Pharmacy Council Newsletter November 2011 - PRINT VERSION

Report from the Chair

Welcome to the final newsletter of 2011 and my first report to you in my new role as Chair of Council. As you'll see it's been a busy year!

I am pleased to announce that Council has adopted the Maori name *Te Pou Whakamana Kaimatu o Aotearoa*. Council is committed to the implementation of the Maori Health Strategy for the pharmacy profession, and adoption of this name recognises Maori as an official language in New Zealand. I wish to acknowledge the assistance from Ngā Kaitiaki o Te Puna Rongoā o Aotearoa (Māori Pharmacists' Association), and in particular, kaumātua Hiwinui Heke in the process.

At our August meeting we were joined by Steve Marty, the Chair of the Pharmacy Board of Australia (PBA) and Joe Brizzi the Executive Officer of the Australian Health Practitioner Regulation Agency (AHPRA). This was our first meeting with our Australian counterparts and was an excellent opportunity to discuss issues of common interest and in particular learn from their experiences following their transition from the eight individual states and territory Boards to one Board, sharing executive and administrative functions with other regulatory authorities through the AHPRA. Council and PBA have agreed to work together closely and we will sign a Memorandum of Understanding at our next joint meeting.

In the June we reported on Council's concerns regarding a proposal by Health Workforce New Zealand (HWNZ), as part of government's consolidation agenda, to amalgamate New Zealand's health regulatory authorities' secretariat functions and reduce their board sizes. HWNZ has considered the responses to its proposal and has now asked regulatory authorities to scope ways in which they can achieve greater efficiencies and provide more "value for money", in addition to providing better workforce data. We have taken a lead in this and will report to HWNZ before the end of this year, ahead of a review of the HPCA Act in early 2012.

With the projected future increase in demand on health resources, the opportunities for pharmacists to practice in advanced patient-centred and clinical roles will increase. There is a general acceptance that pharmacists are an under-utilised resource in the health sector and the success of the warfarin monitoring pilot is testament to the capability of pharmacists to carry out advanced roles in a collaborative environment. Funded MUR and developments such as the Long Term Conditions and proposals for Subsidised Autonomous Dispensing indicate a clear willingness of funders to utilise the pharmacy profession more. Looking ahead, additional supervised prescribing opportunities for pharmacists are proposed in the Medicines Amendment Bill.

Council continually monitors the changing health environment and has a responsibility to ensure that the profession can safely and effectively practice in new and changing roles. Council has recently endorsed Medicines Therapy Assessment (MTA) Standards and continues to work closely with HWNZ to progress the Pharmacist Prescriber application. To free up pharmacist's time to take on more patient centred activities, Council sees

merit in investigating how suitably qualified pharmacy technicians could work under more flexible supervision requirements without compromising patient safety.

PCNZ hosted the Life Long Learning in Pharmacy Conference in July this year. Opened by the Associate Minister of Health Hon Peter Dunne, this international forum provided the opportunity for pharmacists, pharmacy educators, regulatory authorities and professional bodies to present and discuss best practice in continuing education and continuing professional development. Well done to the organising committee for such a successful conference.

Finally, I'd like to acknowledge my predecessor Carolyn Oakley Brown, for her tremendous contribution to the Pharmacy Council over the last nine years and as chair for the last six of those. Carolyn completed her final term of appointment in August. Her hard work and dedication, pragmatism and outcomes driven leadership will be missed. I wish her well in her future endeavours. I also warmly welcome Leanne Te Karu as the newly appointed pharmacist member of Council, and look forward to working with Leanne.

Andrew Bary

From the Council's latest meeting

The Council meets five times a year and the most recent meeting was in October. At this meeting, as part of its education and standard-setting role, Council endorsed the Medicines Therapy Assessment (MTA) Standards prepared by the Pharmaceutical Society and set the accreditation standards for the Pharmacist Prescriber scope of practice. (For more information see below)

A number of policies were reviewed including the registration policy for pharmacists from countries which don't have recognised equivalent qualifications, the English Language policy for registration, the return to practice policy and the the Preregistration Assessment Board (PRAB) appeals policy.

