COLLEGE OF PHARMACISTS OF MANITOBA

2022

SUMMER NEWSLETTER

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

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

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

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

FEATURE

President's Message

Dear Colleagues,

I couldn't be more thrilled to write my first message as President of the College of Pharmacists of Manitoba (CPhM).

It is an honour to be placed at the forefront of our profession in a position to lead, inspire and inform. I plan to do just that as we all work together to advance the profession of pharmacy in the province.

First, I would like to thank the outgoing President, Wendy Clark, for all the hard work she has done over her presidency. I want to acknowledge that for many reasons, it has been a challenging few years, which makes her achievements all the more significant. While following her will be tough, I look forward to the challenge of being the President for the next two years.

We would not be here if it were not for the leadership and engagement of our Council members. I believe our Council is a group of talented people who will help move our initiatives forward. There have been some changes around the table, and we look to these new members for fresh insight on ongoing tasks and ideas. With change also comes the loss of some Council members whose hard work did not go unnoticed. They have provided a solid foundation for this Council term to build upon. On behalf of the CPhM Council, I would like to thank Ashley Walus, Ravi Pandya and Drupad Joshi.

I look forward to working with the new councillors and public representatives that make up our Council for the 2022–2024 term. We will continue building on our strengths while also taking on new directions to ensure that all of us can perform our critical role: protect the health and well-being of the public by providing safe and ethical pharmacy care.

I encourage all registrants to take advantage of the upcoming professional development opportunities listed in the Friday Five publications and to watch for the latest updates and resources, as it is always an ideal time for pharmacy professionals to reflect on their practice and their skills and to contemplate new ways to improve.

It has been a busy few months at the CPhM as we roll out some major projects and continue working on important initiatives.

First, CPhM continues working on the 2021–24 Strategic Plan and its initiatives to promote equitable access to pharmacy care and regulatory services, to foster professional services and care environments free from racism and discrimination, and to also advance practice and standards in a framework that is consistent with modern and best regulatory practices, while maintaining the provision of care in a safe and ethical manner.

At its inaugural meeting, the new Council of CPhM elected officers to serve on Executive Committee for the 2022–2024 term. Through this process, council acknowledges the value and importance of public representation at all levels of its governance framework and strives to achieve transparent and accountable governance in the public interest troughout all levels of work and function.

The Council of CPhM has also recently supported the establishment of both a Technician and Extended Practice Pharmacy Advisory committee to inform the council of current challenges and future recommendations within those specific areas of practice. I would encourage all registrants to provide feedback through the member representatives of these advisory committees so that we can continue to develop these important areas of practice in the province of Manitoba to grow our teams and better support our patients

Safety IQ introduced new resources and completion deadlines. In addition to reviewing past incidents and near-miss events, Safety IQ emphasizes proactive analysis of pharmacy processes through the completion of a Safety Self-Assessment (SSA) and an annual Continuous Quality Improvement (CQI) meeting requirement to reduce the chances of patient harm.

Finally, CPhM continues to monitor the development of pharmacy practice and government regulation due to the pandemic and collaboratively works to provide registrants with ongoing guidance and resources to support their safe delivery of pharmacy care. Please refer to the COVID-19 Updates page for the latest updates and advice.

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

It is an honour to take my place at the forefront of our profession to lead, motivate and inform pharmacy practice in Manitoba.

Sincerely,

Jane Lamont

Safety Feature – Reminder: Safety Self-Assessment and Continuous Quality Improvement Meeting Deadline

Over the past several months, CPhM has communicated that the deadline for completing the mandatory safety self-assessment (SSA) and annual continuous quality improvement (CQI) meeting was extended.

The deadline for your pharmacy to complete an SSA and CQI meeting was 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 be reminded that the pharmacy manager must use the Pharmacy Portal on cphm.ca to declare that the pharmacy's SSA and annual CQI meeting are complete. To make the declaration, please log into the Pharmacy Portal and click the '**Update Safety IQ Engagement Information**.' Scroll down to the Safety IQ Engagement section and fill out the **SSA** and **CQI** meeting engagement fields.

Resources

- How are we doing? Toolkit for effective CQI Meetings
- CQI Meeting webpage
- SSA webpage

Safety Huddles and Annual CQI Meetings: What's the Difference!?

