COLLEGE OF PHARMACISTS OF MANITOBA

# NEWSLETTER

FALL 2021

# Contents

This Newsletter is published four times per year by the College of Pharmacists of Manitoba (the College) and is forwarded to every licenced pharmacist and pharmacy owner in the Province of Manitoba. Decisions of the College of Pharmacists of Manitoba regarding all matters such as regulations, drug-related incidents, etc. are published in the newsletter. The College therefore expects that all pharmacists and pharmacy owners are aware of these matters.

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**The mandate of the College is to serve and protect the public interest**

Our mission is to protect the health and well-being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice in collaboration with other health-care providers.

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# SIQ Feature – NIDR Shares Safety Brief on the Data Reported from Manitoba Community Pharmacies

Manitoba is now several months into Safety IQ and pharmacies are reporting incidents and near-miss events to their online incident reporting platform. Your de-identified reports have been sent to the National Incident Data Repository (NIDR) for Community Pharmacies hosted by ISMP Canada. Medication safety experts at ISMP Canada analyse the aggregate data from across the country to share learnings and recommendations with pharmacy professionals and other health care providers via Safety Bulletins and other communications.

In the spirit of knowledge dissemination and shared learning, the NIDR has communicated its first Manitoba Safety Brief. This report includes:

- Number of incidents received by the NIDR;
- Top five types of incidents reported; and
- Level of harm from reported incidents.

In addition, the report shares medication safety recommendations for you to consider.

You will note that the number of "No Error/Near-Miss" reports are almost three-times the number of incidents that have reached a patient. This confirms that pharmacy professionals serve as a safety net for patients and that pharmacy professionals see the value in reporting and learning from near-miss events to continuously improve quality. Near misses should be viewed as "good catches" to be celebrated but also heeded as a warning of potential gaps in pharmacy processes or systems. **We commend you for your efforts to prevent patient harm.**

## Reporting is the Cornerstone of Continuous Quality Improvement

Frequent, high-quality reporting of medication incidents and near-miss events made by people across the pharmacy team are the bedrock of continuous quality improvement.

## Make the Most of Your Medication Incident Report

All medication incidents must be promptly reported by pharmacy staff member(s) to the pharmacy's medication incident reporting platform. **Safety is everyone's responsibility and all staff should be trained and encouraged to report.**

While there are several basic required reporting fields, the narrative quality of your report is the richest data source. Your greatest impact on shared learning is possible in the 'Incident Description/How the Incident was Discovered' category. A rich, detailed, and clear description of the incident ensures that analysis at the pharmacy and NIDR level is as comprehensive as possible.

A medication incident is a preventable occurrence or circumstance that may cause or lead to inappropriate medication use or patient harm.

### Ask yourself the following questions as you make and review your incident description:

- Does your description include the 'What? When? Where? Why? and How?' of the incident
- Is the incident description clear and concise?
- Have contributing factors been identified and are they included in the incident description?
- Is the action to be taken to prevent the incident from recurring included in the incident description?
- Is your description free from patient and/or provider information?

The 'Quick Start to Reporting' resource can be used to support pharmacy staff in reporting medication incidents and near-miss events.

### Near-Miss Events Are Ideal Opportunities for Learning and Improvement

Near-miss events are far more common in community pharmacies than medication incidents. Because no harm has come to a patient, this presents an opportunity to celebrate a good catch with your team while looking at the potential for risk in pharmacy processes that a near-miss event or pattern can signal. Near-misses are a psychologically safe opportunity to improve your pharmacy's processes and foster a preoccupation with safety among the pharmacy team.

> A near-miss event is an event or circumstance that took place and could have resulted in an unintended or undesired outcome(s) but was discovered before reaching the patient.

If your pharmacy has not entered any incidents or near-miss events into your medication incident reporting platform, **consider reporting even near-miss events that may seem trivial** such as almost choosing the wrong medication from the shelf. If look-like or sound-alike drugs are side-by-side on the shelf, should your pharmacy consider a new way of organizing medications to prevent patient harm?

