COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

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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.

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FEATURE

President's Message

Dear Colleagues,

It has now been a little over a year since COVID-19 was first characterized as a pandemic and where we began witnessing the toll it took on our province and personal lives. I remain impressed with the pharmacy community working hard to do what is necessary to ensure the safety of those most vulnerable to the virus — most notably and recently, the willing participation in the provincial COVID-19 immunization plan.

Thank you to all of the pharmacies who took part in the application process for the COVID-19 Immunization Program and for complying with all College of Pharmacists of Manitoba (College) regulations and practice directions on administering drugs and vaccines by injection. If you have any questions or require further information on College requirements regarding COVID-19, please visit the COVID-19 Updates page on the CPhM website.

Doing our part as health professionals in a pandemic has meant dealing with overwhelming quantities of new information, guidance and recommendations, and working quickly to adapt to them to continue to provide high-quality patient care. A few notable adaptations and changes demonstrating the pharmacy community's strength and commitment to patient care include the following: the continued contribution to the COVID-19 vaccination program; development of processes for virtual site inspections, which helped with social distancing and providing a safer alternative for both the inspectors and frontline workers; and the continued rollout of Safety IQ, with the deadline for implementation coming into effect on June 1, 2021.

I encourage everyone to mark their calendars for the 143rd Annual General Meeting (AGM) on Saturday, May 8th, 2021, to join me in recognizing and congratulating the award recipients of 2020 for pharmacy excellence and showing superior service to our community and patients.

Thank you again for your continued hard work during this pandemic, and let's continue demonstrating the strength of collective action.

President,
Wendy Clark

FEATURE

COVID-19 Vaccine Program

On February 8, 2021, Manitoba Health and Seniors Care (MHSC) sent a letter via email to all pharmacies in Manitoba with an invitation to apply to participate in the Manitoba COVID-19 Immunization Program.

This next phase of the province's immunization campaign against COVID-19 will allow for more accessible and equitable vaccine roll-out to all Manitobans. It coincides with Health Canada's approval of Non-mRNA vaccines, which has less stringent storage and transport requirements than the vaccines previously approved.

Pharmacies interested in participating in the COVID-19 Immunization Program can review the program requirements and complete/submit the online registration eForm available at the following web address: https://manitoba.ca/covid19/vaccine/partners/index.html. Participation in the COVID-19 vaccine campaign is voluntary, and it is expected that the application process will be open for several weeks.

For frequently asked questions about the COVID-19 immunization campaign, please see MHSC's Q&A page at the following web address: https://manitoba.ca/covid19/vaccine/partners/faq.html

Please note that for the purposes of the COVID-19 vaccine administration in community pharmacies, all pharmacists wishing to participate must have an active Certification of Authorization to Administer Drugs and Vaccines by Injection from the College. Please see the Administering Drugs and Vaccines by Injection Information Sheet for more information on obtaining and maintaining authorization.

In addition to the MHSC requirements, Pharmacists must also comply with all CPhM regulations and practice directions on administering drugs and vaccines by injection. For information on CPhM requirements and for additional COVID-19 related resources, please see the COVID-19 Updates page.

CPhM continues to work with its partners at MHSC on the COVID-19 Vaccine Immunization Program. CPhM will continue to update registrants about the program through it COVID-19 Updates page, the bi-weekly Friday Five publication, and direct emails.

FEATURE

Safety IQ – Continuous Quality Improvement Coordinator

Community pharmacy managers are responsible for overseeing the implementation of Safety IQ, the College continuous quality improvement (CQI) program. The deadline for implementing Safety IQ in community pharmacies is **June 1, 2021.**

There will be many tasks and obligations that come along with implementing Safety IQ. The Medication Incidents and Near-Miss Events Practice Direction (in effect June 1, 2021) outlines the following requirements of the Safety IQ program:

- Anonymous reporting of medication incidents and near-miss events to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) National Incident Data Repository (NIDR) using a medication incident reporting platform that satisfies the Safety IQ Reporting Platform Criteria;
- Completing a safety self-assessment within the first year of Safety IQ implementation (or pharmacy opening) and every three years thereafter;
- Developing and monitoring the progress of improvement plans from review of medication incidents and near-miss events and the safety self-assessment; and
- Conducting of a formal CQI meeting with pharmacy staff at a minimum annually with informal huddles occurring as medication incidents occur and as deemed necessary.

Additionally, the pharmacy must have written policies and procedures for addressing, reporting, investigating, documenting, disclosing and learning from medication incidents and near-miss events.

Depending on the workload and size of pharmacy staff, it may be beneficial for an additional pharmacy staff member to assist the pharmacy manager with implementation and the ongoing practice of Safety IQ by acting as a Continuous Quality Improvement (CQI) Coordinator.

The CQI Coordinator can be a staff pharmacist or a pharmacy technician. The individual should be competent and confident in their understanding of Safety IQ elements and processes and have a real focus on improving safety. The CQI coordinator's responsibilities could include:

- Ensuring staff are trained on the use of the incident reporting program
- Ensuring incidents and near-misses are consistently reported and discussed
- Fostering communication on incidents and safety concerns
- Leading CQI meetings or informal huddles
- Conducting the Safety Self-Assessment with other pharmacy staff
- Educating staff relating to safe medication practices and other safety issues.

