Bulletin

College of Pharmacists of British Columbia

May/June 1999 Volume 24, No. 3

Council Initiates Tobacco Sales Restrictions For New Pharmacies

At its April meeting, the Council of the College of Pharmacists of B.C. reviewed information received from Ministry of Health representatives during a March meeting regarding the province's Tobacco Strategy initiatives and related topics. As a result of the new information, the Council decided to begin a stepwise process towards the elimination of tobacco product sales from premises which include licensed pharmacies.

Effective 1 June 2000, the Council plans to have legislation in place which will prohibit the licensure of new pharmacies in premises from which tobacco products are sold or distributed. The legislation will be designed to address the definition of a "new pharmacy" and "premises" in order to provide sufficient clarity for pharmacy owners and managers.

Further discussions regarding the College's initiatives in this area are scheduled to occur at the June meeting of the Council, at which time a further report will be received from the Pharmacy Tobacco Sales Task Force.

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

Safe Medication Practices

The Institute for Safe Medication Practices (ISMP) issued two important safety alerts in a recent *ISMP Medication Safety Alert!* issue (Vol. 4, Issue 3, Feb. 10, 1999).

1. Over-reliance on pharmacy computer systems may place patients at risk.

An ISMP computer field test and survey found many individual pharmacy computer systems to be of limited reliability for detecting and correcting prescription errors, most notably serious drug interactions. Only four of 307 systems tested in the United States detected all unsafe orders presented in the test field.

When results for each vendor's computer system and the drug information provided by the systems were analyzed separately, no computer system or drug information provider was better than another at detecting unsafe orders.

While pharmacy computer systems have become a common and essential professional tool to increase staff efficiency and support effective drug therapy monitoring, the study shows that pharmacists must not rely solely on this tool.

Clearly, technology alone is not the answer. In practice, complex self-programming and the unrealistic time commitment necessary to achieve desired results may prohibit full use of the system's capabilities.

2. Checking functions require a pharmacist's undivided attention

The two main enemies of concentration are haste and distraction. Many pharmacists are required to rush through several activities simultaneously. Checking medication doses cannot be done automatically or at a subconscious level; it requires undivided attention.

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PharmAction Research Shows Professional Value Of Tool

Over 4,000 pharmacies across Canada are participating in the PharmAction program to help them counsel their patients. Approximately 281 are in B.C., representing more than a third of the province's pharmacies.

PharmAction recently conducted research to document the professional value of pharmacy. One hundred pharmacists were asked to return their completed PharmAction pamphlets, showing the actions they have taken to improve their patients' health. The results are encouraging, and confirm that pharmacists are intervening to achieve the best possible treatment outcomes.

Preliminary results of this ongoing research show that:

- Pharmacists intervened in 83% of the cases tabulated to date.
- Pharmacists intervened most commonly when treating patients with asthma, menopause, cholesterol or antibiotics.
- For each of the PharmAction therapeutic classes, the most common interventions were:

Allergies
Recommending specific antihistamines

Antibiotics
Reinforcing the importance of completing therapy to avoid resistance

Arthritis
Recommending exercise; referring the patient to a physician when needed (e.g. for G.I. problems)

Asthma
Recommending that the patient stop smoking

Cholesterol
Reinforcing the importance of compliance; providing advice on lifestyle changes

Depression
Providing encouragement and advice on dosing, dose scheduling, and managing side effects

Diabetes
Reinforcing the need for lifestyle changes, particularly diet

Ear Infections
Reinforcing the importance of completing therapy to avoid resistance; providing advice on dose scheduling

Menopause
Reinforcing the importance of HRT and of compliance

Yeast Infections
Providing advice on avoiding and dealing with current infections

These results demonstrate that pharmacists who participate in the PharmAction program are taking an active role in counselling their patients, and are using PharmAction to help them intervene and document their interventions.

PharmAction would like to hear how other pharmacists are using the program in their pharmacy. Program comments or suggestions are welcomed at the PharmAction office, Tel: 1-800-363-5634.