Low-priority near-misses such as this can familiarize your team with reporting, offer surprising opportunities to prevent patient harm, and contribute to a positive safety culture. Your team should talk about which near-miss events should be reported to ensure that everyone understands the basics of reporting and the workload is consistent and manageable.

For low priority near-miss events, the pharmacy may consider using a "Safety IQ basket":

- Near-miss event details are manually recorded on a standardized form (some incident reporting platforms allow you to print a hard copy of the form)
- Hard copy forms are placed into the Safety IQ basket, and then entered online as batches during a quiet period or near the end of a shift.

**With each incident and near-miss report, your pharmacy is contributing to patient safety within your pharmacy as well as the public good through the NIDR.**

For information on what near-miss events should be reported and how to improve your incident description, please review the Safety IQ Quick Guide: Reporting Medication Incidents and Near-Miss Events. If you wish to learn more about Safety IQ, please view the comprehensive Guide to Safety IQ.

## SAFETY MEASURES

Data matters! Statistical reports from the NIDR for Community Pharmacies bring awareness to the common types of incidents and near-miss events in Manitoba and can focus the improvement efforts of pharmacy professionals and the College. Here are the latest medication incident, near-miss event, and engagement statistics reported by Manitoba's pharmacy professionals:

From June 1, 2021 - September 30, 2021, Manitoba Community Pharmacies input 949 reports to the NIDR. Please see the NIDR Safety Brief for details on the types of incidents and levels of harm.

- 47 Pharmacies have completed at least one formal Continuous Quality Improvement Meeting
- 44 Pharmacies have completed their Medication Safety Self-Assessment

## RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES

### Featured Resource: SMART Medication Safety Agenda

The SMART Medication Safety Agenda is a two-page quarterly tool published by ISMP Canada that briefly describes contributing factors and recommendations for a medication incident. The quartlerly SMART Medication Safety Agenda tool is made possible by the ongoing reporting contributions of pharmacy assistants, pharmacy technicians, and pharmacists.

Your pharmacy can use the quarterly SMART Medication Safety Agenda tool to guide improvement plans and bring team awareness to similar incidents or near-miss events in your pharmacy. The most current agenda examines direct oral anticoagulants.

## WE WANT TO HEAR YOUR IMPROVEMENT STORIES

One of the goals of Safety IQ is to support shared learnings between Manitoba pharmacies about medication incidents, near-miss events, continuous quality improvements, and medication safety. If your pharmacy has experienced an incident or near-miss event that would be a good learning opportunity for other pharmacies, please forward your story to the Safety IQ team at safetyiq@cphm.ca. Your story will be shared with the profession through College publications and any identifying Information about the pharmacy or staff will be kept anonymous.

For some examples of shared learning contributions of pharmacy professionals on medication incidents, please see the latest edition of [directions], the Saskatchewan College of Pharmacy Professionals' continuous quality improvement newsletter.

FEATURE

# President's Message

## Dear Colleagues,

Fall is always a busy time of the year with flu vaccinations under normal circumstances. Thank you for providing this valuable service at a time of heightened need amid this pandemic when the added protection of influenza immunization may be vital to maintaining the health and well-being of many of our vulnerable Manitobans.

With both the annual Influenza campaign and the COVID-19 pandemic ongoing, pharmacy professionals are providing vaccination to a greater number of Manitobans. Therefore it is essential to remember that administering vaccines by injection is not without risk and requires professional knowledge, skill and due diligence with every injection administered. Please take a special look at the Shoulder Injury Related to Vaccine Administration (SIRVA) article within this Newsletter to refresh your memory on techniques used to prevent SIRVA.

It is hard to believe that we have been navigating through this "new normal" for over a year and a half now as healthcare professionals. While we have the assurance that many Manitoban's have been and continue to get vaccinated against COVID-19, it appears that we need to continue to anticipate the unexpected with new COVID-19 variants. Thank you for continuing to put the care of patients first despite feelings of physical, mental, and emotional fatigue.

