Newfoundland and Labrador Pharmacy Board

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

The Apothecary

Summer 2012

Continuing Professional Development Audit Results 2012

The Continuing Professional Development (CPD) Audit Process for 2011 is nearing completion. This year, 169 pharmacists were audited and the results of the reviews are as follows:

First Review (March 1st & 2nd 2012)	Second Review (April 13th 2012)
169 reviewed • 140 compliant • 29 request additional information by March 26th including two portfolios that were not received	29 reviewed • 27 compliant • 2 given additional time to submit information

At this time, the Registration and Licensing Committee would like to call attention to several important points:

- The Professional Development Log and Learning Portfolio Record Sheet have been revised over the years to reflect changes made to the Standards of Pharmacy Practice on Continuing Professional Development. Pharmacists still using the old form may be **flagged for audit**.
- The Learning Portfolio (all Learning Portfolio Record Sheets & supporting documentation) should be submitted to the Committee in an organized fashion – i.e. in the order the events are documented on the Professional Development Log (ideally in chronological order of completion).
- Learning Portfolios should be submitted by mail, courier or hand. Facsimile will not be accepted as multiple copies and pages are often transmitted and the quality of the transmission is often poor.
- When completing the forms, credits should be documented as accredited or self-assigned but not both. Pharmacists who assign credit as both may be **flagged for audit**.
- Pharmacists attending multiple events at a time (i.e. at a conference), or completing individual vignettes must document each event or vignette separately even though the Certificate of Participation may give a total amount of credits for the whole program.
- Certificates of Participation must be included for all online programs. All Certificates of Participation should indicate who accredited the program as well as the number of credits acquired.
- Pharmacists are reminded that a pharmacist who has been non-compliant in the previous audit year **may be automatically audited again in the next audit year**.
- "Review of Peer-Reviewed Journal Articles" has been added to Appendix B of the Standards of Pharmacy Practice on Continuing Professional Development (self-assignment of credits), which can be found on the **Standards, Policies & Guidelines page** of the NLPB website.

The committee has also decided to provide copies of a few well-documented Learning Portfolio Record Sheets. Pharmacists can use them as good examples to follow when documenting professional take home messages that relate back to the program's learning objectives as well as when evaluating what elements from the program could be applied to your practice. These examples are attached at the end of this newsletter and can also be found on the **Standards, Policies & Guidelines page** of the NLPB website.

Complaints and Discipline Resolution

Case #1

A hearing of an Adjudication Tribunal of the Newfoundland and Labrador Pharmacy Board (NLPB) was held on April 10, 2012 to consider a Complaint made against a registered pharmacist, Paul Gill ("the respondent").

At the hearing, the Tribunal considered and accepted an Agreed Statement of Facts, an Admission Statement by Mr. Gill and a Joint Submission on Penalty, all of which had been agreed to by Mr. Gill and the Secretary-Registrar.

In the Agreed Statement of Facts, it was agreed that between 2007 and 2010 the respondent did not comply with his responsibilities as Pharmacist-in-Charge with regards to supervision of a pharmacist at his pharmacy (Downtown Pharmacy). During that period on a number of occasions the respondent was made aware of allegations against the pharmacist and neither did anything to address the allegations nor brought this issue to the attention of the NLPB. The respondent did not remove the pharmacist from her duties, but continued to allow her to practice, mostly unsupervised. Even following notification from the NLPB that allegations against that staff pharmacist were being investigated, the respondent denied previous knowledge of the allegations and at no time took steps to ensure that public safety was protected in the practice of pharmacy at Downtown Pharmacy. The allegations made against the staff pharmacist were of a nature that, if true, would place the public at risk and would suggest that the pharmacist in question should not be practicing. The allegations also included suggestions of possible criminal activity on the part of the staff pharmacist. By failing to intervene, the respondent placed the public served by the Pharmacy at risk and violated his responsibilities as Pharmacist-in-Charge.

In the Admission Statement the Respondent pleaded guilty to violating section 12.(1) of the *Pharmacy Act*; subsections 12(1)and(2), 37(1) (b), (t), (z) and (bb) of the *Pharmacy Regulations*; and Statement VI (1) and (2) of the *Code of Ethics* which relate to the responsibilities of the Pharmacist-in-Charge, the definition of professional misconduct and the requirement to preserve high professional standards.

