Tarek ..... Weller Pharmacy
Schell, Maria ..... Shoppers Drug Mart
Sekhon, Charanjeev ..... Shoppers Drug Mart
Slack, Andrea ..... Shoppers Drug Mart
Todd, Paula ..... Costco Pharmacy

KITCHENER

Abbas, Zohaib ..... Shoppers Drug Mart

Abdel Sayed, Ehab ..... The Tannery Pharmasave
Abdel Shahid, Mina ..... Queens Pharmacy
Brar, Gurinder ..... Fairway Lackner Pharmacy
El Sheikh, Salah ..... Victoria Hills Pharmacy
Fawzy, Hoda ..... Aim Medical Pharmacy
Johnson, Michael ..... Wal-Mart Pharmacy
Muncic, Marina ..... Pharma Plus
Naidoo, Abilashen ..... Shoppers Drug Mart
Saad, Maged ..... Shoppers Drug Mart
Young, Cathrine ..... CATP

LAKEFIELD

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LASALLE

Adebayo, Adeniyi ..... Loblaw Pharmacy

LEAMINGTON

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Soulliere, Kimberly ..... Leamington District Memorial Hospital

LINDSAY

Tatchell, Kelly ..... Ross Memorial Hospital

LONDON

Adeniran, Modupe ..... Loblaw Pharmacy
Alade, Oluyemisi ..... Prescription Centre
Awad, Gamal ..... Guardian Wonderland Pharmacy
Baskette, John ..... London Health Sciences Centre
Bhalodia, Mitul ..... MedicalRx Pharmacy
Brown, Tracy ..... Shoppers Drug Mart
Chatha, Naveed-e-Sahar ..... Shoppers Drug Mart
Dacosta, Jaclyn ..... London Health Sciences Centre
El-Sabbahi, Assmaa ..... Medisystem Pharmacy
Geoffrey, Belinda ..... London Health Sciences Centre
Gohil, Subhashchandra ..... MedSave Pharmacy Ltd.
Kolendowski, Kimberly ..... London Health Sciences Centre
Lefave, Laura ..... North Tower Prescription Centre
McCaskill, Jody ..... London Regional Cancer Centre
O'Hara, Robert ..... Medcen Pharmacy
Patel, Vikas ..... Rexall I.D.A Medsana Pharmacy
Redae, Sahleslassie ..... Masonville Pharmacy
Sarga, Emad ..... Lambeth Drugs
Semchism, James ..... Ealing Pharmacy Limited
Sensabaugh-Parker, Sabrina ..... Victoria Hospital
Soni, Amar ..... Pharma Plus
Stovel, Jessica ..... London Health Sciences Centre
Suleiman, Munir ..... Shoppers Drug Mart
Yausie, Amanda ..... University Hospital

MAPLE

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Khan, Ahsan ..... Medi Pharm 2 Pharmacy
Zafar, Khuzaima ..... Mackenzie Pharmacy

MARKHAM

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Chowdhury, Michael ..... Wal-Mart Pharmacy
Kho, Katherine ..... Markham Stouffville Hospital
Luong, Michelle ..... Costco Pharmacy
Mody, Manika ..... Loblaw Pharmacy
Vali, Parvaneh ..... World Pharmacy
Woo, Willie ..... The Chemist Pharmacy
Yuen, Ann ..... Markham Stouffville Hospital
Zaidi, Syed Muhammad ..... Costco Pharmacy
Zaki, Salwa ..... Focus Drug Mart

MIDLAND

Gignac, Danielle ..... Wal-Mart Pharmacy
Mallows, Vaughan ..... Georgian Bay General Hospital
Tolmie, Michael ..... Shoppers Drug Mart

MILTON

Boctor, Samar ..... Medicine Shoppe Milton
Fikry, Nesreen ..... Total Health Pharmacy
Ghali, Alfonse ..... Main St. Center Pharmacy
Jeon, Hee ..... Rexall
Philips, Hany ..... St. George Pharmacy
Shalvardjian, Peter ..... Shoppers Drug Mart

MISSISSAUGA

Abd El Malak, Jakleen ..... Lisgar Pharmacy
Ahmad, Jauher ..... Shoppers Drug Mart
Ahmad, Navid ..... Battleford Pharmacy Inc
Ahmad, Nwar ..... Calea
Ahmad, Sarah ..... Medisystem
Al Khafaji, Sarah ..... Shoppers Drug Mart
Alyazgi, Shadi ..... Dundas Medical Pharmacy
Andipara, Bhargav ..... Medisystem
Aziz, Ehab ..... Marcos Pharmacy
Aziz, Farid ..... Shoppers Drug Mart
Badran, Mai ..... Health Plus Pharmacy
Bahnam, Mais ..... Guardian Matheson Pharmacy
Basar, Marvin ..... Shoppers Drug Mart
Bassi, Navpreet ..... Shoppers Drug Mart
Bath, Jagdeep ..... The Credit Valley Hospital
Bedi, Jasvinder ..... Shoppers Drug Mart
Benegal, Suraj ..... City Centre Remedy's Rx
Berbecel, Manuela ..... Costco Pharmacy
Cabading, Leonora ..... Total Health Pharmacy
Chan, Pui Kar ..... Shoppers Drug Mart
Chaudhry, Nadim ..... Clarkson Pharma Choice
Cheng, Lucy ..... Shoppers Drug Mart
Dias, Angelo ..... Derry Village IDA
Doan, Peter ..... Shoppers Drug Mart
Esguerra, Monaliza ..... Shoppers Drug Mart
Girgis, John ..... Apple-Hills Medical Pharmacy
Gould, Kelly ..... Baxter Pharmacy Services
Haj-Bakri, Mohamad ..... Hiway 10 Pharmacy
Hanna, Rita ..... Shoppers Drug Mart
Hussain, Khurram ..... Shoppers Drug Mart
Ibrahim, Nader ..... Shoppers Drug Mart
Jewusiak, Natalka ..... The Credit Valley Hospital
Kamal, Neda-Siddiqui ..... The Credit Valley Hospital
Karmali, Sadiq ..... Costco Pharmacy
Kaushal, Neha ..... Shoppers Drug Mart
Khullar, Bobita ..... Vardhman's Guardian Pharmacy
Kim, Mee Sun ..... Medisystem
Kim, Sue Min ..... Shoppers Drug Mart
Kolekevska, Tatjana ..... Shoppers Drug Mart
Lam, Sun ..... FuWal-Mart Pharmacy
Lau, Ying ..... Express Scripts Canada Pharmacy
Le, Wayne ..... Shoppers Drug Mart
Lekhi, Ameesh ..... Shoppers Drug Mart
Luong, Duy ..... Shoppers Drug Mart
Maalawy, Moheb ..... Sandalwood Drugs
Maghera, Jagjit ..... Shoppers Drug Mart
Mah-Allum, Yee-ping ..... Costco Pharmacy
Mahrous, Tamer ..... Eglinton Churchill Medical Pharmacy
Masroor, Maryam ..... The Trillium Health Centre
Mikhael, Marc ..... Erin Centre Pharmacy
Morgan, Nabil ..... Shoppers Drug Mart
Moussa, George ..... Millcreek Pharmacy
Nguyen, Anna ..... Shoppers Drug Mart
Nguyen, Ellie ..... Shoppers Drug Mart
Paggos, Marios ..... Shoppers Drug Mart
Patel, Anil ..... Shoppers Drug Mart
Patel, Jai ..... Unicare Pharmacy of Mississauga
Patel, Nikki ..... Shoppers Drug Mart
Patel, Pradip ..... River Run Pharmasave

Rajput, Jasbir . . . . . City Centre Remedy's Rx
Rambaksh, Zarin . . . . . Shoppers Drug Mart
Saad, Adel . . . . . Thomas Pharmacy
Saad, Morcos . . . . . Parkside Pharmacy
Sarofiem, John. . . . . Main Drug Mart
Sathyanarayanan, Sri . . . . . Derry Village IDA
Shafqat, Qaisar. . . . . Battleford Pharmacy Inc
Shah, Alpaben. . . . . Drugstore Pharmacy
Shah, Khyati . . . . . Shoppers Simply Pharmacy
Shin, Sandra . . . . . Marketplace Pharmacy
Stoch, Malgorzata. . . . . Shoppers Drug Mart
Subrath, Rhea. . . . . The Credit Valley Hospital
Suthar, Pareshkumar . . . . . Floradale Medical Pharmacy
Talwar, Sheena . . . . . Medisystem
Tang, Waymond. . . . . The Credit Valley Hospital
The, Nikita . . . . . Shoppers Drug Mart
Tran, Michelle . . . . . Shoppers Drug Mart
Tran, Thao . . . . . Costco Pharmacy
Ur Rehman, Najeeb . . . . . Shoppers Drug Mart
Yuan, William . . . . . Medisystem
Zaidi, Syed . . . . . Greenfield Pharmacy
Zou, Xin . . . . . Shoppers Drug Mart

