COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

Winter 2019

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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.

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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.

200 Taché Avenue, Winnipeg, MB | Phone: (204) 233-1411
Fax: (204) 237-3468 | Email: info@cphm.ca | www.cphm.ca

Feature

2019 at the College
Year in Review

Medical Examiner Meetings

In 2019, the College participated in 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.

Starting with the spring 2019 newsletter, case studies provided an opportunity for education and self-reflection for all pharmacists on patterns of opioid, benzodiazepine and other drug dispensing in their own practice.

All dates, patient initials, names of pharmacies, and prescribers have been changed and de-identified to protect the identity of the patient and their family.

Spring 2019 case study

Summer 2019 case study

Fall 2019 case study

Safety IQ

It was a busy year for the development of the Safety IQ program in Manitoba. Beginning with the Safety IQ Advisory Committee's first meeting in early January, the College and committee members have been busy finalizing the necessary details.

The College looks forward to the implementation of the program in late 2020.

For more information on Safety IQ and what happened in 2019, please review the previous eQuipped issues from this year.

Community Pharmacy Safety Toolkit

The Community Pharmacy Safety Toolkit was developed. It launched in collaboration with the Safety IQ Professional Development (PD) event and fall newsletter release. The toolkit outlines key concepts of safety culture and provides resources to support pharmacy professionals in making necessary ongoing changes to improve communication of medication incidents and safety in their community pharmacy.

We look forward to this resource being useful for years to come.

Vanessa's Law

The Protecting Canadians from Unsafe Drugs Act, also known as Vanessa's Law, came into force on December 16, 2019. Vanessa's Law honours the memory of Vanessa Young, a 15-year-old who died in the year 2000, due to an adverse drug reaction to Cisapride.

Vanessa's Law requires all hospitals to perform mandatory reporting of all Adverse Drug Reactions (ADRs) and Medical Device Incidents (MDIs) to Health Canada within 30 days.

The new regulations amend the Food and Drug Act ("FDA") and aim to improve the quality and increase the quantity of serious adverse drug reaction and medical device incident reports provided to Health Canada.

It is important to note that medication incident reporting remains separate and available for all Canadians to voluntarily report through CMIRPS (Canadian Medication Incident Reporting and Prevention System).

For additional reading, please see the Government of Canada Website here.

New CPD Self-assessment

The College's Continuing Professional Development (CPD) Self-assessment Tool was updated and improved. It is designed to provide pharmacists with a document based on The National Association of Pharmacy Regulatory Authorities (NAPRA) Standards of Practice (2009), while utilizing the CPD cycle learning philosophy.

The purpose of this tool is to enable reflective learning and improve competence when performing the duties of a pharmacist. There is no requirement to submit this document to the College upon completion, but every member is encouraged to use it for guiding their learning needs.

Make sure to visit the College's Professional Development page for more information on available PD programs, in addition to learning portfolio requirements.

By-law Change (Quorum)

Council amended Section 4.03 of the By-laws to read as follows:

Five percent of the Voting Members constitute the quorum for any vote held in accordance with section 4.01 herein, with the exception of a general meeting in which case 30 Voting Members constitute the quorum for any vote held at a general meeting.

This previously read:

Five percent of the Voting Members constitute the quorum for any vote held in accordance with section 4.01 hereof.

This by-law was changed to align this section of the By-laws with the changes to Section 3.04 of the By-laws in which quorum for the transaction of business at any annual meeting of the College was changed to thirty (30) voting members.

Remembering Lois Cantin

(1951 - 2019)

The College mourns the passing of Lois Cantin, a champion, leader, mentor, colleague and friend who made a significant contribution to the pharmacy profession provincially, nationally and internationally.

Lois Cantin entered the Faculty of Pharmacy at the University of Manitoba in October of 1969 after having made a tremendous personal decision to leave the Canada National Ski Team. She contributed to the Faculty through participating in all student activities and ultimately graduated in 1973. Her experience in pharmacy practice was broad working in retail pharmacy for several years, and then embarking on a hospital pharmacy career as Pharmacy Director at Portage General Hospital. In 1981, Lois moved to Flin Flon and following a 10-week locum and a one-year position, remained there as Pharmacy Director for the Nor-Man Regional Health Authority. She moved to Winnipeg in 2006 where she undertook the position of Pharmacy Director at Concordia Hospital Pharmacy. In recent years, Lois' practice took her most often to Churchill.

Lois served on College Council from 1994 to 2006 and served as the first female President in the history of the College of Pharmacists of Manitoba from 2002-2004. Improving patient safety, public protection, health care reform, development of meaningful relationships with government, strategic planning, and accountability in pharmacy practice are but a few of the challenging issues Lois faced head-on during her term as President of the College.

Her firm belief, and the commitment of Council to protect the public, resulted in the College (formerly the Manitoba Pharmaceutical Association) receiving the 2004 Fred T. Mahaffey award at the 100th Anniversary Annual General Meeting of the National Association of Boards of Pharmacy (NABP) in the United States. The College was the first and only Canadian organization to be honored with this award which recognizes exemplary work in the protection of public health and welfare through the enforcement of state and federal laws. It was as a result of Council's actions taken under Lois' steadfast leadership, to preserve public protection on both sides of the border that resulted in the College receiving this very prestigious recognition.