Council also began scoping a project to determine the feasibility of a consolidated regulatory authority organisation in response to a request from Health Workforce New Zealand for proposals, by the end of 2011, to increase efficiencies amongst the authorities.

REMINDER: Consultation on the Proposed new Recertification Framework closes 16 December

The Council is seeking your views on a proposed new recertification framework – the mechanism used to ensure pharmacists maintain their competence as required by legislation.

A working party comprising representatives from all areas of pharmacist practice reviewed the current framework and developed a new approach which addresses the concerns that pharmacists have had about the current approach, that:

- there is no recognition of learning that is relevant but not "used in practice"

- there is no peer involvement, unlike in other professions
- the system is not user-friendly and is difficult to document

Details of the proposal developed by the working party are contained in the consultation document, which has gone out to all pharmacists, pharmacist groups, pharmacist professional organisations and stakeholders.

Please view the consultation document and provide your feedback on this page of our website - http://www.pharmacycouncil.org.nz/consultations
Alternatively you can download a hard copy of the feedback form from this page and return it to us by post or fax.

Due to a request from pharmacists, we have extended the closing date for submissions to **Friday 16 December 2011**.

We look forward to receiving your views which will contribute to the development of the final Recertification Framework for Pharmacists.

Recertification Audit

The 2011 recertification audit was completed in early September and for the first time since the audits commenced, the auditors did not have to request further evidence from any pharmacists.

The audit, of a random selection of pharmacists, assessed CPD documentation for the three year period from April 2008 to March 2011 and confirmed the pharmacists participation in the ENHANCE recertification programme.

91% of pharmacists selected had their documentation confirmed as meeting an acceptable standard. This continues the trend of ongoing improving documentation.

ENHANCE has prepared a learning log template that pharmacists can use to provide a description of completed professional development activities. The auditors considered the learning log in conjunction with the CPD records before giving feedback on the overall quality of the audit submission. The feedback provided was designed to assist pharmacists to improve their future professional development activities.

Pharmacists whose overall quality of documentation was considered poor were advised to work with an ENHANCE programme pharmacist to improve the quality of their documentation and/or learning. Pharmacists who do not address identified concerns will be selected for a future audit.

New Intern Assessment Centre trial

The Pharmacy Council is currently considering the results of recent trials of new assessments for intern pharmacists before making a final decision on future assessments.

Last year Council decided to review the intern programme. An external review was commissioned and earlier this year the Preregistration Assessment Board (PRAB), a subcommittee of the Council, commenced a project to review the final assessment of intern pharmacists.

Since 1997 all interns have been required to successfully complete the Intern Training Programme prior to being eligible to register as pharmacists. This programme, run by the Pharmaceutical Society of New Zealand, includes a final assessment referred to as the Assessment Centre. This involves Objective Structured Clinical Examinations (OSCE) – a type of examination used in health sciences to test clinical procedures and the interpretation of results by role-playing common clinical situations. The Pharmacy Council reviews and moderates the assessment material for the Assessment Centre.

The PRAB has completed its work reviewing the assessments of interns and set out recommendations for future possible assessments.

Multiple Choice Exam

One recommendation is for the introduction of a written multi-choice exam to test interns' application of clinical knowledge. In September, 20 intern volunteers trialled an Australian Pharmacy Council (APC) exam modified to suit New Zealand context. This approach follows the Council's successful adoption of APC exams for use with overseas qualified pharmacists seeking registration in New Zealand.

OSCE Assessment Centre

The PRAB subcommittee recommended that future OSCE stations should be developed by following a multiple step process, developed by Professor Zubin Austin from the University of Toronto, which is used for assessing pharmacists in Canada.

This process ensures that as much as possible the assessments match real practice and expectations. The steps followed for OSCE development are: blueprinting, station development, case writing, case review and standard setting. A different group of pharmacists developed each step.

The **Blueprinting Group** developed a new blueprint for the Assessment Centre, which describes the content, context and competence standards to be assessed in future Assessment Centres. The blueprint ensures that the standard expected from each Assessment Centre remains consistent.

