The Apothecary

Spring 2013

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.

Continuing Professional Development Goes Online

The NLPB is pleased to offer online recording of Continuing Professional Development (CPD). To facilitate the online format, the CPD deadline will now coincide with the annual registration renewal process, resulting in the Professional Development year running from December 1st to November 30th.

One Record

The new CPD process is quick and easy! No more separate log and record sheets—just record each activity once and you're done. This allows you to document your learning while the activity is still fresh in your mind.

One Deadline

For your convenience, both renewal payment and CPD will be due on the same day. No need to worry about sending your Professional Development Log later through the mail or having to deal with the hassle and expense of a courier.

One Solution

One access point for renewal, CPD, committees and other activities. It's accessible anywhere, anytime, securely online.

Online Professional Development Frequently Asked Questions

1. **How do I enter my CE's using the online system?**
   Log into www.nlpb.ca. Under **My Professional Development,** click on **Record a New Learning Activity**. Complete the form and click **Next.** This takes you to a review screen. Review the record and click **Save** to add it to your Learning Portfolio. That's it!
2. **How do I view a summary of my Learning Activities?**
   After logging in, under **My Professional Development,** click on **View/Edit Your Learning Portfolio.**
3. **What materials do I need to provide if I am audited next year?**
   You will need to retain your records of participation and other supporting documentation as defined in our *Standards of Pharmacy Practice on Continuing Professional Development*. Should you be selected for the annual CPD review and your records are stored in the online system, you will not need to submit Learning Portfolio Record Sheets.

Remember, if you ever have any questions, comments or concerns, or would like help walking through the system, please call Aileen or Meghan at the NLPB office at (709) 753-5877 or toll-free at 877-453-5877.

Forgot Your Password?

From the login screen, under **Forgot Your Log In/ Password**, enter the email address associated with your profile and press **Retrieve.**

You will receive an email within a few minutes with your user name and password.

Letter from the Registrar

> Statement l: Pharmacists hold the health and safety of each patient to be of primary consideration
>
> *NLPB Pharmacist Code of Ethics*

Medication errors are a wide spread problem which can, in the worst case, cause harm to patients. During my five month tenure with Board, four medications incidents resulting in patient harm have been brought to my attention. I suspect that this is a small representative of the growing number of medication incidents that are reaching patients.

Every healthcare professional will be involved in some type of medication error during their professional career. It is inevitable. However, patient safety can be improved by optimizing the opportunities to learn from the incidents. Errors are best corrected when real and potential errors are documented, reported and evaluated as a cycle of continuous quality improvement.

You don't need to wait for a medication error to happen to start mitigating the risk in your practice. There are many simple self-assessment approaches to quality assurance such as Failure Mode and Effects Analysis (FMEA) which you can implement in your pharmacy to identify risks and prevent "accidents waiting to happen".

The Institute for Safe Medicine (ISMP) (**www.ismp-canada.org**) has developed a stepwise process to use FMEA. This system is a toolbox you can use to help you met the requirements of quality practice. The article "Dispensing Accuracy Tips - *Check, Check and Check Again!*", published in a previous edition of the Apothecary, also offers some great tips to reduce risk and is reprinted on page 8 of this issue for your convenience.

The newly proclaimed Pharmacy Act 2012 (**http://assembly.nl.ca/Legislation/sr/statutes/p12-2.htm**) establishes a quality assurance program that includes continuing education, professional development, and quality improvements. Stay tuned as the regulations for this new initiative are developed.

An ounce of prevention is a pound of cure.

Margot Priddle

Margot Priddle
Registrar

Complaints and Discipline Resolution

Case #071217

On December 17, 2007, a letter was received from the Audit and Claims Division of the Department of Health and Community Services alleging that Mr. Lloyd Bennett and Mr. J. Gerald Whalen of East End Pharmacy had engaged in conduct deserving of sanction. The letter was accompanied by a copy of the 80-page report relating to the audit conducted on East End Pharmacy as well as additional binders of materials obtained during the audit and responses provided by the respondents to the audit report.

