COLLEGE OF PHARMACISTS OF MANITOBA

2022

SPRING NEWSLETTER

Contents

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

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

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FEATURE

College Registrar Announces Retirement

A message from Wendy Clark, President

Dear Colleagues,

It is with mixed feelings that we announce the retirement of Susan Lessard-Friesen, Registrar and Chief Executive Officer (CEO) of the College of Pharmacists of Manitoba (College), effective May 31, 2022. We are happy for Susan to begin her well-deserved retirement, and she will be sorely missed.

Susan has admirably guided the College for over 26 years in various roles serving as Director of the Professional Development Program, Acting Chair of the Interprofessional Continuing Professional Development Network for the Health Professions in Manitoba (iCPD Manitoba), Deputy Registrar, and now as current Registrar and CEO.

Her unconditional dedication towards patient safety and improving patient outcomes, relentless work ethic, and contributions serving the best interests of the public always ensured the College stayed focused on its mission and vision: to lead the advancement of pharmacy to enhance the health and well being of patients through patient-centred pharmacy care. We are grateful for her expertise, perspective, and diligent efforts in guiding the work of the College. She will always be valued and remembered.

"*Susan has demonstrated years of great effort, time, responsibility, and determination to do the best for both the public and pharmacy professionals in Manitoba. Advancing the practice of pharmacy in Manitoba has been a challenging, uphill battle; however, Susan worked diligently over great lengths of time with other affiliates and stakeholder groups to make the significant accomplishments that we see today*." - Sonal Purohit, Vice President, District 1

It is difficult and almost impossible to sum up Susan's achievements as she has close to 40 years of experience in the field of pharmacy, including hospital and community pharmacy practice in Manitoba, Saskatchewan and Ontario, teaching at the University of Manitoba, Rady Faculty of Health Sciences' College of Pharmacy, being the honored recipient of the 2013 Manitoba Pharmaceutical Association Patient Safety Award and the 2014 MIPS Patient Safety Champion Award, and contributing as a long-term member and participant of several provincial, national, and international pharmacy-related organizations.

Susan was instrumental in guiding the College through collaborations with stakeholders on the development of joint statements that would ensure the safe access and delivery of controlled medication therapy to some of the province's most vulnerable populations; the foundational work and full implementation of Safety IQ in all pharmacies in the province; various consultations for amendments to *The Pharmaceutical Act* (Act) and Regulation to advance the scope of pharmacy practice in Manitoba; and milestone decisions during the COVID-19 pandemic that will have lasting, positive impacts on patient safety, the practice of pharmacy, and the regulatory work of the College. These are just a few of the many initiatives that have been successfully introduced and implemented under Susan's leadership.

"*As a public representative, I always felt acknowledged and appreciated by Susan for any contributions that I made on pharmacy practice*." - Donna Forbes, Public Representative

On behalf of Council and the staff of the College, we graciously thank Susan for her steadfast vision and unwavering commitment that has propelled the work of the College to its current position.

"*Thank-you for your tireless commitment to the college and the profession of pharmacy*." - Jane Lamont, Executive Treasurer, District 2

Please join me in extending our sincerest gratitude, to Susan, for her unwavering and steadfast commitment to the profession of pharmacy. We wish her all the best as she embarks on this next phase of her journey.

President,
Wendy Clark

FEATURE

Board Governance: Many Perspectives, One Interest

The following article is reprinted with permission by author Bruce Matthews. This article was originally published by the Council on Licensure, Enforcement, and Regulation (CLEAR).

"Successful regulatory boards reflect and embrace a diversity of perspectives, and they acknowledge that the public interest is the only interest that must impact their decision making." - B. G. Matthews

In my 17 years of professional and occupational regulatory experience, including 11 years involved with CLEAR, I've worked with numerous boards and changed views with senior staff at countless regulatory organizations. I've always been struck by the commonality of experience on a broad range of issues. Board governance, board composition and the primacy of the public interest are just a few of those issues.

The composition of professional and occupational regulatory boards can vary greatly within a given jurisdiction, and it does vary greatly across jurisdictions, nationally and internationally. Some boards are filled with appointed members, some have only elected members, and many include a combination of the two. In any case, it is more than likely that specific members are selected, or elected, to fill a specific requirement—e.g., they come from a specific geographic region, they come from some pre-defined subset of the practitioner base, or they possess some specific qualification or credential required by statute.

It is both reasonable and appropriate for governing legislation to enumerate such requirements for the composition of a board. Having a diversity of perspectives—driven by geography or other factors—makes for a more balanced, inclusive and effective board. The challenge faced by regulators, however, is that the individual board members who are chosen or elected based on these subdivisions often feel that they "represent" that group. This is especially true of board members who are elected—there is a natural tendency to believe that they have a constituency to represent when serving on the board. This is patently untrue, but it can be a significant challenge to communicate and educate such board members about their core roles and responsibilities.

At the heart of the challenge is understanding the difference between interests and perspectives, or in other words the difference between representing a group versus employing personal knowledge and experience based on membership within a group. A professional or occupational regulatory

board has one interest only—the public interest. It is sometimes expressed more specifically as the public welfare or public safety, but at its essence is the notion that the regulator exists so that there may be a well-ordered society in which public interest risks are mitigated and managed. This is the foundation of risk-based regulation.

