The Apothecary

Newfoundland and Labrador Pharmacy Board

Summer 2011

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.

NLPB Board Elections

With the Call for Nominations deadline passed, we are pleased to report that we have several nominations for Zone 3 and the "At Large" Board member positions:

Zone 3 (1 seat available)	At Large (3 seats available)	
David Cramm	Keith Bailey	Jeremy Reid
Theresa Hill	Sheldon Baines	Shawn Vallis
	Linda Hensman	

Ballots, which will include a brief bio for each candidate will be sent to all pharmacists by August 18, 2011.

The Board greatly appreciates each of these candidates' willingness to offer to serve the profession of pharmacy in this province. We hope that all pharmacists take the time to consider the candidates and vote for your representatives at the Board table.

Report from June 10, 2011 Board Meeting

Annual Report

The Newfoundland and Labrador Pharmacy Board Annual Report for 2011 was approved by the Board. It has since been published to the **About the Board** page of the NLPB website and will be officially presented to attendees of the Board's Annual General Meeting which will take place during the PANL Conference n September of this year.

Strategic Planning

This year's Strategic Planning session took place on April 8, 2011. At this session, the attendees, which included Board members and staff, as well as committee chairs, MUN School of Pharmacy students and representation from PANL, identified the goals and direction of the Board for the next three years. At the June meeting the Board endorsed the facilitator's report and planned to meet again in late-July to set priorities and timelines for the goals. A summary of the Board's Strategic Plan for 2011-2013 is available on the **About the Board** page of the NLPB website. The full report will be published later in the year after it is finalized by the Board.

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NLPB Policy - *Professional Liability Insurance*

As reported in the Spring 2011 edition of The Apothecary, at its February 2011 meeting, the Board approved several changes to this policy. At the time, the Board was awaiting further information on whether or not it was feasible for students and interns to purchase their own personal liability coverage. At the June 10th meeting, the Board reiterated the fact that individual liability insurance will now be required of pharmacy students and interns as well as pharmacists. The policy came into effect July 1, 2011 with the deadline for pharmacy students and interns to acquire this coverage set at September 30, 2011. The revised policy (as well as the revised "*Registration as a Pharmacy Student / Intern*" policy can be found on the **Standards, Policies & Guidelines** page of the NLPB website.

Pharmacy Assistant Observer

At its February meeting, the Board accepted several recommendations from the Professional Practice Sub-Committee on Pharmacy Technician Regulation. One of these recommendations was to appoint a Pharmacy Assistant to sit as an observer at Board meetings. Since that meeting, the Board's Executive Committee met and discussed this recommendation again. They felt that this was a bit premature and should be delayed for a while. At the June meeting, the Board accepted the Executive Committee's recommendation and decided to defer appointing a Pharmacy Assistant observer to a later date.

Update to *Guidelines for Dispensing Buprenorphine*

At the time these guidelines were initially developed, in 2008, there was only one form of buprenorphine on the market, Suboxone, which was indicated for the management of opioid dependence. Since then, a new buprenorphine product, BuTrans, has been developed for pain management and the Board has received many calls and emails asking for clarification regarding whether or not the same guidelines apply to both products. As such, it was appropriate to update our guidelines to reflect the new situation. The Board considered and approved changes as follows:

- The title of the document was changed to reflect its intended purpose - *Guidelines for Dispensing Buprenorphine for the Management of Opioid Dependence*
- A new introduction was added to further clarify the issue
- A new section was added to reference the fact that the guidelines do not apply to buprenorphine for pain management.
- The latest version of the College of Physicians and Surgeons of Newfoundland and Labrador's guideline on prescribing buprenorphine for the management of opioid dependence was attached.

The full revised Guidelines can be found on the **Standards, Policies & Guidelines** page of the NLPB website.

Update to *Standards of Pharmacy Practice - Security and Accountability Procedures for Narcotics and Controlled Drugs in Community Pharmacies*

The Board approved a minor revision to this Standard of Practice. In section 2.3 of the document, several scenarios are described in which a physical inventory count should take place in addition to the regular quarterly counts. The phrase "When a pharmacy closes" was added to this list. The full Standards can be found on the **Standards, Policies & Guidelines** page of the NLPB website.

