OCTOBER 2006

newsletter

pharmacycouncil
OF NEW ZEALAND

New qualification routes for registration

As a result of the consultation on the new proposed qualification routes referred to in the August 2006 Council newsletter, and taking into consideration comments made in submissions, the Council has now set two new qualification routes which will come into force on 1 December 2006. These qualifications are set under the HPCA Act 2003 and ensure that all pharmacists entering New Zealand, apart from those from Australia, are assessed for their competency to practise. Under the Trans Tasman Mutual Recognition Act, Australian pharmacists are still able to register in New Zealand with the same four week conditions as before.

Key changes from 1 December 2006:

- Pharmacists from the UK and Ireland will be required to sit an examination before completing the minimum of four weeks supervised practice and the Law and Ethics Interview and calculations assessment
- A quicker route for pharmacists from Canada and USA applying for an APC in New Zealand will be available
- Pharmacy graduates from Australian Universities will be eligible for registration as intern pharmacists in New Zealand.

1. Pharmacists from United Kingdom, Ireland, Canada and USA

The Recognised Equivalent Qualification Route (REQR) is the new registration pathway for overseas pharmacists from United Kingdom, Ireland, Canada and USA. This route allows registered pharmacists from these countries, who have qualifications and competencies recognised as equivalent to New Zealand and Australia, to establish their competency to practise by successfully completing a new multiple choice examination called the Competency Assessment of Overseas Pharmacists (CAOP). This exam has been developed by the Council of Pharmacy Registering Authorities (COPRA) of Australia and New Zealand.

CAOP Exam

The CAOP is an open-book, multiple choice test of clinical competence with a focus on patient-centred care. It includes questions related to patients' medicines regimens and diagnoses and questions about common health conditions that are treatable with over-the-counter medicines and advice. Pharmacists' knowledge of the clinical uses and common side effects and interactions of medicines will be tested. There will also be a short test of written English skills. The questions are not related to country specific pharmacy issues.

The CAOP will be offered four times a year in March, June or July (to be determined), September and December. Applicants will have the choice of sitting the exam overseas before arriving in New Zealand, as it will be available simultaneously in Auckland, Australian state capitals and London, England.

To be eligible to register for the CAOP a pharmacist will need to complete the Pharmacy Council's application form and have supplied the appropriate certificates of good standing and IELTS / OET certificates (only for those who did not learn and speak English as a first language). An 8 week lead-in is required to take the exam e.g.1st January for March session. However, to assist with the transition, an extension may be granted if the certificate of good standing is received by 1 December 2006. Details of this are on the website.

Following the exam, results will be available in four weeks. The cost to the applicant is $787.50 (inc GST) for the CAOP exam if sat in NZ, or $700 (GST excl) if the applicant sits the exam from overseas.

On successful completion of the CAOP examination, pharmacists from the United Kingdom and Ireland will be eligible for unconditional registration and practising certificates after they have satisfactorily completed a minimum period of four weeks' supervised practice in New Zealand, in addition to the Council Law and Ethics Interview and written calculations assessment. For pharmacists from Canada and the US, the supervised practice period will be prescribed as a minimum of three months. In addition pharmacists from Canada and the US will be required to complete the Pharmacy Council-accredited Return to the Workforce programme (called Revisit the Workplace) of the New Zealand College of Pharmacists. Full details of this new route are now available on the Council website **www.pharmacycouncil.org.nz.**

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The Pharmacy Council of New Zealand has been 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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Standard Operating Procedures (SOPs) for Dispensing – time for a review?

As reported in a recent Pharmacy Today article, many pharmacists have recently reviewed their dispensing SOPs. The Pharmacy Council regularly receives referrals from the Health and Disability Commissioner (HDC) to review the Dispensing SOPs from pharmacists who have been under investigation by the Commissioner's office. Pharmacies' SOPs usually focus on the practical steps, and there is sometimes a lack of a "patient-centred" or clinical focus. There has been a lot of media coverage of dispensing errors in recent months and the Council reiterates the importance of being patient-centred in your work (Code of Ethics obligation 2.3) which will help you to avoid making errors.

