



Feedback Requested On Draft Pharmacy Closure Policy

The College has drafted operational policies for how long pharmacies need to be open and is now seeking member feedback on the policies. The proposal outlines:

- ▶ Pharmacies may be closed a maximum of four consecutive days, provided at least one day is a statutory holiday.
- ▶ Closure hours are to be posted a minimum of one week prior to the first day of the closure period.
- ▶ During the closure period, a telephone answering device and exterior signage should inform the public about the closure.

For "lock and leave" operations, as well as traditional pharmacy operations, the proposal suggests:

- ▶ The pharmacy must be open 20 hours of each seven-day period (Sunday to Saturday).

- ▶ Hours should be posted and visible from the exterior of the premises.

Emergency situations requiring pharmacy hours different from policy will be reviewed by the College office on an individual case-by-case basis.

Members' comments on these draft policies are welcomed, and can be forwarded to the Registrar by 15 May.

New Date For College Annual Meeting

The College's 1999 annual meeting is being held in conjunction with the B.C. Pharmacy Conference in October, at the suggestion of the B.C. Pharmacy Association (BCPhA). The conference dates are Thursday, 30 September through Sunday, 03 October in Victoria. The College's 108th annual meeting will begin at 2 p.m. on the Thursday, immediately following the 12 noon hosted luncheon and the BCPhA annual meeting. Mark your calendars now for the conference and meetings!



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

BC.A.R.E. Program Finalized

The Council has approved the final form of the College's quality assurance program, which will continue to be known as the BC.A.R.E. Program. The acronym means *Pharmacist Continuing Assessment, Reflection and Enhancement*, and it encompasses the program's professional development and accountability purposes.

The BC.A.R.E. Program is being launched in the fall. It will feature:

- ◆ A six-year cycle, involving one-third of College members every two years.
- ◆ Three levels (screening, verification and comprehensive assessments).
- ◆ College payment of basic assessment costs at Levels 1 and 2.
- ◆ Assistance with learning resources and other support throughout the cycle.

The program details were developed by the Board of Examiners to comply with the Council's eleven policy directions relating to the overall program.

A detailed information package was distributed to all College members in March.

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Sustained-release Morphine Tablets Or Capsules

Pharmacare's announcement regarding the selection of M-Eslon® as the Low Cost Alternative when sustained-release morphine tablets or capsules are prescribed has prompted a number of questions to the College office. The College advises that:

- ◆ The four available products are considered noninterchangeable due to their sustained-release formulation.
- ◆ In order to exercise product selection, it is necessary that the pharmacist contact the prescriber concerning each individual prescription for which product selection is contemplated. Having received the prescriber's authority to interchange one brand for another, the pharmacist should also advise the patient of the decision.
- ◆ As with other adjustments of this nature, it is acceptable for the pharmacist to document the change of brand on the hard copy of the prescription, noting that the prescriber was consulted and what brand was authorized by the prescriber. It is not necessary for the prescriber to rewrite the prescription with the new brand name (unless the product selection involves Kadian® SR 20 mg or 50 mg, in which case a new written prescription is necessary).

The College's Drug Advisory Committee has not been requested by the manufacturers to review the noninterchangeable status, but the committee is initiating a preliminary review due to questions expressed by our members. Results of the review will be presented in a future *Bulletin* issue.



Dispensing Personal Prescriptions For Medical Or Dental Practitioners



When medical or dental practitioners decide to prescribe medications for themselves or their family members, pharmacists need to respond appropriately, giving due consideration to the known circumstances.

The College of Dental Surgeons has provided its members with guidelines stating that they should not prescribe medications for themselves or their close family members.

The College of Physicians and Surgeons has also addressed the situation by saying that physicians should not treat themselves or members of their immediate families and, except in emergencies, it is not appropriate for physicians to write prescriptions for themselves

or immediate family members.

The College has defined "immediate family" as spouse and children, as well as cousins, aunts, uncles, parents and grandparents of the doctor and the doctor's spouse.