A regulatory body is not a club, and the interests of the practitioners do not matter. These are probably the biggest hurdles for board members who are practitioners, and/or have been elected by practitioners, to overcome. It can be very hard for them to understand that there is no constituency to be represented at the board table. It can seem unnatural for elected board members to not be a voice for those who elected them. What needs to be explained and illustrated, initially during an onboarding or orientation process and frequently reinforced thereafter, is that board members are there to represent the public interest—period. Fairness to practitioners and to others who engage the regulator is essential, and tenets of accountability and transparency must be followed, but the only interest is the public interest.

Board members must be made to realize that they are there to provide their particular perspective, whether it is borne of geography or some other subdivision of the practitioner population, or based on some other qualification or credential. A board of like-minded individuals with identical backgrounds cannot function well—it cannot foresee challenges and cannot respond to them in a fulsome way. Such a board is like a toolbox filled only with hammers. The unique perspective of a diverse range of individual board members, based on their life experiences, both related to the practice of the profession and otherwise, enriches the board as a whole and brings benefits where the total is greater than the sum of the parts. Getting a board, and its individual members, to accept and adopt the philosophy of "many perspectives, one interest" isn't easy. Primary responsibility should fall on the board chair, and perhaps extend to the executive committee. But what does a regulator do when the board chair doesn't "get it", and takes on the persona of a representative of a constituency and promotes other interests? This is when the CEO or Executive Director of the regulatory organization must step in and set the record straight.

The orientation and training of board members is an ongoing effort. In most jurisdictions, board members are volunteers and/or are only engaged in regulation on a limited, part-time basis. They do not live and breathe regulation as staff do. The best chance for success is when the seed of "many perspectives, one interest" is planted early, and frequently revisited. This message should not be delivered only after individuals are appointed or elected to the board, but rather communicated to individuals who are considering appointment or running for election. It is in this way that expectations can be managed—both early and comprehensively, and newly appointed or elected board members won't have to deal with whiplash associated with their actual roles and responsibilities.

Successful regulatory boards reflect and embrace a diversity of perspectives, and they acknowledge that the public interest is the only interest that must impact their decision making.

SAFETY. IMPROVEMENT. QUALITY.

Safety Feature – Reporting Medication Incidents is Key to Building Safety During Times of High Stress

Even in these difficult times, Manitoba pharmacies continue to engage in Safety IQ, understanding that reporting medication incidents is a **mandatory** requirement. We know that incidents and patient harm are more likely when pharmacies and staff are under stress due to increased workload and the addition of new pharmacy services. Reporting becomes even more important in situations of stress or crisis, such as the COVID-19 pandemic, to ensure we share learning to support medication safety improvements across Canada. Recent ISMP Canada Safety Bulletins on COVID-19 vaccine and Paxlovid errors demonstrate the urgent necessity of sharing and learning to prevent patient harm.

Each month an average of 120 Manitoba community pharmacies are reporting 240 incidents and near-miss events to their online incident reporting platform. Your de-identified reports are sent to the National Incident Data Repository (NIDR) for Community Pharmacies hosted by ISMP Canada. Medication safety experts at ISMP Canada analyse the aggregate data from across the country to share learning and recommendations with pharmacy professionals and other health care providers via Safety Bulletins and other communications. Your reports benefit the entire pharmacy profession and Canadian patients everywhere.

The College urges all pharmacy professionals to engage with reporting of medication incidents and near-miss events.

Thank you for your commitment to sharing medication incident and near-miss event experiences to benefit Manitoba patients, and patients across Canada.

To Report or Not to Report: Identifying What **Near-Miss Events** Your Pharmacy Should be Reporting

Pharmacy professionals excel at discovering potential medication incidents before they reach a patient. Safety IQ involves also proactively reviewing near-miss events to prevent future harm. Near-miss event reporting and analysis is an opportunity to address gaps in existing pharmacy systems or procedures to improve the safety of your pharmacy.

Not all near-miss events are valuable from an improvement or learning perspective and pharmacy professionals juggle many tasks throughout the workday. Your pharmacy should consider the following points to increase the efficiency and quality of your pharmacy's near-miss event reporting:

- **Establish a near-miss event protocol as part of your policy, procedure and training. When building a near-miss event protocol, your team should consider the following:**
  - **Potential impact on the patient:** Would the patient be harmed if they were given this medication? If yes, report the near-miss event.

- **Recurring nature of the near-miss event:** Does the same near-miss event happen repeatedly? If yes, report the near-miss event.

- **The potential for shared learning:** Could learning from a near-miss event benefit colleagues and patients in other pharmacies? If yes, report the near-miss event.

It's important that your team finds a balance between efficiency and medication safety improvement to build a plan that works.

- **Find ways to maintain near-miss event reporting when your pharmacy is busy.** For example, use paper reports to quickly document near-miss event details to be entered into your reporting platform during a less busy time. Check if your reporting platform has a printable version of its reporting template or use the CPhM near-miss report form.