On January 28, 2008, a panel of the Complaints Authorization Committee (CAC) met to consider the allegation. At this time, since responses had not yet been received from the pharmacists, the panel decided, in accordance with section 39(1) (a) of the Pharmacy Act, to refer the allegations back to the Secretary-Registrar for further investigation.

Due to the complexity of the investigation and the large volume of material to be reviewed, the Board spent a significant amount of time investigating the allegations and corresponding with the respondents and their legal representation. During this time there were also a number of postponements and delays due to health reasons as well as the availability of legal counsel.

On February 27 and 28, 2012, the panel of the CAC reconvened to consider the allegation, the numerous responses from the respondents and their legal representation as well as the results of the Board's investigation. After careful review and discussion of the information presented, the panel determined that there were reasonable grounds to believe that there were a number of issues of concern including:

- dispensing without a valid prescription;
- dispensing unauthorized prescription refills, or for quantities in excess of that authorized by prescriptions;
- dispensing verbal prescriptions which did not contain all required information;
- dispensing prescriptions monthly but billing for daily dispensing;
- dispensing expired prescriptions;
- dispensing narcotics on the basis of a verbal prescription;
- dispensing repeat prescriptions for narcotics;
- dispensing from prescriptions which were not on the required TRPP prescription pad;
- dispensing prior to the date of the prescription;
- Submitting claims for cancelled prescription, and billing for prescription not dispensed;
- dispensing refills earlier than authorized under the supporting prescription;
- dispensing invalid prescriptions (e.g. no quantity noted);
- altering prescriptions after the prescription had been dispensed;
- providing "verbal orders" that in fact had not been prescribed by the indicated prescriber on the date indicated on the prescription;
- dispensing drug different from that prescribed;
- dispensing monthly where the prescription directed for three months, without appropriate documentation or reason;
- dispensing an excessive or unreasonable or improper amount of a drug;
- falsifying records respecting a prescription or the sale of a drug; and
- failing to maintain records required to be kept respecting patients.

The issues identified above raise the further general issue as to whether conduct deserving of sanction, including professional misconduct, professional incompetence, conduct unbecoming a pharmacist, and/or acting in breach of the Pharmacy Act, the Regulations, or the Code of Ethics made under the Pharmacy Act, has occurred. Ultimately, the panel decided that there were reasonable grounds to believe that conduct deserving of sanction had occurred and, in accordance with section 39(3) of the Pharmacy Act, directed that the allegation be considered as constituting a complaint and that it be referred to the Disciplinary Panel for a hearing.

On October 15, 2012, an adjudication tribunal of the Disciplinary Panel met to consider a request from the respondents to have the hearing postponed. The tribunal denied this request citing, among other things, the amount of time that had already passed since the allegation was laid. However, the tribunal did agree, in accordance with section 41(4) of the Pharmacy Act, to have the hearing closed to the public when it proceeded.

On February 27, 2013, the adjudication tribunal accepted guilty pleas and Joint Submissions on Penalty from both Mr. Bennett and Mr. Whalen. In arriving at this decision, the adjudication tribunal considered Agreed Statements of Fact and Admission Statements signed by Mr. Bennett and Mr. Whalen. In these Admission Statements, both respondents admitted having, by their conduct, contravened provisions of the Pharmacy Act, various sections of the Pharmacy Regulations, the Code of Ethics and the Regulations to the Food and Drugs Act.