While it is not necessary for pharmacists to enforce another profession's code of ethics, it is important for pharmacists to be aware of situations when continued self-treatment or treatment of family members should be addressed. A private conversation with the prescriber will usually help the pharmacist make the best judgement for each individual situation. Further guidance is available from pharmacy practice consultants at the College of Pharmacists of B.C.

Update On Methadone Carries

After a patient has been on methadone for approximately three months and has demonstrated their ability to meet the requirements of the program, the physician may indicate on the prescription that the patient may take a quantity of methadone home with them for doses on subsequent days. Although maximum carry quantities are 400 mg or 400 mL, whichever is less, a physician may obtain authorization from their College to prescribe a larger quantity. Unless a pharmacist has concerns about a specific prescription, it is not necessary to routinely confirm with the physician that they have sought approval from their College. Physicians who prescribe methadone are aware of the requirement to obtain authorization from their College for these larger quantities.

In order to assist patients in the appropriate use of methadone carry medication, the **first dose** of a carry should be supervised by the pharmacist, unless the physician indicates otherwise on the written prescription. For example, if a patient's prescription indicates that on Friday the patient should receive a carry for the weekend, they should consume Friday's dose in the pharmacy and be given the doses for Saturday and Sunday to take home.



Documenting Refill Authorizations

Although it is possible to tell from the transaction records of a pharmacy's local computer software when additional refills were added, how many were added and what pharmacist made the addition, that information can be difficult to access at the time of an audit or a routine pharmacy inspection.

Because of this, pharmacists must use some method to document on a hard copy the date that new refill authorizations have been obtained, who authorized the refills, who received the authorization and how many refills have been authorized. Three examples of how this can be done are outlined below. Other methods that meet the requirements will also be acceptable.

1. If refill authorizations are obtained via facsimile, the fax record should be retained for at least two years from the time of the last refill.
2. Telephone refill authorizations may be reduced to writing on a separate hard copy (e.g. a blank prescription form) and retained for two years after the last refill.
3. Acknowledgement of a telephone refill authorization may be retained on the refill log (usually this is a page on which the strips from the bottom of the prescription labels are affixed), provided that the above information is recorded.

Council Highlights

- ▶ The College's 1999-2000 annual budget has been approved by Council. Total revenues are projected at \$2,624,825, with pharmacist registration and pharmacy licence fees at \$2,180,315.

The balanced budget projects \$2,589,200 in operating costs. Expenditure increases are budgeted for professional activities (11%), inspection (23%), and education (8%), the latter primarily due to grants for the Community Pharmacy Residency Program and Structured Practical Experience Program. An expenditure decrease (23%) is forecast for assessments, with the ^BC.A.R.E. Program accounting for 42% of the \$240,100 costs. The new budget includes \$38,625 in capital expenditures, mainly comprised of computer hardware/software upgrades.

- ▶ At its January meeting, Council reviewed its work plan for the coming year. With the ^BC.A.R.E. Program now finalized, the next two issues of focus for Council will be the sale of tobacco products by pharmacies, and pharmacy technician training issues.

Other Council news can be read in the February 1999 *Council Commentary* mailed to members in February and March.

Emergency Contraception: A Washington State Demonstration Project

A two-year demonstration project in the Puget Sound region of Washington State is seeking to improve women's access to emergency contraceptive pills (ECP) by promoting collaborative drug therapy agreements between pharmacists and prescribers.

Participating community pharmacists have received training in all aspects of providing ECPs, including therapeutic and dispensing information, patient care concerns

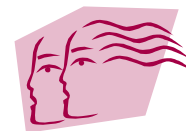
(e.g. screening, counselling, referral), administrative issues, public relations and other relevant matters. Once trained, pharmacists work with prescribers to file a collaborative drug therapy agreement with the Washington State Board of Pharmacy. Web sites and toll-free emergency contraception hotlines inform women which pharmacies can provide this valuable service.