The Medication Incident and Near-Miss Event Practice Direction requires that community pharmacies conduct at least one formal CQI meeting with pharmacy staff annually with informal huddles occurring as medication incidents occur and as deemed necessary.

Safety huddles are short informal meetings (10 to 15 minutes) where your pharmacy team can quickly share information about safety issues or concerns in a non-punitive manner. Safety huddles can be as frequent as your pharmacy needs them to be. A safety huddle should promptly occur following a medication incident, especially if the incident harmed a patient; however, safety huddles are not a substitute for a formal CQI meeting.

Your pharmacy's annual CQI meeting should have most staff in attendance to discuss medication incidents and ways to improve the use of Safety IQ. CQI meetings provide a scheduled and dedicated time for pharmacy staff to have fulsome discussions on multiple topics relating to safety issues.

Your annual CQI meeting should include:

- Discussion about medication incidents and near-miss events and brainstorming to create improvement plans and progress of existing improvement plans
- Review of your SSA results (if completed) and status of related improvement plans or discussion of new plans
- Review of your pharmacy's incident data summary for trends and discussion of potential issues
- Share learning and staff education on medication safety from other sources such as CPhM or ISMP Canada
- Assessment and discussion of the quality and efficacy of Safety IQ in your pharmacy

CQI meetings help foster a culture of safety with open discussion about medication incidents and potential improvements. It also is an opportunity

Reducing the Chance of Patient Harm: CQI Resources and Strategies for Pharmacy Professionals

Shared learning is a key element of CQI that your pharmacy team can use to reduce the chance of patient harm.

CPhM has published two real-life Manitoba case studies that examine medication incidents and provide improvement strategies: https://safetyiq.academy/share-learning-and-communicate/

- Missing or Extra Doses in Compliance Packaging
- Hospital Discharge Prescription and Compounded Prednisone for Pediatric Patient

Shared learning is a cornerstone of Safety IQ, and the above resources are a representation of community pharmacy's commitment to CQI in Manitoba. Your reports and CQI stories are contributing to shared learning across Canada.

If your pharmacy has experienced an incident or near-miss event that would be a good learning opportunity for other pharmacies, please forward your story to the Safety IQ team at safetyiq@cphm.ca. Your story will be shared with the profession through CPhM publications and any identifying information about the pharmacy or staff will be kept anonymous.


SAFETY MEASURES


RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES


YOUR IMPROVEMENT STORIES

SAFETY MEASURES:

New Provincial and National Data 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 medication incident, near-miss event, and engagement statistics reported by Manitoba's pharmacy professionals:

From October 2021 – March 2022, Manitoba Community Pharmacies submitted 1848 reports to the NIDR. Please see the NIDR Safety Brief for details on the types of incidents, levels of harm, and improvement strategies for your pharmacy.

In July 2022, the NIDR also published a National Snapshot which shares information about the types of medication incidents that have been reported by community pharmacies across Canada. The Snapshot is an overview of the top ten medications involved in medication incidents and five **quick, actionable safety recommendations.**

155 Pharmacies have completed at least one formal Continuous Quality Improvement Meeting

199 Pharmacies have completed their Safety Self-Assessment

RESOURCES & PROFESSIONAL DEVELOPMENT OPPORTUNITIES:

College of Pharmacists of Manitoba Resources

- **Quality Improvement Case Studies from Safety IQ: Medication Incidents *NEW*** Review shared learning from your colleagues across Manitoba with new case studies of medication incidents that can offer your team improvement strategies: https://safetyiq.academy/share-learning-and-communicate/

- **CQI Meeting Resource:** How are we doing? Toolkit for Effective CQI Meetings *NEW*

- Medication Incidents in COVID-19 Vaccine Administration in Children: Contributing Factors and Prevention Strategies

- Preventing Liver Failure, Injury, and Death: The Pharmacist's Role in Acetaminophen Safety (Friday Five Article)

ISMP Canada Safety Bulletins

- Safer Labelling of Repackaged Active Pharmaceutical Ingredients for Pharmacy Compounding (August 10, 2022)

- Infusion Errors Leading to Fatal Overdoses of N-Acetylcysteine (July 21, 2022)

- Emergency Care Plans Can Save Lives (June 22, 2022)

- Substitution Error with Tranexamic Acid During Spinal Anesthesia (May 26, 2022)

- Pediatric Medication Errors in the Community: A Multi-Incident Analysis (April 20, 2022)

- Heightened Risk of Methotrexate Toxicity in End-Stage Renal Disease (March 17, 2022)

ISMP Medication Safety Exchange Webinar: Acetaminophen Death Investigation and Recommendations

ISMP Canada's most recent complimentary webinars reviews a death investigation involving acetaminophen within a health facility and Medication Without Harm for Canadians in recognition of World Patient Safety Day.