The tribunal also considered the Joint Submission on Penalty before determining the appropriate sanctions. As such, the tribunal ordered:

⇒ With respect to Mr. Bennett,:

- Mr. Bennett's licence to practise pharmacy shall be suspended immediately for a period of 5 years. The respondent is not permitted to work in any capacity as a pharmacist, pharmacist assistant, pharmacy technician, or in any manner relating to the practice of pharmacy in any pharmacy and shall not work in any capacity in the dispensary of any pharmacy during the period of suspension.
- Any reinstatement of the license of Mr. Bennett is conditional on his successful first attempt passing of Part II of the Pharmacy Examination Board of Canada (PEBC) Qualifying Examination, successful first attempt of rewriting the NLPB Registration Examination, successful completion of 5 months internship, and completion of 15 Continuing Education Units within the previous 12 months.
- Mr. Bennett is to pay the costs incurred by the Board with respect to the investigation and hearing of the complaint, which are fixed at $40,000.
- Publication of the decision or order of the Adjudication Tribunal as required under section 44(3) of the Pharmacy Act, and publication in The Apothecary on a named basis.

⇒ With respect to Mr. Whalen,:

- Mr. Whalen's license to practice pharmacy shall be suspended immediately for a period of 3 years. The respondent is not permitted to work in any capacity as a pharmacist, pharmacist assistant, pharmacy technician, or in any manner relating to the practice of pharmacy in any pharmacy and shall not work in any capacity in the dispensary of any pharmacy during the period of suspension.
- Any reinstatement of the license of Mr. Whalen's is conditional on his successful first attempt passing of Part II of the PEBC Qualifying Examination, successful first attempt of rewriting the NLPB Registration Examination, successful completion of 5 months internship and completion of 15 Continuing Education Units within the previous 12 months.
- Mr. Whalen is to pay the costs incurred by the Board with respect to the investigation and hearing of the complaint, which are fixed at $20,000.
- Publication of the decision or order of the Adjudication Tribunal as required under section 44 (3) of the Pharmacy Act, and publication in The Apothecary on a named basis.

Case #150530

On May 29, 2012, a letter was received from a patient alleging that a pharmacist, Derrick Ryan of Catalina Pharmacy, had billed and labelled their prescription for a brand name product, Plavix, on several occasions even though a generic form of the drug, clopidogrel, was dispensed.

On June 6, 2012, a panel of the CAC met to consider the letter of allegation. The panel felt that there was insufficient information with which to make a decision and in accordance with section 39(1) (a) of the Pharmacy Act, the panel referred the allegations back to the Secretary-Registrar for further investigation.

On July 4, 2012, the panel reconvened to consider the letter of response from Mr. Ryan as well as additional information gathered by the Deputy Registrar during the investigation. The panel decided that there were reasonable grounds to believe that conduct deserving of sanction had occurred and, in accordance with section 39 (3) of the Pharmacy Act, directed that the allegation be considered as constituting a complaint and that it be referred to the Disciplinary Panel for a hearing.

On February 8, 2013, an adjudication tribunal of the Disciplinary Panel accepted a guilty plea and Joint Submission on Penalty from Mr. Ryan. In arriving at this decision, the adjudication tribunal considered an Agreed Statement of Fact and Admission Statement signed by

Mr. Ryan. In this Admission Statement, Mr. Ryan admitted having, by his conduct, contravened provisions of the Pharmacy Act, various sections of the Pharmacy Regulations and the Code of Ethics. In the Agreed Statement of Fact, Mr. Ryan agreed that:

- he told the patient that the generic form had accidentally been given to him and that he had asked the patient to bring the drug back and he would refund his copay and reverse the billing to the third party payer.
- An inventory audit of the pharmacy's purchases and sales for Plavix, Apo-clopidogrel, and Teva-clopidogrel, conducted by the Deputy Registrar for the period of January 1, 2012 to June 7, 2012, indicated a large discrepancy between the amount of Plavix purchased and dispensed.
- The large discrepancy of Plavix on the inventory audit could not be explained away as the result of an isolated incident.
- On a number of occasions, Mr. Ryan dispensed drugs that had not been prescribed for the patient, nor substitutable under the Interchangeable Drug Products Formulary.
- The Board investigation revealed that the prescriptions dispensed had been mislabelled, charges occurred for drugs that were not dispensed and the patient profile did not reflect accurate information.