NAPANEE

Burns, William . . . . . Wallace's Drug Store Limited
Hager, Jason. . . . . Gray's IDA Drug Store

NEPEAN

Doshi, Jayal. . . . . Shoppers Drug Mart
Frankenne, Angela . . . . . Loblaw Pharmacy
Gabriel, Sally. . . . . Centrepointe Gabriel Drugs
Ghadianlou, Leila. . . . . Rexall
Guest, Michael. . . . . Medisystem Pharmacy
Nahal, Bikramjit . . . . . Pharmacity Drugstore
Taban, Katayoun . . . . . Rexall Pharma Plus

NEW LISKEARD

Alexander, Bruce . . . . . Findlay's Drug Store

NEWMARKET

Bashta, Mena . . . . . Skycare Pharmacy
Gasic, Dragana. . . . . Shoppers Drug Mart
Khalil, Shehab. . . . . Newmarket Pharmacy
Lau, Simon. . . . . Southlake Regional Health Centre

NIAGARA FALLS

Ibrahim, Medhat. . . . . Portage Medical Pharmacy
Isak, Mina . . . . . Golden Care Pharmacy
Rezkalla, Ihab. . . . . Valley Way Pharmacy

NORTH BAY

Brown, Kalvin . . . . . Kalvin Brown Pharmasave
Dorie, Erin . . . . . Shoppers Drug Mart
Godreau, Mary. . . . . Shoppers Drug Mart
Latimer, Sarah . . . . . Kalvin Brown Pharmasave
Pilon, Andreea . . . . . Pharmacy
Remillard, Roch . . . . . CATP
Simpson, Pamela . . . . . Pharmasave

NORTH YORK

Abd El Sayed, Fakhry. . . . . Rainbow Drug Mart
Aletaha, Hamid. . . . . North York City Centre Pharmacy
Atalla, Manar. . . . . Health Drug Mart
Bouls, Hany. . . . . Ben Medical Pharmacy
Fung, Jonathan . . . . . Shoppers Drug Mart
Ghali, Carole. . . . . Victoria Terrace Pharmacy
Hanna Guirguis, Karim . . . . . 3M Lawrence Pharmacy
Jacoub, Phieby. . . . . Main Drug Mart
Kupchak, Taras. . . . . Shoppers Drug Mart
Lamonica, Vincenzo . . . . . Columbus Pharmacy
Lin, Yong. . . . . Shoppers Drug Mart
Mehany, Bahaa. . . . . Main Drug Mart
Rajan, Shamin. . . . . Shoppers Drug Mart
Rajan, Vinit. . . . . Shoppers Drug Mart
Rezaei, Soheila . . . . . Ariana Pharmacy
Soroka, Yevgeniya. . . . . Shoppers Drug Mart

OAKVILLE

Bebawy, Adel. . . . . Queen's Drug Mart
Boutros, Rania . . . . . White Oaks Pharmacy
De Rango, Fabio . . . . . Shoppers Drug Mart
De Rango, Marie . . . . . Shoppers Drug Mart
Eskandar, Tamer. . . . . Advanced Care Specialty Pharmacy Inc.
Gendy, Mervat . . . . . Oakville Town Centre Pharmacy
Gouda, Michael . . . . . Halton Pharmacy
Iskandar, Nermin . . . . . Cims Pharmacy
Janmohamed, Alim. . . . . Pharma Sense
Kamel, Christine . . . . . Total Health Pharmacy
Masud, Muhammad . . . . . Shoppers Drug Mart
Moon, Jane . . . . . BioScript Pharmacy Oakville
Sourial, Emad . . . . . Oak Park Community Pharmacy
Spisich, Barbara . . . . . Shoppers Drug Mart
Tieman-Sengupta, Barbara . . . . . Shoppers Drug Mart

ORILLIA

Spinosa, Lisa . . . . . Classic Care Pharmacy
Vashishta, Yash. . . . . Downtown Dispensary
Yassa, Sameh. . . . . Downtown Dispensary

ORLEANS

Khalil, Raafat . . . . . St. Mary Health Center Pharmacy
Nashed, Marc . . . . . Asclepios Pharmacy

OSHAWA

Bansal, Sandeep. . . . . Shoppers Drug Mart
Bick, Erin . . . . . Medical Pharmacy
Cheung, Chun-keung . . . . . Shoppers Drug Mart
Dengre, Neha. . . . . Loblaw Pharmacy
Froude, Nancy . . . . . Lakeridge Health
Jejna, Marsha . . . . . Loblaw Pharmacy
Shah, Sujay . . . . . Oshawa Discount Pharmacy
Tsang, Cecilia . . . . . Wal-Mart Pharmacy
Wan, William. . . . . Sobeys Pharmacy

OTTAWA

Abdalla, Amira. . . . . Shoppers Drug Mart
Abdalla, Mohamed . . . . . Shoppers Drug Mart
Abushaikha, Wael . . . . . Shoppers Drug Mart
Albitar, Eda. . . . . Shoppers Drug Mart
Ali-abdullah, Samira . . . . . Loblaw Pharmacy
Bhatti, Sarah . . . . . Medical Pharmacy
Blanchard, Susan. . . . . Childrens Hospital of Eastern Ontario
Desjardins, Veronik. . . . . Montfort Hospital
Forster, Shannon. . . . . Loblaw Pharmacy
Hassan, Zaineb. . . . . Rexall
Hayes, Carolyn. . . . . Classic Care Pharmacy
Ibrahim, Najlaa . . . . . Shoppers Drug Mart
Jean, Melina . . . . . Saint-Vincent Hospital
Keryakos, Emad . . . . . Wellington Drug Store
Komy, Hany. . . . . Kilborn Pharmacy
Kuo, Alexander. . . . . The Ottawa Hospital
Lamont, Kimberley. . . . . The Ottawa Hospital
Lloyd, Adam . . . . . Shoppers Drug Mart
Ma, Guo . . . . . Pharm Can Drug Mart
MacKenzie, Jane . . . . . The Ottawa Hospital
Ngo, Van Chuong Nathaniel . . . . . Costco Pharmacy
Pour-Ghorban, Mandana. . . . . Costco Pharmacy
Rizk, Adel . . . . . Shoppers Drug Mart
Salidis, Maher . . . . . Greenboro Pharmacy
Singh, Navdeep . . . . . Medical Pharmacy

Swetnam, Jennifer ..... Shoppers Drug Mart
Thai, John ..... Medical Pharmacy

OWEN SOUND

Garrett, Lisa ..... Shoppers Drug Mart
McCarley, Barbara ..... Grey Bruce Health Services

PARIS

Balicki-Bencic, Maureen ..... Sobeys Pharmacy

PEMBROKE

Fazaa, Karim ..... Rexall Pharma Plus
Warlich, Amy ..... Pembroke Regional Hospital Inc

PENETANGUISHENE

Dubeau, Valerie ..... Waypoint Centre for Mental Health Care
Livingston, Lori ..... Waypoint Centre for Mental Health Care

PERTH

Webster, Heather ..... Perth and Smiths Falls District Hospital

PETAWAWA

Oza, Jaimin ..... Shoppers Drug Mart

PETERBOROUGH

Azubuike, Madukwe ..... Loblaw Pharmacy
El Sayed, Ghada ..... Sherbrooke Heights Pharmacy
Elmedany, Heba ..... Wal-Mart Pharmacy Hong, Ely
Loblaw Pharmacy Kim, Jennifer ..... Loblaw Pharmacy
Lovick, Stephen ..... Medical Centre Pharmacy
Milbury, Evan ..... Rexall
Recoco, Russelle ..... Westmount Pharmacy
Semlitch, Courtney ..... Mather & Bell Pharmacy Limited
Wong, Becky ..... CATP/DrugSmart Pharmacy