SAFETY. IMPROVEMENT. QUALITY.

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 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

AB was a 72-year-old male who was found dead on the floor at home on August 14, 2018. Earlier that day, he had fallen while going to the bathroom and hit his face against the wall. His partner helped him get to the couch and he asked to be left there. His medical history included coronary artery bypass surgery, myocardial infarctions, pancreatitis, hypertension, stroke, cholecystectomy, osteoporosis, and appendectomy. An autopsy was performed, and the immediate cause of death was determined to be an accidental multi-drug toxicity involving diphenhydramine, metoclopramide, metoprolol, zopiclone and sertraline. His family had reportedly expressed concern that AB may have overdosed on his zopiclone prescription.

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)**
Diphenhydramine*	544	14 - 112
Metoclopramide*	1860	200 - 400
Metoprolol*	1000	20 - 340
Sertraline*^ Norsertraline (active metabolite)* ^	1600 5500	20 - 187 33 - 516
Zopiclone*	113	25 - 65s
Oxycodone, acetaminophen, clonazepam, nortriptyline, ondansetron,	Detected but not quantified	Various

^ Selective serotonin-reuptake inhibitors like sertraline undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report.

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

Generic Name	Date Dispensed	Strength	Quantity	Days' Supply	Prescriber	Pharmacy
Levofloxacin	Aug 7, 2018	500 mg	6	6	Dr. B	GHI Pharmacy
Clonazepam	Aug 2, 2018 July 6, 2018 May 8, 2018	0.5 mg 0.5 mg 0.5 mg	84 84 168	28 28 56	Dr. A	ABC Pharmacy
Sertraline	May 8, 2018	100 mg	180	90	Dr. A	ABC Pharmacy
Zopiclone	Aug 3, 2018 May 8, 2018	5 mg 5 mg	180 180	90 90	Dr. A	ABC Pharmacy
Metoprolol	May 8, 2018	100 mg	180	90	Dr. A	ABC Pharmacy
Ramipril	May 8, 2018	2.5 mg	90	90	Dr. A	ABC Pharmacy
Acetaminophen/ Oxycodone	June 13, 2018	325 mg/ 5 mg	60	30	Dr. A	XYZ Pharmacy
Alendronate	June 13, 2018	70 mg	12	84	Dr. A	XYZ Pharmacy

Discussion

The concurrent use of central nervous system (CNS) depressants (benzodiazepines, z-drugs, metoclopramide, and diphenhydramine) in this elderly patient resulted in an increased risk of falls and led to accidental mixed drug toxicity, which was the primary cause of death.

According to the Screening Tool of Older Persons' potentially inappropriate Prescriptions (STOPP) and the American Geriatrics Society (AGS) Beers Criteria, potentially inappropriate medications include long-acting benzodiazepines, first-generation antihistamines, as well as medications that increase the probability of falls in those already prone to falls.[1,2] Benzodiazepines, z-drugs, metoclopramide, and diphenhydramine can impair psychomotor function and increase the risk of falls, fractures, injury, and cognitive impairment. The risks are elevated in the presence of polypharmacy and comorbidities, including osteoporosis, which was present in this patient's medical history. Furthermore, diphenhydramine is an antihistamine with potent anticholinergic side effects that is also listed in the AGS Beers Criteria as a potentially inappropriate medication for use in older adults.[1,3] Pharmacists should advocate for patient safety by recommending to patients and prescribers to reduce the use of combination CNS-depressing medications, and recommending safer alternatives if available.[1] Pharmacists must also ensure that elderly patients are given proper counselling before CNS-depressing agents or anticholinergic agents are dispensed as they may increase the risk of cognitive impairment and adverse effects in older individuals.[3]

In addition, a large quantity of zopiclone was dispensed for this patient. AB was prescribed 10 mg of zopiclone a day, which is twice the recommended maximum of 5 mg/day for older patients.[4] According to the new Standard of Practice for Prescribing Benzodiazepines & Z-Drugs by the College of Physicians and Surgeons of Manitoba (CPSM) that came into effect in November 2020, benzodiazepine and z-drug prescriptions can only be written for a maximum of three months at once and only a one-month supply can be dispensed at a time.[5] The rationale for this new change is to allow for more regular follow-up of the risks versus benefits of these medications.