Lois Cantin was on the Board of the National Association of Pharmacy Regulatory Authorities for several years, serving as President in 2005. In addition she served as Chair of the College Discipline Committee, on the Executive of the Nor-Man Regional CQI Committee, as Chair of the Manitoba Association of Pharmacy Directors, as President of the Canadian Society of Hospital Pharmacists – Manitoba Branch, as well as many other committees of the Flin Flon Hospital and Nor-Man Regional Health Authority. Lois was recognized by the College for her significant contribution to the profession at a provincial and national level as Pharmacist of the Year in 2006 and as an Honorary Life Member in 2013.

We will miss Lois' strength, courage, energy and unwavering commitment to public protection and making a difference. She will remain an inspiration for many.

President's Message

As we move into the busy holiday season, it is important to take the time necessary to reflect on the past year to ensure Council is on track to meet its strategic objectives. In 2019, Council's focus to increase patient access to quality care within a safer health system was the priority.

Amendments to The Pharmaceutical Act and Regulation originally contemplated in early 2016, thoughtfully developed over 2017, thoroughly vetted through a rigorous consultation with the public, pharmacy professionals, government and other stakeholders of the College in 2018 and then reconsidered, revised and/or fine tuned based on this consultation in 2019, have been formerly presented to Manitoba Health Seniors and Active Living for their review and consideration. The process to bring these amendments forward has been onerous and has taken the collective efforts of pharmacy professionals from all areas of practice. While the efforts to create these amendments aimed at improving patient care and safety have been great, the benefits to patients and the public will be even greater. The Executive Committee looks forward to discussing the proposed amendments with the Minister of Health at his earliest opportunity.

Throughout 2019, much foundational work was undertaken under the direction of the Quality Assurance Committee and Council to support full implementation of Safety IQ in all pharmacies in the province by 2021. Great care has been taken in this province to consult with the other provincial pharmacy regulators, platform providers and pharmacies in the development of principles and criteria for Safety IQ that will facilitate inclusion, innovation and sustainability of this continuous quality improvement program in all community pharmacies.

In partnership with the College of Physicians and Surgeons of Manitoba (CPSM) and College of Registered Nurses of Manitoba, the CPhM has continued its efforts in 2019 to address the opioid crisis. In early December, revised Opioid Agonist Therapy (OAT) Guidelines (formerly ORT Guidelines) were approved by Council. The 101 OAT Workshop is the interprofessional education session where practitioners will receive hands-on experience in implementation of the revised guidelines. As the guidelines and workshop go hand in hand, pharmacists dispensing OAT should be informed and participate in these sessions.

Throughout this past year, CPhM staff have also participated in meetings with the CPSM and the Office of the Medical Examiner. The aim of these discussions is to review cases in which the concurrent use of opioids and other medications has resulted in death and then to develop learnings for pharmacists and prescribers on ways to work together to reduce the harms caused by these drugs.

As a member of Council, you play a critical role in guiding the College's efforts on these fronts aimed at improving patient and public safety. It can be some of the most rewarding work you can be involved in. With the upcoming College Council election in 2020, be sure to take some time to consider whether you may be in a position to put your name forward in the election. If you are interested, please see page 10 for a general overview. More information regarding nomination as a candidate in the election will be forwarded to practicing pharmacists in the coming weeks.

Happy holidays!

Kevin Hamilton
President

In Case You Missed It - Fall PD Events

The College hosted two professional development events in the fall of 2019.

The first event, held on Thursday, September 26, was titled A Safer Future: Preparing your Pharmacy for Safety IQ.

This well-attended event provided pharmacists with information about the upcoming implementation of Safety IQ.

Ronda Eros, practice consultant at the College, discussed the different aspects of Safety IQ and a Continuous Quality Improvement (CQI) program. Next, Gus Gottfred, Communications and Quality Assurance Coordinator, spoke about the analytical side of Safety IQ and how pharmacies can use the data to improve their practice, much like how athletes use analytics to improve their performance. The program also highlights the experiences of a multidisciplinary team from CancerCare Manitoba and their approach to disclosure following a critical incident.

The recording is now available on sbrstream.ca and the program is accredited for 2.0 CEU.

The next event, held on Thursday, October 10, was titled From the Script to the Medical Examiner: Resources for Pharmacy Intervention.

Dr. Marina Reinecke, Meret Shaker, and Jill Hardy discussed the learnings derived from their meetings with the Office of the Chief Medical Examiner and how these lessons learned can form the basis for improved prescribing and dispensing practices that will improve safety.

The recording is now available on sbrstream.ca and the program is accredited for 2.0 CEU.

Bridging Program (Option B) ends December 31

Two pathways have been established for individuals who wish to become pharmacy technicians in Manitoba:

Option A: Individuals who have graduated from a Canadian Council for Accreditation of Pharmacy Programs (CCAPP)-accredited pharmacy technician program.

Option B: Pharmacy assistants who had worked at least 2000 hours as a member of a pharmacy team within the last three years. Option B pathway included the additional requirements of successful completion of the PEBC Evaluating Exam and NAPRA Pharmacy Technician Bridging Program.

