COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

SUMMER 2021

Contents

FEATURES

Increased Access to Naloxone Products in Manitoba 4

Safety IQ 6

President's Message 10

FOCUS ON PATIENT SAFETY

Methadone 11

Pharmacist Administration of Hazardous Medications 13

Education from the Adult Inquest Review Committee Meetings of the Chief Medical Examiner's Office 14

QUALITY ASSURANCE

Competence in Dispensing Drugs to Animals 17

PHARMACY TECHNICIANS

Performance Review FAQ for Pharmacy Technicians and Pharmacy Managers 18

NEWS & EVENTS

Welcome to the Profession 20

DISCIPLINE DESICIONS/SUSPENSIONS

Pharmacist Licensure Decision 21

This Newsletter is published four times per year by the College of Pharmacists of Manitoba (the College) and is distributed 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.

OFFICERS

Wendy Clark, President, District 2
Sonal Purohit, Vice President, District 1
Jane Lamont, Executive Treasurer, District 2
Kevin Hamilton, Past President, District 2

LIAISONS TO COUNCIL

Stephen Jackson, Pharmacy Technician
Brenda Rosenthal, C.S.H.P. (MB Branch)
Dinah Santos, PEBC
Marina Rofaeil, Student Representitive, College of Pharmacy

COUNCILLORS

Amanda Andreas, Public Representative
Ryan Buffie, District 1
Tory Crawford, Public Representative
Alanna Doell, District 1
Donna Forbes, Public Representative
Donald Himbeault, Public Representative
Drupad Joshi, District 2
Ravi Pandya, District 2
Dr. Lalitha Raman-Wilms, Dean, College of Pharmacy
Ashley Walus, District 1
Vacant, Public Representative

COLLEGE STAFF

Susan Lessard-Friesen, Registrar
Rani Chatterjee-Mehta, Deputy Registrar
Brent Booker, Assistant Registrar - Review and Resolution
Chris Louizos , Assistant Registrar - Field Operations
Kevin Chaboyer, Quality Assurance and Field Officer
Kim McIntosh, Assistant Registrar - Qualifications and Practice Development
Ronda Eros, Practice Consultant
Meret Shaker, Practice Consultant
Lori McKietiuk, Director of Operations
Bev Robinson, Registration Officer
Stacey Hjorleifson, Senior Administrative Assistant
Lindsay Henderson, Executive Assistant to the Registrar & Deputy Registrar
Brittany Delaquis, Administrative Assistant
Hazel Suh, Administrative Assistant
Rachel Carlson, Communications Specialist
Anja Sadovski, Communications Coordinator

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.

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

FEATURE

Increased Access to Naloxone Products in Manitoba

The COVID-19 pandemic and its associated stressors (social isolation, job losses, decreased accessibility to health and social support services, etc.), has accelerated the rate of opioid overdose deaths across the country (Niles, Gudin and Radcliff).

According to data from the Public Health Agency of Canada (Opioid- and Stimulant-related Harms in Canada 2020): "1,628 apparent opioid toxicity deaths occurred between April and June 2020, representing the highest quarterly count since national surveillance began in 2016. This number also represents a 58% increase compared to January to March 2020 (1,029 deaths) and a 54% increase from the same time frame in 2019 (1,059 deaths). In 2020 (January to June), 97% of apparent opioid toxicity deaths were accidental (unintentional)."

On December 15, 2020, naloxone products packaged for use in opioid overdose became unscheduled in Manitoba in order to increase public access to naloxone and reduce opioid overdose deaths.

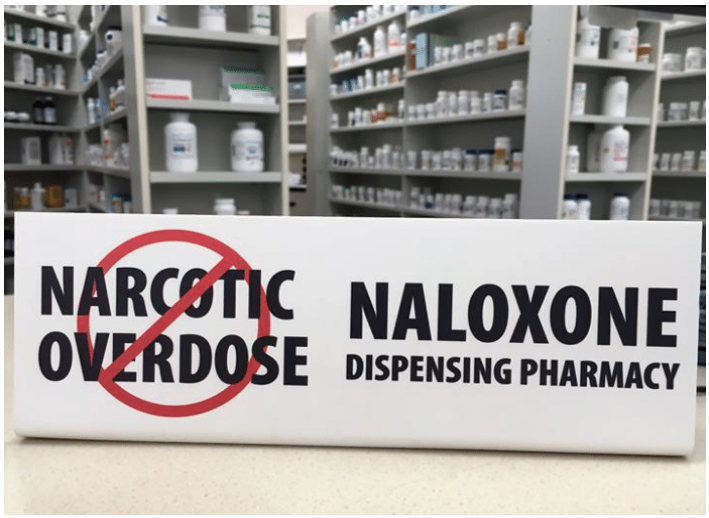
After member consultation, legislative amendments were introduced to the Pharmaceutical Regulation, as approved by Council with the addition of subsection 84(5). This section excludes naloxone products packaged for use in opioid overdose from the conditions for the sale of NAPRA Schedule 2 products. Naloxone products packaged for use in opioid overdose are now permitted to be sold:

- from any location or shelf in the pharmacy;
- without the involvement of a licensed pharmacist in the sale of the product; and
- without the requirement for the pharmacist to counsel individuals on the proper use and administration of the product in an opioid emergency; however, if requested, pharmacists are encouraged to provide counselling on proper use and administration.