While it is recommended that the CQI coordinator oversees the activities described above, it is still the responsibility of the pharmacy manager to ensure that the pharmacy complies with the Safety IQ program and the practice direction requirements. Patients and pharmacies benefit most when all pharmacy staff are engaged and play a role in improving medication safety.

Forgeries for Codeine Cough Syrups on the Rise

The College of Physicians and Surgeons of Manitoba (CPSM), the College of Registered Nurses of Manitoba (CRNM), and the College of Pharmacists of Manitoba (CPhM) are aware of a large increase in prescription forgeries for liquid codeine preparations in January and February of 2021. A staggering 37 forgery reports, all for Ratio-Cotridin, have been made to the CPhM since January 1, 2021.

BACKGROUND & CURRENT SITUATION:

Ratio-Cotridin (Cotridin) is a prescription syrup with codeine, triprolidine, and pseudoephedrine as the main therapeutic ingredients. It is one of many prescription codeine syrups listed in the Health Canada Drug Product Database.

The 37 Cotridin forgeries reported *during the first two months of 2021* are a sharp increase compared to the total of 70 forgery reports received by CPhM for all drugs in 2020. Most forged prescriptions were presented in Winnipeg, however rural Manitoba locations such as Dauphin, Swan River, Steinbach, Selkirk, and Portage La Prairie have also been targeted. The forgeries were presented as computer generated prescriptions with forged ink signatures. Some forgery attempts have used fraudulent or invalid personal health identification numbers or individuals have claimed to be from out of province.

WHAT PHYSICIANS CAN DO:

Report Forgeries. Physicians should notify CPSM, CPhM, and the pharmacies involved upon becoming aware of forgeries. Likewise, pharmacies should alert prescribers of forgery attempts and notify CPhM.

Notify Police. If impersonated, physicians can report to local police authorities. If a patient's information was fraudulently used, the physician may review this with their patient and involve police if safety concerns arise.

Safeguard Practice. Reduce risk of theft and forgery by locking up all prescription pads, letterhead, and fax templates. Pharmacists may contact prescribers to verify prescriptions for codeine or other potential products of abuse, particularly if they seem unusual or concerning.

WHAT RN(NP)S CAN DO:

Report Forgeries. Nurse Practitioners should notify CRNM, CPhM, and the pharmacies involved upon becoming aware of forgeries.

Notify Police. If impersonated, RN(NP)s can report to local police authorities. If a patient's information was fraudulently used, the RN(NP) may review this with their patient and involve police if safety concerns arise.

Safeguard Practice. Reduce risk of theft and forgery by locking up all prescription pads, letterhead, and fax templates.

WHAT PHARMACISTS CAN DO:

Verify Suspected Forgeries. Pharmacists should contact the prescriber to confirm any unusual or concerning prescriptions prior to dispensing.

Report Forgeries. Pharmacists should notify the prescriber, CPhM and Health Canada Office of Controlled Substances of any forgery attempt. The Forgery Report Form for Controlled Substances can be found on the CPhM website here.

Notify Police. Pharmacists should report prescription forgeries to the local police authorities. Whenever possible, this should be done while the individual(s) is/are waiting in the pharmacy. If the individual requests the forgery back, the pharmacist should take a copy, stamp the original with the pharmacy contact information and document refusal to fill on the original and in DPIN.

WHAT CPSM, CRNM, & CPhM ARE DOING:

Education & Support.
CPSM, CRNM, and CPhM are working directly with prescribers and pharmacies involved in the forgeries.

Raise Awareness.
The Colleges are monitoring the situation and are collaborating to inform their broader registrant base of this trend, including risks to the public and actions to take.

CODEINE FORGERIES REPRESENT A PUBLIC SAFETY RISK:

The opioid crisis is well-documented in Canada. Codeine cough syrup misuse, abuse, and diversion is a known phenomenon. The Chief Medical Examiner's death review program, involving prescription medications, has shown that **codeine is one of the most frequently implicated opioids in overdose deaths in Manitoba.** Codeine is a prodrug with variable metabolism to morphine. Polypharmacy increases the risk of accidental overdose and death involving opioids.

Not all forgeries are identified; the number reported likely underrepresents the true prevalence. Collaboration and communication can help identify forgery attempts to decrease the risk of abuse or diversion, and to protect the public.

Concentrating on Concentrations

The following case study is a deidentified shared learning opportunity from the complaint resolution process involving a medication error with a pediatric patient. This incident highlights when contributing factors can increase the risk of serious patient harm. While this error occurred during the compounding process, the learnings and contributing factors are applicable in all pharmacy environments.

Levi is an 8-year old patient with a refill prescription for compounded clonidine suspension (0.01 mg/mL), which is to be filled at "Pharmacy A."