The Station Development Group confirmed the suitability of a number of practice scenarios based on actual occurrences in practice, which were submitted to Council by interns and pharmacists earlier in the year, and developed some additional ideas.

The **Case writing group** developed 10 OSCE 'stations' that covered the blueprint. Each case included a checklist of activities for the interns to demonstrate (e.g. asks about medical history) and a global rating to measure communication, logical process and overall performance. A separate group reviewed the case and made changes as required.

The Standard Setting Group agreed on the standard for each OSCE station. This involved extensive discussion to agree on the score for each checklist item and for the global score. Some items were regarded as crucial (high score) whilst others were not as critical and/or relevant. The pass score for each OSCE is derived from these scores.

At the beginning of November, a trial assessment of the new OSCE stations, involving 20 interns from Auckland, was completed in partnership with the EVOLVE team of the Pharmaceutical Society.

The trials of both the Multiple Choice Exam and the trial OSCE Assessment Centre will be evaluated by Council in early 2012 before decisions are made about future assessments.

We are most grateful for the energy and the valuable contribution of the numerous pharmacists who participated in this work. Your assistance is highly valued.

Pharmacist Prescriber Scope of Practice

The accreditation standards for the Post Graduate Certificate in Pharmacist Prescribing have been finalised and are now available on the Pharmacy Council website.

Council will be using these standards to accredit the Post Graduate Certificate, which it will prescribe as the qualification for the proposed Pharmacist Prescriber scope of practice. The Schools of Pharmacy at Otago and Auckland Universities are currently collaborating to develop a common qualification for delivery in 2012.

The Post Graduate Certificate will be provided as two papers equivalent to 300 hours of study each. The first paper will focus on the Principles of Prescribing. The second Prescribing Practicum paper will require the pharmacist to work for periods of supervised and unsupervised practice with a designated medical practitioner in the area of practice in which they intend to prescribe. Entry will require prior completion of a Post Graduate Diploma in Clinical Pharmacy or equivalent.

More information about the current progress of the Pharmacist Prescriber Scope of Practice is available on the website.

Getting up to speed on cultural competence

The new cultural competence standard becomes mandatory in 2012 following a year giving pharmacists time to get up to speed on the new requirements.

In January all pharmacists on the practising register were sent a copy of the new Competence Standard 1, which incorporates elements relating to cultural competence. Included in this posting (in the distinctive orange box) was a copy of the 2011 Code of Ethics.

By now pharmacists should be familiar with the contents of both publications, particularly Competence Standard 1, and should have determined where any cultural competence

knowledge gaps might be. Ideally, a practice review may have been carried out against the new standard and the Code of Ethics.

A range of learning opportunities and phamacy-specific education programmes are available for pharmacists, although these are not the only learning opportunities. For example, Nicolette MacDonald's blog in a recent issue of Pharmacy Today outlines her research to find a better way to connect with a core group of her Panmure pharmacy customers which will benefit both them and the pharmacy.

The programmes have been designed to be delivered in a variety of ways from on-line, face-to-face or a combination of both so you can choose an approach that suits you personally. The content may be Māori focussed but the tools can be applied to any situation. Contact details for the programme providers are on the Council website. Programmes include:

- Ngā Kaitiaki o Te Puna Rongoā o Aotearoa (Māori Pharmacists' Association): 1-day workshop (weekday or weekend) introduction to health disparities and cultural competence and its contemporary application for pharmacists
- Whānau.Biz: 1-day workshop providing practical cultural competence tools for everyday use in the delivery of pharmacy services
- Māori Multimedia Limited: on-line Te Reo Māori course delivered over 6 months

More information about the new standard, which aims to improve health outcomes, is available in the Council's January newsletter and on the website.

October was also the first Health Literacy month in New Zealand. This was supported by Workbase's Health Literacy e-News, which provides information on health literacy publications and resources. Improving health literacy is key issue to improving the health of New Zealanders. More information is available on www.healthliteracy.org.nz/

2011 Workforce Report now available

A comprehensive demographic profile of New Zealand pharmacists is contained in the Council's most detailed workforce report to date, recently published on the website.

