



## Pharmacy Council visits Auckland

The Pharmacy Council took the opportunity to hold its most recent meeting in Auckland at the University of Auckland School of Pharmacy. This was one of the regular five meetings a year held by the Council, and proved an opportunity for Council and staff to engage with the University and also with health and pharmacy stakeholders in the Auckland region.

The Council was very kindly hosted by the School of Pharmacy, and Councillors and staff had meetings with a range of university groups including the Dean of the Faculty of Medical and Health Sciences Dr Iain Martin, Senior Faculty Staff, School of Pharmacy staff and School of Pharmacy student representatives. These meetings were very successful in building on relationships with the University, and raising the profile of the profession of pharmacy within the University as a whole. The Council has an excellent relationship with the School of Pharmacy and is responsible for ensuring that the B.Pharm programme meets the standards required by the profession.

On the second day of the meeting, the Council took the opportunity to invite some key stakeholders and pharmacists to a sector liaison lunch. Carolyn Oakley-Brown, the Council Chair, gave a short presentation to the gathering of over 40 on the achievements of the Council, the initiatives the Council has set in its strategic plan, and also thanked organisations and individuals for their feedback and support in helping the Council set standards for the profession.

The Council has been invited to hold a future meeting at the University of Otago School of Pharmacy and hopes to do this in 2008.

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.

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Pharmacy Council members and staff with University of Auckland School of Pharmacy staff and students in front of the Pharmacy School in Auckland, July 2007.

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## Pharmacy Council Statement on the Promotion and Supply of Medicines over the Internet

The Pharmacy Council has ratified a statement on the internet promotion and supply of medicines by New Zealand registered pharmacists. The statement has been developed following consultation with key pharmacy stakeholders.

The Council has become aware of inconsistencies in the way pharmacists market products over the internet. The provision of internet pharmacy services is a growth area and, in some circumstances, may improve patient access to and choice of pharmacy services, but that provision must

ensure public protection and confidence in the profession. The public is entitled to expect the same quality of pharmaceutical care irrespective of whether the service is provided on-line, or face-to-face on the pharmacy premises. The challenge to website operators is to create an online environment that facilitates appropriate supply of medicines, accompanied with quality information that the public can utilise safely and effectively

Enclosed with this newsletter is a copy of the statement, which is also available on the Council website.



## Health Practitioners Disciplinary Tribunal decision

On 25 July 2007, the Health Practitioners Disciplinary Tribunal (HPDT) heard a charge brought by the Director of Proceedings (the Director) against John William Morrison, pharmacist of Palmerston North.

The Director's charge alleged professional misconduct. The particular of the charge states:

*On or about 5 August 2006, as supervising pharmacist checking a dispensing of labetalol tablets for a patient, Mr Morrison failed to observe that Largactil had been prepared instead of labetalol, and/or checked the dispensing as correct when it was not correct.*

The Tribunal noted that the key matters which should have enabled Mr Morrison to dispense the prescription correctly were:

1. The prescription was for one 200mg tablet to be taken three times daily; the dispensing was for two 100mg tablets three times daily;
2. The second technician (who also misread the prescription as Largactil) was alerted by two factors:
  - The unavailability of Largactil in 200mg tablets; and
  - No reference to Largactil in the patient history.
3. Mr Morrison noted the dosage was high, and placed a red tag on the script to remind him to speak with the patient. After speaking with the patient, he rechecked the prescription but did not notice that the label on the medication did not correlate with the script.
4. The patient informed Mr Morrison that she was taking blood pressure medication.
5. The patient had a new baby with her, and at the same time purchased Lansinoh cream and two baby pacifiers.
6. The prescription had been written in the maternity department of Mid Central DHB, and this should have alerted Mr Morrison to the context of the prescribing.
7. The Largactil was dispensed with a statement on the label: "Don't take with antacids, iron or calcium. The patient was dispensed iron tablets.

The Tribunal stated that these opportunities should have alerted Mr Morrison to the dispensing error, and therefore concluded that there was a negligent

dispensing of Largactil tablets to the patient. Mr Morrison accepted that the error amounted to negligence, and did not oppose the finding that the circumstances required a disciplinary sanction. The Tribunal made a finding of professional misconduct.

