

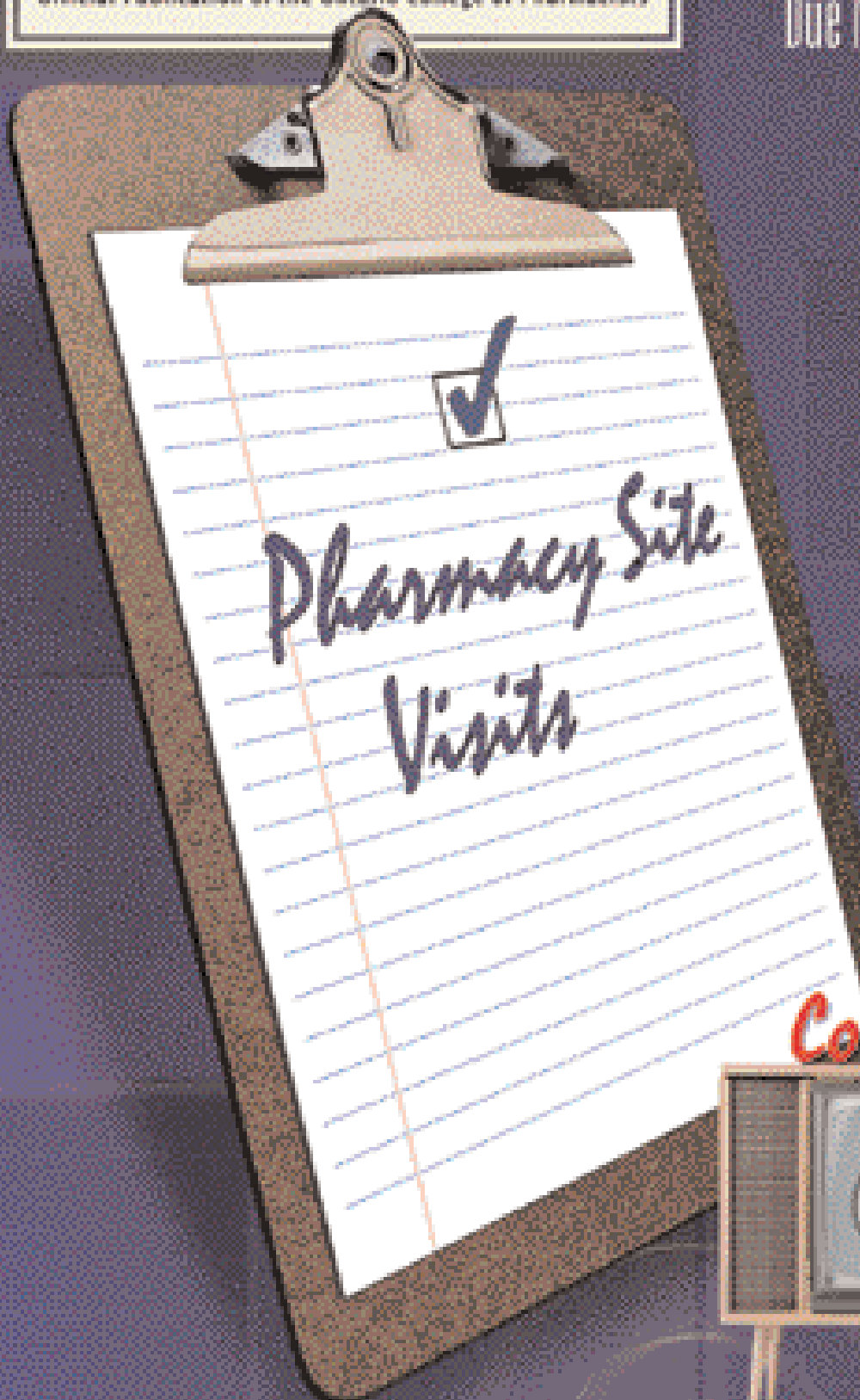
Pharmacy Connection

Official Publication of the Ontario College of Pharmacists

ONTARIO COLLEGE OF PHARMACISTS
2003

Annual
Pharmacist Fees
Due March 10, 2003

January/February 2003



Coming Soon



...see page 8



Mission Statement

The mission of the Ontario College of Pharmacists is to regulate the practice of pharmacy, through the participation of the public and the profession, in accordance with standards of practice which ensure that pharmacists provide the public with quality pharmaceutical service and care.

Council Members

Council Members for Districts 1-17 are listed below according to District number. PM indicates a public member appointed by the Lieutenant-Governor-in-Council. DFP indicates the Dean of the Faculty of Pharmacy, University of Toronto.

1 Marie Ogilvie	11 David Malian, <i>President</i>	PM Bob Drummond
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3 Oluremi Ojo	13 Donald Stringer	PM Tina Gabriel
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Statutory Committees

- Executive
- Accreditation
- Complaints
- Discipline
- Fitness to Practice
- Patient Relations
- Quality Assurance
- Registration

Standing Committees

- Finance
- Professional Practice

Special Committees

- Communications
- Standards of Practice Working Group
- Structured Practical Training

- Task Force on Primary Health Care Reform
- Working Group on Certification Examination for Pharmacy Technicians
- Working Group on Pharmacy Technicians

ASSESSORS NEEDED

You Can Help!!!

The International Pharmacy Graduate Program is looking for pharmacists to act as assessors for the Prior Learning Assessment (PLA) Component of the Program.

If you are interested in participating or would like more details, please contact Artemis Diamantouros at 416-946-5779 or e-mail artemis2@sympatico.ca.

**International
Pharmacy
Graduate
Program**





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Pharmacy Connection

The objectives of Pharmacy Connection are to:

- Encourage ongoing dialogue with pharmacists by communicating information on College activities and discussing issues of interest to members.
- Promote understanding and appreciation of the role of the pharmacist among members of our profession, allied health professions and the public, and provide access to resources that will facilitate the provision of pharmaceutical care.

We welcome original manuscripts for consideration. We publish six times a year, in January, March, May, July, September and November. Manuscripts should be received no later than 10 weeks prior to publication. If you intend to submit material, or would like a copy of the publishing requirements, please contact the Associate Editor. The Ontario College of Pharmacists reserves the right to modify contributions as editorial staff feel is appropriate. To be published, subject matter should promote the objectives of the journal. We also invite you to share with us any suggestions for topics, or journal criticisms, etc. Letters must include the name, address and telephone number of the author for verification purposes, and may be reprinted in the *Letters* column. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.



*Della Croteau
Deputy Registrar/
Director of Programs*

Editor's Message

As Health professionals we promote health and wellness to our clients, but are we taking care of our own health so we can provide the best possible care to our patients?

While College staff do not have the same physically demanding jobs as those of you who work in pharmacies standing every day, we had noticed an increasing incidence of staff complaining about back problems. Most College staff have "desk jobs" and with that comes long periods of sitting, physical inactivity, and the glare of computer monitors. And sure enough, as the hours pass each day, our posture becomes poorer and poorer. So, we decided to take some action.

November 4-8 was "Back to Health Week" at the College. We put up posters promoting the five days of planned activities and asked each staff person to sign up for introductory classes that were held either at the beginning or end of the each day. Staff participated in one-hour introductions to Yoga, Pilates and Tai Chi. We also had a massage therapist come in and teach us how to give each other mini back massages. Our week finished with flu shots. One of our

staff members also had a great idea for "seventh inning stretches" twice a day, so we paged all staff in the building at 10:30am and 2:30 pm each day to gather and stretch for a few minutes. Even Council, committee members and guests attending meetings at the College were asked to join us!

The event was a success but staff wanted to make sure that we keep the

Most College staff have "desk jobs" and with that comes long periods of sitting, physical inactivity, and the glare of computer monitors.




Back2Health week @ The College

momentum by ensuring that exercise remains part of our work day. As such, we are now organizing an ongoing exercise class that will be held before work, one day a week. Many have said that the opportunity to exercise in the workplace removes the excuse for not being able to exercise regularly. And we are all (guests and committee members included) still taking five minutes, twice a day, to stop, stand up and stretch! It only takes a few minutes (less than a cigarette break) and is invigorating and fun. We gather together in a couple of different places and stretch together to stay enthusiastic.

Thanks to the efforts of Lisa Baker, our human resources coordinator, the staff at the Ontario College of Pharmacists have taken a renewed interest in their health and well-being.

I encourage you to think about wellness projects for your workplace. As health professionals who are expected to provide optimal patient care, we should also be demonstrating that the health and well-being of our staff and ourselves is a priority.

What types of activities and programs inspire you and your staff to keep healthy? Let us know what your pharmacy does to create and maintain healthy lifestyles for its employees.

As we begin 2003, make the effort to establish a healthy lifestyle and work/life balance for yourself and the people with whom you work. The Ontario public will be better served by healthy pharmacists and staff. 

What types of activities and programs inspire you and your staff to keep healthy? Let us know what your pharmacy does to create and maintain healthy lifestyles for its employees.



OCP COUNCIL REPORT

December 2002

REGISTRATION REGULATION AMENDMENTS APPROVED

Council approved amendments to the College's Registration regulation that will, once approved by government, allow pharmacists registered in other Canadian jurisdictions on or before July 1, 2001 to register directly into Part B of the OCP Register. This is not currently possible under the existing Registration regulation, which requires all pharmacists seeking licensure in Ontario under the *Mutual Recognition Agreement for Pharmacy in Canada (MRA)* to meet the requirements for licensure into Part A (active, direct patient care). These amendments, which were approved in draft form by Council in June of this year, will facilitate mobility under the MRA. The proposed amendments were circulated for member feedback this past fall and no comments were received. Council has ratified the amendments and has directed that they be submitted for government approval.

NEW POLICY RESPECTING OUT-OF-COUNTRY PRESCRIPTIONS APPROVED

Council unanimously approved a recommendation from the Professional Practice Committee that the following policy be adopted by the College:

"Pharmacists shall not facilitate or enter into agreements with physicians for the purposes of co-signing or rewriting prescriptions for out-of-country patients. If a prescription is filled in Ontario, the *Standards of Practice* for pharmacists and pharmacies in Ontario must be met regardless of where the patient resides and these Standards cannot be waived through any agreements or contracts."

Council considers that pharmacists who knowingly facilitate the practice by any Ontario prescriber to co-


sign/authorize prescriptions where no established physician/patient relationship exists are acting unethically and fall below a standard of practice of our profession. This policy is effective immediately.

NEW POLICIES AND GUIDELINES FOR METHADONE APPROVED

New policies and guidelines for pharmacists and pharmacies dispensing or wishing to dispense methadone in Ontario were approved by Council and will be printed in their entirety in the March/April issue of *Pharmacy Connection*.

In addition, Council agreed with the Professional Practice Committee's recommendation that there be a two-year implementation period for these policies so that methadone-dispensing pharmacists have sufficient time to undertake the education and training required under the new policies. The College will carry out an education and communication campaign to raise the level of awareness of these guidelines for all members wishing to dispense methadone. Please contact Elaine Maloney x 293 or Greg Ujiye x 235 or for more information.

EMERGENCY CONTRACEPTION- UPDATE

The Emergency Contraception Pilot Project, which was conducted in several Toronto-area locations beginning June 2001, ended in late November. Further to policy approved by Council in September to support continued and ongoing access to emergency contraception through trained pharmacists across Ontario, the President and Registrar have met with representatives from government and the College of Physicians and Surgeons of Ontario to discuss the necessary legislative amendments. Discussions are ongoing, however, at present a prescription is required in all instances before emergency contraception is dispensed. 

Pharmacists' Annual Fees due March 10, 2003



Your member fee of \$522.07* is due no later than March 10, 2003. Renewal forms will be mailed to you by mid-January; please contact the College if you have not received your form by January 31st

Fee Payments

As prescribed in the by-laws, members are responsible for timely renewal and payment

March 10th Deadline: Your form and fee must be received and/or postmarked no later than March 10th. The sooner your form and payment are received, the sooner they will be processed and the sooner you will receive your receipt and wallet card. (We will try to notify you prior to March 10th if there is a problem with either the form or the payment)

Preferred Mailing Address: Your preferred mailing address will appear only on lists given to providers of accredited CE courses and candidates running for election to Council. In the absence of a workplace address, all mail will be sent to your residence until such time as a workplace address has been registered

Postdated Cheques cannot be processed early by the College, however staff can verify their receipt (call Member Services for confirmation)

Late payments are subject to a penalty of \$107.00 if paid within 30 days after the due date or \$160.50 if paid more than 30 days after the due date. This includes cheques that are received early but postdated after March 10, 2003. Furthermore, late payments are not processed until the penalty has been received

NSF cheques are treated as late and incur both a late penalty fee and a \$5 NSF service charge. As well, all unsigned cheques and forms will be returned for signature

When filing your fee, please ensure that you:

Include your fax number and e-mail address for faster receipt of College updates and notices

Make sure your cheque is signed and made payable to the Ontario College of Pharmacists or OCP for the correct amount of \$522.07

* **All fees listed above include GST**

For further information contact Member Services:

Roland Starr (416) 962-4861 x 237, rstarr@ocpinfo.com

Maria Beck x 298, mbeck@ocpinfo.com

Ifrah Osman, x 230, iosman@ocpinfo.com

MEMBER EMERITUS

Any pharmacist that has been a member of the College for 25 years or more can voluntarily resign from the Register and make an application for the **Member Emeritus** designation. Members Emeritus are not permitted to practice pharmacy in Ontario but will be added to the roll of persons so designated, receive a certificate and continue to receive *Pharmacy Connection* at no charge.