The Adjudication Tribunal accepted the Respondent's guilty plea and the Joint Submission on Penalty and ordered that:

- The respondent's license to practice pharmacy be suspended immediately for a period of five months. The respondent is not permitted to work in any capacity as a pharmacist, pharmacy assistant, or 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 Downtown Pharmacy or any other pharmacy, during the period of suspension;
- The respondent's license be restricted so that he cannot be Pharmacist-in-Charge of a Pharmacy for a period of five years from the date of the suspension of his ability to be Pharmacist-in-Charge on November 14, 2011;
- The respondent will participate in an interview satisfactory to the Secretary-Registrar to review the responsibilities of the Pharmacist-in-Charge before being permitted to become a Pharmacist-in-Charge in the future;
- The respondent shall be subject to, and co-operate fully with, periodic inspections and audits by the Secretary-Registrar, or designate;
- The respondent will pay the costs as incurred by the Board of the investigation and hearing of the Complaint, as defined in the *Pharmacy Act*, such costs to be set at a maximum of $30,000.00.
- Publication of the Order of the Adjudication Tribunal as required under the *Pharmacy Act*, and in the Apothecary on a named basis;
- The respondent shall advise the Pharmacist-in-Charge of all pharmacies where he works / practices of the Order of the Adjudication Tribunal, for a period of five years from the date of the Order of the Adjudication Tribunal;
- The respondent shall advise the Secretary-Registrar in writing of every pharmacy where he practices, prior to commencing practice there, for a period of five years from the date of the Order of the Adjudication Tribunal.

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Case #2

A hearing of an Adjudication Tribunal was held on April 27, 2012 to consider a Complaint made by the Chair of the Registration and Licensing Committee, against a registered pharmacist ("the respondent") indicating that the pharmacist had failed to meet the requirements of the *Standards of Pharmacy Practice on Continuing Professional Development*.

At the hearing, the Tribunal considered as evidence:

- The standard Notice of Professional Development Audit sent in January 2012. It was noted to the panel that in addition to being randomly selected for audit this year, the respondent had also been audited in the previous year and, as a result of non-compliance, had been advised he would be audited again this year.
- A letter sent to the respondent in March 2011 indicating that an allegation had been sent to the CAC due to the fact that required documentation to permit the auditing of his 2010 Professional Development Log had not been received. The panel was informed that, with respect to that complaint, the CAC had recommended to the Board that if the required documentation was not submitted by the deadline, the respondent's licence to practice be suspended until he complied with the requirements. The respondent subsequently submitted the documentation in time and his licence was not suspended.
- A document prepared by board staff showing that the respondent had indicated he was aware that the required documentation was due by February 17, 2012 and that he would comply.
- The March 13, 2012 Decision of the CAC directing that the complaint be sent to a hearing. Noting that this was the second year in a row that the respondent was delinquent in submitting the required documentation, the CAC recommended that the respondent's licence to practice be suspended until he complied with the requirements. The recommendation of the CAC was accepted by the Board on March 16, 2012 and the respondent's licence to practice was suspended effective immediately.
- A letter from the respondent, attached to his documentation submitted on March 23, 2012, indicating that the documentation was late because of "several miscommunication attempts". It was also noted to the panel that the original notice of audit had been returned by Canada Post because an incorrect address had been provided by the respondent. This was later resent to the respondent at a corrected address.
- A letter sent to the respondent on March 26, 2012 indicating that the submitted documentation had been reviewed and was found to be acceptable and that his licence to practice was reinstated.

The Secretary-Registrar further noted that there had been no request for an extension and no explanation for the respondent's failure to provide the required documentation. The respondent also made no acknowledgement of the Notice of Hearing and had failed to attend the hearing.

Decision of the tribunal:

Having considered the evidence before it, the Adjudication Tribunal found that the respondent's conduct in this matter demonstrated a blatant disregard for the requirements of the Continuing Professional Development audit process. The panel determined that the respondent was guilty of conduct worthy of sanction as defined in section 35(c) subsections i), iii) and iv) of the *Pharmacy Act* and found to be in violation of sections 5(1),9(1),14(1) and 37(1)(w) of the *Pharmacy Regulations*.

As such, the tribunal ordered:

- A formal reprimand be placed on the respondent's file with the Board, which shall be considered public information for a period of three years;
- The respondent must submit his complete Professional Development Portfolio semi-annually in 2012 - in June and December. Failure to comply will result in the filing of an allegation;
- The respondent will be automatically flagged for audit for the years 2012, 2013 and 2014;
- The Order of the Adjudication Tribunal will be published in The Apothecary on an unnamed basis;
- The respondent shall pay the costs of the investigation and hearing, within six months of the Order of the Adjudication Tribunal, or as directed by the Board.
- The respondent is fined $500.00, which shall be paid within 30 days of the Order of the Adjudication Tribunal.

Professional Practice Issues

Error Prevention—Computer Alerts

When dispensing medications, pharmacists must ensure that the right patient receives the right drug at the right dose by the right route at the right time. During the checking process, pharmacists must also look for possible drug-drug interactions, drug-disease state interactions, duplication of therapy, non-compliance, potential abuse or misuse of the drug, possible drug allergies, etc.