PICKERING

Hanna, Adel ..... Glendale Pharmacy
Patel, Hiren ..... Rexall
Prasad, Ajish ..... Shoppers Drug Mart
Zaidi, Mahnoor ..... Shoppers Drug Mart

PICTON

Arbiter, Fiona ..... Pharma Plus

PORT ELGIN

Khan, Muhammad ..... Shoppers Drug Mart

PORT HOPE

Plummer, Donald ..... Port Hope Pharmasave

POWASSAN

Cheverie, Danielle ..... Clements IDA Pharmacy

PRESCOTT

Liang, Xiao Bei ..... Remedy'sRx

RENFREW

Johannesson, Anna ..... Rexall Pharma Plus

REXDALE

Labib, Ihab ..... Humber Green Pharmacy
Ratti, Gaurav ..... Shoppers Drug Mart
Sharma, Bharti ..... Shoppers Drug Mart

RICHMOND HILL

Abu El Khire, Anis ..... Health Link Pharmacy
Ahn, Jennifer ..... Shoppers Drug Mart
Avetissov, Vera ..... Shoppers Drug Mart
Avinashi, Gunjan ..... Shoppers Drug Mart
Colella, Giuseppe ..... Shoppers Drug Mart
Goudarzi, Alireza ..... Oakridges Plaza Pharmacy
Habashy, Mary ..... Shoppers Drug Mart
Habib, Sameer ..... Uptown Apothecary
King, Renee ..... Medical Pharmacy
Li, Kwan Ting ..... Shoppers Drug Mart
Lim, Suhyeon ..... Costco Pharmacy
Loduca, Richardo ..... Shoppers Drug Mart
Lorestani, Shohreh ..... Shoppers Simply Pharmacy
Mandlsohn, Mark ..... Shoppers Drug Mart
Motahari, Massoud ..... Costco Pharmacy
Rahman, Md Khalilur ..... Yonge Medical Centre Pharmacy
Youssef, Lina ..... Elgin Care Pharmacy
Zhang, Li Ping ..... Upper Yonge Pharmacy

SARNIA

Laporte, Marcel ..... BMC Pharmacy
Miller, Jennifer ..... Loblaw Pharmacy
Moore, Darryl ..... Bluewater Pharmacy
Parekh, Subhashh ..... Vidal Pharmacy
Wallis, Darryl ..... Shoppers Drug Mart

SAULT STE MARIE

Disano, Joel ..... Market Mall Pharmacy
Kniahnicki, Carissa ..... Rexall Pharma Plus
Lappalainen, Carla ..... Group Health Centre Pharmacy
Law, Jordan ..... Group Health Centre Pharmacy

SCARBOROUGH

Abdel Sayed, Amgad ..... Extra Care Pharmacy
Abdullah, Ahmad ..... Shoppers Drug Mart
Amro, Moe ..... Shoppers Drug Mart
Atagu, Zorah ..... Shoppers Drug Mart
Baig, Asad ..... Shoppers Drug Mart
Balani, Meenakshi ..... Shoppers Drug Mart
Balpande, Darshana ..... Shoppers Drug Mart
Benegal, Kiran ..... Shoppers Drug Mart
Cau, Chieng ..... Shoppers Drug Mart
Chan, Brent ..... Progress Centre Pharmacy
Chen, Silvia ..... Shoppers Drug Mart
Chin, Joe ..... Centenary Hospital
Farag, Mamdouh ..... Danforth Pharmacy
Hack, Frank ..... Shoppers Drug Mart
Huynh, Hoa ..... Shoppers Drug Mart
Ip, Jerry ..... Shoppers Drug Mart
Iskander, Maged ..... Woburn Medical Pharmacy
Jina, Hanif ..... Shoppers Drug Mart
Kassam, Zain ..... Shoppers Drug Mart
Kezdi, Elena ..... Shoppers Drug Mart
Mok, Timothy ..... Guildview Pharmacy
Mwanza, Leaggy ..... Shoppers Drug Mart
Nakhla, Medhat ..... Port Union Pharmacy
Pamidi, Sravani ..... Guildview Pharmacy
Patel, Rajvi ..... Rexall Pharma Plus
Rascu, Maria ..... Shoppers Drug Mart
Rubbani, Ghulam ..... Shoppers Drug Mart
Shah, Kaushil ..... Ellesmere Healthcare Pharmacy
Shtein, Viktoria ..... Shoppers Drug Mart
Vaidya, Arvind ..... Rexall
Vo, Hanna ..... The Scarborough Hospital
Wong, Victor ..... Shoppers Drug Mart
Yamasaki, Mei-Fe ..... Pharmasave
Zhou, Quan ..... Total-Care Pharmacy

SHELBURNE

Gill, Ravinder ..... Loblaw Pharmacy

SIMCOE

Arrojo, Reynald ..... Wal-Mart Pharmacy
De Fields, Pamela ..... Shoppers Drug Mart
Holton, Joanne ..... Roulston's Discount Drugs Ltd
Kafeel, Sheereen ..... Clark's Pharmasave Whitehorse Plaza

ST. CATHARINES

Ahmed, Adnan ..... Shoppers Drug Mart
Costiniuk, David ..... Ontario Street Pharmacy - Pharmasave
Ikola, Jamie ..... Shoppers Drug Mart
Kooter, Rosmarie ..... Shoppers Drug Mart
Paolone, Thomas ..... Neighbourhood Pharmacy
Patel, Dipikaben ..... Loblaw Pharmacy
Shalaby, Fady ..... Shoppers Drug Mart
Sharobim, Rafik ..... Campus Pharmacy

ST. THOMAS

Fletcher, Kathryn ..... St. Thomas-Elgin General Hospital
Lindsay, David Grahame ..... Shoppers Drug Mart

STITTSVILLE

Walsh, Angela ..... Stittsville IDA Pharmacy

STONEY CREEK

Chatur, Salima ..... Remedy's Rx Healthcare Plus Pharmacy
Nardini, John ..... Shoppers Drug Mart

STRATFORD

Alhadrab, Summur ..... Loblaw Pharmacy
Al-qazazi, Senan ..... Shoppers Drug Mart
Roulston, Paul ..... Shoppers Drug Mart
Voicu, Theodora ..... Shoppers Drug Mart

STRATHROY

Merritt, Bruce ..... Wal-Mart Pharmacy

STREETSVILLE

Shalvardjian, Berge ..... Robinsons IDA Pharmacy

STURGEON FALLS

Co, Enrich ..... Loblaw Pharmacy
Monette, Sophie ..... West Nipissing General Hospital

SUDBURY

Esposto, Cassandra ..... Loblaw Pharmacy
Jarvis, Kathryn ..... Rexall
Kilby, Micheal ..... Costco Pharmacy
Lagrandeur, Rebecca ..... Health Care Pharmacy
Landry, Sarah ..... Ramsey Lake Health Centre
Matthews, Kristen ..... Health Sciences North - Ramsey Lake Health Centre
Mullen, Scott ..... Herman's Pharmacy
Thompson, Julie ..... Loblaw Pharmacy
Tyson-Rouleau, Sandra ..... Medical Pharmacy

SUTTON WEST

Mikhail, Nashwa ..... Bens Pharmacy

THORNHILL

Armanious, Hany ..... Baygreen Pharmacy
Maurice, Bichoy ..... Main Drug Mart
Modabber, Minoo ..... Pharmacy 7
Seiha, Ashraf ..... Bayview IDA Pharmacy
Shterenberg, Khristina ..... North-Med Pharmacy

THUNDER BAY

Grzelewski, Andrea ..... St. Joseph's Hospital
Kapoor, Vinay ..... Shoppers Drug Mart
Prevett, Hazel ..... Thunder Bay Regional Health Sciences Centre

