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Vol. 31 No. 4 July/August 2006

PDAP feedback positive

Participants score well, provide useful survey replies

The results are in, and they're good on both fronts. CPBC registrants who participated in the inaugural run (cycle 1) of the college's Professional Development and Assessment Program scored well and provided positive feedback on their experiences.

Over 90 per cent of pharmacists selected to take part in PDAP cycle 1 met assessment standards in both the knowledge assessment (KA) and learning practice portfolio (LPP) segments. PDAP includes a participant program assessment, and feedback from over 60 per cent of cycle 1 participants has been used to refine cycle 2, which begins this fall.

The executive summary of participants' feedback is posted on the college's website.

PDAP provides a framework for continuous improvement in pharmacy practice delivery. Those cycle 1 participants who developed an LPP or wrote the KA said the process taught them something new about their knowledge, skills, and/or abilities, and correspondingly, participation increased awareness of skill-set gaps and limitations.

Cycle 1 survey highlights

The KA and LPP assessment options scored well in several areas:

- Practice needs: 76 per cent of LPP participants said the LPP helped link professional development activities to practice needs; 78 per cent of KA participants said the KA reflected common pharmacy practice.
- Learned something new about knowledge, skills, and/or abilities: 70 per cent of LPP participants and 53 per cent of KA participants said they learned something new about their knowledge, skills, and/or abilities.
- Recommend assessment option: 63 per cent of LPP participants said they would recommend the LPP to their peers; 90 per cent of KA participants said they would recommend the KA to their peers.
- Increased awareness of gaps/limitations: 54 per cent of LPP participants found the LPP process provided an increased awareness of gaps/limitations in knowledge, skills, and/or abilities; 57 per cent of KA participants found the KA provided the same type of increased awareness.
- Encountered difficulties in understanding or applying policies: 19 per cent of LPP participants found this to be true; seven per cent of KA participants found this to be true.

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PharmaNet pumps up

eHealth adds more capacity

PharmaNet, a tool community pharmacists use everyday, is about to be improved as part of an electronic health records initiative.

The provincial government's eHealth strategic framework consists of more than 20 projects, and is designed to integrate electronic patient records and connect pharmacists, doctors, and other health-care providers in a new way. eHealth will fully comply with all privacy and security legislation.

continued on page 4

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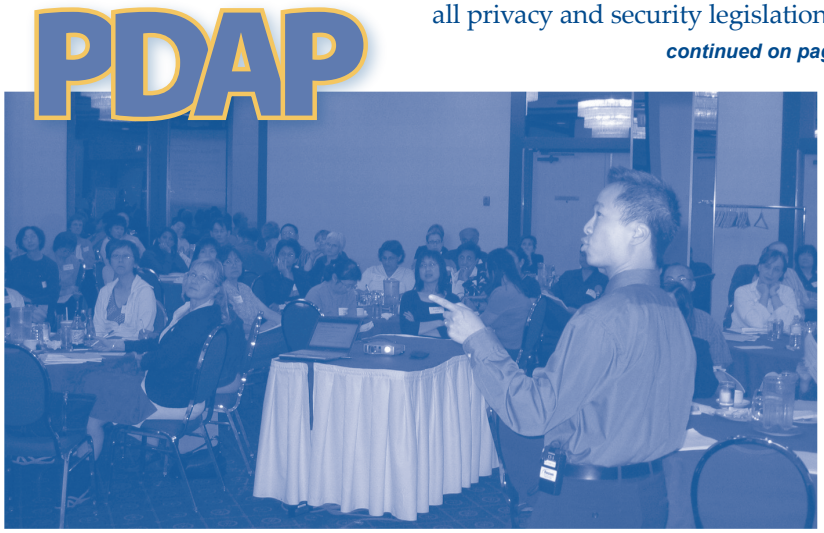

Raymond Jang, a pharmacist who works at Richmond Hospital, co-moderated a June 7 PDAP orientation session in Vancouver.