This data is becoming increasingly important for policy development, service delivery planning and research. The contribution that pharmacists make every year in returning this information is appreciated.

With data having been collected since 2004, when the Health Practitioners Competence Assurance Act came into force, there is now sufficient depth of data to see trends and patterns emerging. We can see, for example, that there are now more female than male pharmacists; that pharmacist numbers are growing slowly – an increase of 15% in the past seven years and that most pharmacists (no surprise) work in the community.

What is really interesting is the trends in retention rates and we are publishing this here for the first time. The retention rate of New Zealand pharmacist graduates has increased significantly (by 20%) in the past three years; 67% of our 2006 graduates have stayed in New Zealand. This probably reflects the removal of the reciprocal agreement for United Kingdom registration for New Zealand pharmacists back in 2006.

Pharmacists who come to New Zealand from the “recognised” countries – the United Kingdom, Ireland, the United States and Canada which are recognised as having equivalent qualifications - stay the shortest amount of time, whereas those from the “non-recognised” countries such as India, South Africa stay the longest. The data influence and allow better evidence-based planning both of Council services, for example around the registration of overseas qualified pharmacists and of future pharmacy services to meet the medicine needs of the public.

Another interesting fact the workforce data shows up is that the ethnicity of the profession is slowly changing, with proportionally less New Zealand European/Pakeha and greater numbers of Chinese and Middle Eastern pharmacists. That trend undoubtedly matches changes in the population of New Zealand as a whole and helps ensure community needs are met. What is disappointing is the insignificant change in the Māori workforce over the years, with less than 2% of our workforce identifying as Māori. This is despite considerable effort through the Pharmacy Reference Group for the Implementation of the Māori Health Strategy (PRISM).

Competence review “My experience”

This is a personal story from a pharmacist who recently went through the Council’s competence review process. The Council thanks this pharmacist for sharing their story with the profession.

The Pharmacy Council requires practising pharmacists to operate within a range of Competence Standard as well as complying with individual pharmacies standard operating procedures.

After a career of over forty years and working long hours and under huge pressures some of my practices began to slip. Eventually after a dispensing error that was not appropriately attended to, a patient made a complaint to the Health and Disability Commissioner and although this was resolved “in-house” and did not involve any disciplinary measures Council was notified of my shortcomings.

Every practising pharmacist must live in constant awareness of the consequences of an oversight eventuating into a critical situation. In my case I was mortified that I had allowed my practice to come to this stage. As an individual I was processing on an average 250 prescriptions per day, which required unacceptable short cuts to occur, and with constant interruptions my concentration was often diverted away from the task at hand. I was also too busy to follow through with patient advice.

Council’s way of handling a situation such as I was in, is to endorse my practice condition on my A.P.C. requiring all work to be checked by another pharmacist. Pharmacy Defense became involved and recommended to Council a local pharmacist to act as my counsellor. Council also appointed a competency review team to visit the pharmacy and review my work process and to determine the “gaps” in my practice. This process involved two days and was very focused and stressful. I was reassured that this was an educational procedure and NOT a disciplinary one. The review team identified my short-comings and reported to Council.

The local pharmacist acting as my counsellor and I were required to met every two weeks and complete a series of exercises based on the Competency Standards and "gaps" in my practice to ensure I was becoming more focused on my practice.

After Council had become satisfied with the reports from my counsellor the review team made arrangements to re-visit me and conduct another review. This report was presented to Council, and to my delight was accepted.

The whole process from the time of my error being reported to Council to my full re-certification has taken two years, at times I felt quite despondent and depressed, as my pride had taken a considerable battering. Staff at Council and the pharmacists acting as my counsel and on the review team have been a great support and have encouraged me at every stage of the process.

I have now changed my place of employment and working with a team that is supportive of one another's efforts. I am not working up to fifty hours a week with an hours travel each day as well. I am also pleased that I have recovered my self-esteem and enjoy the ability to communicate with the public and act as a professional once again.

Practice Issues

Patients and their medicines – it's all about communication

Getting the right information to patients about their medicines is a fine balance between over-loading a patient with too much information and not giving enough and all pharmacists need to ensure patients are adequately informed.

