

NOVA SCOTIA COLLEGE OF PHARMACISTS

DECISION OF THE HEARING COMMITTEE

In the matter of: Recommendation of the Investigation Committee for acceptance of the Settlement Agreement between the Nova Scotia College of Pharmacists and Ms. Alexandra Willson.

The Hearing Committee met on December 19, 2016 to consider the proposed Settlement Agreement being recommended for acceptance by the Investigation Committee regarding Ms. Alexandra Willson.

After careful review of all of the information from the Nova Scotia College of Pharmacists, including the proposed Settlement Agreement (attached) and relevant precedents;

The Hearing Committee has decided to accept the recommendation of the Investigation Committee with regard to the Settlement Agreement between the Nova Scotia College of Pharmacists and Ms. Alexandra Willson.

December 19, 2016

Harriet Davies, Chair



On behalf of Hearing Committee Members:

John McNeil

Tom Mahaffey

Harriet Davies

attachment

**PROVINCE OF NOVA SCOTIA
HALIFAX REGIONAL MUNICIPALITY**

IN THE MATTER OF: The *Pharmacy Act*, R.S.N.S. 2011, c.1 and Regulations
made thereunder

-and-

IN THE MATTER OF: Ms. Alexandra Willson, Pharmacist, [REDACTED] Nova
Scotia, [REDACTED]

SETTLEMENT AGREEMENT

WHEREAS pursuant to the *Pharmacy Act* of Nova Scotia, allegations were set out in a complaint dated May 31, 2016 alleging that Ms. Alexandra Willson breached provisions of the *Pharmacy Act* and regulations made there under, and conducted herself in a way in which a Hearing Committee properly constituted under the *Pharmacy Act* could conclude that her conduct amounted to professional misconduct,

AND WHEREAS the Nova Scotia College of Pharmacists and Ms. Willson agree that a Settlement Agreement is the proper method of disposing of this matter,

AND WHEREAS the Nova Scotia College of Pharmacists and Ms. Willson agree to the following statement of facts:

1. **THAT** you failed to be diligent in taking the necessary steps to determine the accuracy of a prescription prior to dispensing it to the patient. You did not confirm the accuracy of the contents of each blister / compartment prior to dispensing the compliance package, all contrary to the *Pharmacy Act* section 32(1) and its regulations, the *Standards of Practice* and the *Compliance Packaging* policy. Specifically:
 - a. You were the Pharmacy Manager, practising pharmacy at [REDACTED] Nova Scotia, [REDACTED] Canada (the "Pharmacy").
 - b. On May 3, 2016 you dispensed four weeks of medications in compliance packaging for a patient.
 - c. During the prescription checking process, you discovered that the pharmacy assistant had placed one and a half (1.5) tablets of methotrexate 10mg, for a total of 15mg, in a blister compartment for every day of the week, rather than for just once weekly, on Wednesdays, as prescribed.

- d. You asked the pharmacy assistant to remove the extra tablets from the compliance packages.
 - e. The pharmacy assistant only removed a half tablet (5mg) from six of the seven days each week, rather than the full one and a half tablets, leaving the compliance packages with 15mg of methotrexate on Wednesdays as prescribed, and 10mg of methotrexate on each of the other days of the week, which was not prescribed.
 - f. You did not recheck the compliance packages prior to dispensing them to the Patient.
 - g. The Patient received the compliance packages with the incorrect extra methotrexate doses. Methotrexate is an immune system suppressant.
 - h. On May 23, 2016 the Patient was admitted to hospital with severe infections. The Patient subsequently died on June 16, 2016.
2. **THAT** you failed to develop, maintain and enforce policies and procedures to comply with the *Standards of Practice* or otherwise required to ensure optimal patient care contrary to the *Pharmacy Act*, section 32(1), the *Pharmacy Practice Regulations*, section 21 and the *Compliance Packaging* policy. Specifically:
- a. You failed to ensure that your staff had the necessary knowledge and skills to properly provide compliance packaging services. The pharmacy assistant who prepared the compliance packages on May 3, 2016 was a new employee of the Pharmacy who did not have sufficient training or experience in preparing compliance packages.
 - b. The pharmacy assistant who prepared the compliance packages on May 3, 2016 had made the same error when preparing the compliance packages in April 2016.
3. **THAT** you failed to establish and maintain a continuous, documented quality assurance program that includes a process for documenting, reporting and analyzing known, suspected, intercepted and corrected medication errors and discrepancies, and the steps taken to resolve the problems and prevent their recurrence contrary to the *Pharmacy Act*, section 30, the *Pharmacy Practice Regulations* sections 21 and 22 and the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies*. Specifically:
- a. In April 2016 while preparing the compliance packages for the Patient, the pharmacy assistant made the same error as described in #1.
 - b. In April 2016, you discovered and corrected the error.
 - c. After discovering this error, there was no submission of the details of the error to the Canadian Pharmacy Incident Reporting Program. There was no attempt to discuss the error with the staff involved, no staff meeting to discuss the error, and no actions were taken to minimize the likelihood of the error recurring.

