College of Pharmacists of Manitoba

NEWSLETTER

SPRING 2024

INSIDE THIS EDITION:

Safety IQ Feature

In early 2023, Manitoba pharmacy professionals participated in the Community Pharmacy Survey on Patient Safety Culture (SOPS) to understand the state of safety culture in Manitoba.

Medical Examiner Review

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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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Tanjit Nagra, Pharmacists Manitoba
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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.

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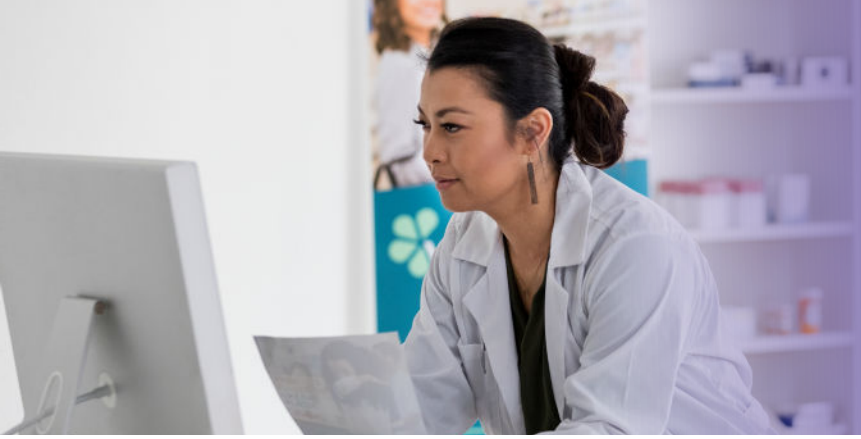

Safety.
Improvement.
Quality.

Feature: Measuring Safety Culture Through Analysis of Incident Reporting

Safety IQ enables community pharmacies to promote a culture of safety in which all pharmacy staff feel comfortable reporting and talking about medication incidents. In a safety culture, we recognize that most incidents happen because there is something wrong with the system in which people work and rarely caused by a single event or the actions of a single person. Analysis of medication incidents and near-miss events often reveal a system failure or environmental factors that must be changed to prevent medication incidents.

In early 2023, Manitoba pharmacy professionals participated in the Community Pharmacy Survey on Patient Safety Culture (SOPS) to understand the state of safety culture in Manitoba. In the Summer 2023 Newsletter, the survey results showed pharmacies excelled in patient safety culture areas such as communication openness and teamwork as well as areas for improvement – staff training, physical space, and environment. The survey results will be used as a benchmark but also to assess areas where resources are needed.

Patient safety culture can also be measured through analysis of medication incidents using an ISMP Canada tool – Medication Safety Culture Indicator Matrix (MedSCIM). When completing a medication incident report pharmacy professionals must complete the "description of the incident" field. This field is a free form text field allowing the reporter to describe what happened, how it happened and possible changes the pharmacy made to prevent recurrence of the error. Pharmacy staff can also complete the optional fields "contributing factors", "actions at store Level," and "shared learning."

How does a MedSCIM analysis work?

Two independent analysts review the description of multiple incidents to assess two factors:

1. the core event or degree of documentation and
2. the maturity of the culture.

In addition to the mandatory incident description field, the optional fields "contributing factors", "actions at store Level", and "shared learning" were also assessed.

Latest from the Safety IQ Blog

The Safety IQ Blog features short, actionable articles to support continuous quality improvement in your pharmacy. Here's the latest posts:

- Enhancing Patient Safety: Optimizing Prescription Copy Functions in Pharmacy Software (March 6, 2024)
- From Assessment to Action: Six Steps to Proactive Improvement using your Safety Self-Assessment (February 7, 2023)
- Everyone has a Role to Play: Continuous Quality Improvement and Patient Safety in Community Pharmacy (January 3, 2024)
- Perfecting Patient Profiles: 3 Tactics to Safer Pharmacy Practice (December 6, 2023)

Core Event: Degree of Documentation

Core Event: Degree of Documentation evaluates incident reports based on its clarity and completeness. From the description, can the reader understand what happened and why (i.e. contributing factors)?