Over 900 pharmacists in 110 pharmacies have attended the

training sessions.

In one nine-month period, 7000 prescriptions for ECPs were provided through this program. Equally important, 2000 referrals to physicians, family planning clinics or other agencies were generated as a result of these visits.

After June 1999, the end of the two-year project, the impact of the project on women's access to and use of ECPs will be evaluated.





Drug Updates



- ◆ Further to information in the September/October 1998 *Bulletin*, **ticlopidine** is an important part of the pharmacological treatment for patients at risk of stroke. This class of platelet aggregation inhibitors is associated with a small, but significant risk of serious blood dyscrasias during the initial three months of therapy. If the patient is not monitored closely during this three-month period and blood dyscrasias reversed, these side effects can be fatal.

Health Canada has warned that the manufacturer's inserts must be supplied advising all patients to have a white blood cell count with a differential and platelet count performed every two weeks starting at baseline, before treatment is initiated. In order to ensure bi-weekly testing, it is recommended that pharmacists should only dispense 14-day supplies during the first three months.

The package insert containing "Information for the Consumer" must be given to patients.
(Reprinted from the *Saskatchewan Pharmaceutical Association*.)

- ◆ When **Coumadin**[®] (warfarin sodium) is prescribed for anticoagulation, physicians' dosage adjustments are often required. Physicians have contacted the College regarding the difficulties encountered when trying to instruct a patient over the telephone about dosage adjustments when the patient has been dispensed several tablet strengths for the prescription.

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In Brief



► Pharmacy-based Laboratory Testing

The College has recently received several inquiries regarding pharmacy-based laboratory testing. As outlined in the November/December 1997 *Bulletin* issue, Council has an interim policy to address the increasing availability of pharmacy-based glucose and cholesterol screening and patient monitoring programs:

A pharmacist may conduct, administer or interpret a diagnostic test for demonstration purposes only, but may supervise the performance and interpretation by the patient of a diagnostic test performed in the pharmacy.

Pharmacists have raised questions about the inclusion of testing procedures in pharmacy's scope of practice definition, due to liability insurance issues. Concerns have also been expressed by other professions and groups about pharmacists' qualifications to perform the procedures.

Legal advice obtained by the College indicates that the conduct of laboratory tests is not currently included within the scope of practice description. While likely a lengthy process, efforts are currently under way to amend the College's scope of practice to incorporate these practices.

► Triplicate/Duplicate Prescription Program Form

Pharmacists are reminded that they do not have to fill in details for the "Pharmacy Use Only" part of the Triplicate/Duplicate Prescription Program form. However, a patient or agent signature is still required to show receipt of the prescription. If a customer questions signing the form when all boxes are blank, the pharmacist should complete the "R Number" and "Quantity" boxes.

► Optometrist Prescribing Authority

Optometrists are permitted to purchase two prescription drugs for diagnostic use in their offices. The drugs are cyclopentolate and tropicamide. Optometrists are not permitted to prescribe Schedule I drugs for their patients.

They can, however, recommend Schedule II and III drugs, and patients may approach pharmacists with written notes which include the drug and directions for use. The products should be provided to patients on a nonprescription basis while ensuring that the optometrist's directions for use are conveyed to the patient.

► Sale of Tobacco Products

Ministry of Health representatives scheduled a meeting for 23 March with the College President and Registrar, along with the B.C. Pharmacy Association President and Executive Director. The purpose of the meeting was to discuss the joint proposal developed by the College and the Association to address the issue of tobacco product sales from pharmacies.

The College Council has directed the tobacco sales task force to reconvene and explore existing and alternate options for banning tobacco sales from pharmacies. Preliminary options developed by the task force will be discussed at the Council's April meeting, with a full report to be presented to Council at its June meeting.



ETHICS IN PRACTICE



The Ethics Advisory Committee was established by the College Council to help pharmacists respond to ethical conflicts arising in professional practice. This is the second real life situation reviewed by the Ethics Advisory Committee.

