



Emergency Contraception Program Training Sessions Now Available

Steps to implement the Emergency Contraception Program in the province are continuing. Eighty-five pharmacists have been trained by Don Downing, Sanja Ivankovic and Brenda Osmond to deliver the program session to interested participants. These master trainers are located across the Lower Mainland, on Vancouver Island (even in Port Hardy), in Prince George, Tumbler Ridge, Fort St. John, Kitimat, Smithers, the Okanagan and the Kootenays. With this breadth of coverage, there are no additional train-the-trainer programs planned at this time.

The master trainers can now begin training other pharmacists in the Emergency Contraception Program. Pharmacists wanting to attend a training session should contact the BC Pharmacy Association to register.

They will then be linked with a trainer in their area. The cost of the session is \$50 and includes a comprehensive training manual and certificate. The session has been accredited for 3 CEUs. The BCPhA can be reached at Tel: (604) 279-2061, 1-800-663-2840, and E-mail: bcpharm@bcpharm.bc.ca.

College staff are continuing with negotiations to finalize the exact procedures which will be used by pharmacists to supply the emergency contraception medication. A pharmacist prescribing schedule has been proposed, in addition to the previously mentioned collaborative protocol system.

Change Of Name For BC SMILE

The BC SMILE staff and Management Committee have decided to change the BC SMILE name to more completely reflect the range of projects the program has become involved with. Since its inception in April of 1995, BC SMILE has been growing to meet the demands and needs of student and public education. It has been involved in drug utilization research and expanded its

public education programs from the telephone, to weekly presentations, symposia, and radio and television programs.

The BC SMILE acronym will stay the same, but it will now refer to "Service for Medication Information Learning & Education." BC SMILE brochures and posters have been altered to indicate the change. The next BC SMILE Newsletter will be published in March 2000.

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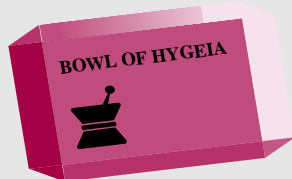
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Your questions and comments about this Bulletin are welcome and may be forwarded to the Registrar.

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Bowl Of Hygeia Nominations Welcome



Through the Bowl of Hygeia Award, Whitehall-Robins honours a British Columbia pharmacist for his/her outstanding community service. The recipient receives a beautiful plaque and an all-expenses paid trip to the United States for the presentation ceremony (conference location to be determined).

The College welcomes nominations from members for this year's award recipient. The Chair of the Selection Committee is Heather Baxter. Nominations should be sent to the Registrar by 1 June, who will then forward all submissions to the committee.

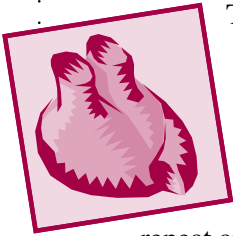


Antiplatelet Therapy Following Coronary Angioplasty And Stent Placement

By Rob Gair BSc (Pharm) and Wendy Gordon Pharm.D

Percutaneous transluminal coronary angioplasty (PTCA) with stent insertion is the current strategy for re-opening and remodelling blocked coronary arteries. Stents are cylindrical devices that help to keep the vessel open. Various strategies have been designed to reduce the risk of subacute thrombosis after stent placement.

Therapies have included acetylsalicylic acid (ASA), dipyridamole, dextran-40, intravenous heparin, and warfarin. The current practice is to combine either ticlopidine (Ticlid®) or clopidogrel (Plavix™) with ASA prior to and following PTCA with stent insertion.



The regimen of ticlopidine plus ASA has been compared in clinical trials to ASA alone, ASA plus warfarin, and ASA plus a combination of heparin and warfarin.¹⁻⁴ The primary endpoint for these studies was similar and consisted of a combination of death, myocardial infarction, or the need for repeat angioplasty. In all cases, ticlopidine plus ASA was shown to be the preferred treatment regimen.

The most common adverse effect was bleeding. Bleeding was documented most often with ASA plus warfarin. Ticlopidine plus ASA was associated with more bleeding episodes compared to aspirin alone.

A significant adverse effect of ticlopidine is neutropenia. Neutropenia is most common in the first three months of therapy and patients require complete blood counts every two weeks during this period. If therapy has been discontinued, an additional complete blood count should be done two weeks after the discontinuation of therapy due to the long half-life of ticlopidine. Some clinicians have chosen to treat with ticlopidine for only two weeks after stent insertion as a result of this adverse effect.

