SEPTEMBER 2010

newsletter

pharmacycouncil
OF NEW ZEALAND

Recertification review

The Pharmacy Council's recertification framework was set in 2004 so that potential providers could develop recertification programmes for pharmacists. Only one programme, ENHANCE, run by the Pharmaceutical Society of New Zealand (Inc) has been accredited by the Pharmacy Council.

Recertification Working Party

The Pharmacy Council recently began a review of the recertification framework and a working party has been set up to develop a new recertification framework. The membership of the working party represents different stakeholders from the pharmacy profession and includes a recently registered pharmacist and a rural pharmacist. The first meeting is planned for November with further meetings in 2011 before the Council consults with the whole profession. The final framework will be ratified once your feedback has been received and considered so that providers can develop new recertification programmes that meet the framework.

Recertification Audit 2010

The recertification audit was started in July. This audit assesses the learning that pharmacists completed from April 2007 to March 2010 and confirms participation in the ENHANCE recertification programme. In line with initial findings from the review of the framework, some modifications have been made to the audit for the current recertification programme.

These changes are:

- No request for further evidence: In previous audits, if the auditor considered that the evidence provided did not support the Outcome Credit assigned, the pharmacist was asked to provide further evidence. This step has been removed from the audit.
- Comments on individual Outcome Credits: Whilst in previous audits the auditors assigned an Outcome Credit for each record submitted, auditors will now not determine Outcome Credits for individual records but comment on the learning outcomes demonstrated from all activities. However, the auditors will comment on a specific Outcome Credit if they consider the Credit assigned by the pharmacist is unreasonable.
- Submission of a learning log: The learning log is a description of the professional development activities that a pharmacist has completed during the audited period. The auditors considered this in conjunction with the CPD records before giving feedback on the quality of the audit submission. The learning log has not been a previous requirement in the audit but the log will help auditors when the CPD records do not clearly demonstrate the amount and quality of the learning completed.
- Auditor feedback: As in previous audits, the auditor will provide feedback so that pharmacists can improve their future professional development activities. When the documentation is considered to be of poor quality, a pharmacist should 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.

For further information on recertification and the audit (including the Council policy documents), see the Council's website: www.pharmacycouncil.org.nz/recertification_main

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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Pharmacist Prescriber Scope of Practice consultation

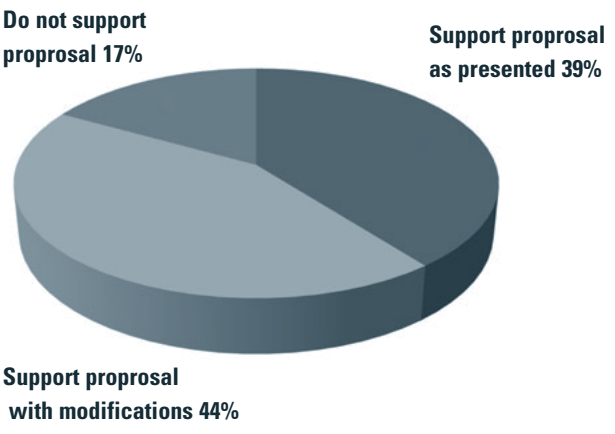
On 2 June 2010 the Pharmacy Council of New Zealand released a consultation document, the Proposed Pharmacist Prescriber Scope of Practice. This document was released in response to section 14 of the Health Practitioners Competence Assurance (HPCA) Act 2003 which requires a regulatory authority to consult on scopes of practice before it is specified by notice published in the Gazette.

The purpose of this consultation document was to:

- outline the context for the proposed scope by detailing the background of pharmacy practice in New Zealand, including the education and training of pharmacists, their expertise in medicines management and their contribution in optimising medicines related health outcomes for patients
- discuss the likely patient benefits of the proposed pharmacist prescriber scope in New Zealand and those seen in similar jurisdictions
- consult on the HPCA Act 2003 requirements for the proposed scope of practice of pharmacist prescribers. This included:
  - scope of practice definition for a Pharmacist Prescriber
  - the prescribing competency framework
  - the prescribed qualifications (additional education and training requirements)
  - the accreditation standards for the qualification
  - the registration requirements and
  - the ongoing competence and monitoring requirements

Council sent out e-mail notification to individual practising pharmacists and to 92 stakeholder groups to advise of the consultation. These groups included pharmacy organisations, academic and teaching institutions, other relevant health professional groups (including current prescribers), regulatory authorities, potential consumer groups, the pharmaceutical industry and other relevant interested parties including District Health Boards, Accident Compensation Corporation (ACC), PHARMAC, and the Health and Disability Commissioner. The closing date for submissions was 7 July 2010.