Deprescribing benzodiazepines and z-drugs can be challenging to initiate in practice. Sometimes, patients appear to be functioning well on their benzodiazepine or z-drug so clinicians may be concerned about destabilizing the patient if they begin to taper it. However, evidence shows that the risks of staying on these agents outweigh the benefits in the long-term, especially in older adults.[4,6] Moreover, as people age, their physical health and ability to cope with stress can change. In this case, the patient received a new prescription for levofloxacin for a respiratory infection from an emergency physician. The additional stress on his respiratory function and ability to eliminate medication can quickly increase the adverse risk of CNS-depressing agents. Drug-related harm could be minimized by reducing the use of combination CNS-depressing agents.

Pharmacist-led educational interventions, including evidence-based recommendations for deprescribing to the prescriber, one-time counselling of patients, and patient brochures about the risks, have been shown to decrease the use of benzodiazepines or z-drugs in older patients.[6,7] This is supported by a study by Martin et al. which has shown that at 6 months, 43% of patients who received pharmacist-led educational interventions no longer filled prescriptions for inappropriate medications as compared to 12% in the control group (risk difference = 31%, 95% CI 0.23 – 0.38).[8] Therefore, pharmacists are strongly encouraged to educate older patients and their caregivers that benzodiazepines and z-drugs are meant to only be used in the short-term and the potential harms of these agents can contribute to the risk of falls and injury, which may eventually lead to hospitalization and death.[6] Pharmacists should collaborate closely with elderly patients and prescribers to construct a gradual and feasible dose reduction plan with the ultimate goal of discontinuing long-term benzodiazepine and Z-drug use.[7,9] Establishing a coherent treatment plan is essential to monitor the progress of deprescribing while managing underlying health conditions.[9] Pharmacists should be empathetic in their approach when overcoming resistance from the patient by involving the family, explaining that tapering is a therapeutic trial that can be slowed or paused, and emphasizing that tapering results in better mood and function while reducing the risk of falls and other adverse events.

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 all potential issues are addressed, even if this entails difficult patient encounters. Measures must be taken to address issues with appropriateness of drug therapy, drug interactions, therapeutic duplication, and inappropriate or unsafe dosing. Pharmacists do not have the obligation to dispense medications that they believe may cause patient harm. In such cases, the patient must be referred appropriately according to the Referring a Patient Practice Direction.

References:

1. 2019 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. J Am Geriatr Soc. 2019;67(4):674-694. doi:10.1111/jgs.15767

2. Gallagher P, O'Mahony D. STOPP (Screening Tool of Older Persons' potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers' criteria. Age Ageing. 2008;37(6):673-679. doi:10.1093/ageing/afn197

3. Schroeck JL, Ford J, Conway EL, et al. Review of Safety and Efficacy of Sleep Medicines in Older Adults. Clin Ther. 2016;38(11):2340-2372. doi:10.1016/j.clinthera.2016.09.010

4. Managing Benzodiazepine Use in Older Adults. Centre for Effective Practice. June 2019. https://cep.health/media/uploaded/CEP_Benzodiazapine_2019.pdf.

5. College of Physicians and Surgeons of Manitoba (CPSM). Standard of Practice for Prescribing Benzodiazepines & Z-Drugs Contextual Document. November 2020. http://www.cpsm.mb.ca/assets/Standards%20of%20Practice/Standard%20of%20Practice%20Prescribing%20Benzodiazepines%20and%20Z-Drugs.pdf.

6. Conn DK, Hogan DB, Amdam L, et al. Canadian Guidelines on Benzodiazepine Receptor Agonist Use Disorder Among Older Adults Title. Can Geriatr J. 2020;23(1):116-122. Published 2020 Mar 30. doi:10.5770/cgj.23.419

7. Choosing Wisely Canada. Toolkit: Less Sedatives for Your Older Relatives. May 2019. https://choosingwiselycanada.org/wp-content/uploads/2017/07/CWC_BSH_Hospital_Toolkit_v1.3_2017-07-12.pdf.