Clopidogrel has emerged as an alternative to ticlopidine. The primary advantage of clopidogrel over ticlopidine is a lower incidence of neutropenia (0.04% vs. 0.8%).⁵ There is no requirement for routine blood monitoring with clopidogrel therapy. Several non-randomized clinical trials have shown clopidogrel plus ASA to be as effective as ticlopidine plus ASA in preventing major adverse cardiac events.⁶⁻⁸ Larger randomized trials are required to validate this information.

The recommended antiplatelet therapy after stent insertion is:

- ▶ Clopidogrel 75 mg daily for one month plus ASA 325 mg indefinitely, or
- ▶ Ticlopidine 250 mg twice daily for two weeks to one month plus ASA 325 mg indefinitely

A 30-day course of clopidogrel therapy costs approximately \$78 compared to \$42 for ticlopidine. Ticlopidine is currently covered as a British Columbia Pharmacare Benefit. Clopidogrel is approved for "Special Authority" coverage in patients who have had either treatment failure or intolerance to ASA.

The combination of ASA plus either ticlopidine or clopidogrel is imperative following PTCA plus stent insertion. If patients are prescribed clopidogrel and are unable to pay for therapy, the pharmacist must contact the prescribing physician. Incomplete therapy may result in subacute thrombosis leading to myocardial infarction and death.

References:

1. Urban P, Macaya C, Rupprecht H, et al. Randomized Evaluation of Anticoagulation Versus Antiplatelet Therapy After Coronary Stent Implantation in High-Risk Patients. *Circulation* 1998;98:2126-2132.
2. Schomig A, Neumann F, Kastrati A, et al. A Randomized Comparison of Antiplatelet and Anticoagulant Therapy After the Placement of Coronary-Artery Stents. *N Engl J Med* 1996;334:1084-1089.
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4. Goods C, AL-Shaibi K, Liu M, et al. Comparison of Aspirin Alone Versus Aspirin Plus Ticlopidine After Coronary Artery Stenting. *Am J Cardiol* 1996;8:1042-1044.
5. Anon. Clopidogrel for reduction of atherosclerotic events. *Med Lett Drugs Ther* 1998;40:59-60.
6. Moussa I, Oetgen M, Roubin G, et al. Effectiveness of Clopidogrel and Aspirin Versus Ticlopidine and Aspirin in Preventing Stent Thrombosis After Coronary Stent Implantation. *Circulation* 1999;99:2364-2366.
7. Mishkel G, Aguirre F, Ligon R, et al. Clopidogrel as Adjunctive Antiplatelet Therapy During Coronary Stenting. *J Am Coll Cardiol* 1999;34:1884-1890.
8. Berger P, Bell M, Rihal C, et al. Clopidogrel Versus Ticlopidine after Intracoronary Stent Placement. *J Am Coll Cardiol* 1999;34:1891-1894.



Three Discipline Hearings Conducted

Value V of the Code of Ethics states that “A pharmacist protects the patient’s right of confidentiality.” Bylaws 40(4)* and 40(14)* describe the only purposes for which a pharmacist may use PharmaNet patient record information: dispensing a prescription, counselling a patient with regard to the patient’s drug therapy, drug usage evaluation, or claims adjudication and payment by any insurer providing drug coverage.

Recent discipline hearings have inquired into the practice of three pharmacists as a result of allegations that they inappropriately accessed patient information in the PharmaNet database.

Danielle Chong (Diploma #7510)

At a Discipline Hearing held 14 December 1999, Danielle Chong pled guilty to professional misconduct related to a number of inappropriate accesses made to PharmaNet patient records.

The College received a complaint that Danielle Chong had accessed a PharmaNet patient record for reasons unrelated to health care. In investigating this complaint, it was determined that between July 1996 and December 1998, Ms. Chong made a number of PharmaNet accesses while working at one community pharmacy.

Ms. Chong acknowledged that many of those accesses were not related to the provision of health care. The accesses demonstrated a pattern rather than an isolated incident. Ms. Chong could not provide an explanation for the accesses.

Although there was a PharmaNet access log kept in the pharmacy, Ms. Chong stated that she was not aware of the existence of this log. The Panel indicated it was Ms. Chong’s responsibility to be aware of and to follow procedures within the pharmacy for recording PharmaNet patient profile accesses when a prescription is not dispensed.

Ms. Chong’s actions were in contravention of Bylaw 40 and Value V of the Code of Ethics. She was assessed a fine and required to pay the costs of the hearing and the investigation. The penalty assessment totalled approximately \$6,500.