Computer systems can play a key role in reducing medication errors during the dispensing process by alerting pharmacy staff of a potential drug-related problem. However, in addition to the clinically significant warnings, computer systems may also provide many clinically insignificant alerts. If the numbers of clinically insignificant alerts are high, pharmacy team members may inadvertently perceive alerts to be a hindrance to workflow and may override these warnings without adequate investigation, especially during busy times. As a result, potential drug related problems may be overlooked resulting in a medication error.

CASE:

A senior citizen was taking Eltroxin® 50mcg once daily. Her physician called her pharmacy to increase her dose to 75mcg once daily. Synthroid® 75mcg was prepared correctly and delivered to the patient. No note was entered into the patient profile regarding the discontinuation of Eltroxin® 50mcg. Approximately one month later, the patient called the pharmacy and requested a refill of Eltroxin® 50mcg. Since refills remained on the old prescription, Eltroxin® 50mcg was processed and delivered. The clinical warning of "duplicate drug" was likely overridden at the computer entry point.

A few weeks later, the patient also requested a refill of Synthroid® 75mcg. This was again dispensed and delivered. It appears that the patient was taking both Eltroxin® 50mcg and Synthroid® 75mcg daily.

Approximately one month later, the patient again requested Eltroxin® 50mcg. On this occasion, the pharmacist noticed the "duplicate drug" alert and called the physician to investigate. On checking the patient's chart, the physician confirmed that the patient should be taking only Synthroid® 75mcg once daily.

POSSIBLE CONTRIBUTING FACTORS:

- Incomplete documentation was made in the patient profile regarding the discontinuation of Eltroxin® 50mcg.
- Synthroid® 75mcg was delivered to the patient. Counseling on the discontinuation of Eltroxin® 50mcg may have been incomplete.
- The patient was unaware that Eltroxin® and Synthroid® was the same drug.

RECOMMENDATIONS:

- If there is a change in drug therapy, inactivate or discontinue the "old" prescription to prevent the inadvertent dispensing of the drug. Appropriate notes should also be added to the patient profile.
- Remind staff of the potential pitfall of looking for "old" prescriptions with repeats to refill.
- Patients must be called for counseling following the delivery of any new medication. Ensure that the patient is appropriately counseled regarding any change in drug therapy. Suggest that the patient return any unused medication for safe disposal. In the interim, suggest placing an X on the prescription label to indicate that the medication should no longer be taken.
- Remind all staff to check all clinical alerts to prevent the inadvertent overriding of significant clinical alerts. Clinically significant alerts should be overridden by pharmacists only.
- If excessive clinically insignificant warnings are received, contact your software vendor to suggest a reduction of the numbers.

Adapted from the Ontario College of Pharmacists Pharmacy Connection Winter 2012

Pharmacy Network: A Year in Review

The Centre for Health Information (the Centre) continues to make progress in Pharmacy Network deployment, including the following highlights from 2011-2012 and exciting plans for 2012-2013.

- *Connection update:* Forty percent of community pharmacies are now connected to the Pharmacy Network, including the DRUGStore Pharmacy Group, Lawtons/Sobeys Pharmacy Group, Zellers, and 26 independents. A resounding thank you to all who have connected to date, including Shoppers Drug Mart on Gibson Drive in Mount Pearl, the latest connection on April 17, 2012.
- *Welcoming new pharmacies*: Pharmacies under the Rexall family of pharmacies using ProPharm Practice Management Systemare scheduled to deploy this month and Walmart Pharmacies are anticipating connection in September 2012. Their patients will join the almost 200,000 patients in our province that currently have a Pharmacy Network profile.
- *Connecting in emergency rooms (ERs):*June will mark an important milestone for Electronic Health Records (EHR) development in our province. Pharmacy Network information will be available in our first emergency room at Western Memorial Hospital via the care provider portal (CPP). As patients present in that ER, the ER clinician will be able to consult the patients' Pharmacy Network medication profile thereby saving phone calls and extensive follow-up contacts with linked community pharmacies. There are plans to roll out the CPP viewer in each Regional Health Authority throughout 2012-2013.
- *Public awareness campaign*: A second Pharmacy Network public awareness campaign is in development, intended to increase Newfoundlanders and Labradorians' awareness of the advantages of their community pharmacies being connected. The campaign theme, "Care is Better When You're Connected", focuses on the benefits to care delivery when pharmacists have access to more complete information. As the campaign implementation gets closer, more details will be provided.
- *Providing support when connecting:* The provincial Peer-to-Peer program has been launched to provide mentorship in the community for clinician connection to the EHR. The Peer-to-Peer initiative is a partnership between the Centre for Health Information and Canada Health Infoway. It is part of a pan-Canadian program that connects experienced peer leaders with their colleagues to provide support and education when transitioning to EHR systems. For the Pharmacy Network, this means **six** experienced pharmacist peer leaders already connected to the Pharmacy Network will be available to share their knowledge and experience with colleagues about to connect. The end goal is to enhance and support your connection experience and adoption of the system.
- *System stability:* The Pharmacy Network is pleased to announce it has turned the corner on the stability issues experienced in December 2011 with the help of positive stability metrics, reports from end-users, and ongoing stability enhancement plans. The Centre will continue to support deployments with on-site education, three month follow-up visits and annual visits.