In addition, the government of Manitoba introduced other amendments to the Pharmaceutical (General Matters) Regulation (which is under Ministerial authority) and the Regulated Health Professions General Regulation that allows for naloxone products packaged for use in opioid overdose to be sold at any retail location in Manitoba without the requirement for professional intervention.

These legislative changes allow for expanded distribution and use of this life saving medication. However, overdose prevention education remains paramount to combat the rising number of opioid overdose deaths during the pandemic and beyond.

Pharmacists continue to have an important role to play in preventing opioid overdoses. Pharmacists are encouraged to take every opportunity to educate patients and their caregivers on the potential risks of opioid medications, the importance of their secure storage, appropriate identification of an opioid overdose, the benefits of a take-home naloxone kit, and their proper use.



Naloxone kits can be proactively provided to any patient receiving opioids (Tsuyuki, Arora and Barnes), and to those who may be likely to witness an opioid overdose event. Specifically, patients at high risk of opioid overdose include those receiving >90 mg morphine equivalents, on Opioid Agonist Therapy, live with respiratory illness (e.g., COPD, asthma, sleep apnea), have multiple prescribers, request frequent early refills or frequently visit emergency rooms requesting opioids, have a history of opioid use disorder, receiving concomitant CNS depressants, or patients on a tapering plan.

The following resources can be reviewed for more information and guidance on naloxone products:

- Canadian national consensus guidelines for naloxone prescribing by pharmacists, Canadian Pharmacists Journal, published August 2020 (Tsuyuki, Arora and Barnes)
- Canadian Pharmacists Association (CPhA) Opioid Crisis and Naloxone Resources
- Manitoba Health Take-Home Naloxone Distribution Program Information for Service Providers
- Naloxone: Frequently Asked Questions, College of Pharmacists of Manitoba
- Canadian Centre on Substance Use and Addiction (CCSA), resources related to the opioid crisis
- School of Pharmacy, University of Waterloo, Naloxone and Opioid Crisis Resources
- The naloxone category in the College Resource Library for additional resources and patient information sheets

Works Cited

Niles, J, et al. “The Opioid Epidemic Within the COVID-19 Pandemic: Drug Testing in 2020.” Population Health Management (2021): 24:S1, S-43-S-51.

Public Health Agency of Canada. Opioid- and Stimulant-related Harms in Canada 2020. December 2020. 17 February 2021.

Tsuyuki, R, et al. “Canadian national consensus guidelines for naloxone prescribing by pharmacists .” Canadian Pharmacists Journal (2020): 153(6):347-351.

FEATURE

Safety IQ — How does Safety IQ change the way our pharmacy handles medication incidents and near-miss events?

Many of the existing principles and requirements for handling medication incidents and near-miss events are unchanged for community pharmacies after the launch of Safety IQ on June 1, 2021.

Safety IQ improves upon your current medication incident and near-miss event practices with a standardized approach to continuous quality improvement (CQI).

For an overview of what is unchanged and what is new to the Medication Incident and Near-Miss Event Practice Direction, please see the chart on the following page.

Standardized CQI

With Safety IQ, all community pharmacies now record a standard data set into an online incident reporting platform. The reporting platform stores this data and provides tools to review and analyze a single incident or aggregate (combined) data. Reporting platforms also provide tools to record improvement plans so your team or manager can monitor the effective of changes over time. This is a big improvement on paper-based processes such as incident binders that make comparing incidents or tracking trends difficult.

Your pharmacy's incident reporting platform automatically sends de-identified (anonymous) incident data to the National Incident Data Repository (NIDR) hosted by ISMP Canada. Medication safety experts at ISMP Canada analyze this data to share learning and trends with healthcare professionals across Canada.

The information you report contributes to improved medication safety for all Canadians.

Your pharmacy must also meet, at a minimum, once per year to discuss medication incidents, trends, and improvement plans. One of the primary aims of Safety IQ is to encourage the open and honest discussion of medication incidents and near-miss events. Open discussion encourages all staff to share their unique and valuable prespectives on improving the pharmacy's preparation and dispensing practices. The College encourages your team to have on-going discussions on how your pharmacy can improve its processes and procedures.

CQI is about asking 'how are we doing?' and 'how can we do things better?'

Finally, Safety IQ requires your pharmacy to complete a Safety Self-Assessment (SSA). The SSA provides a structured approach to examining dispensing and preparation to proactively identify weaknesses in practice or processes. Information from your pharmacy's SSA is used to develop improvement plans to help prevent future medication incidents

Important Points about Safety IQ

- The College does not have access to individual report data and is at arms length from your reporting platform and the NIDR.
- Your reporting platform and the NIDR are separate organizations that have worked together to facilitate the population of the national database for community pharmacy medication incidents.
- Each pharmacy has its choice of incident reporting platforms. This aspect of Safety IQ ensures that pharmacies are not burdened by double reporting. In some jurisdictions in Canada, the regulatory authority mandated a single reporting platform which has meant that some pharmacies must report to their pharmacy's internal incident reporting platform and to the platform mandated by the regulatory authority.