Sandford Leung (Diploma #7596)

At a Discipline Hearing held 16 December 1999, Sandford Leung pled guilty to professional misconduct related to a number of inappropriate accesses made to PharmaNet patient records.

The College received a complaint that Sandford Leung had accessed a PharmaNet patient record for reasons unrelated to health care. In investigating this complaint, it was determined that between September 1996 and December 1998, Mr. Leung made a number of PharmaNet accesses while working at two community pharmacies.

Mr. Leung acknowledged that many of those accesses were not related to the provision of health care. Although the accesses demonstrated a pattern rather than an isolated incident he could not provide an explanation for the accesses.

Mr. Leung expressed remorse over his actions. The Discipline Panel, nonetheless, considered his actions to be a most serious offence. His actions violated the Code of Ethics of the College of Pharmacists of British Columbia and compromised the position of trust held by the profession.

Mr. Leung’s actions were in contravention of Bylaw 40 and Value V of the Code of Ethics. He was assessed a fine and required to pay the costs of the hearing and the investigation. The penalty assessment totalled approximately \$6,500.

Stephen Mar (Diploma #7490)

At a Discipline Hearing held 6 January 2000, Stephen Mar pled guilty to professional misconduct related to a number of inappropriate accesses made to PharmaNet patient records.

The College received a complaint that Stephen Mar had accessed a PharmaNet patient record for reasons unrelated to health care. In investigating this complaint, it was determined that between September 1995 and December 1998, Mr. Mar made a number of PharmaNet accesses while working at three community pharmacies.

Mr. Mar acknowledged that many of those accesses were not related to the provision of health care. Although the accesses demonstrated a pattern rather than an isolated incident he could not provide an explanation for the accesses.

(Continued on page 5)



In Brief



Drug Updates



- ◆ As outlined in previous Drug Update *Bulletin* columns, ASA 80 mg greater than 24 requires a prescription. ASA 81 mg does not. The following chart summarizes the requirements:

Package Size and Strength	Schedule
More than 24 ASA 80 mg	I
24 or less ASA 80 mg	II
More than 50 ASA 81 mg	III
50 or less ASA 81 mg	Unscheduled

- ◆ **Minoxidil** in solutions for topical use in concentrations of 2% or less was deregulated to nonprescription status by the federal government, effective 8 February 2000. Regulatory amendments to the British Columbia Drug Schedules also permit the sale of the drug in the above-noted concentration for topical use from the Professional Products Area (Schedule III).
- ◆ The following is a summary of drug interchangeability decisions recently approved by Council:
 - **PMS Verapamil SR 240** remains noninterchangeable with **Isoptin SR 240**.
 - **M-Eslon®** remains noninterchangeable with **MS Contin**.
- ◆ Glaxo Wellcome is discontinuing its **beclomethasone dipropionate** line in Canada as of March. This includes:
 - Becloforte® Inhalation Aerosol
 - Beclovent® Inhalation Aerosol
 - Beclovent® Rotacaps® (100 mcg and 200 mcg)
 - Beclodisk® (100 mcg and 200 mcg)
 - Beconase® Aq. Nasal Spray

▶ Duplicate/Triplicate Prescription Changes

In order to ensure consistent responses to registrants, it was decided that it is acceptable for the pharmacist to change information on a duplicate/triplicate prescription form except the drug entity name and the total authorized quantity. All change notations should be documented following consultation with the prescriber (if the change requires consultation).

▶ Additional Drug Added to Multiple Strengths List

M-Eslon® (morphine sulfate) has been added to the list of selected Duplicate/Triplicate Prescription Program drugs for which more than one strength can be included on the same prescription form.

▶ Veterinary and Poison Register Changes

Pharmacists are advised that it is no longer necessary to record veterinary drug and poison sales in a register (although you can continue to do so voluntarily).

▶ Compliance Standards Update

In response to requests for Council to review the *HealthNet/BC Professional and Software Compliance Standards*, Council has completed a bylaw review. It has recommended a number of changes which will be submitted to the Ministry of Health for consideration.

▶ Usefulness of Manager's Audit

In response to concerns expressed by several members, the College would like to remind pharmacists of the beneficial purpose of the Manager's Audit, part of a pharmacy's annual license renewal process. The self-inspection is completed by the manager to note and correct any deficiencies before a College Practice Consultant visits the pharmacy. There are often educational opportunities from the audit, with managers learning more about regulations and becoming aware of non-compliant issues in their site before problems develop. If no problems are found during the consultant's visit, the manager and consultant can focus on other matters important to the manager.