After December 31, 2019, all individuals wishing to become listed as a pharmacy technician will be required to have graduated from a CCAPP-accredited pharmacy technician program and will have five years from graduation to do so.

Pharmacy Technician Final Check Application

In order for pharmacy technicians to undertake the task of completing the final check of a prescription within a pharmacy, the pharmacy manager must submit a Pharmacy Technician Final Check Application for College review and approval.

The application process requires pharmacy managers and staff to assess current dispensing processes to determine the changes required for a pharmacy technician to perform the final check safely and in compliance with legislation. Pharmacy managers complete the application and also submit the pharmacy's final check policy and procedures document outlining the checks that technicians will undertake and procedures they will follow. The Pharmacy Technician Final Check Information Sheet provides additional information to help pharmacies develop their Final Check policies and procedures.

Please view the recently updated Pharmacy Technician Final Check Application on the College website.

Practice Hour Requirement

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. For example, if a pharmacy technician was first listed with the College in March 2017, they must work at least 600 hours as a pharmacy technician by March 2020.

The pharmacy technician must be employed as a pharmacy technician and not as an assistant and have performed the duties or tasks of a pharmacy technician and not only those of a pharmacy assistant. The College has provided a scope of practice chart found in the Pharmacy Technician Resource Guide (page 17) outlining the different tasks that can be performed by a pharmacy assistant and a pharmacy technician. 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 would qualify.

In addition to the practice hours requirement, a pharmacy technician must participate in a performance review conducted by the pharmacy manager or delegate at the practice site at a minimum of every two years. This includes documentation of hours worked as a pharmacy technician; an assessment of a technician's job performance in terms of quality of patient care, administrative skills and the ability to work consistently within the rules governing the pharmacy and pharmacy practice; and, documentation of attaining the Council approved professional development requirement.

For more information, please visit the technician page on the College website or the Pharmacy Technician Resource Guide.

Become Involved - 2020 College Council Election

Every two years, the College of Pharmacists of Manitoba holds an election to determine the licensed pharmacists that will serve on College Council.

Council has a duty to carry out its activities to govern the profession in a manner that serves and protects the patients and public interest.

Council conducts the business affairs of the College in a transparent, objective, and impartial manner. It makes decisions to establish and enforce regulations and practice directions by – laws, policies, and programs that protect the public interest, as outlined in The Pharmaceutical Act of Manitoba, (The Act). These decisions include:

- set education and other entry-to-practice and licence requirements for pharmacists and pharmacies;
- set professional and ethical standards of practice for pharmacists;
- set quality assurance programs to ensure the continuing competence of pharmacists; and

Elected and appointed individuals contribute by bringing their own unique set of knowledge, skill and experience to the role of council member. Council involvement provides individuals with rewarding opportunities to participate in public protection.

All members of Council are expected to be effective contributors. The desired skills and background include:

- the ability to work in a group to make informed decisions;
- the ability to understand and follow democratic processes;
- a willingness to devote time and effort to the work of the Council;
- good communication skills;
- clear understanding of the mandate of the College to serve and protect patients and the public.

Who is Council comprised of?

The Council of the College of Pharmacists of Manitoba is composed of fifteen members: eight (8) elected pharmacists who are licenced to practice pharmacy in the province, five (5) public representatives appointed by the Minister, the immediate past president of Council, and the Dean of the College of Pharmacy, Rady Faculty of Health Sciences, University of Manitoba (or the Dean's designate).

There are two electoral districts: District 1 is the urban area within the City of Winnipeg; District 2 is the rural area outside the City of Winnipeg. Four individuals, who are pharmacists holding a current pharmacist license with the CPhM, are elected from each electoral district.

How much time does it require?

Council meetings are held five times a year (February May, June, September, and December). Meetings are typically held on Monday between the hours of 9:00 a.m. and 4:30 p.m.

In addition to attending Council meetings, many Council members are required to serve on statutory or standing committees of the College. The number of committee meetings per year varies according to the committee workload.

Council meeting packages are distributed approximately 1 week in advance of the meeting and pre-reading is required.

Council members should be aware of the Pharmaceutical Act, the Regulations and by – laws, as well as various other provincial and federal legislation which form the regulatory framework for pharmacy practice in Manitoba.

Elected Council members serve for a two-year term and may serve consecutive terms. The immediate past president serves an additional two-year term

and appointed public representatives serve for the term, as determined by the Minister of Health.

Council meetings are held at the College office, 200 Taché Avenue, Winnipeg. The option to attend by video conference is also available. Those who attend by video conference must have access to a computer equipped with a webcam and audio capabilities.

The College is busy preparing for the 2020 election. More information will be released soon.

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

The College attends monthly Adult Inquest Review Committee (AIRC) 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 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 on patterns of opioid, benzodiazepine and other drug dispensing in your own practice. All dates, patient initials, names of pharmacies, and prescribers have been changed and de-identified to protect the identity of the patient and their family.