All New!

Soon to be seen across Ontario

Pharmacists Have Heart!!



Airing March 24-May 23, 2003

Stay tuned for details...

New Member-Focused Information System

Changing How the College Does Business

Wendy Davidson, Manager,
Information Technology Services

The College has embarked on creating a new, member service information system that will greatly improve how daily operations are conducted — from how it initiates new student registrations through to how annual member fees are collected and recorded.

The most significant benefit of having this new fully integrated database will enable the College to accurately track emerging member trends or needs and respond to them in a much more timely manner.

We have long maintained various electronic (and paper) files for each member on the OCP Register. With a new electronic database and task management system that will be put into place over the coming months, we soon will be able to work from a single portal that will integrate all of the College's regular business operations including:

- Database management
- Contact management
- Task management
- Scheduling
- Workflow

WHAT DOES THIS MEAN FOR YOU?

The new information system will integrate all of the College's current IT systems and its websites. Once completed this system will offer pharmacists:


- Enhanced service from all areas of the College
- Improved member-record accuracy on the Register
- More convenient initial online form submission, better recording of licensure milestones completed by students/interns, tracking of steps achieved by technicians seeking certification, etc.
- The convenience to update some parts of OCP Register record (i.e. change of practice address, phone, email, primary mailing address, etc.)

- The convenience to review important notifications and general College information by email
- The convenience to pay your annual fee renewals online using a credit card
- The convenience of receiving practice-related information documents or web links by email

For College staff the system will:

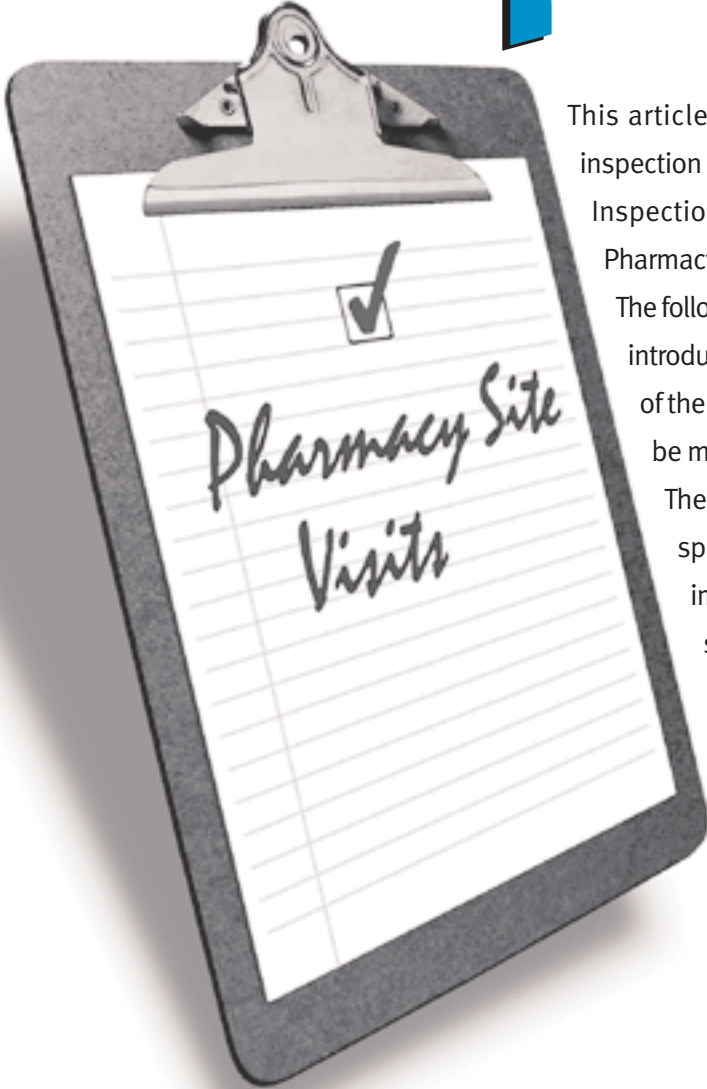
- Provide a single portal with up-to-date technological functionality based on industry-standard software, that will allow staff to access OCP databases remotely, and retrieve and file documents and applications online
- Allow staff to link key member files electronically with the member's record (versus the current paper-based cross-referencing system)
- Improved efficiency by having tasks, work assignments, action and item follow-ups developed from a single unified system
- Improve communications through an email system that can link to electronic documents in OCP files and our websites
- Offer online scheduling for improved meeting coordination

The new system will improve how the College conducts its business. Over the last few months, all College departments have closely examined their business functions to find new or more efficient ways to carry out these functions and to ensure that the new system will be customized to their needs.

The new system is a flexible set of customizable *Customer Relationship Management* tools and it was developed by a Canadian company based in Vancouver. The College's system will be supported by a local Toronto company. We expect the system to be operational by fall 2003. 

PHARMACY SITE

Visits & Inspections



This article summarizes the current Ontario pharmacy inspection process and serves as an update to “The OCP Inspection Process” that was previously published in *Pharmacy Connection* (March/April 1999).

The following protocol reflects key modifications that were introduced to reflect changes in requirements as a result of the revised Standards of Practice. (The protocol will be modified as the practice of pharmacy changes.)

The report highlights some of the major areas of inspection, and is not complete checklist. It is also important to note that, while College pharmacy inspections must review necessary operational regulations and requirements, the College has broadened its inspection philosophy to include a greater emphasis on providing education and guidance to pharmacists operating pharmacies.

HIGHLIGHTS OF THE INSPECTION PROTOCOL

I. Accredited Pharmacy Area

Looks at the physical location and some of the requirements that should be visible to the public such as:

- Is the most current accreditation certificate publicly displayed?
- Is the license of the designated manager displayed?
- Are both black and yellow OCP signs prominently displayed and do they meet regulation size?
- Is the pharmacy set up as a lock and leave operation? & Does the barrier comply with current guidelines?
- Are all pharmacy-related drugs located behind barriers in the absence of pharmacist? [DPRA Reg 551 s78]
- Is there clear counter space of 12 sq. ft. available for efficient prescription filling?
- Are there provisions for an acoustically/visually private consultation area? (Policy Handbook)

II. Compounding Equipment and Consumable Materials [DPRA Reg 551 s 73 (1)]

These are the requirements required for the safe practice of pharmacy and act as quality assurance checks.

- Are the torsion/electronic balances properly calibrated and defect-free?
- Are all areas and equipment kept in a clean, sanitary and clutter-free condition?
- Does a pharmacy performing sterile dispensing comply with guidelines?
- Does the pharmacy use either dossette or blisterpak compliance packs? If so, does the pharmacy's compliance and package labelling comply with OCP policy (Policy Handbook)
- Are the pegged blisterpaks containing "light-sensitive" drugs protected?
- Are the automatic drug dispensers properly labelled in accordance with federal regulations? (drug/manuf. |lot #/expiry date)

III. Pharmacy Maintenance [DPRA Reg 551 s72, s73]

Again, this is to ensure that the pharmacy is in a clean and sanitary condition. This is also to ensure that drugs being sold in a pharmacy are safe for the public.

- Are the dispensary shelves regularly cleaned?
- Are all floors/carpets/mats regularly swept & cleaned?
- Is there a system in place to monitor and remove any expired drugs in the dispensary? (*Pharmacy Connection* November/December 1995)
- Are front shop shelves regularly monitored for cleanliness, and is all inventory regularly checked for expired drugs?

IV. Labels: [(DPRA : s 156 (3)]

- the prescription labels display all required information as required by the regulations?

In cases where there has been an acquisition or relocation, does the information reflect the changes made either to the corporate name, trading name address of pharmacy or telephone number? New amended prescription labels must be used immediately upon receipt of same.

V: Non-Prescription Sales Control

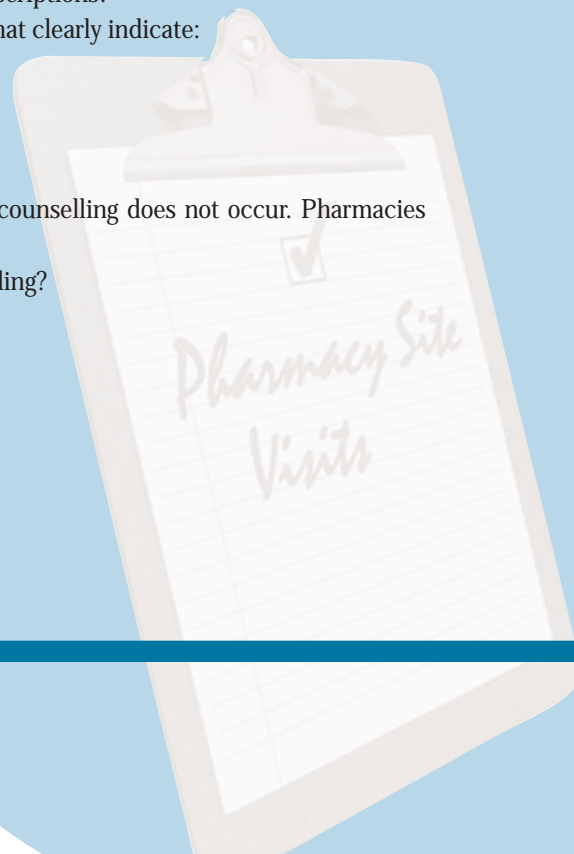
- Are all Schedule II drugs located in a non-public access area?
- Are all Schedule II narcotics located in non-public view area?
- Are all Schedule III drugs located in an area that allows pharmacist audio-visual control?

VI: Pharmacy Library [DPRA Reg 551 s 73 (k) & Library Guide]:

- The most current library guide can be found at www.ocpinfo.com. It lists all current and/or required editions.
- Pharmacies (with Internet access in the professional area that can access the ocpinfo.com website online) may rely on the online OCP Manual in lieu of having a physical hard copy of the Manual in the dispensary. Pharmacists should also research whether other library requirements can be accessed online.

VII. Prescription Processing: Systems & Procedures

- Is important information relating to the patient being gathered by the receiving pharmacist?
- Are dispensed prescriptions being compared to their originals for accuracy?
- Are auxiliary labels available and affixed to containers when deemed necessary?
- Is it the pharmacist or intern that is making the final check of filled prescriptions?
- Is documentation of dialogue being recorded on all new prescriptions that clearly indicate:
 - The patient's name
 - identification of agent acting in behalf of patient
 - contact person on delivered prescriptions
 - any reason for non-dialogue (Policy handbook)
- Documentation must also be recorded, indicating reasons, whenever counselling does not occur. Pharmacies should not use pre-programmed defaults for the dialogue function.
- Is there a system in place to flag new prescriptions that require counselling?



VIII. Prescription Records: (Regular & Narcotic/Control drugs)

Inspectors check prescriptions to ensure compliance with the regulations. Some of the areas checked are: filing and retrieval, retention of records, prescription transfers, verbal and written orders, and recording and labeling. Accuracy of directions and documentation regarding any changes to prescriptions are also checked. Following are some of the items on the inspection report:

- Is all information on transferred prescriptions being recorded as per regulations, particularly the date that the prescription was originally issued by the prescriber?
- Are single ingredient drugs being labelled generically? (Policy Handbook)
- Are prescriptions being dispensed in the quantity prescribed?
- Is documentation being recorded for:
 - Reduced quantity or quantities (Patient or agent must sign)
 - "No sub requests" by patient
 - Modifications or interventions conducted by the pharmacist
- Are receipts indicating "Cost, fee, total" being provided to ALL PATIENTS? [DIDFA: s(10), DIDFA Reg 205/96 s 4(1)]
- Are all prescriptions dispensed, logged or inputted into the computer for later dispensing being signed by the pharmacist? [DPRA: s 156 (1) (g)]
- Are all faxed prescriptions received on "thermal paper" subsequently photocopied onto plain paper for image retention? [Policy Handbook]

There are also supplementary portions of the inspection process that address different practice settings such as long-term care, methadone dispensing or sterile compounding. Specific checklists have been designed to reflect these particular practice settings.