There are three levels for assessing the reports' completeness:

- **Level 1 – Report fully complete –** The medication incident provides sufficient information to describe the medication incident and contributing factors.
- **Level 2 – Report semi-complete –** The medication incident provides sufficient information to describe the medication incident. No information is provided about contributing factors.
- **Level 3 – Report is not complete –** The medication incident provides insufficient information to allow meaningful qualitative analysis.

Maturity of Culture to Medication Safety

Maturity of Culture to Medication Safety evaluates the incident report based on the reporter's approach to describe the root cause. Are the incidents viewed from a system-based approach or rather on individual fault?

There are four levels for assessing the maturity of culture:

- **Grade A – Generative –** the medication incident uses a systems-based approach to describe the root causes and develop possible solutions to prevent future recurrence.
- **Grade B – Calculative –** The medication incident uses a systems-based approach to describe the root causes. No solutions are offered to prevent future recurrence.
- **Grade C – Reactive –** The medication incident is treated as an isolated incident. No solutions are offered to prevent future recurrence.
- **Grade D – Pathological –** The incident focuses on human behaviours instead of a systems-based approach.

Safety IQ MedSCIM Results

ISMP Canada conducted an analysis of medication incidents associated with harm in Manitoba using the Medication Safety Culture Indicator Matrix (MedSCIM) tool to examine the medication safety culture in community pharmacies. From June 1, 2021, to May 31, 2023, 138 incidents associated with patient harm were reported by community pharmacies in Manitoba with 129 included in the analysis.

The table below presents the MedSCIM analysis of Safety IQ pharmacies conducted by ISMP Canada on incident reports associated with patient harm From June 1, 2021, to May 31, 2023. A total of 129 incidents were included in the analysis.

Maturity of Medication Safety Culture

	Grade D: Pathological	**Grade C:** Reactive	**Grade B:** Calculative	**Grade A:** Generative
Level 1: Report fully complete	4	10	16	42
Level 2: Report semi-complete	1	34	3	3
Level 3: Report not complete	3	13	0	0

= positive medication safety culture = neutral medication safety = negative medication safety culture

Degree of Completeness – most reports were either fully or semi-complete.

- 56% (72 of 129) of the medication incidents were rated as "fully complete" (Level 1) - the reports included a good description of the medication incident as well as potential contributing factors were identified.
- 32% (41 of 129) of reports were "semi-complete" (Level 2)– reports sufficiently described the incident but offered no potential contributing factors.
- 12% (16 of 129) of reports were found to be "not complete" (Level 3), where details of the medication incident remained unclear.

Maturity of Medication Safety Culture – the analysis shows some variability in the maturity of culture to medication safety.

- Nearly 35% (45 of 129) of the medication incidents were characterized as having a "generative" (Grade A) culture - reporters identified system flaws and offered solutions to prevent error recurrence.
- Meanwhile, 15% (19 of 129) of the reports were categorized into the "calculative" (Grade B) culture - the reporters considered how the medication system may have allowed the incident to occur but did not advance remedial strategies.
- A "reactive" (Grade C) culture was identified in 44% (57 of 129) of the reported incidents - the reports treated incidents as isolated events and did not approach the incidents from a system-based perspective or offer a solution.
- Lastly, 6% (8 of 129) of the reports displayed a "blame and shame" or "pathological" (Grade D) culture that emphasized human behaviours and individual fault in their description of incident details.

As part of this analysis, the optional fields, "contributing factors", "actions at store Level", and "shared learning" were considered alongside the information from required fields. For the level of both "degree of documentation" and "maturity of culture", the completion of these optional fields correlated to a more positive safety culture.

- Approximately 82% (59 of 72) of the Level 1 (fully complete) reports included information in at least one of the three optional fields of interest.
- A majority of the Grade A reports (43 of 45) included entries for either "actions at store level" alone or both the "actions at store level" and "shared learning" optional fields.