COLLEGE of PHARMACISTS OF BRITISH COLUMBIA

www.bcpharmacists.org

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ReadLinks

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***ReadLinks* Editor in Chief:** Marshall Moleschi
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Your questions and comments about this newsletter are welcome and may be forwarded to the registrar.

The *ReadLinks* newsletter provides important college and pharmacy practice information. All pharmacists are expected to be aware of these matters.

Printed on Recycled Paper

from the
Registrar


Marshall Moleschi

Tech talk

In 1979 California high school student Kristi Jones got a chance to volunteer at a local hospital to earn work-study credits. Kristi was assigned to the pharmacy and was soon hired as a part-time pharmacy technician. This was a very cool opportunity for a 17-year-old.

In 1985 Kristi relocated to Seattle. She was surprised to find that Washington, unlike California, required pharmacy technicians to be licensed by the Washington State Board of Pharmacy. With the help of a preceptor, Kristi obtained her pharmacy technician accreditation. There was something very satisfying about receiving a license acknowledging her position as a certified health-care professional.

Now, 20 years later, this scenario could soon be playing out in Canada. Earlier this year, CPBC council established a pharmacy technician task force to explore accreditation and licensing options in B.C. At its April 2006 meeting, council approved "The pharmacy technician task force recommendation that the CPBC establish a new class of licensure for pharmacy technicians." While this is just a first step, it is significant. Over the next few months the college will set up a steering committee to guide the development of this new plan.

Other provinces are working on similar initiatives. In May 2006, Ontario's Health Professions Regulatory Advisory Council recommended that pharmacy technicians be formally regulated as an independent profession, and as a separate class of registrant under the Ontario College of Pharmacists. Alberta is also working on a regulatory framework for pharmacy technicians. Elsewhere, pharmacy technicians in the United Kingdom and most American states are licensed and regulated.

Why should pharmacy technicians be formally recognized as health-care professionals? Their role has undergone substantial change over the years, and pharmacy technicians in hospital and community pharmacies now have expanded responsibilities based on their training, experience, and qualifications. However, there is no standardization in these areas. Additionally, with practice innovations, increased prescription volumes, and greater demands on pharmacists to use their medication knowledge for counselling, the need for standardized pharmacy technician training and regulation is apparent.

Why should pharmacy technicians be regulated? As pharmacy technicians take on new tasks that reflect changing practices, accountability needs to be addressed. Currently, only pharmacists can be held responsible for pharmacy technicians' work. Regulation of pharmacy technicians would hold them responsible for their own actions in a pharmacy, freeing up pharmacists from supervising and allowing them to focus on direct patient care.

Ontario has already defined roles, competencies, skills, standards, and a code of ethics for pharmacy technicians. Alberta is not far behind, and now B.C. has started on a similar path. Twenty years later, if Kristi moved to B.C., she would see that pharmacy technicians are on their way to becoming recognized health professionals.

HPA brings minor changes to pharmacy

Health Professions Act-related confusion between pharmacy and nursing clarified

In 2003 the Ministry of Health notified the college that the regulation of pharmacy practice would be moved under the Health Professions Act (HPA). We expect that this transition will occur in the near future.

This transition is consistent with a trend in other provinces to regulate all health professions under one act. Essentially, the basic requirements for regulating every health profession are the same: accountability for standards of practice; conducting quality assurance programs to ensure the profession meets those standards; administering rigorous and fair registration processes; and providing a mechanism to review public concerns about practitioners. The Health Professions Act is accompanied by regulations and bylaws that are specific to each profession.

There will be few changes to the way the CPBC conducts its business. Council will continue to consist of a majority of pharmacists. PDAP will remain, as will other quality outcomes programs such as pharmacy site visits and professional conduct reviews. While there will be adjustments in how the college administers some programs, for the most part this transition will have a minimal impact on the day-to-day work of pharmacists.

The Ministry of Health has made it clear that the HPA will not dramatically change the scope of pharmacy practice. As we get more information about the timing of the transition, we'll be sure to keep you informed.

Along with pharmacy, medicine and dentistry will soon be under the HPA. The College of Registered Nurses of British Columbia (CRNBC) is the most recent organization to be brought under the HPA, a move which included the mechanism to register nurse practitioners.