For more information about Safety IQ, please visit

https://cphm.ca/practice-education/quality-assurance/safety-iq/

Please share your questions or concerns with us by email at safetyiq@cphm.ca.

Comparison Chart: The New and Unchanged Elements of the Medication Incident and Near-Miss Event Practice Direction

The principles and requirements for Safety IQ are outlined in the updated Medication Incident and Near-Miss Event Practice Direction (formerly called the Medication Incident and Discrepancies or Near-Miss Event Practice Direction). Safety IQ has only changed some of the requirements for how your pharmacy handles medication incidents and near-miss events. The following chart outlines the unchanged requirements and the new requirements of the Medication Incident and Near-Miss Events Practice Direction.

Requirement	Unchanged	New
Policies and Procedures (Section 3.1)		
The pharmacy must have written policies and procedures for addressing, reporting, investigating, documenting, disclosing and learning from medication incidents. Licensed pharmacists, pharmacy technicians, and pharmacy assistants must be trained on and comply with policies and procedures related to medication incidents.	✓	
Pharmacy must meet and follow the requirements of Safety IQ, including but not limited to • using specfic tools for recording and reporting medication incidents and near-miss events • proactively identifying any safety issues within the pharmacy • documenting improvement plans to ensure medication safety within the pharmacy • ensuring all dispensary staff are trained on the elements of Safety IQ		✓
Discovery of an Incident: Patient Care (Section 3.2)		
Determine if the patient has experienced harm or is at risk of possible harm and provide care to protect the patient's health and safety. Ensure the patient receives the right medication in a timely manner Take reasonable steps to ensure that the incorrect medication is quarantined and/or returned to the pharmacy to avoid risk of harm or further harm, if relevant. Notify the pharmacy manager, prescriber, and any other personnel of the medication incident.	✓	

Comparison Chart: The New and Unchanged Elements of the Medication Incident and Near-Miss Event Practice Direction (Cont'd)

Requirement	Unchanged	New
Discovery of an Incident: Disclosure and Apology (Section 3.2)		
Acknowledge that something has happened and the distress the incident has caused the patient and express empathy and concern. Listen to the patient. Inform the patient that the medication incident will be reported to pharmacy manager, investigated transparently and steps taken to reduce the likelihood of the medication incident happening to others.	✓	
Advise the patient of the potential consequences (both short and long term) from the incident. Provide the patient with a description of the facts that are known about the incident and update the patient as new information is obtained. Advise the patient that the pharmacy will anonymously report the medication incident to a national medication incident database to enable other pharmacies to learn from this incident Notify patient of any changes to systems or processes made after analysis of the incident.		✓
Reporting Incidents (Section 3.2.4)		
Medication incidents are promptly and anonymously reported by pharmacy staff member(s) to a medication incident reporting platform which will export the report details to a national medication incident database. Near misses that are recurrent or could potentially cause harm if not corrected are also reported to identify trends and preventive recommendations.		✓
Investigation of an Incident (Section 3.2.3)		
Upon discovery of a medication incident, the pharmacy manager must ensure that: • The staff member(s) involved in the incident are made aware of the incident. • The investigation of the factors associated with the medication incident is done in a transparent and timely manner. • Findings and changes to be implemented are shared with pharmacy staff and changes reflected in the policies and procedures manual if deemed necessary	✓	
Staff involved in the incident are provided access to support if needed. Inform the patient of the action plan implemented to prevent further incidents		✓

Comparison Chart: The New and Unchanged Elements of the Medication Incident and Near-Miss Event Practice Direction (Cont'd)

Requirement	Unchanged	New
Analyzing for Improvement (3.2.5)		
Changes in processes or systems that may have led to the medication incident are identified, and a plan is developed and implemented to reduce the risk of the incident recurring.	✓	
The pharmacy manager must ensure that: • Incidents and recurrent or potentially harmful near-misses are reviewed and analyzed by pharmacy staff to identify contributing factors. The pharmacy manager or designate should review individual near-misses and incidents to identify contribution factors and opportunities for improvement. • Review of aggregate data should happen on a quarterly basis to look at trends or opportunities for improvement and compare to national data. • A pharmacy-specific safety self-assessment (SSA) is completed during the first year of the Safety IQ program, and every three years thereafter. For new pharmacy openings, the safety self-assessment should be completed within the first year of operation. The SSA can be completed more frequently if deemed appropriate by the pharmacy manager. • A formal CQI meeting be conducted with pharmacy staff at a minimum annually with informal huddles occurring as medication incidents occur and as deemed necessary.		✓
Documentation (Section 3.2.6)		
The Pharmacy manager must ensure that following is documented and accessible for regulatory review: • Medication incidents, CQI improvement plans and formal CQI meetings. • Communication with the patient and prescriber (in addition to information reported to the medication incident reporting platform) • CQI improvement plans and outcomes, as a result of medication incidents and near misses. • CQI improvement plans and outcomes, as a result of completion of the SSA. • CQI meetings with pharmacy staff including date, staff present and topics of discussion.		✓