- **Leverage existing resources to support and encourage reporting.** For example, the Safety IQ Quick Guide to Reporting Medication Incidents and Near-Miss Events can be posted near work stations as a helpful reminder.

If your pharmacy has not entered any incidents or near-miss events into your medication incident reporting platform, consider reporting even near-miss events that may seem trivial such as almost choosing the wrong medication from the shelf. If look-alike or sound-alike drugs are side-by-side on the shelf, should your pharmacy consider a new way of organizing medications to prevent patient harm?

Pediatric Allergy Near-Miss Improves Manitoba Pharmacy's Patient Counselling Process

The following case was submitted to CPhM by a Manitoba community pharmacy and demonstrates the value of reporting and discussing near-miss events. CPhM and the Safety IQ team are grateful to the pharmacy professionals who shared their experience for the benefit of their colleagues. Additional cases are available at https://cphm.ca/practice-education/safety-iq/

Background
The pharmacy received a faxed prescription for an antibiotic suspension for a new patient. The patient's parents were called to collect general information (address, PHIN, etc.) and to confirm that the prescription was to be filled. The pharmacy professional did not assess the patient's medical history or allergies during the phone conversation.

Situation
The prescription for the antibiotic suspension was prepared and during patient counselling the pharmacist asked the patient's parents to confirm the patient has no allergies. At that point, it was determined that the patient was, in fact, allergic to the antibiotic prescribed. A pharmacist contacted the prescriber and the prescription was changed to an appropriate antibiotic.

Decision to Report
The near-miss event in this case could have harmed the patient. A standard process for gathering patient information is in place when the pharmacy receives a prescription in-person, but in the case of prescriptions delivered to the pharmacy by phone or fax, the process is not consistent.

Outcome
The pharmacy team determined that all patient information including medication history, allergies, etc. must be obtained before filling all new prescriptions whether received in-person, by fax or phone. If information is missing, then the prescription must be highlighted to alert pharmacy staff to verify the missing information before they release the prescription to the patient.

Council Approves Extended Deadline for Safety Self-Assessment and Continuous Quality Improvement Meeting

Healthcare professions, including pharmacy, have faced stressful and dynamic working conditions throughout the COVID-19 pandemic, yet have remained committed to providing patients with the best possible care. In recognition of the current pharmacy environment and workload issues, Council approved an extension for community pharmacies to complete the mandatory safety self-assessment (SSA) and continuous quality improvement (CQI) meeting.

The new deadline for your pharmacy to complete an SSA and CQI meeting is October 1, 2022, if your pharmacy

- **implemented Safety IQ on the June 1, 2021, program launch date; or**
- **opened between June 1 and September 31, 2021.**

If your pharmacy opened after October 1, 2021, then your team must complete an SSA and CQI meeting within one year of opening.

Please see the Safety IQ SSA FAQ for additional information about SSAs.

With this extension, pharmacies will have additional time to meaningfully engage with these requirements and source updated versions of SSA tools when they become available. Information related to SSA and CQI meetings can be found in the Guide to Safety IQ, CQI Meeting Resources, and the SSA Improvement Plan resource. CPhM will provide additional SSA and CQI meeting information and resources at cphm.ca/practice-education/safety-iq/.

SAFETY MEASURES | RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES | YOUR IMPROVEMENT STORIES

RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES

Quality Improvement Case Studies from Safety IQ: Near-Miss Events *NEW*

Review shared learning from your colleagues across Manitoba with new case studies that can offer your team improvement strategies: https://cphm.ca/practice-education/safety-iq/

CPhM Shared Learning Page *NEW*

Safety IQ aims to foster a culture of open communication and shared learning from incidents and near miss events. Shared learning is a key element in how pharmacy professionals can continuously improve the safety of their practice. To support shared learning of Manitoba pharmacy professionals, the CPhM has developed a Shared Learning page within the College website. The Shared Learning page includes:

- Case Studies from the Medical Examiner
- Opioid Agonist Therapy and Patient Safety
- ISMP Canada Safety Bulletins and SMART Medication Safety Agenda

Check back to the Shared Learning page often as new resources will be added over time.

ISMP Canada Safety Bulletin - February 28, 2022

Mitigating Risk for Medication Errors Involving Paxlovid

ISMP Medication Safety Exchange Webinars

ISMP Canada offers complimentary 50-minute webinars that provide a platform for frontline healthcare practitioners to share, learn and discuss incident reports, trends and emerging issues in medication safety with colleagues across Canada.

You can register in advance by visiting ISMP Canada's website or view a recording of the webinar and past webinars at your convenience.

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 sedating/psychoactive drugs. 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

AK is a 63-year-old man who was found dead in his bed at home on May 30, 2017, after not being seen for several days. He had a history of bipolar disorder, depression, heavy cigarette smoking with chronic obstructive pulmonary disease (COPD), atrial fibrillation, high cholesterol, and an untreated seizure disorder (with no seizures for more than 11 years). An autopsy was performed, and the immediate cause of death was determined to be quetiapine toxicity. The manner of death was determined to be suicide.