On completion of the inspection, the inspector will leave a computer printout of his/her report and indicate to the pharmacist on duty any deficiencies noted, comments, and/or corrections that need to be made. An action plan will also be left with the pharmacist for completion.

The inspectors respect the time and effort that many pharmacists have made in preparing the actions taken to address any issues and deficiencies noted during the visit. However, it is incumbent upon pharmacists to ensure that all such action plans submitted be completed with sufficient detail, and include any required documentation or invoice(s). (When submitting action plans, please include copies of invoices as proof of purchase for texts or material previously cited as missing.)

As always, if you ever have questions about your inspection or general practice issues, please feel free to contact your inspector. 📧

Ronald Kyniski, B.Sc. Phm.
Field Inspector



Bernie Des Roches, Ph.D.

Manager, Continuing
Education Programs

A couple of words about

Learning Portfolios...

port-fo-li-o: From *portare*, **to carry** + *foglio*, **sheet**

learn-ing: *To gain knowledge or mastery through experience or study*

A Learning Portfolio is simply a collection of papers that document professional development activities undertaken by a professional to help him/her maintain the necessary skills to enable them to provide consistent quality healthcare.

Your learning portfolio should provide a summary of all practice-related learning activities in which you participate. Maintaining a portfolio helps you:

- Focus on the quality of each learning opportunity versus the time spent on each activity
- Broaden your appreciation of the range of learning activities that you do to include non-traditional or non-structured activities such as literature searches on a specific topic, time spent reading pharmacy journals or even public or professional presentations on pharmacy issues
- Recognize the value of developing skills that complement the delivery of pharmacy care such as communication skills, time management and/or computer skills
- Become more focused and systematic in what you study so that your time, though limited, is directed to learning activities that reflect your specific needs within your current practice setting

However, maintaining a learning portfolio is not without its challenges! You might wonder: *How can I get started?; What should my portfolio look like?; or How can I most easily maintain my portfolio?*

There is no right or wrong way to develop and maintain your learning portfolio. Pharmacists who participated in the Practice Review's learning portfolio sharing sessions have said it was very helpful speaking to colleagues about maintaining their portfolio.

We suggest you speak to a colleague if you have similar questions about your portfolio. (See also the *September/October 2002* for tips on maintaining a portfolio.)

Learning Portfolio Sharing Sessions in 2003

Throughout the coming year the College and the Regional CE Coordinator Team will be working to provide you with opportunities to hold local learning portfolio sharing sessions in your community. To find out more, contact your local CE Coordinator (See listings on pages 15-16 of this issue) or Bernie DesRoches at (416) 962-4861 x 249; email bdesroches@ocpinfo.com.

THE CE COORDINATOR TEAM

Thanks for your continued support and dedication!

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“Because pharmacy can be professionally solitary at times, as Regional CE coordinator, it gives me an opportunity to network with other pharmacist...”

Beth Gallagher, Region 3

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10 Vacant

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“Opportunity to volunteer for my profession, connect with other pharmacists, and learn what others are doing.”

Henry Halapy, Region 12

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THE CE COORDINATOR TEAM

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16 Vacant (2 positions)

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18 Vacant (2 positions)

Being a CE Coordinator/Associate: o – “... I feel it is rewarding and at the end of the day it gives me a good feeling.”

Janet Shore, Region 11

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22
Ms Adele Kaminski
Tiverton
tel/fax (519) 353-5307
e-mail: adele.kaminski@utoronto.ca

Mr. Dinesh Shah
Owen Sound
tel (519) 376-2121, x 2100
fax (519) 376-8984
e-mail: dinesh.shah@sympatico.ca

Mr. Mauri Kuyper
Owen Sound
tel (519) 371-0120

Mr. Martin Keeping
Owen Sound
tel (519) 371-0758
fax (519) 371-3089
e-mail: coincup@sympatico.ca

23 Vacant (2 positions)

24
Ms Janet Groulx
Windsor
tel (519) 969-1234
fax (519) 969-4147
e-mail: jgroulx@mnsi.net

25
Ms Maria Coccimiglio
Sault Ste. Marie
tel (705) 759-3434, x 5732
fax (705) 759-3693

Ms Janet Jennings
Sault Ste. Marie
tel (705) 759-3333
fax (705) 759-3675

Ms Marie Paluzzi
Sault Ste. Marie
tel (705) 759-3434, ext. 5732
fax (705) 759-3693

“I find there is a need for these educational evenings that bring together pharmacists from different areas. ... As a CE coordinator I try to fill that need which at the same time makes me feel that I am contributing a very small part in helping our profession.”

Danielle Caron, Region 11

26
Mr. Vinay Kapoor
Thunder Bay
tel (807) 623-2390
fax (807) 622-7389
e-mail: ASDM677@shoppersdrug-mart.ca

Mr. Tim Slack
Thunder Bay
tel (807) 475-5385
fax (807) 473-9790
e-mail: tslack@tbaytel.net

27
Mr. Calvin Brown
South Porcupine
tel (705) 235-5217
e-mail: kbrown@nt.net

28
Ms Stella Rupert
Sudbury
tel (705) 522-6113
e-mail: ps.rupert@sympatico.ca

Mr. Wilfred Steer
Sudbury
tel (705) 522-3030
fax (705) 522-8360
e-mail: wsteer@sympatico.ca

29
Ms Karen Riley
Samia
tel (519) 464-4500, ext. 5208
fax (519) 383-6237

Ms Kelly Miodowski
Brights Grove
tel (519) 869-4224
fax (519) 869-8684

Are You Interested in Learning?

In order to help support local, live education opportunities for pharmacists in all parts of Ontario, the College is looking for pharmacists interested in joining the CE Coordinator Volunteer Team to represent the following areas:

CE Region 9: Ashburn, Blackstock, Fenelon Falls, Greenwood, Lindsay, Locus Hill, Millbrook, Oakwood, Port Perry, Sunderland, Uxbridge

CE Region 10: Astorville, Bala, Bracebridge, Burks Falls, Callander, Corbeil, Hunstville, Mactier, Mattawa, McKellar, Minden, North Bay, Novar, Onaping, Parry Sound, Port Carling, Port Sydney, Powassan, Rosseau, South River, Sundridge, Utterson

CE Region 16: Beamsville, Caistor Centre, Canfield, Cayuga, Delhi, Dunnville, Fenwick, Fonthill, Fort Erie, Grimsby, Hagersville, Hespeler, Jarvis, Jordan, Niagara Falls, Niagara-on-the-lake, Oshweken, Port Colborne, Port Dover, Port Rowan, Ridgeville, Ridgeway, Selkirk, Sherkston, Simcoe, Smithville, St Catharines, St Davids, Stevensville, Thorold, Vineland, Virgil, Wainfleet, Waterford, Welland, Winona

CE Region 18: Ailsa Craig, Arva, Aylmer, Belmont, Courtland, Delaware, Denfield, Dorchester, Eden, Fingal, Granton, Ilderton, Ingersoll, Innerkip, Iona Station, Komoka, London, Lucan, Mount Brydges, Nairn, Norwich, Port Stanley, Salford, Seaford, Southwold, Sparta, Springfield, St Marys, St Thomas, Straffordville, Thamesford, Thorndale, Tillsonburg, Val Therese, Woodstock

CE Region 23: Appin, Blenheim, Bothwell, Chatham Comber, Cottam, Dresden, Dutton, Eriean, Glencoe, Ridgetown, Rodney, Stoney Point, Thamesville, Thedford, Tilbury, Wallaceburg, West Lorne, Wheatley

This rewarding opportunity will appeal to you if you enjoy:

- *Planning* and organizing events
- *Collaborating* with providers of pharmacy education
- *Influencing* the quality of learning within your region
- *Interacting* with a team of enthusiastic volunteers who are also interested in lifelong learning.

If you are interested in learning more about this opportunity, please contact Dr. Bernie DesRoches at (416) 962-4861, x 249, fax: (416) 847-8281 or e-mail: bdesroches@ocpinfo.com.



Greg Ujiye, B.Sc.Pharm.

Manager, Pharmacy
Practice Programs

Q&A Pharmacy Practice

Q Can any physician prescribe methadone?

No. Under the *Narcotic Control Regulations*, physicians are prohibited from administering, prescribing, giving, selling or furnishing methadone to any person unless they are exempted under section 56 of the Act (CDSA). Exempted physicians fall under two categories of methadone prescribers – Methadone Maintenance Treatment Program (MMT) or methadone for treatment of pain. Physicians can qualify for one or both of the programs and must be re-certified regularly. Physicians can only prescribe for the programs in which they are certified.

Before dispensing methadone, pharmacists must first ensure that the prescribing physician is exempted and can legally prescribe methadone. You should either call the College of Physicians and Surgeons' Methadone Program at (416)-967-2661 or the Ontario College of Pharmacists at (416)-962-4861 x 236 to verify the physician's status. The information provided is confidential and for pharmacist and physician-use only. Complete lists of physicians are not provided and only information relevant to the specific practitioner or specific area can be provided.

Q Can any pharmacist dispense methadone?

Yes. The *Narcotic Control Regulations* do not place any prohibitions on pharmacists wishing to dispense methadone. However, the College strongly recommends that pharmacists wishing to dispense methadone complete the methadone workshop provided by the Centre for Addiction and Mental Health (CAMH). (The College's new Methadone Guidelines will be published in the March/April issue.)

The CAMH provides education and training on the


Methadone Maintenance Treatment Program. CAMH has also published "*Methadone Maintenance: A Pharmacist's Manual*" which provides the necessary guidelines that must be followed when dispensing methadone. (Both the program and manual have been endorsed by the OCP.)

The College also recommends each pharmacist become familiar with the guidelines and understand the pharmacist's role in this program prior to dispensing methadone. For information on the training program and/or to order the manual, contact:

Centre for Addiction and Mental Health
33 Russell Street
Toronto, ON M5S 2S1
Phone (416) 595-6059

Q Thirty days notice must be provided to the College prior to either opening a new pharmacy or relocating a pharmacy. Is this the same for an acquisition?

No. An acquisition requires only 15 days notice. However we urge you to respect this time requirement as the filing of forms by the new owners and subsequent College verification requires a significant amount of time.

Reminder: Please also remember that any *changes in information* concerning pharmacies — such as amalgamations of corporations — must be reported to the Registrar within seven days of the noted change (OCP By-laws, Article XIII, 13.2.2). 

Please see new OCP Policy for
Out-of-Country Prescriptions
in the Council Report on page 6

NOTICE TO PHARMACISTS

UPDATE ON CFC/HFA SALBUTAMOL INHALERS

Pharmacists and pharmacy personnel have received communication from the College and the Ministry of Health and Long-Term Care on the Discontinuation of CFC inhalers and the interchangeability of CFC/HFA Salbutamol inhalers effective January 1, 2003.

It is important that patients are informed and understand that differences exist between the two products. These differences will not affect the effectiveness of their medications.

All retail sales of Salbutamol-metered dose containing CFC are prohibited effective January 1, 2003, with the exception of Combivent® (January 1, 2005). Ensure that all stocks of these products are returned to either the manufacturer or wholesaler as instructed.

Please refer to the OCP website (www.ocpinfo.com) for further information, in particular the interchangeability of Salbutamol-containing metered dose inhalers.

NOTICE TO PHARMACISTS

FORGERY ALERT

The following prescription information has been reported to the College:

- 1) December 5, 2002: Guelph General Hospital has reported that three prescription pads have been stolen
- 2) September 4, 2002: Dr. Peter A. Charlebois has reported that he now uses green prescription pads that are numbered. He no longer uses yellow or white prescriptions.

A number of prescription forgeries have been confirmed on items such as Viagra® Imovane®, Ionamin® and other targeted substances / benzodiazepines. Pharmacists should take more care when filling prescriptions for these drugs in addition to the more common narcotic and controlled drugs forgeries
(Please see the forgery article on page 24 of November/December issue)



Chris Schillemore, B.Sc.Pharm.

Manager, Registration Programs

Q&A Registration

Q I've heard rumours that the College has a mutual recognition agreement with Michigan. Can you provide any information on this arrangement?

No formal agreement has been negotiated between pharmacy regulators in Michigan and Ontario. However the State of Michigan has enacted temporary legislation (until 2004) which will allow increased mobility for Canadian pharmacists.

Previously, Canadian-licensed pharmacists who received their pharmacy degrees from faculties outside the U.S. were first required to pass the *Foreign Pharmacy Graduate Equivalency Examination* (FPGEE) before they could undertake Michigan's subsequent entry-to-practice requirements. (This situation was similar to the College's requirement that candidates who have received their pharmacy degree outside North America to pass the Pharmacy Examining Board of Canada Evaluating Examination in order to become eligible to register as students with the College.)

