Newfoundland and Labrador Pharmacy Board

The Apothecary

Spring 2016

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.

NL Pharmacy Board Symposium

Saturday, May 7, 2016

Ramada St. John's, 102 Kenmount Road, St. John's, NL

As previously announced through The PostScript, the NLPB will be hosting a Pharmacy Symposium to accompany the Annual General Meeting (AGM) of the Board. The Program of Events for the Symposium as listed below will include the AGM, a Professional Development Program and the NLPB Awards Luncheon.

At the Awards Luncheon, three new NLPB awards will be presented:

- The **Emerald Achievement Award** recognizing 35 years of registration with the NLPB
- The **NLPB Certificate of Recognition** recognizing registrants who have shown outstanding dedication and contribution to the Newfoundland and Labrador Pharmacy Board.
- The **Patient Safety Award** recognizing the achievement of an individual registrant, a group of registrants, an interdisciplinary group, or a pharmacy organization that has made a significant and lasting contribution to improving patient safety.

Program of Events	
8:30 am	Welcome *(Coffee & Tea will be served)*
9:00 am	NLPB Annual General Meeting
10:00 am	Nutrition Break *(Coffee, Tea, Juice, Pastries & Fruit will be served)*
10:30 am	Professional Development Program - Navigating the Gray Areas of Pharmacy Practice
12:30 pm	NLPB Awards Luncheon *(Entrée is Apple Roasted Pork Loin - for dietary restrictions or allergy concerns, please contact the NLPB Office)*

Registration is now open for the symposium. To register, visit www.nlpb.ca, log in using your username and password and click the blue "Events" button located at the top of the Member Home screen. From there, click on "View Upcoming Events" and click on "NL Pharmacy Board Symposium". The cost to register for the day is just $30 per person - you may pay by VISA or MasterCard, or click "Invoice Me" to pay with cheque or cash later. Please note, payment must be received no later than May 3, 2016. Payments will not be accepted on the day of the event.

Physician-Assisted Dying

As communicated in the April 2016 issue of The PostScript, physician-assisted dying (PAD) is about to become an important part of the Canadian healthcare landscape. To recap the key points:

- The Supreme Court decision in "Carter v. Canada", in February 2015, created a new legal right to physician-assisted dying in Canada.
- While originally the decision was to come into effect in February 2016, the Supreme Court granted the Federal Government a four month extension to consider its approach. As such, Parliament now has until June 6, 2016 to act before the decision comes into effect.
- Between now and June 6, 2016, individuals who wish to seek assistance in ending their life may still avail of PAD through a court authorization process.
- The Supreme Court decision recognizes the role of physicians but does not address the involvement of other health care professionals. Therefore, many questions remain unanswered regarding a pharmacy professional's involvement in PAD.
- With this in mind, pharmacists and pharmacy technicians are reminded that, as registrants of the Board, they:
  - ⇒ are compelled to comply with the law;
  - ⇒ are expected to practice within their scope and the limits of their professional competence, and to comply with the Code of Ethics and Standards of Practice to ensure safe delivery of quality health care;
  - ⇒ have a professional responsibility to provide respectful care for patients and have an obligation not to abandon patients under their care;
  - ⇒ have an obligation to provide patients with health information, referrals, and health services in an unbiased and respectful manner to enable patients to make well-informed decisions; and
  - ⇒ have a right to conscientious objection but such an objection must not impede the right of patients to receive unbiased information, including where to access legally permissible and available health services.

Without a doubt, implementing a safe and thoughtful PAD framework with equitable access will require substantial collaboration between the federal and provincial governments and health professional regulators. The College of Physicians and Surgeons of NL has recently approved a policy on physician-assisted dying, which can be found at: **http://www.cpsnl.ca/userfiles/file/CPSNL%20PAD%2029%20Mar%2016.pdf**.

It is important for pharmacists and pharmacy technicians to continually monitor information from NLPB about physician-assisted dying. Any development in policies, legislation and regulations will be communicated to the profession as it unfolds. In the meantime, if you are approached with a request to participate in PAD, please contact the NLPB Office and/or consult your own legal counsel for guidance before proceeding.