Introduction

DN was a 52-year-old female found dead in her home in 2015, where she was discovered by her spouse. No evidence of foul play or suicide note was at the scene, however, empty bottles of quetiapine with another individual's name were uncovered. DN struggled with depression, alcohol abuse and smoking, regularly used prescribed opiates for arthritis pain, and had an episode of "substance intoxication" in the previous year. According to her spouse, DN also suffered from insomnia, and regularly used over-the-counter (OTC) acetaminophen products. An autopsy was performed, and the cause of death was determined to be probable cardiac arrhythmia, and mixed drug intoxication was a contributing factor. This case was identified by the College as an important learning opportunity for pharmacists to review dispensing practices.

The toxicology report was positive for amitriptyline, codeine, quetiapine, and diphenhydramine, all of which were above the acceptable therapeutic range. Acetaminophen was also present and alcohol was involved. The following chart presents the results of the toxicology report:

Drug	Level (ng/mL)	Therapeutic Range, if applicable (ng/mL)
Amitriptyline Nortriptyline **Total**	523 104[∞] **627*^**	75-200
Codeine (free)	400*	10-100
Morphine (free)	15	10-80
Diphenhydramine[#]	1540*	14-112
Quetiapine	2439*	100-1000

* Indicates drugs that were above the therapeutic range

^ Tricyclic antidepressants undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report. Nortriptyline is an active metabolite of amitriptyline.

∞ Nortriptyline is an active metabolite of amitriptyline

Diphenhydramine is the primary constituent of dimenhydrinate

DN's DPIN showed the following prescriptions dispensed for the past 6 months:

Generic Name	Date Dispensed	Strength	Quantity	Days Supply	Prescriber	Pharmacy
Acetaminophen/ codeine/caffeine	Aug 18, 2015 Jul 25, 2015 Jun 30, 2015 June 5, 2015 May 12, 2015 Apr 19 , 2015 Mar 22, 2015 Feb 26, 2015	300/30/ 15 mg	240	30	Dr. Vee	XYZ Pharmacy
Citalopram	Aug 13, 2015 Jul 11, 2015	20 mg	60	30	Dr. Vee	XYZ Pharmacy
Esomeprazole	Aug 13, 2015 Jul 11, 2015 Jun 10, 2015	40 mg	60	30	Dr. Vee	XYZ Pharmacy
Amitriptyline	Jun 10, 2015 Jun 10, 2015 May 8, 2015 May 8, 2015 Apr 9, 2015 Apr 9, 2015 Mar 10, 2015 Mar 10, 2015 Feb 9, 2015 Feb 9, 2015	50mg 25mg 50mg 25mg 50mg 25mg 50mg 25mg 50mg 25mg	30	30	Dr. Vee	XYZ Pharmacy

DN was consistently requesting and receiving early refills for acetaminophen/codeine/caffeine (300/30/15). A month prior to her death, she was started on citalopram for depression, and her amitriptyline was discontinued.

Discussion

Although DN's DPIN history shows a typical combination of drugs at doses that are within the recommendations, it was the combined effects of the four sedatives ingested (as shown on the toxicology report) that ultimately resulted in death. The learnings from this case will specifically focus on the harms of OTC drugs when combined with other sedative prescription or street drugs.

DN's toxicology report showed high levels of diphenhydramine (DPH), indicating that she likely ingested large amounts of DPH (e.g. Benadryl) or dimenhydrinate (DMH) products (e.g. Gravol).

First generation antihistamines like DPH and DMH are easily accessible in single entity or combination OTC products. Although intended for the treatment and relief of allergies, insomnia and motion sickness, their abuse is commonly cited in literature[1,2,3] and seen frequently in post-mortem toxicology reports in the medical examiner files. DMH is composed primarily of DPH and 8-chlorotheophylline in a salt form. It has lower potency than pure DPH, as the addition of 8-chlorotheophylline was initially intended to counteract the sedative effects of DMH[4]. DMH breaks down into DPH to achieve its therapeutic action, and thus appears as DPH in toxicology reports.

In therapeutic doses, DPH side-effects include mild sedation, dizziness, and mild anticholinergic effects. However, when used in large doses (between 200-1200 mg depending on body weight), the drug has psychedelic properties characterized by hallucinations, delirium, euphoria, and disorientation resembling a "high."[5] In cases of severe toxicity, it can cause irregular heartbeat, seizures, and coma[6]. When combined with other sedative prescription drugs, as in DN's case, or when combined with street drugs, mixed drug toxicity can lead to death[7,8].

According to the Addictions Foundation of Manitoba, approximately one-fifth of teenagers have said they use over-the-counter (OTC) medications to experience euphoria[9]. A study by Thomas et al[10]. speculated that DPH abuse may occur in patients with psychiatric comorbidity and antipsychotic treatment, because of the combination of anti-extrapyramidal, euphoria, and stimulant effects.