PHARMACTION

Council Highlights

At its April meeting, the Council of the College of Pharmacists of B.C. reached decisions on several important pharmacy practice issues:

- Reports and recommendations were received from the Community Pharmacy Practice Committee, and the Council approved the continuation of the current pharmacist-to-technician ratio of "1:1 + 1" (which allows one pharmacist to supervise two technicians, two pharmacists to supervise three technicians, etc.).
- The Council also approved the committee's recommendation that pharmacist-patient dialogue be permitted to occur at any stage of the dispensing process, provided that the pharmacist-patient dialogue bylaw requirements are fulfilled. A more detailed notification of this policy change, along with guidelines, will be published in the next issue of the *Bulletin.*
- Dr. Stephen Shalansky and Bita Bateni presented a collaborative drug therapy proposal for Council's consideration, in compliance with Section 31(2)(c) of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*. The protocols relate to a proposed community pharmacist warfarin therapy management process using a dosing nomogram. The proposal was approved by the Council.
- Proposed amendments to the drug schedules for midwives' prescribing were reviewed, and it was agreed that a joint letter of response be prepared with the College of Physicians and Surgeons to express concerns about several proposed adjustments to the schedule.
- After receiving a report from the Council's Pharmacy Examining Board of Canada (PEBC) appointee, Mits Miyata, the Council formalized

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Discipline Hearing Conducted

At a Discipline Hearing held 25 March 1999, Albert Dubois, Diploma #6583, pled guilty to professional misconduct related to inappropriate accesses of a PharmaNet patient record.

Albert Dubois acknowledged that he inappropriately accessed the complainant's PharmaNet patient record for reasons unrelated to health care. This is a contravention of Section 36 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*, Bylaw 40 and Value V of the Code of Ethics. These contraventions constitute offenses pursuant to Section 48(8)(a) and (d) of the Act.

As outlined in Bylaw 40, the only purposes for which a pharmacist may use PharmaNet patient record information are:

(a) dispensing,

(b) counselling a patient with regard to the patient's drug therapy,

(c) drug usage evaluation, or

(d) claims adjudication and payment by any insurer providing drug coverage.

Value V of the Code of Ethics states that "A pharmacist protects the patient's right of confidentiality."

A printout of the complainant's PharmaNet patient record documented eight profile accesses from February 1998 to June 1998. None of these accesses were related to the provision of health care, or any other appropriate use of PharmaNet information. Six of these accesses listed Mr. Dubois as the pharmacist responsible for the access. Two of the accesses were made while other pharmacists were logged on to the computer. Mr. Dubois acknowledged that he made all of these accesses himself.

In hearing the facts of the case, the panel noted that Mr. Dubois has been in practice for 10 years. His behaviour did not suggest a pattern of inappropriate PharmaNet accesses but rather an isolated indiscretion related to a personal situation. He expressed remorse and recognized that his actions were inexcusable. Nevertheless, his actions constituted a most serious offence. They violated the complainant's right to privacy and confidentiality and the profession's Code of Ethics, and they compromised the position of trust held by the profession.

The following penalty was assessed:

1. A one-month suspension.
2. A fine of $1500.
3. Payment of the costs of the proceedings, totalling $4,673.40.

Council Highlights - *Continued from page 2*

its support for the addition of an objective structured clinical evaluation (OSCE) component to the current PEBC examinations. Council also clarified that when the OSCE component is incorporated, the College will cease the administration of the Panel Assessment procedure.

- The results of a survey on the current policies pertaining to the facsimile transmission of prescriptions were reviewed. Of the 85 respondents, a clear majority of the pharmacists who utilize the faxing option have not experienced any serious problems with the process. The Council decided to maintain the current policy and guidelines.
- The Councillors discussed the issue of palliative care medication kits and the potential need for legislative changes to permit their more extensive use. The Community Pharmacy and Hospital Pharmacy Practice Committees have been requested to review the issues and to prepare options for Council's consideration at a future meeting.

The next Council meeting is scheduled for 18 June 1999.