When nursing moved under the Health Professions Act, there was some confusion about long-standing practices in hospital pharmacy because the regulations for nurses state that there are five health professionals who can give orders to registered nurses: physicians, dentists, midwives, podiatrists, and nurse practitioners. In recent discussions with CRNBC we have been able to clarify that pharmacists are currently permitted, and will continue to be permitted under the HPA, to interchange or substitute medications in certain circumstances, and to adjust medication orders under a therapeutic interchange program or protocol approved by the governing body of a hospital. This clarification is described in a joint statement issued in June 2006 and is available for viewing on the college website.

Go www

www.bcpharmacists.org/resources/hospital/

PARENTAL LEAVE REMINDER

New parents can apply for registration fee refund

Are you a soon-to-be mother or father planning to take time off to enjoy being a new parent? College of Pharmacists of B.C. registrants can apply for registration fee reimbursement if they are on parental leave, and do not intend to practise during this period.

To take advantage of this opportunity, registrants must submit a completed Application for Fee Reimbursement form within one month of beginning leave. The reimbursement is pro-rated to cover the remainder of the current year's registration fee, minus a $150 (plus GST) administrative fee.

Along with the reimbursement form, registrants need to include their current registration fee receipt; a new receipt for the revised amount will be issued. As part of the leave, the registrant's name is transferred to the non-practising register. A one-year CPBC mail subscription keeps new moms and dads in touch with the college at no charge.

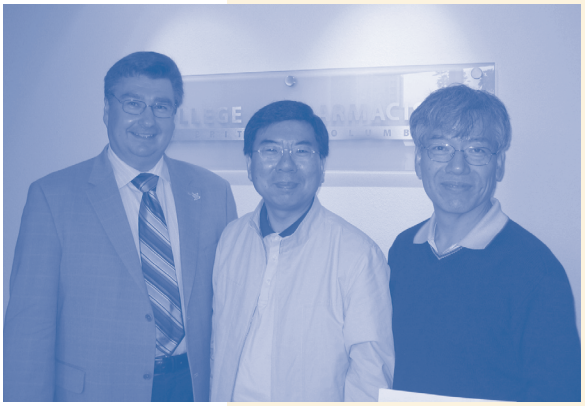
When ready to return to work, registrants complete a Pharmacists Returning to Practice from Maternity/Parental Leave application, along with the current registration fee. Those registrants who return to work within 14 months of transferring from the non-practising register will have the return-to-practice transfer fee waived.

The forms for maternity/paternity leave reimbursement and return are posted on the college website.

Go www

www.bcpharmacists.org/registration/

Registrar Marshall Moleschi, right, hosted a group of visiting Korean pharmacists at the college in June.



Left to right: Registrar Marshall Moleschi; Park Young Dal, Euiwangsi Pharmaceutical Association; Peter Son, Robson College.

PHARMACY ELSEWHERE

ALBERTA

Pharmacists in Alberta have moved ahead of their Canadian peers on two fronts. Later this year, specially certified pharmacists will be able to prescribe some drugs, continue prescriptions initiated by other prescribers, and administer injectable treatments, such as vaccines. And earlier this spring, Alberta pharmacists gained electronic access to patient lab results, as part of the province's electronic health record initiative. By this summer, 85 per cent of all provincial lab results should be available electronically to Alberta health-care practitioners.

Source: Province of Alberta news release, May 31, 2006; *ACP News*, May-June 2006

ONTARIO

An overhaul of the province's prescription drug system has raised the hackles of some community pharmacists. Ontario's needs-based drug plan, similar to B.C.'s PharmaCare, cost the province $3 billion in its last fiscal year and has been growing by 10 per cent annually since 1997, three times the rate of Ontario's tax revenue. To address pressures on government and private plans, Health Minister George Smitherman has said pharmacists must accept reduced rebates from generic drug manufacturers that are paid as an incentive to stock generic products. Smitherman has also announced a slight increase to the provincial dispensing fee, and an extra $50 million to pharmacists for medication counseling.