▶ Updating Information File Binder

Members are reminded to discard old material and update their Information File binder with the important new legislation material sent out in January: updates to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*; an entire Bylaws document; new annual election rules; as well as amendments to Food and Drugs Regulations and to Narcotic Control Regulations.



Ethics In Practice



Moral Conflicts in Pharmacy Practice

The Code of Ethics adopted by the College of Pharmacists of British Columbia acknowledges that some pharmacists have moral objections to providing certain recognized pharmacy services. As a compromise, the Code recognizes conscientious objection as long as patients are not denied legitimate services. These pharmacists must refer patients to colleagues who will provide such services, and in the end deliver these services themselves if it is impractical or impossible for patients to otherwise receive them.

Pharmacy, like all professions, has been granted a monopoly right to provide services to the public. And professions have an obligation to provide recognized services to the public, because the public has no alternative. For this, professions receive prestige and financial reward. In the case of pharmacy some might argue we received one without the other, but this is another subject.

Individual pharmacists may experience conscience problems when requested to provide services to which they have a moral objection. At present these services might include provision of contraceptives, syringes and needles for drug addicts, emergency contraceptives, high doses of narcotics to control intractable pain that might hasten death in the terminally ill, and medications for terminal sedation. In future these services might expand to include preparation of drugs to assist voluntary or involuntary suicide, cloning, genetic manipulation, or even execution.

Some pharmacists have argued that if they have a moral objection to providing certain pharmacy services, neither they nor the profession has an obligation to see that patients are provided with these services, and patients should not receive them. They should be able to dissuade patients requesting these services by denying their availability, or providing information under the guise of patient counselling. In some jurisdictions so-called “conscience clauses” have recognized these arguments.

The moral position of an individual pharmacist, if it differs from the ethics of the profession, cannot take precedence over that of the profession as a whole. The public cannot be expected to consider it to be just bad luck if patients are refused recognized pharmacy services because their pharmacists have moral objections to providing them. And the profession cannot allow pharmacists to lie about the existence of these services or promote their moral viewpoint in an attempt to persuade patients not to seek recognized pharmacy services they find objectionable.

Discipline Hearings

Continued from page 3

The Discipline Panel noted that Mr. Mar’s actions did not appear to be malicious and no individual appeared to have suffered from his actions, and he did express remorse over his actions. Nonetheless, the Panel found that this was a significant breach of privacy and confidentiality which jeopardized the public’s trust in pharmacists.

Mr. Mar’s actions were in contravention of Bylaw 40 and Value V of the Code of Ethics. He was assessed a fine and required to pay the costs of the hearing and the investigation. The penalty assessment totalled approximately \$6,500.

** These cases occurred and were heard before the approval of the December 1999 Bylaws. The bylaw numbers in this article relate to the bylaws that were in effect before December 1999.*



Council Highlights

The Council of the College of Pharmacists of BC met on 11 February. A full agenda was completed, and the following are some highlights from Council's discussions:

- ▶ The possibility of developing guidelines for the electronic storage of original prescriptions was raised. It was determined that the necessary equipment and procedures would be very expensive and time-consuming to develop. The topic will be reconsidered when the required technology has evolved further.
- ▶ The Community Pharmacy Practice Committee will be requested to develop recommendations and practice guidelines for the repackaging of bulk nonprescription drugs for sale from the Professional Services Area (Schedule II) and the Professional Products Area (Schedule III) of pharmacies.
- ▶ Council will submit recommendations to the Minister of Health for bylaw amendments to remove the mandatory inclusion of certain patient characteristics (such as weight, tobacco use, alcohol use, laboratory data, etc.) on pharmacy and PharmaNet patient records. The inclusion of allergies and idiosyncratic reactions would still be required. The current requirements remain in force until the government approves the bylaw amendment.
- ▶ Correspondence will be sent to the Ministry of Health to outline problems with submitting patient address updates on PharmaNet's client registry screens. The ministry will be requested to develop a mechanism to enable addresses to be automatically updated with the pharmacy's transmission of prescription information to PharmaNet.