Drug Updates

- Hepatitis C virus (HCV) is a common chronic infection. Nonsteroidal anti-inflammatory drugs (NSAIDs) are commonly obtained on both a nonprescription and prescription basis. Three recent case reports described a marked rise in hepatic transaminases (> 5-fold) following **ibuprofen use in patients with chronic hepatitis C** (with one case repeating on rechallenge). The doses of ibuprofen prescribed ranged from 600 mg to 800 mg twice daily for 3 to 4 days. The mechanism by which ibuprofen induces liver injury is thought to be immunogenic or metabolic idiosyncrasy, but cases of overdoses with resultant liver injury suggest an intrinsic mechanism.

  The fact that these three cases occurred with ibuprofen is of concern because ibuprofen is thought to be the safest NSAID in terms of liver toxicity. Frequently, acetaminophen is avoided by individuals with chronic liver diseases because of concern for intrinsic liver toxicity. No cases of hepatic injury have been reported in patients with HCV, either with or without cirrhosis, and no active alcohol use when taking $\leqslant$ 2 g/24 hours of acetaminophen. These cases support the recommendation of acetaminophen, rather than nonsteroidal anti-inflammatory drug use in patients with chronic hepatitis C. If NSAIDs are deemed necessary, careful monitoring of liver func-tion should occur.
  (Excerpted from the AM J

(Continued on page 5)

In Brief

Change of Address Notification Requested

The College has changed its membership database policy, now disallowing the provision of member contact information to other pharmacy organizations for informing members of support services and resources. The three organizations to which the College previously provided member contact information are now receiving numerous returned mailings. The Canadian Society of Hospital Pharmacists-B.C. Branch, the B.C. Pharmacy Association and UBC's Continuing Pharmacy Education have asked the College to remind members to please forward change of address notifications to the organizations to ensure that mail is properly delivered.

B.C. Pharmacy Association
Suite 150, 3751 Shell Road
Richmond, B.C. V6X 2W2

Canadian Society of Hospital Pharmacists-B.C. Branch
#200 - 1765 West 8th Avenue
Vancouver, B.C. V6J 1V8

Continuing Pharmacy Education
University of British Columbia
#105-2194 Health Sciences Mall
Vancouver, B.C. V6T 1Z3

Sending Confidential E-mail

Should any members wish to send a confidential e-mail to the Registrar or other College management, they should note "CONFIDENTIAL" in the subject line of the e-mail. This will ensure that no staff assisting the Registrar or other management with e-mail during their vacations will gain accidental access to confidential communications.

The Registrar's direct e-mail address is linda.lytle@moh.hnet.bc.ca.

Safety Alerts - *Continued from page 1*

Managers must understand the pressures or influences that make people rush through tasks, and ask themselves the following:

- What can be done to help people adopt a measured pace suitable for accurate completion of a task?
- What circumstances lead to distractions?
- How can we eliminate them?
- How can we improve the checking process?

(Reprinted from the Alberta Pharmaceutical Association)

ETHICS IN PRACTICE

This is the third case in a continuing series reviewed by the Ethics Advisory Committee.

Case 3: Professional Autonomy and Service to Patients

The Dilemma

A pharmacist had an unpleasant interaction with a woman who was upset that her prescription was not ready when she wanted to pick it up. As it turned out, the drug did not arrive from the wholesaler on time so the pharmacist could not dispense the prescription. The patient would not leave the pharmacy. Angry words were exchanged and the patient was not happy with the outcome of the situation.

Some time later the pharmacist made a dispensing error involving the woman's son. The pharmacist believes he feels such anxiety around the woman that he works very quickly to prepare her prescriptions. He does not want to precipitate another angry verbal exchange about prescription delays. He thinks that his anxiety about the patient affected his ability to process her son's prescription correctly.

Can he refuse to service this patient if he believes that their relationship makes it difficult to provide proper pharmacy services?

The Conclusion

In general, professionals cannot abandon patients, but must provide for continuity, whatever the reason they cannot continue to provide such service personally. In this case the patient was not sufficiently unhappy that they took their business elsewhere (in this case there is a pharmacy across the street). Thus, it is hard to justify the continued anxiety felt by the pharmacist.

Since the pharmacist's continued anxiety appears to be due to a failure in communication, he should initiate dialogue with the patient. In all likelihood the pharmacist has a worse recollection of the interaction than the woman, who may even have forgotten about it. The mistake in the woman's son's prescription could have been a coincidence or a convenient excuse, and the pharmacist is making similar mistakes due to some other reason.