Source: *Globe and Mail*, May 16, 2006; *Health Edition*, June 9, 2006

UNITED KINGDOM

Pharmacist prescribing is running behind schedule in the U.K. An "independent prescribers" initiative announced last September and scheduled to be in place by this spring has hit a number of roadblocks, including the lack of a nation-wide electronic medical record system. The Royal Pharmaceutical Society of Great Britain is working with the government on patient-record access, as well as developing prescriber-training programs and convincing U.K. physicians that the initiative is a good one. Pharmacists can currently train to be supplementary prescribers, which allows them to practise with a doctor upon the approval of their local health authority. Just over two-thirds of pharmacists are supplementary prescribers.

Source: *Canadian Pharmaceutical Journal*, March/April 2006

PharmaNet

continued from page 1

PharmaNet is recognized worldwide for its capabilities, and will play a key role in the development of eHealth. Projects underway include:

- Developing a laboratory information bank;
- Expanding telehealth access to specialists for patients in rural and remote communities; and
- Capturing and sharing diagnostic images such as x-rays, ultrasounds, and MRIs.

PharmaNet's recent expansion to medical practices is a first step in the electronic health records strategy. Ministry of Health background material states, "The future vision for PharmaNet not only includes expanding authorized access to medication information but also encompasses expanding the contents of the medication profile to include inpatient, long-term care and cancer medications. This will not only enhance the accuracy and completeness of the medication profile, but will reduce the time required to obtain medication histories." Greater access by individual citizens to their own health records is also planned.

On the health professions' side, drug-to-drug interaction alerts, clinical prescribing guidelines, and PharmaCare formulary information will be available. Financial reference tools will also allow health-care professionals to check a patient's eligibility for a drug under PharmaCare, reducing instances where patients, unable to afford their share of costs on a particular drug, re-consult their physician or do not obtain a prescription. The provision of these tools should enhance patient health outcomes and promote better prescribing practices.

Prescribers will be able to enter prescriptions into PharmaNet and pharmacies will be able to electronically retrieve them for dispensing. This will eliminate the need for pharmacists to enter prescriptions into their computer terminals and should also reduce the number of phone calls between prescribers and pharmacies due to illegible handwriting and unclear instructions, ultimately enhancing patient safety.

The province's eHealth strategic framework is supported by Canada Health Infoway, which has a goal of electronic health records for 50 per cent of Canadians by the end of 2009. The strategic framework can be found on the ministry's website.

Further updates on eHealth will be provided as the initiative progresses.

Go www

www.healthservices.gov.bc.ca/cpa/publications/ehealth_framework.pdf

Win with email!

Email distribution kicks off

Barbara Grayston of Vancouver and Andreas Ortmayr of Coldstream are the most recent college registrants to win $100 each for updating their email addresses. Barbara, Andreas, and hundreds of other CPBC registrants (by June 1 the number was up to 700) have logged on to the college's website, clicked on the e-Services logo, and made the change.

The college took advantage of its refreshed registrants' email address list to send out an electronic version of *Council Highlights* in June. Hardcopies were also mailed, but our goal is to make email the primary distribution method of *Council Highlights* by the end of 2006.

Don't wait to join the movement towards quick and cost-effective communications. Update your email address now, and you will be entered into the next draw where two more college registrants will each win $100!

Go www

www.bcpharmacists.org

New drug applications?

Rosiglitazone and statins may have other uses

Do two drugs, one used for diabetes and the other for cardiac care, have new applications for brain-based ailments?

U.S. researchers have embarked on a study to see if the diabetes drug Avandia® (rosiglitazone) can reduce the likelihood of study subjects developing Alzheimer's disease. According to the *Los Angeles Times*, Avandia® manufacturer GlaxoSmithKline is funding a phase III clinical trial this summer. An earlier investigation of 511 Alzheimer's patients found Avandia® was beneficial among patients who do not carry a gene for an aggressive form of the disease. The researchers are pursuing a theory that Alzheimer's is triggered when brain cells can't process sugars, their main fuel. This is similar to type 2 diabetes, when the body's insulin levels can no longer process sugar. Eighteen million Americans with type 2 diabetes are considered two to five times more likely than non-diabetics to develop Alzheimer's.

