MARCH 2006

newsletter

pharmacycouncil
OF NEW ZEALAND

Changes to the Leadership of the Pharmacy Council

Farewell and thank you to the retiring Chair – Eleanor Hawthorn

The Council expresses its heartfelt and sincere thanks to Mrs Hawthorn for the considerable work she has done in establishing the new Council. As a pharmacy owner, and one of six practising pharmacists on the Council, Mrs Hawthorn has brought considerable professional expertise as well as wise guidance to the Council and has led the Council through its very heavy workload, setting standards of practice and establishing a competence and complaints structure. The Council has been fortunate to be able to draw on the expertise of someone with such an extensive knowledge of the profession at a time when many important decisions were being made about issues which have a long-term impact on professional standards for pharmacy.

Welcome to new Chair – Carolyn Oakley-Brown

The Council is pleased to welcome Christchurch pharmacist Carolyn Oakley-Brown as the new Chair. Mrs Oakley-Brown has been a member of the Council since its inception and has taken over from the inaugural Chair, Eleanor Hawthorn. She brings her wide experience as both a community pharmacist and pharmacy proprietor, as well as her involvement in innovative medicines management services in Christchurch, to this leadership role.

Consulting pharmacist Andi Shirtcliffe, has been re-elected as the Deputy Chair of the Council.

New Appointments

As the statutory body set up under the terms of the Health Practitioners Competence Assurance Act to regulate the profession and protect public safety standards, the Minister of Health appoints six pharmacists and two lay people as Council members. As part of the process of scheduled review of appointments, the following changes to the Pharmacy Council have been made.

Two South Island pharmacy proprietors have been appointed as Council members to replace retiring Council members. They are **Dr Andrew Bary** of Queenstown and **Jo Mickleson** of Wakefield, Nelson.

Jo Mickleson is the owner-operator of the Wakefield Pharmacy in Nelson and is a member of the Hospital Advisory Committee to the Nelson-Marlborough District Health Board. Prior to her community pharmacy practice Jo had more than a decade's experience in hospital pharmacy, including three years as a clinical pharmacist at North Shore Hospital and four years in policy and managerial roles with South Auckland Health.

Dr Bary owns Queenstown Pharmacy situated in the Queenstown Medical Centre in partnership with his pharmacist wife. He is the current president of the Otago branch of the Pharmaceutical Society of New Zealand (Inc) and is also a teaching fellow of the School of Pharmacy at the University of Otago.

Pharmacy Council Deputy Chair Andi Shirtcliffe, Professor John Shaw and Dr Judith Johnston have each been reappointed for a further three-year years. Darryn Russell and Brian Irvine remain on the Council.

Intern Pharmacists numbers highest ever for 2006

188 new intern pharmacists have registered with the Council for 2006. These intern pharmacists are all undertaking the Preregistration programme of the PSNZ (Inc) and we welcome them to the profession. They join 15 interns from the 2005 programme who are still working towards completion of requirements for registration.

The breakdown of the interns in 2006 is as follows

2005 B.Pharm Otago graduates	90
2005 B.Pharm Auckland graduates	82
Overseas registered pharmacists	14
Return-to-practice NZ pharmacists	2
Unsuccessful 2005 Prereg programme interns	15
Total Intern Pharmacists	**203**

In comparison, 157 new intern pharmacists were registered with the Council in 2005, and 142 in 2004.

With 100 and 120 places respectively in the Auckland and Otago University Schools of Pharmacy now producing graduates, Council expects the numbers of graduates to remain around this year's level.

The Pharmacy Council of New Zealand was established under the Health Practitioners Competence Assurance Act 2003 and has a duty to protect the public and promote good pharmacist practice.

IN THIS EDITION

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Have you renewed your 2006/7 Annual Practising Certificate ?

If you have not already done so, please submit your Annual Practising Certificate renewal form to the Council urgently. It is illegal to practise as a pharmacist in New Zealand without a current APC and 31 March 2006 is when the 2005/6 APCs expire.