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Hospital Pharmacy Insights



Fatal KCl Errors

Potassium chloride (KCl) injection that is infused too rapidly or given by direct IV can cause cardiac arrest. There are numerous reports of accidental deaths that have occurred in hospitals across North America as a result of medication errors where KCl concentrate has been given by direct injection. The most commonly reported scenarios include:

- ◆ A KCl polyamp is picked up instead of normal saline. KCl concentrate is then accidentally used to flush an IV line.
- ◆ KCl is stored next to heparin and is accidentally used to flush a central venous catheter.
- ◆ A KCl polyamp is picked up instead of sterile water for injection. KCl is used to reconstitute a medication given by IV push.
- ◆ Medication orders commonly include orders for furosemide 40 mg IV push and a concurrent IV infusion with KCl 40 mmol/L. Many errors have been reported where "40" of KCL was given by direct IV instead of "40" of furosemide.

If your hospital still has KCl concentrate available as stock on any nursing unit, this error could happen at any time.

Preventing KCl Errors

The single most effective way to prevent KCl medication errors is to remove KCl concentrate from all nursing units, including medication storage areas, medication carts, unit dose carts, nightcupboards, etc.

Strategies to Remove KCl Concentrate

- ◆ Begin a campaign to educate physicians and nurses about the risks and potentially fatal consequences of KCl medication errors.
- ◆ Encourage physicians to prescribe oral KCl whenever possible.
- ◆ Premixed KCl large volume parenteral and minibags are commercially available. The increased cost of the premixed solutions is far outweighed by the potential consequences of a KCl error.
- ◆ Prohibit the addition of KCl concentrate to premixed KCl solutions. KCl concentrate can pool at the injection port, effectively delivering a "bolus" of KCl to the patient.
- ◆ Use automatic substitution orders (e.g. For orders for 1-30 mmol KCl/L, substitute premixed 20 mmol KCl/L. For orders for >30 mmol KCl/L, substitute premixed 40 mmol KCl/L).
- ◆ Update the hospital's KCl IV monograph. The monograph should note the use of premixed solutions only, the maximum IV infusion rate, the use of an infusion device to prevent "runaway" infusions of KCl, etc.



Long-term Care

Long-term Care Checklist

As a provider of pharmacy services to facilities and group homes, a pharmacy is required to meet the following criteria:

Description	Frequency	Documentation *
		<i>* To be available in the pharmacy for the period stated below.</i>
Monitored dose system	Routine medications must be supplied automatically on an agreed upon cycle (e.g. monthly or 35 day); prn medications are re-ordered by the facility on a when-needed basis	
Medication Administration Record	Provided monthly, showing the month and year of use (not just the date on which they were printed)	3 years if a pharmacy copy is being initialled and dated as the accountability log for refills. Otherwise, no need to keep a pharmacy copy.
Medication room inspection	Every 3 months for a care facility (7 beds or more); once a year for a residential care home (3 to 6 beds)	3 years (and a copy of the report supplied to the facility)
Medication review	Every 6 months, at the facility , with the physician attending if possible, along with appropriate facility staff. Reviews for residents of a group home (3 to 6 beds) need not be done on site	A summary of the review must be kept for 3 years (and a copy supplied to the facility)
Physician authorization letters	Every 6 months (usually sent immediately following the medication review, or signed by the doctor at the medication review)	3 years
Medication Safety and Advisory Committee meeting	Every 6 months, at a care facility. Often occurs during the same session as medication reviews, but covers different topics (e.g. policy and procedure matters, concerns, etc.)	3 years
Standing orders, if applicable, as determined by each facility's Medication Safety and Advisory Committee	Must be signed and dated by the physician every 12 months	A copy of a resident's current standing orders must be readily accessible to the nursing staff
Contingency medications, if applicable, as determined by each facility's Medication Safety and Advisory Committee	Reviewed occasionally by the Medication Safety and Advisory Committee to ensure that the items listed are still appropriate	A copy of the Contingency Medication list must be readily available to facility staff
Policy and Procedure Manual, specific to <u>each</u> facility and agreed upon by the Medication Safety and Advisory Committee	Must be reviewed occasionally by the Medication Safety and Advisory Committee to ensure that it reflects current regulations and the facility's current procedures	A copy of the Policy and Procedure Manual must be readily available at the facility and pharmacy

If you require further assistance, please contact your Community Pharmacy Practice Consultant at the College office (733-2440, 1-800-663-9430): Margaret McLean (Lower Mainland) - ext. 235, Donna Hayward (Vancouver Island) - ext. 404, or Regan Ready (Interior) - ext. 401. You may also reach us by e-mail and fax.



Community Pharmacy Corner



Quality Management

The development of a quality management program is a requirement of both the Community Pharmacy Bylaw (Section 27) and the Residential Care Facilities and Homes Bylaw (Section 54).