If no resolution to his anxiety can be found, the pharmacist might suggest the woman take her business elsewhere, and he could ultimately refuse to dispense prescriptions for her and her family, except in emergencies.

Drug Updates - *Continued from page 4*

Gastroenterol 1998; 93: 1563-1565)

- An **amendment to the Controlled Substances Import and Export Act in the United States** stipulates that a resident of the U.S. who re-enters the U.S. across an international land border with a drug for which a prescription is required in the U.S. may only bring in a maximum of 50 dosage units of that drug if the person does not have documentation verifying that a valid prescription for that drug has been issued to the individual. A main focus of this new provision of the law is codeine, an active ingredient in nonprescription exempted codeine products regularly purchased at Canadian pharmacies by visiting U.S. residents.
- **Hydroxyzine HCl and hydralazine HCl** are alphabetically similar and have similar dosage strengths, tablet dosage form, nearly identical packaging and adjacent listings in computer databases. These all add up to potential for frequent dispensing errors.

  While the manufacturer has agreed to create new packaging to lessen confusion, pharmacists should consider taking measures in their dispensary to raise awareness of the two products. *(Reprinted from the Alberta Pharmaceutical Association)*

Hospital Pharmacy Insights

Standing Medication Orders

"Standing" orders or protocols are found in many hospitals and facility settings. They are known by a variety of names, including "standing," "emergency," and "nurse-initiated" orders. For this article, the term "standing orders" is used to describe medication orders that are in effect for a patient or resident upon admission and are preauthorized to be valid without a prescriber's signature.

Some years ago, the Canadian Council on Health Facilities Accreditation standards contained statements aimed at eliminating the use of unapproved, prescribers' standing orders (e.g. Standing Admission Orders for Dr. X's Patients). These orders often disregarded any need to individualize medication regimens according to a patient's weight, renal function, pre-existing medical conditions, medication history, etc.

Standing orders used today in hospital and facility settings must be reviewed and approved according to several criteria:

Standing orders must state the medication name, route, frequency and duration. Dosages must be individualized, where possible. An order for a single medication dose and route should be preauthorized only when the same drug and dose would be therapeutically appropriate for all patients.

e.g. A standing order for the emergency treatment of anaphylactic reaction in adults might include subcutaneous epinephrine 0.3 mg STAT, may repeat x1 in 15 minutes (no dose adjustment).

e.g. Nurse-initiated orders for ECU residents might include orders for acetaminophen 325-650 mg po Q4-6H prn pain, maximum 4 doses and 24 hour duration.

The standing orders must be within the staff's scope of practice. Hospital or facility staff must have the skill, knowledge and experience to use the standing orders to determine the appropriate medication, dose and route and to manage any anticipated or unanticipated medication outcomes.

e.g. A standing order for "start phenytoin IV for seizures" in a residential care facility is inappropriate. Diagnosis and prescribing are reserved acts. In addition, residential care staff may have little training or experience in the use of IV lines and medications.

e.g. Nurse-initiated orders in ECU could include the selection of appropriate dose for a nonprescription medication for the limited treatment of simple sore throats, heartburn, etc.

e.g. General orders protocols in acute care might include "RN to give digoxin orally x 24 hours at same dose if IV discontinued."

Standing orders are reviewed and approved prior to implementation. The review and approval process for most hospitals and facilities would include the medication advisory committee (P&T or equivalent) and other applicable committees or groups (medical records, medical advisory and/or nursing committees).

Standing medication orders should be reviewed and approved on a regular basis to ensure that the medication therapy regimens are current.

Community Pharmacy Corner

Prescription Repeat Authorization

Pharmacists are advised that Council policy restricts the time span of ongoing prescription authorization to a maximum of one year from the prescribing date.

In the interest of providing safe and effective patient care, prescriptions being dispensed from an authorization which originated more than one year before are to be confirmed with the prescriber. The condition may need to be reassessed; the prescriber may now have a different drug of choice; and/or the person may no longer be a patient of the prescriber.

Transfer of Refill Authorization

As of July 1998, pharmacists in Ontario are permitted to transfer refill authorizations to pharmacists in other provinces. However, remaining authorizations cannot be transferred back into Ontario, as this would still be considered a violation of their Act.