The Tribunal imposed the following penalties:

1. As a condition of practice, the Tribunal recommended that Mr Morrison undertake a competency review by the Pharmacy Council of New Zealand forthwith (section 101(1)(c) HPCA Act).
2. A fine of \$5,000.00 was imposed (section 101(1)(e) HPCA Act).
3. An order for costs was made:
  - \$2,500.00 of the costs as to the conduct of the hearing by the Tribunal is to be paid by Mr Morrison (section 101(1)(f) HPCA Act).
  - \$2,500.00 of the costs incurred by the Director is to be paid by Mr Morrison; and
4. The interim order as to non publication ceased to have effect, and the application for a permanent order of non publication was declined (section 95 HPCA Act).
5. The Tribunal directs that details of this decision are to be published in the Pharmacy Council Newsletter, and on the Tribunal's website (section 157 HPCA Act).

A copy of the HPDT decision is available on the HPDT website: [www.hpdt.org.nz](http://www.hpdt.org.nz) under tribunal decisions, pharmacists.

The HPDT is an independent tribunal, separate from the Pharmacy Council, set up under the HPCA Act. The Tribunal is funded, via the various health Councils, by the disciplinary levy imposed on practitioners as part of practising certificate fees.

The Director of Proceedings is an independent prosecutor under the Health and Disability Commissioner Act. In this case the pharmacist was referred to the Director of Proceedings by the Health and Disability Commissioner and subsequently the Director brought a charge against the pharmacist before the Tribunal.



## Dispensing for Children

Prescribing, dispensing and administration of medications represent a substantial portion of the preventable medical errors that occur with children, and research has highlighted that children are more at risk from medication errors than adults.

A recent Health and Disability Commission ruling emphasised the need for pharmacists to pay particular attention when dispensing medicines for children. Referring to a specific case, the commissioner commented "Pharmacists are independent health professionals, well placed to consider the suitability of prescribing common, powerful medications for children".

Generally it is agreed that "children" include neonates, infants and school age up to adolescents of 14 - 15 years. Extra care must be taken in formulations, doses, routes and methods of administration, as children's needs change throughout these stages of development. Age bands are often used to determine doses for licensed products with large therapeutic indices and, although convenient and easy to calculate, they do not allow for inter-patient variability. Doses based on body surface area may be more accurate, but few drug doses are available using this method of calculation. Calculations of doses for children are more likely to be done on an mg/kg basis.

Some medicines for which specific paediatric dosing information is given are not available in a paediatric dosage form. The absence of paediatric dosage forms may lead to problems such as higher rates of medication errors resulting from dilution of adult dosage forms, and lack of stability associated with liquid formulations that are prepared by pharmacists from solid-dose forms.

Some children (especially those under 5 years) are unable to swallow, or dislike swallowing tablets, so liquid preparations are needed. Others may prefer a crushed tablet, or the contents of a capsule offered with a spoonful of yoghurt or ice-cream. If offering this choice, remember that if crushed, modified-release preparations will lose these properties.

Extemporaneous preparation of suspensions is not ideal because evidence of bioavailability, physical, chemical and microbiological stability is often not available. Taste, colour and texture are also important considerations. Unfortunately, extemporaneous preparations are often unpleasant tasting, with short shelf-lives and little evidence to support their use.

Tablet cutters may be used to halve or quarter tablets, although this can be inaccurate and dose equivalence is unlikely to be achieved. Soluble tablets can be used if available. Dissolving or dispersing a tablet in a specified volume, and administering an aliquot of the resulting liquid with an oral syringe, can be done if the dose is less than a full tablet. Some tablets are soluble or dispersible even if not marked as such. However, for many drugs it is not known whether the drug disperses uniformly throughout the suspension produced, so precise doses may not be guaranteed.

The pharmaceutical needs of children in the community offer much scope for pharmacists to extend their role, but every care must be taken to ensure the safe and effective delivery of medicines for children. Pharmacists must also have sufficient knowledge of paediatrics to enable them to advise parents on prescription medicines, and to counter-prescribe effectively.

Key points:

- For all children's prescriptions, highlight the date of birth on the prescription so the checking pharmacist can ask – "would this be a reasonable dose for a child of this age"?