Complaints and Discipline Update

In recent months, the Board has received an increased number of allegations of unprofessional conduct on the part of pharmacists. While a number of these cases are still being dealt with in accordance with the required complaints and discipline process outlined in the Pharmacy Act and Regulations, a number of other cases have been resolved.

Since **ALL** pharmacists have something to learn from these cases, summaries of the decisions reached are published here for the information of all pharmacists.

It should be noted that when letters of caution, counsel or reprimand are issued to pharmacists as a result of the complaints and discipline process, these letters remain on the pharmacist's file for a minimum of five years and would be referenced in any Letter of Standing issued by the Board respecting the pharmacist in question.

Case #1

An allegation was received concerning the conduct of a pharmacist while dispensing a narcotic, as well as other allegations of unprofessional conduct.

After consideration of the information presented, the CAC directed that the allegations be considered as a complaint and referred to a hearing of the Discipline Tribunal. Given the potential risk posed to the public if the allegations made were correct, the CAC further recommended to the Board that the pharmacist's licence to practice be suspended immediately pending the outcome of a discipline hearing. Immediately following the decision of the CAC, a special meeting of the Board was called and the recommendation of the CAC was endorsed by the Board. The pharmacist's licence to practice was suspended and a public notice to that effect was circulated to all pharmacies in the province and to the public.

Case # 2

An allegation was received from the mother of a young child that when her sister brought a prescription for the child to the pharmacy the medication (an antihistamine syrup which is also available over the counter) offered by the pharmacist was outdated. The pharmacist responded that the medication prescribed was on back order from their usual wholesaler but that a bottle of the medication (which was outdated by about three weeks) had been obtained at another pharmacy and was available if her sister wanted to use that temporarily while in date stock was sought from other wholesalers. Alternatively, another similar product could be used instead. The mother chose not to take the outdated medication and the pharmacist contacted the prescribing physician, at which time the prescription was changed to the alternative product suggested by the pharmacist.

After consideration of the information placed before it, the panel ruled that there was no indication that the outdated medication in question had ever left the pharmacy, been administered to the patient, or been displayed in the patient self-selection area of the pharmacy for possible purchase without the advice of a pharmacist. The panel was also of the opinion that, even if the outdated drug had been dispensed, it would not have posed a risk of injury to the patient. Consequently, the panel found there were not reasonable grounds to believe that the respondent had engaged in conduct deserving of sanction with respect to the practice of pharmacy and therefore, in accordance with section 39(2) of the *Pharmacy Act,* the panel dismissed the allegation.

Case # 3

An allegation was received from a patient that when she brought a prescription for a thyroid medication, which she had not been prescribed before, to the pharmacy, the wrong drug (a blood pressure medication) was dispensed to her. It was after having taken the wrong medication and experiencing adverse effects that resulted in her being taken to the emergency department of the hospital that this error was detected. A response was received from the Pharmacist-in-Charge of the pharmacy. Taking into consideration the response from the Pharmacist-in-

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Charge, as well as other extenuating circumstances, there will be no further action by the Board with respect to this allegation and the case is now closed.

Case #4

An allegation was received from the Chair of the Registration and Licensing Committee indicating that four pharmacists had not complied with the audit requirements of the *Standards of Practice regarding Continuing Professional Development*. Having considered the information before it, the Panel found that there were reasonable grounds to believe the respondents had engaged in conduct deserving of sanction and that the allegation be considered a complaint. The Committee recommended to the Board that if the requested documentation has not been received at the NLPB office by 10:00am, March 25, 2011 the respondents' licenses to practice be suspended until they had adhered to the requirements for continuing education, and that the respondents' licenses be reinstated once they have provided documentation of the required continuing education satisfactory to the Registration and Licensing Committee. The required information was provided by all of the pharmacists named before the deadline and their licences to practice were not suspended.

Case #5

An allegation was received from a Pharmacist Supervisor indicating that a pharmacist under their supervision was failing to adhere to conditions of licensure imposed as a result of earlier discipline proceedings.

After consideration of the information placed before it, the Panel was of the opinion that there were reasonable grounds to believe the pharmacist had engaged in conduct deserving of sanction and the allegation be considered as constituting a complaint.

The Panel instructed the Secretary-Registrar to file a complaint against the pharmacist and refer it to the Disciplinary Panel. After consideration of the concern for public safety, the panel further recommended to the Board that the pharmacist's licence to practice be suspended immediately pending the outcome of a hearing of an adjudication tribunal. Based on consideration of the allegations, and upon the recommendation of the CAC, the Board suspended the pharmacist's licence to practice.