The OTC availability of these products make their abuse more difficult to detect and monitor, however, findings from the AIRC show that in the last five years, these medications have been linked to at least one hundred deaths in Manitoba. Other notable OTC drugs of abuse also include doxylamine, chlorpheniramine, pseudoephedrine, and dextromethorphan (DM).[11]

Pharmacists must be well informed of the OTC medications that have an abuse potential, as pharmacist vigilance can play a positive role in the management of OTC medication abuse. To strike a balance between patient/public safety and the patient's right to access needed medications, the following intervention strategies are recommended:

- Entering all purchases of DPH and DMH medications on patient profiles, especially for adolescents, patients with mental health conditions, or those prescribed antipsychotic medication, thereby creating a tracking system of the quantity and frequency consumed by patients. Directing patients to their prescriber or specialist as required can mitigate risks.
- It is strongly recommended that DPH and DMH stock be kept behind the counter, requiring an interaction and assessment by the pharmacist prior to purchase.
- Stocking and dispensing packs of 30 tablets is strongly recommended over packs of 100 tablets, limiting the number of milligrams that can be ingested at once. Most self-limiting conditions can be managed well with 30 tablets of DPH/DMH.
- If DPH and/or DMH is kept over the counter, consider stocking only a limited number of packs for patient self-selection. This lessens the chances of an individual buying a large number of packs at once.
- If DPH and/or DMH is kept over the counter, ensure it is within the direct line of sight from the dispensary (e.g. immediately adjacent to the cash register), so that staff can monitor purchases and pharmacists can intervene more readily.
- Inquire about OTC medication use when taking a drug history. Patients must be warned that opioids and benzodiazepines should never be combined with alcohol or OTC antihistamines as their combined effects could lead to life-threatening respiratory depression.

In addition, although DN was never prescribed quetiapine, it was found in supra-therapeutic levels in her blood (likely contributing to the arrhythmia), and an empty prescription quetiapine vial was found on the scene. As a part of the College's involvement in the AIRC, pharmacy managers are also alerted if a prescription dispensed at their location has been found at a crime scene, in order to raise awareness regarding the dangers of diverted prescription drugs. This provides an opportunity for the pharmacy team to review the practices in place within the pharmacy, and to discuss with the prescriber of that diverted medication an appropriate course of action for the patient it was dispensed to. Mitigation strategies can include opting to dispense a shorter days supply, switching to other agents with less potential for diversion, offering lockboxes, and

discussing with the patient the dangers of diverted medications for other people.

Lastly, DN was switched from amitriptyline to citalopram for depression on July 11, 2015, but citalopram was not detected on the toxicology report. However, amitriptyline levels were found to be supra-therapeutic, and it is probable that DN was stockpiling amitriptyline from previous fills. It is strongly recommended to ask patients to return their old medications and encourage them to bring it to the pharmacy for disposal, especially if the patient is known to have a history of substance abuse, or is within an environment that may encourage drug diversion and misuse.

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. Measures must be taken to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing.

Resources

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11. Canadian Centre on Substance Abuse. (2017). The Effects of Psychoactive Prescription Drugs on Driving. Ottawa: Canadian Centre on Substance Abuse. Retrieved August 6, 2019, from https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Psychoactive-Prescription-Drugs-and-Driving-Report-2017-en.pdf

Case Study: Methadone Overdose

KC was on a stable dose of methadone (45mg), once daily for opioid agonist therapy (OAT) for several months. She was also using puffers for asthma, antidepressants, and muscle relaxants regularly. KC attended a busy pharmacy that had numerous OAT patients and prepared methadone doses ahead of time.

One day, KC arrived for her dose near the end of the day, and the pharmacist erroneously selected a bottle that contained 115mg of methadone for another patient. KC ingested the incorrect dose and handed her empty bottle back. The pharmacist then saw the incorrect label and immediately realized that an error had been made. The pharmacist suggested that KC could try to vomit the dose, but emesis made KC uncomfortable and she declined. The pharmacist suggested going to the emergency room if she felt side effects in 2 to 4 hours (e.g. drowsiness, trouble breathing). KC accepted this suggestion and decided to leave and go home without any further consultation.

The pharmacist was able to make contact with the prescribing physician and reported the incident.

The next day, KC described to the pharmacist some unexpected drowsiness and loss of balance the previous evening as she was preparing dinner for her kids, but she tried to stay awake until the effects sufficiently wore off.

Discussion

In this case, pharmacy staff did not:

- use an adequate method to double check that the correct dose was being given to the correct patient and
- take sufficient measures to ensure the safety of the patient after the incorrect dose was ingested, especially considering the higher dose and her other medical conditions.

Preparation of methadone or buprenorphine-naloxone doses ahead of time can improve workflow in a busy pharmacy, but it can lead to a higher risk of dose mix-ups between patients. When administering OAT to a patient, stating their name and dose in a confidential manner can reduce this risk. For example, using open-ended questions ("What dose are you on?") is recommended.

Methadone and buprenorphine-naloxone can have peak effects in 1-2 hours (buprenorphine is usually faster) and can last for several hours. When an OAT overdose occurs, adverse effects will be most apparent during these peak times, which can include drowsiness, intoxication, and respiratory depression at higher doses (which can lead to death).

Overdose Pharmacy Protocol

In the event of an accidental OAT overdose, quick decisions need to be made by the pharmacy team, and a succinct protocol should be in place to manage these situations. An overdose protocol should cover, but is not limited to, the following steps:

- make every reasonable effort to contact, inform, and follow up with the patient about the overdose,
- promptly contact the physician,
- assess the risk to the patient and make an appropriate recommendation to go to emergency or urgent care,
- stress to the patient the reasons for seeking medical attention,
- involve a trusted person to care for the patient, especially if they refuse to go to the hospital,
- management of other current medications,
- supply a naloxone kit, and
- document the incident

A pharmacy may consider creating a checklist that is to be used by the pharmacist-on-duty if this type of event occurs.