- Many children take non-prescription medicines or dietary supplements – ask about these to ensure the prescription medicine is not going to interact with anything else.
- To ensure correct dosing, make the directions on the label practical and easy to follow, e.g. Give ONE 5ml measuring spoonful... or Give FIVE ml (by measure)... and provide the spoon to the caregiver.
- When is a teaspoon not a teaspoon? Dose inaccuracies can occur when household spoons are used to administer liquid medicines. Ensure the person giving the medicine knows the best device for measuring a liquid medicine.
- When compounding for children or determining a mg/kg dose, the use of a second, independent check of all dose calculations is recommended. Remember – decimal points can "move" unintentionally, thereby creating a potential source for error.
- A consideration when calculating the volume of a liquid medicine dose is to ask – can this be measured easily and accurately using a common measure? It is as important to be practical as to be accurate.
- Many paediatric medicines are prescribed as **mg** / dose and you may have to convert this to **ml** / dose.
- If in doubt about the drug, dose or directions, contact the prescriber – even if it's a specialist prescription, make the call. Often house-surgeons, with little experience, write discharge prescriptions, so it's better to check than guess. If the prescription is from the hospital, utilise the hospital pharmacists for clarification.
- Dispense all children's prescriptions in recloseable, child-resistant containers where appropriate.
- Wherever possible, medication administration should be organised to fit into the family's routine. Medicine use in school can be a difficult issue, and if possible, should be avoided. Otherwise, pharmacists can help by providing separate, appropriately labelled doses for use at lunchtimes.
- Counsel the parent or caregiver about what to do if they notice any new symptoms or unexpected side effects, or if the medicine does not appear to be working.
- Where suitable licensed formulations are not available, careful consideration should be given to ensure the safest alternative is used.
- Communication between hospital and community pharmacists regarding unusual, hospital-initiated prescriptions for children is essential to ensure seamless care. It also increases the likelihood that the child will continue to receive the same strength and formulation as was supplied in hospital. Changing the formulation of an extemporaneously prepared liquid can significantly alter the drugs' bioavailability.

The handbook BNF for Children (BFNC), available from Pharmacy Press ([www.pharmpress.com](http://www.pharmpress.com)), is the first comprehensive information resource for healthcare professionals involved in prescribing, dispensing and administration of medicines to children. The guide covers newborn babies to 18-year olds and gives a range of guidance on specific doses and formulations

To have safe and effective input into medicine use for children, pharmacists need to remember **children are not small adults**.

## Designated Prescriber Optometrists

Since 2005, optometrists who meet specified requirements for competence, qualifications, and training have been authorised to prescribe certain prescription medicines. The list of substances that are optometric medicines

if they are prescription medicines and therefore can be prescribed by designated prescriber optometrists has recently been expanded. The complete list is as follows:

<i>Aciclovir</i>	<i>Atropine</i>	<i>Betamethasone</i>	<i>Chloramphenicol</i>
<i>Ciprofloxacin</i>	<i>Cyclopentolate (new addition)</i>	<i>Dexamethasone</i>	<i>Diclofenac</i>
<i>Fluorometholone</i>	<i>Flurbiprofen</i>	<i>Framycetin</i>	<i>Fusidic acid</i>
<i>Gentamicin</i>	<i>Gramicidin</i>	<i>Homatropine</i>	<i>Hyoscine</i>
<i>Ketorolac</i>	<i>Neomycin</i>	<i>Olopatadine</i>	<i>Polymyxin B</i>
<i>Prednisolone</i>	<i>Tobramycin</i>	<i>Trimethoprim</i>	<i>Tropicamide (new addition)</i>

## The "Top 10" medicine errors and how to deal with them

The past several months have seen the adverse effects of medication errors very publicly aired, but this is not just a New Zealand phenomenon. At the 2007 American Pharmacist Association (APhA) Annual meeting, participants learned about common medication errors, steps to avoid or eliminate them, and ways to recognise and reduce stressful situations in the pharmacy workplace, that may contribute to medication errors.

The following is taken from highlights of the APhA meeting.

There is a subtle difference in the list of "Top 10" medications involved in adverse events versus the "Top 10" medications involved in drug errors. Most of the data in America represents drug errors associated with acute hospital care<sup>1</sup> and there is limited comparable data available for outpatient care, but these errors and trends are reflected in the New Zealand healthcare environment.

The number one error-prone medication in America is insulin, which has the unenviable position of top ranking on both lists. Eleven percent of all serious medication errors involve insulin misadministration<sup>2</sup> including mixing up products with similar packaging (look-alike products); confusing generic names; similarity in trade names (Humalog and Humulin) and most importantly, confusing the abbreviation "u" for units with the number "0".