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)**
Quetiapine*	19700	100 – 1000
Methylphenidate Ritalinic acid (Inactive metabolite)	0 180	5 – 20 80 – 250

AK's DPIN history below only includes a summary of the medications relevant to his toxicology results:

Generic Name	**Date Dispensed**	**Strength**	**Quantity**	**Days' Supply**	**Prescriber**	**Pharmacy**
Quetiapine	Apr 3, 2017	300 mg	180	90	Dr. A	ABC Pharmacy
Methylphenidate	Apr 3, 2017	36 mg	90	80	Dr. A	ABC Pharmacy
Duloxetine	Apr 3, 2017	60 mg	180	90	Dr. A	ABC Pharmacy
Levothyroxine	Apr 3, 2017	175 mg	90	90	Dr. A	ABC Pharmacy

Discussion

Quetiapine toxicity is associated with levels greater than 1,500 ng/L, which can be life-threatening.[1] This patient's toxicology report showed a quetiapine level of 19,700 ng/L, which is significantly higher than the therapeutic range and 13-fold more than the toxicity level found in literature.

Quetiapine is an atypical antipsychotic used for the treatment of schizophrenia, bipolar disorder, and as adjunctive treatment for major depressive disorder. It has also been reported to be used off-label to treat anxiety and sleep disorders.[2] However, its antagonist activity on many receptors contributes to its side effect profile such as dizziness and somnolence due to H1 receptor antagonism, hypotension due to alpha-1 receptor antagonism, and anticholinergic effects from M1 blockade.[3] Quetiapine has also been associated with myocarditis, stroke, and metabolic dysregulation with long-term use.[1,4,5]

In acute quetiapine toxicity, the most common symptoms that patients exhibit are drowsiness, tachycardia, and respiratory depression.[6] Since this patient had COPD, the risk of respiratory events during quetiapine toxicity is elevated due to the obstructed airway from this chronic inflammatory disease.[7] Additionally, quetiapine in high doses can increase the risk of QTc prolongation or life-threatening Torsades de Pointes, especially in patients with risk factors (e.g., older age, concurrent QTc prolonging drugs, hypothyroidism).[1] Neuroleptic malignant syndrome (NMS) is another life-threatening side effect of antipsychotics that can occur as a result of a sudden drop in dopaminergic transmission. Signs and symptoms of NMS include fever, autonomic instability (e.g., unstable heart rate, blood pressure, sweating, drooling), rigidity, and mental status changes. Any sign or symptom of overdose requires immediate medical attention and quetiapine should be immediately withdrawn.[8,9] Unfortunately, there is currently no available antidote to reverse quetiapine toxicity.[1]

The role of a pharmacist when dispensing quetiapine is to provide counselling that includes the potential risks of the drug and document these conversations appropriately. Quetiapine is commonly prescribed for its sedating and mood stabilizing properties.[2,10] However, pharmacists must also consider the drug's potential for harm in overdose. According to a paper by Peridy et al, it was shown that 79.8% of quetiapine self-poisonings were voluntary, and within this group, 91.4% had a history of mental illness.[6] The 2020 Annual National Poison Data System Report also identified quetiapine as being the most common antipsychotic involved in overdose cases, often in combination with other sedating agents.[11] Therefore, pharmacists must critically consider these points when reviewing a patient's medications and carefully assess whether it is appropriate to dispense quetiapine. This can include deprescribing medication that is no longer providing benefit to the patient (e.g., reducing the use of combination sedating agents in older adults with an uncontrolled chronic respiratory condition) or that have been prescribed as a result of prescribing cascade (e.g., discontinue the use of a stimulant that was initiated to override sedating effects of medication), and having contact information available to counseling services in your area or to a crisis line (e.g., Mobile Crisis Line, Klinic Crisis Line, Crisis Services Canada).

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.

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Pharmacy Technician Listing Renewal

Pharmacy technician listing renewals opened on March 14, 2022. The deadline for pharmacy technicians to submit their application for listing renewal is June 1, 2022, to be listed with the College by June 1, 2022. 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;
- submission of a recent satisfactory criminal record check, including a vulnerable sector search;
- 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 least 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.

QUALITY ASSURANCE

Narcotic, Controlled and Targeted Drug Accountability

With respect to narcotic, controlled, and targeted drug (collectively referred to as controlled substances) accountability, pharmacists (community and hospital) are required to comply with federal legislation, including the Narcotic Control Regulations (NCR), the Benzodiazepines and Other Targeted Substances Regulations (BOTSR) made under the *Controlled Drugs and Substances Act* (CDSA) and Part G of the Food and Drug Regulations (FDR-G) made under the *Food and Drugs Act*, along with provincial requirements outlined in *The Pharmaceutical Act*, corresponding Pharmaceutical Regulation, and applicable Standards of Practice. Following this, pharmacists are responsible for ensuring controlled substances, including narcotics, controlled drugs, and targeted drugs under their care are secure and accounted for with appropriate record-keeping and documentation.

