COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

Fall 2020

Feature: Safety IQ

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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.

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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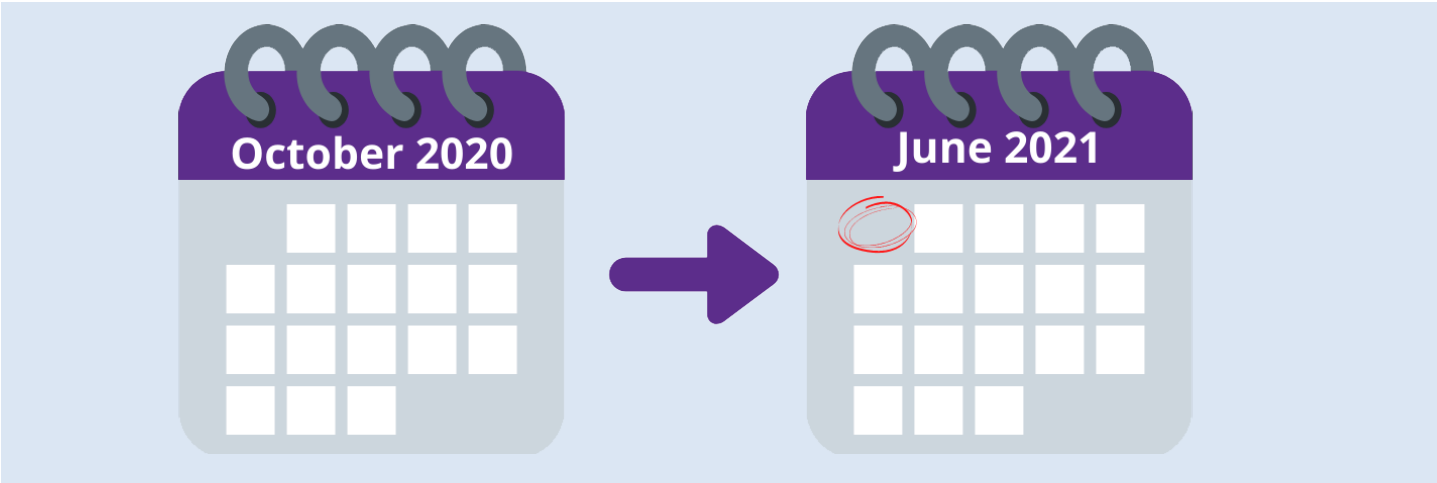
Safety IQ Implementation Update – Navigating Stage Two

From October 2020 to May 2021, pharmacy teams and managers have a variety of tasks to complete to ensure a smooth transition to the full, mandatory implementation of Safety IQ on June 1, 2021.



Stage One

Stage One of Safety IQ implementation encourages all pharmacy professionals to become familiar with the principles and requirements of Safety IQ. The following resources are available on the Safety IQ webpage and the Resource Library on the College website:

- Medication Incident and Near-Miss Event Practice Direction (effective June 1, 2021)
- Safety IQ Implementation 2020-21 Quick Facts
- Safety IQ Frequently Asked Questions
- Community Pharmacy Safety Culture Toolkit

Additionally, two professional development programs that support Safety IQ are available on the Continuing Competency webpage:

- Culture Shift 101: Safety and Just Culture in Community Pharmacy
- A Safer Future: Preparing Your Pharmacy for Safety IQ

Stage Two

Stage Two of Safety IQ Implementation focuses on the responsibilities of pharmacy managers to operationalize the program. From now until May 2021, pharmacy managers must choose a platform provider or determine if the pharmacy's current platform satisfies the College Medication Incident and Reporting Platform Criteria.

The College encourages pharmacy managers or teams to appoint a Continuous Quality Improvement (CQI) Coordinator to ensure the successful implementation of Safety IQ. The following resources will help pharmacy managers and CQI Coordinators to ensure a smooth transition to Safety IQ:

- Safety IQ 2020-21 Implementation Guide for Pharmacy Managers
- Safety IQ Implementation Checklist
- Medication Incident and Reporting Platform Criteria
- 4 Steps to Submit Data to the NIDR

While pharmacy managers are responsible for implementing Safety IQ, patient safety is everyone's responsibility and the College encourages pharmacy teams to review the Safety IQ resources and to discuss the principles and requirements of the program.