Pharmacy Awareness Month - *Pharmacists: Doing More. For You.*

Pharmacist Awareness Month (PAM) was celebrated across Canada during March, with the theme *Pharmacists: Doing More. For You.* Here is a summary of some of the activities that PANL participated in during this month:

- ⇒ PANL kicked off the month with a reception attended by members, partners and supporters, including pharmacists, the School of Pharmacy, the NLPB, government representatives and industry. Bernard Davis, Parliamentary Secretary to the Minister of Health and Community Services, attended the event on behalf of the Minister and the Premier.
- ⇒ During March, PANL also ran a radio ad campaign, *More Than Just Pills*, which highlighted the many services a pharmacist can provide.
- ⇒ Results of an Abacus Data poll were released mid-March, showing strong support and recognition for the important role of pharmacists in health care. These activities generated lots of media attention. It is always important to raise awareness and educate the public about the pharmacists' role in health care delivery.
- ⇒ PANL also participated in events with the School of Pharmacy and CAPSI - Executive Director Glenda Power served as a judge for NL's Next Top Pharmacist and Board member David Collins joined students at a public information display at the Avalon Mall to help spread the word about expanded scopes of pharmacy practice.
- ⇒ As part of PAM, PANL also opened up nominations for the third annual Pharmacist of the Year award - the deadline is April 29!

Two main goals of PAM were to educate the public and to recognize the many contributions of pharmacists - these goals were achieved with a successful strategic campaign that informed and generated a high level of interest. PANL would like to thank MUN School of Pharmacy students, volunteers, stakeholders, the pharmacy community, and the public for coming together to promote the pharmacy profession and celebrate pharmacists for "Doing More" to support the health and wellness of the people of NL.

Submitted by: Glenda Power, Executive Director, Pharmacists Association of Newfoundland and Labrador

Lupus - An Autoimmune Disease Often Referred as a Disease of 1000 Faces

Many lupus patients within our province are not aware that there is a Provincial Chapter of Lupus Canada in Newfoundland and Labrador. Lupus Newfoundland and Labrador is a non-profit, registered, charitable organization that provides support to people affected by lupus, promotes education and awareness of lupus and supports advances in research and in the treatment of lupus. The organization is in the process of creating a database and would like to provide information and support to all patients and their families 'living with lupus'. Our request is, if you have any patients with this condition, you mention Lupus Newfoundland and Labrador to them and provide our contact information.

Shawn Layman (Pharmacist and Lupus NL Board member): (709) 745-2048 (H)

Provincial Office: (709) 368-8130

Email: lupus.nl.ca@gmail.com

Website: www.envision.ca/webs/lupusnfldlab/

Expectations for Inventory Management of Narcotics, Controlled Drugs, Benzodiazepines and Targeted Substances

Pharmacists-in-charge, as well as staff pharmacists and pharmacy technicians, are responsible to ensure the security of narcotic, controlled drug, and benzodiazepine and targeted substance inventory in the pharmacy. Security of the inventory must be maintained from the time drugs are received at the pharmacy to the time when they are dispensed to the patient or removed from inventory, until the point of destruction.

The applicable federal legislation and NLPB Standards include:

- Food and Drug Act and Regulations;
- Controlled Drug and Substances Act;
- Narcotic Control Regulations;
- Benzodiazepine and Targeted Substances Act Regulations; and
- NLPB Standards of Pharmacy Operation

While Health Canada's requirements for benzodiazepines and targeted substances may be less specific than for narcotics, documentation of purchases and sales is still required (the form is not specified) as well as loss/theft reporting. For this reason, in order to meet the loss/theft reporting requirements, pharmacists need to include benzodiazepines in physical inventory counts, reconciliations, and auditing procedures.

A drug reconciliation is a detailed audit of the perpetual inventory for a given drug (quantity of drug purchased minus the quantity of drug dispensed) compared to the current physical inventory on hand in order to assess for any shortages or overages.