This program will be an ongoing process of developing and updating policies and procedures to comply with the legislation and current pharmacy practice standards. Pharmacy managers and their staff members are expected to ensure that:

- ▶ The policies and procedures are documented,
- ▶ There is a process to monitor them for compliance,
- ▶ There is a process to monitor the outcomes for appropriateness and accuracy.

Most pharmacies already have much of the information that this section of the bylaw refers to. In many instances this will simply involve consolidating the information and ensuring that there is proper documentation. For instance:

- ▶ The Manager's Audit is now being distributed on an annual basis. This is an opportunity for the manager to review procedures with staff to ensure that the procedures are still appropriate to your practice as well as meeting the regulations; to encourage staff input to changes or additional steps that could be taken; and to ensure that the policies and procedures in place are, in fact, being followed by everyone.
- ▶ Job descriptions should be formalized, specifying functions that are the responsibility of the pharmacists and clarifying what the limits are for technicians and clerks.
- ▶ The College's *Framework of Professional Practice* sets out many points that could be used in formulating policies and procedures.
- ▶ Most pharmacies have written policies about handling errors and complaints. The policy should include an educational element whereby the staff reviews errors to determine why they

happened and what can be done to workflow, checking procedures, pharmacy layout, etc. to reduce or eliminate the chance of them happening again.

The Community Pharmacy Practice Committee and the Long-term Care Committee will be offering suggestions in future *Bulletins* as the program evolves. And, as always, ideas from all pharmacists are welcome.

Automated Tablet Dispensers

The Community Pharmacy Practice Committee has discussed the use, in community pharmacies, of Baker Cells and various cassette-type counting machines. The committee recommends that pharmacy managers review the following points and ensure that there are effective policies in place for automated dispensing machines and that the policies and procedures are clearly communicated to all dispensary staff.

1. Drug Identification

The cell or cassette needs to be identified with the drug name, lot number and expiry date of the stock currently in the cell. It is not acceptable to ignore this requirement on the basis of the drugs being "fast-movers."

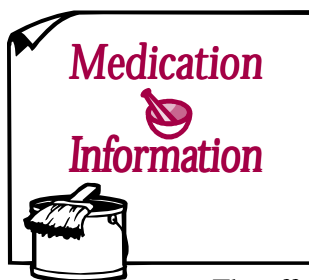
It is also a good idea to include the DIN on the cell label. The person who retrieves the tablets takes the prescription label to the cell and can then compare the DIN on the label with the DIN on the cell.

2. "Topping up"

Cells and cassettes must never be "topped up." The containers are to be empty of stock before being refilled. This is to prevent a mixing of lot numbers and expiry dates, and stock bearing different markings.

3. Physically separate look-alike drugs

Look-alike drugs should have their cells well separated to minimize the chance of the wrong drug being accessed in error when several orders have been processed at approximately the same time.



4. Retrieving the medication

In the case of Baker Cells, the computer should print a cell number. This serves as another check, in addition to comparing the DINs, for the technician when retrieving the medication from the machine. It also directs the pharmacist to the proper cell for their own visual check.

Medication should be retrieved immediately from the chute. If the medication is not found when expected, the matter needs to be investigated immediately. It may be that the medication was retrieved in error by someone else.

In the case of cassettes, the cassette should be placed with the dispensed prescription for the pharmacist to check, just as with a stock bottle.

5. Accountability

The filling of the cell or counting machine cassette needs to be checked by a pharmacist. An accountability record has to be kept of the cell-filling date and the handwritten identification of the pharmacist who checked the stock.

6. Responsibility

The most important point is that the pharmacist is ultimately responsible. Procedures must be in effect that permit the pharmacist to feel confident that the correct drug is being dispensed.

Medication Information Sign

Section 28(4) states that “a sign reading ‘Medication Information’ must be clearly displayed to identify a counselling area or counter at which a member of the public can obtain a registrant’s advice on Schedule I, II, and III drugs.”

The required wording is “Medication Information.” It is important to encourage people to seek advice from the pharmacist regarding nonprescription medications and to make it clear that the pharmacist is available. “Medication Information” is the term that was determined to be most universally understood by the public.

The effectiveness of this sign, of course, depends on it being clearly visible to the public from the Professional Products area of the pharmacy.

Three-Year Retention of Records

Prescriptions and other pharmacy records are now required to be retained for **three** years from the last dispensing date instead of the former two years.

Most pharmacies set a date of two years, past which they will not refill a prescription. Instead it is treated as a new prescription and given a new number. This sets a “baseline.” You then know that you need to keep prescription files for three years **past** that date, a total of 5 years from the current date.