Any questions or comments can be sent to College through email at safetyiq@cphm.ca.

President's Message

Dear Colleagues,

I would like to thank pharmacy professionals for their continued efforts to keep patients and staff safe while providing outstanding pharmacy services during the pandemic. Many of your patients may be dealing with extraordinary challenges during this public health crisis. Increased stress, fear and anxiety can be overwhelming and cause strong emotions that take a toll on one's mental health. As some of the most accessible health care providers, pharmacists play a key role in supporting patients with mental illness or injury. Thank you for being a partner in ensuring the mental health and wellness of Manitobans.

Despite the challenges of the pandemic, the College continues to operate within its regulatory scope and fulfill its mandate of public protection. All of the primary functions of the College — from registration and licensing to professional conduct — continue as Council, committees and staff work remotely, to the greatest extent possible. These are unprecedented circumstances that have affected us all in very different ways, and the College has responded to keep operating safely.

Fall is always a busy time of the year with flu vaccinations under normal circumstance. 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 key to maintaining the health and well-being of many of our vulnerable Manitobans. Front line pharmacists have embraced their expanded role as leaders in community public immunization campaigns. The demand for influenza vaccine has been overwhelming and truly unprecedented this year and pharmacists have risen to this public health challenge.

The College has been hard at work with the implementation of Safety IQ leading up to the June 1, 2021, compliance deadline. I encourage everyone to watch the brief video overview found on the College website and continue to monitor your email for important updates. You can find Safety IQ updates in the Friday Five, in the quarterly Newsletters, and under the website's Quality Assurance page.

A very successful professional development event, Safety Matters: Trends and Learnings from the Medical Examiner, 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.

Wendy Clark
President

In Case You Missed It

The College hosted the second Medical Examiner Professional Development (PD) event titled "Safety Matters: Trends and Learnings from the Medical Examiner" on September 29, 2020. This was the first virtual PD event held by the College, and it was very well attended.

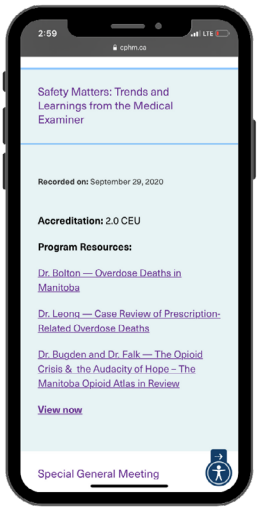
The first speaker, Dr. Bolton, is a professor of psychiatry at the University of Manitoba, and the medical director at the Crisis Response Centre and HSC Emergency Psychiatry. Dr. Bolton provided an overview of the demographic of individuals dying by overdose in Manitoba, the pharmaceutical substances contributing and expanded upon options available to prevent these deaths.

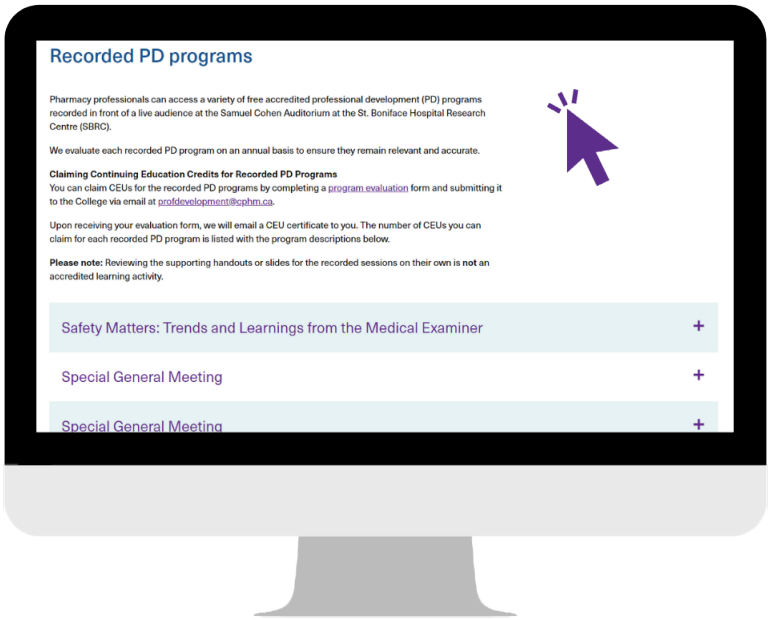
Next, Dr. Leong, an Assistant Professor at the College of Pharmacy at the University of Manitoba, presented several medical examiner case studies and highlighted strategies for risk identification and safer dispensing practices for patients who may be at risk of overdose.