FEATURE

President's Message

Dear Colleagues,

This summer has been a busy and very productive time for the College. Just a few of the accomplishments and collaborations over the past few months include:

- the official launch of Safety IQ, Manitoba's community pharmacy continuous quality improvement (CQI) program on June 1, 2021,
- Council approving the new Professional Development Pharmacist Independent Study Self-Accreditation Package, and
- the ongoing work with Manitoba Health and Seniors Care (MHSC) to implement prescribing authority to pharmacists for uncomplicated cystitis and proceed with an amendment to pharmacy practice legislation.

The College remains focused on supporting pharmacy professionals in providing safe and quality care throughout the COVID-19 pandemic. While Manitoba is beginning to see loosened restrictions and changes in public health orders signalling the potential end of the pandemic, we need to remember it is unlikely that we will completely return to business as usual. Therefore, the College will continue to monitor the development of pharmacy practice and government regulation due to the pandemic and collaboratively provide registrants with ongoing guidance and resources to support their safe delivery of pharmacy care. Please refer to the COVID-19 Updates page for the latest updates and advice.

Congratulations to the 2021 graduating class — what you've accomplished has been no minor feat.

Graduating from university and entering into a career is challenging enough, but now you're entering into the professional world of pharmacy during a time we have never experienced before. I encourage you to take care of yourselves and each other, and above all, remember why you chose this profession as it will help guide you through your trying times.

Thank you again to all pharmacy professionals for your ongoing commitment to your patients throughout these challenging times.

President,
Wendy Clark

Methadone

The Institute for Safe Medication Practices (ISMP Canada) issued a safety bulletin that analyzed data from four Canadian Medication Incident Reporting and Prevention System (CMIRPS) databases between 2015 and 2020 and summarized the most frequent medications cited in harm incidents. Methadone was listed as the most frequent medication in community pharmacies to cause harm incidents, accounting for 6.3% of cases. Furthermore, methadone accounted for 4.5% of incidents that caused either severe harm or death across all health-care settings.

For incidents involving methadone, the safety bulletin underscored three contributing factors:

- Insufficient patient identification processes,
- The need for individualized dosing regimens, and
- Complex preparation steps.

The risks that result can be reduced with policies and procedures fashioned from the guidance in the Opioid Agonist Therapy Guidelines for Manitoba Pharmacists.

Insufficient patient identification processes can often lead to errors that cause patients to receive a methadone dose meant for a different patient. In the context of the pandemic requirement to wear face masks, identification can be even more challenging.

Patient identification processes to reduce errors should include:

1. Asking for two patient identifiers such as their full name and a secondary identifier (e.g. date of birth or address) at each visit,
2. Keeping a photo of the patient on file, and
3. Confirming their dose before witnessing ingestion.

It is important to ensure that the procedures are clear, consistent, and put in force and patients are aware as well as staff.

When multiple patients receive their methadone from the same pharmacy, the pharmacy must prepare individualized dosing regimens for each patient, which can be a contributing factor leading to reduction in harm incidents. Routines and procedures that support organization will be helpful in managing significant variability in doses, witnessing schedules, and other components of the dosing regimen. Some examples of policies that can be useful in these circumstances include using the same unit of measure for all OAT medications (i.e. “mg”), marking the witnessing schedule on the administration log, and establishing an organized and secure method of preparing and storing doses for multiple patients.

At times the complex steps of preparing methadone can lead to harm incidents. Confusion can occur when converting doses in “mg” to stock solution in “mL”. This is especially dangerous since the stock solution is 10mg/mL. A calculation error can easily lead to a ten times dose error, which can be fatal. A careful analysis of the dose on a new prescription by the pharmacist, and having two staff members, including the pharmacist, observing the preparation process can be useful towards preventing this error. The preparation of methadone doses can also involve stock solution being transferred between multiple containers and this increases the risk of exposure to the potent substance. Segregation and security of the stock solution is imperative.

Proper training of staff to administer opioid agonist treatment will further cement their skills in managing the risks associated with methadone dispensation. The College requires that at least one pharmacist must be extensively knowledgeable at each pharmacy that provides opioid agonist therapy, and one of the required courses listed in the guidelines must be completed within 6 months of initiating care. This pharmacist is expected to train any other pharmacist at that pharmacy who will be dispensing OAT. While the guidelines currently only require one pharmacist at a pharmacy to receive the specialized training in OAT, it is strongly recommended that all pharmacists who are dispensing OAT receive the training as well as they must be comfortable and competent. A pharmacy that is waiting for availability of the specialized training and is dispensing OAT must have a trained/knowledgeable pharmacist acting as a mentor at another pharmacy until such training is complete.

Each pharmacy dispensing OAT must have their own written policies and procedures to ensure that OAT guidelines and relevant legislation are followed as well to ensure safe patient care.