Case 2: Deciding Whether or Not to Breach Patient Confidentiality

The Dilemma

A pharmacist in a very small town had a patient who was going through a difficult time. Initially her family physician prescribed benzodiazepines for panic disorder. She was then referred to a psychiatrist who also prescribed benzodiazepines. Over time the woman's use of medication increased. The pharmacist contacted both physicians and related her concerns, and spoke to the patient as well. After the patient moved to another town, she called the pharmacist request-

ing her medication profile. The woman told the pharmacist her new caregiver said her former physician had lied to her about her diagnosis and she had not received appropriate care. She said she might sue the physician for malpractice, and also questioned the pharmaceutical care she received.

As a professional courtesy, the pharmacist considers telling the family physician about the conversation to make him aware the patient is considering a lawsuit.

The Conclusion

In general, pharmacists should treat patients with respect and keep any information received from patients in confidence. Such confidentiality is not absolute, but there must be compelling reasons for confidentiality to be breached. In this case the confidential information does not directly involve the patient's health, and there is no compelling reason to give the physician a

"heads up" notice that the patient is considering filing a malpractice lawsuit. The physician's life is not in danger, and there is nothing the physician can, or should, do, in the time between notification by the pharmacist and the possible serving of legal papers on behalf of the patient, that would benefit the patient. The pharmacist should not let a misguided sense of professional courtesy outweigh her responsibility toward her (former) patient in maintaining confidentiality with regard to the telephone conversation.

However, the patient would not be harmed if the pharmacist told the physician about the telephone conversation. But any breach of confidentiality is better justified on the basis of protection of others, rather than an absence of harm or "professional courtesy."

Drug Updates - *continued from page 4*

For example, 4 mg tablets are prescribed, and the pharmacy uses two 2 mg tablets for the patient.

The College suggests that pharmacies stock the full array of tablet strengths available (1, 2, 2.5, 4, 5 and 10 mgs), and also inform the physician's office via fax about the tablet strengths dispensed for the patient.

- ◆ There is a need to clarify the status of **ASA 80 mg and 81 mg** due to the existence of both federal and provincial legislation affecting its status and the introduction to the market of new products in assorted package sizes. 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

- ◆ The labelling of **Denorex® Extra Strength** shampoo states that the product contains coal tar solution 10.4%. Coal tar solution 10.4% provides an actual coal tar content of 2.08%. Because it contains coal tar 10% or less, it is an unscheduled product and may be sold from non-pharmacy outlets.
- ◆ As noted in the January 1999 list of Noninterchangeable Drugs, all **5-aminosalicylic acid** products are now noninterchangeable. A recent independently conducted in-vitro dissolution study has demonstrated that there are differences in the dissolution characteristics of Novo-5 ASA® and Asacol® at relevant physiological pH values. Mesasal®, Pentasa®, and Salofalk® have always been noninterchangeable.



Hospital Pharmacy Insights



Donations for Disaster Relief

Hospital pharmacists are frequently asked to donate outdated or unusable drugs or IV solutions for disaster relief efforts or other charitable causes. There are several problems with honouring these requests.

- ◆ The *Pharmacists, Pharmacy Operations and Drug Scheduling Act* prohibits any person from selling or distributing any drug after it has expired.
- ◆ Hospital pharmacists cannot redistribute "unusable" medications. This includes any returned medications not in sealed dosage containers, any opened topical or ophthalmic products and any product with missing or obliterated labelling.
- ◆ The College's Act, bylaws and standards have no provisions for a lower standard of pharmacy care for citizens of another country.

The World Health Organization (WHO) has documented numerous problems with disaster relief drug donations. In 1995 in Bosnia, 340 tonnes of expired or unusable donated drugs occupied valuable space in one relief centre until they could be destroyed. In 1997 in the NEJM, Berckmans et al. reported that 50-60% of all drug donations to Bosnia were unusable. Of the unusable drugs, 60% were small amounts or single quantities of inappropriate items.