For those of you who may be considering reviewing your SOPs, the following recommendations highlight aspects arising from HDC reviews in relation to purpose, clarity, privacy, communication, clinical focus, interruptions, checking procedures, and counselling, and as such do not include all the requirements. We suggest that pharmacists consider the points below when undertaking the annual review of pharmacy SOPs and incorporate any relevant changes. **Don't forget to notify your staff of any changes to procedures.**

- The purpose of the SOP should be clearly defined.
- The SOP should be written with sufficient detail and clarity so that a locum would know exactly how to follow the procedure in your pharmacy.
- The title(s) of staff member(s) responsible for carrying out the procedures must be included.
- When determining the priority of the prescription, it can be a good idea to give patients a realistic waiting time or offer to deliver a medicine if a person is in a hurry, to avoid putting yourself under undue pressure.
- The SOP should include a clinical check of the appropriateness of the medicine. This should be undertaken by the pharmacist and include a check to make sure that the medicine, its strength, dose and formulation are all appropriate in light of the patient's age and history (e.g. a new script for NSAID to asthmatic or for a patient with a history of antacid use; an antibiotic to a patient with history of oral contraceptive use).
- When discussing the prescription or checking the appropriateness of the medicine the pharmacist may need to ask the patient or their caregiver for some details. This should be done privately and in a sensitive manner.
- There should be a procedure describing how relevant information from the patient's file (e.g. allergies, interactions, delivery details, new patient, new medicine, brand change, dose change, omission from regular regimen, early, late or infrequent dispensings, duplication of therapy, individual requirements, for example to halve tablets, and any anomalies) is conveyed to the checking pharmacist.
- The labelling process should include the requirement to label every container; multiple labels may be required for some medicines.
- When preparing the medicine the strength and quantity should be checked and selected against the prescription, not the label, and the expiry date of the medicine is also checked at this point.
- It is recommended that staff members are made aware of the importance of minimising distractions when counting, measuring or extemporaneously compounding medicines to help maintain high standards of accuracy. Customers should not be allowed to chat to dispensary workers while they are busy.
- Repeats should be ideally dispensed from the original prescription (note: this is mandatory for controlled drugs). As an alternative to holding a repeat file, pharmacists may undertake a daily check of repeat prescriptions against the electronic claim which may detect any data inputting errors that could lead to an error being repeated.
- The pharmacist who checked the dispensing of an owing must be identifiable.
- It is recommended that when "signing off" the prescription after checking that the pharmacist initials each item.
- If you do not work with another pharmacist we suggest that a technician, if available, provides a 'second pair of eyes' by routinely checking prescriptions to ensure the correct medicine has been selected in the correct strength (these are the most common dispensing errors and near misses).
- The checking process should include the requirement that each bottle and skillet is to be opened to check the contents and that the dispensed medicine, including blister packs, should be checked against all of the stock containers used to prepare the final product.
- It is strongly recommended that those prescriptions requiring counselling or other information (such as a change in brand) are not pre-bagged. They could be put into a clear plastic bag or into a basket. This is because when discussing the medicines with the patient, especially new or changed medicines the pharmacist should physically show the medicine to the patient to reinforce the message. This is also another opportunity to pick up dispensing errors. The prescription should accompany the dispensed medicines while awaiting collection and only be filed after the patient has received the medicine. In addition the checking pharmacist should ensure that all aspects that must be communicated to the patient or to other staff members are clearly noted; e.g. delivery details, refrigerated item to be included, queries about dose changes, interactions to advise patient about, any special instructions for use or storage.
- SOPs must be dated and the review date should be no longer than one year or an SOP should be amended whenever procedures or policies are changed in the pharmacy. These changes should be clearly communicated to all relevant staff.
- The date, name(s) of the person(s) who created and checked the SOP and the date of review need to be included.

One way to approach the writing of SOPs is to ask, "Does the SOP demonstrate that each step has been thought through, are any risks identified and is the process for minimising the risk clearly documented?"

Avoiding confusion when labelling dispensed medicines

To avoid confusion for patients, prescribers, and caregivers the Council recommends that pharmacists follow best practice by labelling prescription medicines, including labels on blister packaging, with the medicine name used by the prescriber. Ideally, prescriptions should be written (and labelled) generically and pharmacists can suggest this option to prescribers they work with. Pharmacists should note that it is illegal to label a prescription with a registered trademark if the brand name printed on the prescription label is different to the brand dispensed.