71 submissions were received from across the range of stakeholder groups. Overall, there was strong support for the proposed scope with 83% of the submissions supporting the proposal, either as presented (39%) or with modifications (44%). Predominantly, modifications related to strengthening the definition of a collaborative health team environment; the communication and clinical recording of decisions; the registration requirements and aspects of the education and training of the proposal.



17% of the submissions did not support the proposed scope; most of these were from individual medical practitioners or medical organisations. The main reasons included a perceived conflict of interest relating to the financial relationship between prescribing and dispensing and concerns relating to the level of education and training of pharmacists in diagnosis, physical examination and clinical assessment of patients. A number of these unsupportive submissions seemed to be based on an assumption that all pharmacists would become prescribers.

Response to the Consultation

Stakeholder Group	Number of Submissions
Academic/Teaching Organisation	2
Accident Compensation Corporation (ACC)	1
DHBNZ	1
District Health Board (DHB)	3
Funding Authority	1
Health and Disability Commissioner (HDC)	1
Medical – General Practice	4
Medical – Specialist	5
Medical Centre	1
Medical Organisation	7
Nursing Organisation	3
Other Health Professional Group	3
Pharmaceutical Industry	1
Pharmacy – Community	13
Pharmacy – Hospital	10
Pharmacy – Other	5
Pharmacy Organisation	5
Primary Health Organisation (PHO)	2
Regulatory Authority (Health Professions)	3
TOTAL	**71**

The Council will be considering the results of the submissions analysis at its September meeting and any changes that need to be made to the proposal. A report of the consultation results will be published on the Council website following this and the Council will be submitting an application to the Ministry of Health later this year for pharmacists registered in this scope to hold designated prescriber status.

Lessons from HDC complaints

The following is a précis of an article written by Ron Paterson, Health and Disability Commissioner 2000-2010, for the New Zealand Medical Journal (NZMJ, 14-May-2010, Vol 123 No 1314).

Having read and handled thousands of patient complaints, and undertaken hundreds of detailed investigations, Mr Paterson has some very pertinent insights, gained from a unique perspective on the health and disability system, to offer health professionals. Although the article was intended for the medical profession, the lessons can apply equally to pharmacists.

Courtesy, kindness, empathy and communication

Patients have very good antennae for whether a doctor is genuinely interested in them and their health problem. It is no accident that Robyn Stent, the inaugural Commissioner, placed 'the right to be treated with respect' first of the 10 Code rights. In 2009, HDC reviewed and consulted on the Act and Code, which resulted in forty-four of 122 submissions supporting the addition of a 'right to compassion' in the Code. Compassion was defined as 'the humane quality of understanding suffering in others and wanting to do something about it'. It is clear that patients and doctors perceive that compassion is a quality increasingly absent from clinical interactions.

An effective doctor needs to be an effective communicator. A breakdown in communication often sets the stage for a complaint. But good communication is not important simply because it is protective against complaints. Good communication matters because it is strongly correlated with better outcomes for patients. In HDC files, doctors who are truly open to their patients – listening to them, engaging them in conversation, trying to answer their questions – are seen infrequently.

Self-reflection and openness to criticism

The doctors who appear before HDC are a defensive bunch. What is striking is the degree to which a minority of doctors who are subject to patient complaints are unwilling or unable to move beyond technical justifications for their treatment, to reflect on why the patient was so unhappy that they made a complaint. Some doctors are very good at pointing the finger at others but poor at self-reflection or accepting constructive criticism from peers.

Teamwork

From primary to tertiary care, health care is delivered by teams, and the ability to be a team player is essential for the team to function well for the benefit of patients. Yet we still see the old medical hierarchy at play, with junior doctors, nurses, pharmacists and technicians feeling unable to speak up and question the treatment being provided to the patient. Teamwork is not just important with fellow health professionals – it extends to clerical staff, managers and employers.

Quality improvement

A key aspect of quality improvement is understanding the role of human factors and systems problems in the reduction of preventable harm to patients. Patient safety has been a major theme of my work as Commissioner. Making healthcare safer demands a new set of skills from health professionals – adverse events will not be prevented simply by focusing on individual performance.