Other documented problems include donated drugs that are not relevant to a particular emergency situation or donated drugs that do not comply with local drug policies or standard treatment plans.

The World Health Organization, in conjunction with major disaster relief organizations, has published *Guidelines for Drug Donations*. The following statements have been excerpted for pharmacists:

- ◆ Drug donations should be relevant to a specific need and/or disease pattern in the recipient country.
- ◆ Donated drugs should be approved for use in the recipient country, unless specifically requested otherwise by the recipient.
- ◆ Donated drugs must comply with quality standards in both donor and recipient country.
- ◆ Drugs that have been issued to patients and then returned to a pharmacy or elsewhere, and drug samples are not appropriate.
- ◆ After arrival in the recipient country, donated drugs should have an expiry date of at least one year.
- ◆ Donated drugs should be labelled in a language understood by health care workers in the recipient country. Minimum labelling includes the generic name, dosage form, strength, storage conditions and expiry date.

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Community Pharmacy Corner



Special Counselling

The Community Pharmacy Practice Committee reminds pharmacists that when discussing certain drugs and drug categories with a patient, special emphasis may be required concerning the dangers of taking the medication in conjunction with other drugs. Concerns brought to the College's attention by the Coroner have been associated with antidepressant drugs, and pharmacists may want to provide special attention to other categories as well. Also remember during counselling that patients often do not think of nonprescription products as "drugs", and that they generally do not realize how long some drugs may remain in their system.

Change of Manager

A narcotic count must be carried out at the time of a manager change. This provides a baseline should there be any discrepancy identified at a later date. Ideally, the count is completed with both the outgoing manager and incoming manager in attendance, thereby providing both with the assurance that they are in agreement about the stock present. Each manager keeps a copy of the record, and one record of the count is kept on file at the pharmacy. If this is not possible, the incoming manager should do a count on her/his first day in the pharmacy, in conjunction with another employee.

Managers and pharmacists providing holiday relief may wish to use this same procedure at the beginning and the completion of the relief pharmacist's term of employment.



Long-term Care

Verbal Orders from Facility Nurses

Council recently approved a policy regarding the acceptance of verbal orders transmitted by facility nurses for facility residents. Terms used in the policy include:

Residential care facility/home - a residence licensed under the *Community Care Facility Act* to provide care.

Nurse - a registered nurse, registered psychiatric nurse or licensed graduate nurse working in the care facility/home.

Pharmacy - the pharmacy designated as the facility/home service provider.

The Policy

Except in the case of a narcotic or controlled drug, a pharmacist may accept a new medication order given verbally by a practitioner to a facility nurse provided that:

1. The nurse writes the verbal order on a physician order form and transfers the written order to the pharmacy; and
2. The transcribed order is clear, understandable, reasonable, logical and safe.

In all cases the pharmacist will use professional judgement in deciding whether to accept the transcribed order or to confirm it with the practitioner. If any one of the parties involved (pharmacist/nurse/practitioner) is unfamiliar with the resident or facility, or any aspect of the procedure, the pharmacist should confirm the verbal order directly with the practitioner.

Procedure

- ▶ The nurse shall immediately reduce the verbal practitioner order to writing on a physician order form. This must include the patient's full name, the date, medication name, strength, quantity or duration of use, directions for use, physician's name and initials, nurse's name, signature and professional designation, and indication that the order was verbal.
- ▶ This order must be faxed or delivered to the pharmacy prior to release of the medication.
- ▶ If, in the pharmacist's professional judgement, any part of the order is unclear, inappropriate or contradicts other medication regimens, she/he must confirm the order directly with the practitioner.
- ▶ Orders for all narcotic and controlled drugs require direct communication between practitioner and pharmacist.

Procedure Summary

- ▶ The practitioner gives the telephone order to the facility nurse.
- ▶ The nurse writes the verbal order on the physician order form.
- ▶ The order is faxed or delivered to the pharmacy before the prescription can be released.
- ▶ The pharmacy processes the order and delivers it to the facility.