From time to time Council receives calls from patients concerned about the lack of information and guidance they receive from pharmacists about their medicines. The prescription may be as simple as a course of antibiotics or as complex as an initiating course of amiodarone. Both of these may seem straightforward enough to a pharmacist, but for many patients it can be complicated and baffling.

Patient counselling should, at the very least, cover:

- what the medicine is for
- how to take it properly and what special precautions to take
- how soon to expect it to work
- what foods or medicines to avoid
- common side effects, what to expect, how long they might last and how to treat them
- what other medicines, including CAMS, interact with it
- why it might look different from last time
- what to do if a dose is missed
-

The Council website (www.pharmacycouncil.org.nz/services) gives patients an overview of the information they can expect to receive about their medicines – it's up to all of us to ensure they do.

Keeping patients safe – getting the medicines right when they transfer between care facilities

Ensuring medicine information is transferred with patients when they move care settings is important for patient safety and is the responsibility of all healthcare professionals involved in a patient's care.

The Health and Disability Commission recently notified Council about a dispensing error involving a rest home patient who was incorrectly dispensed clonazepam instead of the prescribed clozapine. The case raised a number of issues in addition to the dispensing error.

The patient had been transferred from a residential care facility in one DHB to a second DHB, and therefore into the care of a different pharmacy. The patient had been stabilised on clozapine but this information was not conveyed to the new pharmacy by either the rest home or the DHB. Compounding this omission, the pharmacy misread the patient's medication chart and dispensed clonazepam instead of clozapine in the patients' compliance packs. The dispensing error was undetected by both the pharmacy and the rest home for nearly two months during which time the patient became increasingly frail.

A request to take on a new rest home patient should prompt a pharmacy to initiate contact with the patient, their family/whānau and the rest home nurse manager to ensure all relevant information regarding the patient's medications is also transferred.

Medication charts received from rest homes should be treated with all the care and attention given to 'ordinary' prescriptions ie all the usual checking processes should be in place. The checking of blister packs should also be done in an area where the pharmacist can work uninterrupted whenever possible.

Sound alike – looK alike

Confusion between drug names that look alike or sound alike is a common cause of medicine selection errors, although a recent study published in the International Journal of Pharmacy Practice (2011;19:51) found that lack of attention to different strengths is behind most medicine selection errors in the dispensary.

The use of enhanced text such as "Tallman" (writing part of a medicine's name in capital letters) is becoming more common and may help prevent errors by drawing attention to the dissimilarities in their names. Examples of this text include

aMILoride confused with amlodipine

cloNIDine	clonazePAM
FLUoxetine	PARoxetine
LaMICtal	LamISIL
metroNIDAZOLE	metFORMIN

Sound alike-look alike names that have come to PDA's attention recently include:

quinine 200mg	quetiapine 200mg
nortriptyline	Normison
norfloxacin	moxifloxacin
cyclophosphamide	cyclosporine

Servent	Seretide
doxazosin	dexamethasone
allopurinol	amlodipine
Neomercazole	NeuroKare*
Largactil 100mg	Lamactil 100mg
Siterone 50mg	sertraline 50mg
Siterone 50mg	serophene 50mg
carbimazole	carbamazepine

*This selection error has occurred on a number of occasions and requires particular care.

These similarities are often compounded by packaging that is very similar e.g. pantoprazole and ondansetron, and by the lack of marking on some tablets. To minimise selection errors ensure all stock bottles used when dispensing are left with the prescription, and ensure all bottles and skillets are opened to check contents if you are the checking pharmacist.

Baskets or bags

There is often debate over whether completed prescriptions should be 'bagged' or put in a basket until collected by the patient or their carer/agent. Best practice is to use either individual baskets or a clear re-usable plastic bag, which also provides an opportunity for a 'final' final check.

A recent complaint to HDC was the end result of a patient simply being handed a bag with her 'completed' prescription with no counselling offered or provided. When she opened the bag at home a number of her medications were missing. The pharmacy's records indicated they were dispensed but they have no knowledge of where they went.