The tribunal also considered the Joint Submission on Penalty before determining the appropriate sanctions. As such, the tribunal ordered that:

- Mr. Ryan be fined an amount of $5,000.00.
- Mr. Ryan pay the costs incurred by the Board, in addition to the fine.
- Mr. Ryan and Catalina Pharmacy be subject to a one year period of monitoring by the Office of the Registrar of the Board.
- the decision of the tribunal be published on a named basis on *The Apothecary*.

Case #120725

On July 25, 2012, a letter was received alleging unsafe practices including billing and labeling for brand name drugs when generic drugs were dispensed and billing and labeling for one generic brand when a different brand was dispensed.

On February 15, 2013, a panel of the Complaints Authorization Committee (CAC) met to consider the letter of allegation as well as responses from the pharmacist-in-charge and several pieces of evidence that had been requested following prior meetings of the CAC in 2012.

In the pharmacist-in-charge's response, he explained that there was a transition period when the entries for the generic alternatives of certain brand name medications were not available in their computer practice management system. He said that in order to process claims for these drugs during this time, the brand name was billed with the pharmacist ensuring that the price was reduced to the generic price and any customer co-pay was adjusted to ensure the correct amount was charged.

He also addressed the issue of dispensing one generic and billing another by saying this only happens when their preferred product is on backorder and that when this occurs the patient is informed of the shortage and reassured that the medication is 100% equivalent to the previous one. He also stated that there is complete documentation each time a substitution is made. The drug name and DIN is written on the label given to the patient and a note of the change is made on the patient's file.

The panel reviewed all the material that had been presented and discussed the issues involved in the allegation including the patient safety issue of not having the prescription labeled with the correct brand name of the drug or generic name of the drug and name of manufacturer as required in Pharmacy Regulation 13(9). They noted that if there was a drug recall involving any of these medications, it would be impossible for the pharmacist to retrieve the medication. The panel also had concerns that while a thorough and consistent checking procedure is the best defense against dispensing errors, in this case, a prescription could not be reasonably checked for accuracy if the name and DIN number on the prescription vial label did not match the name and DIN number on the hardcopy dispensing summary.

After review of all information presented, the panel decided that there were reasonable grounds to believe that conduct deserving of sanction had occurred and, in accordance with section 39(3) of the Pharmacy Act, directed that the allegation be considered as constituting a complaint and that a letter of counsel or caution be sent to the pharmacist-in-charge and adhered to by all pharmacists working at the pharmacy. The panel further directed that specific points should be noted in the letter

of caution:

- That a copy of the pharmacy's policy and procedure for checking prescriptions be used at all times when checking prescriptions.
- Reinforce that a DIN check is performed by all pharmacy staff when checking a prescription.
- If the brand or generic name printed on the label is not available the transaction must be cancelled and the correct brand or generic name used as per Pharmacy Regulation 13(9).
- That the drug inventory should computerized as staff would then be able to tell if there was adequate stock to fill a prescription before the label and hard copy dispensing summary were printed.
- Hardcopy dispensing summaries for both first fills and refills must be filed in such a way so that all information on the summary is readable (i.e. not overlapping).
- If the Brand name drug or generic equivalent is not listed in the computer practice management system, the software vendor support team should be contacted as soon as possible to request that it be added.
- That a report of this complaint be published in the next edition of the Board's newsletter, The Apothecary, on a no-names basis, so that ALL pharmacists will be reminded by this incident of their responsibilities to review policies and procedures in their pharmacy to ensure error prevention as much as possible.
- A visit by an inspector of the Newfoundland and Labrador Pharmacy Board will be scheduled within the next six months.

Case #121026

On October 26, 2012, a letter was received from a patient alleging that a pharmacist had made a mistake in compounding a prescription medication. The patient further explained that, as a result of the error, she became very ill to the point of being hospitalized, resulting in stress and financial hardship for both her and her family.

On February 15, 2013, a panel of the CAC met to consider the letter of allegation, as well as the response from the respondent pharmacist.