In a similar vein, the journal *Headache* (2006;46:672-675) recently carried an article reporting initial positive results when a patient with frequent migraines was treated with statins. According to the article's authors, people suffering from migraine with typical aura are at an increased risk of cardiovascular events and ischemic stroke. The authors say a randomized clinical study could provide a more definitive answer to the migraine/cardiovascular-risk relief statins provide.

Source: *Los Angeles Times*, May 1, 2006; www.ingentaconnect.com

New LCA/RDP booklet

An updated low cost alternative/reference drug program (LCA/RDP) booklet, effective August 16, 2006, is now available in PDF on the PharmaCare website.

It includes all drug information changes published in the PharmaCare newsletter up to the June 16th edition (06-005).

Prior to August 16, the current booklet will also be accessible on PharmaCare's website.

Go WWW

www.health.gov.bc.ca/pharme/publications.html

This column prints questions and answers from the OnCall Information Line

Toll free 1-800-663-1940

OnCall PHARMACIST INFORMATION LINE

Questions & Answers

Q It's impossible to get a full prescription label affixed to small eye drop bottles. How am I supposed to meet labelling requirements when I dispense eye drops?

A If the bottle is too small to accommodate a full label, you need to affix a trimmed prescription label to it. At a minimum, this label must include:

- Prescription number,
- Current dispensing date,
- Full name of the patient, and
- Name of the drug.

Affix the complete prescription label to a larger container and counsel the patient to keep the small eye drop bottle inside the larger container.

Q A doctor wrote a controlled prescription for "Codeine Contin® 50 mg, take one tablet every 12hrs, 120 tabs." Before I dispensed it, the doctor called to say he wants to change it to "Codeine Contin® 100 mg, take one tablet every 12hrs, 120 tabs." Can I accept such a change to a controlled prescription?

A According to the Federal Narcotic Control Regulations, neither the drug entity nor total quantity to be dispensed can be changed on a prescription for a narcotic. Changes to the direction's section are acceptable but require direct communication with the prescriber including written confirmation.

In this case, there are three options. Since the original prescription is for 120 tablets of Codeine Contin® 50 mg SR, which amounts to a total of 6000 mg of Codeine Contin®, you could:

- Dispense 60 tablets of Codeine Contin® 100 mg tabs with directions that read, "take one tablet every 12hrs" after receiving written confirmation from the prescriber.
- Dispense 120 tablets of Codeine Contin® 50 mg tabs with directions that read, "take two tablets every 12hrs", after receiving written confirmation from the prescriber.
- Obtain a new controlled prescription form for "Codeine Contin® 100 mg, take one tablet every 12hrs, 120 tabs."

Q What is the maximum methadone carry quantity? Is it still limited to a maximum period of four days or a maximum total dosage of 400 mg, whichever is less?

A There is no maximum carry quantity any longer. Physicians can now make a decision on the quantity and days supply based on the patient's clinical stability and the patient's ability to safely store their medication. If you believe a patient isn't ready to manage their prescribed carries, discuss your concerns with the prescriber.

Somebody call a doctor

Physicians' website offers searchable directory

Ever wonder what is the quickest way to find contact information for a B.C. physician? The College of Physicians and Surgeons of British Columbia's website has a directory with a multi-feature search function. Doctors can be traced by first name, last name, city of practice, specialty, or whether or not they are accepting new patients.

Search results show the individual's current registration status, medical degree, business address, phone number, and gender. The physician directory is located at the top of the CPSBC homepage.

Go WWW

www.cpsbc.ca/cps

PRACTICE NOTES

Dilantin™ 30 mg extended change

Canada gets U.S. version

Manufacturing challenges have caused Pfizer Canada to replace Dilantin™ 30 mg extended capsules with the company's U.S. version of the drug. The difference is apparent on the product bottle, which carries a label noting, "New presentation," and the capsule. Capsules now have a pink band and are imprinted with "PD 365."