Case #6

An allegation was received from the representative of a pharmacy in the province that a pharmacy in another community might not be adhering to the Board's Standards of Practice related to the faxing of prescriptions and the delivery of prescriptions.

After consideration of the information presented to it following an investigation, the CAC found that there was sufficient evidence of conduct worthy of sanction on the part of the respondent pharmacist and ordered that the pharmacist ensure that the Standards are adhered to completely and that a letter of caution be sent to the pharmacist pointing out:

- Standards of Pharmacy Practice related to the faxing of prescriptions are not being fully adhered to and should be reviewed to ensure that they are followed by all pharmacists at the pharmacy.
- The Standards of Pharmacy Practice regarding the delivery of prescriptions are not being fully adhered to and should be reviewed to ensure that they are followed by all pharmacists at the pharmacy.
    - In particular, the Standards require that "*The pharmacist shall take reasonable steps to satisfy himself or herself that all personnel responsible for the delivery of prescriptions are reliable and must provide a documented paper trail and proof of delivery. Signatures shall be obtained from the recipient and kept on file at the pharmacy.*" In addition, "*Patients requesting delivery of prescriptions to a person other than themselves must provide the pharmacy with written delegation of authority for that person to act as the patient's agent. The written delegation of authority to an agent must include the name of the designated agent and the name and signature of the patient, and must be kept on file in the pharmacy and noted in the patient's profile.*" The

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pharmacist was cautioned that **a signature on a delivery log acknowledging receipt does not meet the requirement for specific written delegation of authority to act as the patient's agent, particularly if the receipt is signed by a person who is not the patient. A signed document should be kept on file for each patient requesting delivery to an agent**.

- Also, "*In the case of delivery of prescriptions to an agent, prescriptions that are not delivered to the patient within three (3) days shall be returned to the pharmacy and it is the responsibility of the pharmacist to ensure that the prescription is delivered to the patient in a timely manner*." While documentation was presented that a Delivery Log was kept by the pharmacy, it was not always complete and did not record important tracking information. The Panel cautioned the pharmacist that **the Delivery Log utilized by the pharmacy should be reviewed to ensure that it documents all information needed to maintain a trail of delivery. It should also be ensured that all required tracking information is recorded on the log and signed for both by the patient or their agent and by the person who provides the delivery**.

- Finally, while the prescription Delivery Slip presented is clear in offering to the patient the availability of a pharmacist's advice and consultation, and a toll free number is provided, **the offer of counselling and the provision of patient information sheets is not adequate, in itself, to meet the requirements of the *Pharmacy Regulations* respecting patient counselling regarding their prescriptions. The pharmacist (and all pharmacists in the province) is also reminded that specific documentation on the patient profile that counselling on specific prescriptions was provided to the patient would be a clear indication that the requirements of the *Pharmacy Regulations* in this respect had been met.**

Case # 7

An allegation was received from a patient that when a renewed prescription (for a laxative) that had been previously logged on at the pharmacy was dispensed some time later, the wrong medication (a blood pressure medication) was dispensed. Upon investigation of this incident on behalf of the CAC, it appeared that the drug prescribed had been incorrectly recorded when the prescription had been first logged and that the error had not been detected at a number of steps, or by a number of pharmacists, during the dispensing process. There were also concerns expressed that polices and procedures in place at the pharmacy regarding professional accountability may not have been followed by the pharmacists on staff or enforced by the Pharmacist-in-Charge, or may not have been clear.

The CAC extensively discussed several issues:

- Which pharmacist or pharmacists were actually involved with filling the prescription
- Whether the pharmacy's policies and procedures were actually followed during the filling of this prescription
- Whether the pharmacy's policies and procedures have deficiencies which resulted in or contributed to the dispensing error in this case
- Was there conduct deserving of sanction on the part of one or more pharmacists, and if so what is the appropriate action to be taken by the CAC.