In a continued effort for quality improvement, the College has been hard at work to support a standardized approach to the legislated responsibilities for pharmacy managers. This includes the development of a new set of resources starting with a series of articles and new website content. The articles will be published in the quarterly Newsletter and the College will advise registrants when the new website content is available.

A very successful professional development event entitled, Lessons from Complaints: Navigating Mental Health and Addiction, was recently hosted by the College. For those who did not have a chance to participate, please be sure to view the recorded webcast on the Previously Recorded Programs page of the College website.

Thank you again for your continued commitment to patient healthcare during this highly challenging time.

President,
Wendy Clark

# Shoulder Injury Related to Vaccine Administration (SIRVA)

The College Complaints Committee has received an increasing number of complaints involving possible cases of Shoulder Injury Related to Vaccine Administration (SIRVA).

Manitoba pharmacists who are authorized by the College of Pharmacists of Manitoba to administer injections play a key role in public vaccination efforts, such as annual influenza campaigns and during the COVID-19 pandemic, resulting in a greater number of vaccinations provided to all Manitobans. However, the administration of vaccines by injection is not without risk and requires professional knowledge, skill and due diligence with every injection administered.

## Symptoms and Causes of SIRVA

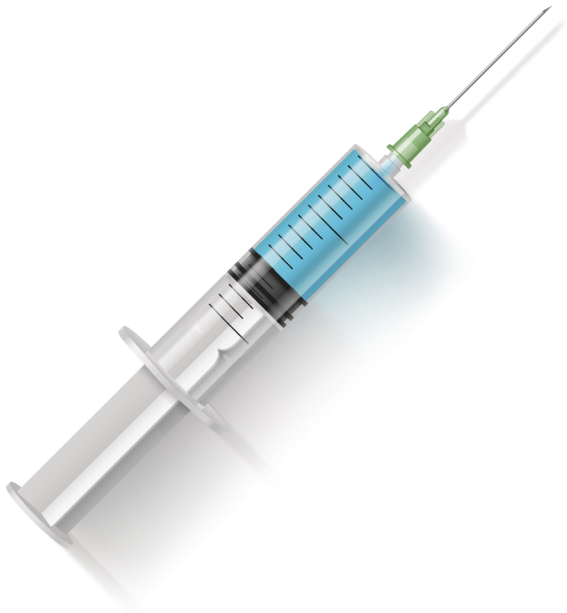
While it is normal for patients to experience transient shoulder pain after an intramuscular injection into the deltoid, SIRVA is characterized by persistent and prolonged shoulder pain with restriction of function. Because the shoulder seems frozen, some refer to it as 'frozen shoulder' syndrome. SIRVA should be suspected in any individual who has no prior history of shoulder pain or dysfunction and are experiencing sudden onset of shoulder pain with reduced range of motion following administration of a vaccine into the deltoid area.

While some patients experiencing SIRVA will develop symptoms within hours after injection, approximately 84 per cent of them will experience severe pain and limited range of motion within 48 hours of injection. Shoulder symptoms from SIRVA have been reported to last anywhere from 6 months to years and can greatly impact a person's ability to function in daily life.

The most common reported cause of SIRVA is thought to be improper landmarking whereby the injection is administered 'too high' in the deltoid and delivered into the deltoid bursa or within the joint space. Some have defined 'too high' as less than 3 cm from the lateral edge of the acromion process. Not only would missing the injection zone compromise vaccine efficacy, but it may lead to inflammation, pain, shoulder weakness, significantly reduced range of motion and nerve damage.