This change only applies to Dilantin™ 30 mg extended capsules, and not to other Dilantin™ formulations, such as other capsules, suspensions, or Infatabs.

Acetaminophen reminder

Perils of "double dosing"

The journal *Hepatology* recently found most acute liver failure cases in the U.S. are due to acetaminophen poisoning [*Hepatology*, 2005;42(6):1364-72]. It seems many patients don't realize that some prescription (e.g., Endocet®, Tylenol® 3) and non-prescription (Tylenol® 1, Neo Citran®) drugs contain acetaminophen, so they aren't aware that they may be exceeding the recommended 4 g/day limit. Among those patients with unintentional OD, the article authors found 38 per cent had taken two or more acetaminophen-containing medicines, and 63 per cent took narcotics containing acetaminophen. At least one firm, Pharmex (1-888-PHARMEX) markets auxiliary labels pharmacies can use to draw patients' attention to medications with acetaminophen. The labels state "This medicine contains ACETAMINOPHEN. Taking more acetaminophen then recommended may cause serious liver damage."

AR centre relocates

No change to reporting process

The regional Adverse Reaction (AR) centre in B.C. has relocated from DPIC's St. Paul's Hospital site to a Health Canada regional office in Burnaby, and is now called a regional AR monitoring office. AR reporting mechanisms remain the same. Health professionals and consumers may report an adverse reaction, request an AR reporting form, or obtain further information by phone, fax, or Internet.

Tel: 1-866-234-2345
Fax: 1-866-678-6789
Web: www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html
Email: British_Columbia_AR@hc-sc.gc.ca

Canadian Adverse Reaction Monitoring - BC and Yukon
400 - 4595 Canada Way
Burnaby, BC V5G 1J9

PDAP feedback

continued from page 1

- Communication with college staff: 73 per cent of LPP participants reported positive communications; 74 per cent of KA participants report positive communications.

Cycle 1 survey challenges

While survey participants found PDAP to be a comprehensive, professional assessment tool, some feedback offered constructive suggestions on assessment and the overall program:

- Assessment option motivators: 62 per cent of LPP participants and 73 per cent of KA participants cited convenience-linked motivators in the selection of their assessment option, versus 38 per cent and 27 per cent who respectively cited professional development-linked motivators.
- Participation led to changes in practice: 43 per cent of LPP participants and 22 per cent of KA participants said participation in PDAP led to changes in their practices.
- Feedback usefulness: 33 per cent of LPP participants found the feedback they received "very helpful" or "helpful" (66 per cent found it "somewhat helpful" or "not helpful"); 44 per cent of KA participants found the feedback they received "very helpful" or "helpful" (56 per cent found it "somewhat helpful" or "not helpful").
- Promotes continuous learning and PD: 57 per cent of LPP participants think the PDAP process promotes continuous learning and professional development "very well" and "well" (30 per cent found it did this "somewhat well"); 44 per cent of KA participants found the PDAP process promotes continuous learning and professional development "very well" and "well" (35 per cent found it did this "somewhat well").

Cycle 2 revisions

Based on ongoing staff review and cycle 1 participant feedback, cycle 2 has been refined to include the following:

Knowledge assessment

- Increased exam time from two and a half to three hours.
- Calculators will be provided.
- More detailed post-exam feedback related to domains/disease states.
- More consistent test administration procedures.
- Additional support materials on exam-writing strategies in the KA information guide, and future CPBC/UBC initiatives.

Learning and practice portfolio

- More detailed, specific examples of completed portfolios on the CPBC website.
- Expanded criteria in a revised LPP information guide.
- All forms will be available online.
- Online submission of desired practice outcomes (DPOs) for review by practising pharmacists to ensure they're on the right track.
- More specific and personalized LPP feedback.

GoWWW

www.bcpharmacists.org

Ashifa Keshavji, CPBC assessment programs administrator, jots down discussion points at a PDAP orientation session.

