College of Pharmacists of Manitoba

NEWSLETTER

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CPhM Launches Social Media

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2023 Award Recipients

Professional awards and service recognitions were presented at a virtual program, following the 145th Annual General...

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

The mandate of the College of Pharmacists of Manitoba is to serve and protect the public interest.

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

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Safety.
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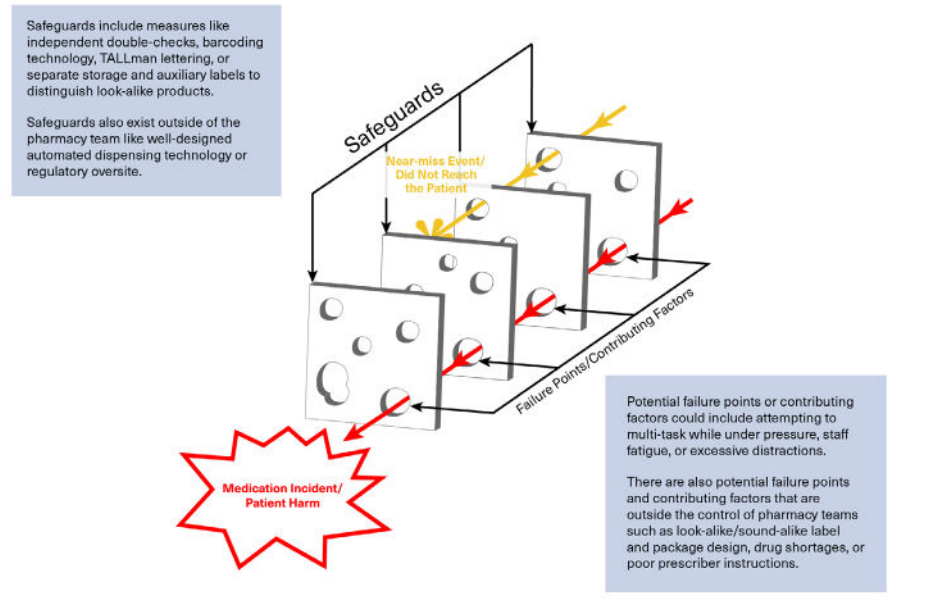
Safety Feature:
Near-Miss Event Reporting: A Proactive Approach to Patient Safety and System

Near-miss events in healthcare are incidents where harm or injury was prevented because of timely intervention or good luck. James Reason's[1] Swiss cheese model can help us understand the high-stakes value of reporting and learning from near-miss events. The Swiss cheese model is a framework for understanding how accidents or safety incidents can occur in complex systems like healthcare. It is based on the that idea that overlapping safeguards against accidents or incidents still contain potential failure points that can coalesce into a harmful occurrence or catastrophe:

Swiss Cheese Model: Medication Incidents and Near-Miss Events in Community Pharmacy Practice
Adapted from Reason (1990).



From this perspective, a near-miss event is both a warning and an opportunity. Near-miss events can tell us something about the 'holes' in our defense systems without the tragic outcome of patient harm. They hold significant value and should be reported and analyzed. Near-miss events are an opportunity to improve the entire system of medication safety stretching beyond your pharmacy practice.

Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. For 2023, Safety IQ Academy will feature blog posts and recommendations based on ISMP Canada's Multi-Incident Analysis of Incidents Associated with Harm Reported by Community Pharmacies in Manitoba.

- Strategies for Enhancing Patient Engagement and Identification
  Patient identification and engagement are common contributing factors to medication incidents. These two simple safety recommendations can help prevent an incident.

- 5 Recommendations for Safer Vaccine Administration
  COVID-19 vaccines were rapidly introduced and a spike in medication incidents followed. Learn more about making vaccine administration after today with these five key recommendations.

- 3 Key Recommendations for Safer Opioid Agonist Therapy in Community Pharmacy
  Opioid agonist therapy (OAT) is a high-risk process with potential to cause serious harm and death. Learn how your pharmacy's OAT practice can be improved.