8. Martin P, Tamblyn R, Benedetti A, Ahmed S, Tannenbaum C. Effect of a Pharmacist-Led Educational Intervention on Inappropriate Medication Prescriptions in Older Adults: The D-PRESCRIBE Randomized Clinical Trial. JAMA. 2018;320(18):1889-1898. doi:10.1001/jama.2018.16131

9. Institute for Safe Medication Practices Canada (ISMP). Deprescribing: Managing Medications to Reduce Polypharmacy. March 2018. https://www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-03-Deprescribing.pdf.

Decision and Order of the Discipline Committee: Adel Adly Helmy AbouHammra

Pursuant to the Amended Notice of Hearing (the "Notice") dated January 21, 2022, 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 February 23, 2022, with respect to charges formulated by the College alleging that Mr. Adel Adly Helmy AbouHammra ("Mr. AbouHammra"), 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 Nations-First Pharmacy (the "Pharmacy"), 102-19 Pine Street, Pine Falls, Manitoba, Mr. AbouHammra:

1. failed to secure narcotics and controlled substances in contravention of: section 43 of the Narcotic Control Regulations, C.R.C., c. 1041, (the "NCRs"), subsection 72(1)(a) of the Benzodiazepine and Other Targeted Substances Regulations, SOR/2000-217, (the "BOTSRs"), subsection G.03.012 of the Food and Drug Regulations, C.R.C., c. 870 (the "FDRs"), and, the Narcotic and Controlled Drug Accountability Guidelines, or any of them, in that he:

    a. failed to establish, implement, ensure compliance with, and maintain policies and procedures to protect narcotics and controlled substances in contravention of: subsections 56(1)13 and 65(1) of the Pharmaceutical Regulation, Man Reg 185/2013 (the "Regulation"), or either of them;

    b. STAYED;

    c. STAYED;

    d. failed to investigate discrepancies in the inventory of narcotics and controlled drugs in contravention of subsections 2.3.2.3 and 2.3.2.4 of the DDS Practice Direction, or either of them;

    e. STAYED;

    f. failed to perform and record physical inventory counts of narcotics and controlled drugs in contravention of subsections: 2.3.2.2 of the DDS Practice Direction, and subsections 2.1.1, 2.1.2, and 2.1.3 of the RI Practice Direction, or any of them:

    g. failed to perform an inventory count, and maintain a record of expired, damaged, or patient returned drugs included in the Controlled Drugs and Substances Act (S.C. 1996, c. 19) (the "CDSA") in contravention of: subsection 2.3.2.2 of the DDS Practice Direction and subsections 2.1.1, 2.1.2, and 2.1.3 of the RI Practice Direction, or any of them;

h. on multiple occasions between August 2013 and January 2020, 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, subsection 72(2) of the BOTSRs, and, section 2.3.2.5 of the DDS Practice Direction, or any of them;

i. on multiple occasions between August 2013 and January 2020, and January 2016 to January 2020, failed to submit Loss and Theft Reports for Controlled Substances and Precursors to the College, in contravention of section 2.3.2.5 of the DDS Practice Direction;

j. failed to manage and/or protect the narcotic inventory at the Pharmacy, in that he:

    i. failed to securely store the SNS-oxycodone/acetaminophen inventory, Tylenol® with Codeine No. 3, and various generic acetaminophen/caffeine/codeine 8mg preparations including Stanley brand, inventory in a narcotic safe in contravention of sections 2.2.8, and 2.2.15 of the Facilities Practice Direction, or either of them;

    ii. failed to enter certain Tylenol® with Codeine No. 3 inventory upon receipt of a narcotic from a licenced dealer in contravention of section 30 of the NCRs;

    iii. STAYED;

k. STAYED;

2. STAYED;

3. STAYED; and,

4. STAYED.

The hearing into the charges convened on February 23, 2022. Mr. Jeffrey Hirsch ("Mr. Hirsch") and Ms. Sharyne Hamm appeared as counsel on behalf of the Complaints Committee. Mr. AbouHammra appeared unrepresented before the Panel. He was encouraged to retain counsel, but he declined. Mr. Joseph Pollock appeared as counsel to the Panel.