The previous requirement was explained in the May/June 1998 *Bulletin*. It may be helpful to review that article, keeping in mind the new requirement (three years from the date of the last refill instead of two years).

Accepting Orders from Nurses

Council’s policy permitting a pharmacist to dispense a prescription transferred by certain designations of nurses was printed in the March/April 1999 *Bulletin*. The Long-term Care Committee reminds pharmacists that if they and their facilities are implementing the procedure, there must be a written policy formulated by each facility’s Medication Safety and Advisory Committee, and appropriate measures taken to ensure that facility staff members understand its application.

The committee recommends that, besides the points noted in the *Bulletin* article, the policy incorporates the requirement that staff members who are sending orders to the pharmacy include their professional designation on the order, and that a list of the RNs, Registered Psychiatric Nurses and graduate nurses on staff be provided to the pharmacy for reference.



Rx C.A.R.E Program

Participation Update

There are 893 participants in the first cycle of the ^{BC}C.A.R.E. Program. They registered for the assessment choices as follows:

Practice Review with Peer Consultation	260
Professional Portfolio	83
Knowledge Assessment	550

For the Knowledge Assessment, 120 people registered for the February sitting, and 125 registered for the April sitting. The balance will be required to sit in April or request a further deferral until the fall sitting. There have been 46 transfers in and out of the three assessment options.

Fifty-five one-year deferrals have been granted (for medical, schooling, pregnancy, maternity, and out-of-country reasons). Six five-year deferrals have been granted for individuals who have recently completed Doctor of Pharmacy degrees, a College peer review procedure, and continuing competency programs required by other provincial regulatory authorities.

Four participants were given deferrals due to disabilities, 42 individuals decided to transfer to the Nonpractising Register, and one person was transferred to the Suspended Register. Fifteen people have declined to participate.

Participant Feedback

In beginning to work through their ^{BC}C.A.R.E. assessment material, some of those individuals selected for mandatory participation have forwarded comments and questions to the College.



Highlights include:

Practice Review:

- require assistance in identifying peers, clarifying peers' role
- need guidance in interpreting *Framework* for non-traditional roles
- need clarification re: completing ratings if not applicable but person still able to perform functions

Professional Portfolio:

- need guidance in writing narratives, linking with evidence, amount of evidence, indexing
- require assistance in interpreting *Framework* and explaining if not applicable

Knowledge Assessment:

- need study tips, references, sample questions
- request to sit in on review even though not in selection

General:

- timing issues
- relevance questions
- standards issues - what is required to pass?
- understanding consequences of: limited portfolio, not passing, not doing a number of functions in practice.

The College has found this participant input very useful and welcomes ongoing questions, comments and requests to use in the continuing refinement of the ^{BC}C.A.R.E. Program.

For More Information . . .

For current information on the ^{BC}C.A.R.E. Program and its assessments, or to share feedback, members can contact the College office or view the ^{BC}C.A.R.E. web site at www.rxcare.com.

Council Highlights

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- ▶ The Council proposed a bylaw amendment that would allow pharmacists to withhold nonprescription, nonbenefit items from transmission to PharmaNet. Until the bylaw amendment is approved by the government, the current requirement that all drugs processed as prescriptions must be transmitted to PharmaNet remains in force.
- ▶ Council considered concerns expressed by pharmacists about the entry of PharmaNet user identification during the prescription preparation and counselling process, but decided not to recommend any changes to the current requirements.

Pharmacists are invited to contact the Councillor from their district if they would like to have more information on these topics or if they have any questions about the Council's discussions.



Appropriate Access To PharmaNet

All accesses to a PharmaNet patient record, clinical conditions or adverse reactions are recorded on the patient's access record when no prescription is dispensed for that patient. The information recorded includes the pharmacist making the access, the pharmacy from which the access took place, the date of the access and the type of transaction (e.g. Profile request, Profile mailing, Drug Utilization Evaluation (DUE) inquiry).

The bylaws state that a pharmacist may access a patient's PharmaNet record only for the purposes of dispensing, counselling a patient with regard to the patient's drug therapy, drug usage evaluation, or for claims adjudication and payment by any insurer providing drug coverage. All other accesses to PharmaNet patient records are considered inappropriate.

The College has implemented an "Appropriate Access to PharmaNet Patient Records" audit to ensure that patient records are only accessed for appropriate reasons. Pharmacists are being asked to explain the reason for an access to the patient record where no prescription has been dispensed to the patient on the date of the access. The pharmacist identified on this access log is accountable to the patient and the College for the access.

