Newfoundland and Labrador Pharmacy Board

The Apothecary is the newsletter of the Newfoundland & Labrador Pharmacy Board. It contains information on a wide variety of topics intended to enhance the practice of all pharmacists in the province of Newfoundland & Labrador. Pharmacists are responsible for reviewing any and ALL INFORMATION contained within including documents which are made available on the NLPB website via links throughout the newsletter. The Apothecary is now circulated electronically and is available in hard copy format only upon specific request.

The Apothecary

Spring 2012

Don Rowe, Secretary-Registrar, to Retire This Year

Fellow Pharmacists,

It is with regret that I announce the upcoming retirement of Mr. Don Rowe from his position as Secretary-Registrar to the Newfoundland and Labrador Pharmacy Board (NLPB).

Mr. Rowe has served as the Secretary-Registrar of the NLPB (previously the Newfoundland Pharmaceutical Association) for the past 18 years. During his tenure in this position, he has upheld the virtue of fairness, and demonstrated leadership and integrity in carrying out the mandate of the Board to protect the public's interest in matters pertaining to the profession of Pharmacy. He has been a pillar of the pharmacy profession in this province, and his contributions to the NLPB, the profession and the public will be sorely missed.

Mr. Rowe has indicated his intention to retire from his position no later than November 24, 2012, to coincide with his 65th birthday. On behalf of the Board, I sincerely wish Don and his wife, Marie, a healthy and happy retirement. A celebration to recognize Don's contributions to the NLPB and the profession is being planned for a later date. Pharmacists will be informed of the details when they become available.

Dr. Debbie Kelly
Chair, Newfoundland and Labrador Pharmacy Board

REMINDER TO ALL PHARMACISTS

Pharmacists are reminded that in accordance with the *Standards of Pharmacy Practice - Medication Management by Community Pharmacists*, any pharmacist who intends to perform any action under these standards - provide an interim supply, extend a prescription or adapt a prescription must first complete and submit the *NLPB Medication Management Declaration Form* found in Appendix B of the Standards. Once this form has been received at the NLPB Office, it is retained in the pharmacist's permanent file and an indicator that this person is registered to perform Medication Management is added to the Pharmacist Registry posted regularly to our website. Failure to comply with this Standard of Practice could be considered professional misconduct and could also result in losses of revenue related to such prescriptions if the pharmacy was to be audited. We would strongly recommend ALL PHARMACISTS check the current Register of Pharmacists posted on the NLPB website and confirm that their information related to Medication Management is correct.

Complaints and Discipline Resolution

Case #1

A hearing of an adjudication tribunal of the Newfoundland and Labrador Pharmacy Board was held on January 27, 2012 to consider a complaint against a registered pharmacist ("the respondent"). The original allegation, received on August 16, 2011, had been considered by the complaints authorization committee (CAC) on November 25, 2011. At that time the CAC found that there were reasonable grounds to believe the respondent had engaged in conduct deserving of sanction and instructed the Secretary-Registrar to file a complaint against the respondent and refer the complain to the disciplinary panel for a hearing.

At the hearing the tribunal was presented with an Agreed Statement of Facts in which the respondent admitted to the following:

- On a number of occasions in 2011, she dispensed Methadone carries without authorization and dispensed Methadone carries to a person other than the patient (the patient's husband).
- The Methadone Dosage Record submitted to the Board was altered by her and was signed by the patient on a number of occasions where the patient was not the person receiving the carry dose.
- On one occasion in 2009, the respondent left a Methadone carry dose at a location other than the pharmacy for pick up by the patient.
- On a number of occasions Methadone prescriptions were not entered in the computer, consequently they did not show up on the Narcotic Record. The respondent would subsequently adjust inventory levels for Methadone.

The adjudication tribunal accepted the respondent's guilty plea and received a Joint Submission on sanction and ordered that:

- The pharmacist's license to practice pharmacy be restricted immediately from the dispensing of Methadone, until such time as she satisfies the NLPB that she has successfully completed an educational training program on Methadone Maintenance Treatment satisfactory to the NLPB.
- The pharmacist will submit to the NLPB proof of compliance with the *Standards of Pharmacy Practice - Security and Accountability Procedures for Narcotics and Controlled Drugs for Community Pharmacies*, on a quarterly basis, beginning the end of February 2012, for a period of one year, unless that period is extended by the Secretary-Registrar of the NLPB.
- The pharmacist shall be subject to, and co-operate fully with, periodic inspections and audits by the Secretary-Registrar of the NLPB, or his designate, for a period of three years.
- The pharmacist will pay the costs of the investigation and hearing up to a maximum of $5000.00. Such costs are to be paid within sixty days of notification from the NLPB of the amount of such costs, unless such time is extended by the NLPB.
- The decision of the Adjudication Tribunal will be published as required under section 44(3) of the Pharmacy Act, and in the Apothecary on a no-named basis.