## What to Do If You Suspect SIRVA

If you suspect you have administered a vaccine too high on the shoulder, or into the shoulder capsule, you should inform the patient and counsel them on the typical signs and symptoms of SIRVA and notify their physician. If a patient reports symptoms consistent with possible SIRVA to you, the patient should be referred to a physician for a timely assessment which may include imaging to assess the level and type of damage. Reports suggest, that provided there is no nerve damage, patients who begin a physician directed treatment pathway within three weeks of the onset of pain trended towards good to excellent outcomes. As a reminder, diagnosis is not within a pharmacist's scope of practice, so referral of suspected SIRVA to a physician is imperative.



## Prevalence and Diagnosis of SIRVA

Diagnosis of SIRVA is difficult because the link between recent vaccination and the onset of symptoms are often missed, and SIRVA presents like other common shoulder injuries. Often, clinical diagnosis is made when a healthcare practitioner recognizes the link between a recent vaccination and the symptoms, suspects incorrect vaccination technique, and confirms the diagnosis with imaging studies such as an ultrasound or MRI. Diagnoses is not within the scope of practice for pharmacists, and clinical diagnosis of SIRVA must be referred to a physician.

The exact prevalence of SIRVA is uncertain. Although there has been an association of SIRVA following influenza and tetanus immunization, many believe there are numerous other confounding factors such as injection technique, frequency of vaccine administration, and under-reporting due to health professionals failing to recognize SIRVA. Further complicating matters, SIRVA may not always be the result of improper injection technique but may manifest from an immunological reaction within the muscle to the vaccine itself; however, there is no definitive clinical study demonstrating a quantitative link between vaccine antigen and/or adjuvant and an immune mediated shoulder inflammation that causes prolonged symptomology, as with SIRVA.

## What to Do If You Suspect SIRVA

If you suspect you have administered a vaccine too high on the shoulder, or into the shoulder capsule, you should inform the patient and counsel them on the typical signs and symptoms of SIRVA and notify their physician. If a patient reports symptoms consistent with possible SIRVA to you, the patient should be referred to a physician for a timely assessment which may include imaging to assess the level and type of damage. Reports suggest, that provided there is no nerve damage, **patients who begin a physician directed treatment pathway within three weeks of the onset of pain trended towards good to excellent outcomes**. As a reminder, diagnosis is not within a pharmacist's scope of practice, so referral of suspected SIRVA to a physician is imperative.

## Proper Technique is Key to Preventing SIRVA

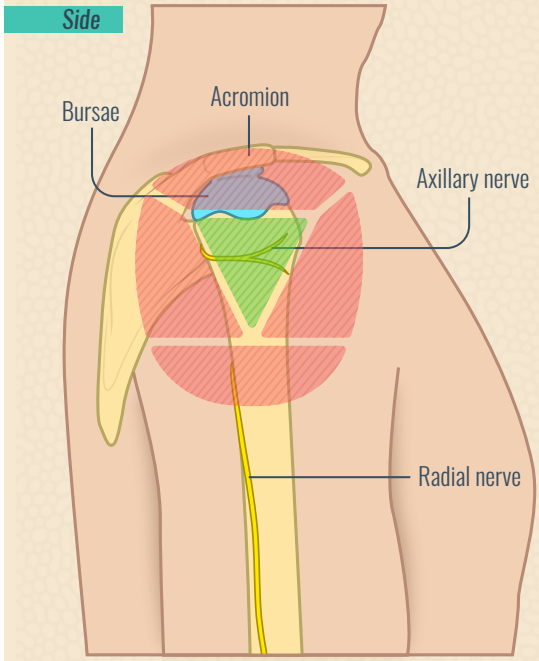
The best way to prevent SIRVA is correct injection technique. Although pharmacists must individually complete training to obtain their certificate of injection authorization from the College, pharmacy managers are encouraged to have their staff review proper injection technique and landmarking regularly, and prior to the busy influenza vaccination season.

The attached infographic on page 10. succinctly illustrates key fundamental points when administering a vaccine, and may be referred to during the review. Other great educational resources are the SIRVA module developed by the University of Waterloo School of Pharmacy in www.pharmacy5in5.ca or Institute for Safe Medication Practices Canada's Safety Bulletin on COIVD-19 vaccination errors.