Lessons from a dispensing error: Frumil® and Frisium®

A recent error referred to the Health and Disability Commissioner involved a mix-up between Frisium® and Frumil®. The prescription was written for clobazam liquid for a young child, to be compounded as a suspension using Frisium® tablets. The pharmacist calculated the quantities required and had another pharmacist check these and the label directions, which were for an increasing dose regimen; however it wasn't until five days afterwards that the pharmacist, when dispensing a repeat of Frisium® for another patient realised that the child's suspension had been made up using Frumil® tablets. In the meantime, the child's condition had not improved and she became drowsy, pale, thirsty and unwilling to eat. The parents were concerned and took the child to hospital where they were advised to continue with the treatment. Fortunately the parents were contacted by the pharmacy the next day and notified of the error. The child regained her health after receiving the correct treatment. The labelling and packaging of these two medicines, made by the same company, are very similar. The Council has written to the company concerned to highlight this. However, pharmacists should take extra care when selecting medicines for dispensing that have look-alike or sound-alike names and/or packaging. (See also the Council's May 2005 Newsletter). We also recommend that another pharmacist or technician (where there is a sole pharmacist) routinely check that the **correct medicine and correct strength** have been selected.

Safe use of colchicine

Colchicine is highly toxic in overdose and we remind pharmacists of the risk of fatalities. There was a recent tragedy where a young man died after swallowing a number of tablets when he awoke during the night in severe pain. He was admitted to hospital after developing nausea and diarrhea but liver and renal failure were irreversible. English was his second language and it is possible that he did not fully understand the instructions. This highlights the importance for pharmacists of Code of Ethics Obligation 1.2 which describes the requirement to ensure the patient is provided with understandable information about the safe and effective use of prescribed medicines. This obligation should be followed in conjunction with Right 5 of the HDC Code of Health and Disability Services Consumers' Rights, the right to effective communication, which requires you to provide a competent interpreter, 'where necessary and reasonably practicable'.

Please note new dosing guidelines recently introduced for colchicine: Initial dosage: 2 tablets (2 X 0.5mg) followed every six hours by 1 tablet until relief is obtained, up to a maximum daily dose of 5 tablets (2.5mg) in the first 24 hours. A cumulative oral dose of 6mg (twelve tablets) over four days should not be exceeded. Additional colchicine should not be administered for at least 3 days after a course of oral treatment.

If a patient develops gastrointestinal adverse effects (abdominal pain, diarrhoea, nausea or vomiting), then colchicine must be discontinued immediately, even if symptoms of an acute attack have not been relieved. In elderly patients, patients with renal or hepatic impairment and patients weighing <50kg other treatments should be considered or lower doses of colchicine used. Patients on long term colchicine for gout prophylaxis should not increase the dose if an acute flare occurs. Some patients may have a supply of colchicine at home with previous instructions to continue dosing until gastrointestinal side-effects occur – in which case a timely reminder of the new dosing guidelines may be appropriate. See also the Prescriber Update Vol 26 No 2 December 2005 on the Medsafe website, www.medsafe.govt.nz. We acknowledge with thanks the Safe and Quality Use of Medicines Group (SQUM) for help in preparing this article.

New qualification routes for registration (continued from cover)

2. Australian Pharmacy Graduates as intern pharmacists

From 1 December 2006, pharmacy graduates from Australian Universities holding provisional or full accreditation of their programmes from the New Zealand and Australian Pharmacy Schools Accreditation Committee (NAPSAC) will be eligible for registration as intern pharmacists in New Zealand. This process is intended to assure all the regulatory authorities for pharmacy that all graduates have the initial knowledge to meet the minimum standard to practise pharmacy in both countries.

The following web site link provides current information on the accreditation status of Australian and New Zealand universities: http://www.copra.org.au/pages/pharm_school_acc_aps.html.

The same English language requirements apply for Australian graduates as apply to New Zealand graduates entering the intern scope of practice. New Zealand graduates have always been accepted into Australian internship programmes, and this new route allows Australians to register in New Zealand.

Medicines classification changes

The following changes were agreed to by Medsafe's Medicines' Classification Committee (MCC) and were gazetted recently.