Michigan's requirement for the FPGEE has been eliminated only for Canadian-licensed pharmacists who have completed their undergraduate pharmacy degree within Canada. Michigan's other licensure requirements include passing NAPLEX (North American Pharmacist Licensure Exam, the US equivalent of the PEBC Qualifying Exam), the MPJE (Multistate Pharmacy Jurisprudence Examination) and a period of internship.

This change in Michigan's requirements brings them more in line with Ontario's current requirements for U.S. licensed pharmacists, which include the PEBC Qualifying


Exam, Ontario's Jurisprudence Exam and 12 weeks of structured practical training internship.

If you want further information, you can reach the Michigan Board of Pharmacy at: <http://www.cis.state.mi.us>

Q I was surprised to hear that the College has discontinued structured practical training. Could you clarify this for me?

Structured practical training refers to training that is done during both studentship and internship. In March 2002, the four-week Structured Practical Training studentship period was discontinued only for pharmacy undergraduates and unlicensed graduates from accredited North American faculties of pharmacy.

These faculties have now included a training component within their curriculum. However these candidates must still complete the 12-week Structured Practical Training internship.

Both structured practical training studentship and internship remain for international pharmacy graduates. The current requirements of 32 weeks studentship (comprised of 16 weeks of academic modules and 16 weeks of Structured Practical Training studentship) and 16 weeks of Structured Practical Training internship remain unchanged. For a more detailed explanation of this change, please refer to the May/June 2002 issue. 

International Pharmacy Graduate Program



Mentorship is a Success

Bill Dingwall B.Sc.Pharm.

Mentorship Co-Ordinator, International Pharmacy Graduate Program

Now in its second year, the International Pharmacy Graduate Program is well underway. Past columns have discussed the four key “pillars” or objectives to the program — one of which is a **mentorship network**.

WHAT IS MENTORSHIP?

The purpose of mentorship is to match the “mentee” (IPG pharmacist candidate) with an experienced Ontario-licensed pharmacist (the mentor) who will help introduce the mentee to the profession.

Mentorship should not be confused with preceptorship. Preceptoring involves a student/intern working with a pharmacist who provides the student/intern with formal assessment and direction.

On the other hand, mentorship is a supportive/advisory relationship between a pharmacist and IPG student. They will meet or talk one hour per week to discuss the nature of Ontario pharmacy and various issues or challenges that the student encounters as he/she progresses through the required pre-licensing training and testing.

The mentor provides coaching, advice and support for the student. The mentor will also help clear pathways for the mentee while making connections with fellow professionals and pharmacy organizations.

PILOT

This past summer an initial mentorship pilot program was conducted with six pharmacist mentors and six Spring 2002 IPG class students. The pilot project was very successful as it clearly demonstrated the value of mentorship for the IPG student.

The mentors also found the experience to be a personally rewarding one, knowing that they would be the person their mentee would turn to whenever they had questions about life in Canada, its culture and geography or specific

questions about professional practice. The mentors were also helpful in introducing their mentees to professional colleagues, organizations and experiences.

Congratulations to our pioneer mentors and mentees:

MENTORS:

Aubrey Brown
Diane Hindman
Christine Stewart
Art Ito
Ruth Mallon
Paul Kuras

MENTEES:

Kal Mukherjee
Lin Yong
Ramy Banoub
Nabil Younan
Cecelia Reyes
Muhammad Afzal

We are also pleased to advise that this past Fall we were successful in getting mentors for each of the 52 IPG students registered in the October 2002 offering of CPS I.

However, we can not stop here. **More mentors will be needed for upcoming classes** to ensure our goal of a 1:1 ratio (mentee to mentor) can be maintained. We will also provide you with self-guided materials including any “intercultural communications” skills that you may need to make your mentoring experience more valuable. 📖

The commitment is only one hour per week, but the satisfaction will last a lifetime.

For more information, please contact:

Bill Dingwall B.Sc.Pharm.
Mentorship Co-Ordinator
IPG Program

(416) 946-8334 or ipg.phm@utoronto.ca



Connie Campbell, C.A.M., C.A.E.

Director of Finance and Administration

Q&A Incorporation

Since my November/December Q&A article, I have received many calls from lawyers — and a number of pharmacists — seeking clarification about the new rules for the professional incorporation of health professionals. As I talked to pharmacists (confused about how a professional incorporation may or may not benefit a pharmacist) I found myself drawing boxes on my notepad as a way to explain. I began suggesting that the callers do the same as we talk so that I can clearly communicate which type of corporate structure is permissible and which is not. In light of this, I thought it best to publish a few of these visual aids as a reference.

However, I want to reiterate a key message that was conveyed in the last article. Namely, that the College **cannot** advise you whether you can gain any advantage — tax or otherwise — from incorporation. We can only clarify what type of corporate structure is permissible in accordance with the legislation and what is not.

Please consider the following two points:

1. CORPORATE STRUCTURE

a.) Prior to New Incorporation Provisions

Prior to the new incorporation provisions, (initially embedded in the *Business Corporations Act*, and followed up with amendments to the RHPA and the DPRA, among others), a pharmacy could be owned by a pharmacist or by a corporation which had the majority of its shares held in the name of pharmacists. Majority shareholding of the oper-

ating company could not be held by a corporation regardless of the shareholding (e.g. wholly owned or majority owned by pharmacist).

Corporate structure in compliance

Operating Company – owns and operates the pharmacy	
49% held by non-pharmacist(s), family members, holding company, etc.	51% held directly in the name of pharmacist(s)

Corporate structure not in compliance

Operating company – owns and operates the pharmacy	
49% held by non-pharmacist(s), family members, holding company, etc.	51% held by “123456 Ontario Limited” which is wholly owned by pharmacists

b.) With New Incorporation Provisions

Since the professional incorporation amendments were made to the DPRA, the majority share of a pharmacy can now be held either directly by pharmacists or by health profession corporations owned by a pharmacist(s).

Operating Company – owns and operates the pharmacy


49% held by non-pharmacist(s), family members, holding company, etc.	51% by J. Smith Pharmacist, Professional Corporation (a health profession corporation holding a certificate of authorization issued by the Ontario College of Pharmacists) *
--	--

* The 51% can be held by one or more *health profession corporation(s)*. Although the *health profession corporation* can be owned by one or more pharmacist shareholders, you should be aware that each shareholder is jointly and severally responsible for the professional conduct of the health profession corporation (Refer to subsection 3.4(4) of the *Business Corporations Act*).

2. INCORPORATION WITHOUT PHARMACY OWNERSHIP

If you are not intending to own or operate a pharmacy, but simply wish to incorporate yourself and be paid through the corporation as opposed to directly as an individual, you should be aware that there are Revenue Canada rules relating to employment with which any employer would have to comply. If, according to those rules, you are deemed to be an employee, your employer will have no choice but to deduct tax at source and issue you a T4 or employment income receipt at the end of each year.

Application Forms

Certificate of Authorization application forms and instructions are available on our website at ocpinfo.com or can be obtained by calling the College. The fee for the application is \$600 (plus GST) and non-refundable. The annual renewal fee for the Certificate of Authorization is \$300 (plus GST). Please contact Ifrah Osman (iosman@ocpinfo.com, ext. 230) or Maria Beck (mbeck@ocpinfo.com, ext 298). 

NOTICE

STATUS OF ONTARIO PRIVACY LEGISLATION

The proposed Ontario privacy legislation was again considered for introduction in the Legislature but did not proceed during this past session. If the proposed legislation is not considered in the Spring government session, it will likely not be passed nor receive necessary approval prior to the January 1, 2004 deadline. If this happens, the *Federal Personal Information Protection and Electronic Documents Act* (PIPEDA) will become the privacy legislation for Ontario as of January 1, 2004.

PIPEDA will have significant compliance implications for frontline pharmacists as it will apply to all entities that collect, use or disclose personal information in the course of commercial activities.

We keep you apprised of the status of this legislation over the coming months.



Focus on Error Prevention



Ian Stewart, B.Sc.Pharm.

Dispensing a large quantity of medication when filling a prescription may require the use of more than one stock bottle. As a result, there have been cases where two different drugs or two different strengths of the same drug have been dispensed.

CASE 1:

An 83-year-old patient requested a refill of her prescription for 300 Effexor® 75mg tablets, with the directions to take one and a half tablets twice daily.

The technician selected two stock bottles of Effexor® 75mg (100 tablets each) and in error, also took one stock bottle of Effexor® 37.5mg. The contents of all three bottles were emptied directly into a large prescription vial and dispensed. The patient did not detect the difference in tablet size and strength, and therefore continued to take one and a half tablets daily. This resulted in a variation of each dose between 56.25mg and 112.5mg depending on the tablets she selected. A few days into taking these tablets, the patient's daughter reviewed her mother's medication and observed the difference in tablet size and strength. Assuming that the pharmacy had purposely given the 37.5mg tablet to avoid the need for cutting the 75mg tablet, she explained to her mother that she no longer needed to cut the tablets in half.

On requesting the next refill of her mother's Effexor® prescription, the daughter complained that though the

37.5mg tablet assisted her mother in the cutting of the tablet, the pharmacy should have informed her mother of the change. On investigation, the pharmacy confirmed and admitted that an error had indeed been made.

Possible Contributing Factors:

- The stock bottles of Effexor® 37.5mg and 75mg tablets are similar in size, shape and colour
- The tablets are the same in shape and colour
- The tablets were emptied directly into the prescription vial from the stock bottles
- The pharmacist did not check all three stock bottles

Recommendations:

- Use a red marker to circle and highlight the difference in strength on the stock bottle
- Ask the technicians to leave all stock bottles that were used out on the counter when dispensing a prescription so that they could also be checked by the pharmacist
- The pharmacist must check all stock bottles closely, including the Drug Identification Number (DIN)

CASE 2:

The parent of a seven-year-old year child requested a refill of a prescription for 750ml Phenobarbital 4mg/ml, with the directions to give 25mls once daily. On filling the prescription, the technician selected a 500ml stock bottle of


Phenobarbital 4mg/ml, and in error, a stock bottle of Codeine 5mg/ml for filling the remaining 250mls. As a result, the parent received a 500ml stock bottle of Phenobarbital along with 250ml Codeine labelled as Phenobarbital 4mg/ml.

On attempting to give a dose of Phenobarbital to the child, the father noticed the change in colour from a bright red (Phenobarbital 4mg/ml) to a pale yellow (Codeine 5mg/ml). The father then contacted the physician who asked that the medication be returned to the pharmacy.

Possible Contributing Factors:

- The stock bottles of Phenobarbital and Codeine are from the same manufacturer and therefore look alike
- Since the Phenobarbital was dispensed in the stock bottle, only the Codeine was poured during the dispensing process. The difference in colour between the two liquids was therefore not detected

Recommendations:

- Consider purchasing these products from different manufacturers to reduce the potential for error
- Whenever possible, separate look-alike packaging or highlight the specific differences
- Ask the technician to record and initial the DIN of all stock bottles used during the dispensing process 

HEALTH CANADA

Advisories & Notices

DATE	TYPE	GENERIC NAME	TRADE NAME
October 11/02	Important Drug Safety Information <ul style="list-style-type: none"> • Cerebrovascular Adverse Events in Placebo-controlled Dementia Trials 	Risperidone	Risperdal®
October 17/02	Important Drug Safety Update For Consumers <ul style="list-style-type: none"> • Elderly Dementia Patients 	Risperidone	Risperdal®
October 22/02	Health Canada Notice of Urgent Vaccine Recall	Voluntary Recall of Single Dose Menomune® – A/C/Y/W – 135 Meningococcal Polysaccharide Vaccine, Groups A, C, Y and W – 135 Combined	
October 30/02	Important Safety Information Regarding Refludan®	Lepirudin (rDNA) for injection	Refludan®
October 31/02	Public Advisory and Important Safety Information Regarding Medication Errors Resulting From Confusion Between Seroquel® and Serzone-5HT ₂ ®		
November 7/02	Important Safety Information Regarding Tamoxifen and the incidence of uterine malignancies, stroke and pulmonary embolism.		
November 26/02	Advisory on Tamoxifen associated with increased risk of stroke, pulmonary embolism and uterine cancer.		

For an electronic mailing of the Health Canada Advisories / Warnings health professionals, subscribe online at: www.hc-sc.gc.ca/hpb-dgps/therapeut/htmleng/mail_list.html

RECOMMENDATIONS FROM THE

Geriatric & Long-Term Care

COMMITTEE

Editor's Comments

Each year, the Chief Coroner of Ontario receives a report from the Geriatric and Long-Term Care Review Committee. This is the twelfth annual report of this committee and its recommendations are made to ensure that elderly residents of acute and long-term care institutions and residential "care" homes in Ontario receive the best possible care in the future.