Conclusion

Overall, Manitoba pharmacies excel in many areas of patient safety culture. Most reports from this MedSCIM assessment were classified under a positive medication safety culture (green sections of Safety Culture Matrix graph). Manitoba pharmacies are submitting detailed reports using a system-based approach to address possible causes of the incident. While most patient harm incidents were reported with enough detail to understand the medication incident and potential contributing factors, the reports varied in safety culture maturity with a significant number of reports lacking solutions to prevent future recurrences of incidents.

Manitoba pharmacies are encouraged to continue providing detailed descriptions of medication incidents and include system-based contributing factors to help understand how and why an incident occurred. Pharmacies should reflect on possible strategies to prevent similar errors from occurring and include this information within the relevant optional fields.

Your commitment to diligently reporting medication incidents and sharing your learning within your incident reports is beneficial for both your pharmacy and patients and contributes to multi-incident analysis from a national perspective.

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 CPhM.

Here is a review of 2023 Year in Review data for medication incident, near-miss event, outcomes and top incidents types reported by Manitoba's pharmacy professionals:

- Pharmacy professionals have submitted 2317 reports to the NIDR in 2023
- Pharmacy professionals have reported 1333 medication incidents (medication dispensed reached the patient) and 193 caused patient harm
- Pharmacy professionals reported 984 near-miss events in 2023

The top three incident types were:

- Incorrect dose/frequency
- Incorrect drug
- Incorrect strength/concentration

Please view the Safety IQ: 2023 Year in Review graphic

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.

Resources for Professional Development

ISMP Canada Safety Bulletins

- Central Fill Services for Community Pharmacies: A Multi-Incident Analysis (March 6, 2024)
- A New Canadian Approach to High-Alert Medications (February 14, 2024)
- Pre-pouring Medications: A Risky Approach (December 19, 2023)
- Oral Opioid Agonist Therapy: A Multi-Incident Analysis of Reports from Community Pharmacies (November 16, 2023)
- ALERT: Clonidine Compounding Errors Continue to Harm Children (October 11, 2023)

Safety.
Improvement.
Quality.

Message from the Chair

Dear Pharmacy Professionals,

I hope this message finds you in good health and spirits.

First and foremost, in light of Pharmacy Appreciation Month in March, I want to express my heartfelt gratitude for your steadfast dedication to your patients and the pharmacy profession. Your efforts in upholding standards of care are a testament to your unwavering commitment and are truly inspirational.

As this marks my final address as Chair, I am honoured to share some significant developments that have transpired during my tenure on the CPhM Council. Our recent council meeting on February 23, 2024, marked a pivotal moment with the passage of a comprehensive bylaws package and supporting policies. These changes are designed to align CPhM with modern governance best practices, ensuring our ability to adapt efficiently and effectively within the dynamic healthcare landscape.

One notable decision was transitioning from an elections-based selection to an appointment-based selection for council members. This strategic move empowers CPhM to operate with increased agility, enabling us to better navigate the evolving challenges and opportunities in pharmacy practice and regulation.

Additionally, the council approved updates to the self-limiting conditions and smoking cessation training programs, prerequisites for pharmacists seeking authorization to prescribe specific medications. The recent Friday Five communications provide detailed information about these updates.

On February 7, 2024, CPhM hosted a mandatory continuing professional development webinar on pharmacy practice integration of Indigenous health standards in a significant and meaningful collaboration with the Indigenous Pharmacy Professionals of Canada (IPPC). This initiative, a testament to our commitment to promoting equitable healthcare and fostering cultural competence among pharmacy professionals, is a step forward in our journey towards a more inclusive and diverse healthcare system.

I extend my sincere appreciation to each of you for your contributions to advancing the pharmacy profession in Manitoba. Your unwavering dedication to patient care has enabled us to continue elevating the role of pharmacy professionals within our healthcare ecosystem.

As I conclude my term, I offer my best wishes to the incoming Chair and Council members. May your leadership be guided by wisdom, empathy, and a steadfast commitment to excellence, driving positive change for our profession and the communities we serve.