Case #2

An allegation was received by a patient's mother alleging that outdated Garamycin Ear Drops were dispensed to her child from a pharmacy. The mother had put the drops in the child's ears for a day and a half before noticing the expiration date of August 2011, six months before the prescription was dispensed. She also expressed concern that other medication may be out of date at the pharmacy.

A panel of the Complaints Authorization Committee met to consider the letter of allegation and the Pharmacist-in-Charge's response which acknowledged the error. It found that there were reasonable grounds to believe the respondent had engaged in conduct deserving of sanction and, in accordance with section 39(3) of the Pharmacy Act, the allegation be considered a complaint. Further to this, the panel issued a counsel or caution to the respondent that a written policy and procedure for checking all medications for expiry dates be developed (if not already included in the pharmacy's policy and procedure manual) and submitted to the Secretary-Registrar by March 15, 2012. This policy and procedure will be reviewed and any comments will be forwarded to

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the respondent as well as to the complainant for her information.

The panel further directed that this case be reported in the next edition of The Apothecary newsletter, on a no-named basis, so that all pharmacists will be reminded of this requirement.

Finally, a visit by an inspector of the Newfoundland and Labrador Pharmacy Board will be scheduled within the next six months.

The Dangers of Dextromethorphan

While recent news out of Quebec (www.cbc.ca/news/health/story/2012/03/05/montreal-cough-syrup.html) has brought the issue of dextromethorphan (DM) safety back to the forefront, DM abuse, particularly by teenagers, remains prevalent and continues to be an important issue.

Pharmacists know that DM is a cough suppressant commonly available in many over-the-counter (OTC) cough and cold products that, in therapeutic doses, is considered safe in most people. However, DM abuse has occurred since the 1960s and continues to be a problem today. In an annual study conducted by the National Institute on Drug Abuse in the US, 4.2% of eighth grade students surveyed reported using DM-containing products during the past year to get high. The rate increased in older children, with 5.3% of tenth graders, and 6.9% of twelfth graders reporting ingestion of cold or cough medicines with DM during the past year to get high.

Dextromethorphan, the d-isomer of the opiate agonist levorphanol, is metabolized by the cytochrome P450 2D6 enzyme system in the liver. The metabolite, dextrorphan, has a high affinity for the excitatory amino acid receptor, the N-methyl-D-aspartate (NMDA) receptor, producing a "high." Symptoms following ingestion of high doses (five to ten times the normal therapeutic dose) include euphoria, an altered sense of time, paranoia, and disorientation. In addition, tactile, visual, and auditory hallucinations may occur. The effects seen with DM abuse are similar to those seen after phencyclidine (PCP) use, another agent which blocks NMDA receptors. Physical symptoms associated with ingestion of high doses of DM include sweating, tachycardia, dyskinesias, speech disorders, mydriasis, and photophobia. Nausea and vomiting can also occur. DM toxicity may be worse in patients who take it along with monoamine-oxidase (MAO) inhibitors or selective serotonin reuptake inhibitors due to the possibility of serotonin syndrome. For patients who chronically abuse large doses of DM, bromide poisoning is another concern. Bromide is found in the hydrobromide salt form of DM. Symptoms of bromide poisoning include behavioral changes, irritability, headache, confusion, anorexia, slurred speech, and lethargy.

Besides the risk of toxicity from DM and bromide, toxicity can occur due to other agents commonly found in OTC cough and cold preparations such as pseudephedrine, phenylephrine, acetaminophen, and antihistamines. For example, abusers of Coricidin II Cough & Cold not only ingest excessive amounts of DM but large doses of chlorpheniramine as well. Symptoms of chlorpheniramine toxicity include agitation, hallucinations, confusion, sedation, coma, seizures, hypertension, tachycardia, hyperthermia, mydriasis, dry flushed skin, decreased gut motility, and urine retention.

We would advise that while DM remains in Schedule III of the *Newfoundland and Labrador Provincial Drug Schedules* (available on the Provincial Drug Schedules page of the NLPB website), pharmacists should be mindful of the sale of DM products in the pharmacy. The issue can also be discussed with other dispensary and "front store" staff members so that the pharmacist may be alerted if higher than normal sales or losses of DM-containing products are detected. Pharmacists should also watch for signs of possible abuse, or inappropriate use in combination with other drugs or medical conditions when consulting with patients.