Events

Monday

On Monday, his parents arrive and pick-up Levi's compounded clonidine suspension (0.01 mg/mL) prepared and dispensed by "Pharmacy A."

Later that evening, Levi was given his first dose. He didn't feel well afterwards and went to bed early that night, which his parents noticed was unusual.

Tuesday

The next day, Levi had to be woken up, even though he usually had no problem waking up on his own. His parents noted that he "didn't seem like himself" and lacked his usual excitement. Throughout the day, Levi remained tired and listless compared to his normal behaviour. That evening he went to bed early and missed his second dose of clonidine.

Wednesday

When he received his dose on Wednesday morning, his parents noticed he became lethargic and had trouble breathing comfortably. His parents attributed this to the clonidine medication and took Levi to the hospital. Levi's parents also contacted "Pharmacy A" with their concerns. The pharmacy reviewed the prescription records to determine if an error had occurred.

Identification of the Medication Error:

The pharmacy's internal investigation found that when pharmacy staff was selecting the recipe for clonidine suspension within their software, the recipe for a 0.1 mg/mL concentration was selected instead of the correct recipe for a 0.01 mg/mL concentration, which resulted in a concentration ten times higher than prescribed.

The pharmacy manager contacted Levi's parents to acknowledge and apologize for the error but did not convey empathy or self-reflection, causing further concern by Levi's parents and subsequent filing of a complaint with the College.

Had Levi been given his evening dose, there is a significant likelihood that he would have suffered a devastating outcome.

Contributing Factors	Results
Staffing levels were particularly low for the demands at the pharmacy, both leading to, and on the day of, the medication error	Additional stress on staff causing a rushed work environment.
Multi-tasking during the final check as the only pharmacist on duty was trying to "juggle" multiple tasks when performing the final check.	Mental distraction and interruption during the final checking process causing an incomplete checking process.
Lack of patient counselling because the dispensing pharmacist assumed the family was familiar with the medication thinking it had been a transferred prescription.	No review of the prescription label with the patient's parents leaving the strength error unnoticed.
Overlapping labels may hinder the legibility of details on the label.	Identifying the incorrect strength may have been more difficult even in a complete final checking process and patient counselling session.

Learnings and Recommendations:

Staff Levels – Not just for pharmacy managers

All pharmacists have an obligation to ensure that the pharmacy work environment has adequate human resources (pharmacists, pharmacy technicians and other staff) to enable optimal practice and meet patient health care needs.

- advise pharmacy manager and/or owner of the risk to patient safety when insufficient staff levels become a concern and document your recommendation
- be persistent if change is not noted within a reasonable amount of time, reiterate your concerns
- use historic data to predict necessary staff levels (manager specific)

Patient Counselling - Always

Patient counselling is required on all prescriptions; even refills.

A counselling session, including the "show-and-tell" method and reading the label aloud to the patient, are valuable opportunities to catch errors together.

Responsibilities in a Medication Error

Apologize to the Patient/Advocate:

Upon learning of a potential medication error, immediately and sincerely apologize to the patient. Demonstrating empathy and self-reflection can promote the emotional healing of patients and pharmacy staff. Manitoba's Apology Act allows healthcare professionals the freedom to sincerely apologize without fearing their apology will affect their liability.

Investigation and Change

Investigate transparently, with outcomes focused on learning and change, not blame.

- identify where the system broke down
- identify changes that can cover the identified gap to reduce the chance of a similar incident from happening again
- implement the changes that have been identified as mitigating
- educate all staff to promote shared learning
- reassess the changes later to ensure that they have, in fact, addressed the concern they were implemented to address

For more information and best practices in responding to medication incidents and near misses, visit the Safety IQ webpage.

Conclusion

Medication errors are rarely the fault of the individuals involved. Most often, medication errors arise due to systemic factors that contribute to the occurrence of an error, regardless of the specific individuals involved.

The lessons from this case can be applicable to any pharmacy. They underline the importance of:

- ensuring adequate staff resources to support patient safety
- eliminating distractions during final checks
- counselling patients on every prescription; even refills
- showing compassion and authenticity apologizing when informed of a potential medication incident
- implementing procedural and policy changes to reduce the risk of recurrence
- sharing the learnings with all pharmacy staff

Resources

Code of Ethics
Community Pharmacy Safety Culture Toolkit
Medication Incidents and Discrepancies or Near-Miss Events Practice Direction
Patient Counselling Practice Direction
Safety IQ Homepage
The Apology Act

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

SK was a 63-year-old male who was found unresponsive in the front yard of his home on May 6, 2019. He was taken to hospital, but all attempts at resuscitation were unsuccessful. SK's past medical history included chronic pain (following a fall from his bike with left rib fracture in May 2018), hypertension, and depression. Shortly after his fall, SK visited the emergency room (ER) eight times (between May to July of 2018) requesting opioid analgesics due to ongoing left rib pain interfering with sleep. He was prescribed oxycodone/acetaminophen for the first two visits by ER providers but was not given any opioids in his subsequent six visits and told to follow-up with his regular health care provider. His regular care provider then regularly prescribed acetaminophen/codeine.