Thank you for your ongoing support and collaboration.

Jane Lamont
Chair, College of Pharmacists of Manitoba

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 psychoactive medications. 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

LH is a 67-year-old who was found dead in their home on November 7, 2023, with multiple fentanyl patches on their forearms. They were known to cut the fentanyl patches in half and keep them on longer than prescribed. Their past medical history included hypertension, diabetes mellitus type 2, coronary artery disease (coronary artery bypass grafting with a recent non-ST-elevation myocardial infarction in February 2023), depression, osteoarthritis, pancreatitis, hepatitis C virus infection, left breast invasive ductal carcinoma status post lumpectomy and radiation in 2021, opioid use disorder, and a spinal fusion performed in October 2023. The manner of death was determined to be accidental with the immediate cause of death being combined toxic effects of fentanyl and venlafaxine.

Results

The following chart represents the results of the toxicology report. Drugs that were above the therapeutic range are indicated by an asterisk (*):

Drug	Level in blood	Therapeutic Range (if applicable)
Fentanyl*	144 ng/mL	Within 24 hours of the application of a 100ug/hr transdermal patch, the expected serum concentration is 1.9-3.8 ng/mL.
Gabapentin*	55 ug/mL	2-20
Metformin*	37 ug/mL	1-2
Metoprolol	62 ng/mL	20-340
Venlafaxine*^	100 ng/mL	28-64
O-desmethylvenlafaxine*^	2040 ng/mL	118-252
Mirtazapine*	100 ng/mL	28-64

Clonazepam and quetiapine were detected in the drug screen but were below the limit of quantitation.
^Selective serotonin and norepinephrine reuptake inhibitors undergo significant post-mortem redistribution and levels may be elevated in the toxicology report.

LH's DPIN history below only includes a summary of medications relevant to the toxicology report from the month prior to death:

Generic Name	Strength	Date Dispensed	Quantity	Days' Supply	Prescriber	Pharmacy
Fentanyl	75ug/hr patch	November 2, 2023 October 18, 2023	7 7	14 14	Dr. A	ABC Pharmacy
	100ug/hr patch	November 2, 2023 October 18, 2023	7 7	14 14	Dr. A	ABC Pharmacy
Clonazepam	0.5mg	October 31, 2023 October 11, 2023	42 42	14 14	Dr. A	ABC Pharmacy
Clonidine	0.1mg	October 31, 2023 October 11, 2023	42 42	14 14	Dr. A	ABC Pharmacy
Gabapentin	300mg	October 31, 2023 October 11, 2023	126 126	14 14	Dr. A	ABC Pharmacy
Metformin	500mg	October 31, 2023 October 11, 2023	56 56	14 14	Dr. A	ABC Pharmacy
Metoprolol	25mg	October 31, 2023 October 11, 2023	28 28	14 14	Dr. A	ABC Pharmacy
Mirtazapine	15mg	October 31, 2023 October 11, 2023	14 14	14 14	Dr. A	ABC Pharmacy
Quetiapine XR	50mg	October 31, 2023 October 11, 2023	42 42	14 14	Dr. A	ABC Pharmacy
Venlafaxine XR	150mg	October 31, 2023 October 11, 2023	28 28	14 14	Dr. A	ABC Pharmacy
Acetaminophen/ oxycodone	325/5mg	October 17, 2023	40	5	Dr. B	DEF Pharmacy

Discussion

The immediate cause of death in LH's case was determined to be combined toxic effects of fentanyl and venlafaxine. LH was known to cut their fentanyl patches and keep them on longer than prescribed. This case study will focus on the appropriate use of fentanyl patches.

Fentanyl is a highly potent opioid which can be dispensed as a transdermal patch. Upon initial application of a fentanyl patch, the onset of action is ~6 hours with the drug being released at a nearly constant rate where it accumulates in the skin, with a time to peak at 20-72 hours . This accumulation results in a depot of the drug in the outer later of the skin, where it then gets absorbed systemically. This depot allows for a gradual increase in serum concentration over the first 12-24 hours, with a fairly consistent concentration for the dosing interval1. Absorption is increased with exposure to external heat. Steady state serum concentrations are typically reached after two sequential 72-hour applications[1].