This year's report focuses on a review of 30 cases; 11 of which include recommendations related to the use of drugs in the elderly. Council considers these recommendations to be very important to pharmacy practice and all Ontario members. We urge you to review these recommendations carefully.

Recommendations ¹


Use of Drugs in the Elderly

1. When using psychoactive drugs in the ill or elderly, the lowest dose possible should be the initial dose and further doses titrated upwards depending on the response, unless there is convincing evidence that a

higher dose is necessary because of compelling clinical considerations, (i.e. acute delirium) which puts the patient at extreme risk and requires rapid intervention to eliminate the associated agitation which might interfere with medical care.

2. Long-term care facilities in the Province of Ontario should develop a policy and procedure to ensure continuity of the supply of residents' medications, especially limited-use medications which require a physician-signed special authorization form.
3. Health care professionals should be reminded of the potential for the development of complications, overuse, and abuse of commonly used medications which are widely prescribed and considered to be "safe".
For example, when commonly prescribed medications such as anti-nauseants (Dimenhydrinate) or narcotic-containing analgesics are prescribed for patients with bowel motility disorders, the medication(s) may mask and/or aggravate the patient's condition.

¹ Reprinted from: 12th Annual Report of the Geriatric and Long-Term Care Committee submitted to the Chief Coroner for the Province of Ontario, June 2002

4. Health care professionals should be reminded that in the elderly the use of combinations of psychoactive medications may increase the risk of adverse reactions. When combinations of psychoactive medications are indicated, health care professionals should be reminded of the importance of closely monitoring the elderly person for any evidence of an adverse reaction. Should the elderly patient's condition decline, dosage reduction or preferably psychoactive medication discontinuation should be seriously considered.
5. Health care professionals should be reminded of the importance of reviewing the medication profile of elderly patients who develop a delirium. Frequently, these elderly patients are taking numerous psychoactive medications. The importance of aggressively pruning these psychoactive medications and medications that may potentiate the effects of the psychoactive medications cannot be overemphasized.
6. When prescribing major tranquilizers to modify behaviour in the confused elderly, health care professionals should be reminded of the importance of monitoring not only the beneficial effects of the medication, but also the potential adverse effects such as altered mobility, falls, interference with swallowing, paradoxical agitation, constipation, and urinary retention.
7. Health care professionals and group home workers in the Province of Ontario should be reminded that "as needed" sedative medications can be a valuable tool for the management of violent outbursts. These medications should NEVER be used solely for the convenience of staff in the group home setting.
8. Health care professionals should be reminded that the prescribing of medications with anticholinergic effects, such as commonly used over-the-counter medications including Dimenhydrinate, may potentiate the effects of psychoactive medications already being taken.
9. Health care professionals should be reminded that Dimenhydrinate is an inappropriate anti-nauseant/antiemetic for elderly patients who have developed postoperative bowel motility complications. This medication can promote gastrointestinal stasis which can aggravate bowel motility.
10. Health care professionals should be reminded that Meperidine is a narcotic that should rarely, if ever, be prescribed for the elderly because of its prolonged half-life, penchant for causing and/or exacerbating a delirium, and tendency to mask other symptoms. If narcotic analgesia is required, consideration should be given to using a narcotic such as Morphine which has a shorter half-life and less anticholinergic effects.
11. Health care professionals should be reminded of the importance of not prescribing medications known to increase the risk of falls for elderly residents at risk for falls.
12. Health care professionals should be reminded that Docusate is a stool softener, not a prokinetic medication, and by itself is not an appropriate medication to be administered as a bowel routine for postoperative elderly patients who require narcotic analgesia.
13. Health care professionals should be reminded that Thiamine can be helpful in the management of Wernicke's encephalopathy but is generally non-therapeutic in the management of Korsakoff's dementia.
14. All hospitals and long-term care institutions in the Province of Ontario should develop a policy and procedure to monitor the use of dietary supplements when they are used for therapeutic purposes. 



Larry Boggio, B.Sc.Pharm.

Perspectives on

DISCIPLINE:


Addressing Dispensing Errors

Over the past year the Discipline Committee has expanded its range of dispositions to make meaningful orders that support practice improvement. The Discipline Committee believes that members can always benefit from continuing practice improvement and, therefore, the Committee endeavors to identify learning opportunities best suited to each member that comes before one of its panels.

This issue reports on a number of recent decisions on matters that involved dispensing errors. While not all dispensing errors result in a referral to the Discipline Committee, the following cases describe the types of instances that have been deemed to warrant disciplinary proceedings and to constitute professional misconduct.

The orders reflect the Committee's realistic approach towards medications errors within the context of the standards of practice of the profession. In each of the following cases the Committee carefully considered suitable courses offered through the Faculty of Pharmacy or the Ontario Pharmacy Association that address the fundamental prac-

tice issues that contributed to the unfortunate, but preventable, errors that occurred in a pharmacist's practice. In a couple of instances, and with a view to accommodate the member's current place of residence and accessibility to remediation venues, suitable courses were identified and ordered in jurisdictions other than Ontario. The pre-hearing conference process (described in the November/December issue) has also contributed to the Discipline Committee's ability to broaden its scope of meaningful remediation as it provides an approach to explore and customize the most suitable outcome for the unique circumstances of each case.

The availability of a wide range of remediation courses, all of which require commitment on behalf of the pharmacist, have presented excellent opportunities for the disciplined pharmacist to remit part or all of the period of suspension ordered by the Committee. This focuses on the College's belief that remediation is an important way to prevent the recurrence of errors and to promote safe pharmacy practice settings. 

Deciding on Discipline

CASE 1

Dispensing Error

Members: Nagi Hanna, Oakville and Magdy Nashat, Mississauga

Hearing Date: October 25, 2002

Mr. Hanna was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

Mr. Nashat was found to have:

- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to his response regarding a medication dispensing error

The Discipline Committee accepted pleas of professional misconduct from Mr. Hanna and Mr. Nashat and was provided with an Agreed Statement of Facts which formed the basis of their pleas.

The Facts:

This matter arose from a referral from the Complaints Committee. The patient (the complainant's wife) was prescribed Prednisone and Plaquenil® to deal with symptoms of Systemic Lupus Erythematosus (SLE). In filling a refill on the Prednisone prescription, Mr. Hanna dispensed drugs in a container marked "300 APO-Prednisone 5mg. The patient (though surprised that the pills were a different size and shape than the ones that had been dispensed on

previous occasions) began to use the new supply. Shortly thereafter, she began to feel unwell, to the point that she became too ill to work.

Due to his wife's deteriorating condition, the complainant contacted the pharmacy and spoke to Mr. Nashat, who advised him to bring the medication in question back to the pharmacy. Mr. Nashat examined the pills and reviewed the pharmacy's computer records. He then dispensed three new bottles of medication which were labelled as Prednisone 5mg and contained pills that were the same size and shape as those that the patient had been taking prior to the last refill.

The complainant questioned Mr. Nashat about the unknown medication and described his wife's symptoms. Mr. Nashat advised that he could not determine what medication had been dispensed, and that he would have to review it with the dispensing pharmacist. Mr. Nashat did recommend, however, that the patient take sugar and drink lemonade, suggesting that she would be fine since she had only taken the unidentified medication for one day. He did not advise the complainant that the patient should contact her physician. Nonetheless, on returning home, the complainant contacted the Poison Control Centre, a hospital, and the patient's physician for advice. Later that day, Mr. Nashat contacted the complainant to advise him that the medication that had been dispensed to the patient was probably Glyburide. Mr. Nashat also indicated that he had been in touch with the prescribing physician, who subsequently contacted the complainant instructing him to take the patient to the hospital. The patient was admitted and received treatment for approximately four hours to address the complications caused by the medication error.

Mr. Hanna contacted the patient the next morning to acknowledge responsibility and apologize for the dispensing error.

Mr. Hanna has since taken steps to prevent further incidents as follows:

- He physically double-checks every vial and its contents
 - He double-checks the Drug Identification Number
 - He instructs all technicians to not return any bottle containing medication to the shelf unless on his instruction
 - He marks the hard copy after double-checking the bottle
- Mr. Nashat acknowledged that he was reasonably certain on first examining the pills returned to the pharmacy by the complainant, that Glyburide had been dispensed — not Prednisone as prescribed. He could have resolved any doubts by consulting the *Compendium of Pharmaceuticals and Specialties* to identify the dispensed medication so that he could have advised the complainant immediately to contact the patient's physician regarding the medication error.

Reasons:

The members and the College provided the Committee with Joint Submissions on Penalty. In considering whether to accept the joint submissions, the Committee noted that both members entered pleas of professional misconduct, which has saved the College the time and expense of a lengthy hearing. The Committee also noted however that the conduct of Mr. Hanna and Mr. Nashat cannot be tolerated by this College.

The Committee felt that the Joint Submissions on Penalty were appropriate in that they deal with the rehabilitation of the members and the courses described will raise their level of practice and re-educate them about the essential fundamentals of pharmacy practice. The Committee also noted however, that ordinarily in a case such as this, it would have expected a period of suspension that cannot be remitted.

The Committee accepted both of the Joint Submissions on Penalty, noting that if the conditions are not satisfied, Mr. Hanna and Mr. Nashat will face further disciplinary action. The Committee made the following Order:

Order:

1. Mr. Hanna and Mr. Nashat will each receive a reprimand
2. Mr. Hanna's and Mr. Nashat's Certificates of Registration shall each be subject to specified terms, conditions and limitations, in that they shall each attend, and participate, in both modules ("Understanding the Issues and Dealing With Incidents" and "Taking Action to Improve Patient Safety") of the education program and "Confronting Medication Errors", offered through the Ontario Pharmacists Association, at their own expense, within 12 months of the date of this Order
3. Mr. Hanna's and Mr. Nashat's Certificates of Registration shall each be suspended for a period of one month, the suspensions to be remitted on condition that each member completes the remedial training exercise in accordance with the terms set out in paragraph 2 above

CASE 2

Compounding/Dispensing Error

Member: Bankim Sheth, Edison, New Jersey

Hearing Date: October 25, 2002

Mr. Sheth was found to have:

- Failed to maintain a standard of practice of the profession in that he failed to take sufficient care when he prepared and dispensed a Hydroquinone/ Tretinoin/ Desonide cream mixture

The Discipline Committee accepted Mr. Sheth's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

The Facts:

This matter arose from a referral from the Complaints Committee. A Hydroquinone/ Tretinoin/Desonide cream mixture was compounded and dispensed to the complainant by Mr. Sheth. The mixture separated into solids and liquids

the following day at which time the complainant returned the mixture to the pharmacy where Mr. Sheth compounded and dispensed a new cream mixture. The complainant applied the new cream mixture which caused marks on her face. The new cream mixture also separated into solids and liquids within a couple of days.

In the course of investigating the complaint, the remains of the second cream mixture were analyzed for their contents by the Health Canada Drug Testing Laboratory. The lab analysis was not comprehensive but provided evidence that the concentration of Tretinoin in the solid phase of the separated mixture was 4 to 5 times the prescribed strength. The marks on the complainants face were consistent with an overdose of Tretinoin. Lack of care and failure to follow correct procedures resulted in the “cracking” of the cream mixture on the two occasions and also resulted in an excessive concentration of Tretinoin in the second cream mixture compounded and dispensed by Mr. Sheth.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. The Panel considered the member’s misconduct and determined that there was no evidence to suggest that this was an intentional act. It was the Committee’s view that a Joint Submission on Penalty which focuses on education and rehabilitation was appropriate. The Committee concluded that the Joint Submission was fair and reasonable and made the following order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Sheth’s Certificate of Registration and that he attend and successfully complete, at his own expense, the Basic Compounding Course offered through the American College of Apothecaries, within 12 months of the date of the order

CASE 3

Dispensing Error

Member: Aldo Anzil, Mississauga

Hearing Date: November 14, 2002

Mr. Anzil was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

The Discipline Committee accepted Mr. Anzil’s plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

The Facts:

This matter arose from a referral from the Complaints Committee. The Complainant’s father, who was diagnosed with prostate cancer, was prescribed Androcur® 100mg (with 10 repeats) to slow the spread of his cancer. Mr. Anzil dispensed Andriol®, a testosterone therapy, in error. The patient consumed the medication dispensed by Mr. Anzil for approximately one month. The complainant noticed that the refill was different than the medication originally dispensed and contacted the pharmacy. Mr. Anzil acknowledged the dispensing error as soon as he was notified of it. He also contacted the physician regarding the error and apologized to the family.

The patient died of cancer shortly thereafter. According to the complainant, the physician had advised at the time of the diagnosis, that her father might be expected to live six to twenty-four months. He survived only six weeks. The complainant was concerned that his death had been hastened by Mr. Anzil’s dispensing error. In the Agreed Statement of Facts it was noted that no evidence was provided to attribute the patient’s death to the medication mistakenly dispensed by Mr. Anzil. It was also noted that Andriol® is contraindicated for males with known or suspected carcinoma of the prostate gland.