The immediate cause of death was determined to be accidental mixed drug toxicity (cocaine, codeine, amitriptyline, gabapentin).
A significant condition contributing to death was coronary artery disease.

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
Benzoylecgonine (main metabolite of cocaine)	827 mg/dL	--
Amitriptyline Nortriptyline (active metabolite) Total*	250 ng/mL 63 ng/mL 313^ ng/mL	 75 - 200
Codeine* Morphine	110 mg/mL 8.9 ng/mL	10 - 100 10 - 80
Alprazolam	41 ng/mL	20 - 70
Gabapentin*	42 ug/mL	2-20
Ethanol	23 ng/mL	--

^ Tricyclic antidepressants undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report.

SK'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	Pharmacy
Acetaminophen/ codeine	May 5, 2019 Apr 5, 2019 Mar 17, 2019 Mar 2, 2019 Mar 1, 2019 Feb 1, 2019	300/30 mg	120 120 60 60 120 120	30	Dr. X	XYZ Pharmacy
Alprazolam	May 5, 2019 Apr 5, 2019 Mar 17, 2019 Mar 2, 2019 Mar 1, 2019 Feb 1, 2019	0.5 mg 1 mg 1 mg 1 mg 1 mg 1 mg	120 60 30 30 60 60	30	Dr. X	XYZ Pharmacy
Amitriptyline	May 4, 2019 Apr 4, 2019 Mar 6, 2019 Feb 11, 2019	25 mg	30	30	Dr. YY	XYZ Pharmacy
Gabapentin	May 4, 2019 Apr 4, 2019 Mar 6, 2019 Feb 11, 2019	400 mg	180	30	Dr. YY	XYZ Pharmacy
Zopiclone	Apr 20, 2019 Mar 21, 2019	5mg	30	30	Dr. X	XYZ Pharmacy

Discussion

This patient was receiving multiple sedating medications, which is associated with an increased risk of opioid-related deaths[1-4] The risk of an opioid-related death is higher in those exposed to an opioid concurrently with gabapentin (adjusted odds ratio (aOR) 1.49, 95% CI 1.18 to 1.88)[1] and benzodiazepine (aOR 3.86, 95% CI 3.49-4.26)[3] compared to those taking an opioid prescription alone. Higher daily doses of sedating medications are more likely to be taken by individuals who experienced an opioid overdose compared to their matched controls.[5] Pharmacists can play a role in reducing the risk of opioid-related deaths by re-evaluating the use of combination sedating medications.

One strategy is to re-assess the efficacy and safety of medications to determine the need for continued use. For instance, evidence suggests that the efficacy of benzodiazepines diminish and dependence risk increases beyond 4-6 weeks of use, and there is evidence of safety risk associated with long-term use especially in older adults, such as accidents, injury, and cognitive impairment.[6] In this case, alprazolam and codeine were being used for a longer period than what would be recommended for anxiety (typically < 8 weeks for benzodiazepine)[7] or pain management (typically < 1 week for acute pain)[8]. Identifying barriers to treatment that offer a better efficacy and safety profile long-term (e.g., cognitive behavioural therapy for insomnia, selective serotonin

receptor inhibitors for anxiety) and setting realistic functional goals can help engage patients in making a change. Pharmacists can work with prescribers to help create a gradual taper schedule with frequent follow-up to reduce the risk of combination sedating medications.

Asking patients about the use of other substances can help identify potential drug interactions and determine whether safer pharmacotherapy options are available for the patient. This patient was taking amitriptyline in addition to cocaine with underlying coronary artery disease. Both amitriptyline and cocaine have cardiotoxic effects particularly at higher doses. Providing both patient and prescriber with information on potential risks and alternative options to reduce the risk could be helpful in this case.

This patient was also receiving an early refill March 2, and different prescribers were prescribing different psychoactive medications. More frequent follow-up with the patient may be required when dose changes are being made. It is also important to recognize potential red flags for early refill requests for psychotropic medications, including pattern of running out early, lost or stolen medication, and multiple self-sanctioned dose increases.[9] Limiting the dispensing quantity could be considered to reduce the risk of overdose or diversion of lost or stolen medication.

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

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8. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use - United States, 2006-2015. MMWR Morb Mortal Wkly Rep. 2017;66(10):265-9
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Reminder: CPSM Standards of Practice for Prescribing Opioids and Benzodiazepines and Z-Drugs

The College of Physicians and Surgeons of Manitoba (CPSM) Standard of Practice for Prescribing Opioids and the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs came into effect on September 30, 2018 and November 1, 2020, respectively.

Although the Standard of Practice for Prescribing Opioids and the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs are CPSM Standards, pharmacy staff must be familiar with the Standards and resources in their entirety and must adhere to these principles when dispensing these medications to ensure patient safety. The College of Pharmacists of Manitoba (CPhM) is currently developing a pharmacist companion document to these Standards.