Fentanyl patches should only be used in opioid-tolerant patients who are receiving at least 60mg of oral morphine equivalents per day for at least one week[1234]. Dispensing a fentanyl patch to an opioid-naïve patient can result in fatal or life-threatening respiratory depression and overdose. Elderly patients are also at an increased risk of unintentional overdoses with opioids due to age-related comorbidities, polypharmacy, and drug-drug interactions[2].

To determine the appropriate initial dose for a patient, pharmacists should consult the fentanyl product monograph for opioid conversion guidance (available through the Canada Drug Product Database: https://

www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html). The maximum initiation dose of a fentanyl patch should not be higher than that equivalent to the total dose of opioids the patient is receiving due to risks of serious or life-threatening overdose[3]. Pharmacists are also reminded to be cognizant of other factors that may affect the selection of an initial dose for a fentanyl patch such as poor fat stores, muscle wasting, altered clearance, concomitant diseases, or other drug therapies[3].

In the case of LH, the DPIN profile suggests that this patient was using a total of 175mcg/hr of fentanyl and changing the patches every 48 hours. While the majority of patients are adequately managed with the patches being administered every 72 hours, a small number of patients may not achieve sufficient pain control at that dosing interval and may require that the patches be applied every 48 hours[3]. If patients are experiencing breakthrough pain repeatedly at the end of the 72 hour dosing interval, the product monograph suggests that this is generally an indication that a dose increase is required rather than more frequent administration[3].
However, if a dose increase does not improve pain and function, it may be possible that the patient is experiencing opioid-induced hyperalgesia, or their pain is not responsive to opioids. Given the high dose of fentanyl that the patient is receiving and their history of both pain and opioid use disorder, consultation with a pain and addiction specialist could help identify safer options for chronic pain management in this patient. Pharmacists should be working collaboratively with the prescriber and patient to determine the appropriate path forward for treatment.

As with other opioids, there is potential for diversion and non-medical use with transdermal fentanyl which may happen through application of multiple patches, ingestion or rectal insertion of patches, or intravenous injection of the gel removed from the patch reservoir . Between 28% and 84% of the initial fentanyl dose remains in the patch after three days of use5. As the patient in this case was known to leave patches on longer than prescribed, they may have still been absorbing a considerable dose of fentanyl after their prescribed application period. In addition, it was also stated that they would cut their fentanyl patches in half. It is NOT recommended to cut fentanyl patches as exact dosing is critical. Cutting fentanyl patches can result in leakage and unpredictable release and absorption of the medication from the patch, potentially resulting in a fatal dose of fentanyl[6].

Pharmacists play a crucial role in educating patients on the proper use of fentanyl patches and the risks associated with improper use. Thorough counselling of patients receiving fentanyl patches (for all new and refill prescriptions) can include, but must not be limited to, the following counselling points:

- Accidental exposure to fentanyl can occur if the patch is accidentally transferred to another person during any forms of physical contact, such as hugging or bedsharing[3]. Patients should be instructed to be vigilant that the patch remains on their skin for the prescribed period of time.
- Patches should be kept in a safe place, out of the sight and reach of children and pets before, during and after use.
- For safe disposal of fentanyl patches, patients and their caregivers must be instructed to:
    - » Wear protective gloves to prevent accidental exposure to the drug
    - » Fold the patch in half so that the adhesive sides are stuck together
    - » Dispose of the patch in a tamperproof and childproof storage container (a garbage bin is not considered safe)
    - » Bring the container holding the patch back to the pharmacy for safe disposal
    - » Do NOT flush the patch down the toilet
- Patients should be warned to avoid exposing the application site and surrounding area to direct external heat sources1 (e.g. heating pads, electric blankets, heat or tanning lamps, sunbathing, hot baths, saunas, hot tubs, and heated water beds), which may increase fentanyl absorption and has resulted in fatal overdoses of fentanyl.
- Patches are intended for transdermal use on intact skin only; use on compromised skin can lead to increased exposure to fentanyl3.
- Due to the formation of a subcutaneous depot of fentanyl, plasma levels may continue to rise even after removal of a fentanyl patch3. Therefore, patients who experience a serious adverse event due to a fentanyl patch must be monitored for at least 24 hours after patch removal, or longer depending on clinical symptoms.
- It is recommended that all patients receiving an