TIMMINS

Larocque, Lee-Anne ..... Timmins and District Hospital

TORONTO

Abdel Maseh, Nagib ..... Pharmasave
Ahmed, Mohamed ..... Eagle Manor Pharmacy
Ahsan, Golam ..... Warden Woods Pharmacy
Akhtari, Faraneh ..... Zaillan Pharmasave
Azim, Sheikh Muhammed ..... Shoppers Drug Mart
Aziz, Marlien ..... Dawes Drugmart Ltd
Aziz, Nabil ..... The Medicine Shoppe
Bautista, Adriano ..... Shoppers Drug Mart
Booth Rumsey, Tamara ..... The Princess Margaret Hospital - Inpatient Pharmacy
Bortolotto, Doris ..... The Toronto General Hospital
Boshara, Roshdy ..... Bay College Drug Mart
Boshara, Wafaa ..... Bay College Drug Mart
Botross, Riva ..... Royal Care Pharmacy
Bregu, Esmeralda ..... Shoppers Drug Mart
Brittain, Cherry ..... Shoppers Drug Mart
Brun, Rita ..... Toronto East General Hospital
Chan, Christopher ..... The Princess Margaret Hospital - Inpatient Pharmacy
Chan, David ..... Moss Park Pharmacy Ltd.
Chan, Grace ..... Shoppers Drug Mart
Chau, Diana ..... Medisystem Pharmacy
Chen, Yan ..... Shoppers Drug Mart
Chiang, Chi Ming Jimmy ..... Sunnybrook Health Sciences Centre
Chong, Chun Yin ..... Shoppers Drug Mart
Chong, Doris ..... Pharma Plus
Cordero, John Paul ..... Hilary's Pharmacy
Cornacchia, Andreo ..... The Toronto General Hospital
Da Silva Moniz, Odette ..... The Toronto Western Hospital
Dang, Edward ..... Shoppers Drug Mart
Delawala, Soebmohmed ..... Shoppers Drug Mart
Dhaliwall, Jatinderjit ..... Shoppers Drug Mart
Dhalla Sunderji, Tazeem ..... Shoppers Drug Mart
Dhiman, Roma ..... Rexall
Di Scipio, Rita ..... Sunnybrook Health Sciences Centre
Djazayeri, Shabdis ..... Transplant Outpatient Pharmacy
Dookhu-Sampson, Savitri ..... St. Joseph's Health Centre
Douglas, Tamara ..... Sunnybrook Health Sciences Centre
Elias, Basem ..... Islington IDA Pharmacy
Farrahi, Sepideh ..... Shoppers Drug Mart
Fisher, Martin ..... Rexall
Fuller, Charmaine ..... Toronto Rehab Institute
Fung, Jodie ..... Rexall
Gally, Iman ..... North Park Medical Pharmacy
Gandevia, Hemamalini ..... Loblaw Pharmacy
Ghobrial, Sali ..... St. Gabriel Medical Pharmacy
Giraudi, Alexander ..... Omni Pharmacy
Girgis Boktor, Amir ..... College Medical Pharmacy
Goda, Mohammed ..... Canes Community Pharmacy
Greenidge, Sherida ..... Toronto Rehab Institute
Guirguis, Guirguis ..... Pharmacy By The Grange
Hanna, Magdy Yashoue Rizkalla ..... Northcliffe Pharmacy
Hansra, Manjit ..... Shoppers Drug Mart
Ho, Hsin-Ying ..... Medisystem Pharmacy
Hu, Baolian ..... The Toronto General Hospital
Iftikhar, Muhammad ..... Shoppers Drug Mart
Ip, Robert Siu Lin ..... Shoppers Drug Mart
Islam, Shahana ..... Shoppers Drug Mart
Javaid, Suhail ..... Shoppers Drug Mart
Johari, Mahtab ..... Rexall
John, Annabel ..... The Hospital For Sick Children
Kakani, Padma ..... Shoppers Drug Mart
Kaliy, Olesya ..... Shoppers Drug Mart
Kar, Jennifer ..... Rexall
Kim, Susan ..... Shoppers Drug Mart
Knight, Robyn ..... Rexall
Kolta, Samer ..... Northview Pharmacy
Lad, Kiran ..... Sobeys Pharmacy Rosebury
Lee, Vicky ..... The Princess Margaret Hospital - Inpatient Pharmacy
Lekhi, Amit ..... Shoppers Drug Mart
Leung, Pui ..... The Princess Margaret Hospital -

Inpatient Pharmacy
Li, Wilson ... Shoppers Drug Mart
Lim, Lai ... Medisystem Pharmacy
Liu, Rachel Yin Pok ... Rexall
Liu, Ying ... The Toronto General Hospital
Lopez Palacios, Marisol ... Nova Pharmacy
Lytwyn-Nobili, Elizabeth ... Shoppers Drug Mart
Manshouri, Ali ... Shoppers Drug Mart
Mansoubi, Abdoulnaser ... Shoppers Drug Mart
Marsden, Carla ... The Hospital For Sick Children
Maseh, Mina ... Friendly Care West King Pharmacy
Mehawed, Merry ... Northcliffe Pharmacy
Metyas, Jerry ... Lakefront Medical Pharmacy
Mitchell, Yoko ... Shoppers Drug Mart
Mohamed, Ibrahim ... Shoppers Drug Mart
Molnar, Judy ... The Hospital For Sick Children
Nadeem, Zamir ... Mount Sinai Hospital
Nathoo, Falzana ... St. Michael's Hospital
Nejati-Aghdam, Soroush ... Lakeside Pharmacy
Nguyen, Diep ... River Hill Pharmacy
Nhan, Jonathan ... Shoppers Drug Mart
Pakbaz, Parisa ... Shoppers Drug Mart
Park, Hyun Jung ... Shoppers Drug Mart
Perry, Amanda ... Shoppers Drug Mart
Petrov, Edgard ... Procare IDA Pharmacy
Phillips, George ... Shoppers Drug Mart
Prajapati, Poonam ... Shoppers Drug Mart
Ramzy, Amir ... Trinity Drug Store
Reci, Brunilda ... Don Russell Drug Mart
Remtulla, Nadeem ... Shoppers Drug Mart
Rofaiel, Lillian ... White's Pharmacy
Rubbani, Ghulam ... Shoppers Drug Mart
Shafagh-Motlagh, Nima ... Shoppers Drug Mart
Shah, Kaushil ... Bloor-Dundas Pharmacy
Singh, Priya ... The Toronto Western Hospital
Solecka-Janik, Bogumila ... Shoppers Drug Mart
Sourial, Safwat ... Shoppers Drug Mart
Sperling, Cailin ... St. Joseph's Health Centre
Spinosa, Joanne ... Sunnybrook & Womens Col H.S.C.
Tan, Kenny ... Shoppers Drug Mart
Tang, Fone-Ning ... The Toronto General Hospital
Teng, Xin Ying ... The Toronto General Hospital
Tran, Chan ... Shoppers Drug Mart
Venugopal, Narayanasamy ... Darcy 2 Pharmacy Inc.
Walton, James ... Shoppers Drug Mart
Wdowczyk, Anna ... St. Joseph's Health Centre Pharmacy
Weyland, Laura ... Shoppers Drug Mart
William, Joseph ... Main Drug Mart
Wong, Carol ... The Toronto Western Hospital
Wong, Wing ... Danny's Drugstore Inc.
Xiao, Xiao Yan ... On Care Pharmacy
Xu, Heng ... Pharma Plus
Yam, David ... The Drugstore Pharmacy
Yeganegi, Kamal ... Willowdale Pharmacy
Yeh, Walter ... Shoppers Drug Mart
Yip, Paul ... Rexall
Youhanna, Peter ... Liberty Market Pharmacy
Yousef, Aziz ... Terrace Square Pharmacy

UXBRIDGE

Remtulla, Sameer ... Pharmasave Uxbridge Medical Pharmacy
Singh, Uday Pratap ... Shoppers Drug Mart

VANIER

Barnes, Mark ... Respect Rx Pharmacy
Fisher, Steven ... Vanier Pharmacy

VAUGHAN

Chan, Charles ... Sobeys Pharmacy
Kahlon, Shaminder ... Shoppers Drug Mart
Metyas, John ... Jane Medical Pharmacy
Sabzvari, Ali ... Shoppers Drug Mart
Sharma, Rajiv ... Summeridge Guardian Pharmacy

WALLACEBURG

Damani, Rushabh ... Wallaceburg Pharmacy
Desat, Jeremy ... Shoppers Drug Mart

WATERLOO

Horner, Maria ... Shoppers Drug Mart
Jobanputra, Poshin ... Cook's Pharmacy
Mendoza, Jasmin ... Rexall
Racine, Sheri ... The K-W Pharmacy
Sim, Mario ... Loblaw Pharmacy