In the pharmacist's response, he noted that while the prescription had been written for liothyronine 8.5 micrograms, he "failed to notice that the [pharmacy assistant] had used liothyronine concentrate instead of the diluted form. As a result the patient received a dose of 8.5 milligrams NOT micrograms."

Upon being informed of this error, the pharmacy staff immediately implemented a revised procedure for checking compounds that includes verifying that the correct dose of the medication has been compounded by using the weight/volume of the ingredients to calculate the final concentration as well as having a second pharmacist double check these calculations. The lot number of the ingredients will be also be checked in addition to a "name" check.

The panel acknowledged that the pharmacist took responsibility for the medication error and responded to the patient in an appropriate manner. The pharmacy has implemented a number of policies and procedures for all compounding staff aimed at preventing future medication incidents. Despite this, the panel decided that there were reasonable grounds to believe that conduct deserving of sanction had occurred and, in accordance with section 39 (3) of the Pharmacy Act, directed that the allegation be considered as constituting a complaint and that letters of caution be sent to the pharmacist and the pharmacist-in-charge. The panel further directed that specific points should be noted in the letters of caution:

- That a copy of the pharmacy's policy and procedure for checking prescriptions be forwarded to the Newfoundland and Labrador Pharmacy Board for review.
- That a copy of the pharmacy's policy and procedure for diluting medication to be used in a compounded prescription be forwarded to the Newfoundland and Labrador Pharmacy Board for review.
- Reinforce the checking procedure to ensure that checking occurs against the prescription.
- Reinforce the checking procedure to ensure that every compounded prescription be checked for the appropriate dosage.
- That a report of this complaint be published in the next edition of the Board's newsletter, The Apothecary, on a no-names basis, so that this incident will remind other pharmacists of their responsibilities to safe medication practices, prevention of harmful medication incidents, and facilitating quality improvement initiatives.

Dealing with Medication Incidents

"I think you made a mistake with my prescription."

As a pharmacist, this statement immediately causes a rush of anxiety. In spite of our best intentions, there are times when things can go very wrong and medication incidents occur. It is, however, the manner in which we respond to notification of a medication incident that can make the biggest difference in both the outcome for the patient and pharmacist involved. Quite often when patients report incidents to the Board, they are more upset with the response, or lack thereof, they received from the pharmacist or pharmacy management than with the actual error itself.

Immediate, clear, open and continued communication with the patient is necessary. Pharmacists must take steps to determine why the medication incident occurred and implement any necessary changes to ensure the prevention of a recurrence of the incident. It is a fact that most medication incidents are the result of a series of events that have failed and not the actions of one individual. It is vital that all pharmacy staff are aware of and follow proper policies and procedures so that medication incidents may be responded to promptly and with the patient's health and safety a priority.

Steps to take to improve your response to a medication incident include:

- ⇒ When a patient presents a possible medication incident to the pharmacy, **the pharmacist must give the patient their immediate and total attention**. The safety of the patient is the pharmacist's primary concern at this time.
- ⇒ It is important to **listen intently to the patient** as they describe the situation and not interrupt even if you can immediately identify the reason for the concern. To ensure understanding, repeat or paraphrase what you have been told.
- ⇒ **Acknowledge the distress** and risk that the incident has caused the patient and express empathy and concern for the patient. Do not try to diminish the seriousness of the incident.
- ⇒ **Determine if the patient is at possible risk of harm**. Notify the prescriber of the medication and any other emergency personnel deemed necessary.
- ⇒ **Apologize to the patient** even if you are still unsure about the circumstances of the medication incident. In accordance with the *Apology Act*, making an apology does not constitute admission of fault or liability.
- ⇒ **Determine the cause of the medication incident** in a transparent and timely manner ensuring that necessary changes are made in policies and procedures that may have led to the medication incident.
- ⇒ **Communicate this information to the patient**, without excuses, so that they understand that steps have been taken to fully address the medication incident and to prevent a recurrence.
- ⇒ **Document and communicate information about the medication incident**. Document as much information about the incident as possible. Share and discuss details about the medication incident with all dispensary staff, focusing on possible contributing factors and any changes to pharmacy policies and procedures necessary to prevent a recurrence.
- ⇒ **Report medication incidents and near misses** to the Institute for Safe Medication Practices – Canada's **Medication Incident and Near Miss Reporting Program**. Medication incidents and near misses can be reported anonymously. Remember, everyone can learn from medication incidents when they are reported.

