COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

Summer 2020

Feature: Moving Forward with Safety IQ

Table of 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.

OFFICERS

Wendy Clark, President, District 2
Sonal Purohit, Vice President, District 1
Jane Lamont, Executive Treasurer, District 2
Kevin Hamilton, Past President, District 2

COUNCILLORS

Ryan Buffie, District 1
Tory Crawford, Public Representative
Alanna Doell, District 1
Donna Forbes, Public Representative
Donald Himbeault, Public Representative
Amanda Jenkyns, Public Representative
Drupad Joshi, District 2
Bharti Kapoor, Public Representative
Nicole Nakatsu, District 1
Ravi Pandya, District 2
Dr. Lalitha Raman-Wilms, Dean, College of Pharmacy

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.

LIAISONS TO COUNCIL

Brenda Rosenthal, C.S.H.P. (MB Branch)
Dr. Brenna Shearer, Pharmacists Manitoba
Marina Rofaeil, Student Representative, College of Pharmacy

COLLEGE STAFF

Susan Lessard-Friesen, Registrar
Rani Chatterjee-Mehta, Deputy Registrar
Brent Booker, Assistant Registrar - Review and Resolution
Kathy Hunter, Assistant Registrar - Field Operations
Kim McIntosh, Assistant Registrar - Qualifications and Practice Development
Ronda Eros, Practice Consultant
Meret Shaker, Practice Consultant
Chris Louizos, Quality Assurance and Field Officer
Lori McKietiuk, Director of Operations
Bev Robinson, Registration Officer
Stacey Hjorleifson, Senior Administrative Assistant
Lindsay Henderson, Executive Assistant to the Registrar & Deputy Registrar
Brittany Delaquis, Administrative Assistant
Hazel Suh, Administrative Assistant

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

Feature

Moving Forward with Safety Improvement in Quality – Safety IQ

Over the past year, the Safety IQ Advisory committee and College staff have built a comprehensive implementation plan for Safety IQ, a standardized continuous quality improvement (CQI) program for community pharmacies.

The College successfully piloted Safety IQ with 20 community pharmacies for one year starting in September 2017. Participants in the Safety IQ Pilot Program credited the Safety IQ tools with making it easier to find and address medication incident trends and make changes to pharmacy practices that improve patient safety. Safety IQ will be mandatory for community pharmacies starting on June 1, 2021, and everyone has a role to play.

Why Safety IQ?

The World Health Organization (WHO) identifies medication errors as a leading cause of injury and preventable harm in healthcare systems across the world. Globally, WHO estimates the cost associated with medication errors at $42 billion USD annually. In response, WHO identified Medication Without Harm as the theme for the third Global Patient Safety Challenge in 2017. Medication Without Harm set out to reduce severe avoidable medication-related harm by 50 per cent, globally in the next five years. Incident reporting and learning by healthcare professionals as well as monitoring and evaluation of systems and practices of medication dispensing are two areas that healthcare professionals can focus on to improve patient safety.

In Canada, pharmacy practice regulators across the country are taking up this challenge by implementing CQI programs to report medication incidents and near-miss events to improve the safety of community pharmacies. Nova Scotia, Saskatchewan, Ontario and New Brunswick have already implemented programs or standards and other provinces are looking to follow. Healthcare facilities such as hospitals already have processes for reporting, investigating and learning from medication and critical incidents.

A message from Melissa Sheldrick, Patient Safety Advocate

On March 13, 2016, our 8-year-old son Andrew passed away suddenly and we later discovered that it was due to medication errors made during the dispensing process. Andrew's compounded tryptophan liquid was substituted with baclofen, unbeknownst to us and the pharmacy. Since discovering that the only reporting program in existence at the time was in Nova Scotia, I made it my work to bring anonymous reporting and more stringent quality improvement programs to pharmacies across the country.

I was not ready to accept the fact that this devastation could happen to another family.

Keeping patients safe remains the priority for community pharmacists in Manitoba. Safety IQ has been designed not only to help prevent errors from happening, but to take the learning from past incidents and turn it into resources and tools for your daily use. Working together to share your knowledge will help to develop a strong culture of safety and learning, and will continue to protect the people who rely on your team, everyday. Please use all of the tools robustly to maximize the effectiveness of this important program.

You can learn more about my mission with the following short video created by the Ontario Pharmacists Association:
https://www.youtube.com/watch?v=g0p47ThUcoQ

Sincerely,

Melissa Sheldrick

Safety.
Improvement.
Quality.

What Value does Safety IQ Add to Current Practices?

Currently, all community pharmacies are required to document medication incidents and ensure patient safety. Safety IQ improves current practice by ensuring that pharmacy professionals across the province share lessons learned from medication incidents using standardized CQI practices. Safety IQ enables community pharmacies to

- anonymously report medication incidents and near-miss events to the National Incident Data Repository;
- enhance patient safety using standardized tools and practices;
- learn from medication incidents and near-miss events in other pharmacies;
- contribute to analysis that will identify causes of medication incidents in Canada and potential system safeguards; and
- promote a culture of safety in which all pharmacy staff feel comfortable reporting and talking about medication incidents.