Dear college,

I recently spent four weeks in the psychiatric ward of my local hospital. During this stay the psychiatrist prescribed clozapine for me. I was quite concerned about the side effects of the medication. Initially I had difficulty with sedation but that improved with time. The most annoying part of treatment was the weekly blood work!

Once out of hospital I picked up a one-month supply of clozapine from my local pharmacy. I noticed that the pills looked slightly different from what I received in hospital but the pharmacist reassured me that it was clozapine.

Two weeks later I met with my case manager. I brought in my medication to discuss the changes with her. She told me that I got the wrong product and that I had been given too many pills at once. Now I am not sure that I should be taking them at all.

Confused about Clozapine

what went wrong

The pharmacist involved reports:

The patient brought in a prescription for a specific brand of clozapine 350 mg at bedtime for one month. Our pharmacy carries a different brand so I provided the brand that we carry. The patient commented on the different appearance of the tablets so I reassured her that it was another brand of the same drug.

Two weeks later the patient's case manager contacted me to ask whether a registration form had been completed. I was surprised by her question because I thought that would have been done by the physician. The case manager must have contacted the manufacturer's clozapine registry because they contacted me and requested a completed patient registration form. We do not handle a lot of clozapine prescriptions at our store.

Why does Health Canada require mandatory monitoring for clozapine?

Patients using clozapine have a small but significant risk of developing agranulocytosis. Mandatory monitoring through clozapine registries decreases this risk. Quick identification of patients who experience this adverse effect permits the physician to intervene in a timely manner.

Why is the issue of changing brands so important with clozapine?

The introduction of clozapine from multiple manufacturers has resulted in the establishment of manufacturer-specific registry, distribution, and monitoring systems.

Manufacturer-specific patient registration forms must be completed prior to starting a patient on clozapine. They are completed by the physician and the pharmacist and include patient consent. Pharmacists may not switch patients from one brand of clozapine to another without the completion of a new manufacturer-specific patient registration form signed by the prescribing physician. When brands are changed the physician must also obtain patient consent for the sharing of hematological data between clozapine registries. The prescribing physician is ultimately responsible for verifying a patient's hematological/non-rechallengable status so the physician must know which monitoring system the patient is registered in. The risk of harm due to agranulocytosis increases if there are gaps in the monitoring process.

If a patient is switched from one brand of clozapine to another, the frequency of hematological monitoring may continue unaltered unless a change is clinically indicated.

Confusion over the product brand change may increase the risk of non-compliance so thorough patient counseling explaining the substitution is crucial. All pharmacists involved in dispensing clozapine must be fully aware of these guidelines.

How much can I dispense at once?

Pharmacists signing the patient registration form are agreeing to provide clozapine on a weekly or two-weekly basis only. In addition, the pharmacist agrees to provide clozapine only after they have confirmed that the appropriate lab work (CBC and differential) has been completed. No blood – no drug.

Lab work is required weekly for the first six months of treatment. After six months, if there have been no abnormalities in the lab work, the physician is able to extend the interval for lab work to every two-weeks and the pharmacist is permitted to dispense a two-week supply.

What happens if the patient misses their lab work and they are out of medication?

It is important that patients on clozapine stay on the medication. Abrupt discontinuation can result in rapid deterioration. The pharmacist may have to dispense a small emergency supply, refer the patient to the lab ASAP, and inform the physician. If a patient refuses lab work they will have to discontinue clozapine.

What if a patient wants to go on holidays for more than two weeks?

If the physician writes a prescription for a larger quantity of clozapine the pharmacy must contact the physician to ensure that the patient will be getting their blood tested while they are away. It may be prudent to get the patient to agree to this in writing with full disclosure of potential side effects.

Go WWW

www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2004/clozapine_hpc-cps_e.html

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.