Since the dispensing error was brought to his attention,

Mr. Anzil has implemented procedures at the pharmacy to minimize the possibility of such errors, including the requirement to check the Drug Identification Numbers to ensure that the drug being dispensed is the drug that was prescribed.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. In arriving at its decision to accept the Joint Submission on Penalty, the Committee considered the following factors: Mr. Anzil has no prior disciplinary history with this College in his 37 years of practice. He promptly acknowledged that the wrong medication had been dispensed, advised the patient's physician regarding the error and apologized to the family, hence he took ownership for this error. He has expressed his sincere remorse to the College, the profession and especially the family of the patient and has implemented new guidelines to guard against dispensing errors. He entered a plea of guilty saving the College the time and expense of a hearing and allowing the family to put closure to this matter. Mr. Anzil has been a valuable contributor to his professional community. He was a founding member of his local professional association and has been a facilitator for this organization for a number of years.

The Committee noted that all pharmacists must be aware that dispensing is at the heart of the pharmacist's professional responsibilities. The pharmacist represents one of the final checks in the health care system.

The Committee concluded that this penalty appropriately captures the significance of the error, and made the following Order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Anzil's certificate of registration, that:
 - a) He arrange with the Ontario Pharmacists' Association to participate in the education program,

"Confronting Medication Errors", including Module #1, "Understanding the Issues and Dealing with Incidents", and Module #2, "Taking Action to Improve Patient Safety"; scheduled for participation with the Peel Pharmacists' Association within 12 months of the date of this order

- b) He attend and participate in both modules of the education program described in paragraph 2(a) above, at his own expense, within 12 months of the date of this order
3. A suspension of Mr. Anzil's Certificate of Registration for a period of one month, the suspension to be remitted on condition that he complete the remedial training exercise in accordance with the terms set out above.

CASE 4

Dispensing Error

Member: Sailesh Patel, Etobicoke

Hearing Date: November 14, 2002

Mr. Patel was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

The Discipline Committee accepted Mr. Patel's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

The Facts:

This matter arose from a referral from the Complaints Committee. Mr. Patel was presented with a prescription for 60 Morphine Sulfate 30mg tablets for pain, for a cancer patient who was living at home after receiving treatment in hospital. Mr. Patel erroneously dispensed 60 Morphine Sulfate 100mg labeled as 60 MS Contin (Morphine Sulfate) 30mg. According to the complainant the patient became increasingly ill after she began using the medication

and was subsequently hospitalized for treatment of seizures and other symptoms of a Morphine overdose. The patient's family contacted Mr. Patel at the pharmacy and described the medication to him. Mr. Patel advised that the 100mg tablets had probably been dispensed, in error, and sent a courier to retrieve the medication. The family refused to give the medication to the courier and so it was not returned to the pharmacy. Mr. Patel did not provide any advice to the family or notice to the prescribing physician regarding the dispensing error.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. In considering whether to accept it the Committee noted that this dispensing error involved a straight narcotic with a narrow therapeutic index resulting in patient harm. As well, Mr. Patel failed to communicate with the family or notify the prescribing physician regarding the dispensing error when the error was brought to his attention. The Committee further noted that with this type of misconduct, it would ordinarily have expected a period of suspension to be served and not capable of being remitted.

The Committee also noted however, that Mr. Patel has no prior disciplinary history with this College; he advised the panel that he had successfully completed the College's Quality Assurance Practice Review in 2000 and provided documentation to support it; he has implemented new guidelines to guard against dispensing errors; he provided letters of reference demonstrating that he is an exemplary member of the medical community; and he entered a plea of guilty saving the College the time and expense of a hearing. The Committee concluded that the Joint Submission on Penalty was fair and reasonable in the circumstances, and made the following Order:

Order:

1. A reprimand
2. Terms, conditions and limitations on Mr. Patel's

Certificate of Registration, that he attend at and participate in the education program, "Confronting Medication Errors", offered by the Ontario Pharmacists' Association including Module #1, "Understanding the Issues and Dealing with Incidents", and Module #2, "Taking Action to Improve Patient Safety", at his own expense, within 12 months of the date of this Order

3. A suspension of Mr. Patel's Certificate of Registration for a period of one month, to be remitted on condition that the member complete the remedial training exercise in accordance with the terms set out in paragraph 2 above
4. Costs to the College in the amount of \$3,000

CASE 5

Dispensing Error

Member: Margaret Wing, Edmonton, Alberta

Hearing Date: November 18, 2002

Ms. Wing was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication dispensing error

The Discipline Committee accepted Ms. Wing's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of her plea.

The Facts:

The matter arose from a referral from the complaints Committee. The Complainant had been prescribed Indomethacin 25mg 50 capsules for gout. Ms. Wing dispensed Apo-Indomethacin 50mg 50 capsules in error. After taking the medication for three days the complainant developed symptoms of stomach pain, loss of appetite and black stools, culminating in vomiting blood and loss of consciousness.

Ms. Wing first realized that she had made an error when the patient's wife attended the pharmacy to request a copy

of the prescription. Ms. Wing immediately sought information regarding the patient's symptoms, contacted the physician to advise him about the dispensing error and apologized to the patient and his wife. Ms. Wing stated that she received the prescription at a time when the pharmacy was extremely busy. She further stated that the pharmacy records indicated that the patient had been prescribed Indomethacin 50mg previously and that she copied forward the old prescription information, made the necessary amendments, but failed to notice the difference of strength between the old and new prescriptions.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. The Committee noted that Ms. Wing demonstrated remorse for this error and took appropriate action as soon as she was notified of the error. Ms. Wing also implemented new procedures at the pharmacy to prevent this type of error from occurring again. In particular, Ms. Wing took steps to ensure that original written prescriptions are checked against the hard copy and prescription label. The Committee also felt that the proposed remedial courses are appropriate in that they reinforce the skills and knowledge required to prevent dispensing errors. The Committee therefore accepted the Joint Submission on Penalty and made the following Order:

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Ms. Wing's Certificate of Registration, that she successfully complete, at her own expense, within 12 months of the date of this Order, the following courses and evaluations:
 - a.) "Law Lesson 6: Standards of Practice" and "Law Lesson 7: Professional Liability", both of which are offered through the Canadian Pharmacy Skills Program, Leslie Dan Faculty of Pharmacy, University of Toronto

b.) "Course No. 4778: "Management of Medication Errors offered through Continuing Pharmacy Education", Faculty of Pharmacy and Pharmaceutical Sciences, University of Alberta

3. A suspension of Ms. Wing's Certificate of Registration for a period of one month, the suspension to be remitted on condition that she complete the remedial training exercises in accordance with the terms set out in paragraph 2 above
4. Costs to the College in the amount of \$2,000

CASE 6

Unauthorized Dispensing; Dispensing Error

Member: Laura Fannin, Ottawa, Ontario

Hearing Date: October 25, 2002

Ms. Fannin was found to have:

- Failed to maintain a standard of practice of the profession with respect to a medication error as well as dispensing medication without authority

The Discipline Committee accepted Ms. Fannin's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of her plea.

The Facts:

This matter arose from a referral from the Complaints Committee. The investigation of the complaint revealed that Ms. Fannin dispensed medication (non-narcotic) to herself and other members of her family without authority on approximately 20 occasions between June 15, 1999 and July 24, 2000.

The complaint investigation also revealed that on January 31, 2000, Ms. Fannin dispensed Lotensin®, when Loniten® was prescribed. The patient noticed that the tablet differed in colour from that of which he was familiar

and returned the medication to the pharmacy to have the error corrected.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. In considering whether to accept it, the Committee noted that Ms. Fannin entered a plea of professional misconduct, saving the College the time and expense of a hearing and she expressed remorse for her behaviour. As well, Ms. Fannin provided numerous reference letters from her co-workers and members of her community attesting to her character and dedication to her profession. The Committee was further provided with a copy of a management performance appraisal of Ms. Fannin by her current employer. In this appraisal, the overall rating indicated that Ms. Fannin meets her employer's expectations. As well, it was noted that Ms. Fannin has been a practising pharmacist in Ontario since 1978 and has no prior disciplinary history with the College. The Committee also noted however, that the misconduct in this matter cannot be tolerated.

The Committee felt that the Joint Submission on Penalty was appropriate in that as it deals with the rehabilitation of Ms. Fannin and the courses described will raise her level of practice and re-educate her about the essential fundamentals of pharmacy practice. The Committee also noted however, that ordinarily, it would have expected a period of suspension in a case involving unauthorized dispensing and mis-filled prescriptions. The Committee accepted the Joint Submission on Penalty, noting that if the conditions are not met, the member will face further disciplinary action which could result in a suspension and made the following Order:

Order:

1. A reprimand
2. A restriction on Ms. Fannin's Certificate of Registration that she cannot dispense medication to herself or to any member of her family from any pharmacy in which she practises or is employed in any fashion at any time
3. Further condition on Ms. Fannin's Certificate of

Registration that within 12 months from the date of the hearing, she is to attend and successfully complete the College's Jurisprudence course and the course on Pharmaceutical Care, Applied Therapeutics Lectures offered through the Canadian Pharmacy Skills Program at the Leslie Dan Faculty of Pharmacy, University of Toronto, on appropriate drug therapies

CASE 7

Failure to Intervene

Member: Shubhashh Parekh, Sarnia

Hearing Date: October 9, 2002

Mr. Parekh was found to have:

- Failed to maintain a standard of practice of the profession
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that he failed to intervene on behalf of a patient, when he was aware of the patient's substance abuse and psychiatric problems and the pattern of dispensing medications to the patient

The Discipline Committee accepted Mr. Parekh's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

The Facts:

This matter arose from a referral from the Complaints Committee in respect to a complaint by a friend of the patient. The patient had a lengthy history of substance abuse and psychiatric problems which culminated in his suicide in November 1997. According to the complainant, the pharmacy dispensed drugs to the patient without sufficient control or intervention, despite knowledge of his substance abuse and psychiatric problems.

The pharmacy records show that prescriptions for drugs dispensed by the pharmacy including but not limited to Paroxetine, Alprazolam, Lorazepam, Sertraline, Diazepam, Fluoxetine, Tylenol #3® and Imipramine, were provided by nine different physicians. The pharmacy records also showed that each dispensing transaction included a warning about the patient's propensity to access various physicians and drugs.

In particular, on 22 occasions between December 1996 and October 1997, Mr. Parekh or another pharmacist at his pharmacy dispensed the following drugs to the patient:

- Alprazolam .5mg: a 90-day supply was dispensed on January 4, 1996, again on February 1, 1996; March 13, 1996 and March 22, 1996
- Fluoxetine 20mg: a 30-day supply was dispensed on December 12, 1996, again on January 10, 1997 and February 21, 1997
- Lorazepam 1mg: a 30-day supply was dispensed on January 10, 1997, again on January 30, 1997, February 21, 1997 and March 14, 1997; a further 10-day supply was dispensed on April 8, 1997; another 30-day supply was dispensed on April 17, 1997, May 3, 1997, and May 15, 1997; a 14-day supply was dispensed on May 23, 1997; additional 30-day supplies were dispensed on May 29, 1997 and June 13, 1997; a 10-day supply was dispensed on June 26, 1997; a 20-day supply was dispensed on August 6, 1997; a 14-day supply was dispensed on October 17, 1997 and a 7-day supply was dispensed on October 23, 1997

Despite the pattern of dispensing drugs to the patient that was apparent in the pharmacy records, Mr. Parekh only contacted the prescribing physicians on two occasions regarding possible drug abuse, one of which resulted in the cancellation of a prescription for Lorezepam 1mg on October 10, 1997.

Order:

The member and the College provided the Committee with a Joint Submission on Penalty. The Committee accepted

the Joint Submission and made the following Order:

1. A reprimand
2. Terms, conditions and limitations on the Mr. Parekh's Certificate of Registration, that he successfully complete, at his own expense, within 12 months of the hearing date, remedial training in the following courses and evaluations from the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:
 - a.) Advanced Professional Practice Labs
 - b.) Advanced Interviewing Techniques
 - c.) Law Assignments:
 - Law Lesson 2 – Regulation of Pharmacy Practice
 - Law Lesson 4 – Standards of Practice
 - Law Lesson 5 – Complaints and Discipline Procedures of the College
 - Law Lesson 7 – Professional Liability
3. A suspension of Mr. Parekh's Certificate of Registration for a period of two months, with one month of the suspension to be remitted on condition that he complete the remedial retraining program described in paragraph 2 above within 12 months

Postscript: Mr. Parekh's Certificate of Registration is currently suspended on an interim basis with respect to allegations of professional misconduct in an unrelated matter.