WAWA

Fenlon, Ann ... Fenlon's Pharmacy

WESTON

Hassan, Farhana ... Shoppers Drug Mart

WHITBY

Ram, Linda ... Shoppers Drug Mart

WINDSOR

Al-tirh, Mohammad-Nabil ... Rexall
Belisle, Jodi ... Hunter's Pharmacy
Blacher, Michael ... Family Health Pharmacy West
Braccio, Elisa ... Shoppers Drug Mart
Chang, Robin ... Grand Marais Pharmacy
Garant, Justin ... The Drive Pharmacy
Garcha, Jasjit ... Shoppers Drug Mart
Haq, Irshad-Ul ... Shoppers Drug Mart
Hijazi, Amal ... Ultima's Apothecary
Kaur, Harsimran ... Rexall
Landry, Heather ... Roseville Medical Pharmacy Ltd.
Leung, Hoi Man ... Shoppers Drug Mart
Levnajic, Ivana ... Shoppers Drug Mart
Lopez, Alyssa Ann ... First Medical Pharmacy
Mannarino, Giuseppina ... Community Care Pharmacy
Mousseau, Brandon ... IDA Prescription Centre
Paraschak, Patricia ... Shoppers Simply Pharmacy
Scratch, Erica ... Shoppers Drug Mart
Vella, Francesco ... Olde Walkerville Pharmacy

WINGHAM

Seth, Manmohan ... Rexall

WOODBRIDGE

Ali, Helen ... Shoppers Drug Mart
Al-Kassed, Alaa ... Weston-Rutherford Medical Pharmacy
Atia, Yehia ... Weston-Rutherford Medical Pharmacy
Barta-Lenart, Ida ... Pulse Rx LTC Pharmacy
Bhatia, Gautam ... Weston Pharmacare
Labib, Ihab ... ihealth Centre Pharmacy
Latif, Imran ... Costco Pharmacy
Lawrence, James ... Pulse Rx LTC Pharmacy
Levine, Lisa ... Panacea Pharmacy
Mazza, Caterina ... Rexall Pharma Plus
Pandit Pautra, Akhil ... Costco Pharmacy
Shetty, Prajna ... Shoppers Drug Mart
Valela, Anna ... Rexall Pharma Plus

WOODSTOCK

Silverthorne, Elizabeth ... Shoppers Drug Mart

YORK

Daneshvari, Enaiatreza ... Ayda Pharmacy

DISCIPLINE DECISIONS

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Member: Joseph Abd El Maseh (OCP #211264)

After a hearing on May 19-22, 2015, June 3, 2015, and June 19, 2015, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Abd El Maseh in a decision dated June 1, 2016, with respect to the following:

- he failed to provide to the Registrar the details of charges against him under the Criminal Code of Canada, as set out in an information sworn on or about June 3, 2011, namely charges relating to the offence of sexual assault*

- in written and/or electronic material he submitted to the College during the renewal of his certificate of registration in or about February 2012, he indicated to the College that he was not the subject of any current proceeding in respect of any offence in any jurisdiction, whereas he knew this information was false or misleading, in that he was the subject of charges under the Criminal Code of Canada, as set out in an information sworn on or about June 3, 2011

In particular, the Panel found that the Member:

- contravened a term, condition or limitation imposed on his certification of registration

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

- engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be disregarded by members of the profession as disgraceful, dishonourable and/or unprofessional

After submissions heard on August 30, 2016, the Panel issued the following Order related to findings of professional misconduct made against Mr. Abd El Maseh in a decision dated June 1, 2016:

1. A reprimand

2. That the Registrar be directed to suspend the Member's certificate of registration for two (2) months, one (1) month of which to be remitted if the member satisfies the conditions set out in paragraph 3.

3. That the Registrar be directed to impose a condition on the Member's certificate of registration that he successfully complete, within 12 months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, but with the general aim of addressing the objectives of professional regulation and the importance to the public interest of complying with a practitioner's regulatory obligations, including complying with reporting requirements to the College. The following terms shall apply to the course:

   a. The number of sessions shall be at the discretion of the consultant.

   b. The manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant.

   c. The Member shall be responsible for the cost of the course.

   d. Successful completion of the course will include completion of an essay, acceptable to the Registrar, addressing the objectives of professional regulation and the importance to the public interest of complying with a practitioner's regulatory obligations, including complying with reporting requirements to the College.

   e. The essay shall be at least 1000 words in length. The Member shall be responsible for the cost of review by the consultant to assist the Registrar to determine whether the essay is acceptable, up to a maximum of $500.

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

In its reprimand, the Panel noted that it was disturbed by the events in question, particularly as they were under the Member's own control and he ought to have known better. The Panel indicated that the practice of pharmacy is a privilege, which carries obligations to maintain high professional standards and preserve public trust and safety in a manner that will not compromise the integrity of the profession. The Panel noted that the mandatory reporting requirements rely on the honour system, and any violation is of significant concern to the College and the public. The Panel pointed out that the onus and accountability to report truthfully and accurately rests on the Member alone. The Panel expressed its expectation that the Member now realizes the importance of this responsibility, and

that the remediation ordered will make him a better pharmacist.

* Note: these charges were withdrawn at the request of the Crown on or about July 13, 2012.

Member: Eric Henderson (OCP #604883)

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

- That he approved the wrong medications or dosage of medications to be dispensed to the patient, [Name], and/or failed to indicate that counseling of the patient was required, on or about November 14, 2014, and/or failed to follow up appropriately regarding possible dispensing errors regarding the prescriptions for [Name], on or about November 15, 2014.

In particular, the Panel found that he:

- Failed to maintain a standard of practice of the profession
- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts, and in particular, section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H. 4, as amended, and/or section 4 of O. Reg 58/11, as amended
- Contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, 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 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 that the Member shall complete successfully the following courses and evaluations, at his own expense and within eighteen (18) months of the date of this Order, or provide proof satisfactory to the College that he completed the courses and evaluations within the six (6) month period prior to the date of this Order:

   a. the Ontario Pharmacists Association program, "Confronting Medication Incidents"; and

   b. the Institute of Safe Medication Practices Canada program, "Medication Safety for Pharmacy Practice", including Root Cause Analysis and Failure Mode and Effects Analysis.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of two (2) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraphs 2(a) and (b) above

4. Costs to the College in the amount of $1,000

In its reprimand, the Panel observed that integrity and trust are paramount to the profession, as pharmacists provide care to the public and are, in turn, held in high regard. The Panel noted that the Member's actions were not consistent with the Standards of Practice for pharmacists. The Panel pointed out that all healthcare professionals are expected to conduct themselves in a manner that maintains public confidence and safety. The Panel expressed its expectation that the remediation ordered will result in an improvement to the Member's practice and will safeguard the public interest.

Member: Martha Fabello (OCP #98876)

At a hearing on November 7, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Fabello with respect to the following incidents:

- Between January 2015 and February 2015, on at least two occasions, she misappropriated narcotics and/or other controlled drugs or substances from the High Park Pharmacy in Toronto

In particular, the Panel found that she

- Failed to maintain the standards of the profession
- 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, as follows:

a. She contravened section G.03.002 of the Food and Drug Regulations, C.R.C., c. 870, as amended;

b. She contravened section 4 of the Controlled Drugs and Substances Act, S.C. 1996, c. 19, as amended; and

c. She contravened section 31(1) of the Narcotic Control Regulations under the Controlled Drugs and Substances Act

- Engaged in conduct relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members of the profession as dishonourable and unprofessional

(Note: Ms. Fabello resigned her membership with the College on October 6, 2015.)

The Panel imposed an Order which included as follows:

1. A reprimand

2. That the Registrar be directed to impose the following specified terms, conditions or limitations on Ms. Fabello's Certificate of Registration if she successfully applies for registration with the College:

   a. that Ms. Fabello shall complete successfully, at her own expense and within twelve (12) months of obtaining a Certificate of Registration, the ProBE Program on Professional/Problem Based Ethics for Healthcare Professionals, with an unconditional pass;

   b. that Ms. Fabello shall be prohibited, for a period of sixty (60) months after obtaining a Certificate of Registration, from acting as a Designated Manager or narcotic signer at any pharmacy;

   c. that for a period of twelve (12) months from the date Ms. Fabello returns to active practice as a pharmacist in Ontario;

      i. Ms. Fabello shall notify the College in writing of any employment in a pharmacy, which notification shall include the name and address of the employer and the date on which Ms. Fabello began or is to begin employment, within seven (7) days of commencing such employment, and

      ii. Ms. Fabello shall only work for an employer in a pharmacy who provides confirmation in writing from the Designated Manager of the pharmacy to the College, within seven (7) days of Ms. Fabello commencing employment at the pharmacy, that the Designated Manager received and reviewed a copy of the panel's decision and reasons in this matter before Ms. Fabello commenced employment.