When pharmacists in B.C. are dealing with such transactions for visitors from Ontario, they should advise the patients that they will need new authorizations from their physician when they return to Ontario.

What Went Wrong?

Dear Inquiry Committee:

This column in the January /February 1999 issue of the *Bulletin* reported on a situation where a pharmacist released Mr. Brown's local store medication profile to Mr. Brown's wife. She used the medication profile as evidence in a child custody case. The pharmacist believed that she was Mr. Brown's primary care-giver, because over the past two years she always brought in his prescriptions and usually ordered his refills for him over the telephone.

Despite the unfortunate consequences of the pharmacist's actions, I do not feel a reprimand was necessary. Issue should be taken with Mrs. Brown who misrepresented her current relationship with her husband.

The problem could have been avoided if the pharmacist had contacted Mr. Brown; however, this is putting the pharmacist in the awkward position of being mediator.

The pharmacist's actions should be compared to what reasonable action the majority of pharmacists would have taken. I think the majority, myself included, would have given the information without a second thought because the wife had been the husband's agent for two years or more.

A Concerned Pharmacist

The Inquiry Committee's Response:

Although some pharmacists may have handled Mr. Brown's case in the same way, issues of privacy and confidentiality are constantly being re-evaluated by the public, the government and the professions. What we may have done in the past may not be appropriate in the face of ever-changing and evolving values.

In determining a resolution for Mr. Brown's complaint, the Inquiry Committee acknowledged that Mrs. Brown had acted as Mr. Brown's personal representative over the years. The Committee believed that although the pharmacist's actions were not malicious, some form of sanction for the inappropriate release of information was warranted. By issuing a reprimand rather than referring the matter to the Discipline Committee and printing the pharmacist's name in the *Bulletin*, a balance was struck between acknowledging the inappropriate release of information and recognizing the extenuating circumstances of this case.

It may appear inconsistent that a pharmacist should not provide a written printout to a person who had the opportunity to know about all of someone's medications. Section 39(2) of the Act outlines the appropriate conditions for disclosure of patient record information. A pharmacist must, on request, disclose patient record information to the person who is the subject of the record or the personal representative of the person named in the record, if that person directs in writing that the disclosure be made. This section anticipates that providing written records without the patient's consent could facilitate the use of the information in ways that the patient may not have authorized.

In recent years, privacy and confidentiality have become paramount in the minds of the public. Increased electronic exchange of information and the use of centralized databases have prompted the development of legislation addressing these issues. The public is demanding additional assurances that their privacy and confidentiality will be respected.

Although other authorities, such as coroners and the Ministry of Children and Families have legislation allowing access to health records related to cases they are investigating, pharmacists may wish to refer those requests to the College office for assessment and disposition.

℞C·A·R·E Program

Responses to common questions about the ℞C.A.R.E. Program raised by some pharmacists in recent weeks are summarized here for all members' information. The College welcomes other comments and questions about the program's next steps.

Why will 20% of members be required to take a Level 2 assessment, even though they will have "passed" Level 1?

Members will be selected at random to complete the Level 1 assessment. All Level 1 participants with "border line" results will be required to complete a Level 2 assessment.

In addition, 20% of Level 1 participants who pass the first assessment will be asked to complete a Level 2 assessment as a "spot check" for the tools and process. Results will be used for quality assurance for the College's assessment criteria and testing standards.

How will standards be set?

The standards for each type of ℞C.A.R.E. assessment will be set by panels of practising pharmacists. Panel members selected will be representative of different practice sectors and known to be following good practice. They cannot be in the group undergoing assessment, but will be asked to take the test to become familiar with the questions or tasks and the "test experience."

Test standards will be developed using a process designed to establish the score or performance rating that pharmacists deem necessary for safe, effective pharmacy practice. The process steps will include:

- A standard is set for each task on a performance assessment by estimating the rating a person who is "just able" to practice safely and effectively would achieve on that task.
- After going through the whole test, the test standard or "passing score" is calculated by averaging the standards set by the panel for each question or task on the test.
- Once standards are set, panel members estimate the passing rate (proportion of pharmacists that would likely pass the test), based on their experience with the test and with a variety of practitioners.