Notes

If the pharmacist wishes, she/he may send the practitioner an informational fax stating that "This order was transmitted by nurse 'X' on your behalf and was dispensed."

It is important to remember that the pharmacist has the final say. If she/he is not completely comfortable with the order or the transmission of it, the practitioner must be contacted.

This policy does not apply to new verbal medication orders for community-based patients. Direct communication between practitioner and pharmacist for non-resident patients remains mandatory.

(Continued on page 11)



What Went Wrong?



The following incidents highlight reports received and investigated by the Inquiry Committee. This information is provided to help all pharmacists reflect on their own practice and take steps to ensure that similar incidents will not occur in their setting.

Wrong Drug

- ◆ A prescription for **Nizoral**[®] was dispensed incorrectly with **Novo-Nidazol**. The problem was detected during counselling and corrected before the patient left the dispensary. This incident demonstrates the importance of conducting thorough patient counselling.
- ◆ A prescription for **Singulair**[®] was dispensed incorrectly with **Sinequan**[®]. The patient took the wrong medication for two months before the problem was discovered. The use of open-ended questions such as "What did your physician tell you about this medication?" might have detected this problem before the patient left the dispensary.
- ◆ A prescription for **Salofalk**[®] was dispensed with **sulfasalazine EC 500 mg**. The patient took the incorrect medication for approximately one month. The patient visited his physician twice to discuss adverse effects of the medication before it was discovered that he had been given the wrong medication.
- ◆ A prescription for **Migranol**[®] was dispensed incorrectly with **Stadol NS**[™]. The patient used a number of doses before the problem was discovered.

Wrong Dose

- ◆ A patient on **glyburide 5 mg** daily was to increase her dosage to 5 mg twice a day. The pharmacist received a verbal order from the physician and believed the physician said "Increase to two tablets twice a day." The words "to", "two" and "too" can be easily confused during a telephone conversation. All orders taken verbally should be repeated back to the prescriber to ensure accuracy of transcription.

Package Sizes

- ◆ A prescription for 40 capsules of **Accutane**[™] 40 mg was dispensed incorrectly with 30 capsules of Accutane 40 mg in the manufacturer's compliance packaging and a strip of 10 capsules of Accutane 10 mg cut from the manufacturer's compliance packaging. The manufacturer recommends that Accutane be dispensed in multiples of 15 so that a complete compliance card including the "Information for the Patient" is provided, and the incorrect strength of capsules cannot be dispensed inadvertently.
- ◆ A prescription for 100 **selegiline** tablets was dispensed incorrectly with 60 tablets because the person dispensing the prescription assumed that the stock bottle contained 100 tablets.
- ◆ A prescription for 100 **nefazodone** tablets was dispensed with 60 tablets because the person dispensing the prescription assumed that the stock bottle contained 100 tablets.

Direct Interaction with Patient

- ◆ A pharmacist wishing to speak with a patient about his medications telephoned the patient's home. The pharmacist left a message with the baby-sitter for the patient to call the pharmacy to discuss the pain medications. The patient was concerned about the breach of confidentiality.
- ◆ A prescription was to be delivered to a person's home. Because there was no one home to receive the medication, it was left on a woodpile beside the door. A dog carried the package in his mouth, broke the container and may have ingested some of the medication.

Hospital Pharmacy Insights - *Continued from page 6*

- ◆ Donations should be larger quantity units (i.e. case lots or sealed bulk stock bottles).
- ◆ Drug donations should be accompanied by a detailed packing list.

A copy of the complete WHO drug donation guidelines may be obtained from the WHO web site: <http://www.who.int/dap/dapdogui.html>, or contact Sharon Clark at the College office.

There are a number of Canadian and international agencies that coordinate requests for drug donations for disaster relief or medical missions. The College office has a listing of some organizations, or contact your local Red Cross relief office.