3. That, if she successfully applies for registration with the College, the Registrar be directed to suspend Ms. Fabello's Certificate of Registration for a period of five (5) months, with one (1) month of the suspension to be remitted on condition that Ms. Fabello complete the remedial training exercises set out in subparagraph 2(a) above, as specified. The suspension shall commence immediately on the date that Ms. Fabello becomes a registrant of the College and shall run without interruption for four (4) months. If the balance of the suspension is required to be served by Ms. Fabello because she fails to complete the program as specified in subparagraph 2(a) above, the suspension shall continue for one month from the date the College is notified that Ms. Fabello has not completed the remedial training in the manner specified in paragraph 2(a) above.

4. Costs to the College in the amount of $2,500.

In its reprimand, the Panel observed that integrity, trust, and professional conduct are at the core of the practice of Pharmacy. The Panel noted that pharmacists bear the responsibility to ensure that the trust of the public is maintained, and that the practice of pharmacy carries with it obligations to the public, the profession, and oneself.

The Panel observed that Ms. Fabello acknowledged responsibility for her actions. The Panel agreed that her conduct was dishonourable and unprofessional, and that the Order imposed is fair and reasonable. The Panel expressed its belief that Ms. Fabello has learned from this process and its confidence that she will not appear before a panel of the Discipline Committee again.

Member: Robert Awad (OCP #208436)

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

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

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

- On or about July 19, 2012, he dispensed drugs in advance of the interval originally specified by the prescriber and/or in advance of the expiry of the prior prescription's dosing period without adequately documenting the reasons for the early release, with respect to Rx No. N015197;

- On or about May 23, 2013, he dispensed drugs in advance of the interval originally specified by the prescriber and/or in advance of the expiry of the prior prescription's dosing period without authorization from the prescriber and/or without adequately documenting the reasons for the early release, with respect to Rx Nos. N022003, N022004, N022005, N022006, N022007, and N022008;

- He dispensed certain identified drugs without accurately and/or properly recording the Drug Identification Number on the prescription hardcopy and/or label;

- He failed to adequately document the actions taken in response to, and/or the reasons for not taking any action in response to, certain identified Narcotic Monitoring System alerts.

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

- 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 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 unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

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

   a. complete successfully, at his own expense, within six months of the date of this Order, a session with Gail Siskind, expert in ethical issues for regulated health care professionals, or such other expert as is acceptable to the College, regarding the issues raised by the facts and findings of professional misconduct in this case, including the role of pharmacists in monitoring, advising on, and recommending changes to, patients' medication therapy; in order to successfully complete the session, the Member must ensure that the expert delivers to the Manager, Investigations and Resolutions, a report on the results of the session;

   b. retain, at the Member's expense, Beth Sproule as a practice mentor (or such other practice mentor as is acceptable to the College) within three months of the date of this Order;

   c. meet at least three times with the practice mentor, at the mentor's place of practice, for the purpose of reviewing the Member's practice with respect to narcotic dispensing and any other issues raised by the facts and findings of professional misconduct in this case, 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:

      i. a copy of the Notice of Hearing;

      ii. a copy of the Agreed Statement of Facts;

      iii. a copy of the Joint Submission on Order;

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

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

   d. develop with the practice mentor a learning plan to address the areas requiring remediation;

   e. demonstrate to the practice mentor, in a manner directed by and acceptable to the practice mentor, that the Member has achieved

success in meeting the goals established in the learning plan; and

f. ensure that the practice mentor reports the results of the mentorship program to the Manager, Investigations and Resolutions at the College, after its 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 3 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2 above. The suspension shall commence on December 5, 2016 and shall continue until January 4, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in paragraph 2 above, the balance of the suspension shall commence on December 5, 2017, and continue until February 4, 2018, inclusive.

4. Costs to the College in the amount of $3,750.

In its reprimand, the Panel noted that Pharmacy is a self-regulating profession and that there is a responsibility to ensure that the trust of members and the public is preserved. The Panel observed that the practise of Pharmacy is a privilege that carries significant obligations to the public, profession, and oneself. The Panel emphasized that the provision of narcotics carries additional responsibilities. The Panel expressed its concern that the Member failed in his responsibilities by dispensing narcotics without questioning the outcome and potential harm that could occur.

Member: Ayman Wasef (OCP #210012)

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

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

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

- He dispensed certain identified narcotics in advance of the interval originally specified by the prescriber and/or in advance of the expiry of the prior prescription's dosing period without adequately documenting the reasons for the early release;

- He permitted to be dispensed and/or condoned the dispensing of certain identified drugs without taking adequate steps to ensure that the Drug Identification Number was accurately and/or properly recorded on the prescription hardcopy and/or label;

- He failed to adequately document the actions taken in response to, and/or the reasons for not taking any action in response to, certain identified Narcotic Monitoring System alerts.

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

- 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 unprofessional

The Panel imposed an Order which included as follows:

1. A reprimand

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

   a. complete successfully, at his own expense, within six months of the date of this Order, a session with Gail Siskind, expert in ethical issues for regulated health care professionals, or such other expert as is acceptable to the College, regarding the issues raised by the facts and findings of professional misconduct in this case, including the

role of pharmacists in monitoring, advising on, and recommending changes to, patients' medication therapy; in order to successfully complete the session, the Member must ensure that the expert delivers to the Manager, Investigations and Resolutions, a report on the results of the session;

b. retain, at the Member's expense, Beth Sproule as a practice mentor (or such other practice mentor as is acceptable to the College) within three months of the date of this Order;

c. meet at least three times with the practice mentor, at the mentor's place of practice, for the purpose of reviewing the Member's practice with respect to narcotic dispensing and any other issues raised by the facts and findings of professional misconduct in this case, 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:

i. a copy of the Notice of Hearing;

ii. a copy of the Agreed Statement of Facts;

iii. a copy of the Joint Submission on Order;

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

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

d. develop with the practice mentor a learning plan to address the areas requiring remediation;

e. demonstrate to the practice mentor, in a manner directed by and acceptable to the practice mentor, that the Member has achieved success in meeting the goals established in the learning plan; and

f. ensure that the practice mentor reports the results of the mentorship program to the Manager, Investigations and Resolutions at the College, after its 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 3 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2 above. The suspension shall commence on a date to be determined between the parties that shall be no later than April 5, 2017. For clarity, if the suspension has not already commenced by April 5, 2017, it shall commence on that date. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in paragraph 2 above, the balance of the suspension shall commence on December 5, 2017, and continue until February 4, 2018, inclusive.

4. Costs to the College in the amount of $3,750.

In its reprimand, the Panel noted that pharmacy is a self-regulating 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 practise of pharmacy is a privilege that carries significant obligations to the public, profession, and oneself, and that the Member, as Designated Manager, has additional accountabilities to ensure that safe practices are carried out. The Panel emphasized that the provision of narcotics carries additional responsibilities. The Panel expressed its concern that the Member failed in his responsibilities both as a Designated Manager and as a pharmacist by dispensing narcotics without questioning the outcome and potential harm that could occur.

Member: Joy Abanzukwe (OCP #103497) and Bathurst-Dundas Pharmacy (Accreditation #39244)

At a hearing on December 7 and 8, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Ms. Abanzukwe, as pharmacist and Designated Manager at Bathurst-Dundas Pharmacy and Brock Medical Pharmacy, and as sole director and sole shareholder of the corporations that own and operate each pharmacy, with respect to the following incidents:

- She processed prescriptions from Bathurst-Dundas Pharmacy at Brock Medical Pharmacy for billing purposes, including prescriptions for certain identified patients, in or about March-September 2014, and/or for certain other identified patients, in or about August 2015;

- She failed to maintain security; keep accurate records of purchases, sales and remaining inventory; and/or make timely reports of losses to Health Canada in relation to certain identified narcotics and other

controlled drugs and targeted substances, in or about May-October 2014;

- She billed at 7-day or 14-day intervals for medications in blister packs that were actually dispensed to patients at 28-day intervals for certain identified patients, in or about January 2013-October 2014; and/or

- She breached the undertaking given to the College on or about May 31, 2015 by continuing to process prescriptions from Bathurst-Dundas Pharmacy at Brock Medical Pharmacy for billing purposes, including prescriptions for certain identified patients, in or about August 2015, and/or failing to complete recorded audits at Bathurst-Dundas Pharmacy for purchases, sales and remaining inventories of narcotics and other controlled drugs and targeted substances at least every two months, as noted in the Pharmacy Assessment Report dated August 31, 2015.