Prescription Medicines

- Sedating antihistamines (either singly or in combination) for children under two years (e.g. Demazin Syrup®) are now Prescription Medicines. The reason for this change is that some sedating antihistamines have been implicated in sudden death in this age group and there is evidence of misuse and abuse in children.
- Oseltamivir (Tamiflu®): the MCC has recommended that pharmacists should be able to sell oseltamivir between May and September for the treatment of influenza but not for prophylaxis. The change from current Prescription Medicine status to Pharmacist Only Medicine is expected to occur before next winter.
- Amphotericin (Fungilin® Lozenges) has been reclassified as a Prescription Medicine because of the risk of resistance to its therapeutic effects. This risk for amphotericin is considered to be greater than that of the OTC alternatives (e.g. mycostatin and nystatin) because it is also used intravenously.

Pharmacist Only Medicines

- Sumatriptan 50mg tablets (Imigran®) in a pack size of two tablets is now a Pharmacist Only Medicine. It is not yet available in an approved pack for OTC sale. Sumatriptan will be indicated for the acute relief of migraine attacks with or without aura in patients who have a stable, well-established pattern of symptoms.
- Ibuprofen 400mg tablets is now a Pharmacist Only Medicine in an approved pack of no more than 50 tablets. Once again there is no approved pack available with the required warnings at present.

Pharmacy Only Medicines

- Pharmacy Only Medicines containing sedating antihistamines when combined with a sympathomimetic are no longer restricted to the treatment of coughs, colds or influenza. They may now also be sold for other conditions such as allergy and hayfever.
- Hydrocortisone 0.5% (or less) in combination with a local anaesthetic in rectal medicines was considered safe enough to be reclassified as a Pharmacy Only Medicine, provided it is sold in quantities no greater than 30g or 12 suppositories, and that the packs contain warnings against use in children, recurrent use and the need for medical advice if the condition persists and to seek medical advice in the event of rectal bleeding.
- Paracetamol in medicines containing 665mg or less of paracetamol is a Pharmacy Only Medicine when in slow release form.

The minutes of the Medicines Classification Meetings make interesting reading and are available on the Medsafe website: **www.medsafe.govt.nz**

Voltaren Rapid® 12.5mg (Pharmacy Medicine) & 25mg (Pharmacist Only Medicine)

Although diclofenac 12.5mg was reclassified as a pharmacy medicine in 2003, it is only recently that an over-the-counter product has become available. Pharmacists should ensure that all pharmacy staff members are aware that:

- Diclofenac 12.5mg is a Pharmacy Medicine in pack sizes of no more than 20 tabs/caps. Maximum daily dose is 75mg (6 tablets in 24 hours).
- Diclofenac 25mg is a Pharmacist Only Medicines in pack sizes of no more than 30 tabs/caps.

More on the storage of medicines with abuse potential

The Code of Ethics Obligation 3.16 requires the Charge Pharmacist to ensure that medicines with a potential for misuse, abuse or dependency are **not accessible** to the public for self-selection. It is your ethical responsibility to reject offers from suppliers who suggest you display dump-bins of codeine-containing medicines, for example. The Council has also become aware of a recent situation where a suspected 'shopper' was able to shoplift a cold and flu medicine containing pseudoephedrine. See also the August 2006 Newsletter, "Storage and sales of medicines with abuse potential".

Increase in number of practising pharmacists

Workforce data for the 12 months to 30 June 2006 has now been compiled and shows some interesting results. While certain demographics are similar to those in the report for the year ended 30 June 2005, the overall number of pharmacists holding an Annual Practising Certificate has in fact increased by 2% – a net increase of 56 over the 12 month period. This is in spite of an 83% increase in the number of Certificates of Identity issued for pharmacists traveling to the United Kingdom and Ireland to register (274 issued in 2005/2006 and 150 issued in 2004/2005). Some of the net increase in practising pharmacists can be attributed to a larger number of 2004 graduates from the NZ Schools of Pharmacy who have now registered as practising pharmacists and an increase of pharmacists from the UK, Ireland and Australia. Also, a total of 85 pharmacists who did not hold an APC at 30 June 2005 returned to practice during the year. Intern pharmacists registered have also increased from 168 at 30 June 2005 to 189 at 30 June 2006.

The full workforce demographics report is published on our website at **www.pharmacycouncil.org.nz/news/documents/WebsiteReportAug06.pdf**

Slimfast® and Benzylpiperazine (BZP)

The Pharmacy Council advises pharmacists to carefully consider the ethics of selling Slimfast® or any other product that contains benzylpiperazine (BZP), a restricted substance under the Misuse of Drugs Act because of its use in 'party pills'. We draw your attention to Code of Ethics obligations 1.3, 2.7, 3.7, 3.15 and 7.7. Slimfast®, which is promoted for weight loss, has not been assessed as a medicine. Therefore a therapeutic claim cannot be made about this product. Medsafe has taken action against distributors and retailers who have made therapeutic claims about Slimfast®.