Recertification

It is a requirement that all pharmacists are participating in recertification by March 2006. On your APC renewal form (Item 7) you must be able to declare that you are participating in recertification and name the standards that you are practising in – you will know this when you have completed a Practice Review.

ENHANCE is currently the only Council accredited recertification programme. Participation in ENHANCE means that you have undertaken a review of your pharmacy practice, by completing the Self Assessment of Competence (Practice Review), and you are continuing your Professional Development in areas directly relevant to your work. ENHANCE is a documentation system that teaches you how to record your learning, decide how much impact that learning has had on your practice, and, assign a credit value to the learning. The system uses the Pharmacy Council CPD Record Forms and Outcome Credit Scale ©.

The Pharmaceutical Society of New Zealand (Inc) is the professional body for pharmacists in New Zealand and is currently the only accredited recertification provider. Please contact them (by email enhance@psnz.org.nz or phone 04 381 8357) to discuss membership options and to sign up to the ENHANCE programme.

Recertification Requirements in Maintaining Competence – First Aid Certificate

Currently all practising pharmacists who provide primary healthcare (i.e. identify Competence Standard 3 as forming part of their practice) are required to hold a current First Aid Certificate as evidence for activity 3.6.1.

Council discussed this requirement at their last meeting and has resolved to keep the first aid certificate requirement. In doing this Council considered whether pharmacists who practise within a medical centre and pharmacists who are practising in a rural setting who have difficulty attending first aid training courses, could be exempt from the requirement.

However, the Council has determined that even when a pharmacy is within a medical centre setting, doctors are not always available and that the accreditation is for the pharmacist, not the doctor.

Council will work with Pharmacy sector groups to find other ways of delivering first aid training to pharmacists practising in a rural setting, so as to support them in their isolation and assist with the difficulty they experience in obtaining cover while attending first aid training.

Council acknowledged that NZQA requires that a First Aid Certificate is revalidated every two years and will explore with NZQA any available options regarding the two year revalidation requirement.

FAQs: Employers and Annual Practising Certificates (APCs)

This information relates to pharmacists registering in New Zealand for the first time or returning to practice.

Who needs an annual practising certificate?

Any pharmacist who wants to practise in NZ must be registered and issued with a current APC by the Pharmacy Council of NZ. Practising without a current APC is a breach of the HPCA Act 2003.

Non-practising pharmacists are registered with the Pharmacy Council of NZ but do not hold an APC. They can apply to transfer to the practising register if they intend to practise and then be issued with an APC (see website for further details, www.pharmacycouncil.org.nz)

How do I find out if the pharmacist I am employing is registered and has been issued an APC?

There are two ways you as an employer can find this out:

- Ask the pharmacist you will be employing for a copy of their APC or
- Visit the Pharmacy Council of NZ website www.pharmacycouncil.org.nz and do an online register search in the public domain of the website. You will need to enter the surname and by clicking on the name of the pharmacist you intend to employ you find information on whether the pharmacist holds an APC or not.

How long does it take for Council to issue an APC?

This depends on the information that is required from the pharmacist before an APC can be issued. The type of information that is required by Council for assessment includes:

- Work history i.e. when and where did the pharmacist last practise pharmacy
- Continuing professional development (CPD) records i.e. what types of CPD activities have they been undertaking
- Letters of good standing (if applicable)

All of the above information is used to determine the eligibility of a pharmacist for an APC. At least FIVE (5) working days should be allowed for the issue of an APC from the time all information is received from pharmacists registering in New Zealand for the first time and returning to practice.

Does the intern need an APC before starting their internship?

Yes they do. Interns need to register in the intern scope of practice and be issued with an APC before they start their internship. When the requirements of the Intern Training programme have been successfully completed and they receive an invitation to register as pharmacists they can then be issued with an APC in the pharmacist scope of practice.

Who can I contact for further information regarding this?