Mr. AbouHammra admitted that:

a. he was at the time of the hearing, and all times pertinent to the charges, a member of the College;

b. he was at the time of the hearing, and all times pertinent to the charges, the owner of the Pharmacy; and

c. the time limits set forth in sections 46(2) and 46(3) of the Act had been met.

Mr. AbouHammra waived the reading of the charges, following which:

a. The Complaints Committee entered a stay of proceedings with respect to counts 1(b), 1(c),

1(e), 1(j)(iii), 1(k), 2, 3, and 4; and

b. Mr. AbouHammra entered a plea of not guilty to all remaining counts.

Evidence

The Panel heard the evidence of two witnesses presented by the Complaints Committee. The first was Dr. Brent Booker, Assistant Registrar – Review and Resolution of the College. The second was Mr. Ken Zink, a contract investigator who investigated the complaint on the behalf of the Complaints Committee.

Dr. Booker explained to the Panel the statutory and regulatory provisions, as well as the guidelines and practice directions referenced in the counts. Mr. Zink explained to the Panel the substance of his investigation, including his discussions with Mr. AbouHammra. Mr. AbouHammra was given an opportunity to cross-examine both Dr. Booker and Mr. Zink. After Mr. Hirsch closed the case on behalf of the Complaints Committee, Mr. AbouHammra was given an opportunity to testify on his own behalf. Mr. AbouHammra did not call any other witnesses.

After Mr. AbouHammra closed his case, Mr. Hirsch made submissions on behalf of the Complaints Committee and Mr. AbouHammra made submissions on his own behalf.

Following the submissions of the parties, the Panel deliberated and then reconvened to inform the parties that it has found Mr. AbouHammra guilty on all counts. The Panel advised the Parties that written reasons would follow. The Panel also gave the parties an opportunity to speak to the penalty to be imposed by the Panel.
In arriving at its decision, the Panel concluded that the evidence established that Mr. AbouHammra's conduct demonstrated professional misconduct, conduct unbecoming a member, or displayed a lack of skill or judgment in the practice of pharmacy or operation of a pharmacy, as described in section 54 of the Act.

Decision

Count 1(a)
The Panel concluded the evidence showed that the Policy and Procedure Manual (the "P&P") excerpts for the Pharmacy were insufficient for the proper protection of narcotics and controlled substances. There was minimal information provided in the P&P that would allow proper and consistent practice for the management of narcotic and controlled drug inventory of the Pharmacy.

Count 1(d)
The Panel concluded that the evidence showed a significant number of unexplained discrepancies, 49 in total, for narcotic and controlled substances within the Kroll pharmacy management system that did not have any explanation or documentation for the adjustment of inventory. Mr. AbouHammra did not provide any evidence or any explanation for the lack of documentation for the 49 unexplained discrepancies. The Panel concluded that Mr. AbouHammra failed to investigate the unexplained discrepancies in the inventory of narcotics and controlled drugs in contravention of subsections 2.3.2.3 and 2.3.2.4 of the DDS Practice Direction.

Count 1(f)
The Panel concluded that testimony of Mr. Zink together with the exhibits filed by the Complaints Committee illustrated that there were no physical inventory counts of narcotics and controlled drugs which are to be recorded and performed at least every three months. The evidence showed that Mr.

AbouHammra admitted that physical counts of narcotics and controlled drugs were not performed at least every three months. While Mr. AbouHammra disputed that physical counts were not performed, he failed to present any evidence indicating that physical inventory counts were performed and recorded in compliance of subsections 2.3.2.2 of the DDS Practice Direction and subsections 2.1.1, 2.1.2, and 2.1.3 of the RI Practice Direction.

Count 1(g)
The Panel concluded that the evidence showed there were expired, damaged or patient returned narcotics and controlled drugs on site of the Pharmacy that did not have inventory count records in contravention of subsection 2.3.2.2 of the DDS Practice Direction and subsections 2.1.1, 2.1.2, and 2.1.3 of the RI Practice Direction. The evidence showed a destruction of records for narcotic and controlled substances destroyed in 2017. However, Mr. AbouHammra failed to provide any evidence or explanation why there were no records for inventory counts for the expired, damaged or patient returned drugs included in the CDSA and identified at the time of the investigation.