Certain risk factors can contribute to a higher incidence of harm/death with an OAT overdoseas follows:

- Any type of overdose during the initiation phase of OAT (i.e. first 2-3 weeks). All attempts should be made to ensure the patient receives medical attention immediately.
- If an overdose is 50% higher than the patient's usual dose
- Other sedating medications
- Contributing medical conditions (e.g. asthma)
- The patient is stable at a lower dose (e.g. below 40mg),
- The patient receives more carry-home doses, or
- Patients with an uncertain level of opioid tolerance.

All patients who experience an OAT overdose should be advised to consider and/or seek medical attention. Using an assessment of the risk factors, along with consultation from the prescriber, the pharmacist should use their professional judgment in determining and recommending the level of medical attention required (e.g. emergency room). The pharmacy staff should be actively involved with ensuring that the patient receives the appropriate medical intervention, which may include finding transportation or calling an ambulance.

The pharmacist can make other recommendations to mitigate harm, especially in the event where the patient refuses to go to the hospital. Involving a trusted, knowledgeable person known to the patient (e.g. spouse) who can oversee and monitor for adverse effects during the peak times can be critical to preventing harm. Managing current medications, such as reducing the consumption of sedating drugs, can reduce the risk of additional drug-drug interactions. Supplying a naloxone kit to the patient or a trusted person coming for the patient is also recommended.

Pharmacists should use caution when advising on the induction of emesis. Pulmonary aspiration is a risk of inducing emesis, and the risk is higher in the presence of CNS depression. Emesis may also create a false sense of resolution for the patient because there may only ne a partial expulsion of the contents of the stomach. Emesis might be used only as a first aid measure if medical help is not readily available, there is no apparent CNS depression, and the pharmacist or another person with first-aid training is available to assess the patient post-emesis.

Keep up-to-date contact information for each patient on OAT (including alternate phone numbers) so that you can contact them quickly in the event of an emergency, like discovery of an accidental overdose. Ensure that the patient also has the contact information for the pharmacy readily available.

Conclusions

Pharmacists play a crucial role with ensuring that OAT is administered in a safe and effective manner. An OAT administration error can result in an accidental overdose, therefore preventative measures to reduce the risk of OAT administration errors should be a top priority for all pharmacists and pharmacy managers. In the event of an accidental overdose, a knowledgeable pharmacist who follows a readily available protocol is the best line of defense to prevent any further harm to the patient.

Additional Reading:

Opioid Agonist Therapy Guidelines for Manitoba Pharmacists. December 2019

Methadone Maintenance Treatment: Quick Guide to Keep Your Patients, Staff, and Community Safe

Isaac, P., Janecek, E., Kalvik, A., and Zhang, M. 2015. Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders.

Stewart, I., Fall 2010. Focus on Error Prevention.

Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment Opioid Dependence: 4.4 Incorrect Dose Administered. 2003

Opioid Replacement Therapy Guidelines Update

The Opioid Replacement Therapy Guidelines have recently been updated and renamed the Opioid Agonist Therapy Guidelines for Manitoba Pharmacists (OAT Guidelines). The new title reflects current changes in terminology used in practice.

Revisions to the guidelines include:

- Additional information related to new Health Canada exemptions for community health facilities. The exemptions allow for nursing staff to possess, administer and transport methadone and buprenorphine. It also allows pharmacies to supply these medications to community health facilities with nursing staff.
- Intervention that should occur in cases of overdose due to a dosing error
- Information from the College of Physician and Surgeons document on Take Home Dosing Recommendations for Buprenorphine
- Addition of a Centre for Addiction and Mental Health course for buprenorphine training
- Additional clarification on witnessed ingestion, deliveries, pregnancy and breastfeeding, M3P total dose requirement, secure storage of methadone doses

Pharmacists dispensing OAT must review the updated OAT Guidelines.

If you are interested in registering for the Opioid Agonist Therapy 101: An Introduction to Clinical Practice workshop, please see the Upcoming PD page for dates and links to registration information.

NAPRA Virtual Communication Toolkit

The National Association of Pharmacy Regulatory Authorities (NAPRA) released the Pharmacist's Virtual Communication Toolkit. This valuable resource is designed to provide pharmacy professionals with communication tips and strategies to effectively engage patients in conversations with patients about the safety risks associated with opioid use.

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Holiday Safety

The holiday season is a busy time when many homes are filled with gatherings of friends and family. It is also a time when young children may be visiting homes where medication may not be stored as securely and out of reach as in their own homes.

The College reminds all pharmacists to stress the importance of proper medication storage when counselling patients, especially during the holidays.

Please remind your patients to:

- Store medication where children cannot reach it.
- Put medication safely away after each use.
- Make sure safety caps on all medication are locked.
- Teach children about medication safety.
- Follow any special instructions, for medication storage such as those for cancer treatment medicines.
- Be informed about what to do in the event an emergency occurs.

For more information on counselling patients on safe medication storage, please see the College Practice Direction on Patient Counselling.