Registrations Officer, Pharmacy Council of NZ
email s.mckibbin@pharmacycouncil.org.nz or 04 495 0333.

Pharmacy Council Consultation on Competence Standards for Medicines Management Services

Consultation on Competence Standards for Medicines Management Services has been carried out with pharmacists and health sector stakeholders including doctors' and other health professionals' organisations, District Health Boards and consumer groups. The feedback from the consultation has been comprehensive, useful and generally positive. The Council's working group will meet in April to review the feedback. The Pharmacy Council is conscious of the need for clarity in describing the competencies and the medicines management services to which they apply. The work on competencies will be aligned with the services generated by the DHBNZ as outlined in the Draft National Framework for Pharmacist Services. Thank you very much to all the pharmacists who responded and provided such well thought out and useful feedback.

Safe Practice Tips

Quinine now prescription medicine

Previously a pharmacist-only medicine for the treatment of muscle cramp, quinine has been re-classified to prescription medicine except for medicines containing 50mg or less per recommended daily dose. The classification change was notified in the New Zealand Gazette on 9 March 2006 and took effect from that date. The change has been made because of the risk of thrombocytopenia and to harmonise with Australia, where quinine was re-classified in 2004.

Potential for confusion with Oxynorm® and Oxycontin®

Pharmacists should take extra care when dispensing these look-alike/sound-alike brands for oxycodone hydrochloride. There have been errors reported where Oxycontin® has been dispensed when Oxynorm® was prescribed.

Oxynorm® is a short-acting oxycodone formulation for four-to-six hour dosing and may be used "prn". (Clue: "norm" = normal four to six hour dosing)

Oxycontin® is a prolonged-release oxycodone formulation for twelve hourly dosing and is not suitable for "prn" dosing. (Clue: "contin" = continued effect)

If possible, store these two preparations well apart in the safe in order to help avoid selection errors or consider using a coloured sticker or other "flag" to differentiate them.

Special Authority numbers

Not all pharmacists may be aware that in cases of urgent need, when patients' Special Authority numbers have expired, an interim number may be issued by HealthPac. This means that the patient will not have to pay the full price for the medicine while waiting for their renewal.
Phone 0800 243 666 to arrange an interim number.

Good communication is key to a professional service

Recently the Pharmacy Council has had a number of calls from consumers with concerns about the level of service they have received from pharmacies.

Interacting with the public is often challenging. However patients and customers have a right to high standards of professional service. The Council expects pharmacists to conduct themselves in a manner which inspires confidence in the profession as described by our Code of Ethics, Principle 7: The pharmacist shall act in a manner that promotes public trust in the knowledge and ability of pharmacists and enhances the reputation of the profession. Competence Standard 1 Practise Pharmacy in a Professional Manner also details pharmacists' obligations.

The following reported behaviours were upsetting to patients and are considered unprofessional:

- A pharmacist loudly refused to sell a pseudoephedrine-containing medicine without apparent reason, in front of other pharmacy clients, and without consulting with the patient to determine appropriateness. The patient felt that a judgement was made on the basis of her appearance. The pharmacist "rolled her eyes" at the pharmacy assistant and the patient left the pharmacy in tears.
- At the opposite extreme, a customer felt that the pharmacist lectured and interrogated her at length without explanation when she requested a medicine for a congested cough for her sick father. She felt confused and insulted.
- Pharmacy staff members were rude and did not take seriously complaints about being short-changed on prescription quantities. There were also many miscommunications about repeats. It happened so many times to one family that they concluded the pharmacy was "dispensingly disorganised" and they took their business elsewhere.

These types of situations would be less likely to occur if better communication skills are utilised by pharmacists. The Council suggests complainants with these types of enquiries contact the free advocacy service of the Health and Disability Commissioner, but some prefer to make formal complaints to the Commissioner.