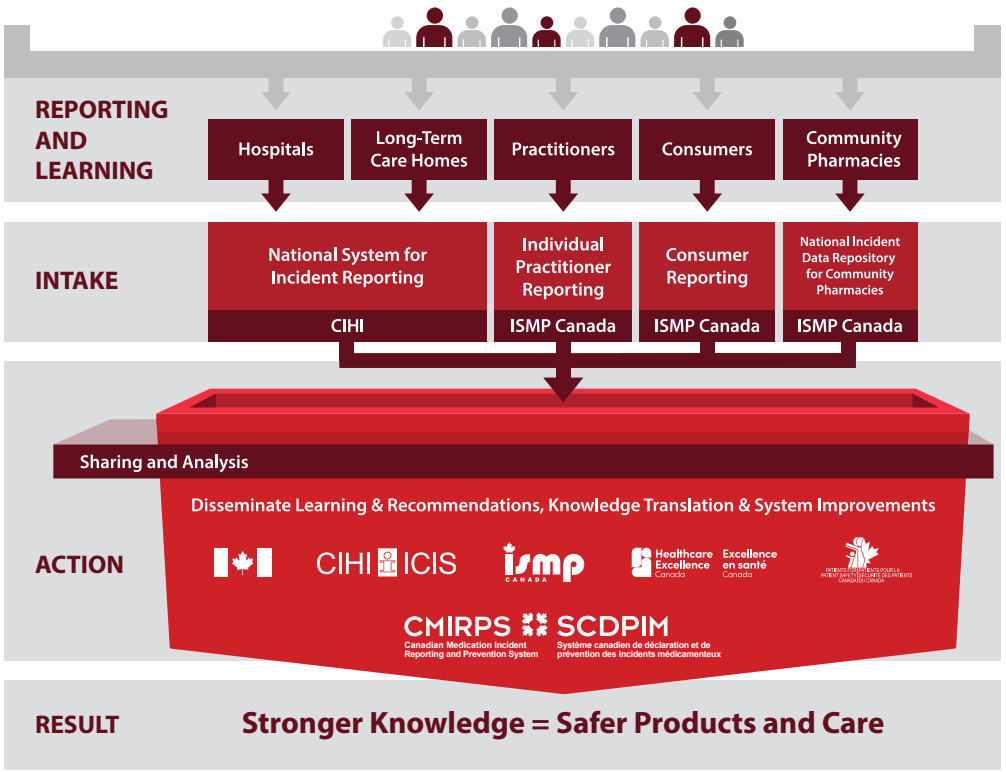
Three Reasons to Encourage and Support Near-Miss Event Reporting

Non-punitive near-miss event reporting in community pharmacy is crucial for improving patient safety and identifying potential areas of weakness in the system. By reporting near-miss events in a non-punitive environment, healthcare providers can create a culture of safety and accountability, ultimately improving the quality of care provided to patients. Here are three key reasons you should make a habit of reporting near-miss events:

1. **Reporting and analyzing near-miss events improves overall quality of patient care.**
Near-miss events provide valuable information to your pharmacy team about potential weaknesses in your systems or processes. When your team consistently reports and analyzes near-miss event, they are taking advantage of an opportunity to identify the root causes of future harm to a patient. Near-misses offer key insights into medication safety.

2. **Near-miss event reporting supports a culture of safety.**
When pharmacy professionals feel safe reporting near-miss events, they are more likely to report actual medication incidents. A culture of safety can foster a sense of accountability and responsibility among your team. They are more likely and more able to identify potential areas of improvement and take action to address them.

3. **Near-miss event reports provide valuable data to national change and policy influencers without patient harm.**
Your team's near-miss event and incident data flows to the National Incident Data Repository (NIDR) for Community Pharmacies. Your de-identified near-miss event and incident data is analyzed by experts at ISMP Canada who share their insights with healthcare professionals across Canada through Safety Bulletins and educational events.



Equally important, the data you submit contributes to improving the conditions for medication safety that are beyond the control of any one pharmacy. One example of this is ISMP Canada's Good Label and Package Practices Guides. These documents provide guidance and recommendations to drug manufacturers to support the design and development of clear and effective packaging to prevent medication incidents. Your near-miss event reports can contribute to wider regulatory change to support the prevention of incidents like those related to package design and branding (think look-alike, sound-alike drug mix-ups). And they contribute value to pharmacy practice without the impacts of patient harm.

Near-miss event reporting is important because it helps improve patient safety, creates a culture of safety and accountability, and provides valuable data for quality improvement initiatives.

[1] Reason, J. (1990) Human Error. Cambridge University Press, Cambridge.

Safety Measures

Data Reports from the NIDR

Data matters! Statistical reports from the National Incident Data Repository (NIDR) for Community Pharmacies bring awareness to the common types of incidents and near-miss events in Manitoba and can focus the improvement efforts of pharmacy professionals and the College. Here are the latest provincial and national reports from the NIDR:

NIDR for Community Pharmacy Manitoba Safety Brief: Incorrect Dose/ Frequency Top Contributor to Manitoba Incidents

The NIDR Manitoba Safety Briefs are your report data in action. Use them as a tool to talk about medication incidents, near-miss events, and potential improvements in your pharmacy. The Manitoba Safety Brief for April – September 2022 includes:

- Prevention strategies for incorrect dose/frequency incidents related to direct oral anticoagulants;
- Number of incidents received by the NIDR;
- Top five types of incidents reported;
- Level of harm from reported incidents; and
- Medication safety tips to prevent "incorrect drug" errors.

Thank you for your commitment to continuous quality improvement. Each report you submit to the NIDR contributes to provincial, national, and international learning about medication incidents and near-miss events. You are contributing to a broad movement to improve pharmacy practice and reduce the risk of patient harm.

NIDR for Community Pharmacies National Snapshot: Top 10 Medications Causing Harm (2016-2021)

The NIDR National Snapshot shares information about the types of medication incidents reported by community pharmacies across Canada. Use the Top Ten Medications Causing Harm report to review your pharmacies practices in relation to preparing and dispensing these medications.