DRUG UPDATES

For full details please check:

www.napra.ca or
www.bcpharmacists.org

- Triaminic® Vapour Patch.
- Heart-related risks of ADHD drugs.
- Oral laxative mineral oil (United pharmacists brand) recall.
- Weight loss products containing ephedrine and caffeine.
- Heart patients and products containing L-arginine.
- Minitran® Transdermal System 0.6 mg/hr (nitroglycerin) recall.
- Sandoz Prednisolone 1% Ophthalmic Suspension.
- Nasutra™.
- Availability of Pork Insulins.
- Oral laxative mineral products in round white plastic bottles.
- Child resistant cap on Eucalyptus Oil BP bottles.
- Possible salmonella in Lifetime Complexed Potassium Tablets.
- Salus-haus liquid vitamin products in glass bottles.
- Unauthorized products containing anabolic steroids.
- Unapproved products containing yohimbine or yohimbe bark including Strauss Energy SIX capsules.
- Avian Influenza A (H5N1) update.
- Super Fat Burning and LiDa Daidaihua Slimming capsules.

Feds chastised for NIHB Rx plan

AG notes ongoing issues in fixing First Nations health care

Federal Auditor General Sheila Fraser's most recent report has a familiar ring to it. The AG's department raised concerns a decade and a half ago about the vagueness of Health Canada's legislation for its Non-Insured Health Benefits program (NIHB). Resulting inefficiencies in assessing client prescription drug use and prescription drug-related deaths remain a serious problem.

NIHB pays for a variety of health services for this country's First Nations population, including prescription drugs. Fraser's latest report on NIHB is generally negative. While she notes some minor improvements, a previous AG's 1993 recommendation that Health Canada seek renewed legislation to clearly define the role and responsibilities of NIHB, and the services its clients could expect, has gone unheeded.

Additionally, a four-year attempt beginning in 2000 to collect patient consent to a prescription drug-assessment program ground to a halt, with only 25 per cent of clients registered.

Fraser and her predecessors have expressed concern about a lack of patient drug-use data, with reports from the AG's office singling out the need for better tracking in 1997 and 2000. In 2004, the auditor general's office again expressed concern after finding that the number of NIHB clients using more than 50 prescription drugs over a three-month period – criteria many provinces use for identifying potential drug abuse – had tripled since 2000.

Fast forward to 2006. Fraser's report uses simple language to repeat a well-known refrain and underscore the lack of action: "In this audit, we found that Health Canada still does not gather data on prescription drug-related deaths. Nor has it sought enabling legislation for its Non-Insured Health Benefits program…and the rights and obligations of the department and its clients have not been defined."

www.oag-bvg.gc.ca/domino/reports.nsf/html/20060505ce.html

UBC PD SURVEY RESULTS

Hundreds of pharmacists voice interests

A Saturday in October, close to home, and let's have a formal lecture on cardiovascular conditions: that is a snapshot of the "ideal" full-day pharmacy professional development session, according to a survey conducted by the faculty of pharmaceutical studies at UBC.

In April 2005 the faculty's continuing pharmacy professional development (CPPD) division mailed and emailed surveys to 2,536 B.C. pharmacists and 922 pharmacies. CPPD received 347 responses, with about 60 per cent of replies from community pharmacists, and 30 per cent from hospital pharmacists.

The survey, which is posted on the faculty's website, provides a wealth of information about the PD needs, interests, likes, and dislikes of B.C.'s pharmacists, including the following:

- Wednesday and Saturday are the preferred days for events (Friday and Sunday the least popular);
- October and February are the most convenient months (December, July, and August the least popular);
- An evening program, one to three hours long, is the most popular format for short PD programs.
- Local offerings rather than out-of-town events are the preferred format for full-day weekend programs.
- The top three of 20 preferred topics are cardiovascular conditions, pain management, and antimicrobial therapy.
- Preferred delivery formats for distance education are print-based home study programs, pharmacy journals, and newsletters.
- Preferred delivery formats for live PD events are formal lectures, case discussions, and study groups/journal clubs.
- CPD programs are the preferred re-evaluation strategy for certificate programs.
- Every five years is the preferred frequency for certificate program re-evaluation.

To view the complete CPPD survey results, visit the faculty of pharmaceutical science's website.

www.pharmacy.ubc.ca/cppd/index.html