In particular, the panel was very concerned that, in their responses to the allegation, the pharmacists questioned the validity of the computer records regarding who had performed which role in the filling of the prescription in question. The two staff pharmacists indicated that it was the practice in the Pharmacy for the first pharmacist to arrive in the morning to log on to the system and then not log out before another pharmacist used that same terminal. The result of this would be that subsequent prescriptions filled on that terminal would indicate the "logged in" pharmacist's initials on the computer record, which would not necessarily indicate the actual pharmacist who had performed that role in the filling

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of the prescription. The pharmacists stated that it was impossible to tell if a given pharmacist did actually fill any particular prescription, even if his/her name was indicated on the record.

The panel also discussed the fact that **responsibility also rests on the Pharmacist-in-Charge, given the apparent knowledge on the part of management staff at the Pharmacy of the practice of logging in and then not logging out, or using terminals on which other pharmacists were logged in (using other pharmacists' passwords), resulting in the situation which occurred.**

The panel considered **the practice of using other staff member's codes to be an unacceptable practice that could contribute to an attitude of reduced acceptance of responsibility on the part of pharmacists**, if it results in an inability to determine who performed what part of the dispensing of the prescription. It is not acceptable to the Panel, or in practice, for a pharmacist to not take responsibility in a situation like this one, because of the "logging in" practice apparently used extensively at the Pharmacy. The public deserves to be able to determine exactly which pharmacist was involved in the filling of any given prescription.

The Panel was left with the conclusion that, in the absence of any other documentation, it had to accept as accurate the indication in the Pharmacy records that three pharmacists were directly involved in filling the prescription and all three pharmacists must take responsibility for the error that occurred. The prescription was incorrectly entered in the computer system, when being "logged" for later use and that error was not detected by any of the other pharmacists who apparently participated in the ultimate filling of the prescription. This included the "visual verification" stage where, either the original prescription (or its scanned image) was not visually checked against what was being dispensed, or, the same error that was made when the prescription was entered was repeated by the pharmacist who did the "visual verification".

It also appears that there was no counseling provided for this prescription, contrary to the *Pharmacy Regulations*. Counselling should have been provided especially in this case, as the drug dispensed was a new drug for that patient. Presumably, if counseling had occurred, the person receiving the dispensed prescription would have been alerted to the fact that the drug being dispensed was a blood pressure medication, not the laxative that she was expecting and had received in the past.

The CAC decided that there were reasonable grounds to believe that the respondents had engaged in conduct deserving of sanction, and therefore the allegation would be considered as constituting a complaint. The Panel ordered that appropriate letters of counsel be forwarded to each of the three staff pharmacists involved. With respect to the Pharmacist-in-Charge, it is the Pharmacist-in-Charge who is generally responsible for ensuring that appropriate policies and procedures are in place and followed in a pharmacy, and it appears that the practice of pharmacists logging in to a computer, not logging out, and allowing other pharmacists to use their computer codes was known to the pharmacy management at the pharmacy, at the time the subject prescription was logged in, and dispensed. **That being the case, the Pharmacist-in Charge was responsible for allowing an unacceptable practice to continue.**

The Panel ordered that the Pharmacist-in-Charge also receive a letter of counsel regarding the inappropriateness of allowing the subject practice to continue. The Panel also recommended that the district office of the pharmacy be made aware of this Decision, and that it take into consideration the findings and recommendations in this Decision regarding policies and procedures in place in the pharmacy. **The Panel also recommended that an article be placed in The Apothecary, on a no names basis, regarding the need for pharmacists to at all times be accountable for their actions in filling or dispensing a prescription, and advising that it is not acceptable for any pharmacist to allow another pharmacist to use his or her name at any stage of the filling or dispensing process.**

Connecting Over the Network

"Pharmacists share feedback on progress of the Pharmacy Network"

Recently, members of our Pharmacy Network (PN) team conducted site visits with various community pharmacies around the province that are connected to the Pharmacy Network. The purpose of their visits was to follow up with pharmacists about their experiences with the Pharmacy Network, as well as to provide an opportunity for pharmacists to meet one-on-one with Pharmacy Network staff. The feedback gathered from these site visits will support our approach for Continued Quality Improvements (CQI), open communications and ultimately, to realize the benefits of the Pharmacy Network.

Pharmacists recognize that there is a learning curve and adjustment time; as well they are seeing the improvements being made to vendor systems, along with the Drug Information System (DIS), based on their feedback as we move forward. Although there have been a few challenges, pharmacists have provided resoundingly positive feedback on the Pharmacy Network. They are seeing value in the Network, and acknowledging the importance of shared medication profiles via this province-wide system.