Resources for Professional Development

ISMP Canada Safety Bulletins

- Reported Concerns with Labelling and Packaging of High-Alert Medications in Vials and Ampoules: A Multi-Incident Analysis (February 15, 2023)
- "No Drug Selected" = Taking the Smart Out of Smart Pumps (January 26, 2023)

ISMP Canada Learning Opportunities

The following learning opportunities are available at https://ismpcanada.ca/education/:

- Incident Analysis and Proactive Risk Assessment
- Multi-Incident Analysis and Medication Safety Culture Assessment
- Medication Reconciliation and Best Possible Medication History
- Keeping Pediatric Patients Safe: Pediatric Safety Consideration for Community Pharmacists
- Application of TALLman Lettering for High Alert Drugs in Canada

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Presidents Address

Dear Colleagues,

I hope this message finds you in good health and high spirits as we continue to make progress and pursue excellence within the pharmacy profession. With great pleasure, I bring you the latest updates and highlights from the College of Pharmacists of Manitoba (CPhM) in this edition of our Spring Newsletter.

First, I am thrilled to share that the Safety IQ Blog has been revamped to provide you with valuable insights and actionable information for continuous quality improvement within your pharmacy. This year, the Safety IQ Academy will feature blog posts and recommendations based on ISMP Canada's Multi-Incident Analysis of Incidents Associated with Harm reported by community pharmacies in Manitoba. I encourage you to explore the blog and take advantage of the valuable resources it offers. In line with our commitment to enhancing patient safety, I want to draw your attention to Safety IQ's latest article, which highlights the three key reasons why reporting near-miss events is crucial. By making it a habit to report such incidents, we contribute to a culture of continuous learning and improvement.

Furthermore, I would like to highlight an insightful de-identified case study from the Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office. This case study offers an invaluable opportunity for education and self-reflection for all pharmacy professionals, allowing us to continually enhance our practices and patient care. CPhM's continued collaboration and partnership with the Office of the Chief Medical Examiner demonstrates our commitment to continuously expand and develop quality improvement practices.

The CPhM Annual General Meeting was hosted virtually on Tuesday May 2nd, 2023, and was a great success. I am happy to announce that the 2023 professional awards and service recognitions were presented during the event. You can find the list of recipients within this edition of the CPhM Newsletter. Congratulations to all the deserving individuals who were honoured for their exceptional contributions to our profession in the interest of patient safety.

Last, I am thrilled to share that CPhM has embraced the power of social media to foster stronger communication and engagement with pharmacy professionals, the public, and our valued partners and stakeholders. We have established new social media channels and invite you to connect with us to stay informed about the latest news, updates, and initiatives. Join us in this exciting venture as we enhance our collective impact and collaboration.

Thank you all for your dedication and commitment to the pharmacy profession. Your unwavering efforts contribute to the betterment of patient care and the advancement of our field. Let us continue working together to promote excellence, innovation, and continuous improvement.

Sincerely,

Jane Lamont
President, CPhM

"Join us in this exciting venture as we enhance our collective impact and collaboration."

Decision and Order of the Discipline Committee: Sara Haverluck-Watson

Pursuant to the Notice of Hearing dated May 1, 2019 (the "Notice"), a hearing was conducted by the Discipline Committee of the College of Pharmacists of Manitoba (the "College") at the law offices of Thompson Dorfman Sweatman LLP, Suite 1700 at 242 Hargrave Street, Winnipeg, Manitoba on November 21, 2022, with respect to charges alleging that Sara Haverluck-Watson, 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 has 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 January 2017 and February 2019, at the Dauphin Clinic Pharmacy, located at 622-3rd Street SW, Dauphin, Manitoba, in her capacity as a pharmacist and/or pharmacy manager:

1. That in or about May of 2018 Ms. Haverluck-Watson failed to manage and control the controlled drug inventory, resulting in discrepancies in 10 controlled drugs as counted by Health Canada in contravention of section 43 of the Narcotic Control Regulations, C.R.C. c1041 (the "NCRs"), section G.03.012 of the Food and Drug Regulations C.R.C. c870 (the "FDRs"), subsection 7(1)(b) of the Benzodiazepines and Other Targeted Substances Regulations (the "BOTSRs"), sections 2.3.1 and 2.3.2.4 of Practice Direction: Drug Distribution and Storage (the "DDS") and/or Statement I of the College's Code of Ethics (the "Code"), or any of them.

2. That on nine separate occasions between September 22, 2018 and February 23, 2019 Ms. Haverluck-Watson failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada, in contravention of section 42 of the NCRs, section G.03.013 of the FDRs, subsections 7(1)(b) of the BOTSRs and/or 2.3.2.5 of the DDS, or any of them.

3. That on nine separate occasions between September 22, 2018, and February 23, 2019 Ms. Haverluck-Watson failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the College, in contravention of 2.3.2.5 of the DDS and/or Statement I of the Code, or either of them.

4. That between January 2017 and February 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "A". with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Pharmaceutical Regulation, 185/2013 (the "Regulation") to the Act, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, and 2.5 of the Practice Direction: Ensuring Patient Safety (the "EPS"), Recommendations 8 and 9 of the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain (the "Guideline") and/or Statements I, II, VII, IX of the Code, or any of them.