Competence

Despite the appropriate emphasis on teamwork and systems, individual skills and competence remain critical. Consumers expect a high level of medical competence – good up-to-date medical knowledge and awareness of limitations. Patients assume that doctors have to maintain their professional skills and that this is checked, much as a car must have a valid 'warrant of fitness' to stay on the road. In fact the current Medical Council requirements for recertification are light, based on a fairly soft CME model. There is too much mileage given to attending update conferences and not enough focus on participation in audit, peer review, and quality improvement activities.

Ethical blind spots

The final category is one called 'ethical blind spots'. Of course all the issues raised thus far have an ethical dimension. But there are also some classic ethical issues. Examples include financial dealings with patients or with pharmaceutical companies, lack of sensitivity to patient confidentiality, ignoring the cultural and health needs of different ethnic groups.

To quote Judge Sylvia Cartwright 'The public does not see medicine purely as a scientific pursuit. Increasingly, it is demanding evidence that doctors think through the many dilemmas which surround its practice and that they involve the public in ethical decisions.'

Conclusion

Many of these lessons are well captured in a recent article on *'Transforming health care: a safety imperative'*. International patient safety leaders identify reform of medical education as one of 'five transforming concepts' and write:

> *Medical education needs to be restructured to reduce its almost exclusive focus on the acquisition of scientific and clinical facts and to emphasise the development of the skills, behaviours and attitudes needed by practising physicians. These include the ability to manage information; understanding of the basic concepts of human interaction, patient safety, healthcare quality and systems theory; possession of management, communication and teamwork skills.*

Undergraduate, specialist and continuing medical education in New Zealand are already well advanced on these paths. My experience as Commissioner confirms that we need to continue to maintain a balance between teaching (and updating) technical skills and developing and maintaining the broader skills essential to be a good doctor in the 21st Century.

Council would like to thank Mr Paterson for kindly giving his permission to summarise his article for our newsletter.

Halving non-halveable tablets

Council has been advised by Medicines Control that, in the process of checking Controlled Drugs registers, auditors have noticed an increasing trend for some pharmacies to dispense prescriptions using half tablets when these clearly should not be halved. Specific examples are OXYCONTIN® and methylphenidate slow release tablets.

OXYCONTIN® tablets are to be swallowed whole and are not to be broken, chewed or crushed, which could lead to a rapid release and absorption of a potentially toxic dose of oxycodone. Methylphenidate SR tablets i.e. Rubifen® SR, Ritalin® SR and Concerta® tablets should also be swallowed whole and not halved, divided, crushed or chewed. In the case of Concerta®, the medication is contained within a non-absorbable shell designed to release the drug at a controlled rate. Rubifen immediate release tablets should also not be halved as dose equivalence when the tablet is divided has not been established.

Although dispensary software programmes indicate when Reference A, 'swallow whole, do not crush or chew', should be included on a label, too often pharmacists appear to be literally taking prescribers' instructions to halve tablets, without considering the pharmacokinetics of the formulation.

Other commonly dispensed medicines to note that must be swallowed whole are:

- Felodipine ER (Felo®/Plendil®) tablets must not be divided, crushed or chewed.
- Bupropion (Zyban®) tablets should be swallowed whole and not crushed or chewed as this may lead to an increased risk of adverse effects, including seizures.
- Dipyridamole (Pytazen®) SR 150 mg tablets must be swallowed whole and not crushed or chewed.
- Leflunomide (Arava®) tablets must not be divided.

If in doubt about halving enteric coated or controlled release tablets, don't make assumptions. Check the data sheet on Medsafe's website, call the Drug Information pharmacist at your nearest hospital or call the company concerned. Use the opportunity to then discuss what is pharmaceutically appropriate with the prescriber.

Misuse of OTC codeine-containing analgesics

A recent article in the New Zealand Medical Journal (25 June 2010, Vol 123 No 1317) highlighted a new pattern of admissions to a detoxification unit that may relate to the misuse and abuse of OTC codeine-containing analgesics. As the authors noted, despite labelling on combination analgesic products including maximum dosage and cautions regarding potential adverse effects, there remains a potential for misuse because of the dependency potential of codeine. The patients treated described patterns of visiting multiple pharmacies, sometimes travelling considerable distances to obtain these OTC analgesics.