A conversation with staff regarding SIRVA, how to prevent SIRVA and providing direction on how to manage a patient with possible SIRVA is also recommended.

# SIRVA

## Shoulder Injury Related to Vaccine Administration




## What to watch for when landmarking:

### Too High*

*Most reported cause of injury

- Risk of injecting into shoulder joint or bursa
- Can cause inflammation leading to bursitis, frozen shoulder syndrome, and other complications
- Watch for prolonged shoulder pain, weakness, and decreased range of motion
- Symptoms begin within hours to days
- Without treatment, symptoms last months and may never resolve

### Too Far to Side

- Can inject into **axillary** nerve

### Too Low

- Can inject into **radial** nerve

- Can cause paralysis and/or neuropathy
- Watch for burning, shooting pain during injection
- Symptoms start immediately

## What happens when:

### Needle Too Short

Can inject into subcutaneous tissue

- More painful for patient
- Risk of skin reaction
- Vaccine may be less effective

### Needle Too Long

Can hit bone or nerve

- If you hit bone, pull needle **back slightly** and inject
- If you hit nerve, pull needle out and try again

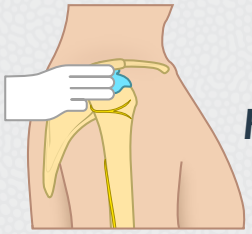
## Tips to Avoid SIRVA

Landmark, don't "eyeball"

Expose the shoulder completely

Always sit to inject a seated patient

When a shirt can't be removed, roll the sleeve up, don't pull the shirt's neck over the shoulder



***Remember!***

2-3 fingers down from the acromion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*Content by Kelly Grindrod, PharmD; Sherilyn Houle, BSP, PhD; Ashley Bancsi, PharmD Candidate. Design by Adrian Poon, BA*




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## There are several techniques pharmacists can use to prevent SIRVA:

1. **Correct landmarking of the deltoid muscle for injection.** Vaccine injections outside of the proper site may not only compromise efficacy, but, injections too high risk injecting into the shoulder joint, injections too low may result in injection into the radial nerve, and injections too far to either side may lead to injection into the axillary nerve. Proper landmarking involves identifying the upper boarder by measuring 2-3 finger widths (approximately 2 inches) down from the acromion process to ensure injection below the shoulder capsule. The lower boarder of the deltoid is marked by the armpit area. Injection should typically occur in the middle of the identified zone. It is imperative that one does not 'eyeball' landmarking; this may lead to injection outside of the deltoid.

2. **Both the vaccinator and the person should be seated with the shoulder relaxed and completely exposed.**

3. **Sleves should be rolled up to expose the shoulder. Avoid pulling the shirt down over the shoulder resulting in a raised shoulder position as for this may lead to incorrect landmarking.**

4. **Select the correct needle length.** Selection of a needle length that is too short results in a subcutaneous injection and may compromise vaccine efficacy, whereas if the needle is too long, the injection can hit a nerve or bone. Consider the patient's build when selecting a needle. People who have a slim build may have a smaller deltoid fat pad resulting in deeper needle penetration that can lead to injury.

## Report Adverse Events Such as SIRVA

In accordance with The Public Health Act, pharmacists are required to report adverse events, following immunization (AEFI) within seven days of becoming aware of the incident. For serious events, the report should be completed within one day, with the written report being completed within 72 hours. Reporting is not required in cases where the reaction is only mild and local and not overly concerning to the vaccine recipient. AEFI reports are submitted to Manitoba Health, Seniors and Active Living – Surveillance Unit.

Full details of what constitutes an AEFI, the reporting requirements, process, and reporting forms can be found here.

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# Education from the Adult Inquest Review Committee Meetings of the Chief Medical Examiner's Office

The College of Pharmacists of Manitoba attends monthly Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office to review deaths, which may have involved prescription drugs, focusing on opioids and other drugs of abuse. A de-identified case study based on information obtained from these meetings is presented in each Newsletter to provide an opportunity for education and self-reflection for all pharmacists.