Lastly, Dr. Bugden, Dean of the School of Pharmacy at Memorial University, and Dr. Falk, Associate Professor at the College of Pharmacy at the University of Manitoba, presented the Manitoba Opioid Atlas. The Opioid Atlas contains trends of opioid use and consumption over time in Manitoba, and the speakers provided an analysis of opioid use patterns based on demographics such as geographic region, age and income.

The College would like to extend its sincere thanks and appreciation to all speakers for sharing their expertise.

The recording of this PD event is now available on the College Website on the Continuing Competency page and under the heading, Recorded PD events. The program is accredited for 2.0 CEU.





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

ML was a 32-year-old female whose medical history included end-stage renal disease (ESRD) requiring hemodialysis, obesity, hypertension, depression, and reported opioid dependence. On December 26, 2019, she experienced chest pain and shortness of breath and was admitted to the hospital for systemic candida infection. On January 3, 2020, she was granted a two-hour pass in the evening for a funeral. She returned to the hospital in the early hours of January 4, several hours after she was due to return. ML then went to bed and was discovered dead later that morning. Her immediate cause of death was cardiac arrhythmia due to cardiomegaly. Mixed drug intoxication was a significant contributory cause, and the manner of death was reported as accidental.

Results

The following chart represents the results of the toxicology report. An asterisk indicates drugs that were above the therapeutic range:

Drug	Level in blood (ng/mL)	Therapeutic Range (ng/mL)
Diphenhydramine^	447*	14-112
Oxycodone	100	10-100
Trazodone	262	500-1200
Venlafaxine O-desmethylvenlafaxine#	366* 2600*	62-138 118-252
Drug	**Level in blood (ng/mL)**	**Therapeutic Range (if applicable) (ng/mL)**
Gabapentin	25*	2-20

^ Diphenhydramine is the primary constituent of dimenhydrinate

O-desmethylvenlafaxine is the major metabolite of venlafaxine

ML was receiving several medications for ESRD; however, the DPIN history below only includes a summary of the medications relevant to her toxicology results for the previous six months:

Generic Name	Date Dispensed	Strength	Quantity	Days Supply	Prescriber	Pharmacy
Oxycodone/ Acetaminophen	December 18, 2019 December 17, 2019 November 20, 2019 September 25, 2019 August 31, 2019 August 4, 2019 July 28, 2019 July 21, 2019 July 14, 2019 July 7, 2019 June 30, 2019 June 23, 2019 June 14, 2019	5/325 mg	120 10 120 120 120 120 28 28 28 28 28 28 56	30 1 30 30 30 30 7 7 7 7 7 7 14	Dr. Bow Dr. BB Dr. J. Doe Dr. J. Doe Dr. J. Doe Dr. J. Doe Dr. Vee Dr. Vee Dr. Vee Dr. Vee Dr. Vee Dr. Vee Dr. Elle	GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy GHI Pharmacy
Diphenhydramine	December 24, 2019 December 9, 2019 November 26, 2019 September 28, 2019 August 30, 2019	50 mg	15 30 30 60 30	5 15 15 60 8	Dr. KP Dr. Hicks Dr. Psy Dr. Gucci Dr. Elle	XYZ Pharmacy ABC Pharmacy ABC Pharmacy DEF Pharmacy ABC Pharmacy
Gabapentin	December 26, 2019 December 19, 2019 November 26, 2019 November 7, 2019 October 8, 2019 September 22, 2019 September 8, 2019 August 10, 2019	600 mg	14 14 28 28 30 14 14 28	14 14 28 28 30 14 14 28	Dr. BB Dr. BB Dr. Bow Dr. Psy Dr. Iris Dr. Gucci Dr. Elle Dr. Vee	ABC Pharmacy ABC Pharmacy ABC Pharmacy ABC Pharmacy DEF Pharmacy ABC Pharmacy DEF Pharmacy ABC Pharmacy
Venlafaxine	December 26, 2019 December 19, 2019 November 26, 2019 November 7, 2019 October 8, 2019 September 26, 2019 September 12, 2019 August 16, 2019	150 mg	14 14 28 28 30 14 14 28	14 14 28 28 30 14 14 28	Dr. BB Dr. Kim Dr. Elle Dr. Bow Dr. Vee Dr. Smith Dr. Smith Dr. Gucci	ABC Pharmacy ABC Pharmacy ABC Pharmacy ABC Pharmacy DEF Pharmacy EFG Pharmacy XYZ Pharmacy XYZ Pharmacy
Trazodone	December 26, 2019 December 19, 2019 November 6, 2019	50 mg	14 14 14	14 14 14	Dr. BB Dr. BB Dr. Vee	ABC Pharmacy ABC Pharmacy ABC Pharmacy