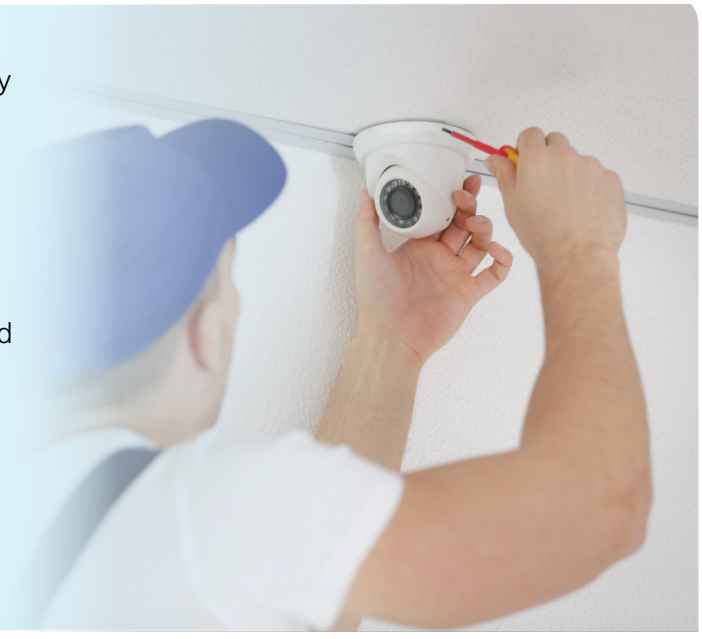
Pharmacy inspections are conducted by the College and Health Canada (HC) to review and ensure compliance with the applicable legislation while promoting best practices. Aside from pharmacy inspections, pharmacy managers are encouraged to conduct regular self-assessments and reviews of practices related to controlled substance accountability. The following provides a review of standards and best practice concepts surrounding narcotic, controlled and targeted drug security and record-keeping, to help facilitate reflection and implementation into your practice.

Security

Pharmacy managers should ensure the pharmacy has robust security in place, utilizing a combination of multiple physical security measures, along with clear policies and procedures.

Physical security

Manitoba pharmacies must store all narcotics and controlled substances in a properly secured narcotic safe, as required by the Pharmacy Facilities Practice Direction. A safe must be bolted to the ground or be immovable to be considered secured. It is also important that the safe be placed in an area that is not visible to the public.



The definition of a safe is a strong, fireproof receptacle with a complex lock used for the storage of valuables. Other specifications of the safe are entirely at the discretion of the pharmacy facility, including size, with the caveat that the storage receptacle is an actual product that is marketed and sold as a "safe." A locked cupboard, drawer or room does not meet the definition of a safe.

Other best-practice physical security measures include:

- A monitored alarm system
  - The pharmacy must have a separate alarm if it is in a larger retail space or clinic
  - To prevent the alarm from being disabled or tampered with, it is highly recommended that the alarm has additional reinforcements in place, including battery backup and wireless capabilities
- A video surveillance system including placement in direct view of the narcotic safe
- Security measures on external windows and glass doors (E.g., metal bars or shatter-resistant security film)

For more information on pharmacy physical security, Health Canada has specific recommendations on community pharmacy security and the Canadian Society for Hospital Pharmacists has recommendations on hospital pharmacy security.

Policies and Procedures

Pharmacy managers are further required to ensure specific policies and procedures are in place regarding controlled substance accountability, which will mitigate risk for loss/theft and/or diversion of controlled substances.

- Only pharmacy personnel are to have access to the dispensary, and a pharmacist is required to physically be on-site at all times during the hours of pharmacy operation.
- The narcotic ordering codes and access to the safe should be restricted.
- Stock is to be received by the pharmacy directly and immediately placed into secure storage, with receipt of such confirmed/signed/dated by the pharmacist.

Additional components of a controlled substance policy may include:

- Double counting all controlled, narcotic, or targeted prescription drugs
- Back-counting controlled, narcotic, or targeted prescription drugs
  - After filling a prescription, back-counting is the process of immediately counting the remaining inventory and comparing it to the perpetual inventory
- Avoiding the use of automated counting machines for narcotic, controlled or targeted drugs, as these may lead to unexplained loss or miscounts.
- Avoid stockpiling and limit the on-hand stock of narcotic, controlled, and targeted drugs to the minimum required amount.

Perpetual Inventory

A perpetual inventory must be maintained. A perpetual inventory is a means of continuously tracking your inventory based on available information (eg. acquisition and sales, etc.) as opposed to actual physical inventory (i.e., physically on-hand). A perpetual inventory can be in the form of a computerized inventory control program or a written record. In simplified terms, all received controlled substances are to be added to the on-hand inventory count and dispensed drugs removed. Any changes to the perpetual inventory, including manual adjustments, must be documented with appropriate justification and be available for audit. Pharmacy managers must regularly review all manual adjustments made to the perpetual inventory. It is recommended that this is reviewed monthly.

Inventory and Reconciliation

A full physical inventory count of all controlled substances (including narcotic, controlled, and targeted drugs) must occur every three months at a minimum. During the physical count, the counted inventory is to be reconciled against the perpetual inventory, along with review of sales records and acquisition records.

Reconciliation confirms the on-hand inventory matches what is expected based on the acquisitions and sales. In other words, inventory in and out should balance and match what is physically on hand. When performing reconciliation, the inventory count, perpetual inventory, acquisitions, sales and inventory adjustments should be reviewed together for comparison to identify any discrepancies.