According to the National Academy of Medicine, "the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm." In a safety culture, learning and sharing within pharmacy teams and across the entire profession can make the healthcare system safer.

Safety IQ and the updated Medication Incidents and Near-miss Events practice direction set specific requirements for reporting, documenting, analyzing, and communicating about medication incidents and near-miss events to lay the foundation for safety culture to flourish in community pharmacies across the province.

How is Safety IQ different from CQI programs in other provinces?

Safety IQ and other provincial programs or standards share many of the same principles with one exception. The College does not mandate pharmacies to use a particular medication incident reporting platform but instead created a specific set of criteria that medication incident reporting platforms must satisfy. 'Dual reporting'—the reporting of medication incident and near-mess event data to both a College mandated platform and a pharmacy's internal reporting platform—was identified by Safety IQ pilot pharmacies as a significant barrier to consistent reporting. Allowing pharmacies to choose a medication incident reporting platform potentially eliminates the 'dual reporting' phenomenon.

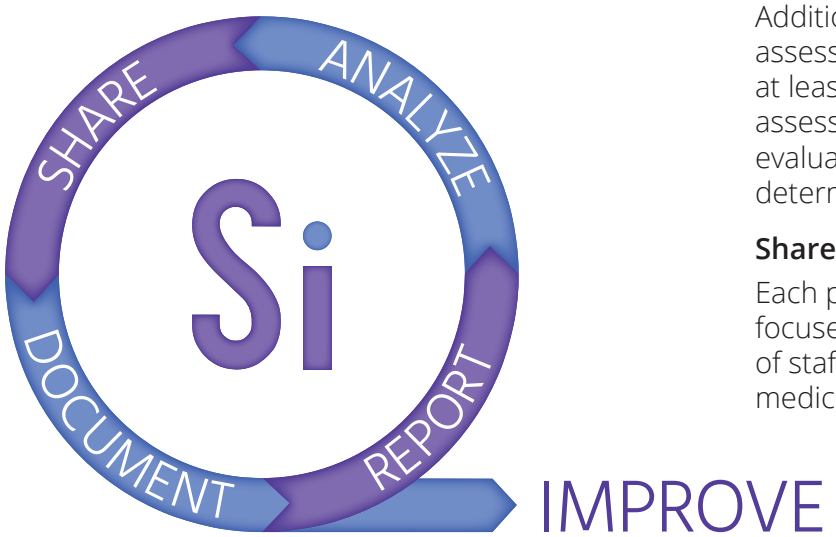
Information on the platform criteria has been sent to pharmacy managers as well as district managers for pharmacy organizations.

Continuous Quality Improvement and the Safety IQ Cycle

Continuous quality improvement (CQI) is an ongoing approach to problem-solving and harm prevention. CQI focuses on identifying the root causes of a problem and introducing ways to eliminate or reduce the problem through open-ended analysis and assessment of process change.

In the pharmacy field, CQI focuses on preventing medication incidents and continually looking for ways to improve medication dispensing, therapy management, and counselling. Safety IQ is a standardized CQI framework that enables pharmacy teams to report, document, analyze, and share learning about medication incidents and near-miss events.

4 Key Elements of Safety IQ



Additionally, pharmacies conduct a safety self-assessment within the first year of Safety IQ and at least once every three years thereafter. The assessment is designed to help pharmacy teams evaluate the level of safety in their practice and determine areas to focus on for improvement.

Share

Each pharmacy conducts at least one formal CQI-focused staff meeting per year, where a majority of staff are present, to analyze and discuss medication incidents and near-miss events as well as the practice changes that have been implemented. The College recommends informal meetings/huddles throughout the year as necessary to review incidents.

Report

Community pharmacies report medication incidents and near-miss events to a reporting platform of their choice. De-identified (anonymous) medication incident and near-miss event data are then exported to the National Incident Data Repository (NIDR), a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) hosted by the Institute for Safe Medication Practices Canada (ISMP Canada).

The NIDR creates a cohesive information-sharing system that facilitates the understanding of medication incidents and the development of strategies to prevent patient harm.

By contributing incident data to the NIDR, experts in incident analysis can review trends and patterns nationally and study contributing factors to develop recommendations to share with pharmacy professionals across the country.

Analyze

Pharmacies analyze their medication incidents and contributing factors to develop improvement plans that change processes or procedures to reduce the likelihood of recurrence. At the same time, de-identified aggregate data from the NIDR are analyzed by medication safety experts to identify contributing factors and causes and make recommendations for the prevention of harmful medication incidents.