Discussion

ML's care was complicated and involved twelve different physicians, including multiple hospital prescribers from nephrology and internal medicine, as well as more than one primary care physician. The days' supply of medication dispensed changed frequently, and she attended several pharmacies numerous times a month. She also received multiple sedating medications.

Uncoordinated care can put patients at risk of prescription-related harm, and mitigation strategies should be implemented to support and protect the patient.

The following recommendations may be appropriate to implement in your practice:

Patients on multiple sedating agents are at higher risk of experiencing an accidental overdose.[1,2] Both venlafaxine and diphenhydramine can also contribute to cardiac conduction abnormalities in overdose.[3,4] ML could have benefited from coordinated care that involved as few prescribers as possible, allowing for regular evaluation of all medications' efficacy and safety and suggesting tapering or deprescribing if the patient is on many sedating medications. Pharmacists are encouraged to reach out to prescribers and formulate a care plan.

Recommending and gradually implementing controlled dispensing to the patient and prescribers may help patients at risk of opioid dependence, diversion, and/or overdose (see the CPhM Summer 2020 Newsletter Medical Examiner case study for more information). Blister packaging of medications may also help reduce the risk of overdose.[6] It should be emphasized to both patients and providers that such interventions are not meant to impede patient care but rather ensure patient safety and allow for regular follow-up.

Communicate to the patient that it is in their best interest to choose one pharmacy. Using a single pharmacy for all medications (prescription and non-prescription) and as a source of drug information will lower the risk of medication errors, especially during transition points of care.[5] Seeking to understand the patient's reasoning and priorities for utilizing multiple pharmacies (e.g. proximity, hours of operation, delivery services, etc.) will help develop a coordinated plan. Patients are much more likely to follow a plan they were involved in establishing. If valid reasons exist for using multiple pharmacies, collaboration between pharmacies is expected to provide the best possible care for the patient.

If you have a patient with reported opioid dependence, consider speaking to them or their prescriber regarding opioid agonist therapy (OAT). Buprenorphine-naloxone and methadone are evidence-based OAT, which have been found to retain individuals in treatment, maintain abstinence from illicit opioid use, and reduce morbidity and mortality.[7] Rapid Access to Addictions Medicine (RAAM) clinics are also available for those seeking help with substance use and addictions, which are accessible without an appointment or referral.[7] Educate patients about the risks of combining opioids and benzodiazepines with over the counter (OTC) medications. High concentrations of diphenhydramine were found in ML's toxicology report. Although ML had been prescribed diphenhydramine, patients often supplement with OTC diphenhydramine or dimenhydrinate (including combination products, in which the patient may be unaware). Pharmacists are reminded to consider keeping diphenhydramine and dimenhydrinate behind the counter (or only keep a limited stock and smaller pack sizes OTC) and entering all purchases of these medications into patient profiles whenever possible.

It is a pharmacist's primary responsibility to ensure patient safety when dispensing prescription medication. All members are reminded of their professional obligation to ensure that each prescription is reviewed thoroughly and that potential issues are addressed — even if it means there may be a difficult patient encounter. Measures must be taken to address issues with the appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists do not have an 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.