A policy and procedures manual should cover topics such as:

- Staff education and training,
- Dispensing procedures (preparation, measuring devices, labelling, storage),
- Witnessing process (patient identification, diversion),
- Documentation (witnessed dose logs, patient agreements),
- Patient assessment (patient under influence),
- Communication with patient, caregivers and prescribers,
- Take-home doses,
- Harm reduction (naloxone, accidental overdose), and
- Security and disposal.

Proper training combined with explicit policies and procedures are essential components of dispensing methadone in a safe and effective manner.

Analysis by ISMP Canada reveals the elevated occurrence of harm incidents involving methadone over the last half decade. This evidence is a clear reason to focus on improving procedures and training with methadone dispensation and administration, and ensuring that safety will remain uncompromised.

Pharmacist Administration of Hazardous Medications

The College has received inquiries about a pharmacist's ability to administer hazardous and/or cytotoxic medications such as testosterone or methotrexate. Hazardous drugs are medications that pose a potential health risk from exposure in the workplace. Information and a list of hazardous drugs in healthcare settings can be found here: National Institute for Occupational Safety and Health (NIOSH) List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016. A pharmacist must check the list as well as the product's safety data sheet and monograph prior to administering a product. The pharmacist must determine whether additional precautions need to be taken and ensure those requirements are met.

The current legislation and practice directions would not prevent a pharmacist from administering these drugs if this is indicated in the product monograph and/or approved by the product manufacturer. However, the pharmacist must have the required knowledge, skill, and competence, and follow the appropriate procedures and precautions for the safe preparation and administration in order to protect and prevent contamination to the pharmacist, patient or other staff. Safe drug administration policies and procedures must be in place, including precautionary measures for safe transport, disposal of the hazardous product, management of an accidental spillage, and measures for handling any adverse reactions that may arise after administration.

The authorization to administer drugs by injection does not automatically mean that a pharmacist is trained and competent to inject all types of drug products. Hazardous drugs pose different considerations and safety precautions. A risk assessment must be performed and training undertaken as needed.

CPhM does not currently have a guideline regarding injections of hazardous drugs by pharmacists, but the Alberta College of Pharmacists (ACP) has published Guidelines for Medication and Vaccine Injection Safety. This guidance should be followed by Manitoba pharmacists administering hazardous medications. It states:

If hazardous drugs are administered in the practice setting they are stored, handled and used safely.

a. A written procedure is in place for the management of hazardous drugs.
b. Hazardous drugs are stored separately from other medications if possible.
c. Employees and others at risk from handling hazardous drugs are identified and provided with adequate training and equipment.
d. Cytotoxic spill kits are available and staff are trained in spill management.
e. Adequate personal protective equipment including but not limited to gloves, disposable gowns and facial protection is worn for administration of hazardous drugs

i. Additional personal protective equipment is used where there is potential for splash, spill or aerosolization.

ii. Personal protective equipment is disposable where possible.

f. Hazardous drug waste and equipment is disposed at point of use into a cytotoxic waste container with minimal manipulation (e.g. needles and syringes are left intact).

In summary, it is not outside of a pharmacist scope of practice to administer hazardous medications, however the necessary policies and procedures, equipment and additional knowledge, skill, and training need to be in place.

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

NL was a 42-year-old male who was found deceased at his home on Aug 23, 2019. NL's past medical history included bipolar disorder, high cholesterol, obesity (BMI 43), hypertension, and migraines. The immediate cause of death was determined to be accidental mixed drug toxicity (morphine, hydromorphone, cetirizine, cyclobenzaprine, gabapentin, hydroxyzine, mirtazapine and clonazepam). A significant condition contributing to death was renal failure.

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
Cetirizine	1400 ng/mL	----
Cyclobenzaprine*	100 ng/mL	3 - 32 ng/mL
Clonazepam	0	20 - 70 ng/mL
7-aminoclonazepam (active metabolite)	18 ng/mL	20 - 140 ng/mL
Gabapentin*	26 ug/mL	2 – 20 ug/mL
Hydromorphone	3 ng/mL	1 - 30 ng/mL
Hydroxyzine	39 ng/mL	20 – 80 ng/mL
Mirtazapine	37 ng/mL	28 – 64 ng/mL
Morphine*	310 ng/mL	10 – 80 ng/mL
Quetiapine	110 ng/mL	100 – 1000 ng/mL

NL's DPIN history below only includes a summary of the medications relevant to his toxicology results for the three months prior:

Generic Name	Date Dispensed	Strength	Quantity	Days' Supply	Prescriber	Prescriber
Clonazepam	Aug 21, 2019	2 mg	21	7	Dr. X	XYZ Pharmacy
Cyclobenzaprine	Aug 14, 2019	10 mg	21			
Duloxetine	Aug 7, 2019	60 mg	7			
Gabapentin	Jul 31, 2019	600 mg	28			
Hydroxyzine	Jul 24, 2019	25 mg	21			
Mirtazapine	Jul 17, 2019	30 mg	7			
Morphine SR	Jul 10, 2019	100 mg	14			
Prazosin	Jul 3, 2019	2 mg	14			
Quetiapine	Jun 26, 2019	300 mg	14			
Salbutamol	Jun 19, 2019	100 mcg	200	21		
Fluticasone/vilanterol	Jun 12, 2019	200/25 mcg	30	30		
	Jun 5, 2019					
	May 29, 2019					
	May 22, 2019					
	Apr 1, 2019					
	Jul 24, 2019					