5. That between January 2017 and March 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "B" with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Regulation, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, 2.5 of the EPS, Recommendations 8 and 9 of the Guideline and/or Statements I, II, VII, IX of the Code, or any of them.

6. That between January 2017 and February 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "C" with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Regulation, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, 2.5 of the EPS, Recommendations 8 and 9 of the Guideline and/or Statements I, II, VII, IX of the Code, or any of them.

At the hearing, Jeff Hirsch attended as legal counsel to the Complaints Committee, John Myers attended with, and as legal counsel to Sara Haverluck-Watson, and David Marr attended as legal counsel to the Panel of the Discipline Committee (the "Panel").

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

I. Jurisdiction, Service and Panel Composition

1. Sara Haverluck-Watson admitted her membership in the College.
2. A Notice of Hearing was issued on May 1, 2019.
3. Ms. Haverluck-Watson admitted valid service of the Notice and that the College has complied with the requirements of sub-sections 46(2) and 46(3) of The Pharmaceutical Act, CCSM c. P60.
4. Ms. Haverluck-Watson 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.

II. Practice and Discipline History

5. Ms. Haverluck-Watson graduated with her pharmacy degree from the University of Manitoba in 2001.
6. Ms. Haverluck-Watson had been registered as a pharmacist under the Act commencing on July 3, 2001.
7. At all times material to this proceeding, Ms. Haverluck-Watson was a member of the College as a practising pharmacist in Manitoba.
8. Ms. Haverluck-Watson's employment history was as follows:

    a) beginning in April 2002, Ms. Haverluck-Watson was employed by Shoppers Drug Mart;
    b) September 2003 to May 2006: Ms. Haverluck-Watson was employed at The Canadian Pharmacy;
    c) beginning in June 2006, Ms. Haverluck-Watson was employed at Dauphin Clinic Pharmacy;
    d) beginning in March 2009, Ms. Haverluck-Watson was employed at Winnipegosis Clinic Pharmacy;
    e) as at November 2011 Ms. Haverluck-Watson was employed at Dauphin Clinic Pharmacy (the "Pharmacy"); and,
    f) as at December 2012 Ms. Haverluck-Watson was employed as the pharmacy manager at the Pharmacy.

9. Ms. Haverluck-Watson has no previous discipline history with the College.

III. Admissions and Plea

10. Ms. Haverluck-Watson had reviewed the Notice as well as this Statement of Agreed Facts. She admitted the truth and accuracy of the facts in this Statement and that the witnesses and other evidence available to the College would, if called and otherwise tendered, be substantially in accordance with these facts.
11. Ms. Haverluck-Watson tendered no evidence and admitted that the conduct described in this Statement demonstrates professional misconduct as described in section 54 of the Act.
12. Ms. Haverluck-Watson agreed to enter a plea of guilty to counts 1, 2, 3, 5, 6, and 8 as set out in the Notice.
13. Ms. Haverluck-Watson agreed that her guilty plea is voluntary, unequivocal, and informed.
14. The College will be entering a stay of proceedings with respect to counts 4 and 7 of the Notice.

IV. Facts and Background

15. On or about September 19 and 20, 2017, the Health Canada Office of Controlled Substances ("Health Canada") conducted a controlled substances inspection at the Pharmacy. During the inspection, the Health Canada inspector counted 24 controlled substances and 22 of the substances were deemed unacceptable variances. The Health Canada inspector was unable to complete section C2 Accountability Reconciliation of the inspection form as there was no reliable sales data available.
16. Health Canada sent a copy of its Inspection Report to Ms. Haverluck-Watson on or about October 2, 2017.
17. On October 16, 2017, Ms. Haverluck-Watson replied in writing to Health Canada's Inspection Report.
18. On November 8, 2017, Health Canada sent correspondence to the College advising it of the inspection and identifying its findings and the identified narcotic accountability issues.
19. On May 22 and 23, 2018, Health Canada and the College conducted a joint controlled substances inspection as a follow up on the September 2017 inspection. On July 3, 2018, the College sent the Inspection Reply report to Ms. Haverluck-Watson.
20. On July 12, 2018, Ms. Haverluck-Watson replied in writing to Health Canada.
21. On July 30, 2018, Ms. Haverluck-Watson sent the completed inspection reply form to the College.
22. On August 14, 2018, Ms. Susan Lessard-Friesen, the then-Registrar of the College, made a referral to the College's Complaints Committee (the "Committee").
23. On or about February 14, March 7 and 20, 2019, Mr. Ken Zink, a College Investigator (the "Investigator") conducted telephone interviews with Ms. Haverluck-Watson. On or about March 11, 2019, Ms. Haverluck-Watson forwarded certain information from the Pharmacy including narcotic reports for January 2019.
24. On or about March 15, 2019, Ms. Haverluck-Watson advised the Investigator by email that the Pharmacy had started a fentanyl exchange program in 2017 and provided narcotic reports for December 2018 and February 2019.

25. Mr. Zink submitted his Investigation Report to the Committee on March 21, 2019.
26. The Notice was issued on May 1, 2019.