Alarmingly, a recent survey of more than 700 New Zealanders found that more than 30% were unsure whether codeine was addictive, 6% said they didn't think it was addictive, and 4% didn't know what codeine was. Many had purchased a codeine-containing analgesic without realising they had.

Issues such as these and the upcoming changes to the classification and labelling of codeine-containing analgesics highlight the role of pharmacists and provide an opportunity to educate the public on the distinct risks around the overuse of codeine. Pharmacists should take the opportunity to increase the level of advice given around its safe use and increase the overall pharmacovigilance around these medications.

Mesalazine oral dosage forms not interchangeable

In April, pharmacists were advised about the availability of currently subsidised formulations of the oral dosage forms of mesalazine. Unfortunately gastroenterologists continue to report dispensing errors by pharmacists who seem unaware that these formulations are not interchangeable.

To ensure the correct formulation is dispensed, it may be worth considering identifying and separating tablets that are long acting from those that are simply enteric coated.

The currently subsidised oral forms of mesalazine are:

- Asacol enteric coated 400mg tablet
- Asamax enteric coated 500mg tablet
- Pentasa long acting (prolonged release) tablet 500mg

These are different formulations and strengths and are therefore not interchangeable.

There has been no change to the subsidy of Pentasa prolonged release 500mg tablets. They remain fully funded on the Pharmaceutical Schedule.

Cultural Competence update

Further to the last update, a draft Expression of Interest (EOI) document was sent to a wide range of tertiary institutions and interested parties. The purpose of the EOI process is to invite parties to register their interest in developing and delivering pharmacy-specific education programmes.

Many pharmacists have signalled to Council that they have 'knowledge gaps' in areas such as New Zealand health disparities, how to apply cultural competence skills, and what the benefits and gains a culturally competent pharmacy workforce might offer. It is intended that these programmes will help fill these gaps relative to the requirements of Elements 1.3, 1.4 and 1.5 of the new Competence Standard 1 which will come into effect from January 2012.

Council believes that the approach taken in the development of Competence Standard 1 has been very innovative, with the aim of creating a practice framework whereby all pharmacists integrate cultural competency into their everyday practice.

The closing date for proposals was 30 July. All responses will now be assessed against the criteria in the EOI and successful providers notified by the end of September. Council will then advise the profession of those providers whose programmes have been approved.

Code of Ethics Interim report

In May, Council advised the profession and key stakeholders that consultation was to begin on a revised Code of Ethics. The consultation draft was done with reference to similar documents from the Royal Pharmaceutical Society of Great Britain, the American Pharmaceutical Association, the Pharmaceutical Society of Australia and the International Pharmaceutical Federation (FIP) statement of professional standards. The New Zealand Medical Association Code of Ethics and the Nurses Code of Conduct were also reviewed to assess similarities and differences in approach within the New Zealand healthcare environment.

The consultation document outlined the seven proposed principles and supporting obligations, many of which have been taken from the current Code. The Code is not intended to be exhaustive. There may be obligations or situations that are not expressly provided for, but pharmacists will still be required to meet all the implied requirements of ethical practice. A key feature of the revised Code is the removal of obligations relating specifically to pharmacy practice as many of these are now covered in the Pharmacy Services Standard. The language has also been simplified and, where appropriate, duplications removed.

Many respondents expressed their appreciation of the 'fresh approach as to what it means to be a pharmacist' and felt the Code reflects well the patient-centred practice pharmacists are aiming for. There was concern expressed about the lack of technical detail proposed. Council believes a Code of Ethics should provide a broad framework of ethical principles within which a profession should operate, rather than provide a prescriptive set of rules and procedures.

The next step in the process is for all responses to be collated and analysed, and for further refinement to be made where appropriate. The revised Code will then be presented to Council in December for ratification.