Adapted with permission from the Spring 2013 issue of the Manitoba Pharmaceutical Association newsletter

Dispensing Accuracy Tips

Check, Check and Check Again!

As pharmacists, we never like to hear or talk about dispensing errors and medication incidents. Now that we've discussed how to respond to an incident, lets consider some ways to prevent further errors from occurring in the future.

KNOW THE RISKS

There are many things that contribute to dispensing errors such as distractions, interruptions, working long hours without a break, quieter periods (research shows that fewer errors occur when the dispensary is busy), lack of focus due to illness or personal problems, an over-reliance on the accuracy of other staff members involved in the dispensing process, self-checking, and new staff members.

DEVELOP THOROUGH CHECKING PROCEDURES

A thorough and consistent checking procedure is perhaps the best defense against dispensing errors. This involves several steps including:

- Triple-check the drug name and strength by comparing:
  - ⇒ the prescription to the label,
  - ⇒ the prescription to the bottle or package, and
  - ⇒ the label to the bottle or package.
- Check the product dispensed after preparation:
  - ⇒ If using multiple bottles or packages, check that *all* bottles or packages are the same
  - ⇒ If using stock bottles, carry out a quick visual check on the contents of the bottles and the contents of the container to ensure they match
  - ⇒ If using packages, open all unsealed packages checking that the contents are correct, the number of strips present in each package is correct, and that there are no loose tablets
  - ⇒ Check the expiry date on each bottle or package
- Check other information on the prescription:
  - ⇒ Patient name
  - ⇒ Prescriber
  - ⇒ Instructions to the patient
  - ⇒ Dosage form
  - ⇒ Quantity
    - ⇒ Check that the correct quantity has been given (the correct number of packages or a quick visual check of the container)
    - ⇒ For controlled drugs, double-count the number of dosage units dispensed

It is also good practice to:

- check that labels have not been transposed when dispensing more than one item to the same patient
- count the number of items on the prescription and then count the corresponding number of dispensed items into the bag
- check that the bag does not contain any stock bottles

DOCUMENT, DOCUMENT, DOCUMENT

Each staff member involved in the dispensing process is responsible for its accuracy and should physically document their involvement by signing or initialing the "hard copy" dispensing summary that is affixed to the prescription. For example, if an assistant picked the drug from the shelf, counted it and labeled the vial, she should check the drug name and strength (triple-check), document the DIN from the stock bottle, the quantity counted and sign/initial the summary prior to passing it to the pharmacist for checking. The pharmacist should then complete all other checks as indicated previously, making some sort of physical mark next to each piece of information on the summary, finishing by signing/ initialing the summary themselves.

DON'T FORGET THE PATIENT COUNSELLING

Effective patient counselling often picks up unidentified errors and should include:

- verifying the patient's and prescriber's names
- discussing the patient's understanding of why the medication is being prescribed
- how, when and for how long to take the medication - ensure appropriate spoons, oral syringes, etc. are included if necessary
- how to store the medication
- what to do if a dose is missed
- how the patient will know the medication is working
- whether or not the prescription can be refilled, and if so, when

Finally, as a last check, show the patient what the medication looks like.