Recording Allergies And Adverse Drug Reactions On PharmaNet

All allergies and adverse drug reactions recorded on the in-pharmacy patient record must also be transmitted to PharmaNet. The public has a clear expectation that information provided to their pharmacist regarding allergies and adverse reactions will also be available on PharmaNet. In addition to the complete patient record PharmaNet provides, the central record of allergies and adverse reactions is one of the most important benefits of PharmaNet.

Enhancements to the automated checking of allergies and adverse reactions on PharmaNet are planned for the upcoming release. These enhancements will provide checking at the drug, the related chemical and the cross allergen levels.

Pharmacists who do not know how to submit the transaction to add an allergy or adverse reaction to PharmaNet should contact their pharmacy software vendor.

Any corrections to this information must be requested through the PharmaNet Coordinator at the College.

Training On PharmaNet

PharmaNet and the College have had reports of pharmacists using the PharmaNet production system to train staff or to test its response. Pharmacists are reminded that under no circumstances should PharmaNet be used for training pharmacy staff, or for testing adjudication results or current system availability using your PHN.

Access to a training environment is available by contacting your pharmacy software vendor.

Emergency Department Access To PharmaNet

In June 1997, the Minister of Health announced a pilot project to bring PharmaNet access to physicians in hospital emergency departments. Fifteen emergency departments were chosen to connect to PharmaNet during the pilot phase. Response from these sites was very positive. Access to the PharmaNet patient records decreased the time to retrieve the patient's medication history and enabled access to information in cases of language barriers or when the patient was incapable of providing it.

Expansion of PharmaNet access to all emergency departments in B.C. on a voluntary basis is expected in the near future.

Appropriate Access To PharmaNet

All accesses to a PharmaNet patient record, clinical conditions or adverse reactions will be recorded on the patient's access record when no prescription is dispensed for that patient. The information recorded includes the date of the access, the name of the pharmacist making the access, the pharmacy from which the access was made, 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.

As announced in the last *Bulletin*, the College will implement a detection of browsing audit on PharmaNet patient records. Each pharmacy should develop a system to record accesses to the PharmaNet patient record where no prescription is dispensed, in case pharmacists are required to explain the reason for an access.



NAPRA Advertisement



Resource Source



◆ Evaluations of Drug Interactions

The comprehensive Evaluations of Drug Interactions (EDI) contains information on over 33,000 interactions for both prescription and nonprescription drugs. Originally developed by the American Pharmaceutical Association, EDI offers immediate access to clinically reviewed drug interaction monographs. Electronic updates are available bi-monthly and the text is updated six times each year. For more information or to order EDI, contact the Inside Sales Department at 1-800-633-3453.

◆ Drug Dosage Guidelines and Formulary

The third edition of the Drug Dosage Guidelines and Formulary prepared by the Pharmacy Department of B.C. Children's Hospital is now available. For the \$30 document, please use the enclosed order form or send a cheque (payable to B.C. Children's Hospital) to: Yvonne Greig, c/o Department of Pharmacy, B.C. Children's Hospital, 4480 Oak Street, Vancouver, B.C. V6H 3V4.

◆ Pharmacy Management in Canada

A revised edition of the comprehensive *Pharmacy Management in Canada* is now available. The book contains the new contents: Management and the Process of Change in Pharmacy, Merchandise Management, Considerations for Succession Planning, and a sample commercial lease. Revised chapters include Pharmacy and the Health Care System, The Business Plan, Human Resources Management, Fixture Design and Layout, Pricing, Risk Management, and Security. The book can be ordered through the Canadian Pharmacists Association (CPhA) at Tel: 1-800-917-9489, Fax: 1-800-601-1904, or E-mail: requests@cdnpharm.ca. The CPhA member price is \$69.96 plus GST, and the nonmember price is \$79.95 plus GST.