Count 1

1.1 That in or about May of 2018 Ms. Haverluck-Watson failed to manage and control the controlled drug inventory, resulting in discrepancies in 10 controlled drugs as counted by Health Canada in contravention of section 43 of the Narcotic Control Regulations, C.R.C. c1041 (the "NCRs"), section G.03.012 of the Food and Drug Regulations C.R.C. c870 (the "FDRs"), subsection 7(1)(b) of the Benzodiazepines and Other Targeted Substances Regulations (the "BOTSRs"), sections 2.3.1 and 2.3.2.4 of Practice Direction: Drug Distribution and Storage (the "DDS") and/or Statement I of the College's Code of Ethics (the "Code"), or any of them.

1.2 During the inspection conducted by Health Canada and the College in May 2018, the inspectors oversaw a physical inventory count of 18 controlled substances within the Pharmacy. Numerous discrepancies were noted in the count.

1.3 During the same inspection, Health Canada conducted an Accountability Reconciliation and determined that nine drugs had unacceptable variances.

1.4 At the time of the May 2018 inspection, the Pharmacy lacked the means to maintain an accurate inventory and had difficulty accounting for all narcotics, controlled drugs and targeted substances stored within the Pharmacy. The inability to maintain an accurate inventory presents a patient safety issue, as the Pharmacy is unable to accurately identify loss, theft, or potential dispensing errors.

1.5 Prior to the May 2018 inspection, the pharmacy conducted advance billing of bubble packed controlled substances, employed software that was inadequate for tracking controlled substance brand changes, and stored controlled substances in automated filling machines, all of which impaired the ability of Ms. Haverluck-Watson to conduct an accurate inventory.

Counts 2 and 3

2.1 That on nine separate occasions between September 22, 2018 and February 23, 2019 Ms. Haverluck-Watson failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada, in contravention of section 42 of the NCRs, section G.03.013 of the FDRs, subsections 7(1)(b) of the BOTSRs and/or 2.3.2.5 of the DDS, or any of them.

3.1 That on nine separate occasions between September 22, 2018, and February 23, 2019 Ms. Haverluck-Watson failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the College, in contravention of 2.3.2.5 of the DDS and/or Statement I of the Code, or either of them.

3.2 All discrepancies in the inventory of narcotics, controlled drugs and targeted substances should be investigated and reconciled. Any losses that cannot be reconciled or explained must be reported to Health Canada and to the College within 10 days of discovery.

3.3 In the inspection report dated October 2, 2017, Health Canada inspectors indicated that the Pharmacy had not submitted a loss/theft report within the last year, despite negative balances being found in the drug inventory reports with no explanation.

3.4 On October 31, 2017, Ms. Haverluck-Watson was emailed a notice from Health Canada outlining the importance of reporting all unexplained negative discrepancies, even if the shortage was a single tablet.

3.5 After the initial Health Canada inspection of September 2017, Ms. Haverluck-Watson conducted 16 narcotic and controlled drug audits within the Pharmacy. The first seven of these showed very significant shortages and were reported to Health Canada and the College.

3.6 Despite every one of them revealing unexplained missing narcotics or controlled substances, the subsequent nine counts were not reported at all.

Count 5

5.1 That between January 2017 and February 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "A" with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Pharmaceutical Regulation, 185/2013 (the "Regulation") to the Act, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, and 2.5 of the Practice Direction: Ensuring Patient Safety (the "EPS"), Recommendations 8 and 9 of the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain (the "Guideline") and/or Statements I, II, VII, IX of the Code, or any of them.

5.2 During the May 2018 inspection conducted by Health Canada and the College, Ms. Rani Chatterjee-Mehta, Assistant Registrar – Quality Assurance, reviewed a number of prescriptions filled at the Pharmacy to ensure prescription validity and proper dispensing practices and identified four patients of the Pharmacy who had been using high-dose opioids for prolonged periods of time of at least 1400 MEQ/day.

5.3 The Guideline recommends a dosage of not more than 90mg MEQ/day as a watchful dose of opioids, where the balance between benefits and harms often becomes unfavorable. When the use of a medication or its dosage is outside of standard practice, there is a risk of serious harm to the patient. In such circumstances, pharmacists should include documentation with each dispensation that records:

a) Counselling points provided to the patient related to safety;
b) Discussion with the patient of any adverse effects experienced;
c) Determination with the patient if the goals of therapy are being met;
d) Any early refill requests;
e) Upon an initial concern and when new or repeated concerns arise, discussion with the prescriber about concerns related to lack of benefit and/or potential for harm, appropriate tapering plan options, considerations for referral as appropriate and the prescriber's subsequent response; and
f) The pharmacist's plan for follow up.

5.4 In addition, when communicating concerns with the prescriber, the discussion ought to include clarification of the dose, current standards of practice or Guideline recommendations, the specific safety implications, options for the best course of action, and the pharmacist's recommendation based on the discussion.

5.5 Patient "A" was prescribed opioids from a physician at the Dauphin Medical Clinic since 2002 for multiple orthopedic injuries affecting his neck, low back and chest. In 2011, patient "A" was switched from oral narcotics to fentanyl patches.