Discussion

NL was receiving all of his medications in bubble packs, dispensed at weekly intervals from the pharmacy. However, a re-evaluation of the safety of long-term combination sedating medications and the use of high-dose (200 mg per day) long-acting morphine is warranted. There is typically little to no dose-response effect of opioids for pain relief and functional recovery[1,2],but there is a dose-dependent increase in the risk of non-fatal and fatal opioid-related overdose[1,3]. Compared to morphine doses of less than 20 mg per day, the risk of experiencing an overdose event is almost four times higher at doses above 50 mg per day, and almost nine times higher at doses above 100 mg per day.[3]

Patients receiving high-dose opioids, especially in combination with other sedating medications, should be prioritized for opioid tapering.[2] Forming a collaborative relationship with the prescriber on reducing the risk of high-dose opioid use is imperative. Requesting information on renal function could be suggested to help re-evaluate the safety of medications. In particular, metabolites of morphine (e.g., morphine-6-glucuronide) can accumulate in renal insufficiency and contribute to central nervous system depression and prolonged respiratory depression. Although wait times may limit the availability of a Sleep Study Assessment, referral to a respirologist may be of benefit for patients with an underlying respiratory disease, high BMI, and those receiving high-dose opioids. An evaluation of medications contributing to sedation and weight gain, including quetiapine, mirtazapine, and gabapentin could also be re-assessed.

Strategies to help engage patients on reducing the risk of high-dose opioid use include providing education on the benefits and harms of remaining on high-dose opioids compared to alternative options, identifying specific, measurable, and relevant functional goals for the patient, having a plan for managing withdrawal symptoms, emerging pain, or reduced functioning during a tapering schedule, re-assuring changes to the dose would be done slowly, and offering an opioid rotation. A naloxone kit should also be recommended.

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.

References

1.Busse JW, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. CMAJ 2017;189(18):E659-666.

2.Rauck R, Rapoport R, Thipphawong J. Results of a double-blind, placebo-controlled, fixed-dose assessment of once-daily OROS(R) hydromorphone ER in patients with moderate to severe pain associated with chronic osteoarthritis. Pain Pract 2013;13:18–29

3.Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92.

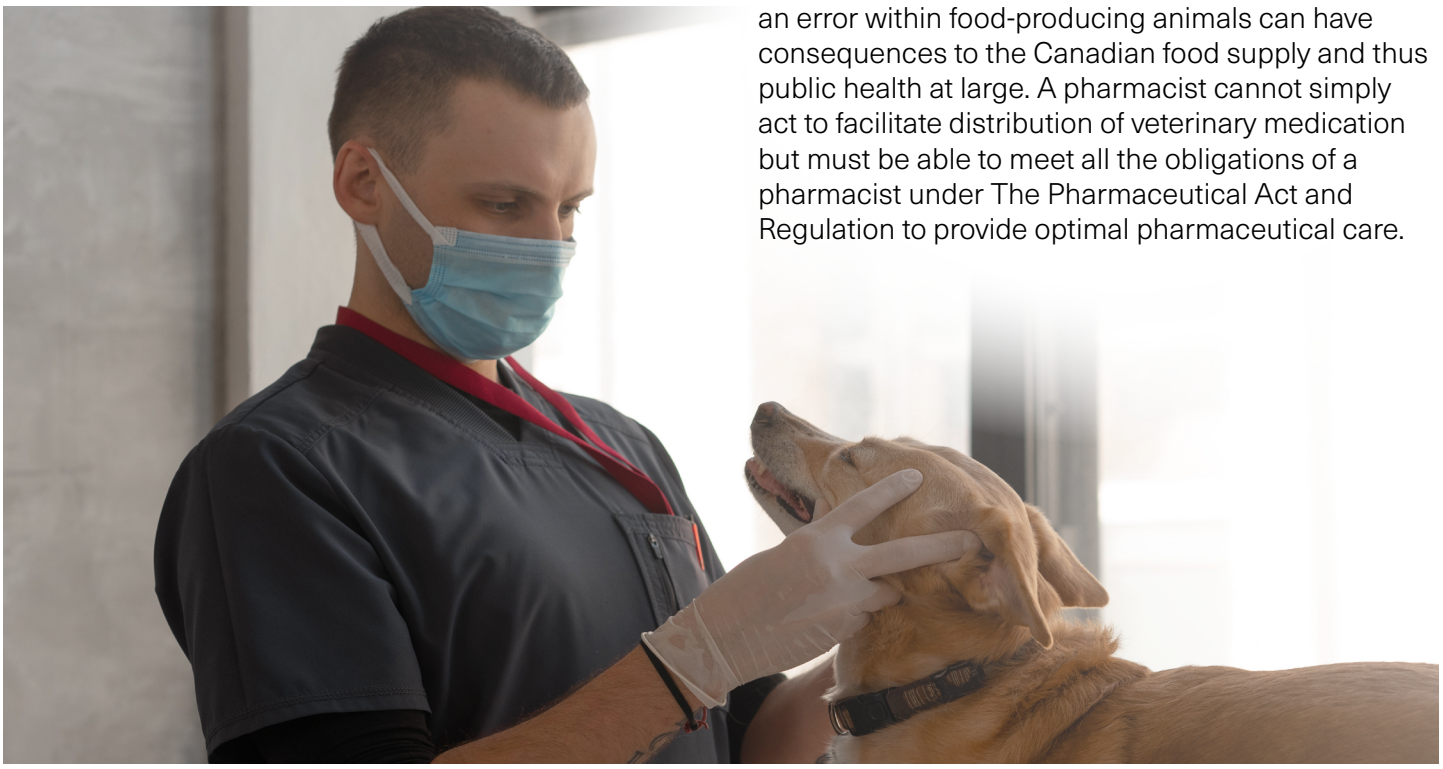
Competence in Dispensing Drugs to Animals