- d. When the error occurred a second time and was brought to your attention on May 23 2016, you did not follow the requirements set forth in the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies* for managing known, alleged and suspected medication errors that reach the patient, including but not limited to ensuring the management of error process is appropriately communicated to the patient; including an apology that acknowledges the negative impact to the patient and commits to taking steps to minimize the likelihood of recurrence of the incident; communicating to the patient causal factors of the error and actions taken to reduce the likelihood of recurrence; proper documentation of the error and communication with staff.
 - e. You did not develop, maintain and enforce policies and procedures to comply with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies*. This deficiency was identified in previous pharmacy inspections. You falsely declared to the College that the deficiency was corrected and you had implemented a Continuous Quality Assurance Program. No Continuous Quality Assurance Program was implemented.
4. **THAT** you mislead the Nova Scotia College of Pharmacists by declaring that you had implemented a Continuous Quality Assurance Program and are guilty of an offence under the *Pharmacy Act* as per section 70(2). This is also contrary to Value VI of the *Code of Ethics*. Specifically:
- a. On October 31, 2014 a professional practice audit of [REDACTED] was conducted and it was discovered that the pharmacy was noncompliant with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies*.
 - b. On January 21, 2015 you signed the Nova Scotia College of Pharmacists' *Deficiency Correction Action Plan and Report* confirming compliance with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies* including that you were holding CQI meetings quarterly and entering Quality Related Events (QREs) online.
 - c. On May 27, 2016 a professional practice audit of [REDACTED] was conducted and it was again discovered that the pharmacy was noncompliant with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies*.
 - d. On June 28, 2016, you signed the Nova Scotia College of Pharmacists' *Deficiency Correction Action Plan and Report* confirming that the pharmacy was compliant with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies* and that you had held a Continuous Quality Improvement meeting on May 30, 2016.
 - e. The Nova Scotia College of Pharmacists' investigator interviewed staff on June 21, 2016 and staff reported no knowledge of a Continuous Quality Assurance Program and informed the investigator that they had not been involved in any Continuous Quality Improvement Meetings.

Ms. Willson specifically acknowledges and agrees to all of the facts stated above.

The Nova Scotia College of Pharmacists and Ms. Willson hereby agree to the following disposition and settlement of this matter.

1. Ms. Willson acknowledges and agrees that her conduct noted above amounts to professional misconduct and conduct unbecoming contrary to the *Pharmacy Act* and *Regulations*.
2. A letter of reprimand in the form attached shall be placed on the file of Alexandra Willson.
3. The licence of Ms. Willson to practise pharmacy in Nova Scotia shall be suspended for a period of 2 months. The period of suspension shall be completed within 4 months of the date of this Settlement Agreement.
4. Ms. Willson shall pay a fine of \$5,000.00 to the NSCP within 90 days of the date of this Settlement Agreement.
5. Ms. Willson shall pay a portion of the College's costs for this matter, fixed at the amount of \$7,500.00 to be paid in equal amounts monthly of \$625.00 over a twelve month period starting within 180 days of the date of this Settlement Agreement. In any event, any amount of the costs not yet paid, shall be due and payable in full, on or before September 1, 2018.
6. There shall be up to twelve (12) professional practice audits performed at any pharmacy in which Ms. Willson is practising. The cost of the professional practice audits shall be borne in full by Ms. Willson.
7. For a period of 6 months, Ms. Willson shall increase the frequency of Continuous Quality Improvement staff meetings to bimonthly. The meetings should focus on managing known, alleged and suspected medication errors and communicating to all pharmacy staff the appropriate details of the error, including the causal factors of the error and actions taken to reduce the likelihood of recurrence. The meetings will include establishing, amending and/or monitoring progress of a written quality improvement action plan consistent with the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies*.
8. Ms. Willson shall enroll in, undertake, and successfully complete, within twelve months of the date of this Settlement Agreement, an educational continuous quality assurance course approved by the Nova Scotia College of Pharmacists.
9. Ms. Willson shall successfully complete the Nova Scotia Jurisprudence Exam within 3 months of acceptance of this agreement.

10. Ms. Willson shall compose an article within 3 months of the date of this Settlement Agreement that includes the lessons learned and the steps that have been taken to minimize the likelihood of reoccurrence, which shall be communicated with all registrants of the NSCP and with the Patient's family.
11. Ms. Willson shall contact the Patient's family, by phone or in person, to confirm her acknowledgment and agreement of the facts set out in this Agreement, and to apologize as defined in the Apology Act such that the requirements of Section 2(IV) of the *Standards of Practice Continuous Quality Assurance Programs in Community Pharmacies* are met.
12. There shall be publication, with name, of the facts and details of the Settlement Agreement in accordance with the *Registration, Licensing and Professional Accountability Regulations*, Section 71.

The Investigation Committee of the Nova Scotia College of Pharmacists and Ms. Alexandra Willson agree that this Settlement Agreement shall be put to a Hearing Committee of the Nova Scotia College of Pharmacists for its review.

DATED at Halifax, Nova Scotia, this 19 day of Dec , 2016

Beverley Zwicker, Registrar, NSCP

Alexandra Willson

Bryan Davis, Chair, Investigation Committee