◆ Informative Newsletter on Web Site

The Community Drug Utilization Program (CDUP) has a web site at: <http://cdup.org>. Managed by the Pharmacy Department at the Lions Gate Hospital, CDUP is an internationally recognized academic detailing program aimed at assisting physicians in selecting the most appropriate and cost effective drug therapy for their patients. CDUP's informative newsletter *R Review* is available for viewing by interested pharmacists at the web site.

Long-term Care - continued from page 7

Pharmacy Reference Library

The Council policy on reference libraries states that a pharmacy providing service to licensed facilities must have a minimum of one reference applicable to the pharmacy's area of service (i.e. geriatric and/or psychiatric residents). To date, a list of approved references has not been determined, leaving reference selection to the discretion of the pharmacist. However, pharmacists may wish to consider the following references.

References which pharmacists at the B.C. Seniors Medication Information Line find useful:

- ▶ *Merck Manual of Geriatrics.* Good review of problems and disease states in the elderly, and the treatment of them.
- ▶ *Geriatric Dosage Handbook* (APhA). Semla, Beizler, Higbee Monograph format.

References on psychiatric medications which Riverview pharmacists use:

- ▶ *Clinical Handbook on Psychotropic Drugs.* 8th ed. (1998).
Bezchlibnyk-Butler, Jeffries Described as their most useful reference; very practical; charts comparing drug classes, etc.
- ▶ *Psychotropic Drugs Fast Facts.*
Maxmen, Ward Includes geriatric doses; does not include newer drugs, though, as latest edition is 1995.
- ▶ *Essential Psychopharmacology.*
S. Stahl Receptor theories, mechanism of action.



Plan To Attend



▶ CSHP Spring Therapeutics Update

Thursday, 8 April - 6:30 to 9:30 p.m. (6:00 p.m. Registration)

Radisson Hotel (formerly the Clarion Villa), Burnaby

- “Challenges in Preventive Cardiology - Reducing Cholesterol Risk”
Dr. Ross Tsuyuki, University of Alberta
- “New Alternatives in Epilepsy Pharmacotherapy”
Dr. Patricia Gerber, B.C. Children’s Hospital/ UBC Faculty of Pharmaceutical Sciences

▶ CSHP Residency Presentation Night

Wednesday, 19 May - 7:00 to 10:00 p.m. (6:30 p.m. Registration)

Hyatt Regency Hotel, Vancouver

- Featuring the residency projects of B.C.’s 15 hospital pharmacy residents, including brief verbal presentations and poster displays

Contact for the two CSHP events: Dr. Richard Slavik, Fax: (604) 875-5267, E-mail: rslavik@interchange.ubc.ca, or register at www.cshp-bc.com

▶ Council Meetings

Friday, 16 April

Friday, 18 June

▶ Forensic Assessments

Friday, 4 June

Friday, 22 October

▶ Panel Assessments

Saturday, 5 June (*results 5 July*)

Sunday, 6 June (*if required*)

Saturday, 23 October (*results 22 Nov.*)

People News



Announcements

- ▶ Pharmacare Director **Bob Nakagawa** will be leaving his position at the end of April to become Director of Pharmacy for the Simon Fraser Health Region.
- ▶ **Marshall Moleschi**, Director of Member and Corporate Services with the Health Association of B.C., and former College President, has been appointed to the Board of the B.C. Pharmacy Association as Director at Large, effective now through 31 August 2000.
- ▶ Active Board of Examiner member **Maria Finamore** has been appointed Chair of the Board, and **Caroline Chin** has been appointed to the Board as the Director of Knowledge Assessment.

Achievements

- ▶ Council has granted **Leroy Fevang** Honorary Member status in the College of Pharmacists of B.C., in recognition of his distinguished service as Executive Director of the Canadian Pharmacists Association for the past 21 years, and for his previous service as the Registrar of the College from 1971 to 1978.

In Memoriam

- ▶ Council regrets the passing of members **Stuart Wallach Boucher** of Delta, **Peter Malyuk** of Coquitlam, and **Edwin Wesley Fockler** of West Vancouver.