The Pharmaceutical Regulation (Regulation) in Manitoba permits the act of dispensing medications to animals solely through pharmacists and/or veterinarians (as dispensing practitioners under section 93 of the Regulation). However, veterinarians are the experts in drug therapy for animals, while pharmacists are drug experts for human health. In accordance with section 18 of the Regulation, pharmacists must only engage in those aspects of the practice of pharmacy for which they have the requisite knowledge, skill and judgment and when appropriate to their area of practice. Pharmacists, whether providing pharmacy services to humans or on occasion to animals, are required to be competent.

Veterinary health is a complex topic which requires knowledge of drug metabolism, drug interactions and dosing, which can all vary between animal species. Pharmacists generally do not have the necessary knowledge in veterinary medicine to provide comprehensive care for pets or food production animals. Competency in veterinary pharmacy requires significant training and cannot be achieved by participating in a few continuing education courses. Veterinary specific drug references can aid pharmacists in providing care to animals but are not a substitute for proper training.

Providing medications to animals must be done only under the direction of a veterinarian that has assessed the animal and prescribed the appropriate drug therapy. This also applies to providing NAPRA Schedule 2, Schedule 3, or Unscheduled (over the counter) medications for animals, which should only be done with consultation of a veterinarian unless the pharmacist has the required knowledge and skills. Even if the animal has received the drug safely before, the health status of the animal may have changed requiring assessment by the veterinarian.

A medication error for a companion animal may lead to the loss of a family's beloved pet while an error within food-producing animals can have consequences to the Canadian food supply and thus public health at large. A pharmacist cannot simply act to facilitate distribution of veterinary medication but must be able to meet all the obligations of a pharmacist under The Pharmaceutical Act and Regulation to provide optimal pharmaceutical care.



Performance Review FAQ for Pharmacy Technicians & Pharmacy Managers

What does the pharmacy manager need to document for a pharmacy technician performance review?

The performance review must include documentation of:

- an assessment of the technician's 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,
- The total number of hours the individual has worked as a pharmacy technician, and
- meeting the annual professional development (PD) requirement, even for the time period between reviews

How often must a Pharmacy Technician performance review be conducted?

Pharmacy technicians must participate in a performance review with their pharmacy manager or delegate at the practice site(s) at least every two years. However, many pharmacy managers will perform these reviews annually (or more often according to their pharmacy's policies).

Does the pharmacy manager need to complete a performance review if the pharmacy technician only works part-time at their pharmacy?

Yes, the pharmacy manager or delegate needs to complete and document the performance review even if a pharmacy technician only works part-time.

Is there a specific template that must be used to document this information?

There is no performance review template specific for pharmacy managers and pharmacy technicians to use. The performance review must include documentation of the items above and can include any other items the pharmacy manager wishes to address.

Does documentation of the performance review need to be submitted to the College?

Documentation of performance reviews does not need to be submitted to the College but should be maintained with the pharmacy's human resource files. These documents may be requested from the pharmacy manager by the College at any time. As well, during a pharmacy inspection, the College field officer may ask the pharmacy manager to provide documentation for any pharmacy technicians employed at the pharmacy. Pharmacy technicians must declare that they have completed the performance review requirements as part of their annual renewal application for listing.

If a pharmacy technician is employed as a pharmacy assistant, can those hours be applied to the practice hour requirement of a minimum of 600 hours in the past three years?

No, if an individual is employed as a pharmacy assistant, those hours are not eligible practice hours. An individual must be employed in a pharmacy technician position to complete the tasks of a pharmacy technician and in order for the hours worked to count towards the minimum practice hour requirements. If a technician will not meet, or anticipates that they will not meet, the practice hour requirement, they must contact the College for more information and direction.

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.