## Introduction

MB was a 39-year-old female who was found deceased in her bedroom at home on Apr 26, 2018. Empty pill bottles and open alcohol containers were found on the bedside table. MB's past medical history included depression and anxiety. Other social determinants of health included the recent passing of a parent earlier in the year, an ongoing criminal matter, and recent loss of her job. MB also had teenage dependent children. The immediate cause of death was determined to be mixed drug overdose (topiramate, bupropion, cyclobenzaprine). A significant condition contributing to death was hepatic cirrhosis.

## Results

The following chart represents the results of the toxicology report. Drugs that were above the therapeutic range are indicated by an asterisk:

| Drug | Level in blood | Therapeutic Range, if applicable |
|---|---|---|
| Bupropion*<br>Hydroxybupropion | 400 ng/mL<br>6100 ng/mL | 50 -100 ng/mL<br>--- |
| Cyclobenzaprine* | 88 ng/mL | 3 - 32 ng/mL |
| Clonazepam<br>7-aminoclonazepam<br>(active metabolite) | 3.7 ng/mL<br>22 ng/mL | 20 - 70 ng/mL<br>20 - 140 ng/mL |
| Topiramate* | 140 ug/mL | 5 – 20 ug/mL |
| Ethanol (urine) | 82 mg/dL | ---- |

MB's DPIN history below only includes a summary of the medications relevant to her toxicology results for the six months prior:

| Generic Name | Date Dispensed | Strength | Quantity | Days' Supply | Prescriber | Pharmacy |
|---|---|---|---|---|---|---|
| Bupropion | Mar 20, 2018<br>Nov 4, 2017<br>Nov 15, 2016<br>Oct 6, 2016<br>Aug 27, 2016 | 150 mg<br>150 mg<br>300 mg<br>300 mg<br>150 mg | 60<br>60<br>30<br>30<br>60 | 30 | Dr X | XYZ Pharmacy |
| Clonazepam | May 15, 2018<br>Mar 20, 2018<br>Feb 27, 2018<br>Nov 4, 2017<br>Oct 6, 2017<br>Jul 12, 2017<br>May 3, 2017<br>Mar 24, 2017<br>Nov 15, 2016<br>Oct 6, 2016 | 0.5 mg | 90<br>90<br>90<br>90<br>90<br>60<br>60<br>60<br>60<br>60 | 30 | Dr X | XYZ Pharmacy |
| Quetiapine | May 15, 2018<br>Mar 20, 2018<br>Feb 27, 2018<br>Jan 13, 2018<br>Dec 21, 2017 | 25 mg | 60<br>60<br>120<br>60<br>60 | 30<br>30<br>60<br>30<br>30 | Dr X | XYZ Pharmacy |

## Discussion

In this case, levels of bupropion, cyclobenzaprine, and topiramate were particularly high, however, these medications were not regularly filled by MB. In addition, clonazepam levels were low, and quetiapine was not detected in the toxicology report, but these medications were regularly filled and were filled post-mortem. It is likely that these medications were being diverted.

While it is not easy to identify and prevent an intentional overdose death based on the dispensing pattern shown in MB's DPIN, it is an important reminder about the need to remind patients about returning unused medications and to avoid sharing or using medications not prescribed to them. As many as one in five adults have reported sharing medications with other people and almost half of all people who received prescription opioids did not receive information about their disposal.[1]

Moreover, of those who did receive information about proper medication disposal, only one-third of people received this information from their pharmacist.[1] Following up with patients and their prescriber about non-adherence to medication may help detect how unused medications are being handled or may help determine whether strategies to improve adherence can be offered. Working collaboratively with prescribers and suggesting urine drug screening to be routine for all patients receiving controlled medications can help improve patient safety and identify potential diversion.