Once the test is given:

- The difficulty of each question or task is assessed by examining the proportion of test takers who answered the question correctly, or the average rating on each task. If the difficulty of a question or task was misjudged by the panel, the standard for that item can be modified.
- The actual passing rate is compared to the estimated passing rate. If the results vary significantly from the estimate, another panel of pharmacists is convened to go through the process again.
- The standards and results are reviewed by the Board of Examiners to determine their validity and to select the standard (if more than one has been set) that seems to be most defensible for safe and effective pharmacy practice and demonstrates reasonable consensus among pharmacists setting the standard.
- The final standard and results are then reported to all who took the test.

This process will be repeated each time a test is given, using different panels to show that similar minimum standards are set by each panel.

Can I see my paper or get a copy of the questions I got wrong?

The security and confidentiality of the tests and questions is related to the relatively small size of the question pool.

None of the tests are "diagnostic" by topic. However, most participants will be able to deduce from their level of comfort with questions and cases where they could benefit from some additional learning. Suggestions made by pilot phase participants will be used to help develop other meaningful test feedback.

How can I prepare for the assessments?

The Learning Centre at UBC and resources available through Regional Coordinators, the College, CSHP and BCPhA may be accessed by individuals and groups. You can join one of many study clubs now forming or can start one with your colleagues. Watch future issues of the *Bulletin* and Learning Highlights for further information and reviews on programs and resources.

User Id Security

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 recent Discipline Hearing regarding an inappropriate access to a PharmaNet patient record by a pharmacist, it was identified that some accesses to the patient record were made by the defendant using other pharmacists' identification codes.

For each access to the PharmaNet patient record, the pharmacist's name, pharmacy name from which the access was made, date of the access and the type of transaction being performed are recorded in the PharmaNet system. The pharmacist identified on this access log is accountable to the patient and the College to explain the reason for the access.

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.

PharmaNet Users Group

Committee Member	Pharmacy Software Vendor	Contact Information
Ken Foreman (Chair)	Zadall	Phone: (604) 925-5446 Fax: (604) 926-4802 E-mail: kforeman@ShoppersDrugMart.ca
Gary Chan	PDX	Phone: (604) 585-7440
Darlene Forsyth	Commander Group (hospital pharmacy package)	Phone: (604) 520-4629 Fax: (604) 520-4802
Amrik Ghag	Applied Robotics	Phone: (604) 850-2494 Fax: (604) 853-9675
Ron Gracan	Commander Group	Phone: (604) 273-5544 Fax: (604) 273-5037
Allen Jang	Zadall	Phone: (604) 278-4521 Fax: (604) 278-4898
Randy Konrad	PDX	Phone: (604) 327-5582 Fax: (604) 327-8860
Janis Mack	Zadall	Phone: (604) 463-8131 Fax: (604) 463-8859
Doug Patterson	Unipharm	Phone: (250) 762-3333 Fax: (250) 862-8829
Vince Zuccaro	Kroll	Phone: (604) 872-2662 Fax: (604) 876-0242
Resource People:		
Melva Peters (Staff Resource Person)		Phone: (604) 733-2440, 1-800-491-6333 Fax: (604) 733-2493 E-mail: melva.peters@moh.hnet.bc.ca
Paul Chazottes		Phone: (250) 952-0992 Fax: (250) 952-1625 E-mail: paul.chazottes@moh.hnet.bc.ca
Nerys Hughes		Phone: (250) 952-3125 Fax: (250) 952-1625 E-mail: nerys.hughes@moh.hnet.bc.ca
Penny Pattison		Phone: (250) 952-2776 Fax: (250) 952-1625 E-mail: penny.pattison@moh.hnet.bc.ca

Emergency Department Access To PharmaNet

On 04 March 1999, Health Minister Penny Priddy announced that emergency departments at all hospitals in B.C. are now eligible to connect to PharmaNet. Connecting to HealthNet/BC is optional, and each hospital must pay its own costs.