CPhM is receiving calls from patients who were not informed of the changes to the prescribing and dispensing of their opioid, benzodiazepine and/or Z-drug medications and are confused why this occurred. Prescribers and pharmacists must work collaboratively and respectfully in providing safe and effective patient care. Both the pharmacist and prescriber should be educating patients on the requirements and importance of the new CPSM Standards and communicating how the Standards will affect the prescribing and dispensing of their opioid, benzodiazepine and/or Z-drug medications.

This is especially true when existing patients are affected by the new rules. Prescribers and pharmacists may need to discuss tapers as appropriate. Prescriptions may need to be altered or replaced and/or dispensing intervals adjusted, to meet the new Standard. Documentation of these conversations with prescribers and patients is key.

CPSM has created a Resource Document for Physicians on the Standard of Practice for Prescribing Opioids, which contains an FAQ and a list of references, guidelines, and continued education resources that may be beneficial to pharmacists.

CPSM has also created a Frequently Asked Questions Document around the Standard of Practice for Prescribing Benzodiazepines & Z-Drugs to help patients understand the Standard's recommendations. Specifically, the FAQs address common questions about:

- The risks and harms associated with benzodiazepines and Z-drugs;
- Reasons to attempt a taper and common experiences with tapering; and
- The new limitations around prescriptions and dispensing.

While this document is patient-focused, prescribers and pharmacists may find it beneficial to review as it can be a resource for patient care.

Pharmacy Technician Listing Renewal

Pharmacy technician listing renewals opened on March 15, 2021. The deadline for pharmacy technicians to submit their application for listing renewal is May 17, 2021, to be listed with the College by June 1, 2021. The pharmacy technician listing renewal must be completed through the Registrant Portal.

The pharmacy technician listing renewal includes declarations that outline the applicant's successful completion, or anticipated completion, of:

- performance review requirements;
- practice hour requirements;
- professional development (PD) requirements, including completion of the professional development module "Pause Before You Post: Social Media Awareness";
- submission of a recent satisfactory criminal record check, including a vulnerable sector search (vulnerable sector search not required if criminal record checks submitted before January 1, 2021), and
- submission of a recent original child abuse and adult abuse registry checks.

Pharmacy technicians must participate in a performance review with their pharmacy manager, or delegate, at the practice site at a minimum of every two years. This review must include documentation of:

- the total number of hours the pharmacy technician has worked (hours worked as a pharmacy assistant are not eligible under this requirement);
- an assessment of the pharmacy 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
- the completion of the PD requirement.

Pharmacy technicians are required to have worked for at least 600 hours in the preceding three-year period (starting three years after first qualifying).

The PD requirement for pharmacy technicians is a minimum of 15 hours of learning activities completed between June 1 and May 31 of each year. Of these 15 hours, a minimum of five hours must be from accredited learning activities, and the remaining 10 hours can be fulfilled by either accredited or non-accredited learning activities.

Virtual Inspections

Pharmacy site inspections play an important role in quality assurance and achieving the College mission: protecting the health and well-being of the public. Historically, all pharmacy inspections would occur in person. However, in February 2020, due to COVID-19 restrictions, processes for virtual site inspections were developed to help with social distancing and providing a safer alternative for both the inspectors and frontline workers. The College Field Operations department conducted the first virtual pharmacy inspection on May 27, 2020.

Currently, Field Operations uses a hybrid model of both virtual and in-person inspections:

Virtual inspections (typically occur in):

- pharmacy openings
- pharmacy renovations or relocations
- simple follow-up inspections

In-person inspections (typically occur in):

- routine inspections
- follow-ups on new pharmacy openings
- referrals from the discipline or complaints committees

What does a virtual inspection look like?

1. A virtual inspection begins with an information-gathering phase where a questionnaire and checklist are provided to the pharmacy manager via email.

2. Next, the pharmacy manager must provide the inspector with blueprints for a new pharmacy or renovation and pictures of the pharmacy site, which allows the inspector to be engaged earlier and identify potential issues sooner. In the case of new pharmacy openings, relocations, and renovations, many problems can be identified before construction and can allow for more straightforward resolution.

3. A virtual inspection can then be scheduled after the inspector has received answers to any outstanding questions and reviewed pictures reflecting the pharmacy's finished state.

4. The virtual inspection occurs over a Zoom conference and typically takes 60 minutes. Please note that the inspector will record the virtual inspection. During the inspection, the pharmacy manager will take the inspector through the entire pharmacy facility, using the camera on a mobile device. The inspector may ask questions, request to see certain parts of the facility, or review documentation.

5. At the end of the inspection, the inspector will provide the pharmacy manager with a summary, and an official report will follow via email. Any deficiencies identified during the inspection will require immediate correction.

Helpful Do's and Don'ts for Virtual Inspections:

DO Engage in the inspection process early. Field Operations is happy to answer your questions through email or over the phone.

DO Provide Field Operations with clearly labelled pictures reflective of the pharmacy's finished state.

DO Attend the virtual inspection using a device that is mobile, has a camera and is connected to the internet.

DON'T Schedule the virtual inspection for new openings, renovations, and relocations too far in advance. Field Operations recommend scheduling the inspection approximately one week in advance once the pharmacy is close to an operational state.