Document

CQI is an ongoing cycle of reviewing what you are doing, making changes, and evaluating the changes to see if they are effective. Therefore, it is important to document discussions with staff and keep track of improvement plans allowing you to continuously evaluate the efficacy of your quality improvement strategies.

How Do We Prepare for Safety IQ?

Preparing for Safety IQ will be a team effort and everyone has a role to play.

All pharmacy staff should start by reviewing and discussing the following Safety IQ documents and resources:

- Updated Medication Incidents and Near-Miss Events Practice Direction
- Safety IQ Implementation 2020 - 21 Guide for Pharmacy Managers
- Safety IQ FAQ
- Safety IQ Quick Facts
- Community Pharmacy Safety Toolkit

All Safety IQ documents can be found at the following link:

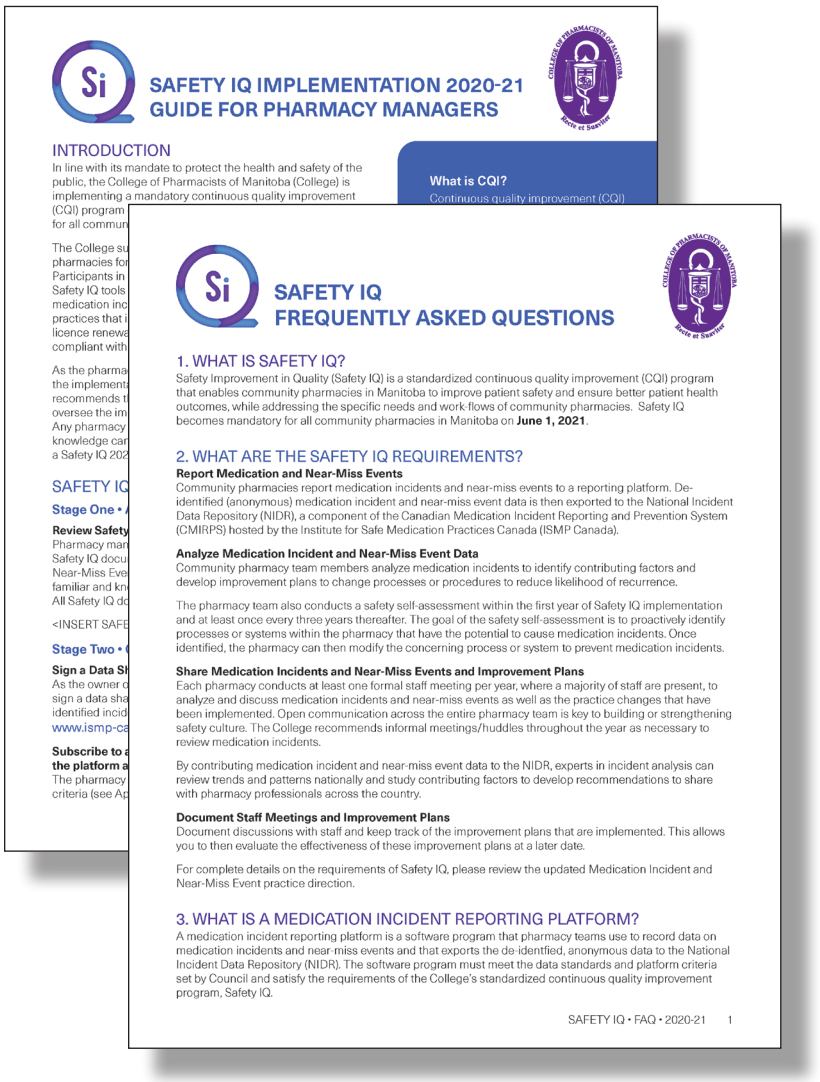
https://cphm.ca/practice-education/quality-assurance/safety-iq/

The College is communicating directly with pharmacy managers and district managers (where applicable) to ensure a smooth integration of Safety IQ into your pharmacy's workflow.

Over the coming months, all members can expect consistent communication about Safety IQ implementation through the bi-weekly Friday Five, quarterly Newsletter, and eQuipped, the official newsletter for Safety IQ. Additionally, the College will also be sharing information through video. Please view the first Safety IQ implementation video here:

https://youtu.be/EE_5FFtpXI4

If you have questions or concerns about Safety IQ, please contact Ronda Eros, Practice Consultant, by email at **SafetyIQ@cphm.ca.**



SAFETY IQ IMPLEMENTATION 2020-21
GUIDE FOR PHARMACY MANAGERS

INTRODUCTION

SAFETY IQ
FREQUENTLY ASKED QUESTIONS

1. WHAT IS SAFETY IQ?

Safety Improvement in Quality (Safety IQ) is a standardized continuous quality improvement (CQI) program that enables community pharmacies in Manitoba to improve patient safety and ensure better patient health outcomes, while addressing the specific needs and work-flows of community pharmacies. Safety IQ becomes mandatory for all community pharmacies in Manitoba on **June 1, 2021**.