opioid should be dispensed a take-home naloxone kit and counselled by the pharmacist on proper use . All pharmacies are encouraged to carry naloxone nasal spray for sale (some third-party insurances provide coverage when prescribed or recommended by a pharmacist). In addition, some pharmacies may be eligible to register as a provincial distribution site for injectable naloxone through the Take-Home Naloxone Distribution Program.

[1] Fentanyl. Lexicomp. https://online.lexi.com/. Published 2023. Accessed October 16, 2023
[2] Inappropriate Fentanyl Patch Prescriptions at Discharge for Opioid-Naïve, Elderly Patients Institute for Safe Medication Practices. https://www.ismp.org/resources/inappropriate-fentanyl-patch-prescriptions-discharge-opioid-naive-elderly-patients. Published July 2020. Accessed January 9, 2024.
[3] Sandoz Fentanyl Patch Product Monograph. https://pdf.hres.ca/dpd_pm/00055220.PDF February 26, 2020. Accessed January 10, 2024.
[4] Follow Safeguards when Dispensing Fentanyl Patches. Pharmacist's Letter Canada. https://ca-pharmacist-therapeuticresearch-com.uml.idm.oclc.org/Content/Articles/PLC/2018/Apr/Follow-Safeguards-When-Dispensing-Fentanyl-Patches. Published April 2018. Accessed January 10, 2024.
[5] Consequences of Unsafe Prescribing of Transdermal Fentanyl. Scott Lucyk, Lewis Nelson. CMAJ June 2016. 188 (9) 638-639; DOI: 10. 1503/cmaj. 160291
[6] Transdermal Fentanyl: A Misunderstood Dosage Form. ISMP Canada. https://ismpcanada.ca/wp-content/uploads/ISMPCSB2006-05Fentanyl.pdf. Published August 2006. Accessed January 12, 2024.
[7] Safe Disposal of Fentanyl Patches. College of Pharmacists of British Columbia. Safe Disposal of Fentanyl Patches | College of Pharmacists of British Columbia (bcpharmacists.org). Accessed January 30, 2024
[8] Canadian national consensus guidelines for naloxone prescribing by pharmacists - Ross T. Tsuyuki, Vinita Arora, Mark Barnes, Michael A. Beazely, Michael Boivin, Anna Christofides, Harsit Patel, Julie Laroche, Aaron Sihota, Randy So, 2020 (sagepub.com). Accessed January 31, 2024.

Pharmacist Licensure Decisions

1. Effective February 6, 2024, the Registrar imposed an interim suspension of the practicing license of Mr. Cory Badger (College Licence No. 37965) under section 24(1) of The Pharmaceutical Act pending review of the matter by the Complaints Committee.

   The profession was previously advised of the interim suspension by the Registrar on February 06, 2024.

   Please be advised effective March 28, 2024, the Complaints Committee has directed the Registrar to maintain the interim suspension of the practicing license of Mr. Cory Badger (College Licence No. 37965) pending the outcome of the proceedings of the matter, in accordance with section 40(1) of The Pharmaceutical Act.

   The profession was previously advised of the interim suspension by the Registrar on March 28, 2024.

   This notice is pursuant to section 132(2) of the Pharmaceutical Regulation.

2. Please be advised effective March 8, 2024, pursuant to section 55 of The Pharmaceutical Act (the Act), the Discipline Committee has issued a suspension of the licence of Dr. Hajra Mirza (College Licence No. 39259) until May 6, 2024, inclusive.