The Council's Vision is that pharmacy practitioners are recognised as the trusted experts in medicines. The public's perception is that as part of their health professional role pharmacists sell products that are of a safe and acceptable quality. The Council reminds pharmacists of their duty of care to customers and believes that it would be prudent to consider whether enough is known about Slimfast® to be satisfied that it is safe and effective for customers. The following information has been provided by the Ministry of Health and forms the basis of the Council's advice:

- There is no known safe dosage of BZP
- The Ministry believes the 60mg of BZP reportedly contained in each daily dose of Slimfast® means the cumulative dose is likely to be more than the amount taken by most people who consume party pills containing BZP intermittently
- There is very limited information available about the short and long term effects and potential harm of BZP
- The Ministry of Health has commissioned several research projects to provide more information on BZP and these are expected to be available next year.

Complaints and notifications to Council about colleagues

From time to time the Council is asked by pharmacists how to deal with dispensing errors that have been made by pharmacists in other pharmacies, particularly where the patient or consumer does not wish to make a formal complaint. An example of this includes when a hospital pharmacist becomes aware that an error made by a community pharmacist has resulted in hospitalisation of the patient.

A number of options can be explored when considering whether to lay a formal complaint or notification, and these are covered within both the Code of Ethics and the Health Practitioners Competence Assurance Act (HPCA Act).

Notifications to Council – risk of harm

All pharmacists have an ethical responsibility to prevent harm to the public (Principle 3: Non-maleficence). If you have a concern about a colleague's competence or ability to practise then you are obliged to **notify the Council** of these concerns. The HPCA Act provides for both competence and health (impairment) processes that the Council can use to help the pharmacist concerned whilst protecting the public.

The Council suggests that you should consider making a notification if the practice of a pharmacist colleague poses a risk of harm by one of the following:

- A serious event that is a significant departure from accepted standards
- A pattern of conduct over a period of time that is below the required standard of competence
- Criminal offending
- Professional isolation with declining standards
- Recognised poor performance where local intervention has failed

Local intervention

Local intervention, as outlined in the final bullet point above, is often appropriate as a first line measure for you to consider. This can be achieved in a number of ways and often is successful in reminding a colleague of the appropriate standards or alternative ways of practice.

If the concern is about a single dispensing error e.g. an incorrect selection of a medicine or dose strength, an omission in a blister pack or a labeling error, then a conversation between colleagues may be appropriate. Most pharmacists are mortified to discover an error has been made, and will make amends and apologise to consumers, giving assurances that systems will be changed (if necessary) and also that changes will be made to SOPs if required (see separate SOP article in this newsletter). If the issue is more than a one-off instance, and falls into the risk of harm categories above, then a notification to Council should be considered.

If the patient does not wish to complain, the pharmacist should take into consideration their wishes, as per obligations 6.1 (Overriding duty to patient) and 10.1 (Compassion for patients) of the Code of Ethics Obligation 9.6 (Not criticise colleagues) is also a consideration, although the commentary in the Code suggests that in the event of a conflict the patient's interests take priority over those of another provider (which could be another pharmacist). However, if in considering these obligations a pharmacist wishes to lay a formal complaint about another pharmacist's practice, then the HDC process described below will be enacted.

Formal Complaints to the Health and Disability Commissioner (HDC)

The Health and Disability Commissioner is an independent agency set up by government statute to:

- promote and protect the rights of consumers who use health and disability services;
- help resolve problems between consumers and providers of health and disability services; and
- improve the quality of health care and disability services.

The HDC is set up for consumers to ensure that their rights are protected. However, regardless of who makes a complaint, the HPCA Act requires that the Pharmacy Council **must refer to the HDC any complaint** that alleges that the practice or conduct of a pharmacist has affected a health consumer. As outlined on page 2 of the August 2006 Council newsletter, the Council cannot act on complaints until the Commissioner has considered the matter.

The Commissioner has a number of options open to him including advocacy, investigation of complaints, referral back to the Council if a competence or conduct issue is indicated, or no further action. The Council may also receive a referral of the complaint after an investigation and may then ask the pharmacist for documentation of changes made or review the pharmacy's SOPs.