2. WHAT ARE THE SAFETY IQ REQUIREMENTS?

Report Medication and Near-Miss Events

Community pharmacies report medication incidents and near-miss events to a reporting platform. De-identified (anonymous) medication incident and near-miss event data is then exported to the National Incident Data Repository (NIDR), a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) hosted by the Institute for Safe Medication Practices Canada (ISMP Canada).

Analyze Medication Incident and Near-Miss Event Data

Community pharmacy team members analyze medication incidents to identify contributing factors and develop improvement plans to change processes or procedures to reduce likelihood of recurrence.

The pharmacy team also conducts a safety self-assessment within the first year of Safety IQ implementation and at least once every three years thereafter. The goal of the safety self-assessment is to proactively identify processes or systems within the pharmacy that have the potential to cause medication incidents. Once identified, the pharmacy can then modify the concerning process or system to prevent medication incidents.

Share Medication Incidents and Near-Miss Events and Improvement Plans

Each pharmacy conducts at least one formal staff meeting per year, where a majority of staff are present, to analyze and discuss medication incidents and near-miss events as well as the practice changes that have been implemented. Open communication across the entire pharmacy team is key to building or strengthening safety culture. The College recommends informal meetings/huddles throughout the year as necessary to review medication incidents.

By contributing medication incident and near-miss event data to the NIDR, experts in incident analysis can review trends and patterns nationally and study contributing factors to develop recommendations to share with pharmacy professionals across the country.

Document Staff Meetings and Improvement Plans

Document discussions with staff and keep track of the improvement plans that are implemented. This allows you to then evaluate the effectiveness of these improvement plans at a later date.

For complete details on the requirements of Safety IQ, please review the updated Medication Incident and Near-Miss Event practice direction.

3. WHAT IS A MEDICATION INCIDENT REPORTING PLATFORM?

A medication incident reporting platform is a software program that pharmacy teams use to record data on medication incidents and near-miss events and that exports the de-identfied, anonymous data to the National Incident Data Repository (NIDR). The software program must meet the data standards and platform criteria set by Council and satisfy the requirements of the College's standardized continuous quality improvement program, Safety IQ.

SAFETY IQ • FAQ • 2020-21 1

President's Message

Dear Colleagues,

I hope all College registrants are enjoying the summer and finding time to relax before the upcoming flu season. It has been a busy few months at the College as we roll out some major projects we have been building behind the scenes.

First of all, Safety IQ is here. While we plan to launch in June 2021, there are early steps you can take to prepare your pharmacy for the implementation of this important initiative. I am excited to make this part of my pharmacy and I hope you are too. College staff have monitored how other provinces implemented their incident reporting program and created something meaningful and special for pharmacy practice in Manitoba. Be sure to carefully read our introduction in this newsletter and monitor your email for updates regarding the program.

You may have noticed the incredible update to our website. The College collaborated with Manoverboard to build this concept from the ground up. I think you will like the changes. The resource library was one of our most requested features and we are thrilled with how it turned out.

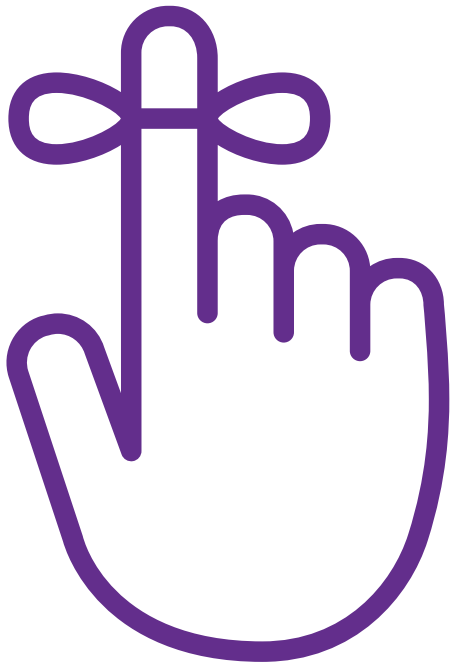
Be sure to review the section on non-sterile compounding for an important reminder regarding the upcoming deadline.

Thanks again for all of your hard work during these uncertain times.

Wendy Clark
President

Professional Development Reminder

With the on-going COVID-19 pandemic, nearly all professional development (PD) programs have shifted to online delivery but yearly PD requirements remain the same.