DON'T Provide pictures during construction unless you have questions related to it or field operations has requested the pictures.

DON'T Attend the virtual inspection using a laptop or desktop computer. This will not allow you to tour the pharmacy facility.

In Memoriam

Vernon Appleyard, February 26, 2021

Notice of 2021 AGM & Award Recipients

The College of Pharmacists of Manitoba will hold its 143rd Annual General Meeting on Saturday, May 8th, 2021. The Annual Awards Presentation will follow directly after the AGM. Please visit the College website for more information on how to register for the event.

Each year, the College allows pharmacists and members of the public to recognize excellence in pharmacy practice in Manitoba. Congratulations to this year's awards recipients and all of the pharmacists who went above and beyond their duties to advance the pharmacy profession for their patients and colleagues in 2020.

2020 PHARMACIST OF THE YEAR

This award is given annually to a Manitoba pharmacist who, in the opinion of his/ her peers, has made a significant contribution to the profession during his/her career, has been elected to office in provincial and/or national pharmacy organizations and possesses high practice standards and innovation.

Congratulations, Jennifer Ludwig

BONNIE SCHULTZ MEMORIAL AWARD FOR PHARMACY PRACTICE EXCELLENCE

The Bonnie Schultz Memorial Award for Practice Excellence is given on occasion to a pharmacist who demonstrates outstanding excellence in optimizing patient care, serving as a role model, demonstrating superior communication skills, and displaying compassion, empathy, and concern.

Congratulations, Colin Langedock

YOUNG LEADER AWARDS

This award is given to recently licensed pharmacists (practicing 1 to 5 years post-graduation) and to pharmacy students 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 College of Pharmacy.

Congratulations:

Karam Al-Bayati

Megha Kaushal

Courtney Lawrence

Leah Pritchett

Michael Szelemej

50-YEARS OF CONTINUOUS MEMBERSHIP

The following members are acknowledged for 50-years of continuous membership with the College:

Lorraine Deans

Penny Thackeray

James Mitchell

Elizabeth Van Middlesworth

Jeffrey Nowatzki

25-YEARS OF CONTINUOUS MEMBERSHIP

The following members are acknowledged for 25-years of continuous membership with the College:

Taky Akhnoukh

Theresa Marquez

Michael Armas

Beteros Mikhail

Jeanette D. Armas

Ebraam Morcos-Botros

Sheri Dyck

Vicki Perron

Leanne Gates

Nancy Remillard

Jennifer Gomes

Adel Shenoda

Ronald Scott Groen

Nadine Small denBrok

Robert Jaska

Lesley Trepel

Robert Kowalik

Commitment to Professional Development Certificate

Each year, the College recognizes individual pharmacists who have gone above and beyond the minimum professional development requirement and participated in 50+ hours of continuing professional development, with at least 30 hours of accredited learning time.

The College of Pharmacists of Manitoba Professional Development Division of the Quality Assurance Committee is delighted to acknowledge the following 96 pharmacists in achieving their Commitment to Professional Development Certificate for their outstanding participation in pharmacy practice learning opportunities throughout the 2019/2020 professional development year.

Joyce Adegbite
Ofelia Adriano
Rizwan Ahmed
Muinat Alayo
Marian Attia
Ayobola Ayowole-Obi
Kelsey Badger
Aline Baldasso
Allison Bell
B. Marie Berry
Gregory Boden
Jenna Bolton
Jaden Brandt
Steven Burczynski
Marina Cameron
Dayna Catrysse
William Cechvala
Ryan Chan
Lengim Chen Ingram
Marcin Cychowski
Sheril Cyriac
Prathmesh Deshmukh
Pritpal Dhanjal
Terry Dubyts
Cecile Dumesnil
Michael Dwilow
Saleh Emran
Ian Findlay
Grace Frankel
Jesse Franklin
Stephanie Geith
Jennifer Gibson
Rajinder Gill
Ruby Grymonpre
Erika Hartel
Warren Hicks
Lorraine Hilderman
Joseph Ho
Tara Hoop
Curtis Hughes
Shannon Hunter
Harris Iacovides
Katherine Jantz
Sabiha Kanwal
Samantha Kendall
Emily Klekta
Meghann Klowak
Christopher Lawson
Katherine Lewis
Christopher Louizos
Dora Ma
Janice Macalino
Heather MacPhee
Amarjeet Makkar
Tara Maltman-Just
Nicholas Malzahn
Tara Jean Martin
Kimberly McIntosh
Anokhi Mehta-Sachdev
Arlene Nabong
Khanh Nguyen
Jason Nutbean
Jodi Pagaduan
Arpitaben Patel
Ketankumar Patel
Jaimin Patel
Caterina Pearson
Ryan Persaud
Kristine Petrasko
Siegfried Pfahl
Mathilda Prinsloo
Petr Prochazka
Janine Rivest
Ligy Russel
Marina Saad
Jean Monique Sanchez
Alison Skrypetz
Timothy Smith
Andrea Spillett
Schalk Strydom
Alice Studney
Mandeep Taggarh
Meera Thadani
Douglas Thidrickson
Tinu Thomas
Keith Tibbatts
Ashley Walus
Travis Warner
Danica Wasney
Holly Watts
Monica Wong
Horst Wuerfel
Amanda Young
Amir Youssef
Osama Zaki
Lisa Zaretzky