5.6 In July 2012, the dose was titrated to 500mcg per hour every three days which equates to approximately 1800-2020 MEQ/day.

5.7 On July 5, 2012, the Pharmacy contacted the prescribing physician at which time the physician indicated that they were aware that the dosage exceeded the guidelines in place at that time.

5.8 In February 2017, through a new prescriber, the dosage for patient "A" was tapered to 300mcg per hour every three days. This represents a 40% reduction in dose, while 10% would be standard practice for an initial taper of opioids.

5.9 By July 2017, patient "A's" dosages were increased to 500 mcg per hour every three days. The Pharmacy confirmed the dose and filled the patient's prescription. Patient "A's" dosage was decreased from 500mcg per hour to 400mcg per hour in or around October of 2017.

5.10 Between January 2017 and February 2019, Ms. Haverluck-Watson only intervened once, on July 16, 2018, advising of the high dose and suggesting a taper. This was subsequent to the July 3, 2018, Inspection Reply Form distributed to her from the College.

5.11 On February 23, 2019, patient "A" presented to the hospital emergency and the emergency physician stopped all fentanyl prescriptions and provided the patient with drugs to alleviate withdrawal symptoms and indomethacin (non-steroidal anti-inflammatory) used to treat patient "A's" pain.

5.12 Ms. Haverluck-Watson admits that she did not meet her professional obligations in having and documenting conversations with patient "A's" prescribers about the dosages provided to patient "A" between January 2017 and February 2019.

Count 6

6.1 That between January 2017 and March 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "B" with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Regulation, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, 2.5 of the EPS, Recommendations 8 and 9 of the Guideline and/or Statements I, II, VII, IX of the Code, or any of them.

6.2 Patient "B" was injured in 2004 and was prescribed opioids for pain in 2005. A number of narcotics were prescribed to control patient "B's" pain, and he was ultimately prescribed oxycodone in February 2009.

6.3 Between November 2013 and November 2017, the dose of oxycodone was increased and reached as much as 600 OxyNeo 80mg tablets every 28 days, or approximately 2520 MEQ/day.

6.4 The Pharmacy contacted the prescriber to express concerns about the high dosages on January 27, 2012 and November 20, 2013.

6.5 The next contact was made after the first Health Canada inspection, on October 30, 2017, when Ms. Haverluck-Watson contacted the prescriber and suggested a taper and/or referral to an opioid addition clinic. A taper was initiated on November 3, 2017.

6.6 Between January 2017 and March 2019, Ms. Haverluck-Watson only intervened twice with the prescriber, (on October 30, 2017, and July 24, 2018) related either to the appropriateness, risks of the dosage, or any request for a tapering plan. These two interventions followed the inspections conducted by Health Canada and the College.

6.7 Ms. Haverluck-Watson admits that she did not meet her professional obligations in having and documenting conversations with patient "B's" prescriber about the dosages provided to patient "B". between January 2017 and

March 2019.

Count 8

8.1 That between January 2017 and February 2019 Ms. Haverluck-Watson dispensed or authorized the dispensing of opioids for patient "C" with either no or insufficient intervention with the prescribing physician, taking into account the high dosages of the opioids ordered and the frequency of administration, in contravention of section 83(a), (e) and (i) of the Regulation, sections 2.2.3, 2.2.4, 2.3, 2.4.1, 2.4.2, 2.4.3, 2.4.6, 2.4.7, 2.5 of the EPS, Recommendations 8 and 9 of the Guideline and/or Statements I, II, VII, IX of the Code, or any of them.
8.2 Patient "C" has been using opioids since 1998 and suffers from chronic TMJ arthritis.
8.3 As of January 2017, patient "C" was receiving 400 tablets of OxyNeo 80mg tablets every 20 days, approximately 2400mg MEQ/day.
8.4 On March 8, 2017, Ms. Haverluck-Watson expressed her concern to the prescriber and suggested a taper for the patient due to the high dosages provided to this patient. This engagement with the prescriber was documented on the patient's profile and a slow taper was implemented in April 2017.
8.5 Over the span of one year, between March 8, 2017, and March 15, 2018, the total dosage of OxyNeo 80mg dispensed to patient "C" dropped from 20 tabs per day (approximately 2400mg MEQ/day) to 17 tabs per day (approximately 2040mg MEQ/day). Ms. Haverluck-Watson made no request for a specific or more rapid taper regimen in the months following the commencement of the taper, despite patient "C" receiving refills approximately every 20 days.
8.6 Ms. Haverluck-Watson contacted the prescriber on July 25, 2018, to ask if patient "C's" dosage was still appropriate.
8.7 Patient "C's" dosage decreased on October 15, 2018 by one tablet per day, and again on February 13, 2019 by one tablet per day. There is no documentation of a suggestion by Ms. Haverluck-Watson to speed up the taper during this 4-month period.
8.8 Patient "C" ceased being a patient of the Pharmacy in March 2019.
8.9 Ms. Haverluck-Watson admits that she did not meet her professional obligations in having and documenting conversations with patient "C's" prescriber about the dosages provided to patient "C" between January 2017 and February 2019.