References:

1. Smolina K, Crabtree A, Chong M, Zhao B, Park M, Mill C, et al. Patterns and history of prescription drug use among opioid-related drug overdose cases in British Columbia, Canada, 2015-2016. Drug and Alcohol Dependence 2019;194:151-158.
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4. Zareba W, Moss AJ, Rosero SZ, Hajj□Ali R, Konecki J, Andrews M. Electrocardiographic findings in patients with diphenhydramine overdose. Am. J. Cardiol. 1997; 80: 1168–73
5. World Health Organization. The nine Patient Safety Solutions, 2007: Assuring medication accuracy at transitions in care. Available: https://www.who.int/patientsafety/events/07/02_05_2007/en/. Accessed October 8, 2020.
6. Hawton K, Ware Ch, Mistry H, Hewitt J, Kingsbury S, Roberts D, et al. Paracetamol self-poisoning characteristics, prevention and harm reduction. British Journal of Psychiatry 1996;168:43-48.
7. Bruneau J, Ahamad K, Goyer M-E, Poulin G, Selby P, Fischer B, et al. Management of opioid use disorders: a national clinical practice guideline. CMAJ 2018;190(9):E247-57.
8. Shared Health Manitoba. Rapid Access to Addictions Medicine (RAAM) Clinic. Available: https://sharedhealthmb.ca/services/mental-health/raam-clinic/. Accessed October 8, 2020.
9. Sinyor M, Howlett A, Cheung AH. Substances used in completed suicide by overdose in Toronto: An observational study of coroner's data. Can J Psychiatry 2012;57(3):184-191.

Pharmacy Use of E-Prescribing Platforms

Information technology and data accessibility continue to evolve and expand rapidly, including the usage and incorporation of such in pharmacy practice. The expanding desire for enhanced connectivity between patient, prescriber and pharmacist has led to the development of several e-prescribing platforms within Canada.

E-prescribing is defined as the secure electronic creation and transmission of a prescription between an authorized prescriber and a patient's pharmacy of choice, using clinical Electronic Medical Record (EMR) and pharmacy management software. This process is intended to integrate clinical workflow and software. E-prescribing platforms enable the digital transmission of prescriptions from community-based prescribers (physicians, nurse practitioners) to the community pharmacy of the patient's choice.

The College of Pharmacists of Manitoba does not explicitly approve nor endorse software programs or information management systems used by Manitoba pharmacies. Pharmacy managers are responsible for ensuring their selected information management system integrates with the provincial Drug Programs Information Network (DPIN).

A key element that pharmacy professionals must be cognizant of when selecting an information management system is that the system and pharmacy are required to comply with and meet the principles and requirements of the Joint Statement - Electronic Transmission of Prescriptions. An integral principle within this statement is that patient choice must always be protected. The patient must have autonomy and the ability to self-determine which pharmacy is to receive the prescription authorization related to their care. Pharmacy managers are required to ensure this key principle is maintained with their selected software program/ integrated e-prescribing platform.

Further to this, pharmacy professionals are reminded of the requirement for compliance with the NAPRA Pharmacy Practice Management Systems (PPMS). The information management system, or PPMS, used by pharmacy professionals must support the delivery of patient care, including the dispensing of drugs in accordance with Canadian regulations and standards. The PPMS must have the ability to facilitate both information exchange with electronic health systems, such as electronic health record systems, and also processes such as electronic prescribing, while still preserving and maintaining confidentiality and security of all personal health information collected, processed, or transmitted.

Adherence and compliance with these standards enhance the prevention of prescription fraud involving electronic prescriptions (e-prescriptions). Benefits of e-prescribing depend on ensuring the authenticity of e-prescriptions and securing their transmission from prescriber to pharmacist. Compliance with the NAPRA PPMS Standard ensures the safety and efficacy of e-prescriptions and related electronic records.

Some concerns pharmacy professionals must consider before embarking on the use of an e-prescribing platform include:

1. The pharmacy professional must ensure the selected e-prescribing platform has the ability to fully integrate with Manitoba DPIN network.

2. The selected e-prescribing platform must fully integrate with all electronic health record systems (such as AccuroEMR) and pharmacy software platforms (such as Kroll, etc.)

3. The e-prescribing platform must meet and comply with the requirements and principles of the Joint Statement: Electronic Transmission of Prescriptions, including maintenance of full patient autonomy.

4. Pharmacy professionals are responsible and accountable for confirming that the selected e-prescribing platform meets the standards of the NAPRA PPMS. The e-prescribing platform chosen must allow for fully functional and secure two-way electronic communication between pharmacists and prescribers. This includes the pharmacist's required ability to directly communicate concerns, including drug therapy problems (DTP) or actions taken (such as if prescription adaptation, refill authorization) to the prescriber. The prescriber must also have the ability to communicate specificities regarding the prescription to the pharmacy as well (e.g. patient concerns, response to a pharmacist's concerns of a DTP, response to a pharmacist prescribing, etc.)