Putting prescriptions in a basket or clear plastic bag gives pharmacists a chance to check the medications with the patient and an opportunity for patients to ask questions about their medications, empowering them to take a more active role in their own health. Handing out bagged prescriptions without counselling or checking with the patient make errors of this nature more likely.

Emergency Supply – Dentists

From 1 December amendments to Medicine Regulation 44(m) will include New Zealand registered dentists as prescribers under which an emergency supply of a previously prescribed medicine can be supplied. Whenever an emergency supply request is made by a patient it is important to determine that the supply is for **current** therapy.

A patient who received a course of antibiotics following dental treatment several months ago, but who now has another toothache/potential abscess cannot be supplied with an emergency supply as it is not current treatment.

The current five day (and a further five day repeat) restriction on dentists prescribing will be also be removed from 1 December ie they will be able to prescribe up to three months supply, within their scope of practice.

Recent Health Practitioners Disciplinary Tribunal (HPDT) Decisions

Supply of unnecessary or excessive quantities of drugs

The Tribunal found Arief Katamat guilty of professional misconduct in that his acts and omissions breached the Medicines Act (1981) and associated Regulations (1984), the Misuse of Drugs Regulations (1977) and the Pharmacy Council Code of Ethics (2004).

The Tribunal stated that Mr Katamat had failed to exercise professional judgement to prevent the supply of unnecessary or excessive quantities of Sudomyl 60mg (approximately 26,260 tablets) and codeine phosphate (25,535 tablets) where he should have known that the medications had the potential for misuse. He failed to record incoming order quantities and associated supply quantities. Mr Katamat's explanations for the discrepancies were held not to be credible by the Tribunal. This conduct also included the sale of prescription medicines without a prescription, sale of Lipitor without a wholesale license, and failure to comply with the requirements for keeping a Controlled Drugs Register.

The Tribunal also commented that Mr Katamat's behaviour was a significant departure from standards expected of a pharmacist.

It ordered the immediate cancellation of Mr Katamat's registration. He was also censured and ordered to pay 25% of the costs of the Tribunal hearing and 25% of the costs of the Professional Conduct Committee - a total of $59,678.

Mr Katamat has appealed the Tribunal decision and penalty to the High Court.

The full decision and the penalty decision can be found at: http://www.hpdt.org.nz/ Tribunal decisions/pharmacists/ Phar10/162P

Poor practice standards

A second pharmacist has also appealed the Tribunal's decision to the High Court, including the penalty imposed. An application to stay the implementation of the orders has also been made and therefore the pharmacist's name is suppressed.

The pharmacist was found guilty of professional misconduct. The Tribunal found that the pharmacist's actions in 1) allowing an unqualified person to dispense prescription medicines; 2) failing to keep a Controlled Drugs Register; and 3) failing to document standard operating standards, amounted to malpractice and brought discredit to the profession. The Tribunal also upheld the charge that the pharmacist had practised when his practising certificate had expired.

The Tribunal stated that the totality of the pharmacist's conduct as well as his attitude in respect of the conduct signalled a complete disregard for his legal and professional obligations, and gave rise to significant concerns for the health and safety of the public. The Tribunal expressed concern that the wide range of breaches over such a period indicated a disquieting pattern of non-compliance.

The Tribunal ordered that the pharmacist's registration be cancelled; that should the pharmacist apply for reinstatement to the register a range of conditions would need to be satisfied; and that costs of $16,000.00 towards the hearing and the investigation be paid;

Going electronic

In the near future, all newsletters will be sent electronically. Please make sure we have your correct email address so you can receive the next one electronically. Log in on our website to update your details - http://www.pharmacycouncil.org.nz/useradmin/ or email us at enquiries@pharmacycouncil.org.nz

When you renewed your Annual Practising Certificate early this year, we asked if you would like to receive your newsletter electronically. Those who selected this option have have received this month's newsletter by email. E-newsletters will improve our communications with you and overtime save significantly on print and postage costs.

IMPORTANT – To ensure you receive your newsletters in the future please update your email address

Thank you