There is limited evidence to recommend for or against routine evaluation of suicide risk, particularly in a community pharmacy setting.[2] Some people are apprehensive to ask about suicide, but previous reports have suggested some patients appreciate the opportunity to talk about suicidal thoughts and may not mention this unless specifically

asked.[3] Pharmacists are in an opportune position to connect patients with appropriate resources. A list of Mental Health Crisis and Non-Crisis Regional Contacts can be found here: https://www.gov.mb.ca/health/mh/crisis.html. Information about the Crisis Response Centre is also available here: https://sharedhealthmb.ca/services/mental-health/crisis-response-centre/.

It is a pharmacist's primary responsibility to ensure patient safety when dispensing a prescription medication. All members are reminded of their professional obligation to ensure that each prescription is reviewed thoroughly, and potential issues addressed, even if it means there may be a difficult patient encounter. Measures must be taken to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists do not have the obligation to dispense medications that they believe may cause patient harm. In such cases, the patient must be referred appropriately according to the Referring a Patient Practice Direction.

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# Medication Safety: Transitions of Care – Compounds

Patients are at greater risk of a medication error when they are in transitions of care – in admission and also upon discharge from hospital. At these points, conditions are prime for potential omissions of medications as well as miscommunication leading to patients not receiving the proper medications and possible patient harm.

Compounds pose additional concerns upon transitions of care for a number of reasons. Firstly, the prescription label may not clearly indicate the ingredients or proportions of the compound. Secondly, health professionals, in addition to interviewing the patient or caregiver will rely on DPIN to confirm a patient's medication history. DPIN has limitations as compounds are listed as "compounded product eligible" providing no indication to the composition of the compound. Pharmacists especially in the Hospital setting need to contact DPIN to speak with the original dispensing pharmacy to obtain specific information on the compound.

Thirdly, DPIN does not provide drug interactions codes nor MY/MZ codes for compounds unlike other medications. It is imperative that pharmacists review DPIN with each admission and discharge prescription to ensure no medications such as compounds have been omitted. With every compound prescription, it should be standard practice to review DPIN prior to dispensing.

Transitions of care are also an opportunity for pharmacists to collaborate with relevant healthcare providers to ensure optimum patient care is provided. Patients also must be engaged during transitions of care and the "5 Questions to Ask" is an excellent tool to help patients and caregivers improve communication with their health care provider especially at transitions of care. This useful tool is available in different languages and printable formats.

# Duties of the Pharmacy Manager: Supervision

The College is experiencing a steady increase in complaint cases that stem from a poor understanding of the role and responsibilities of a pharmacy manager. The position of pharmacy manager is a role that requires strong leadership and communication skills, as well as thorough knowledge and understanding of *The Pharmaceutical Act* (The Act), Pharmaceutical (Regulation), Practice Directions and guidelines that outline the requirements of operating a safe hospital or community pharmacy . For many, the skill set required of a pharmacy manager is learned through mentorship or experience. To support a standardized approach to the legislated responsibilities for pharmacy managers, the College is developing a new set of resources starting with a series of articles and new website content. The articles will be published in the quarterly Newsletter and the College will advise registrants when the new website content is available.

## Pharmacy Managers Must Personally Supervise Pharmacy Operations

A pharmacy manager is required to **personally supervise** the operation of a pharmacy, as stated in section **51(c)** of the Regulation. The Regulation **does not** permit supervision to be delegated to another individual or done remotely.

### Can a Pharmacy Manager Appoint an Interim or Acting Pharmacy Manager if They are Away?

- No, The Act only permits one member to be named and there is no alternate, or 'acting/ interim' pharmacy manager designation. Section **64(2)(d**) of The Act states that the name of a member who will be designated as a pharmacy manager must be on the pharmacy license application.

### Can there be more than one pharmacy manager for a pharmacy?

- No, there can only be one pharmacy manager, and a pharmacist can only manage one pharmacy.