Notably, pharmacists see value in monitoring medications that may cause drug interactions as well as those that have potential for misuse and/or abuse. Pharmacists also commented that the Pharmacy Network will save time and reduce errors, specifically when liaising with other healthcare providers on patient medication profiles.

"Having instant access to a patient's medication profile could be life saving in an emergency situation," said one pharmacist. It can be time consuming for a health professional to acquire this information. Phone, fax and mail do not necessarily offer the quickest response time. Also, pharmacies are not open 24 hours a day, nor are pharmacists always available to answer calls. The Pharmacy Network will provide instant access to information, avoiding delays.

The importance of information sharing was evidenced at one pharmacy in particular, located in Central Newfoundland. A patient of the pharmacy is a resident of a community two hours away, but spends much of her time in the Central area with family. She also receives chemotherapy treatments at Central Health. When filling a prescription for this patient the pharmacist was able to ensure appropriate precautions were taken to prevent adverse events from occurring related to medications filled at another pharmacy location.

This is just one example of the benefits of the Pharmacy Network and how it supports improved health through quality health information. There are many examples from pharmacists who have realized the benefits of the Pharmacy Network already. Continued connection to the Pharmacy Network by all pharmacies will result in the vision of available and accessible medication information where and when it is needed. The people of this province deserve to realize the benefits of our investments and there are many reasons to be optimistic for the promise of enhanced care that the EHR will enable.

NLCHI Pharmacy Network Team

The Pharmacy Network is a provincial drug information system that contains records of patient medication information and comprehensive drug information. It is a component of the provincial Electronic Health Record (EHR), designed to support improved patient safety and overall enhanced care.

As of June 4th 2011, there have been 49 community pharmacies connected to the Pharmacy Network. There have been 1,608,977 additions to a patient's PN profile (prescriptions and dispenses), representing 94,103 patients. There have been a total of 6022 times when additional or shared information has been available to pharmacists for decision-making purposes. To learn more, please visit the ***Pharmacy Network*** *website at www.nlchi.nl.ca/pharmacynetwork/.*

Miscellaneous Notes and Reminders

Disclosure of Patient Information Without Consent Under the Personal Health Information Act

Recently our office received a call from a pharmacist working in an ICU hospital setting regarding a conversation he had with a local community pharmacist. The hospital pharmacist, as a part of a medication reconciliation process, had requested information about a patient's medication profile from the community pharmacist. In this particular case the community pharmacist indicated that he could not release this information without the patient's consent, because of the requirements of the recently proclaimed Personal Health Information Act (PHIA).

While the prohibition of disclosure of personal health information without the patient's consent has long been a cornerstone of privacy and confidentiality standards of practice, and is a fundamental principle of the PHIA legislation, there are indeed some situations in which disclosure without patient consent is considered acceptable, or may in fact be required by law. (The mandatory disclosure of patient information to the Pharmacy Network without patient consent is an example of a legislated requirement for disclosure. The disclosure of information in an emergency situation, when the patient is incapacitated and unable to give consent, is an obvious example of a case where disclosure without consent would be in the patient's best interest, and acceptable practice.)

Section 24 of PHIA specifically permits, through "implied consent", disclosure to other professionals/ custodians involved in the "circle of care" of the patient (see http://assembly.nl.ca/Legislation/sr/statutes/p07-01.htm#24). Also, section 37 of PHIA, regarding disclosure without patient consent, permits disclosure from one custodian to another when explicit consent can not readily be obtained due to incapacity of the patient (see http://assembly.nl.ca/Legislation/sr/statutes/p07-01.htm#37).

Having said that, pharmacists must be reasonably assured that, when a request for disclosure of patient personal information is received, the patient has provided consent to such disclosure, or the situation is one in which implied consent is acceptable. While the Personal Health Information Act aims to protect and ensure the privacy and confidentiality of patients' personal health information, it is not intended that reasonable disclosure of information to optimize the patient's health care be inhibited or prevented.

It might be added that this incident is an excellent example of the future benefits that can come from the linkage of all of a patient's health information into a comprehensive Electronic Health Record which is then accessible to those health care professionals who need that information to properly care for the patient.