If there is evidence of abuse or if you have a particular concern about the potential for abuse in your area, we would support your decision to relocate DM-containing products to a "No Patient Access" (Schedule II) area of the pharmacy.

Reference: Dextromethorphan abuse. Pharmacist's Letter 2007;23 (2):230208.

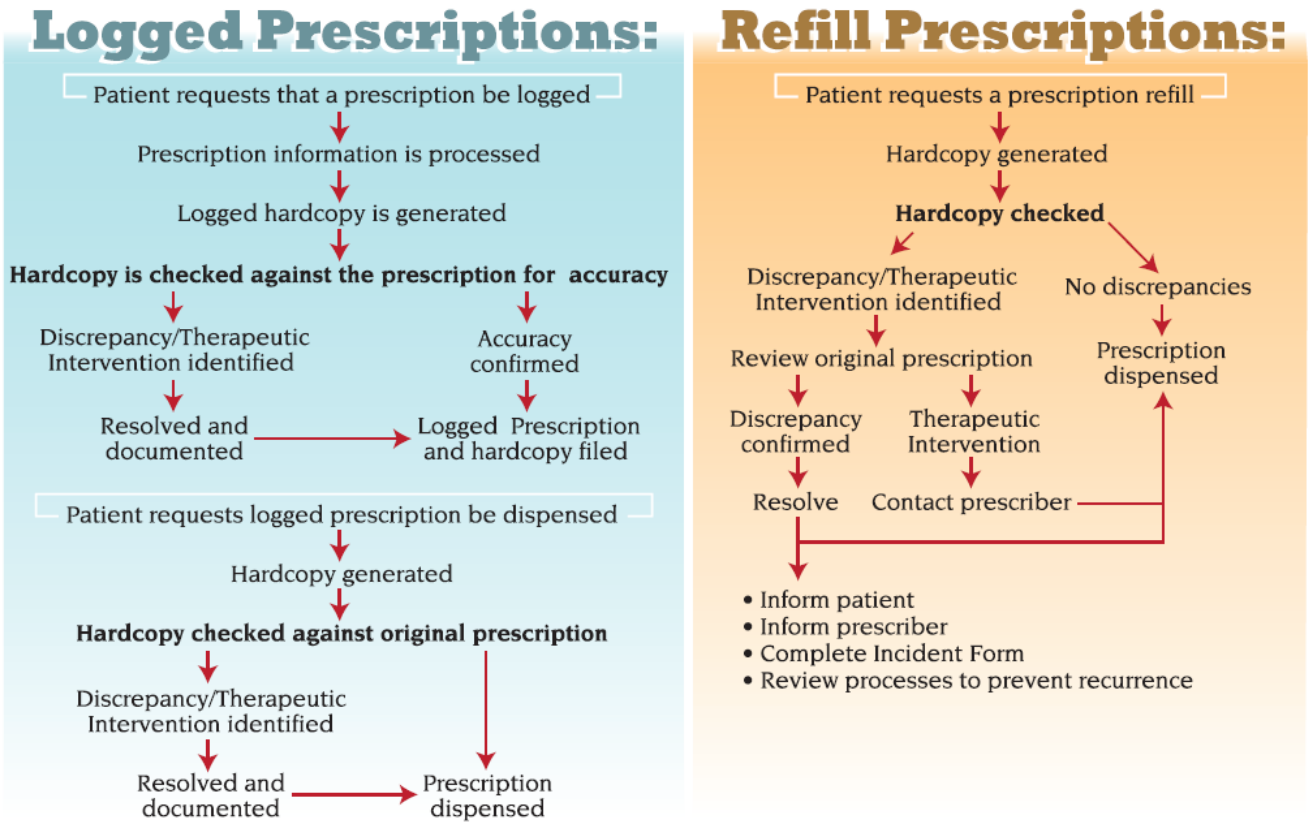
Professional Practice Issues

"Logged Prescriptions" Do Not Equal "Refill Prescriptions"

For the purpose of this article, logging a prescription refers to putting it on hold upon request by a patient. Other terms referring to the same process may be used in individual pharmacies.