Second on the list of medications involved in drug errors are the opioids. In community pharmacy these drugs are often kept close together in a locked area, and many have similar packaging and/or similar names, making it easy to select the wrong one. Morphine oral solutions also cause problems because of the multiple concentrations that are available. For example, it would be easy to confuse "mL" with "mg"; an intended dose of 1mL of morphine 20mg/mL (20mg) might be given as 1mL of 10mg/mL (2mg) and would under-dose the patient. Alternatively, using 5mL of morphine 20mg/mL (100mg) instead of the prescribed 5mg (0.25mL) would lead to an overdose.

Other medications to appear on both lists are paracetamol and, not surprisingly, warfarin. The audience was reminded that paracetamol can be toxic even though it is regularly sold OTC, and not always in a pharmacy where professional advice can be sought. It is also available in many combinations, the labels of which can be confusing for the consumer

### Human error versus system error

Most healthcare professionals have learned the "5 rights" of safe medication use; right patient, right drug, right time, right dose and right route of administration. However, research suggests that these "rights" focus on individual performance, and can overlook system errors such as poor lighting, inadequate staffing, handwritten prescriptions, and look-alike stock bottle labels.

When an error occurs, it is tempting to blame individuals; however a systems approach looks at the whole system, rather than individual errors. Failures in the design or implementation of systems can lead to excessive reliance on memory, lack of standardisation, inadequate access to information, and poor work schedules. Thus, with a systems approach, accountability is expanded to include anyone who had any influence over the error, setting the stage for broader solutions.

### Preventing errors

Nearly half of all adverse drug events have some form of "preventability", and many do not represent errors of commission but, rather, errors of omission. This implies a failure on the part of someone (pharmacist, doctor, patient, or the interactions between these groups) to detect certain factors that most likely led to the adverse event. These factors include:

- failure to detect a disease state contraindication to the drug therapy;
- failure to detect a significant drug interaction;
- failure to detect a significant drug allergy;
- failure to prescribe the correct dose for a specific patient;
- failure to monitor drugs with narrow therapeutic indexes; or
- patient knowledge deficits.

Many of these can be avoided by spending a few minutes counselling the patient and/or the prescriber. Communication is the key. Barriers to effective communication include illegible handwriting, abbreviations, verbal orders, ambiguous orders, and fax or telephone prescribing problems.

1. United States Pharmacopeia Web site. Available at: [www.usp.org](http://www.usp.org)

2. Institute for Safe Medication Practices (ISMP). ISMP action agenda: Oct-Dec 1998. *ISMP Medication Safety Alert!*

## The “Top 10” medicine errors and how to deal with them (continued)

When communicating with prescribers, pharmacists should identify the issues clearly and concisely<sup>3</sup>. Conflicting opinions about patient care can lead to poor communication, which can hinder the discovery of medication errors. Suggestions to improve communication include

- outline the specifics of the problem
- keep focussed on the patient
- provide possible solutions
- ask for prescriber feedback and
- document the final decision.

### Managing stress in a workplace full of risks

Pharmacy work can be highly stressful, and pharmacists who are under extreme stress are at more risk of errors.<sup>4</sup> Pharmacists need to identify their own personal stress triggers, and anticipate their response to stress. Self-analysis is a place to start – ask yourself these questions:

- How do you deal with stress?
- How do you know whether stress is a problem for you?
- What is causing most of your stress?
- What can you do to reduce the impact of stress?

Most people deal with on-the-job stress in one of three ways:

The active-cognitive person draws on past experience, taking one thing at a time. They consider several alternatives, looking for the positive side, and are able to step back and be objective.

The active-behavioural person finds out more about the situation and takes positive action. They may talk with a spouse or friend, exercise more, or talk with a professional in order to find a solution.

The avoider keeps his/her feelings to themselves, prepares for the worst, takes out frustrations on others and eats, drinks alcohol, or smokes more to reduce tension.

3. Bennett M. Communicating drug therapy recommendations to prescribers. Program and abstracts of the American Pharmacists Association 2007 Annual Meeting; March 16-19, 2007: Atlanta, Georgia.

But how do you deal with the unexpected? A sudden increase in prescriptions coming through the door; endless time on the phone chasing Special Authority applications; patient counselling that takes longer than expected; a complex prescription that needs compounding; a request for information from the local GP – these can all throw the “normal” work routine into disarray. The following are some quick strategies to help reduce stress on the job, but this is by no means an exhaustive list.