Count 1(h)
While Mr. AbouHammra indicated that he submitted Loss and Theft Reports for Controlled Substances and Precursors to the Office of Controlled Substances, Health Canada for the armed robberies that had occurred at Nations First Pharmacy, no reports were submitted for any of the 49 instances of unexplained discrepancies.

Count 1(i)
While Mr. AbouHammra indicated that he submitted Loss and Theft Reports for Controlled Substances and Precursors to the College for the armed robberies that had occurred at Nations First Pharmacy, no reports were submitted for any of the 49 instances of unexplained discrepancies.

Count 1(j)(i)
The Panel concluded that the evidence showed there were Tylenol® with Codeine No. 3, various generic acetaminophen/caffeine/codeine 8mg preparations including Stanley brand, and SNS- oxycodone/acetaminophen inventory not secured within a narcotic safe in contravention of sections 2.2.8, and 2.2.15 of the Facilities Practice Direction. The volumes of drug were significant - cases of bottles. Leaving this number of narcotic drugs unsecured can place the community at risk. Mr. AbouHammra did not provide any evidence showing that there was an attempt to find suitable storage facilities or safes to secure the narcotic inventory.

Count 1(j)(ii)
The Panel concluded that 12,000 tablets of Tylenol® with Codeine No. 3 - one case - could not be accounted for during the investigation of the narcotic inventory. The evidence showed that the tablets were found and stored in the Nations First Pharmacy stockroom in contravention of Section 30 of the NCRs. The 12,000 tablets of Tylenol® with Codeine No. 3 had been sent to First Nations Pharmacy several months previous to the investigator visit and had not been entered as inventory upon receipt by Mr. AbouHammra.

Penalty

Mr. Hirsch submitted that Mr. AbouHammra should:
1. pay a fine for lack of compliance in the amount of $5,000;
2. be prohibited from being a pharmacy manager for two years;

3. be prohibited from being a preceptor for two years;
4. be required to successfully complete a remedial quality assurance program, arranged by the College, with the associated costs to be paid by Mr. AbouHammra; and,
5. pay $50,000 in contribution to the costs of investigating and prosecuting the case against him.

Mr. Abou Hammra submitted that:
1. no fine should be assessed;
2. he be permitted to continue as pharmacy manager and eligible as a preceptor;
3. he participate in a remedial professional development program, excluding content on ethics, for which he would bear the associated costs; and,
4. he pay $25,000 in contribution to the costs of investigating and prosecuting the case against him.

Order

The Panel ordered that Mr. AbouHammra:
1. pay a fine in the amount of $5,000;
2. is prohibited from being a preceptor for a period of two years;
3. must successfully complete a remedial quality assurance program as set out by the College. Costs for this program are to be paid by Mr. AbouHammra;
4. submit to the Registrar quarterly physical narcotic, controlled and targeted drugs counts and manual adjustment reports for a one-year period; and
5. pay $50,000 in contribution to the costs of investigating and prosecuting the case against him. It should be noted that this amount is less than 40% of the total costs of the hearing.

In arriving at its decision, the Panel considered:
1. There was recognition by the Complaints Committee that there was no dishonesty, diversion, or moral culpability on Mr. AbouHammra's behalf.
2. Mr. AbouHammra showed willingness to take remedial training designed through the quality assurance program of the College.
3. Mr. AbouHammra continued as a pharmacist and pharmacy manager/owner from the time of the investigation up to the hearing date of February 25, 2022, without further incident.
4. This was Mr. AbouHammra's first disciplinary hearing.
5. The penalty must reflect the risks resulting from Mr. AbouHammra's actions and the impact to staff, patients and community when there is improper record keeping, storage and management of narcotics and controlled substances.
6. The impact on the community and surrounding area of Pine Falls, if this Panel were to prevent Mr. AbouHammra from being a pharmacy manager for two years.

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

DATED at Winnipeg, Manitoba this 31st day of March, 2022.

THE COLLEGE OF PHARMACISTS OF MANITOBA

Ron Eros
Chair, Discipline Panel

IN MEMORIUM

In loving memory,

RICHARD BROWN
APRIL 30, 2022

MAUREEN MORIN
MAY 5, 2022

ALLAN WALDER
July 13, 2022

DOUGLAS PENNER
August 15, 2022