Discipline Decision: Gregory Harochaw

Pursuant to the Notice of Hearing (the "Notice") dated August 8, 2018, a hearing was conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on June 13, 2019, with respect to charges formulated by the Registrar of the College alleging that Mr. Gregory Harochaw, being a pharmacist under the provisions of *The Pharmaceutical Act*, C.C.S.M. c.P60 ("*The Act*") and a registrant of the College, is guilty of professional misconduct, conduct unbecoming a member, or displayed a lack of skill or judgment in the practice of pharmacy or operation of a pharmacy, or any of the above, as described in section 54 of *The Act*, in that, between December 2016 and September 2017, at Tache Pharmacy located at 400 Tache Avenue, Winnipeg, Manitoba:

1. in his role as pharmacy manager, authorized the compounding of methadone capsules when commercially available methadone products were available in Manitoba, in contravention of section 5.1(e) of Health Canada's Policy on Manufacturing and Compounding Drug Products in Canada (POL-0051) (the "Policy");

2. in his role as pharmacy manager, authorized the prescribing of compounded intranasal naloxone outside of and in excess of the patient-healthcare professional relationship in contravention of sections 2.1, 2.2, and 2.4 of the College's *Practice Direction Prescribing* (the "Practice Direction") and Statement VII of the *Code of Ethics*;

3. in his role as pharmacy manager, between December 5 and 22, 2016, authorized the compounding of intranasal naloxone when a commercially available intranasal naloxone product was available in Manitoba, in contravention of section 5.1(e) of the Policy and section 80 of the *Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"); and

4. in his role as pharmacy manager, authorized the dispensing of medications listed on the Manitoba Prescribing Practices Program (M3P) Schedule, to patients without possessing a valid M3P prescription in contravention of section 31 of the *Narcotic Control Regulations*, CRC, c 1041 (the "NCRs"), and sections 77 and 78 of the *Pharmaceutical Regulation*, Man Reg 185/2013 (the "Regulation"), or any of them; and,

5. in his role as pharmacy manager, authorized the distribution of compounded intranasal naloxone, and in his role as pharmacist, distributed compounded intranasal naloxone outside of and, in excess of, the patient-healthcare professional relationship without valid prescriptions, in contravention of section 5.1(a) of the Policy, as well as sections 2.1, 2.2, and 2.4 of the Practice Direction, or any of them, and Statement VII of the *Code of Ethics*; and,

6. [STAYED].

On August 27, 2018, Mr. Harochaw provided the College's Discipline Committee with his written consent to commence the hearing on a date beyond the 120-day period referenced in subsection 46(2) of *The Act*.

On June 13, 2019, a Panel of the Discipline Committee (the "Panel") convened to address the charges. Mr. Jeff Hirsch appeared as counsel on behalf of the Complaints Committee. Mr. Joseph Pollock appeared on behalf of the Panel. Mr. William Haight appeared on behalf of Mr. Harochaw.

A Statement of Agreed Facts was filed in which the parties agreed to the following:

1. Mr. Harochaw admitted membership in the College;

2. Mr. Harochaw admitted valid service of the Notice of Hearing dated August 8, 2018 and that the College complied with the requirements of sub-sections 46(2) and 46(3) of *The Act*;

3. The College would file an Amended Notice of Hearing and that Mr. Harochaw consented to the filing of the Amended Notice of Hearing;

4. The College would be enter a stay of proceedings on Count 6;

5. Mr. Harochaw had no objection to any of the panel members nor to legal counsel to the Panel on the basis of bias, a reasonable apprehension of bias, or a conflict of interest.

The Statement of Agreed Facts stated that:

1. Mr. Harochaw graduated with his pharmacy degree from the University of Manitoba in 1982;

2. Mr. Harochaw had been registered as a pharmacist under *The Act* since June 7, 1982;

3. At all times material to this proceeding, Mr. Harochaw was a member of the College as a practising pharmacist in Manitoba;

4. Mr. Harochaw practised retail pharmacy at McKnight's Pharmacy from 1982 to 1985, at Canada Safeway Pharmacy in Winnipeg from 1985 to 2000, at Cantrust RX from May 2006 to November 2007, and at Tache Pharmacy in Winnipeg from 2000 to the date of the hearing;

5. Mr. Harochaw was pharmacy manager at Tache Pharmacy from January 2001 to December 2, 2004, and from March 16, 2007, to December 2017;

6. Mr. Harochaw had no previous discipline convictions with the College;

7. Mr. Harochaw reviewed the Notice as well as the Statement of Agreed Facts (the "Statement"). He admitted the truth and accuracy of the facts in the Statement and that the witnesses and other evidence available to the College would, if called and otherwise adduced, be substantially in accordance with these facts; and,

8. Mr. Harochaw tendered no evidence and made no submissions on the issue of professional misconduct and conduct unbecoming a member other than to admit that the conduct described in the Statement demonstrates professional misconduct and a lack of skill or judgment in the practice of pharmacy or operation of a pharmacy as described in section 54 of *The Act*.

At the request of legal counsel to the Complaints Committee, Counts 2 and 5 were combined into Count 2, and the dates of December 5 and 22, 2016, were added to Count 3. The Complaints Committee entered a stay of proceedings with respect to Count 6.

Mr. Harochaw entered a plea of guilty to counts 1 through 4.