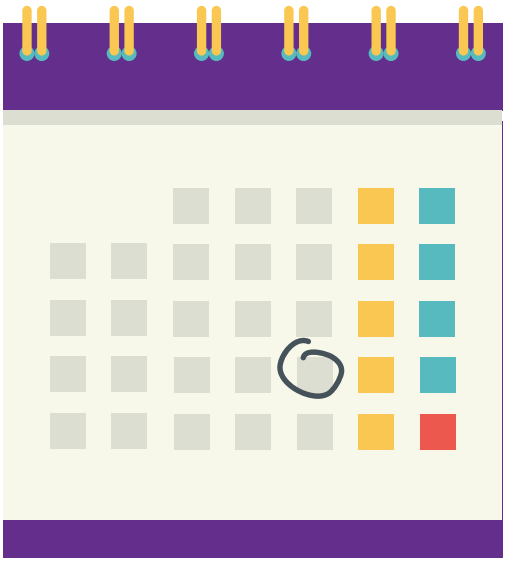


To be eligible for licence renewal, pharmacists must complete a minimum of 25 hours of PD learning activities between November 1 and October 31 of each year. Of the these 25 PD hours, a minimum of 15 hours must be from accredited learning activities with the remaining ten hours from either accredited or non-accredited learning activities.

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

For more information on PD requirements for pharmacists and pharmacy technicians, please visit the **Continuing Competency** page of the College website.

Save-the-Date: College PD Event



The College is developing a second Medical Examiner Professional Development event to take place on Tuesday, September 29, 2020, from 7 to 9 pm.

The event will be online-only and will feature four speakers.

Stay tuned for more information.

Non-Sterile Compounding Communication

With Covid-19, implementation of phase one of the NAPRA Model Standards for Non-sterile compounding was postponed until October 1, 2020. With fall approaching, it is important you are aware of the many aspects of phase one and what this means for compounding in your pharmacy.

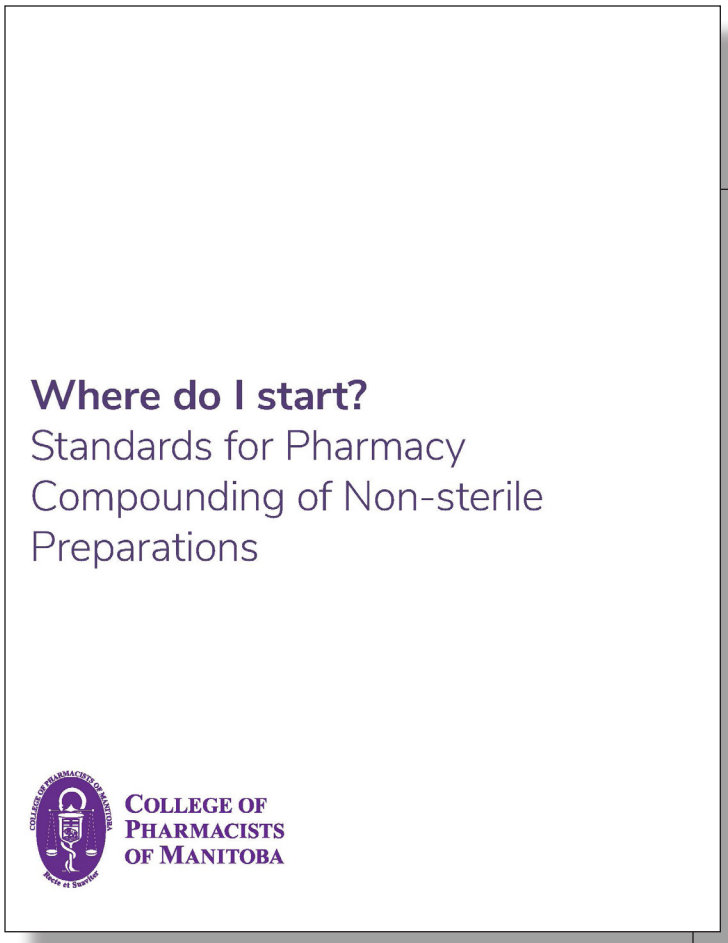
College field officers have developed the following communication resources to support the implementation process:

Where do I start? Standards for Pharmacy Compounding of Non-sterile Preparations

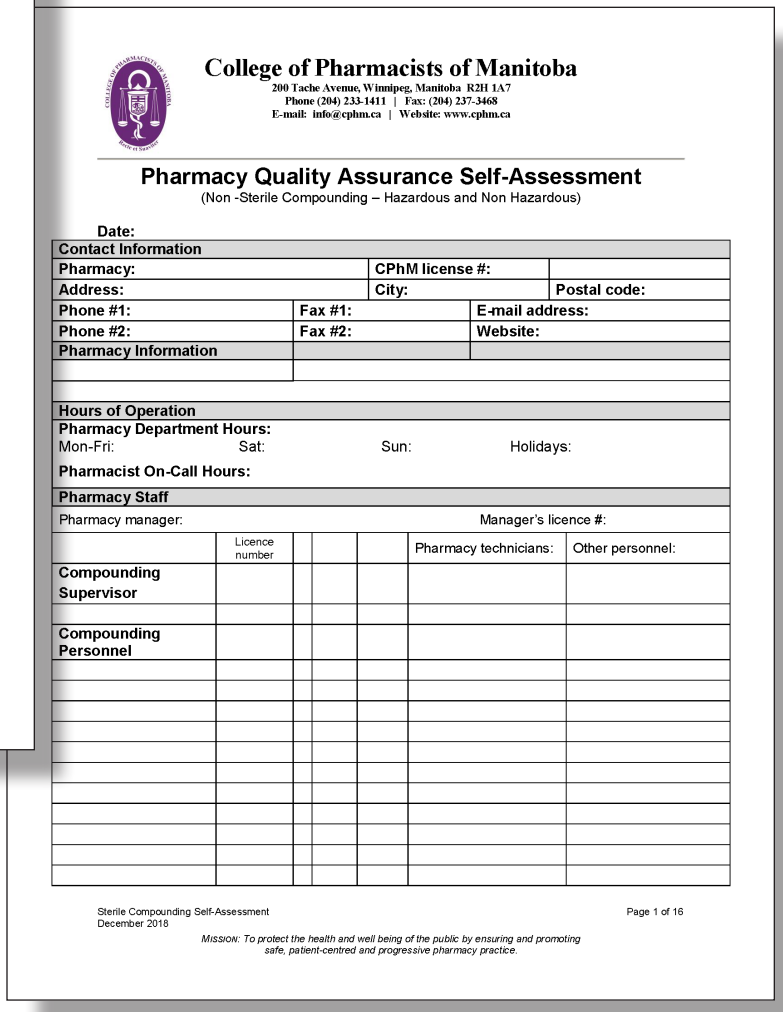
This document discusses the five steps to implementing the model standards in your pharmacy and also includes a decision algorithm for risk assessment.

Pharmacy Quality Assurance Self-assessment for Non-Sterile Compounding

To ease implementation of the standards, the College created the Pharmacy Quality Assurance Self-Assessment (Non-Sterile Compounding — Hazardous and Non-Hazardous) tool.



Please note: The Pharmacy Quality Assurance Self-Assessment is a tool for gap analysis. This tool allows the pharmacist to perform a gap analysis on their own and it is not necessary to submit the gap analysis to the College for approval or review.



College of Pharmacists of Manitoba
200 Tache Avenue, Winnipeg, Manitoba R2H 1A7
Phone (204) 233-1411 | Fax: (204) 237-3468
E-mail: info@cphm.ca | Website: www.cphm.ca

Pharmacy Quality Assurance Self-Assessment
(Non -Sterile Compounding – Hazardous and Non Hazardous)

Date:

Contact Information			
Pharmacy:		CPhM license #:	
Address:		City:	Postal code:
Phone #1:	Fax #1:	E-mail address:	
Phone #2:	Fax #2:	Website:	
Pharmacy Information			

Hours of Operation

Pharmacy Department Hours:
Mon-Fri: Sat: Sun: Holidays:

Pharmacist On-Call Hours:

Pharmacy Staff

Pharmacy manager: Manager's licence #:

	Licence number				Pharmacy technicians:	Other personnel:
Compounding Supervisor						
Compounding Personnel						

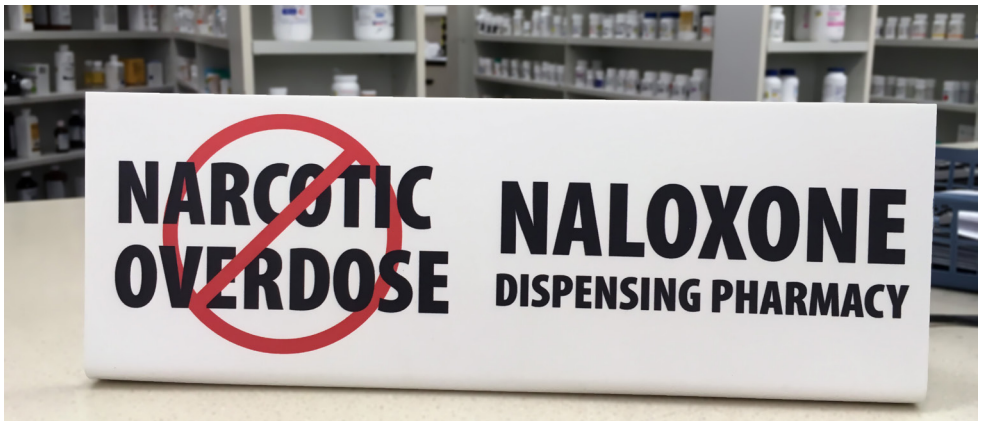
Sterile Compounding Self-Assessment
December 2018

Page 1 of 16

MISSION: To protect the health and well being of the public by ensuring and promoting safe, patient-centred and progressive pharmacy practice.

CPSM Opioid Agonist Therapy Updates

As communicated in previous Friday Five articles, the College of Physicians and Surgeons of Manitoba (CPSM) updated and created new opioid agonist therapy (OAT) practice documents that pharmacists dispensing OAT must review.