CASE 8

Dispensing Without Authorization, Early Refills, False Documentation of Transactions

Member: David Forbes Russell, Colborne

Hearing Date: November 18, 2002

Mr. Russell was found to have:

- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document

- that he knew to contain a false or misleading statement
- Submitted an account or charge for services that he knew to be false or misleading
 - Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act*, 1991 or the regulations under those Acts
 - Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Discipline Committee accepted Mr. Russell's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

The Facts:

This matter arose from a complaint filed with the College by the designated manager of the pharmacy in which Mr. Russell was employed. The complaint arose from incidents involving the dispensing of Percocet®, Stadol® and Nitro-Dur® Patches as follows:

- Mr. Russell inappropriately dispensed Percocet® to a patient on a number of occasions from October 1999 to March 2000. The misconduct with respect to these transactions included dispensing without authorization, early refills and false documentation
- Mr. Russell dispensed Stadol NS® to a patient without authorization. The prescriber was identified as one physician, when in fact the patient attended the pharmacy two days later with a prescription for Stadol NS® issued by another physician. The designated manager discovered the misconduct while reviewing the pharmacy records (which warned of Stadol® abuse) prior to filling the latter prescription
- Mr. Russell dispensed Nitro-Dur® Patches 0.2 but documented that Nitro-Dur® Patches 0.4 had been dispensed when billing a third party insurer, knowing that the insurer covers only the 0.4 patches

Mr. Russell explained that the misconduct in which he

engaged was a misguided attempt to assist his patients and not for any personal gain for himself.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty which it accepted for the following reasons: Mr. Russell was cooperative and did not hinder the investigation; he did not gain personally from this misconduct but acted with the misguided intent to assist the patients; Mr. Russell did, however, dispense narcotics without proper authorization on several occasions and intentionally defrauded a third party insurer — conduct which cannot be tolerated. As well, Mr. Russell has a prior disciplinary history with the College for an unrelated matter. The Committee trusts that Mr. Russell will not appear before this Discipline Committee again.

The Committee noted that pharmacists must realize that cutting corners is not acceptable in the practice of pharmacy. The pharmacist is one of the gatekeepers of the public purse, a responsibility that cannot be taken lightly. It is a privilege and not a right to bill third party insurers on behalf of the patient.

The Committee agreed that the misconduct did not warrant remedial courses, and made the following order:

Order:

1. A reprimand
2. A suspension of Mr. Russell's Certificate of Registration for a period of four months
3. Costs to the College in the amount of \$5,000

CASE 9

Unauthorized Dispensing, Record keeping

Member: Ashraf Latif Barbary Hanna, Richmond Hill

Hearing Date: November 12, 2002

Mr. Hanna was found to have:

- Failed to maintain a standard of practice of the profession
- Failed to keep records as required respecting his patients
- Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act 1991* or the regulations under those acts
- Contravened, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that he dispensed medication without authorization and failed to keep records as required

The Discipline Committee accepted Mr. Hanna's plea of professional misconduct and was provided with an Agreed Statement of Facts, which formed the basis of his plea.

The Facts:

The matter arose from a referral from the Complaints Committee resulting from a complaint received at the College following an audit of Mr. Hanna's place of practice by a third party insurer. The College's investigation of this complaint resulted in the referral of another member to the Discipline Committee, the proceedings of which are being dealt with separately.

During the course of an on-site audit conducted by a third party insurer, it was found that over the period of approximately one year, a number of prescriptions both regular and narcotic had been misfiled. The audit also revealed that Mr. Hanna dispensed an APO-Salvent100 inhaler on one occasion and Ventolin® inhalers on two occasions without proper authority.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. Given the submissions presented by counsel for Mr. Hanna concerning the circum-

stances surrounding the misconduct, including the state of the record keeping at Mr. Hanna's former place of employment and two successful inspections at his current places of employment, the Committee found the proposed penalty to be more than adequate. Notwithstanding this reservation, the Committee accepted the Joint Submission on Penalty and made the following Order:

Order:

1. A reprimand
2. A condition on Mr. Hanna's Certificate of Registration that within 15 months of this Order he shall, at his own expense, attend and successfully complete the appropriate examinations for the course, "Advanced Professional Practice Laboratories" of the Canadian Pharmacies Skills Program, offered through the Lesley Dan Faculty of Pharmacy at the University of Toronto
3. Sixty days' suspension of Mr. Hanna's Certificate of Registration, 30 days of which shall be remitted on successful completion of the course referred to in paragraph 2 above
4. Costs to the College in the amount of \$2,500

CASE 10

Record keeping

Member: Kirsten Hastings, Chesley

Hearing Date: October 9, 2002

Ms. Hastings was found to have:

- Failed to keep records as required respecting her patients
- Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act 1991* or the regulations under those Acts
- Contravened, while engaged in the practise of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs

The Discipline Committee accepted Ms. Hastings' plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of her plea.

The Facts:

This matter arose from a complaint regarding dispensing errors. The errors in question are the subject matter of a proceeding involving another pharmacist at the pharmacy. In the course of investigating the complaint, the College discovered other dispensing and record keeping errors that occurred during the period of 1996 to 1998 attributable to Ms. Hastings, the primary dispensing pharmacist and the designated manager, as follows:

- Various medications were dispensed in dosette format resulting in reduced quantities being dispensed on each occasion. Ms. Hastings advised that authorizations had been obtained from the patients with respect to the reduced quantities; however, she was unable to locate the authorizations in the pharmacy records
- Various medications, including Atenolol, Hydrochlorothiazide, Captopril, Ferrous Gluconate and Glyburide were dispensed. The prescribing physician confirmed that prescriptions were provided, however, Ms. Hastings was unable to locate the written prescriptions, except for Glyburide
- The pharmacy "piggy-backed" new transactions on old expired prescriptions

Reasons and Order:

The member and the College provided the Committee with a Joint Submission on Penalty. After careful consideration the Committee found that it was fair and reasonable and made the following Order:

1. A reprimand
2. Specified terms, conditions and limitations on Ms. Hastings' Certificate of Registration, that she successfully complete, at her own expense, within 12 months of the date of this Order, remedial training in the following courses and evaluations from the Canadian Pharmacy

Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto:

- a. "Professional Practice Laboratories I"
 - b. "Law Lesson 2 – Regulation of Pharmacy Practice"
 - c. "Law Lesson 4 – Standards of Practice"
 - d. "Law Lesson 7 – Professional Liability"
3. Costs payable to the College in the amount of \$2,000

CASE 11

Dispensing Without Assessing or Counselling About Side Effects

Member: Andrew Polcz, London

Hearing Date: November 14, 2002

Mr. Polcz was found to have:

- Failed to maintain a standard of practice of to the profession
- Contravened the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act*, 1991 or the regulations under those Acts
- 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 in that he dispensed three herbal drugs, namely, Barley Plus, a pure barley grass juice concentrate powder; Herbal Fibre Blend, a combination of various fibres, mainly psyllium; and P1 Formulation Herbal Capsules, a combination of Echinacea and Goldenseal, to a patient, without assessing or counselling on the potential side effects arising from the use of those drugs, and while practising within a conflict of interest

The Discipline Committee accepted Mr. Polcz's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.


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Year 2003 Call for Preceptors for OCP Structured Practical Training (SPT)

All Ontario pharmacies have received a College fax related to SPT Programs and preceptor workshops for 2003. (The following page lists the workshop dates for your reference.)

The goals of the preceptor **orientation workshops** are to provide instruction on and/or reinforce preceptors' feedback and assessment skills, and to facilitate the exchange of ideas between preceptors. The **advanced workshops** assist in updating practice or preceptor skills, and are for those preceptors who have previously attended an orientation workshop.

If you are taking a student or intern and are unable to attend a workshop in a city close to you, we would ask you to consider attending a workshop in another city. Preceptors must attend workshops at least every two years if they are taking SPT students/interns on an annual basis.

Please refer to our website (www.ocpinfo.com/Licensing/Preceptor) for preceptor criteria and for updates to workshop dates/locations. If you would like to attend a workshop, please take this opportunity to complete the form and **fax it back to the College, SPT Programs at (416)847-8264.** 

The Facts:

This matter arose from a referral from the Complaints Committee. The complainant, who is elderly and suffers from diabetes and diabetes-related problems, attended an examination by an iridologist. The iridologists' office space, rented in the basement of the pharmacy, could be accessed only during the hours of operation. The iridologist took the complainant's medical history, conducted an eye examination and concluded that the complainant was suffering from parasites. The iridologist accompanied the complainant upstairs to the pharmacy.

Mr. Polcz, dispensed to the patient three herbal medications recommended by the iridologist. The complainant was charged a total of \$158.97, \$106.97 of which was payable to the pharmacy for the drugs, the remainder payable to the iridologist. At the time he dispensed the medications, Mr. Polcz asked the complainant if she was allergic to ragweed or goldenrod, but he did not record a medical history nor did he make sufficient inquiries to determine what other medication she might have been taking. The complainant became ill after taking the medication.

Reasons:

The member and the College provided the Committee with a Joint Submission on Penalty. The Committee noted that the member has no prior disciplinary history with this College and he has expressed remorse and has cooperated fully with the prosecutor in entering a plea of guilty and agreeing on this penalty. This has saved the College the time and expense of a lengthy hearing.

The Committee was impressed that Mr. Polcz took steps to remediate his practice prior to the complaint coming forward. The practice of the iridologist was removed from the premises eliminating the conflict of interest. As well, the remediation that Mr. Polcz is required to take, will specifically address appropriate interviewing and counselling techniques and assist him in properly dispensing drugs or herbal products. For these

reasons, the Committee concluded that the proposed penalty was fair and reasonable and made the following Order:

Order:

1. A reprimand
2. A condition to be placed on Mr. Polcz's Certificate of Registration that within one year from the date of this Order he shall, at his own expense, take and successfully complete the appropriate examination for the course "Advanced Interviewing Techniques" offered by the Canadian Pharmacy Skills Program through the Lesley Dan Faculty of Pharmacy at the University of Toronto
3. A one-month suspension of Mr. Polcz's Certificate of Registration, to be remitted in full on the successful completion of the course referred to in paragraph 2 above
4. Costs to the College in the amount of \$2,000

CASE 12**Dispensing Without Authority, Dispensing Errors, Operational Breaches**

Member: Akram Al-Samarrai, Waterloo

Hearing Date: October 21, 22, and 23, 2002

It was alleged that Mr. Al-Samarrai:

- Failed to maintain a standard of practice of the profession
- *Contravened the Pharmacy Act, the Drug and Pharmacies regulation Act, the Regulated Health Professions Act, 1991 or the regulations under those Acts*
- Contravened, while engaged in the practice of pharmacy, any federal or provincial law or municipal by-law with respect to the distribution, sale or dispensing of any drug or mixture of drugs
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Alleged Facts:

This case proceeded by way of a contested hearing during which the College presented evidence to support the factual allegations that Mr. Al-Samarrai:

- Dispensed PMS Gemfibrozil 300mg capsules when the prescription required Lopid® 600mg tablets, which are not interchangeable
- Dispensed Celebrex® 100mg when Celebrex® 200mg was prescribed
- Dispensed narcotics and other prescription medication on 88 occasions without proper authority, in that the prescriber was not authorized to prescribe narcotics
- Operated a pharmacy, owned and operated by a numbered company, the shares of which were owned by a non-pharmacist
- Closed a pharmacy without filing the required documents, removing signs and symbols relating to the practice of pharmacy or removing and disposing of all drugs according to the law
- Permitted the operation of a pharmacy without the supervision of a pharmacist physically present
- Removed narcotics and controlled drugs from a pharmacy without notifying the Minister of Health and Long-Term Care as required by law


Resignation and Undertaking:

After the College had presented its evidence over a period of three days, Mr. Al-Samarrai offered to resign his Certificate of Registration in lieu of continuing the proceedings. The Committee therefore ordered that the hearing be adjourned sine die (indefinitely, until further notice) pursuant to the provisions of the following Undertaking, signed by Mr. Al-Samarrai and presented to the Discipline Committee in consideration for the adjournment:

- That Mr. Al-Samarrai resigns irrevocably as a member of the Ontario College of Pharmacists
- That Mr. Al-Samarrai undertakes and agrees with the Ontario College of Pharmacists that he shall not be employed or work in a pharmacy or act as a director or

shareholder or officer in a corporation operating a pharmacy

- That Mr. Al-Samarrai agrees that the specified allegations of professional misconduct in the Notices of Hearing dated December 21, 2001, and May 2, 2002, shall be stayed and shall remain on the Register of the Ontario College of Pharmacists indefinitely
- That Mr. Al-Samarrai understands and agrees that this resignation and undertaking be published in *Pharmacy Connection*
- That Mr. Al-Samarrai also agrees never to re-apply for membership in the Ontario College of Pharmacists
- That Mr. Al-Samarrai received independent legal advice as to the effect and consequences of this resignation and undertaking

Mr. Al-Samarrai has a disciplinary history with the College, which includes three findings of professional misconduct over the past six years — the time limitation within which the College is permitted to disclose details of results of disciplinary proceedings. The misconduct in those matters involved unauthorized dispensing and non-compliance with a Discipline Committee's Order. 