Pharmacists-in-charge must take the following steps to ensure accurate inventory records for narcotics, controlled drugs, benzodiazepines and targeted substances:

1. Maintain a perpetual inventory. Ideally, this should be a computerized perpetual inventory within the practice management system; otherwise, a manual perpetual inventory must be maintained for each drug.
2. Perform a physical inventory count at least every three months and compare it with the expected inventory (perpetual inventory) to assess for shortages and overages that are to be investigated and documented.
    a) All drugs in the active inventory should be included in the physical inventory count; including expired or damaged stock, products awaiting destruction, prescriptions with a balance owing, and compounded mixtures containing a narcotic or controlled drug.
    b) Drugs returned by patients should not be included in the physical inventory count as they are not part of the pharmacy's active inventory (a record of drugs returned by patients should be maintained separately).
    c) Inventory counts should be documented in a separate dedicated record that includes:
        i) the name, strength, form, and quantity of each drug that is counted;
        ii) the signature of who performed the count;
        iii) the date the count was taken; and
        iv) identified discrepancies and their resolution.
3. Reconcile invoices with purchase records upon receipt and perform additional random checks; 10% of invoices should be audited monthly.

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4. Reconcile the sales report with filed prescriptions; 10% of monthly sales should be selected for audit. This involves checking that there is an original prescription on file for each sale that is audited, and that the related prescription was filled accurately.

Pharmacists-in-charge may also implement random spot checks for specific drugs with a high risk of diversion.

Pharmacists-in-charge should consider increasing the frequency of reconciliations based on a number of factors, such as:

- volume of drugs dispensed;
- number of staff with access to inventory; and
- a history of security issues.

In addition, reconciliations must also be completed:

- when there is a change in pharmacist-in-charge of the pharmacy (in this instance, the reconciliation must be conducted by both the new and departing pharmacist-in-charge, either separately or together, and the signatures of each pharmacist-in-charge must be recorded);
- when a pharmacy closes;
- when the security of drugs is compromised, such as a robbery or theft;
- to account for discrepancies caused by possible internal diversion or process losses (e.g. compounding, preparing methadone doses);
- to reconcile purchase/invoice discrepancies;
- to address allegations from the public questioning dispensed quantities; and
- to validate or monitor the pharmacy's storage and security.

When investigating discrepancies, consider these questions:

- Are purchases accounted for?
- Is the narcotic sales report accurate?
- Could the shortage be due to a balance owing?
- Is there an error in record keeping for dispensed medications?
- Are all prescriptions accounted for?
- Are authorizations for destruction accounted for?
- Are drugs in compounds accounted for?
- Are there any patterns of false claims?

Any shortages or overages of narcotics, controlled drugs, or benzodiazepines or targeted substances must be investigated. Shortages must be reported to the Office of Controlled Substances within 10 days of discovery using the Health Canada Loss or Theft Report Form, available through Health Canada and also posted on the **Pharmacy Practice Resources** page of the NLPB website.

Following detection and investigation of discrepancies, changes should be implemented in the pharmacy to prevent such occurrences in the future.

All documentation related to narcotic, controlled drug, and benzodiazepine purchases, sales, physical counts, reconciliations, audits, and reported losses or thefts must be retained by the pharmacy in a retrievable manner for two years.

Communicating Health Statistics to Patients and the Healthcare Team

Submitted by: Dr. Debbie Kelly, based on a presentation given by Dr. JM Gamble at the CSHP 67th Summer Educational Sessions in August 2014

I'm sure every pharmacist has struggled to find the appropriate response to "Is that drug going to give me side effects?" When you only have two minutes for counselling, your response is likely to be very brief – "It's very uncommon for this medication to cause serious side effects", or "Most people tolerate this medication very well, and the most common problems tend to be mild nausea or headache".

But sometimes a more thorough discussion of the risks and benefits of a medication are warranted. So what's the best way to describe these risks and benefits in a way that patients can understand? Dr. JM Gamble provided a very useful overview of this topic during his session at the SES conference last summer, and he provided some useful tips, which I'll summarize here.

The first point he made was that an in-depth discussion of risks and benefits cannot be provided in a two minute counselling session across the dispensary counter. But if you have the time to engage the patient in a more personalized counselling session, then knowing how to present health statistics in an understandable way can help patients decide whether a treatment is right for them, and will hopefully result in improved adherence to their therapy.