Sections of the **Methadone and Buprenorphine Maintenance Recommended Practice Manual** were updated in response to significant safety concerns involving community-based methadone inductions for opioid agonist therapy (OAT). A letter summarizing these changes was sent to OAT prescribers and can be found **here**.

The updated recommendations for methadone dose titration during the induction phase are listed below:

- The initial dose should be 10-30 mg of methadone per day for at least the first three days. Patients at high-risk for methadone toxicity should start on no more than 10-20 mg.
- During the early stabilization phase for patients new to methadone, doses may be increased by up to 5 mg every 3-5 days, or by 10 mg increments every 7 or more days.
- During the early stabilization phase for patients new to methadone, prescribers may elect to prescribe a single dose increase of 10 mg after 5 days, but all subsequent 10 mg dose increases should occur no sooner than 7 days apart. Alternatively, a 5 mg dose increase may be considered 5 days after a 10 mg dose increase. **Caution surrounding serial 10 mg dose increases is emphasized**.

A CPSM interprofessional working group, including representatives from the College of Pharmacists of Manitoba (CPhM), College of Registered Nurses (CRNM) and other experts, continues to develop a CPSM Buprenorphine/Naloxone Recommended Practice Manual for OAT.

Sections of the CPSM Buprenorphine/Naloxone Manual will be posted on the CPSM website as they become available and the following sections are now posted:

- **Recommendations for Buprenorphine/Naloxone Induction using the Micro-Dosing Method**
- **In-Hospital Care**
- **Take-Home (Carry) Dosing Recommendations**
- **Unwitnessed (Home) Inductions Recommendations**

CPhM will update the Opioid Agonist Therapy Guidelines for Manitoba Pharmacists to reflect these changes and new documents at a future date.

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

The College attends monthly Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office to review deaths which may have involved prescription drugs, focusing on opioids and other drugs of abuse. A case is presented in each Newsletter to provide an opportunity for education and self-reflection for all pharmacists on dispensing patterns in their practice. All dates, patient initials, names of pharmacies, and prescribers have been changed and de-identified to protect the identity of the patient and their family.

Introduction

SN was a 27-year-old female found dead on the floor of her home on June 22, 2019, with evidence of blunt head trauma. The immediate cause of death was determined to be blunt head trauma with zopiclone toxicity as a contributing factor. SN had a history of chronic back pain and multiple traumatic injuries. Two weeks prior, SN presented to the emergency department with injuries to her face and arm and was unable to recall what happened.

Results

The toxicology report shows baclofen and zopiclone present at supratherapeutic levels. Zopiclone, in particular, vastly exceeded the acceptable therapeutic range. Alcohol was also present, and other drugs including quetiapine and sertraline were detected but not quantified.

Toxicology Results

Drug	Level (ng/mL)	Therapeutic Range (ng/mL)
Baclofen	440 (blood)	80-400
Zopiclone	88 (blood)	25-65
Ethanol	22 (urine)	n/a

Discussion

SN was consistently requesting and receiving early refills for medications with sedating properties, including cyclobenzaprine, quetiapine, sertraline, and zopiclone, which were always authorized by her primary care provider. Only a few weeks before her death, SN requested a refill of zopiclone 23 days early on a 28-day supply. As per previous requests, the prescriber was contacted to authorize the early release, and the patient was dispensed the medication.

SN had a consistent prescriber and a consistent pharmacy. Reasoning for authorizing early refills were often provided by either the prescriber or the patient, such as an upcoming vacation or a lost/stolen medication supply. While these factors may have served to assuage any initial concerns dispensing pharmacists may have had, pharmacists are reminded of their responsibility to ensure appropriate prescribing before dispensing. This responsibility goes beyond simply confirming that an early refill is authorized. Pharmacists must further ensure the authorization of an early refill is not harmful for the patient.

Dealing with consistent requests for early refills and inappropriate prescribing practices can be challenging. The following recommendations may be appropriate to implement in your practice:

- Communicating with prescribers about concerns such as consistent early refills is paramount to patient safety. While one or two occasional early refill requests may be normal, when these become consistent, it may be a sign of other issues. Even if a prescriber authorizes early refills for each instance, it may be valuable to contact the prescriber about the big-picture issue of early refills rather than only each individual request. When early refills become consistent, a conversation about limited supports or access to supports for the patient to minimize risk associated with their prescription is helpful. Therefore, pharmacists should be aware of available resources in the community

Drugs Dispensed to SN January - June 2019 (according to DPIN):