Welcome to the Profession

On June 15, 2021, instead of crossing the stage at a typical graduation ceremony, the class of 2021 participated in a virtual convocation -- and had the opportunity to view the celebration alongside family and friends remotely. The University of Manitoba, College of Pharmacy, and the College of Pharmacists of Manitoba welcome the class of 2021 to the profession of Pharmacy. Forty-five students were presented with their mortar and pestles during the event.

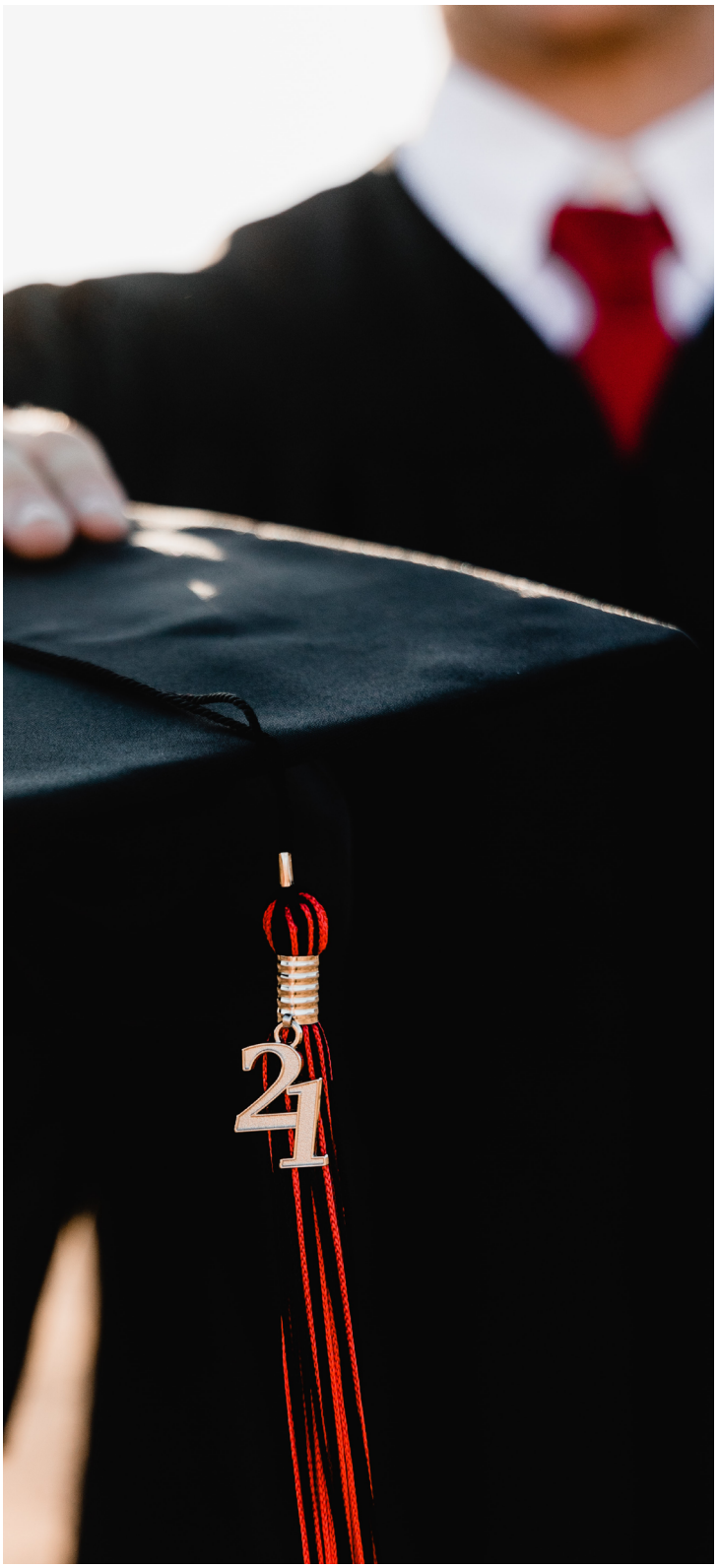
The College of Pharmacists of Manitoba congratulates all the students of the Class of 2021 for their hard work and celebrates the following award recipients on their accomplishments:

College of Pharmacists of Manitoba Gold Medal

- Heather Carney

College of Pharmacists of Manitoba Silver Medal

- Tristan Single



Pharmacist Licensure Decision

1. Effective April 9, 2021, the Complaints Committee has directed the Registrar to maintain the suspension of the pharmacist licence of Mr. Scott Putz (College Licence No. 35345) pending the outcome of the proceedings of the matter, in accordance with section 40(1) of The Pharmaceutical Act.

   Publication of this notice is pursuant to section 132(3) of the Pharmaceutical Regulation.

   The interim suspension by the Registrar pending review of the matter by the Complaints Committee was previously published in the Spring 2021 Newsletter.

2. Effective April 15, 2021, the Complaints Committee has directed the Registrar to suspend the pharmacist licence of Mr. Jeffrey Coldwell (College Licence No. 20800) pending the outcome of the proceedings of the matter, in accordance with section 40(1) of The Pharmaceutical Act.

   Publication of this notice is pursuant to section 132(3) of the Pharmaceutical Regulation.