## Pharmacy Managers on Record are Accountable for Pharmacy Operations At All Times

The pharmacy manager on record is accountable for pharmacy operations even if they are away or on leave for some reason. According to section **99** of The Act, the pharmacy manager on record with the College assumes the associated risks and responsibilities and will be held accountable for any violations that may have occurred while on leave, regardless of the
circumstances surrounding the leave. In situations such as this, it is advisable that the pharmacy transition to a new pharmacy manager . For instructions on changing a pharmacy manager, please visit: here.

## New Pharmacy Managers Are Accountable for All Pharmacy Operations Including Existing and New Deficiencies

The moment a pharmacist assumes a pharmacy manager position, they are accountable for new and ongoing matters that arise from site inspection or complaint resolution. New pharmacy managers should thoroughly review the pharmacy's policy and procedure manual and pharmacy operations to identify deficiencies and implement any necessary changes without delay. The pharmacy manager named on the pharmacy license must ensure compliance with The Act and Regulation, standards of practice and practice directions. Company or corporate policy does not supersede compliance with federal and/or provincial legislation or standards of practice and practice directions.

If the incoming pharmacy manager identifies areas of non-compliance they cannot address, they should contact the College to discuss the deficiencies and create a plan to bring the pharmacy into immediate compliance.

## Lack of Leadership and a Poor Understanding of the Pharmacy Manager Role has Led to Poor Audit Inspection Results, Complaint Issues and Patient Harm

It is critical that current and new pharmacy managers take initiative to be informed of the responsibilities they hold and rise to the challenges of the position. A pharmacy manager must oversee all aspects of pharmacy operation. This cannot be delegated or done from afar. Strong, clear, and supportive direction for staff with strict adherence to well-developed pharmacy policy and procedures translates into a well-functioning pharmacy that provides exceptional patient care.

# In Case You Missed It

In October, the College hosted its second Lessons from Complaints Professional Development (PD) program entitled ***Lessons from Complaints: Navigating Mental Health and Addiction***.

The additional pressure and stress placed on healthcare professionals as a result of the pandemic is tremendous. Pharmacists are faced with ambiguity and uncertainty with constant change and the realities of front-line practice. These stressors can result in a new or exacerbation of a mental health or addiction concern. This program opened the dialogue for consideration of mental health and addiction concerns for pharmacy staff.

The first program segment was presented by Dr. Michael Loudon, MB.Ch.B, where he discussed health, wellness and fitness to practice. The second segment, presented by Dr. Brent M. Booker, Assistant Registrar – Review and Resolution College of Pharmacists of Manitoba,focused on the safe and standardized management of mental health and addiction concerns in a practicing registrant through a structured process.

Participants of the program took away the following learning objectives:

- Examined and learned about the importance and impact of health and wellness and their influencing factors
- Considered the resources available to pharmacists managing a mental health or addiction concern
- Examined a pharmacist's obligations in their Duty to Report
- Summarized initial actions in assessing patient risk in mental health and addiction concerns by the College
- Learned about the risk assessment framework continually applied by the College throughout the resolution of a complaints matter
- Learned about the phases of gradual return to practice
- Examined the benchmarks, conditions and progression of a monitoring program

The College would like to extend its sincere gratitude and thanks to the presenters, as well as those who participated in the program.

The recording of this PD event is now available on the College website, and the program is accredited for 2.0 CEU.

# IN MEMORIUM

*In loving memory,*

**Raymond Joseph Joubert**
Aug 31, 2021

Mr. Joubert devoted over 40 years of service to the advancement of pharmacy provincially, nationally and internationally serving for the past 36 years as Registrar of the Saskatchewan College of Pharmacy Professionals. To his colleagues across this country, Mr. Joubert was considered a champion, leader and mentor for pharmacy professionals everywhere. Among his many awards received in recognition for his tremendous contributions to the profession, Mr. Joubert was awarded Honourary Membership with the College of Pharmacists of Manitoba in 2018.