

FPP gains new status

Practice guide has conciliation role

The *Framework of Professional Practice*, a document the CPBC describes as “a blueprint for good pharmacy practice,” now plays an important role in resolving disagreements between community pharmacies and federal government health insurers.

The B.C. Pharmacy Association and the Federal Health Care Partnership (FHCP) agreed to make the *FPP* the reference resource for use in settling professional practice disputes that occur during pharmacy audits. The FHCP represents the Non-Insured Health Benefits (NIHB) program, Veterans Affairs Canada, and the RCMP.

An information sheet the BCPhA sent to its members noted: “During an audit process, any professional practice issues that arise in the course of the audit will be referred to the College of Pharmacists of B.C. to be adjudicated and resolved, listing the *FPP* as its reference document.”

CPBC registrants participated in the creation of the *Framework of Professional Practice*, and it is used as a practice standards guide in daily interactions with patients and other health-care providers.

The college is pleased the BCPhA and the FHCP selected a made-in-B.C. resource for resolving issues between pharmacists and federal government health insurers in this province.

CPBC email

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Updating your email address is simple: log on to the college website, click on the e-Services logo, and follow the prompts. Can't remember your eServices ID? It now appears on all personally-addressed CPBC documents, including your annual registration renewal card.

Once you've updated your email address, you will be entered into a draw for one of two \$100 prizes. The latest CPBC registrants to win are William Heese of Chase, and Ishan Hirji of New Haven, Connecticut!



www.bcpharmacists.org/legislation/pdf/Drug_Schedules_Regulation.pdf

www.bcpharmacists.org/resources/councilcommittees/pdf/council_highlights_sep_06_final_colour.pdf

what went Wrong

Dear college:

Last week, I had dental surgery and my dentist prescribed an antibiotic (Amoxil®) and a pain killer (Toradol®). I prefer to take all my prescriptions to my regular pharmacy as they know me very well, but since I was in a great deal of pain I decided to take them to the nearest pharmacy instead.

At the drop-off counter, the pharmacy technician did not ask me if I had any allergies, so I volunteered the information and told her I was allergic to penicillin. When I returned 20 minutes later, a pharmacist told me how to take the medications and gave me an information sheet about each of them.

I took both the antibiotic and the pain killer as soon as I got home. By the next day, my neck was covered with hives and my face was swollen. I suddenly realized I was experiencing an allergic reaction and called the pharmacy. I told the pharmacist I was allergic to penicillin and asked if there had been an error. The pharmacist told me that Amoxil® is a type of penicillin antibiotic and said there was no record about my penicillin allergy in the pharmacy computer.

I can't believe the pharmacist dispensed Amoxil® even after I told the pharmacy technician about my allergy to penicillin. I know my dentist is partly at fault for prescribing Amoxil® but the pharmacist is also partly responsible. How did this error happen at the pharmacy?

Alarmed about allergies

The pharmacist involved reports that there were two main contributing factors in this situation:

1. The pharmacy technician did not document the allergy information on the original prescription and did not enter it on the local pharmacy computer.
2. The pharmacist processing the prescription did not notice the patient's allergy information on PharmaNet.

Many patients are aware that it is important to inform pharmacists about medication allergies and routinely offer such information. However, the onus is on the pharmacist to obtain this information. Pharmacists are required to include information about allergies on patient records, keep the PharmaNet patient record current, and review PharmaNet with due diligence before dispensing.

How could the above incident have been avoided?

1. Each time a prescription is dropped off, be sure to ask all patients about allergies.

- a. Document the information provided on the original prescription. If an allergy is reported, draw attention to it by using a coloured pen or highlighter or by noting “New allergy” or “Changed allergy status,” if applicable. If no allergy is reported, write “No known allergy.”
- b. Enter the information in your local software.
- c. Update the patient's PharmaNet record if needed.
2. When processing the prescription, review PharmaNet carefully and take note of any allergy information.
3. During the final check of the prescription, review the allergy information noted on the original prescription. If there is no indication of the patient's allergy status, include a note with the medication to ask the patient for the information at the time of pick-up.
4. When counselling, it may be helpful to also mention the family or class of the medication. This can remind the patient to report any allergies and/or idiosyncratic responses that they may have forgotten to mention earlier.

Situations like the one described above provide an excellent opportunity to reflect on your personal pharmacy practice and to make sure your pharmacy has a system in place to identify, prevent, manage, and report practice errors and omissions.