5. Before incorporating an e-prescribing platform, pharmacy managers must review all workflow processes, including those after receiving the e-prescription. The e-prescribing platform often requires the pharmacy to still rely on a substantial amount of manual transcription. Manual transcription has the potential for prescription errors. There may also be errors in the transcription of instructions for use (sig), which may not transfer over completely or correctly from the prescriber's EMR. There is the possibility that the sig has an error in transfer between EMR and PPMS, or the patient may not fully understand the instructions for use. This requires modification by the pharmacy professional. This may also be the case for allergy and indication for use, whereby they are not always transferred over from the prescriber's EMR. Once again, this requires intervention by the pharmacy professional to ensure the appropriate information is collected and entered. If the information is not apparent, it may even require further follow-up with the prescriber for confirmation.

6. Be cognizant of claims that using e-prescribing platforms will reduce medication errors/incidents. There is no data or evidence to support this. As noted above, there is potential for increased errors, or at minimum, different types of mistakes than currently noted, based on the need for manual transcription or missed information.

7. Be cognizant of claims that the use of an e-prescribing platform will be a time-saver. Although this may be true for prescribers, this may not be the case for pharmacies/ pharmacists on the receiving end of the e-prescriptions, as described above. Pharmacy staff and pharmacists are still required to be involved in a substantial amount of manual entry and input and the inclusion of some additional steps, which may not improve workflow.

As noted, if a pharmacy is considering using an e-prescribing platform, several factors must first be considered and confirmed. Ultimately, it is the pharmacy manager's responsibility to ensure all required standards and principles are adhered to ensuring the provision of safe, quality pharmacy care to their patients.

Pharmacy Technician Practice Hours

Pharmacy technicians are required to work a minimum of 600 practice hours in the preceding three-year period, starting three years after they were first listed, to maintain their listing as a pharmacy technician with the College. These practice hours should be documented by the pharmacy manager as part of the pharmacy technician's performance review. The 600 practice hour minimum must go beyond the duties of a pharmacy assistant to encompass the pharmacy technician scope of practice. These practice hours do not need to include performing a final check of a prescription. If pharmacy technicians have undertaken the other technician tasks within their scope of practice, those practice hours will qualify.

It is important to note that if you are working as a pharmacy assistant and not employed as a pharmacy technician, hours worked as a pharmacy assistant do not qualify for the requirements under section 61(1) of The Regulation.

Member Information

Upon initial listing, pharmacy technicians are asked to review their profile information within their member portal to ensure it is complete and accurate. It is the technician's responsibility to ensure their member portal information is current. If there are any changes in your contact information, including your email, phone number, home address, please update your member portal promptly.

Social Media Module Requirement

The College of Pharmacists of Manitoba collaborated with seven other regulators from the Manitoba Alliance of Health Regulatory Colleges (MAHRC) to develop a professional development (PD) module on social media professionalism. The module is titled "Pause Before You Post: Social Media Awareness."

All pharmacy technicians must complete the online module before May 31, 2021, to be eligible for the 2021-2022 listing renewal.

The Pause Before You Post: Social Media Awareness Module can be found on your member portal. The module has been accredited by the College for up to 1.50 CEU and must be claimed in the PD year the module is completed.

Professional Development Reminder

Pharmacy technicians are required to participate in and document a minimum of 15 hours of PD learning activities from June 1st to May 31st of each year. Of the 15 hours, a minimum of 5 hours must be from accredited learning activities.

Criminal Record and Registry Checks

Current listed pharmacy technicians were required to submit a recent Criminal Record Check and an Adult and Child Abuse Registry Check by September 30, 2020, as an application requirement to maintain their listing with the College of Pharmacists of Manitoba. As of January 1, 2021, a vulnerable sector search as part of the criminal record check will also be required.

All new pharmacy technician-in-training applicants (graduates of a CCAPP accredited training program) will also be required to provide these registry checks, which must be dated within six months before commencing their Structured Practical Training with the College.

Original records and registry checks must be provided to the College office. If you wish to have originals returned to you, you can include a self-addressed, stamped envelope, and the originals will be returned to you; a verified copy will be retained on file.

In Memoriam

Olga Schellenberg, September 2, 2020

Jack Houston, October 13, 2020

Elmer Kuber, November 4, 2020