BULLETIN BOARD

Class of 7T8 Reunion

Your 25th Pharmacy Reunion is planned for October 3 - 5, 2003 at Nottawasaga Inn Resort in Alliston. For future contact and more information, please forward your email and home address with phone numbers to Doris Kalamut (Hallmann) 35 Anderson Avenue, Toronto, Ontario M5P 1H5 (416-485-2067) or dkalamut@rogers.com.

Class of 8T8, 15-Year Class Reunion

Saturday March 29, 2003 the class of 8T8 will be holding their 15-year class reunion in Toronto. Dinner and accomodation has been arranged at the Metropolitan Hotel. Contact your classmates and plan to attend! For details and an e-vite contact Marie Sirdevan (Okazawa) at francis.sirdevan@sympatico.ca or Jane Bamford (VanderHoeven) at rbamford@oxford.net. See you soon!

The College Warmly Welcomes...

Maria Beck who officially joined the College in October of 2002 after working on a temporary basis in our Member Services area since February. Maria is from New Zealand and has decided to make Canada her home. Maria complements the department with a background in medical radiation technology and administrative work.

Sheila Miltchin joined the College in November, 2002 in the newly created role of Continuing Competence Program Secretary. Sheila came to the College from Bombardier Aerospace and brings over 10 years' administrative experience to the position.

Patrick Wong joined the College in January in the capacity of Field Representative. Patrick lives in Ottawa where he has been a pharmacist for 10 years in

hospital, industrial and community settings. Patrick will be focusing on inspections in the Eastern Ontario region.

Deborah Byer also joined the College in January as the Registration Program Secretary. Deborah came to us from Matrox/Typhoon Technologies where she was an administrative assistant and previous to that, was an office manager for a number of years.

The College Bids Farewell to...

Jessie D'Souza who has left the College after almost 13 years of service to start her own business. Jessie was an integral part of the Registration Department and will be greatly missed by all. Jessie will be serving up coffee at her new business at the Pickering GO Station.

Heather Harris has also left the College after 12 years of service to enjoy retirement. Heather was a part of Member Services. We are happy to say that Heather will be back to help us out during our busy fee time.

Carmina Vieiri-Conti returned from her maternity leave in December 2002 but has decided that her place is at home with her daughter Isabella. Carmina was a Complaints Officer in the Investigations & Resolutions area since 1995. We are happy to announce that Eva Markowski, who assumed Carmina's role during her maternity leave, has now joined the College on a permanent basis.

Alumni Death: The Council and College staff mourn the recent death of Gordon Murray. Gordon was a pharmacist at the Toronto Hospital for Sick Children. He served as a Council member from 1997-2000 and previously served as President of the Ontario Branch of the Canadian Society of Hospital Pharmacists. 🇺🇸

Past Presidents' Dinner



Back row (left to right):

Martin Belitz, Barry Phillips,
Bill Bourque, Don MacInnes,
Ron Elliott, Sam Hirsh,
Jim Monaghan, Steve Balestrini

Middle Row:

Della Croteau, *Deputy Registrar and
Director of Programs*, Laureen Bruni,
Bill Lewis, Leslie Braden,
Connie Cambell, *Director of Finance and
Administration*

Sitting:

Deanna Laws, *Registrar*,
Maxine Tenander, Midge Monaghan,
Bill Wendey, Jim Dunsdon

Upcoming Events

Council: March 24, 25

Practice Review Weekend: February 15, 16, 17

Preceptor Workshops: see page 41

CE EVENTS

Visit the College's website: www.ocpinfo.com for a complete listing of upcoming events and/or available resources. A number of the programs listed below are also suitable for pharmacy technicians.

Pharmacist Awareness Week,

March 3-9

Janet Becigneul

tel: 1-800-917-0326

e-mail: paw@pharmacists.ca

Guide Your Patients to a Smoke Free Future 2003

The Ontario Pharmacists' Association, in conjunction with the Ontario Dental Association and the Ontario Medical Association will be holding programs throughout the province. Pharmacy technicians are also invited to attend. For information on these programs or on how to have this program in your area contact Sherrie Hertz.

tel: (416) 385-3472, x 2205 or
1-800-268-8058

Scheduled:

March 18: Waterloo

March 26 & 27: Ottawa

Pharmacist-Patient Dialogue Workshop 1: Enhancing Adherence Medication Errors I & II

OPA will be hosting these workshops throughout the province. For information, or to arrange to have this program presented in your area, contact Karen Cameron.

tel: (416) 441-0788 x 4235

fax: (416) 441-0791

e-mail:

kcameron@ontpharmacists.on.ca

Feb. 1-4: Toronto

Professional Practice Conference 2003, CSHP

Marlo Palko

e-mail: mpalko@cshp.ca

www.cshp.ca/professional/cshp_events.html

Feb. 10-12: Toronto

5th Annual Chain Drug Conference,

Canadian Association of Chain Drug Stores

tel: (416) 226-9100

Feb. 19-20: Toronto

5th Annual Maximizing Market Access,

Strategy Institute

tel: (416) 944-8833

fax: (416) 944-0403

Feb. 21-23: Ottawa

Psychiatric Patient Care - Level 1 Certificate Program,

OPA,

Travelodge Hotel Ottawa West

Karen Cameron

tel: (416) 441-0788 x 4235

e-mail:

kcameron@ontpharmacists.on.ca

March 1: Ottawa

Update/Mise a jour 2003,

Ottawa Valley Regional Drug Information Service (OVRDIS), Congress Centre

tel: (613) 737-8437 or 1-800-267-

4707

March 6-7: Toronto

Critical Caring: Speaking Out

for Children - A Paediatric Critical Care Symposium for

Nursing and Professional

Services, Hospital for Sick Children

Winnie Seto

tel: (416) 813-7655

e-mail: winnie.seto@sickkids.ca

web: www.sickkids.ca/ccuconference

March 8 & 9: Toronto

Humber College Annual

Pharmacy Technician Conference - 2003

Neala Puran

tel: (416) 675-6622 x 4020

fax: (416) 675-0135

e-mail: neala.puran@humber.ca

March 26: Toronto

Diabetes Update 2003,

Continuing Education, Faculty of Medicine,

University of Toronto, Metro Toronto

Convention Centre

tel: (416) 978-2719

fax: (416) 971-2200

e-mail: ce.med@utoronto.ca

web: www.cme.utoronto.ca

Apr 12: Toronto

Current Topics, Sunnybrook &

Women's College Health Sciences

Centre - Sunnybrook Site

Patricia Sauve

tel: (416) 480-4494

e-mail: patricia.sauve@sw.on.ca

April 4-5: Kingston

Fourth Annual Diabetes Workshop,

Options for Diabetes

Margaret Little

tel: (613) 547-3438

Joan Ferguson at (416) 239-0551

Anne Belton at ibelton@ca.inter.net

OCP MANUAL CONTENTS

Changes as of January 31, 2003 - As Highlighted

Each issue of *Pharmacy Connection* includes an up-to-date summary of all current *OCP Manual* items in the table shown. These items are available and can be printed off from our website: www.ocpinfo.com.

Individual copies, or complete sets of the legislation (with binder and tabs), can also be ordered from the College. The *OCP Manual*, sold with the *OCP Policy Handbook* (complete with index and copies of reference articles), is \$85 (\$90.95 with GST). Sold separately, the *OCP Manual* is \$64.20 (GST included) and the *OCP Policy Handbook* is \$32.10 (GST included).

ONTARIO LEGISLATION

Available from OCP or Publications Ontario

Drugs and Pharmacies Regulation Act (DPRA) & Regulations

- Version – Office Consolidation Aug 27, 1999 (Publications Ontario)

Regulated Health Professions Act (RHPA)

- Version – Office Consolidation Jun 30, 1999 (Publications Ontario)
- Ontario Regulation 39/02 Addendum - Certificates of Authorization - February 8, 2002

Pharmacy Act (PA) & Regulations

- Version – Office Consolidation May 28, 1999 (Publications Ontario)
- Ontario Regulation 548/99 Amending O.

Reg. 202/94 – Nov 29, 1999

- Ontario Regulation 550/99 Revoking O. Reg 620/93 – Nov 29, 1999

Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations

- Version – Office Consolidation Dec 4, 1998 (Publications Ontario)
- Ontario Regulation 73/99 Amending Reg. 935 of R.R.O. 1990 – Feb 25, 1999
- Ontario Regulation 496/00 Amending Reg. 935 of R.R.O. 1990 – Aug 28, 2000
- Ontario Regulation 15/01 Amending Reg. 935 of R.R.O. 1990 – Jan 26, 2001

Ontario Drug Benefit Act (ODBA) & Regulations

- Version – Office Consolidation May 12, 2000 (Publications Ontario)
- Ontario Regulation 495/00 Amending Reg. 201/96 – Aug 28, 2000
- Ontario Regulation 16/01 Amending O. Reg. 201/96 – Jan 26, 2001

Publications Ontario

Tel: (416) 326-5300 or 1-800-668-9938

FEDERAL LEGISLATION

Available from OCP or Federal Publications Inc.

Food and Drug Act (FDA) & Regulations

- Updated NAPRA Version as of Oct 25, 2000
- Amendment – Paragraph C.01.004 (1) (b) – Sep 1, 2000
- Updated Health Canada Version as of December 19, 2001
- Amendment 1248 - Ibuprofen - Jan. 31, 2002

Controlled Drugs and Substances Act (CDSA)

- Updated NAPRA Version as of October 25, 2000
- Amendments – Schedules III and IV – Sep 1, 2000
- Regulation 1091 – Benzodiazepines and Other Targeted Substances Regulations – June 1, 2000

Federal Publications Inc.

Ottawa: 1-888-4FEDPUB (1-888-433-3782)

Toronto: Tel (416) 860-1611 • Fax (416) 860-1608 • e-mail: info@fedpubs.com

NAPRA DOCUMENTS

Drug Schedules

- Canada's National Drug Scheduling System – May 16, 2002 NAPRA

Narcotic Control Regulations

- Updated NAPRA Version as of October 25, 2002

Available at: www.napra.org

OCP DOCUMENTS

Available from OCP or www.ocpinfo.com

Drug Schedules

- Summary of Laws Governing Prescription Drug Ordering, Records, Prescription

Standards of Practice

- Reference Page to Policy Handbook, and
- New *Standards of Practice*, Jan 1, 2001 OCP

OCP By-Laws

- By-Law No. 1 (Year 2000) – Jan 4, 2001
- Schedule A – Code of Ethics, May 1996
- Schedule B – Conflict of Interest Guidelines for Members of Council and Committees – Oct 1994
- Schedule C – Member Fees – Dec 11, 2000
- Schedule D – Pharmacy Fees – Dec 11, 2000

Reference

- Handling Dispensing Errors, *Pharmacy Connection* Mar/Apr 1995
- Revenue Canada Customs and Excise Circular ED 207.1
- Revenue Canada Customs and Excise Circular ED 207.2
- District Excise Duty Offices – Oct 10, 1996
- Guidelines for the Pharmacists on “The Role of the Pharmacy Technician”

COLLEGE STAFF

Frequently Accessed Extensions

Registrar's Office x 243
urajdev@ocpinfo.com

Deputy Registrar/Director of Programs' Office x 241
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Director of Finance and Administration's Office x 263
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Registration Programs x 250
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jsantiago@ocpinfo.com

Registration Information Surnames M-Z: x 232
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Pharmacy Practice Programs x 236
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Pharmacy Openings/Closings x 227
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Pharmacy Sales/Relocation x 227
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Investigations and Resolutions x 272
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Continuing Education Programs x 251
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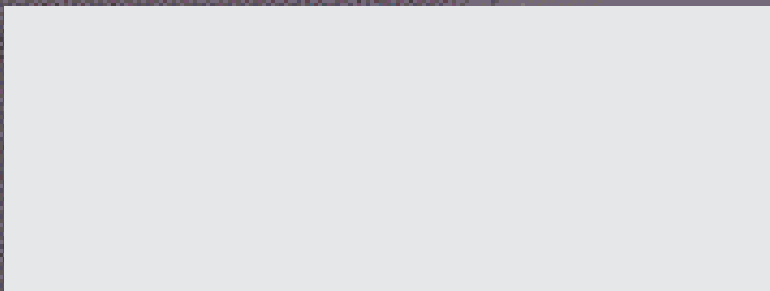
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rstarr@ocpinfo.com



***President David Malian
and Vice-President Iris Krawchenko***



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