In particular, the Panel found that Ms. Abanzukwe

- Failed to maintain a standard of practice of the profession

- Failed to keep records as required respecting her patients

- Falsified a record relating to her practice

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

- Submitted an account or charge for services that she knew was false or misleading

- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular, section 156 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H-4, as amended, and sections 54 and/or 56 of O.Reg. 58/11, as amended

- Contravened, while engaged in the practice of pharmacy, a federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs, and in particular, section C.01.041 of the Food and Drug Regulations, C.R.C., c. 870, as amended; sections 38, 40, 42 and/or 43 of the Narcotic Control Regulations, C.R.C., c.1041, as amended; sections 7, 51 and/or 53 of the Benzodiazepines and Other Targeted Substances Regulations, SOR/2000-217, as amended; sections 5, 6, and/or 15 of the Ontario Drug Benefit Act, R.S.O. 1990, c.O.10, as amended; and/or section 27 of O.Reg. 201/96, as amended

- Knowingly permitted the premises in which a pharmacy was located to be used for unlawful purposes

- 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 dishonourable or unprofessional

At the same hearing, a Panel of the Discipline Committee made findings of proprietary misconduct against Ms. Abanzukwe, as Designated Manager of Bathurst-Dundas Pharmacy and Brock Medical Pharmacy, and as director of Bathurst-Dundas Pharmacy Ltd., c.o.b. Bathurst-Dundas Pharmacy and 2037424 Ontario Inc., c.o.b. Brock Medical Pharmacy, with respect to the following incidents:

- That she continued to process prescriptions from Bathurst-Dundas Pharmacy at Brock Medical Pharmacy for billing purposes, including prescriptions for certain identified patients, in or about August 2015;

- That she failed to complete recorded audits of purchases, sales and remaining inventories at Bathurst-Dundas Pharmacy for narcotics and other controlled drugs and targeted substances at least every two months; and/or

- That she failed to rectify at Bathurst-Dundas Pharmacy the previously identified dispensing, recordkeeping and other practice deficiencies as noted in the Pharmacy Assessment Report dated August 31, 2015

In particular, the Panel found that Ms. Abanzukwe and Bathurst-Dundas Drugs Ltd., as holder of Certificate of Accreditation #39244 for Bathurst Dundas Pharmacy, engaged in conduct or performed an act relevant to the business of a pharmacy that would reasonably be regarded by members as dishonourable with respect to breaching the undertaking given to the College on or about May 31, 2015.

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 that:

(a) the Member shall be prohibited, for a period of 2 years from January 9, 2017, from acting as a Designated Manager any pharmacy

(b) for a period of 3 years from the date of this Order:

(i) the Member shall notify the College in writing of any employment in a pharmacy, other than a pharmacy for which she is effectively the owner, which notification shall include the name and address of the employer and the date on which the Member began or is to begin employment, within seven (7) days of commencing such employment, and

(ii) the Member shall only work for an employer in a pharmacy, other than a pharmacy for which she is effectively the owner, who provides confirmation in writing from the Designated Manager of the pharmacy to the College, within seven (7) days of the Member commencing employment at the pharmacy, that the Designated Manager received and reviewed a copy of the following documents before the Member commenced employment:

A. a copy of the Notices of Hearing;

B. a copy of the Agreed Statement of Facts; and

C. a copy of the Joint Submission on Order; or

D. a copy of the Decision and Reasons, when available;

(c) the Member shall:

(i) retain, at the Member's expense, a practice mentor acceptable to the College, within 3 months of the date of the Order (i.e. by March 8, 2017);

(ii) meet with the practice mentor for the purpose of reviewing the Member's practice with respect to reconciliation of narcotics, controlled drugs, and targeted substances, and record keeping in relation to those reconciliations; to this end, the Member shall provide the practice mentor with the following documents related to this proceeding:

1. a copy of the Notices of Hearing;

2. a copy of the Agreed Statement of Facts; and

3. a copy of the Joint Submission on Order; or

4. a copy of the Decision and Reasons, when available;

(iii) develop a learning plan to address the issues of reconciliation of narcotics, controlled drugs, and targeted substances, and record keeping in relation to those reconciliations;

(iv) meet with the practice mentor at the mentor's place of practice no less than once every three months to address the matters set out in the learning plan, until the goals of the learning plan have been achieved, in the opinion of the mentor; 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 two years after the date of the Order (i.e. December 8, 2018);

(d) the Member shall successfully complete, within 12 months of the date of the order, a course with Gail E. Siskind Consulting Services, or another professional ethics consultant chosen by the College, to be designed by the consultant, but with the general aim of addressing ethical issues for regulated healthcare professionals. The following terms shall apply to the course:

(i) the number of sessions shall be at the discretion of the consultant;

(ii) the manner of attendance at the session(s) (e.g. in person, via Skype, etc.) is a matter to be discussed in advance between the Member and the consultant, but shall ultimately be at the discretion of the consultant;

(iii) the Member shall provide the consultant with the following documents related to this proceeding:

1. a copy of the Notices of Hearing;

2. a copy of the Agreed Statement of Facts; and

3. a copy of the Joint Submission on Order; or

4. a copy of the Decision and Reasons, when available;

(iv) the Member shall be responsible for the cost of the course;

(v) successful completion of the course shall be determined by the ethics consultant, based on the design of the course; and

(vi) the Member shall require the ethics consultant to report the results of the course to the Manager, Investigations and Resolutions at the College, after their completion, which shall be no later than 12 months after the date of the Order;

(e) the Member's practice and all activities at any pharmacies in which the Member has a proprietary interest of any kind will be monitored by the College for a period of two years from the date the Order is imposed by means of inspections by a representative of the College at such times as the College may determine. The monitoring inspections 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 fully with the College during the inspections, and, further, shall pay to the College in respect of such monitoring the amount of $1,000.00 per inspection, such amount to be paid immediately after each inspection, with the total number of inspections for which the Member is required to pay this cost not to exceed four.

3. Directing the Registrar to suspend the Member's Certificate of Registration for a period of 5 months, with 2 months of the suspension to be remitted on condition that the Member complete the remedial training as specified in paragraph 2(c) and 2(d) above. The suspension shall commence on January 9, 2017, and shall continue until April 8, 2017, inclusive. If the balance of the suspension is required to be served by the Member because she fails to complete the remedial training specified in paragraph 2(c) and 2(d) above, the balance of the suspension shall commence on December 10, 2018, and continue until February 9, 2019, inclusive.

4. The Member shall pay costs to the College in the amount of $5,000, payable in quarterly installments of $1,250 each.

In its reprimand, the Panel noted that integrity and trust are paramount to the profession of pharmacy, as pharmacists provide care to the public and, in return, are held in high regard for their role in the provision of healthcare in Ontario. The Panel noted that self-regulation is a privilege that carries significant obligations. The Panel related that it takes the subject matter of the Undertaking and the Member's failure to adhere to it very seriously. The Panel expressed its trust that the disciplinary process will cause the Member to reflect on her practice and motivate her to make changes.