To discuss the Pharmacy Network advantages, enquire about joining, or book a date for your pharmacy connection, contact the Centre's Service Desk at 752-6006 or 1-877-752-6006, or via email at service@nlchi.nl.ca.

Frequently-Asked Questions—Prescription Forgeries

Drug abuse and diversion are ongoing problems that many pharmacists in Newfoundland and Labrador may encounter in the form of a forged prescription. If you suspect a forgery, take action – first, check with the prescriber to confirm, and then report the attempt to NLPB and to the police.

Why should I report forged prescriptions to NLPB?
Reporting a forgery attempt:

- promotes awareness of recent prescription forgery attempts and forgery tactics;
- helps prevent diversion of drugs, thus maintaining the integrity of the drug system.

How do I report a forged prescription?
You can report a forged prescription:

- by phone at 709-753-5877 or toll free at 1-877-453-5877,
- by email at inforx@nlpb.ca, or
- by fax at 709-753-8615

Be sure to include all relevant details as listed below, as well as a phone number where we can reach you during business hours. If you report a forgery via email or fax, we may follow up with you for additional information or clarification.
The alerts are most effective when sent out shortly after the attempted forgery, so please contact us with details as soon as possible.

What details will I need to provide?
You should include:

- Your pharmacy name and location
- Date of (attempted) forgery
- "Patient" gender
- What the prescription was written for (including strengths and quantities)
- What the prescription form looked like
- The prescriber's name and clinic information printed on the form
- Why you suspected (or how you discovered) a forgery (e.g., signs of alteration, checked Pharmacy Network, the form appeared to be a photocopy)
- Whether or not you were able to confirm the forgery with the prescriber
- Any other relevant information

If I receive a forged prescription, am I obligated to call the police?
A forged prescription may constitute fraud and/or theft. Pharmacists have a responsibility to act ethically regarding their profession, with honesty and integrity. Reporting forged prescriptions to the police is an important step in working to decrease the number of prescription forgery attempts.

Can I give the police a copy of a forged prescription?
In the circumstance of a forgery, prescription information would not be regarded as "personal health information" as defined in the Personal Health Information Act (PHIA). There is a good chance that the patient name, address and MCP number are false. Additionally, if a physician did not write the prescription, then a pharmacist would not be providing "health care" by filling the prescription as defined in PHIA. Therefore, a pharmacist can provide a copy of a forged prescription to the police at their request.

Should I keep a confirmed forged prescription? What if the patient asks for it back?
Generally speaking, pharmacists should attempt to retain the prescription if a forgery is suspected, the prescription could serve as evidence.
If an irate patient demands the return of an unfilled prescription, the pharmacist may choose to return it after stamping and initialling it to indicate that they refused to fill the prescription in question.

What if I have additional questions?
Please contact us at inforx@nlpb.ca , 709-753-5877 or 1-877-453-5877

Recent Updates to the NLPB Website

Contact Us (Find A…)

⇒ *Pharmacists & Pharmacies Registers updated*

"The Apothecary" & Other Communications

⇒ *Advertisement for Secretary-Registrar position*

⇒ *Notice regarding Proper Completion of TRPP Pads*

⇒ *Notice regarding Possible Improper Use of DM-containing Products*

⇒ *MedEffect advisories added*

Complaints and Discipline Resolution

⇒ *New page added*

Registration & Licensing

⇒ *Several forms updated*

Legislation

⇒ *NLPB Binder files updated*

Professional Practice Resources

⇒ *ISMP Canada Safety Bulletins added*

⇒ *Narcotics and Controlled Drugs section updated*

Standards, Policies and Guidelines

⇒ *Standards of Pharmacy Practice - Continuing Professional Development updated*

⇒ *Standards of Pharmacy Practice - Required and Recommended Reference Materials for Newfoundland and Labrador Pharmacies updated*

Pharmacy Technician Regulation

⇒ *Pharmacy Technician Regulation News Vol. 7 added*

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published quarterly by the
Newfoundland and Labrador Pharmacy Board
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