A physical count and reconciliation should also occur when:

- The pharmacy manager changes
- The pharmacy relocates, or there is a change of pharmacy ownership
- Security has been compromised (theft, break and enter, or robbery)
- Randomly as part of a pharmacy self-assessment

Discrepancies and Reporting

Any identified discrepancy (loss/shortage or overage) must be investigated with appropriate documentation of the findings. There should be an evaluation of whether procedural changes or preventative measures are required to prevent future discrepancies. For example, pharmacies experiencing inventory control problems should consider conducting inventory counts and reconciliation more frequently.

Any **unexplained** inventory shortage/loss must be reported to Health Canada and the College within 10 days of discovery. This includes an unexplained loss of just one tablet and losses occurring in transit/delivery. The details of the loss, along with results of the investigation, and any changes to pharmacy security or procedure are to be included in the report.

Health Canada's E-service Portal is a convenient way to electronically report loss or theft directly to Health Canada. When reporting, pharmacists should follow Health Canada's Guidance on Reporting loss or theft.

All loss/theft reports submitted on the E-Service Portal must be:

- Manually submitted to the College as well within 10 days of discovery. The report can be downloaded into PDF format, and/or printed from the portal and faxed (204-237-3468) or emailed (losstheft@cphm.ca) to the College.
- Immediately available at the pharmacy in the event of an audit.

Record Keeping

Sales records, acquisition records, and narcotic prescription records must be kept for five years. Records can be kept in physical or electronic format however, all records must be complete, legible, permanent, and be readily available and accessible for audit. Pharmacy managers and pharmacists are required to ensure compliance with the Records and Information Practice Direction, and fully review such prior to transitioning to electronic record keeping.

Records that must be maintained include, but are not limited to:

Sales records

- Sales records should be reviewed monthly by a pharmacist. The pharmacist who reviews it must sign and date the record.
  - Investigate any unusual or suspicious transactions or prescribing patterns that are identified
- A sales record should contain:
  - name and address of the person named in the prescription;
  - name, quantity and form of the drug;
  - name, initials and address of the practitioner who issued the prescription;
  - name or initials of the pharmacist who provided the controlled substance;
  - date on which the substance was sold or provided; and
  - the prescription number.

Acquisition records

- When receiving a controlled substance (such as narcotic, controlled and targeted drugs), a record of acquisition must be kept. A record of acquisition should contain:
  - name and quantity of the drug received;
  - date the drug was received; and
  - name and address of the person from whom the drug was received
- The record of acquisition (or invoices) must be readily accessible and stored in an organized manner.
- The pharmacist should review the physical drug inventory received against the invoice and the receiving report generated by the pharmacy's computer system.
- The record of acquisition must be signed and dated by the receiving pharmacist.
- Inventory received from either a licenced dealer (e.g., pharmacy's wholesaler) or as an exceptional emergency sale/ purchase from another pharmacist must be maintained in the acquisition record.

In closing, insufficient accountability for controlled substances is a recurring reason for complaints and discipline. Pharmacists are responsible for ensuring proper stewardship of controlled substances under their care in the interest of public safety. Pharmacy managers must ensure there are detailed, compliant, strong controlled substance accountability policies and procedures in place to support their staff. Additionally, pharmacy managers must ensure overall compliance with all controlled substance legislation, practice directions, and store policy and procedure at their practice site. If specific guidance is required, pharmacy professionals are encouraged to contact the College for support.

Decision and Order of the Discipline Committee: Shouren Bose

Pursuant to the Amended Notice of Hearing (the "Notice") dated August 22, 2019, 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 November 24, 2021, with respect to charges formulated by the College alleging that Mr. Shouren Bose ("Mr. Bose"), 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, at Health Plus Pharmacy (the "Pharmacy"), 1075 Autumnwood Drive, Winnipeg, Manitoba, Mr. Bose:

1. breached a condition contained in the Order and Decision of the Discipline Committee dated March 3, 2015 (the "Order"), which prohibited him from having ordering and/or signing authority for drugs covered under the Controlled Drugs and Substances Act, S.C. 1996, c. 19 in contravention of section 18 of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation") by:

    a. on or about July 16, 2018, ordered five patches of Mylan-Fentanyl 50 mcg and five patches of Mylan-Fentanyl 100 mcg from another community pharmacy;

    b. STAYED;

    c. on or about August 16, 2018, ordered a 5ml vial of fentanyl citrate 50 ug/ml from another community pharmacy;

    d. STAYED; and,

    e. STAYED;

2. STAYED;

3. STAYED; and,

4. between January 2019 and April 2019, on approximately 10 occasions, dispensed narcotics with no or insufficient documentation of authorization from the prescriber, in contravention of subsection 31(2)(b) of the Narcotic Control Regulations (C.R.C., c. 1041) (the "NCR"), subsection 69 of the Regulation, and Statements 2 and 7 of The Code of Ethics, or any of them.