For further information, or to receive an Emergency Department connection package, please contact Kathy Moore, HealthNet/BC Connections Coordinator at Tel: (250) 952-1784, or E-mail: kathy.moore@moh.hnet.bc.ca.

College Staff Contact List

NEW!

(* Indicates part-time staff)	Ext.
Reception	200
Kelly Baker-Pabla *Junior Receptionist*	214
Amin Bardai* *Internship Program Site Coordinator*	400
Yvonne Beavington *Senior Receptionist*	200
Sharon Clark *Hospital Pharmacy Practice Consultant*	237
Traci Deman *Executive Assistant*	220
Elsie Farkas *Administrative Secretary*	212
Marge Gardner *Administrative Manager* ***E-mail: marge.gardner@moh.hnet.bc.ca***	208
Sharon Kerr *Professional Development Liaison Officer*	239
Doreen Leong *Assistant PharmaNet Coordinator and Community Pharmacy Practice Consultant/ Inspector*	203
Linda Lytle *Registrar* ***E-mail: linda.lytle@moh.hnet.bc.ca***	201
Sharon McLachlan *Assessment Programs Assistant* ***E-mail: cpbc@axionet.com***	241
Margaret McLean *Community Pharmacy Practice Consultant/Inspector - Districts 1, 2 and 3*	235
Carol O'Byrne *Director, Assessment Programs* ***E-mail: cpbc@axionet.com***	240
Brenda Osmond *Deputy Registrar* ***E-mail: brenda.osmond@moh.hnet.bc.ca***	202
Melva Peters *PharmaNet Coordinator* ***E-mail: melva.peters@moh.hnet.bc.ca***	223
Lori Polegato *Junior Receptionist*	211
Regan Ready* *Community Pharmacy Practice Consultant/ Inspector - District 4* ***E-mail: reganr@ibm.net***	401
Arina Reddy *Secretary*	213
Neetika Sethi *Registration Secretary*	216
Lynn Taylor *Administrative Assistant*	219

Resource Source

♦ Pharmacy Practice Toolkits

A *Pharmacy Practice Toolkit* information series has been launched by the National Association of Pharmacy Regulatory Authorities (NAPRA) to provide guidance to pharmacists in meeting the Model Standards of Practice for Canadian Pharmacists. The series consists of nine papers, each identifying and describing a collection of currently available or developing tools and resources, references for further reading, as well as forms and articles where available.

The papers can be viewed on the NAPRA web site's "Canadian Pharmacy Information" section. Print copies of each Toolkit can also be purchased from NAPRA. The first papers include: #1 Pharmacy Care Plans: General Information and Getting Started (April 15 release); #2 Pharmacy Care Plans: Care Plan Tools (May 15); #3 Pharmacy Care Plans: Documentation (June 15); and #4 Pharmacy Care Plans and Documentation: Integrated Resources (July 15). For more information, contact NAPRA at Tel: (613) 569-9658, Fax: (613) 569-9659, E-mail: bawells@compuserve.com.

Plan To Attend

▸ Council Meetings

Friday, 18 June

Wednesday, 29 September

▸ Annual General Meeting

Thursday, 30 September
Ocean Point Resort Hotel
Victoria

▸ Panel Assessments

Saturday, 5 June *(results 5 July)*

Sunday, 6 June *(if required)*

Saturday, 23 October *(results 22 November)*

▸ Forensic Assessments

Friday, 4 June

Friday, 22 October

People News

Announcements

- Junior receptionist **Heather Murphy** has left the College. Welcome to our new junior receptionists, **Kelly Baker-Pabla** and **Lori Polegato**.

Achievements

- The Canadian Pharmacists Association (CPhA) selected **Dale Dodge** of Oliver as the recipient of the Apotex/PACE Innovative Practice Award for his Asthma Management Program. The award was presented to Dale at the Association's Annual Conference in London, Ontario.
- UBC Pharmaceutical Sciences student **Alana Froese** was named one of Pharmacy's Canada Centennial Scholars in acknowledgement of her high academic endeavours and involvement in student activities. Sponsored by the CPhA, Apotex/PACE and Pharmasave, with a travel grant by the College, Alana received a cash award, visited manufacturing and innovative practice sites in Toronto, and then attended the CPhA Annual Conference.