Upon considering the Agreed Statement of Facts, this Panel found pursuant to section 54 of the Act that Sara Haverluck-Watson was guilty of professional misconduct and accepted the joint recommended disposition of legal counsel for the Complaints Committee and Sara Haverluck-Watson and ordered that Sara Haverluck-Watson:

a) pay a fine of $10,000.00;
b) have a prohibition on her license that she not act as a preceptor for a period of two years;
c) successfully completes a five-day Quality Assurance program at her sole cost and to the satisfaction of the Registrar; and
d) pay a contribution to the costs of the investigation and hearing in the amount of $25,000.00.

In arriving at its decision, the Panel considered Ms. Haverluck-Watson's admission of guilt, which alleviated what would have been a very lengthy and complicated hearing, and her lack of any prior history of discipline, and is satisfied that this disposition will serve to act as a deterrent to her and in general, while at the same time balances the protection of the public interest and fairness to Ms. Haverluck-Watson, and would not bring the administration of justice into disrepute or be otherwise contrary to the public interest.

DATED at Winnipeg, Manitoba this 3rd day of January, 2023.

THE COLLEGE OF PHARMACISTS OF MANITOBA

Per Martha Mikulak, Chair, Discipline Panel

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

The College of Pharmacists of Manitoba attends 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

JC is a 62-year-old male who was found dead in his home on March 21, 2020. He was recently diagnosed with diabetes, which went untreated. Prior to his death, he complained about feeling unwell for the past few days and thought he had the flu. He was last seen by his brother on March 20, 2020. His medical history included cardiomyopathy and a right kidney cyst. An autopsy was performed. The manner of death was accidental with the immediate cause of death being dilated cardiomyopathy with a significant contributing factor of mixed drug intoxication involving pseudoephedrine, codeine, and dextromethorphan.

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 (ng/mL)	Therapeutic Range (if applicable) (ng/mL)
Pseudoephedrine * Norpseudoephedrine (active metabolite)	4100 100	Following daily 360mg doses, plasma pseudoephedrine concentrations reach 640 ng/mL. Expected concentration of norpseudoephedrine is one tenth that of pseudoephedrine.
Codeine* (free) Morphine (free)	320 22	10 – 100 10-80
Dextromethorphan*	73	0.5 – 5.9
Doxylamine	42	21 – 100
Hydromorphone	0	1-30

JC's DPIN history below only includes a summary of medications relevant to his toxicology report:

Generic Name	Date Dispensed	Strength	Quantity	Days' Supply	Prescriber	Pharm.
Acetaminophen/ Caffeine/	Feb 7, 2020	300/15/30 mg	120	30	Dr. A	ABC Pharmacy
Codeine	Jan 23, 2020	300/15/30 mg	56	7	Dr. B	ABC Pharmacy
Duloxetine	Jan 10, 2020	300/15/30 mg	56	7	Dr. B	ABC Pharmacy

Discussion

The toxicology report indicates high blood levels of pseudoephedrine, codeine, and dextromethorphan in this patient. Prior to his passing, JC had complaints of feeling unwell due to the flu, which may have led to his increased use of over-the-counter (OTC) medications such as decongestants and cough suppressants.

As OTC medications can be purchased without a prescription, the easy accessibility of these drugs may contribute to the public's false perception of safety and lack of awareness about their potential risk for harm.[1] Moreover, the misuse of OTC medications for nonmedicinal purposes are deemed as more socially acceptable compared to illicit substances because they are perceived to be safer, associated with less stigma, and not detected in standard drug screens.[1] Nonetheless, nonmedicinal use of non-prescription medications is often associated with products containing pseudoephedrine and dextromethorphan.[2]

Pseudoephedrine is a decongestant that works by stimulating alpha and beta-adrenergic receptors, resulting in the vasoconstriction of blood vessels in the nasal mucosa, as well as in the heart and lungs.[3] Due to the possibility of being used illicitly to produce methylamphetamine, restrictions have been imposed on pseudoephedrine products. In Manitoba, single-ingredient pseudoephedrine products may only be sold as Schedule II drugs, behind the counter with no public access, while combination products containing pseudoephedrine can be sold as Schedule III drugs, in the self-selection area under the direct supervision of the pharmacist. [4]

At high doses, common signs and symptoms of toxicity include central nervous system stimulation (e.g., agitation) and cardiovascular instability (e.g., hyper- or hypotension, arrhythmias).[5,6] Risk of hyperglycemia, hypokalemia, and stroke are also elevated during pseudoephedrine toxicity, which are further complicated in a patient with untreated diabetes.[7]

Dextromethorphan is a common ingredient in cough and cold products that is mainly used to suppress dry cough, although there is little evidence for efficacy.[8] However, at high doses, the active metabolite dextrorphan inhibits N-methyl-d-aspartate (NMDA) receptors, resulting in neurobehavioral effects such as hallucinations and dissociation.[5] Dextromethorphan at high doses can also increase the risk of serotonin syndrome, in which symptoms can range from mild to life-threatening, and can include flu-like symptoms, confusion, agitation, sweating, tachycardia, hyperthermia and muscle rigidity. Studies have also reported that dextromethorphan is one of the most commonly misused OTC medications, where it is used for recreational purposes, suicidal attempts, and to achieve a mind-altering effect.[1,2]