The hearing into the charges convened on November 24, 2021. Mr. Jeffrey Hirsch ("Mr. Hirsch") and Ms. Sharyne Hamm appeared as legal counsel on behalf of the Complaints Committee. Mr. Richard Beamish ("Mr. Beamish") and Mr. Jessie Rock appeared with and on behalf of Mr. Bose. Mr. David Marr ("Mr. Marr") appeared as legal counsel to the Discipline Committee (the "Panel").

A Statement of Agreed Facts (the "Statement") was filed in which Mr. Bose admitted:

1. his membership in the College.

2. valid service of the Notice and the Amended Notice of Hearing dated August 22, 2019, and that the College complied with the requirements of sub-sections 46(2) and 46(3) of the Act.

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

4. he graduated with his pharmacy degree from the University of Manitoba in 2000.

5. he has been registered as a pharmacist under the Act since June 29, 2000.

6. he voluntarily surrendered his pharmacist's license on September 27, 2013.

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

The parties further agreed that:

1. the College disciplined Mr. Bose through a decision and order of the College's Discipline Committee dated March 3, 2015 (the "Order") which provided that:

    a. Mr. Bose be suspended for one year, commencing July 8, 2014, and ending July 8, 2015;

    b. During the time he was suspended, Mr. Bose was required:

        i. to complete a chemical abuse assessment approved by the Registrar and provide the Registrar with the findings;

        ii. to comply with all recommendations from the chemical abuse assessment and provide monthly reports in writing to the Registrar; and,

        iii. to make and maintain contact with the Pharmacists at Risk Committee and instruct the Committee to contact the Registrar should he fail to maintain a satisfactory relationship with the Committee;

    c. Upon completion of the period of suspension, Mr. Bose was able to apply for re-instatement of his pharmacist license, subject to all of the re-licensing requirements of the College;

    d. Upon relicensing with the College, the following conditions would be placed on Mr. Bose's license:

i. He could not be a pharmacy manager;

ii. He could not be a preceptor;

iii. He could not have ordering / signing authority for drugs covered under the Controlled Drugs and Substances Act; and,

iv. He could not work in a pharmacy without another person present in the dispensary;

e. Upon relicensing with the College, Mr. Bose was required to advise the pharmacy manager in all pharmacies who employed him in some capacity that:

i. Monthly narcotic inventory verification counts must occur;

ii. Another pharmacist must verify all calculations for compounding medication before the compounding begins; and,

iii. He has restrictions placed on his license as set out above.

2. Mr. Bose resumed practice as a pharmacist as of September 29, 2015, subject to the following conditions:

a. He cannot be a pharmacy manager;

b. He cannot be a preceptor;

c. He cannot have ordering / signing authority for drugs covered under the Controlled Drugs and Substances Act; and,

d. He cannot work in a pharmacy without another person present in the dispensary.

3. Mr. Bose has been employed as a pharmacist at the Pharmacy commencing October 2015.

4. Mr. Bose, through a numbered company, is a 75% owner of the Pharmacy.

5. On November 15, 2017, the conditions were varied by the College such that Mr. Bose was no longer required to complete and provide monthly chemical abuse assessments and no longer required to maintain contact with the Pharmacists at Risk Committee. All other conditions, listed above at paragraph 12 in the Agreed Statement of Facts (paragraph 1 herein) (the "Conditions"), remained in place.

6. Mr. Bose satisfied the College with respect to his narcotic addiction recovery efforts.

7. Mr. Bose reviewed the Amended Notice, as well as the Statement of Agreed Facts, and 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.

Mr. Bose entered a plea of guilty to count 4, and in so doing he admitted to the conduct described therein and that it demonstrated professional misconduct, or a lack of knowledge or skill or judgment in the practice of pharmacy or operation of a pharmacy as described in section 54 of the Act.

The Complaints Committee entered a stay of proceedings with respect to counts 1. b), d), e), 2, and 3 in the Amended Notice of Hearing.

With respect to counts 1(a) and (c), while admitting to the conduct described therein, Mr. Bose denied that his actions were a breach of any of the Conditions and denied that it demonstrated professional misconduct, or a lack of knowledge or skill or judgment in the practice of pharmacy or operation of a pharmacy as described in section 54 of the Act. Accordingly, Mr. Bose entered a plea of not guilty to these two counts, and counsel to the Complaints Committee and Mr. Bose made separate submissions on these issues.

In the Statement, pertaining to count 1. a), the parties agreed that:

1. The Investigator conducted a review of the Pharmacy's narcotic records and observed a number of emergency narcotic drug purchases from Shoppers Drug Mart #542 ("SDM"). The Investigator obtained records from SDM which indicated that on July 16, 2018, a request for transfer for five patches of Mylan-Fentanyl 50 mcg and five patches of Mylan Fentanyl 100 mcg (the "Fentanyl Patches") was placed from the Pharmacy.

2. Mr. Bose was present in the Pharmacy on July 16, 2018. A patient required the Fentanyl Patches on an emergent basis. Mr. Bose contacted SDM to confirm whether they had fentanyl patches that could be transferred to the Pharmacy to fill the emergency order.