The Council's vision is that "pharmacy practitioners are recognised as the trusted experts in medicines". Careless communication can place patients at risk and contributes to a negative image of the profession. How could we as pharmacists improve our professional communication with patients? One way to start is by examining closely our own communication "style". Do we treat clients the way we would like to be treated ourselves?

Insights into people likely to improve safety systems

This article has been adapted with permission from information published in the ISMP (Institute for Safe Medication Practices) April 2004 Newsletter.

It is widely recognised that system failures cause errors. Well-designed systems that employ appropriate technology that is correctly used, offer the best chance of preventing errors. But has our growing attention to systems and technology caused us to overlook interventions that can improve our mental performance? While we are beginning to better understand healthcare systems, have we devoted equal attention to understanding how the human mind operates and what conditions adversely affect its function? Have we done enough to identify how stress-producing aspects of our home and work environment can affect our job performance and what steps can be taken to help people cope with them? Also, do we consider how personal beliefs, values and attitude influence job performance?

Mental performance and psychosocial factors that impact on pharmacists' accuracy were studied by the late Anthony Grasha, PhD., Professor of Psychology at the University of Cincinnati. He considered how environmental factors (work pace, illumination, noise, interruptions), organisational dynamics (supervisory practices), as well as personal qualities (demeanour, patience, ability to manage stress, interpersonal relationships) affect job performance. His research suggests practical methods to prevent errors and improve safety in our workplaces. Here's a sampling of what he found with specific interventions:

Periodic self-monitoring: Catching your own errors helps to improve performance by learning from your own mistakes and identifying error-prone time periods. Errors were reduced by 21% when pharmacists periodically monitored themselves to detect errors (compared to those who did not monitor themselves). In addition, when completed prescriptions awaiting collection were re-checked, 95% of previously overlooked errors were identified. Lastly, mistakes were detected less frequently as the amount of continuous time spent on a specific task increased. Thus, taking a short break or changing tasks increases effectiveness.

Light and magnification: The actual as well as the perceived level of pharmacy lighting can affect job performance. Pharmacists who rated the level of lighting as adequate detected 38% more mistakes during dispensing than those who perceived the lighting as inadequate. Additionally, study pharmacists complained that pharmacy lighting did not appear to be as good in a later shift. This can be the result of eye

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Insights into people likely to improve safety systems *(continued)*

fatigue, which occurs over a shift as eyes adapt to background lighting. When supplied with high intensity task lights to read prescriptions, pharmacists who used them "as needed" reduced product verification errors by 10.7% compared to the control group's accuracy without the lights. A version that combined the light with a magnification lens reduced the same type of error by 22%.

Copyholders: Errors were reduced by 24% after a device to hold prescriptions was installed on the computer monitor. Information provided at a comfortable visual angle, closer to eye level, results in greater attention to details.

Alerts: Posting alerts in strategic locations for 30 error-prone products reduced errors with these products by 71% and reduced potentially significant occurrences by 45%. Errors with non-targeted drugs were reduced by 56% as a result of heightened error awareness.

Exaggerated product labels: After certain medicine stock bottles were affixed with product sleeves that used exaggerated, unconventional fonts to "better-read" sections of drug names or doses, errors with these products were reduced from 27% - 35%.

Cognitive style and coping skills: Pharmacists who were able to attend to details and focus their attention made fewer errors. Approximately 12% of pharmacists had difficulty with details and focus, and these pharmacists produced 33% of all the mistakes observed. High intensity lights, copyholders and exaggerated product labels were especially helpful for such individuals. Pharmacists with adequate coping skills and stress management training also made fewer errors.

Workload: Pharmacists were more vulnerable to mistakes under low workload conditions (15 or fewer prescriptions per hour) and during shifts from high to low workload. Boredom, reduced task focus and disruptions in personal work rhythms made it hard to focus on tasks. When surveyed, pharmacists with both low and high workloads were equally concerned about their job performance.

Breaks: Pharmacists who perceived that break times were adequate and available made fewer errors and detected more errors during self-monitoring.