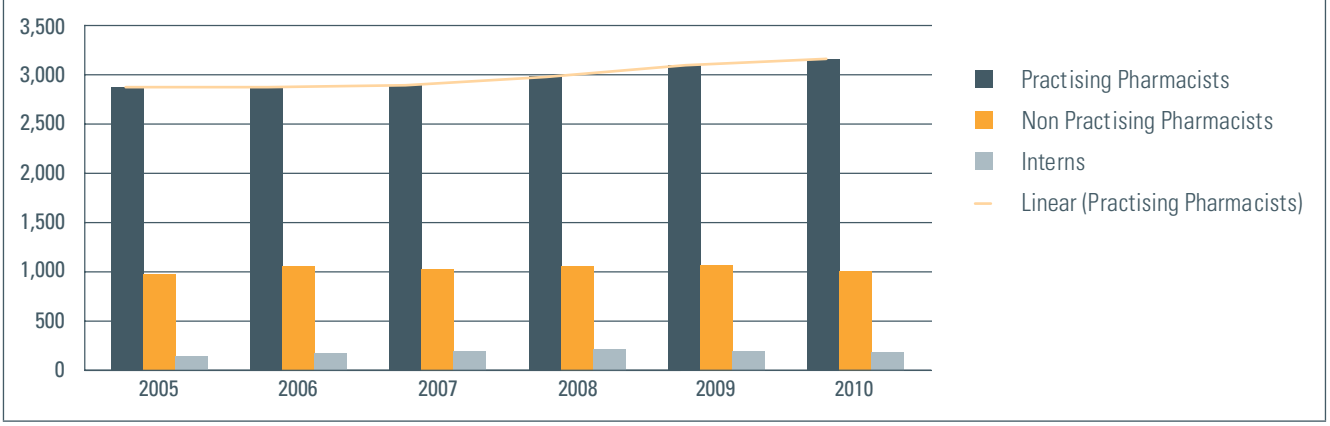
2010 workforce report now available

Data from the 2010 APC renewal has been collated and graphed and it is interesting to note that the number of pharmacists holding an Annual Practising Certificate has again increased. The graph below shows a steady increase since 2005.

As at 30 June 2010, the number of practising pharmacists was 3,180, up 104 (3.4%) from 2009.

Further analysis of Register information, along with details of trends and retention data is now available on our website at: www.pharmacycouncil.org.nz/demographics

Register Numbers as at 30 June 2010



Health Practitioners Disciplinary Tribunal decision

At a hearing of the Health Practitioners Disciplinary Tribunal held 30 April 2010, Mr Brian Mark Marshall, pharmacist of Waikato, admitted that the charge laid against him amounted to professional misconduct. Mr Marshall's conduct in respect of this charge occurred over a number of years and included breaching a trespass order and making inappropriate calls and text messages to female customers after pharmaceutical consultations and prescription purchases for the Emergency Contraceptive Pill (ECP).

The Tribunal upheld the charge viewing his conduct as amounting to malpractice in that it was unethical and was likely to bring discredit to the pharmacy profession. Mr Marshall was fined $15,000 and he was ordered to pay 35% of costs incurred by the Professional Conduct Committee and the Tribunal. The Tribunal imposed a 6 month period of suspension, a censure and conditions on his practice following the period of suspension. One of those conditions being that Mr Marshall must not personally dispense the ECP or its equivalent for three years following the expiry of the suspension period.

The full decision of the Tribunal can be viewed at: www.hpdt.org.nz/Default.aspx?tabid=262

Pharmacist changes since December 2009

Congratulations to the following intern pharmacists (both BPharm graduates and previously registered overseas trained pharmacists) who successfully completed the EVOLVE intern programme in December 2009 and June 2010.