Legal counsel to the Complaints Committee advised that the parties would make separate submissions on disposition with respect to the appropriate fine and contribution to the costs of the investigation and prosecution of the matter. The parties agreed - as part of the disposition - that Mr. Harochaw would not serve as a pharmacy manager for a period of two years commencing June 13, 2019.

Legal counsel for the Complaints Committee recommended to the Panel that Mr. Harochaw:

1. be required to pay a fine of $12,000;

2. be required to pay a contribution to the costs of the investigation and prosecution of $8,000; and,

3. be prohibited from being a pharmacy manager for two years commencing June 13, 2019.

Legal counsel for Mr. Harochaw made recommendation on the disposition that Mr. Harochaw:

1. be fined $5,000;

2. be required to pay a contribution to the costs of the investigation and prosecution of $5,000; and,

3. would not serve as a pharmacy manager for a period of two years commencing June 13, 2019.

After considering the submissions of counsel, the Panel concluded that Mr. Harochaw be:

1. prohibited from being a pharmacy manager for a two year period commencing June 13, 2019;

2. fined $10,000.00; and,

3. required to pay a contribution to the costs of the investigation and prosecution of $8,000.00.

In arriving at its decision, the Panel considered Mr. Harochaw's significant error in professional judgement and lack of responsible communication with the College regarding concerns about procedures and protocols as aggravating factors. The Panel considered Mr. Harochaw's admission of guilt as a mitigating factor.

Based on the foregoing, the Panel was satisfied that this disposition should serve to act as a deterrent, both general and specific, while at the same time ensure that the public's interest was protected and the public's confidence maintained.

DATED at Winnipeg, Manitoba this 27th day of August, 2019.

College Awards

The College is now accepting nominations and applications for the following awards:

Pharmacist of the Year

Bonnie Schultz Memorial Award for Pharmacy Practice Excellence

Patient Safety Award

Honorary Life Members

Honorary Members

Centennial Award

If you or a pharmacist you know, has made a noteworthy contribution to patient care and safety or the practice of pharmacy, please consider submitting a nomination or application for one of the awards listed in the College Awards brochure.

The deadline for submitting nominations and applications for the 2020 College Awards is Wednesday, January 15, 2020. The College has created award submission guidelines for your consideration prior to forwarding your nomination to the College's Awards & Nominating Committee.

Please send all nominations or applications to:

College of Pharmacists of Manitoba

Attention: The Awards & Nominating Committee – CPhM Awards

200 Taché Avenue Winnipeg, MB R2H 1A7

Email: info@cphm.ca with the subject line "Attention: The Awards & Nominating Committee – CPhM Awards"

Awards will be presented during the 2020 Awards Luncheon on Saturday, May 9, 2020 at the Inn at the Forks.

Young Leader Awards

The Young Leader Awards celebrate the efforts of up to ten leaders in pharmacy practice. The recipients will receive a plaque to commemorate their contributions to the pharmacy profession and a $500 cash prize.

The awards are open to recently licensed pharmacists (practicing one to five years post-graduation) and to pharmacy students (interns) in their final year of study who have made a professional contribution to patient care, the pharmacy profession or amongst their colleagues and peers at the University of Manitoba's College of Pharmacy.

If you or someone you know meet these criteria, please submit a nomination or application package including the nominee or applicant's Curriculum Vitae and a summary of their activities and contributions within pharmacy practice or within the University of Manitoba's College of Pharmacy.

The deadline for nominations or applications is Wednesday, January 15, 2020.

Please submit all nominations or applications to the College of Pharmacists of Manitoba:

By regular mail or email:

Mail: College of Pharmacists of Manitoba

Attention: The Awards & Nominating Committee – Young Leader Awards

200 Taché Avenue Winnipeg, MB R2H 1A7

Email: info@cphm.ca with the subject line: Attention: The Awards & Nominating Committee – Young Leader Awards

Awards will be presented during the 2020 Awards Luncheon on Saturday, May 9, 2019 at the Inn at the Forks.

AGM Date

The 2020 Annual General Meeting (AGM) marks the 142nd AGM of the College of Pharmacists of Manitoba.

Mark your calendars for Saturday, May 9, 2020 at the Inn at the Forks in Winnipeg for the 142nd AGM and the 2020 Awards Luncheon!

Holiday Hours

The College's hours of operation for the holiday season will be as follows:

Tuesday, December 24, 2019 – Open 8:30 a.m. – 12:00 p.m.

Wednesday, December 25, 2019 – Closed

Thursday, December 26, 2019 – Closed

Friday, December 27, 2019 + Monday, December 30, 2019 – Open 8:30 a.m. – 4:30p.m.

Tuesday, December 31, 2018 – Open 8:30 a.m. – 12:00 p.m.

Wednesday, January 1, 2020 – Closed

Regular hours of operation will resume on Thursday, January 2, 2020.

Have a safe and happy holiday season.

In Memoriam

Kim Plett - October 4, 2019

Ted Bartman - October 27, 2019

Lois Cantin (see page 6)- November 27, 2019

Joseph Kasper - December 4, 2019

Ray Biglow (1978 MPhA President, 1985 Pharmacist of the Year, 2011 Honorary Life Member) - December 7, 2019