There appears to be a misconception that if a logged prescription hardcopy is checked for accuracy by a pharmacist at the time the prescription is logged, the dispensing pharmacist only has to check the hardcopy and does not need to refer back to the original prescription when dispensing the medication to the patient. **In fact, a logged prescription is, and should be treated as, a new, unfilled order and should be thoroughly checked against the original prescription prior to being dispensed.**

While some liken the process of checking a logged prescription to that of checking a prescription refill - where the process of referring back to the original only rarely occurs - it is important for pharmacists to recognize that dispensing a logged prescription is not identical to dispensing a prescription refill, as is illustrated with the graphic below. The primary difference in these dispensing processes arises from the simple fact that for a prescription refill, the original prescription and hardcopy were thoroughly and completely reviewed when the drug was initially dispensed. Conversely, the initial check that occurs when a prescription is logged, while considered best practice for ensuring correct information is recorded on the patient's profile, is certainly not usually a complete check and does not negate the necessity to check the hardcopy against the original prescription when the medication is ultimately dispensed.



Adapted from the Ontario College of Pharmacists Pharmacy Connection March-April 20008

Reprint of Notice to Pharmacists - MedRunner

The following notice was circulated to all pharmacies and pharmacists on January 19, 2012:

Newfoundland & Labrador Pharmacy Board

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e-mail inforx@nlpb.ca

January 19, 2012

NOTICE TO ALL PHARMACISTS

Our office has been made aware that, in the past week or so, some pharmacies have begun to receive unusual prescriptions via fax from physicians. These prescriptions indicate that they were faxed by a specific physician but lack the "usual" header information that most of us have come to expect and recognize on a traditional fax transmission. These prescriptions are, in fact, being electronically sent by prescribers using specially-enabled tablet-type devices. The system allows them to complete and send the prescription to a pharmacy's fax machine, through a third party provider, MedRunner.

While legislation allows for verbal and "written" prescriptions, there is presently no provincial or national consensus on the acceptability of "electronic" prescriptions, with the exception of prescriptions transmitted by fax machine from the prescriber to the pharmacy of the patient's choice in accordance with the Standards of Practice related to the faxing of prescriptions. These Standards focus on the security of the transmission, protection of the privacy of patient information, assurance of an original prescriber signature, and assurance of the origin of the prescription.

Recently NLPB staff met with officials of MedRunner to see a demonstration of their product, to discuss a number of general issues of concern related to electronic prescription transmission, and to suggest other stakeholder who should also be consulted. At the end of this meeting it was made clear to MedRunner that the Board does not endorse specific commercial software products and that we would be considering the issues further, looking at how this matter is dealt with in other provinces, and then bringing a report to our Board, with a view to establishing more formal guidelines or Standards of Practice for pharmacists.

We also pointed out that the third stage of the implementation of a provincial electronic health record by the Newfoundland and Labrador Centre for Health information includes the provision for electronic prescribing via the secure provincial health network, a proposal supported by our Board.

We caution that, at this time, until the Newfoundland and Labrador Pharmacy Board has completely reviewed this product and determined its compliance with all relevant provincial legislation and standards of practice, **we are advising all pharmacists who receive such transmissions that they should validate the authenticity of the prescription with the prescriber before dispensing it to the patient.**

Sincerely,

Donald F. Rowe
Secretary-Registrar

Recent Updates to the NLPB Website

About the Board

⇒ *Board Meeting Minutes for November 25, 2011 meeting*

Contact Us (Find A…)

⇒ *Committee members updated*

⇒ *Pharmacists & Pharmacies Registers updated*

"The Apothecary" & Other Communications

⇒ *Notices regarding discontinuation of OxyContin added*

⇒ *Notice regarding change to Provincial Drug Schedules added*

⇒ *MedEffect advisories added*

Registration & Licensing

⇒ *Studentship and Internship forms updated*

Legislation

⇒ *NLPB Binder files updated*

⇒ *NLPB Bylaws and Schedule of Fees revised*

⇒ *Optometry Act - Diagnostic and Therapeutic Drug Regulations updated*

Standards, Policies and Guidelines

⇒ *Required and Recommended Reference Materials for Newfoundland and Labrador Pharmacies updated*

⇒ *Licensing Criteria for Satellite Pharmacies in Rural Communities without Conventional Pharmacy Service updated*

Provincial Drug Schedules

⇒ *Official Schedules and Guide to the Drug Schedules updated*

Pharmacy Technician Regulation

⇒ *Pharmacy Technician Regulation News added*

⇒ *Winter 2011 Zone Meeting presentation added*

⇒ *Information related to the Canadian Association of Pharmacy Technicians National Professional Development Conference added*

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published quarterly by the
Newfoundland and Labrador Pharmacy Board
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