Updates to Tamper Resistant Drug Pad Program Schedule of Drugs

Recently, the Department of Health and Community Services updated the list of drugs that are required to be written on TRPP pads. This revision saw the addition of several new drugs / brand names to the

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list as well as the removal of several discontinued or out-dated drugs / brands. This will hopefully make the list more "user-friendly" and alleviate some of the questions surrounding the new drugs, in particular. The list, along with the TRPP Brochure, is linked via the **Legislation** page of the NLPB website.

Clarification Regarding Limitations on CEUs from the "Pharmacist's Letter"

Pharmacists are reminded that, as described in the **Spring 2011** edition of The Apothecary, the number of CEUs that may be claimed for the Pharmacist's Letter "CE-in-the-Letter" has now been limited to 5 CEUs per year (see section 4.1 ii) of the *Standards of Pharmacy Practice - Continuing Professional Development*). However, this limitation **DOES NOT** include CEUs that may be obtained through completion of other, more in depth, Professional Development programs that the Pharmacist's Letter may offer. It only refers to those CEUs obtained through completion of the "in issue" "CE-in-the-Letter".

Clarification on the Use of "Stat Med" Boxes in Personal Care and Community Care Homes

While the *Standards of Pharmacy Practice - The Provision of Pharmaceutical Care to Personal Care Homes and Community Care Homes* does not specifically prohibit the use of "Stat Med" Boxes in these types of homes, **this practice is strongly discouraged by the Board**. The Professional Practice Sub-Committee on Long Term Care is currently developing a draft Standards of Practice for Long Term Care facilities that will discuss and address the appropriate use of "Stat Med" boxes in Long Term Care facilities where they are accessible to properly trained staff at the facility.

Putting Prescriptions "On File" for Later Filling

The practice of putting prescriptions "on file" for a patient to pick up at a later date ("logging", "unfilling", etc.) is very common. On the surface, this is a good practice as the pharmacist has the complete profile and can record any changes to dosage, etc. and the patient does not have to worry about misplacing the prescription. However, as is apparent from the discipline case on page 5, there are several issues with this practice as well. Our biggest concern at this time is the practice of having a pharmacist or assistant enter ("key", "input") the prescription into the computer at one point in time while a pharmacist may not check or verify this prescription until a later time or date. The main issue with this practice is the lag time between these two events and whether it is possible for a patient to return and pick up the medication BEFORE the prescription has been checked.

As such, prescriptions should not be entered into the computer unless it is realistic that the prescription will be checked by a pharmacist within a reasonable time period (at least that same day). Pharmacists-in-Charge are encouraged to review their pharmacy's policy on this practice to ensure that patient safety and prescription accuracy are paramount.

Call for Expression of Interest

Eastern Health Medication Reconciliation Advisory Committee

Eastern Health is looking for a community pharmacist to serve on its Medication Reconciliation Advisory Committee. This committee provides organizational direction to standardize processes and ensure consistency with implementation of Medication Reconciliation (Med Rec) throughout all relevant programs / service areas of Eastern Health.

Pharmacists can contact Melanie Healey (mhealey@nlpb.ca or 709-753-5877) to find out more information about the committee, including membership, frequency of meetings, reimbursement, etc. or to express their interest in volunteering to serve on the committee.

Recent Updates to the NLPB Website

Standards, Policies & Guidelines

- ⇒ *Guidelines - Dispensing Buprenorphine for the Management of Opioid Dependence*
- ⇒ *Policy - Professional Liability Insurance for Pharmacists updated*
- ⇒ *Policy - Registration as a Pharmacy Student / Intern updated*
- ⇒ *Standards of Pharmacy Practice - Security and Accountability Procedures for Narcotics and Controlled Drugs in Community Pharmacies*

Legislation

- ⇒ *NLPB Manual files updated*

Professional Practice Resources

- ⇒ *Canadian Adverse Reaction Newsletter July 2011*

Provincial Drug Schedules

- ⇒ *Official Drug Schedules and Guide to Drug Schedules updated for 2011*

About the Board

- ⇒ *Annual Report 2011*
- ⇒ *Strategic Plan 2011-2013 summary*
- ⇒ *Board Meeting Minutes - February 18, 2011 Meeting*

Contact Us (Find A…)

- ⇒ *Pharmacists & Pharmacies Registers updated*
- ⇒ *Dentists, Optometrists and Veterinarians lists all updated*

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Newfoundland and Labrador Pharmacy Board

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