   The profession was previously advised of the suspension on March 08, 2024

   This notice is pursuant to section 58 of the Act.

In Case You Missed It: CPhM Developments

Mandatory CPD: Mandatory CPD Webinar 2: Pharmacy Practice Integration of Indigenous Health Standards

The College of Pharmacists of Manitoba (CPhM), partnered with the Indigenous Pharmacy Professionals of Canada (IPPC), offered two mandatory continuing professional development webinars. The first webinar, Indigenous Health, was held in June 2023, coinciding with National Indigenous History Month. It explored the history and ongoing effects of colonialism on Indigenous Peoples' health, resilience, culture, and provided practical learning opportunities which aimed to integrate Indigenous health into pharmacy practice.

The second webinar (webinar 2), Pharmacy Practice Integration of Indigenous Health Standards, took place on February 7, 2024, from 6:00 – 7:30 p.m.

Pharmacists and pharmacy technicians must view the live or recorded webinar by October 31, 2024. You can view the recording through your registrant portal.

Webinar 2 aims to provide pharmacy professionals with the knowledge and skills needed to provide equitable care to Indigenous individuals. Participants will learn about the modifiable environmental and practice styles that reflect Indigenous ways of knowing, create safe spaces, and understand how to integrate equitable care strategies to support Indigenous individuals in their pharmacy practice. The webinar will also cover the barriers Indigenous individuals face when accessing care in urban and remote locations and provide strategies to improve access to care in pharmacy practice. By the end of the webinar, participants will be better equipped to provide culturally safe and competent care to Indigenous individuals.

Council Meeting Highlights

CPhM Council met on Friday, February 23, 2024. Highlights from the meeting include:

Amendments to the CPhM Bylaws

Amendments to the CPhM bylaws are part of a broad governance review. Council reviewed feedback from extensive consultations and the independent work of the Governance Committee. After careful consideration, Council approved a comprehensive bylaw package and preliminary policies and process documents to support the governance reform.

Council has pledged to make these governance policies and related documents available on the CPhM website to provide registrants with valuable information and enhance transparency. More detailed information will be provided and posted to the Self-Regulation page on the CPhM website.

Updates to the Self-Limiting Conditions & Smoking Cessation Prescribing Training Programs

Council approved updates to the self-limiting conditions and smoking cessation training programs that pharmacists are required to complete in order to apply to prescribe a drug specified in the treatment of either the self-limiting conditions or smoking cessation.

The Self-Limiting Conditions Independent Study Program and the Smoking Cessation Independent Study Program focus on the principles of safe prescribing, legislation and

standards of practice and include required and suggested clinical resources without the need to complete an external training program or post-test. The modules provide direction while recognizing the pharmacist's professional responsibility to ensure they are competent and seek additional learning as needed.

There is no registration fee for completing the updated Self-Limiting Conditions Independent Study Program and the Smoking Cessation Independent Study Program. Some of the required and recommended readings in the proposed training program require a subscription, so pharmacists may need to pay for access to the resources.

For more information on prescribing drugs for self-limiting conditions, excluding smoking cessation, please visit: Prescribing Drugs for Self-Limiting Conditions | College of Pharmacists of Manitoba (cphm.ca)

For more information on prescribing drugs for smoking cessation, please visit: Prescribing Drugs for Smoking Cessation | College of Pharmacists of Manitoba (cphm.ca)

Annual General Meeting Notice

CPhM will hold its 2024 Annual General Meeting (AGM) on Tuesday May 14, 2024, by webinar.

Registrants are encouraged to review the AGM meeting package in advance of the meeting.

1. AGM Agenda
2. Rules of Procedure
3. AGM Minutes

These documents are also available on the CPhM website.

Registration
To register for the CPhM Annual General Meeting, use the link: https://us02web.zoom.us/webinar/register/7317116430997/WN_0pLZ0wVyQHCo3IRe-Qxe0w

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.

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...

William Dixon	2023
Abe Loewen	2022
George Goldhawk	2019
Ian A. Johnson	2024
Betty Carson	2024
Marina Cram	2024