Decision and Order of the Discipline Committee: Jeffrey Froese

Pursuant to the Notice of Hearing (the "Notice") dated August 11, 2020, a hearing was convened by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the College offices, 200 Tache Avenue, Winnipeg, Manitoba, on September 23, 2020, with respect to charges formulated by the Registrar of the College alleging that Mr. Jeffrey Froese, 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 July 2019 and October 2019, at Ebbeling Pharmacy (the "Pharmacy") located at 722 Watt Street, Winnipeg, Manitoba, Mr. Froese diverted, for his personal use, Tramadol® 200 mg in contravention of Statements VIII and X of the Code of Ethics, or either of them.

The hearing into the charges convened on September 23, 2020. Mr. Jeffrey Hirsch ("Mr. Hirsch") appeared as counsel on behalf of the Complaints Committee (the "Committee"). Mr. Grant Stefanson ("Mr. Stefanson") appeared with and on behalf of Mr. Froese. Mr. Joseph Pollock ("Mr. Pollock") appeared as counsel to the Discipline Committee (the "Panel").

A Statement of Agreed Facts was filed in which Mr. Froese:

1. admitted his membership in the College.

2. admitted valid service of the Notice of Hearing dated August 11, 2020, and that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act.

3. had no objection to the composition of the Panel or to legal counsel for the Panel on the basis of bias, a reasonable apprehension of bias or a conflict of interest.

4. indicated he graduated with his pharmacy degree from the University of Manitoba in 2010.

5. indicated he was registered as a pharmacist under the Act since December 15, 2010.

6. admitted that at all times material to this proceeding, he was a member of the College as a practising pharmacist in Manitoba.

7. indicated that as of April 1, 2014, he became an owner of the Pharmacy and held the position of pharmacy manager from February 1, 2015 to July 16, 2015.

8. indicated that he voluntarily surrendered his pharmacist's licence on July 16, 2015.

9. admitted he was disciplined by the College through a decision and order of the College's Discipline Committee dated January 17, 2017 (the "Discipline Order").

10. admitted that the Discipline Order provided that he:

    a. pay a $25,000 fine;

    b. pay a $12,000 contribution to costs;

    c. was prohibited from being a pharmacy manager until January17, 2022;

    d. was prohibited from being a preceptor until January17, 2022;

e. continue with updated counselling for two years;

f. submit to random drug and alcohol screening (at his cost) for two years;

g. continue to meet regularly with Pharmacists at Risk for two years; and,

h. complete in 2017 at least 10 hours of additional professional development in accredited ethics

11. indicated he resumed practice as a pharmacist on March 16, 2017.

12. admitted that following a relapse in December 2017, he again voluntarily surrendered his pharmacist's licence on January 26, 2018.

13. admitted that as a result, he was the subject of a Registrar's referral to the Complaints Committee (the "Committee") dated February 22, 2018.

14. admitted that he underwent a Fitness to Practice Assessment on August 29, 2018, which recommended various addiction support mechanisms; and follow all recommendations as outlined by the College.

15. admitted that following a meeting with the Committee on October 16, 2018, he signed a Gradual Return to Practice Agreement dated October 24, 2018, as well as a drug and alcohol screening undertaking on October 30, 2018 with the College (the "Undertaking") and his pharmacist's licence was reinstated effective November 28, 2018.

16. admitted that it was identified by the Pharmacy staff on October 21, 2019, that in 2019, on four occasions between July 25, 2019 and October 4, 2019, a bottle of 100 tablets of Tramadol 200 mg was ordered, delivered to, and paid by the Pharmacy, but not tracked on the Pharmacy Inventory Control log and never entered into stock.

17. admitted that the College received information about Mr. Froese from his Pharmacy Manager, on October 21, 2019, which indicated that Mr. Froese admitted to the Pharmacy Manager that he had diverted Tramadol from the Pharmacy for his own use.

18. admitted that Tramadol is a drug with opioid-like effects, including central nervous system depression/sedation, and is used for the management of moderate to moderately severe pain

19. admitted that the Tramadol Product Monograph outlines serious warnings and precautions with respect to its use due to risks of addiction, abuse and misuse which can lead to overdose and death. The Monograph states that the drug should be stored securely, to avoid theft or misuse. Further, the Monograph states, "Dependence and abuse, including drug-seeking behavior and taking illicit actions to obtain the drug are not limited to those patients with prior history of opioid dependence. The risk in patients with substance abuse has been observed to be higher."

20. admitted that pursuant to the Undertaking, between July 25 and October 4, 2019, he was being treated by various addiction recovery supports.

21. admitted that he never informed addiction recovery supports of his use of Tramadol during this period of time and denied substance use.

22. admitted that his last use of Tramadol was on October 22, 2019.