Continuing Professional Development Audit 2012 Results

The Continuing Professional Development (CPD) audit process for 2012 is nearing completion. This year, 130 pharmacist learning portfolios were reviewed and, at the time of print, the Board is pleased to report a 97% success rate for 2012! Details of the review are as follows:

First Review (March 1-2, 2013)	Second Review (April 3, 2013)
129 reviewed • 113 compliant • 16 requests for additional information	16 reviewed • 11 compliant • 5 requests for additional information
*One pharmacist requested and was granted an extension that is still pending.	

Some tips for next year:

- Pharmacists attending multiple events at one time (such as a conference) must document each event separately even when the Certificate of Participation assigns a total number of credits to the whole program.
- A pharmacist who has been non-compliant in the previous audit year may be automatically audited again in the next year. Pharmacists who have been audited should check their *Summary of CPD Review* for indication of whether or not they may be audited in the next year.

Many thanks to the members of the Registration and Licensing Committee for volunteering their time for this year's reviews.

ISMP-Canada's Canadian Medication Incident Reporting and Prevention System

The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a national voluntary medication incident and 'near miss' reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

Medication incidents (including near misses) can be reported to ISMP Canada through their website: **www.ismp-canada.org/err_report.htm** or by phone, toll free, at 1-866-544-7672. ISMP guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

ISMP Newsletter Subscriptions

ISMP Canada Safety Bulletins are designed to disseminate timely, targeted information to reduce the risk of medication incidents. The purpose of the bulletins is to confidentially share the information received about medication incidents which have occurred and to suggest medication system improvement strategies for enhancing patient safety. The bulletins also share alerts and warnings specific to the Canadian market place. All issues of the ISMP Canada Safety Bulletins, including those issued in previous years, are available from the ISMP Canada website.

To subscribe and for more information on all ISMP Canada's publications, events and services visit the ISMP Canada website at **www.ismp-canada.org** .

French-English Translation Tool Now Available

The Newfoundland and Labrador French Health Network has recently released the *Passeport Santé*, a tool created to help facilitate communication and promote dialogue between francophones and English-speaking health professionals. It features the main French terms that are used during health-related consultations and their translation in English. While the booklet is written for the French-speaking patient, it could be very useful for pharmacists who find themselves unable to understand a patient's health concerns due to the language barrier. To view or download a copy of the booklet, visit the French Health Network website at: **www.francotnl.ca/newfoundland-and-labrador-251-french-health-network.php** and click on "*Passeport Santé*".

Recent Updates to the NLPB Website

About the Board
- ⇒ *Vision, Mission, Core Values and Lines of Business added*

Contact Us (Find A…)
- ⇒ *Board members updated*

Finance Committee
- ⇒ *Terms of Reference and Membership updated*

Complaints and Discipline Resolution
- ⇒ *Adjudication Tribunal decisions added*

Code of Ethics & Legislation
- ⇒ *Pharmacy Act 2012 added*
- ⇒ *NLPB Binder files updated*

"The Apothecary" & Other Communications
- ⇒ *News items added*
- ⇒ *MedEffect advisories updated*

Professional Practice Resources
- ⇒ *January 2013 issue of the Canadian Adverse Reaction Newsletter*
- ⇒ *Vol.13, Issues 1 & 2 of the ISMP Canada Safety Bulletin*

Pharmacy Technician Regulation
- ⇒ *Information on CAPT Professional Development Conference added*
- ⇒ *Colleges offering Bridging Program Courses updated*

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Newfoundland and Labrador Pharmacy Board

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BOARD OF DIRECTORS

Elected Members

Zone 1	Debbie Kelly
Zone 2	Ray Gulliver
Zone 3	David Cramm
Zone 4	Christina Tulk
At Large	Keith Bailey, Sheldon Baines, Shawn Vallis

Appointed Members

Government-appointed	Don Mifflin
	1 vacancy
Board-appointed	Donald Anthony
	Shirlene Murphy
Dean, MUN School of Pharmacy	Linda Hensman
MUPS Representative *(observer)*	Amanda Brett

EXECUTIVE COMMITTEE

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Vice-Chair	Christina Tulk
Executive Member	David Cramm
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