Generic Name	Dates Dispensed	Strength	Quantity	Days Supply	Prescriber	Pharmacy
Baclofen	May 1, 30	20 mg	60	30	Dr. A	EFG Pharmacy
Cyclobenzaprine	June 6 May 15 April 22 March 7, 30 February 13	10 mg	90	30	Dr. A	EFG Pharmacy
Quetiapine	May 4, 30 April 22 March 7, 30 February 13 January 15	100 mg	90	30	Dr. A	EFG Pharmacy
Sertraline	June 6 May 15 April 16 March 7, 30 February 13 January 4, 30	100 mg	30	30	Dr. A	EFG Pharmacy
Zopiclone	June 6 May 4, 15, 30 April 11, 22 March 7 February 13 January 4, 23	7.5 mg	60	30	Dr. A	EFG Pharmacy

- Pharmacists do not have an obligation to dispense a medication they believe may cause patient harm. In such cases, the patient must be referred appropriately according to the Referring a Patient Practice Direction.
- If continued attempts to communicate and address concerns with the prescriber are unsuccessful, pharmacists may bring the matter forward to the prescriber's regulatory body (e.g. College of Physicians and Surgeons of Manitoba). As this is a patient safety issue, it is within the mandate of a regulatory college to investigate and intervene as appropriate.

- Recommending and implementing controlled dispensing of commonly abused medications (e.g. monthly or weekly dispensing) may be appropriate for patients who are requesting early refills consistently. Controlled dispensing should be initiated gradually and discussed with the patient and prescriber. In these discussions, make your concerns and reasoning known, focusing the conversation on the patient's safety, and the safety of those around them.

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.

Suggested Responses When Patients Request Early Refills

Example of Patient Request/Reason	Possible Pharmacist Response
"The doctor gave me this prescription early so I should be getting it early."	"That's not always the case. There are some concerns I have with the timing of this refill that I'd like to discuss with your prescriber first so we can move forward in the safest way."
"The medication was stolen" or "I lost the medication."	"I'm sorry to hear that. Is there any way we can prevent that from happening in the future? Would it be helpful to have a lock box for your medications, so you can always have a consistent and safe place to store them? Our pharmacy can provide one."
"The other pharmacist always fills my early refills."	"That may be true, but I feel it's important to discuss some concerns I have about early refills because these can pose a danger to your health."
"I'm travelling and need more medication."	"Are you able to receive your next refill on time at a pharmacy near where you're travelling to? I can talk to your doctor about the best way to do that."
Provides repeated requests for early refills as described above. If you feel it's necessary, this may also be a good time to discuss with the prescriber whether the patient appears to be struggling with a substance use disorder, and a care plan for moving forward.	"It seems that there are some continuous challenges that often require you to request early refills. I'd like to talk with you and your prescriber about what we can do. Perhaps dispensing smaller quantities of medication at a time may be helpful to prevent these challenges."

Pharmacy Technicians Working to Full Scope: Final Medication Check

In Manitoba, the College has listed over 200 pharmacy technicians. For pharmacy technicians to work to their full scope and undertake the task of completing the final check of a prescription, the pharmacy manager must submit a Pharmacy Technician Final Check Application for College review and approval. Both hospital and community pharmacies (corporate and independent) have been approved by the College to permit technicians to perform the final check in their pharmacy.

The final check application process requires pharmacy managers and staff to assess current dispensing processes to determine the changes required for a pharmacy technician to perform the final check safely and in compliance with legislation. Pharmacy managers complete the application and submit the pharmacy's final check policy and procedures document outlining the checks that technicians will undertake and procedures they will follow.

Once approved by the College, any future changes to the process must be submitted to the College for review and approval prior to being implemented. If the pharmacy manager should change, then the new pharmacy manager should confirm that they will continue with the final check program in the pharmacy.

The Pharmacy Technician Final Check Information Sheet provides additional information to help pharmacies develop their Final Check policies and procedures. Please view the information sheet and the Pharmacy Technician Final Check Application on the College **website**.

College Launches New User-friendly Website

Resource Library

Registrants can now find all the documents they're looking for in one place.

We have organized our resource library into categories to help pharmacy professionals find what they are looking for more easily, including:

- Applications
- Complaints
- Guidelines
- Information
- Joint Statements
- Legislation
- Policies
- Professional Development
- Safety IQ
- Standards

The search bar also offers a quick way to find specific documents by title or keywords.

FAQs

The College receives many questions via email and phone, and many of them are repeated. If we notice a question is being asked often, we will add this to our FAQ section.

Accessibility

We used the **Web Content Accessibility Guidelines** (WCAG) 2.1 to ensure that web content is accessible and user-friendly to everyone regardless of ability. The WCAG 2.1 guidelines have three levels of accessibility (A, AA and AAA) and the College chose Level A as the target for its website.

As this website evolves, we will continue to produce accessible content for all audiences.

Please contact the College by email at **info@cphm.ca** with any feedback, questions, or concerns about the new website.

In Memoriam

David Galon - May 6, 2020

Anita Carroll - June 21, 2020

John Rodie - June 30, 2020

Charlie Scerbo - August 1, 2020

Sam Doherty - August 9, 2020