Pharmacist Changes since August 2006

Pharmacists registered from UK, Ireland and Australia

Adderley DM, Child MJ, Davis DR, Dawwas BM, Day DN, Gillen PD, Hawkins TL, John LS, Le TT, McConnell DS, Olshen EJ, Speare TJ, Sweeney HM, Walker G, Watt SM

Pharmacists who have returned to practice in New Zealand

Adsett WM, Clareburt AT, Coster RM, Dunn PE, Edie PA, Gounden M, Graham AR, Hammond A, Hanna NJ, Lee LH, Marcussen P, Marcussen SD, O'Sullivan AM, Owen CM, Penwarden GR, Polonowita DAJ, Ragupathy Y, Sarah G, Stewart BD, Stevens JT, Sullivan T, Sullivan TL, Taylor, TF, Vallabh M

Pharmacists names cancelled from the Register

Ahmadi A, Akoro OE, Al-Hashimi SHMS, Atkinson GA, Avery GS, Baker-Phillips RL, Bethune KM, Bone JM, Booth AM, Bryant DM, Carr JM, Chan CS, Chow S, Christian JB, Coxhead DW, Dalzell SJ, Das P, Davey AK, Desai R, Dunlop RM, Dye WH, Ebbett CJ, Farmer D, Faulconbridge MC, French PR, Frost RB, Gallagher DAM, Hart NM, Heaney A, Horan G, Joe PM, Jowsey JA, King TR, Lee YK, Lee MF, Luca E, MacKellar CA, McDonnell JF, Mckay JC, Mikhail N, Mishhin N, Moir AR, Murfin L, Ng MKS, Oldham BH, Olson AM, Poli MXR, Rentoul FJS, Reynolds NA, Rout WG, Setiawan KG, Singh KP, Skellett LJ, Smith CB, Smyth HDC, Tam KSK, Taylor TM, Thomson LC, Volp HE, Wakefield PR, Wall SM, Weekes SB, Weeks VA, Yaxley RG, Zhong J

APC Renewals 2007

Application forms for Annual Practising Certificate Renewal for the practising year 1 April 2007-31 March 2008 will be posted out in January 2007.
To ensure you have your APC by the 1 April, forms need to arrive at the Pharmacy Council office by 16th March.

Annual Practising Certificates no longer backdated

Applications for Annual Practising Certificate renewals are due by 31 March 2007. In the past, when applications for renewal have been received after the due date, the APC was dated from the beginning of the APC year (ie 1 April).

The Health Practitioners Competence Assurance Act 2003 (HPCAA) states that a pharmacist is considered to hold an APC from the date the application is received in the Council office until the date the certificate expires, or until the pharmacist is advised that the APC will not be issued for some reason. In line with the Act, if your APC application renewal form arrives in our office after your current APC has expired (ie 31 March), it **will not be backdated to 1 April**. We remind you that practising pharmacy without a current APC is an offence under the HPCAA.

Check your APC status on-line

You can check your APC details on line at:
www.pharmacycouncil.org.nz/public/Search.aspx

Key Office Contacts:

Registrations enquiries

Susan Mckibbin
Registrations Officer
Telephone 04 495 0333,
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Practice issues

Jan Clare
Professional Standards Advisor
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Complaints/public safety issues

Jenny Ragg
Deputy Registrar
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pharmacycouncil
OF NEW ZEALAND

Competence Policy Advisor

Parental Leave Opportunity

A unique and interesting opportunity exists for a New Zealand registered pharmacist or a policy advisor with demonstrated experience in the health or education sector to apply for this 12 month parental leave position based in Wellington.

The primary purpose of the Competence Policy Advisor is to ensure the policies and procedures around pharmacists' competence to practise are evaluated, developed and implemented. This encompasses the standards and assessment practices for intern pharmacists, overseas qualified pharmacists applying for practising certificates in New Zealand, pharmacists returning to practice and competence reviews.

The successful applicant will have an excellent understanding of the Health Practitioners Competence Assurance (HPCA) Act 2003 and preferably hold a post-graduate qualification in pharmacy or education.

Ideally the successful applicant will work 40 hrs per week, however some flexibility with hours of work could be considered. The position will commence December 2006. Applications close Friday 3rd of November. For more information and a position description, please contact Claire Paget-Hay at the Pharmacy Council of NZ:

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