COLLEGE OF PHARMACISTS OF MANITOBA

NEWSLETTER

WINTER 2021

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

LIAISONS TO COUNCIL

Stephen Jackson, Pharmacy Technician
Nicole Hager, C.S.H.P. (MB Branch)
Dinah Santos, PEBC
Tanjit Nagra, Pharmacists Manitoba
Marianna Pozidirca, Student Representitive, College of Pharmacy

COUNCILLORS

Amanda Andreas, Public Representative
Ryan Buffie, District 1
Tory Crawford, Public Representative
Alanna Doell, District 1
Donna Forbes, Public Representative
Donald Himbeault, Public Representative
Drupad Joshi, District 2
Ravi Pandya, District 2
Dr. Lalitha Raman-Wilms, Dean, College of Pharmacy
Ashley Walus, District 1
Vacant, Public Representative

COLLEGE STAFF

Susan Lessard-Friesen, Registrar and Chief Executive Officer
Rani Chatterjee-Mehta, Deputy Registrar
Brent Booker, Assistant Registrar - Review and Resolution
Chris Louizos , Assistant Registrar - Field Operations
Kevin Chaboyer, Quality Assurance and Field Officer
Kim McIntosh, Assistant Registrar - Qualifications and Practice Development
Ronda Eros, Practice Consultant - Safety IQ
Meret Shaker, Practice Consultant - Policy and Legislation
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
Rachel Carlson, Communications Specialist
Anja Sadovski, Communications Coordinator

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,

As 2021 comes to an end, we can be proud of how far we have come, from Safety IQ becoming mandatory for all community pharmacies in Manitoba, the full implementation of the NAPRA Model Standards for Pharmacy Compounding of Hazardous and Non-Hazardous Sterile and Non-Sterile preparations came into effect, announced a Regulation amendment allowing pharmacists who have completed a training and application process to prescribe to treat uncomplicated cystitis, to continuing to provide safe and ethical direct patient care despite changing restrictions and rules imposed by the government due to the pandemic.

Thank you to Council, registrants, and the CPhM team for working through all these firsts. This exceptional work will allow us to advance safe pharmacy practice for community pharmacists and pharmacies across Manitoba.

A very successful Medical Examiner Professional Development event, *Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice*, was recently hosted by the College. For those who did not have a chance to participate, you can view the recorded webcast on the Previously Recorded Programs page of the College website for 1.5 CEUs.

The College is now accepting nominations for the 2022 College Awards. If you or a pharmacist you know has made a noteworthy contribution to patient care and safety or pharmacy practice, consider submitting a nomination or application for one of the awards listed in the College Awards brochure.

It has never been more important to remain optimistic, take care of ourselves, and empathize with our patients. Thank you again for your contributions to the pharmacy profession, the continued fight against COVID-19, and once again for your continued efforts and contributions in delivering safe care to all patients of Manitoba.

Happy Holidays!

Safety Feature – Building Resilient Teams and Positive Safety Culture: The Key Role of Pharmacy Technicians and Assistants

Safety IQ aims to foster safety culture in community pharmacies in which all staff feel comfortable bringing forward safety concerns and making suggestions for potential solutions. In the past, reporting and discussion of medication incidents was often limited to managers and pharmacists; however, every team member has a valuable role to play in preventing patient harm. Each pharmacy team member has different jobs, tasks, and responsibilities, resulting in a variety of perspectives on safety in the pharmacy. Pharmacy technicians and assistants play a major role within the pharmacy and can provide an additional layer of safety by identifying actual and potential sources of error before they reach the patient.

It is important to encourage the participation and engagement of pharmacy technicians and pharmacy assistants with Safety IQ in a psychologically safe environment in which anyone can

- ask questions or ask for feedback without looking or feeling incompetent;
- be respectfully critical without appearing negative; and
- suggest innovative ideas without being perceived as disruptive[1].

As pharmacy technicians are more involved with technical responsibilities, they are well positioned to function as a possible Continuous Quality Improvement coordinator (QCI) coordinator to assist in training and encouraging reporting and function as a contact for staff safety concerns in addition to the pharmacy manager/pharmacists. A pharmacy assistant who is competent and confident in their understanding of Safety IQ elements and processes may also function as a CQI coordinator. Please see the Guide to Safety IQ (Section 2) for information on CQI coordinators.

An assessment report of the Safety IQ pilot indicated that pharmacy technicians and assistants were not aware of Safety IQ and the available resources which was a barrier to engaging with the program. The assessment recommended that the College work to enhance pharmacy technician and assistant engagement in Safety IQ with improved communication. Pharmacy technicians automatically receive College publications such as the Friday Five bulletins and Newsletters, but pharmacy assistants are not automatically part of the College mailing list. Pharmacy assistants can be added to the College mailing list by emailing bdelaquis@cphm.ca to request that they be included on the College publication distribution list.

As the College cannot reach pharmacy assistants directly with this information, we ask that you share this information with your pharmacy assistant colleagues.

It is imperative that all pharmacy staff including pharmacy technicians and assistants take an active role in Safety IQ to foster open communication and development of effective solutions.

Below are two articles discussing the role of pharmacy technicians in error prevention:

1. Make the Most of Your Medication Incident Report

https://www.powerpak.com/course/content/119221

2. The Pharmacy Technician's Role in Medication Error Prevention

https://www.pharmacytoday.org/action/showPdf?pii=S1042-0991%2815%2931035-5

We thank you for your ongoing commitment and support of Safety IQ and requesty that you please contact the College if you have any questions.