People have all kinds of different interpretations of statistics, and some people will relate to risks described as percentages (e.g. 2% of people will experience a rash while taking this drug) while others will prefer to hear these same risks presented in terms of natural frequencies (e.g. out of 100 people, 2 will experience a rash).

But however we present these numbers to patients, it is important to remember that up to 50% of people have poor health literacy, which has also been associated with poor health outcomes. It is expected that a similar number have poor numeracy as well, and while this has not been specifically proven, it follows that we should be checking to make sure that our messages are properly understood and interpreted by patients so they don't leave us more confused than when they started!

Here are some tips to consider when discussing health statistics with a patient:

1. **Use the simplest mathematical construct as possible.** For example, don't tell a patient they should aim for 5% weight loss to improve their blood pressure. Instead tell them they should aim to lose 10-15 lbs (or 4-7 kg).
2. **Avoid using descriptive terms only when discussing individual health risks.** Again, this is in the context of providing more in-depth counselling. People have different interpretations of descriptive terms like "very well tolerated" or "rare". In general, people tend to over-estimate the risk of "very rare" so whenever possible provide specific numbers and put them in context for your patient. You could use percentages or natural frequencies here to provide an estimate of risk, and also of expected benefits from therapy.

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3. **Use absolute risks rather than relative risks when talking to patients**. Relative risk reductions tend to be more impressive in describing differences between treatment and placebo because they overestimate the effect in populations with a low baseline risk. A good example of this can be seen from the Shingles Prevention Study comparing the shingles vaccine to placebo. The relative risk reduction for the prevention of shingles was 51%, but the absolute risk reduction was only 1.7%. Why the huge difference? Because there was a low baseline risk of shingles in either group – only a few patients in the placebo (642/19 276 = 3.3%) and the vaccine group (315/19 270 = 1.6%) actually developed shingles throughout the 3 year study.

   - The absolute risk reduction (ARR) is calculated as 3.3% - 1.6% = 1.7%
   - The relative risk reduction (RRR) is calculated as (3.3 – 1.6)/3.3 = 51%

   Put another way, the ARR can be used to calculate the number of patients who need to be treated for 3 years to prevent one case of shingles:

   - Number needed to treat (NNT) = 1/ARR, or in this case 1/0.017 = 59

   So you could say, for every 59 people who receive this vaccine, one case of shingles will be prevented.

4. **Use a consistent denominator when discussing natural frequencies**. Larger denominators are often perceived as having a bigger risk. So avoid presenting the risk of therapy as occurring in 20 people out of 100, and the benefit occurring in 2 people out of 10. In this case, for every 10 people treated, 2 will experience the risk and 2 will experience the benefit.

5. **Offer positive and negative outcomes**. If you were discussing the effectiveness of an antibiotic, for example, you might say the cure rate is 97% with therapy, while the risk of death is 3%.

6. **Avoid compressing time frames**. Shorter time frames exaggerate risk. Generally it is preferable to speak in terms of years rather than weeks when discussing chronic therapy, for example.

7. **Use visual aids where possible**. Many websites offer visual aids to compare risks associated with a variety of common outcomes that people can relate to such as dying in a car accident, winning the lottery, etc. This can be helpful to put risks associated medication side effects or anticipated benefits of therapy into perspective for someone who has reservations about taking the therapy. Interactive decision aids can be used to help individualize risk estimates by considering that person's own risk factors. These involve answering a series of questions and/or describing the risk using visual aids. One example of a decision aid that is used to determine whether or not to take statin and ASA is found here:

   http://statindecisionaid.mayoclinic.org/

In summary, I found this session to be very helpful in deciding how to present what can be fairly complex material to patients in a way that is much more understandable. Our goal is to help patients understand what they can expect from their medications and to manage those expectations realistically. These tips can be used to explain even the most complex health statistics to patients in an understandable way, so we can help them make the best decisions for their own health.

Postscript Recap

Since the last issue of The Apothecary, the Board has posted several issues of The Postscript. A summary of some key articles is provided below. Please visit the **NLPB Newsletters page** of the NLPB website to view past issues in their entirety.