3. SDM confirmed that they had the Fentanyl Patches in stock and could make the emergency transfer. SDM prepared a request for the Fentanyl Patches and Mr. Bose signed the request. On July 17, 2018, SDM delivered the Fentanyl Patches to the Pharmacy to fill the patient's prescription.

In the Statement, pertaining to count 1(c), the parties agreed that:

1. SDM records indicate that on August 16, 2018, a request for transfer for a 5ml vial of fentanyl citrate 50 ug/ml (the "Fentanyl Vial") was placed from the Pharmacy.

2. Mr. Bose was present in the Pharmacy on August 16, 2018. A patient required the Fentanyl Vial on an emergent basis. Mr. Bose contacted SDM to confirm whether they had a fentanyl vial that could be transferred to the prescribing physician to fill the request.

3. SDM confirmed that they had the Fentanyl Vial in stock and could make the emergency transfer. Mr. Bose hand-wrote a request for the Fentanyl Vial and Mr. Bose's name was used on the request. On August 17, 2018, the Fentanyl Vial was delivered to the prescribing physician.

The parties made separate submissions as to whether Mr. Bose's "requests for transfer" of the Fentanyl Patches and Fentanyl Vial, constituted orders, and, as such, was a breach of any of the Conditions.

After reviewing the authorities, documentary evidence, the agreed facts and hearing the submissions of counsel for the parties, the Panel found pertaining to both counts 1(a) and (c), that Mr. Bose had contravened section 18 of the Regulation which states:

> A member may engage only in those aspects of the practice of pharmacy, and perform included practices,
>
> a. that he or she has the requisite knowledge, skill and judgment to provide or perform and that are appropriate to his or her area of practice; and,
>
> b. in accordance with any conditions of his or her license.

The Panel considered section 45(1)(b) of the Narcotic Control Regulations which states:

45(1) A pharmacist may, on receiving a written order for a narcotic

> b. sell or provide to another pharmacist the quantity of the narcotic that is specified in the order as being required for emergency purposes, if the order is signed and dated by the other pharmacist.

The panel found that Mr. Bose's "transfer requests" did in fact constitute orders as required under the Narcotic Control Regulations.

The Panel determined that Mr. Bose was aware of the Conditions imposed on his practicing licence, but proceeded to order the Fentanyl Patches and Fentanyl Vial, thereby exhibiting a lack of judgment and contravening the licence condition which prohibited him from having ordering/ signing authority for drugs covered under the Controlled Drugs and Substances Act.

The Panel found Mr. Bose guilty of professional misconduct, having displayed a lack of knowledge or lack of skill or judgment in the practice of pharmacy, and conduct unbecoming a member in accordance with section 54 of the Act.

Counsel for the Complaints Committee and Mr. Bose made a joint recommendation on disposition, that in accordance with section 54, 55 and 56 of the Act Mr. Bose:

1. be fined in the amount of $5,000.00; and,

2. be ordered to pay a contribution to the costs of the investigation and hearing in the amount of $20,000.00.

After having reviewed the authorities provided to the Panel regarding joint recommended dispositions and the joint recommendation submitted by the counsel for the parties, the Panel ordered that Mr. Bose:

1. pay a fine in the amount of $5,000.00; and,

2. pay a contribution to the costs of the investigation and hearing in the amount of $20,000.00.

In arriving at its decision, the Panel considered Mr. Bose's admissions of guilt, and the cooperative discussions between counsel for the parties. The Panel also considered the remaining conditions on the practicing licence of Mr. Bose, being:

1. Mr. Bose cannot be a pharmacy manager or a preceptor;

2. Mr. Bose cannot order at any practice site, drugs covered under the Controlled Drugs and Substances Act;

3. Mr. Bose cannot work on his own and must always have another trained person in the dispensary working with him at all times; and,

4. Mr. Bose is to advise his pharmacy manager(s) that monthly narcotic inventory counts must be done at their practice sites, another licensed pharmacist must verify all calculations for medication compounding before the compounding begins and of the restrictions noted above.

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

Dated at Winnipeg, Manitoba this 4th day of January, 2022.

Shannon Trapp
Panel Chair

Notice of 2022 CPhM Annual General Meeting

The College will hold its 2022 Annual General Meeting (AGM) on Saturday, May 7, 2022, by webinar. Registrants are encouraged to review the AGM meeting package in advance of the meeting.

- AGM Agenda
- Rules of Procedure
- AGM Minutes, 05 08 2021

These documents are also available on the College website.

Registration

To register for the CPhM Annual General Meeting, use the link:
https://us02web.zoom.us/webinar/register/WN_cm_h6iQdSNODuWwBikvOfg

On-Line Registration

You will receive an automated email confirming your registration. This email will contain a URL to use to join the meeting on the designated date and time. This link should not be shared with others; it is unique to you, serves as your record of attendance, and will enable you to participate fully in the AGM (cast votes).

Registrants are asked to register for the AGM webinar in advance of the meeting. Please direct any inquiries regarding the registration process to info@cphm.ca.

IN MEMORIUM

In loving memory,

SHAUN DENNIS KOHUT
December 20, 2021

HARRY GARFINKEL
December 2021

ANNE DRAPACK
February 20, 2022

JOHN D. (JACK) O'NEIL
February 26, 2022