- Prioritise jobs – time management is a critical aspect of stress management.
- Leave room for the unexpected.
- Give patients realistic expectations of dispensing times.
- De-clutter. An organised, clean, neat and properly lit work area facilitates efficiency and productivity. It helps un-clutter your mind as well.
- Have occasional short breaks away from work where possible – take a walk instead of a coffee break.
- Nurture your leisure time; engage in hobbies; keep a balance in your life.
- Remind yourself you don’t have to be perfect at everything.
- Eat well, get adequate sleep, exercise regularly (30 minutes 3 times weekly) and drink water, not coffee.
- Maintain a sense of humour.
- Communicate – you can cut your stress levels in half if you communicate & function as a team.
- Set limits (learn to say “no”).
- Pick out things that are beyond your control and put them aside.

Whatever you do, there is no way to completely eliminate stress. Instead your goal should be to limit stress, manage it and keep it under control.

To read the article in full, go to [www.medscape.com/viewprogram/7099\\_pnt](http://www.medscape.com/viewprogram/7099_pnt)

4. Cobb H. Dealing with stress: decompression strategies for pharmacists. Program and abstracts of the American Pharmacists Association 2007 Annual Meeting; March 16-19, 2007: Atlanta, Georgia.

## Preliminary Feedback on the Consultation on the Proposed Advanced Scope of Practice and Qualifications for Pharmacists

The consultation period which began in mid June ended on Friday 17 August 2007.

The Pharmacy Council has received 36 responses to the consultation from the following:

- 20 from pharmacy organisations, pharmacy special interest groups, hospital pharmacy departments, other groups within DHBs and individual pharmacists;
- 16 from stakeholders and other organisations.

The responses are comprehensive, well thought out, constructive and they will assist the debate. Collation of the feedback has commenced and a document of the collated feedback will be produced shortly.



## 2007 register and workforce data now available

Data from the register for the year to 30 June 2007 has now been collated and the totals for the registers show that at this date there were 2889 pharmacists who held an Annual Practising Certificate. This represents an increase of 88 from 30 June 2006; a 3% increase for the year. 29 pharmacists from the United Kingdom and Ireland and 11 from Australia registered in New Zealand in the above period.

81 pharmacists signalled their intention to work overseas and applied for a Certificate of Identity in the period 1 July 2006 to 30 June 2007. This

compares with 274 issued in the previous year representing a 70% decrease. Presumably this decrease is a result of the new procedures for registration in the United Kingdom and Ireland. Of the 81 Certificates of Identity issued, 69 were for Australian States.

1012 pharmacists were registered as non practising and 202 registered as intern pharmacists.

More data is available in our annual Workforce Report on our website – see this page: <http://www.pharmacycouncil.org.nz/news/index.asp>



## Review of the Health Practitioners Competence Assurance Act (HPCAA)

The HPCAA is the Act of Parliament under which the Pharmacy Council is set up. As required by s.171 of the HPCAA, the Director-General of Health is undertaking a review of the HPCA Act. This will commence in September 2007, and the findings are expected to be reported by December 2008.

The review is intended to look at the operation of the Act, and stakeholders will have an opportunity to make comment on the review. The terms of reference of the review are available on the Ministry of Health website [www.moh.govt.nz](http://www.moh.govt.nz).



## Change of name for Australian Council of Pharmacy Registering Authorities (COPRA)

The Council of Pharmacy Registering Authorities (COPRA) has changed its name to the **Australian Pharmacy Council**. The Australian Pharmacy Council is an organisation of the Australian registering authorities and will continue to undertake the roles of the former Australian Pharmacy Examining Council (merged with COPRA in December 2006) and the former COPRA.

The Pharmacy Council of New Zealand is a member of the Australian Pharmacy Council and will continue to work closely with them, particularly in the areas of pharmacist qualifications and registration routes.



## Answers to calculations quiz (page 4) in June newsletter

- |                                                   |                      |
|---------------------------------------------------|----------------------|
| 1. <b>0.8ml</b>                                   | 4. <b>130ml</b>      |
| 2. <b>8ml</b>                                     | 5. <b>160mg; 2ml</b> |
| 3. <b>5.625g; 1.125g; 5.625g; 11.25g; 21.375g</b> |                      |

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