January 2016

- Mark Your Calendar! NL Pharmacy Board Symposium
- Expectations for Inventory Management of Narcotics, Controlled Drugs, Benzodiazepines and Targeted Substances
- CCCEP Launches New Initiative to Increase Continuing Education Opportunities for Pharmacy Technicians
- Reminder Regarding Registered Pharmacy Technicians and Prescriptions for Benzodiazepines
- Standards of Pharmacy Operation- Community Pharmacy- Upcoming Implementation Dates

February 2016

- Clarifications Regarding Schedule II Products and the Prescribing Standards
- Provincial Drug Schedules
- Pharmacy Renovations

March 2016

- NL Pharmacy Board Awards – Nominations Now Open!
- Medical Marihuana
- Preceptor Training and Authorization

April 2016

- Update on the Scheduling Status of Naloxone for Emergency Use for Opioid Overdose
- Physician-Assisted Dying (PAD)
- Preceptor Training and Authorization
- Frequently-Asked Questions About Registration & Licensing
- Upcoming Professional Development Opportunities:
  - St. John's Pain & Addiction Day
  - The Prescribing Course – Safe Opioid Prescribing for Chronic Non-Cancer Pain
  - Providing A Hastened Death: What Every Health Care Provider Should Know If They Receive A Request

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Apothecary Hall
488 Water Street
St. John's, NL A1E 1B3

Tel: 709-753-5877
Toll Free: 1-877-453-5877
Fax: 709-753-8615
E-mail: inforx@nlpb.ca
www.nlpb.ca

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BOARD STAFF

Margot Priddle, R.Ph., Registrar ..... mpriddle@nlpb.ca
Melanie Healey, R.Ph., Associate Registrar, Professional Practice ..... mhealey@nlpb.ca
Noelle Patten, R. Ph., Associate Registrar, Quality Assurance ..... npatten@nlpb.ca
Aileen O'Keefe, Registration & Licensing Administrator ..... aokeefe@nlpb.ca
Meghan Handrigan, Office Administrator ..... mhandrigan@nlpb.ca
General Information ..... inforx@nlpb.ca

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National Association of Pharmacy Regulatory Authorities ®
Association nationale des organismes de réglementation de la pharmacie

NAPRA
Executive Director

Established in 1995, NAPRA is the national voluntary association of provincial and territorial pharmacy regulatory bodies as well as the Canadian Forces Pharmacy Services. Providing national leadership in pharmacy regulatory practices that enhance patient care and public protection, NAPRA's members regulate the practice of pharmacy and operation of pharmacies in their respective jurisdictions in Canada. Located in Ottawa, the association is governed by a Board of Directors consisting of practicing pharmacists as well as the Registrar or designated government representative of each member.

Reporting to the Board of Directors, the Executive Director will have overall responsibility and accountability for the operations of the Association. He/She, through the direction of the Board, will be looked upon to develop and implement NAPRA's next strategic plan. Leading a small team, the Executive Director will manage and provide support to NAPRA's programs, including: the *National Drug Schedules*; the *National Pharmacy Technician Bridging Education Program*; the *Pharmacists' Gateway Canada for international pharmacy graduates*; and maintaining the terms of the *Mobility Agreement for Canadian Pharmacists* (and, in the future, pharmacy technicians). As the primary spokesperson for NAPRA, the Executive Director will advocate and promote regulatory standards to the federal government, in particular Health Canada, other national professional associations, and stakeholders at the provincial, national, and international levels.

As the ideal candidate, you are a leader with vision and have experience managing in a complex, multi-stakeholder environment with changing and shifting priorities. You have proven skills in strategic and financial planning, and are a strong team mentor. You are an exceptional relationship builder and espouse respect, trust, and integrity in all of your interactions. Your strong communication and facilitation skills, as well as political acumen will be key in advising and supporting the Board, understanding and respecting the issues faced by each member, creating NAPRA's next strategic plan, and representing NAPRA as a key spokesperson. Written and oral fluency in English and French is highly desirable. Preference will be given to a licensed pharmacist.

If you are interested in leading NAPRA and being at the centre of pharmacy regulation in Canada, please contact Michael Naufal or Kathy Rahme of Boyden global executive search at 613-742-3204 or via email at krahme@boyden.com .