Member: Herman Szeto (OCP #113220)

At a hearing on December 16, 2016, a Panel of the Discipline Committee made findings of professional misconduct against Mr. Szeto with respect to the following:

- That he failed to exercise appropriate professional diligence with respect to the dispensing of fentanyl, which resulted in him filling forged prescriptions without making appropriate inquiries, including one or more of certain identified prescriptions

- That he dispensed narcotics pursuant to certain identified prescriptions without submitting the required information to the Narcotics Monitoring System as required by s. 8 of the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c.22, and the Notice issued thereunder

In particular, the Panel found that he

- Failed to maintain a standard of practice of the profession

- Contravened the Act, the Drug and Pharmacies Regulation Act, the Regulated Health Professions Act, 1991, or the regulations under those Acts, and in particular:

  - Section 155 of the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4, as amended, and/or section 40 of O.Reg. 58/11, R.S.O. 1990, c.H.4

- 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:

  - 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

o Section 8 of the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c.22

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

The Panel imposed an Order which included as follows:

1. A reprimand

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

   (a) that the Member complete successfully with an unconditional pass, at his own expense, within 12 months of the date of this Order, the ProBE Program on professional/problem-based ethics for health care professionals;

   (b) 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 this Joint Submission on Order;

      4) a copy of the Report of Investigation; and

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

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

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

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

3. That the Registrar will be directed to suspend the Member's certificate of registration for a period of three (3) months, with one (1) month of the suspension to be remitted on condition that the Member complete the remedial training specified in sub-paragraph 2 (a) above. The suspension shall commence on December 16, 2016 and shall continue until February 15, 2017, inclusive. If the balance of the suspension is required to be served by the Member because he fails to complete the remedial training specified in subparagraph 2(a) above, the balance of the suspension shall commence on December 18, 2017 and continue until January 17, 2018, inclusive.

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

In its reprimand, the Panel noted that the practice of pharmacy is a privilege, at the core of which are integrity, trust, professional conduct, and the delivery of safe care to the public. The Panel pointed out that, in return, pharmacists are held in high regard by the people they serve. The Panel observed that the Member betrayed the public trust, and also that he acknowledged responsibility for his actions. The Panel expressed its expectation that the Member will take his shortcomings to heart and fulfill his commitment to making the necessary improvements and fulfilling the core elements of pharmacy practice.

The full text of these decisions is available at www.canlii.org
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5 Things to Know
About Renewing Prescriptions

Pharmacists are reminded of their roles and responsibilities when renewing prescriptions for patients

1. Pharmacists can renew prescriptions.

Pharmacists, interns and registered pharmacy students under the supervision of a pharmacist have the independent authority to renew any prescriptions for the purpose of continuity of care (with the exception of controlled substances and monitored drugs).

Assess the situation and consider the following:

- What are the potential risks and benefits to the patient? Has the medication been well-tolerated, safe and effective?
- Is the renewal in the best interest of the patient?
- Do you have the knowledge and skill to prescribe the drug based on its indication for use?
- Do you have access to the original prescription or the information it contained?

2. Pharmacists should be indicated as the prescriber on the prescription dispensing record.

When issuing a renewal, you assume full responsibility and liability for that prescription and the dispensing record should reflect you as the prescriber. In cases where the patient chooses to take the prescription to another pharmacy to be dispensed, it must be clear who issued the prescription.

3. Pharmacists are not limited to only one renewal.

The regulations do not prohibit you from renewing a prescription that was previously renewed by a pharmacist. The regulation defines "renew" as "to provide a patient with a prescription that repeats a prescription previously provided to that patient."

In the interest of continuity of care, you should independently assess the situation, and ensure your primary focus is the well-being of the patient.

The prescribed quantity of a renewal cannot exceed the total quantity (including refills) that was authorized by the original prescriber or a six month supply, whichever is less.

4. Pharmacists must notify the original prescriber of the renewal.

The purpose of prescriber notification is to ensure continuity of care and encourage a collaborative relationship between the pharmacist, the patient, and the patient's primary health care provider.

After prescribing a renewal, you must always notify the original prescriber and, if different, the patient's primary health care provider, within a reasonable period of time. There is no need to ensure receipt of the notification.

5. Pharmacists must document their decision and rationale.

In addition to documenting the renewal itself, the reference to the original prescription, and the prescriber notification, it is equally important to document your rationale for deciding to renew a prescription.

Documentation on the patient record should be thorough and concise and reflect the factors influencing your decision and be completed in a timely manner. These factors may include results of patient assessment, review of medical history, lab tests results or potential drug therapy problems, among others.

FOCUS ON ERROR PREVENTION

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

LIMITED DURATION OF THERAPY

Following an acute coronary syndrome event, patients are usually placed on a long-term platelet aggregation inhibitor to minimize the risk of recurrence. Pharmacists should be reminded that in some instances, the duration of therapy for a specific platelet aggregation inhibitor may be limited.

CASE:

Rx: Brilinta® 90mg

Sig: One tablet twice daily

Mitte: One year

A sixty-six year old patient received the above prescription upon discharge from hospital following an acute coronary syndrome event. The prescription was taken to the patient's regular community pharmacy for processing. The correct medication was dispensed to the patient.

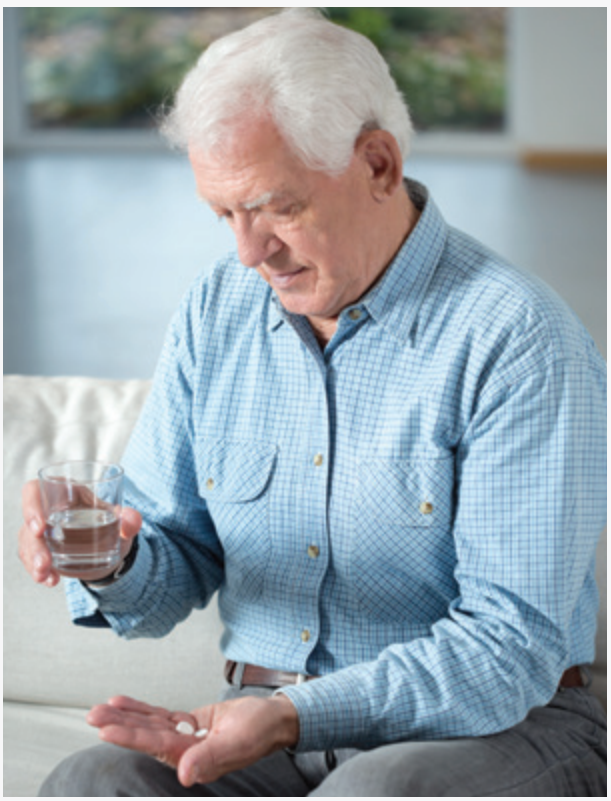
At the end of the twelfth month, the patient called the pharmacy for another refill of the prescription. The original prescriber was contacted for authorization to refill. The prescriber's secretary asked that the family physician be contacted.

Three days after the patient's initial request, the pharmacy had not received a response from the patient's family doctor and the patient was now out of medication and concerned about the implications of stopping his drug therapy abruptly. The pharmacist therefore made the decision to renew/extend the prescription for Brilinta® 90mg and dispensed the medication to the patient. The physician was also informed via fax. The following day, the physician contacted the pharmacy to indicate that the patient should not be taking Brilinta® 90mg beyond the initial one year.

The pharmacist consulted the manufacturer's product monograph and learnt that the recommended dosage for Brilinta® 90mg is twice daily for one year only following an acute coronary syndrome event[1]. The Ontario Drug Benefit Formulary also limits coverage for Brilinta® 90mg to one year[2]. The patient was therefore contacted and asked to discontinue taking the Brilinta® 90mg tablets.

POSSIBLE CONTRIBUTING FACTORS:

- Delay in contacting and communicating with the initial prescriber and the patient's family doctor.
- The patient was unaware of the recommendation that Brilinta® 90mg be taken for one year only following an acute coronary syndrome event. It appears that they did not receive this information when counselled initially.
- The dispensing pharmacist who renewed/extended the prescription was also unaware of the dosing recommendation.



RECOMMENDATIONS:

- Contact your software vendor to discuss the addition of system alerts to identify medications where the duration of therapy is limited. A hard stop mechanism may be implemented to prevent the dispensing of these medications beyond a specific date.
- Ensure patients are appropriately counselled when receiving these drugs for the first time. Suggest that the patient record the end date on a calendar at home. Ensure that these patients understand next steps when the specific drug therapy ends.
- Educate all pharmacy team members regarding the limited duration of some drug therapies and the potential for error.

REFERENCES:

1. Brilinta product monograph available at:

https://www.astrazeneca.ca/content/dam/az-ca/downloads/productinformation/BRILINTA%20-%20Product-Monograph.pdf

Accessed January 11th, 2017.

2. Ontario Drug Benefit formulary available at:

https://www.formulary.health.gov.on.ca/formulary/limitedUseNotes.xhtml?pcg9Id=201200088

Accessed January 11th, 2017.

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

PRACTICE TIP!

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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.

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