Supervision: Pharmacists who made fewer errors had supervisors who fostered appropriate autonomy, and were perceived as being democratic, facilitative and helpful in setting goals. Pharmacists who made more errors had supervisors who were perceived as overly autocratic and punitive. Supportive supervisors lowered stress levels and allowed staff to better focus on tasks at hand.

Performance feedback and goal setting: Midway through the project, half of the pharmacists were asked to calculate the percentage of errors they observed during self-monitoring. Then, based on a chart of the average percentage of errors made by pharmacists in the study, they were asked to set a performance goal for the remainder of the study. Pharmacists who set a goal to maintain their current level of detection increased error detection by 22%, compared with the control group of pharmacists where no feedback was provided. Those who established goals to improve performance increased their ability to detect and prevent errors by 103%. With a heightened awareness of their performance, they were better able to notice problems. Establishing personal improvement goals combined with constructive feedback about errors proved quite beneficial. Pharmacists ranked feedback and goal setting among the most effective strategies investigated by the researchers.

Additional articles from Dr Grasha's work in human factors and how it relates to patient safety and medication errors can be found at: www.pharmsafety.org

Disciplinary Actions

Pharmacist Guilty of Conduct Unbecoming – Disciplinary Decision

On 10 September 2004, at a hearing before the Disciplinary Committee of the Pharmaceutical Society of New Zealand, Mr Bruce Josling was found guilty of conduct unbecoming a pharmacist. The charge arose from Mr Josling being convicted of three offences in the Kaitaia District Court on 19 May 2004. The Pharmaceutical Society Disciplinary Committee deferred making a decision in regard to penalty, with a decision being made on 26 September 2005. The Committee's recommendation on penalty was received by the Pharmacy Council of New Zealand on 23 November 2005.

Although the Pharmacy Act 1970 was repealed on 18 September 2004 disciplinary proceedings commenced under the Pharmacy Act that were not completed before the 18 September 2004 were required to be completed as if the former Act had not been repealed (HPCAA s.216), with the Pharmacy Council acting in place of the Council of the Pharmaceutical Society. The Disciplinary Committee's decision was accepted by the Pharmacy Council pursuant to the Pharmacy Act 1970.

In accordance with the Committee's recommendation, the Council ordered that Mr Josling be suspended from practising as a pharmacist for a period of 12 months from 1 September 2005. The penalty is not to take effect unless, prior to 1 September 2006 Mr Josling again offends in a way that results in him being found guilty of a disciplinary offence. Mr Josling was ordered to pay $7,948.65 being 50% of the costs of and incidental to the hearing of the charges against him (s.31(2)(e) Pharmacy Act 1970). The Council did not restrict the publication of its orders or the Committee's finding and recommendations.

Return to Practice/Additions to the Register

Pharmacists registered from UK, Ireland and Australia since Dec 2005

Boden JR, Buckingham EM, Dowling CE, Dunn HA, Hsiao YC, Jobling M, Johnson CF, Kelly FS, Lombard C, Marsh DC, Mathers JT, McIntyre KJ, Murdoch L, Poli MXR, Roy R, Sam SK, Sandberg PD, Sharratt PM, Sloan L, Smith ER, Smith RG, Wang MJ, Webster DK

Pharmacists returned to practice in NZ or restored to non-practising section of the Register since December 2005

Maingay DG, Austin RJ, Bayliss AE, Borren M, Boyle D, Burt VK, Butterworth JM, Chan MWW, Chieng ASH, Cope LC, Foreman MJ, Gray KM, Hansen JM, Houghton EM, House L, Ismail-Omar S, Keer-Keer EJ, Machin AD, McArthur SM, McKenzie CF, McLachlan JJ, Moon SP, Mouat PJ, Nyika SA, Omar N, Pattillo RA, Rennie MA, Scott MS, Shen YC, Skinner BH, Spooner OC, Wood HMA,