23. admitted that Tramadol was not actively prescribed to him by any practitioner and that he diverted this medication to himself without following any of the required processes.

24. admitted that his use of Tramadol at the time was not exclusively for symptom management but was in fact a drug of abuse.

25. indicated that he met with the Registrar and Deputy Registrar of the College on October 22, 2019, and admitted diverting 400 Tramadol tablets from the Pharmacy for his own use.

26. indicated that he voluntarily surrendered his pharmacist's license for the third time on October 22, 2019.

27. agreed that this matter was referred to the Committee by way of a subsection 32(b) Registrar's referral dated November 25, 2019.

Mr. Froese entered a plea of guilty to the count against him in the Notice.

Mr. Hirsch advised that the parties would make a joint recommendation to the disposition.

The parties submitted that in accordance with sections 54, 55 and 56 of the Act:

1. Mr. Froese be suspended from acting as a pharmacist until December 22, 2020, following which his pharmacist licence would be reinstated on December 23, 2020, subject to his compliance with the conditions set out herein;

2. *prior to resumption of practice, Mr. Froese must successfully complete the PROBE Ethic and Boundaries Program https://www.cpepdoc.org/cpep-course/probe-ethics-boundaries-program-canada offered by The Criminalization and Punishment Education Project Canada;

3. prior to resumption of practice, Mr. Froese must participate in a mental health and addiction evaluation conducted by the College's third-party service provider to establish his fitness to resume practice;

4. upon resumption of practice, Mr. Froese be prohibited for a five-year period from ordering or receiving drugs covered under the Controlled Drugs and Substances Act, the Narcotic Control Regulations, the Food and Drug Regulations, and/or the Benzodiazepines and Other Targeted Substances Regulations;

5. Mr. Froese be permitted to work as a pharmacist only under the supervision of another pharmacy staff member for a period of five years;

6. Mr. Froese be prohibited from being a manager or preceptor for a period of five years;

7. Mr. Froese participate in and successfully complete a mandatory five-year monitoring program which includes drug screening and addiction support reporting;

8. Mr. Froese enter into a "Last Chance Agreement" with the College in an agreed upon form; and,

9. Mr. Froese pay a contribution to the costs of the investigation and hearing in the amount of $4,000.

After having reviewed the authorities provided to the Panel and having considered the joint recommendation on disposition submitted by the parties, this panel orders that:

1. Mr. Froese be suspended from acting as a pharmacist until December 22, 2020;

2. *within 120 days of resuming practice, Mr. Froese must successfully complete the PROBE Ethic and Boundaries Program https://www.cpepdoc.org/cpep-course/probe-ethics-boundaries-program-canada offered by The Criminalization and Punishment Education Project Canada;

3. prior to resumption of practice, Mr. Froese must participate in a mental health and addiction evaluation conducted by the College's third-party service provider to establish his fitness to resume practice;

4. upon resumption of practice, Mr. Froese is prohibited for five years from ordering or receiving drugs covered under the Controlled Drugs and Substances Act, the Narcotic Control Regulations, the Food and Drug Regulations, and/or the Benzodiazepines and Other Targeted Substances Regulations;

5. Mr. Froese must work as a pharmacist only under the supervision of another pharmacy staff member for a period of five years;

6. Mr. Froese be prohibited from being a manager or preceptor for a period of five years;

7. Mr. Froese must participate in and successfully complete a mandatory five-year monitoring program which includes drug screening and addiction support reporting;

8. Mr. Froese shall enter into a "Last Chance Agreement" with the College in an agreed upon form; and,

9. Mr. Froese shall pay a contribution to the costs of the investigation and hearing in the amount of $4,000.

In arriving at its decision, the Panel considered Mr. Froese's admission of guilt, and the nature of cooperative discussions. The Panel acknowledges and supports that counsel engaged in a collaborative process in establishing a joint recommendation to the disposition in this matter.

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

DATED at Winnipeg, Manitoba this 5th day of November, 2020.

*In paragraph 2 of their joint recommendation, Mr. Hirsch and Mr. Stefanson recommended that prior to resumption of practice, Mr. Froese must successfully complete the PROBE Ethic and Boundaries Program offered by The Criminalization and Punishment Education Project Canada. On October 26, 2020, Mr. Stefanson advised Mr. Pollock and Mr. Hirsch that the earliest available date for the PROBE Ethic and Boundaries Program is February, 2021. As a result, Mr. Hirsch and Mr. Stefanson recommended to the Panel, and the Panel agreed, to amend paragraph 2 of the disposition by deleting the words "prior to resumption of practice" and replacing them with the words "within 120 days of resuming practice"

Pharmacist Licensure Decisions

1. Effective March 7, 2021, the practicing license of Mr. Lance Breland (College License No. 35053) has been cancelled, in accordance with section 23(1)(c) of The Pharmaceutical Act.

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

2. Effective March 24, 2021, the practicing license of Mr. Scott Putz (College License No. 35345) has been interim suspended pending a review of the matter by the complaints committee, in accordance with section 24(1) of The Pharmaceutical Act.

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