Michelle Abraham; Walid Abu Shawish; Ahmed Fadhil Al-Alawi; Aula Al-Jubbawey; Karm, Al-Khanaty; Ali Alwash; Woroud Alzaher; Dimana Ashikova; Ka Ying Au;Min Beh; Nicola Bell; Mario Besich; Shereen Bhikoo; Natalie Blake; Rebecca Bloor; Simon Blue; Guobin Boo; Ainsley Braam; Carina Burgess; Alex Chan; Madonna Hiu Ying Chan; Grace Chang; Alice Tsun-Ling Chang; Huijun Chen; Caroline Cheng-Hao Chen; Chang Chen; Nyasha Chimwayange; James Cho; Lisa Chu; Yee Chun; Hollie Clyma; Bradley Collins; Carla Corbet; Kathryn Dean; Balinda Derik; Rachna Devi; Bandhana Dhroptee; Jessica Dodd; Upekha Edirisinghe; Lena Estrin; Megan Ewing; Christine Fahmy; Lovina Fakauka; Sarah Farquhar; Jessica Fothergill; John Fredatovich; Heidi Furlan; Andrew Fussell; Katherine George; Zhongyang Gn; Nirmala Gnanasekaran; Wei Cheng Goh; Ping Gong; Salouni Ketan Govan; Matthew Grey; Kate Griffin; Ibrahim Haider; Maria Havell; Veronika Hegedus-Gaspar; Mate Hegedus-Gaspar; Robert Hill; Kwok, Ho; Sarah Ho; Adam Ho; Samuel Hobbs; Louisa Hoffmann-Vocke; Na Eun Huh; Mohammed Hussein; Tess James; Augustine Hyun-Soo Jang; Edwardine Jayetileke; Daniel Jemberie;Tao Jiang; Lisa Josephs; Nachiket Joshi; Kan Kaneko; Yu Kao; Matthew Kennedy; Go Eun Kim; Duhee Kim; Jung A Kim; Bob Kim; Komal Kirti; Wony Ji-Won Koak; Esther Kostan; Soo-ah Kwon; Sophie La; Fiona Lai; Avishkar Lal; Kwai Ying Lam; Janice Lee; Taun-Jung Lee; Hon Lee; Jessica Lee; Hui Fen Lee; Kyung Lee; Tsz Yu Lee; Wei Lee; Cheng-Kang Lee; Rachael Liddell; Fung Liew; Johanna Lim; Kevin Ling; Sok Ann Ling; David Lornie; Mei Lu; Sylvia Lu; Ruth Lumukana; Cheryl Mabbett; Pei Ting Mah; Helia Mahdavi; Samuel Martin; Fay Matete-Onwubuariri; Claire McSherry; Mehul Mehta; Amir Meshreky; Usama Metry; Maureen Mishriki; Heavenna Moon; Jessie Moon; Kasey Moratti; Martin Munyaradzi; Jenna Murphy; Yonky Na; Komal Nadan; Anya Naidoo; Neera Naidoo; Krishnan Naidu; Sharon Naidu; Shriyash Nair; Ju Hee Nam; Katarina Ngamoki; Sul Noh; Natalie Nowak; Tracy Olivier; Katie Owens; Priyanwada Padukkage; Rubina Patel; Neelam Patel; Disha Patel; Shelley Payne; Lisa Pedersen; Yu-Chen Peng; Yu-Chun Peng; Shelli Penney; Rohan Prasad; Ahmed Raghib;Jennaha Ramachchandran; Jashil Raniga; Joanne Rassam; Rachelle Reber; Roshika Reddy; Shiwangni Reddy; Oliver Rew; Jeanine Rossouw; Lesley Roy; Hang Ruan; Hayley Ryan; Arun Samarasan; Yew See; Lamia Shakir; May-Wei Shan; Devika Sharma; Bohye Shin; Sheenal Shivashna; Nicole Silcock; Agilandeswari Silvam; Myung Sin; Jennifer Sin; Navdeep Singh; Kritika Singh; Anita,Smith; Cecilia So; Joseph Stevenson; Yuanyuan Sun; Jae Yong Sung; Ka-Hwa Sur; Melanie Tan; Guy Tancock; Su Yiing Tang; Kate Taylor; Michael Taylor; Tessy Thomas; Hollie Thomas; Sing Sii Tie; Diana Ting; Helen , Topham; Michelle Ure; Dirk Van Lill; Preetika Vareed; Prateeka Vareed; Stuart Walker; Ricky Wan; Yun Wang; Yongting Wei; Melissa West; Moanamarie Westerlund; Zoe Williams; William Wong; Sylvia Wong;Chi Hang Wong; Hannah Wright; Jason Wright; Neneweh Yacoub; Pei-Chien Yang; Hwee Yap; Nai Hau Yeat; Allen Yeh; Suzanne Yip; Sharyn Young; Yun-Jun Yu;Shanshan Yuan; Hanzhi Zhong; Huanyi Zhou; Amy Zhuang

PHARMACIST REGISTERED FROM AUSTRALIA, IRELAND, NORTHERN IRELAND, THE UK AND THE USA FROM 9 NOVEMBER 2009 TO 16 AUGUST 2010

Naeem Anjam; Charles Barrett; Roisin Daly; Charlotte Dunkley; Domhnall Heron; Emma Horsfield; Ann Hutton; Clare King; Deepti Lal; Michael Lasko; Claire; Kate Lloyd; Yvette Mainwaring; Bronagh McBrien; Edward Neal; Sally Oades; Graham Parton; Michelle Saunders; Niamh Slowey; Stephen Smith; Melle Steringa

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