HealthNet/BC Professional and Software Compliance Standards require the pharmacist responsible for the transaction to be individually identified prior to communication with PharmaNet. In some

cases, however, the in-pharmacy computer software allows only one pharmacist to be "signed on" at a time. In a 1999 discipline hearing regarding an inappropriate access to a PharmaNet patient record by a pharmacist, it was determined that some accesses to the patient record were made by the defendant using other pharmacists' IDs. To ensure that you are not asked to explain an access to a patient record that was actually made by another individual sharing a computer terminal, remember to log out of the computer when you are not responsible for the local patient record review, entry of the details of the prescription, or review of the Drug Utilization Evaluation (DUE) results and PharmaNet patient record returned from PharmaNet.

Some software vendors provide functionality that permits the entry of a "reason for access" when a PharmaNet patient record is accessed. If this functionality is not available on your in-pharmacy software, you should implement a system to manually record accesses (e.g. a note in the comment field of the local profile, an access logbook, a hard copy in the prescription file). Any system should include the patient name, personal health number, date of access, reason for access and pharmacist name. Reasons for access to patient demographics where the patient is not on your local system should also be recorded.

Prescriptions Not Picked Up By The Patient

Pharmacists are reminded that the new bylaws of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* require prescriptions not picked up by the patient within 30 days of the original fill date to be returned to stock. Pharmacists, emergency room physicians, and soon physicians in private practice, rely on the PharmaNet to provide accurate and current information about a patients' medication history. Prescriptions awaiting pickup may provide incorrect information which may potentially result in a pharmacist refusing to fill a prescription.

Patient Education Monographs

In the past, when no specific patient education monograph has been developed for a drug, FirstData Bank (FDB) has provided a general monograph. Since this monograph provides no specific information to the patient, but rather very general recommendations such as contacting a physician or pharmacist in the case of side effects, FDB will be discontinuing these general monographs in March 2000. In cases where no specific monograph is available when requested, PharmaNet will return "No monograph available at this time."

Please report those drugs which do not have patient education monographs to the PharmaNet Coordinator at the College office to ensure that PharmaNet is updated with a specific monograph.



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Resource Source



◆ Health Canada Health Information Service Web Site

Health Canada's has a new internet health information service at www.canadian-health-network.ca. The web site is organized into 26 major health topics and has links to more than 5,000 internet-based resources that meet criteria for credibility set out by the network's countrywide advisers. Its goal is to provide "health information you can trust." The network has been developed in partnership with over 350 health organizations.

◆ Final Paper in Pharmacy Practice Toolkit

The National Association of Pharmacy Regulatory Authorities (NAPRA) has its final toolkit information paper, **Recycling and Disposal of Dispensed Drugs**, now available at its web site, www.napra.org, in the *Canadian Pharmacy Information* section. For further information, contact NAPRA at Tel: (613) 569-9658, E-mail: napra@istar.ca.

◆ Updated Legal Handbook Available

A second and expanded edition of the **Legal Handbook for the Helping Professional** is now available (Max R. Uhlemann, David Turner, Editors, University of Victoria). Chapters summarize key legal information (with a British Columbia focus) in specific areas of daily practice and include answers to commonly asked questions.

The 435-page book is \$48 (including Canadian postage). Orders, with cheque or money order (payable to The Sedgewick Society), should be sent to: The Sedgewick Society, c/o Dr. Max Uhlemann, Dept. of Psychological Foundations in Education, P.O. Box 3010, University of Victoria, Victoria, BC V8W 3N4.



Plan To Attend

▶ Panel Assessments

Saturday, 10 June

Saturday, 4 November (*to be confirmed*)

▶ Council Meetings

Friday, 14 April

Friday, 16 June

▶ Forensic Assessments

Friday, 9 June

Friday, 3 November (*to be confirmed*)

▶ BC Pharmacy Conference

12-15 October

Renaissance Hotel, Vancouver

People News



Achievements

- ▶ College member and pharmacist at Kimberley Drug Mart for 15 years, **Gerry Semenchuk** has been nominated Kimberley's Citizen of the Month. As explained by an appreciative customer, "this community is fortunate to have such a responsible and caring pharmacist." Congratulations Gerry!

The Bulletin newsletter provides important College and pharmacy practice information. All pharmacists are expected to be aware of these matters. Licensed pharmacies must have the last three years of Bulletin issues on file as per reference library requirements.