Pharmacists are the first point of contact for patients purchasing OTC medications and are strongly encouraged to provide patient education on safe, effective, and appropriate OTC drug use.[9] This includes informing patients of the maximum dose per day, raising awareness about ingredients that may be present in more than one cough and cold product, monitoring for signs and symptoms of efficacy and safety, as well as identifying when further evaluation by a primary care provider or referral to urgent care is warranted. Pharmacists can also play a pivotal role in the identification and management of OTC drug misuse, which can include refusing sales if medication misuse or harm is suspected, contacting other pharmacies to warn them of suspicions regarding a patient's misuse, and limiting the amount of OTC medications a patient can purchase at one time.[9] Pharmacy staff should always be alert for suspicious, large quantity purchases or any missing stock of products containing dextromethorphan or pseudoephedrine in the pharmacy.[10]

Patient engagement can also deter OTC drug misuse by encouraging patients to be more involved in their own health. This includes asking directed questions during counselling on the use of OTC medications, counselling on the drug's risk for dependence, and dangers when combined with other sedatives or psychoactive medications and providing resources such as information leaflets.[9]

Pharmacists are reminded of the Practice Direction on Patient Counselling and that dialogue is required by a pharmacist, academic registrant, or an intern with a patient or their agent when a Schedule II drug is sold. If a patient requests a Schedule II or III product, information must be collected to assess the patient's knowledge and needs before providing advice. If a drug-therapy problem is identified during patient counselling, appropriate action must be taken to resolve the problem.

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Notice of the 2023 Award Recipients

Professional awards and service recognitions were presented at a virtual program, following the 145th Annual General Meeting on Tuesday May 2, 2023.

The following registrants received 50 Year Gold Pins and Certificates:

Mrs. Janice Coates
Mrs. Stephanie Fingerote
Mr. Joseph Gwozdz
Mr. George McGhee
Mr. Rajnikant Patel
Ms. Gerri Scott
Mr. Dennis Toy

The following registrants received 25 Year Silver Pins and Certificates:

Mr. Ahmed AL-Tamimi
Ms. Joanna Ayotte
Mr. Jeremy Cockerill
Ms. My Cung
Mr. Pritpal Dhanjal
Mr. Ian Findlay
Mrs. Edna Gan
Mr. Clinton Huber
Ms. Denise Hunt
Ms. Shannon (Kathy) Hunter
Ms. Nadine Karpinski
Mr. Darryl Lancaster
Mr. David Lee
Ms. Ruo Yu Liu
Ms. Jugnu Lodha
Ms. Kara Morcombe
Dr. Olga Norrie
Ms. Kimberly Robins
Mrs. Nerissa Santos Doan
Mr. Mark Scott
Mrs. Marilyn Sidhu
Mr. Douglas Thidrickson
Mr. Dale Warkentin
Mr. Erwin Wiebe
Mr. John Wong

Bonnie Schultz Memorial Award for Pharmacy Practice Excellence

The recipient of this award demonstrates outstanding excellence in optimizing patient care. Factors considered include serving as a role model, excellence in communication skills, demonstration of skilled practice, and compassion, empathy and concern.

Award recipient: *Lisa Zaretzky*

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.

Award recipient: *Christine Vaccaro*

Honorary Life Members

This award is given to pharmacists who have made a significant contribution to pharmacy in Manitoba and at the national level.

Award recipient: Susan Lessard-Friesen

Patient Safety Award

This award recognizes those that have made a significant and lasting contribution to improving patient safety and health care quality through a specific initiative or project. The project or program has demonstrated a positive impact upon patient safety and involves some component of the practice of pharmacy, with innovative and patient centered care projects given preference.

Award recipient(s): *Pharmacy Team at Deer Lodge Center – Pat Honcharik, Dieu Huynh, Jackie Jobin, Alanna McNaught, Grazia Prochazka, Wendy Simoens*

The College of Pharmacists of Manitoba Launches Social Media Accounts

The College of Pharmacists of Manitoba (CPhM) is pleased to announce that we have established new social media channels to enhance our communication and engagement with pharmacy professionals, the public, and all our valued partners and stakeholders.

Our social media channels will provide an effective way for us to keep you informed of our latest regulatory guidance, policies and guidelines, educational resources, as well as news about upcoming events. You will also have the opportunity to engage with us and share your feedback, questions, and concerns with our team.

We invite you to follow us on our newly established social media accounts on Facebook, Twitter, LinkedIn, and Instagram:

Facebook: https://www.facebook.com/thecphm

Twitter: https://twitter.com/TheCPhM

LinkedIn: https://www.linkedin.com/company/college-of-pharmacists-of-manitoba/

Instagram: https://www.instagram.com/thecphm/

In Memorium

In loving memory…

Dennis McMillan	January 13, 2023
Michael Eschun	January 30, 2023
Kenneth Brown	April 20, 2023