[1] https://cphm.ca/wp-content/uploads/Resource-Library/SafetyIQ/CPSC-Toolkit-FINAL.pdf

SAFETY MEASURES

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 June 1 – September 30, 2021, Manitoba Community Pharmacies submitted 949 reports to the NIDR. Please see the NIDR Safety Brief for details on the types of incidents and levels of harm. The NIDR will provide updated statistics to the College on a quarterly basis starting in 2022. Look for fresh stats in the Spring edition of the College newsletter.

- 51 Pharmacies have completed at least one formal Continuous Quality Improvement Meeting
- 73 Pharmacies have completed their Safety Self-Assessment

For additional information and resources to support your pharmacy's CQI meeting(s) and SSA, please see the following resources:

- Guide to Safety IQ
- CQI Summary Form
- Safety Self-Assessment Improvement Plan sheet
- CQI Meeting Resources

RESOURCES & PROFESSIONALDEVELOPMENT OPPORTUNITIES

Featured Resource: ISMP Canada Safety Bulletins

Vaccine Administration Safety

ISMP Canada published a safety bulletin on COVID-19 vaccine errors in August 2021 that outlined analysis and shared learning from the experiences of healthcare professionals over the past year. The bulletin reviews various steps in the vaccination process, incident examples for each step, and strategies to prevent errors.

A recently released NAN Alert in the United States shared reports of inadvertent mix-ups between COVID-19 and influenza vaccines occurring in community/ambulatory pharmacies. Most cases described patients who received a COVID-19 vaccine instead of the influenza vaccine. Based on reports received, the National Alert Network shared numerous strategies to prevent similar errors in the alert.

Lack of Pediatric Formulations – Strategies to prevent errors

The November 2021 ISMP Canada bulletin reviews the systemic reasons for a lack of commercial pediatric formulations available in Canada compared to other countries. The bulletin describes two incidents, in which a lack of a suitable pediatric formulation resulted in the need to provide an alternative form of the medication. These incidents resulted in harmful or potentially harmful patient outcomes. This bulletin provides recommendations and strategies for Health Canada, provincial/territorial public drug programs, prescribers, and pharmacy staff, as well as organizations involved in the development of compounding formulas. All pharmacy staff should review the bulletin and see how they might implement the recommendations to prevent similar incidents within their practice.

To subscribe to ISMP Canada's free Safety Bulletins, please visit ISMP Canada's website.

WE WANT TO HEAR YOUR IMPROVEMENT STORIES

One of the goals of Safety IQ is to support shared learning between Manitoba pharmacies about medication incidents, near-miss events, continuous quality improvements, and medication safety. 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 College publications and any identifying Information about the pharmacy or staff will be kept anonymous.

For some examples of shared learning contributions of pharmacy professionals on medication incidents, please see the latest edition of Directions, the Saskatchewan College of Pharmacy Professionals' (SCPP) Newsletter specific to the SCPP COMPASS CQI program and medication and patient safety.

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

The College of Pharmacists of Manitoba attends monthly Adult Inquest Review Committee meetings at the Chief Medical Examiner's Office to review deaths, which may have involved prescription drugs, focusing on opioids and other drugs of abuse. A de-identified case study based on information obtained from these meetings is presented in each Newsletter to provide an opportunity for education and self-reflection for all pharmacists.

Introduction

BC is a 47-year-old female who was found unresponsive in her bedroom on June 7, 2019. Emergency Medical Services responded but all resuscitation efforts were unsuccessful. Drug paraphernalia was found at the scene. BC had a past medical history of hypertension, hypothyroidism, uncontrolled type I diabetes mellitus, peripheral neuropathy, prior episode of diabetic ketoacidosis and end-stage renal disease requiring hemodialysis. In addition, her history included previous suicidal ideation, suicide attempt, and substance abuse with a recent fentanyl overdose one month prior to her death.

The immediate cause of death was determined to be accidental mixed drug toxicity (cocaine, fentanyl, and multiple non-opioid drugs (alprazolam, clonazepam, diphenhydramine, pseudoephedrine and zopiclone)). A significant condition contributing to her death was end-stage renal disease due to type I diabetes mellitus.

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
Alprazolam Alpha-hydroxyalprazolam	28 ng/mL 0 ng/mL	25 – 55 ng/mL
Clonazepam 7-Aminoclonazepam (Metabolite of clonazepam)	0 ng/mL 111 ng/mL	20 – 70 ng/mL 20 – 140 ng/mL
Diltiazem*	614 ng/mL	50 – 200 ng/mL
Diphenhydramine*	214 ng/mL	14 – 112 ng/mL
Fentanyl	13.9 ng/mL	-- ^within 24 hours of the application of a 100 ug/hr transdermal patch, the expected serum concentration is 1.9 – 3.8 ng/mL
Gabapentin	5 ug/mL	2 – 20 ug/mL
Paroxetine*	341 ng/mL	31 – 62 ng/mL

Pseudoephedrine	286 ng/mL	-- ^following daily 360mg doses, plasma pseudoephedrine concentrations reach 640ng/mL.
Zopiclone	32 ng/mL	25 – 65 ng/mL
Ethanol	11 mg/dL	--

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

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

Generic Name	Date Dispensed	Strength	Quantity	Days' Supply	Prescriber	Pharmacy
Clonazepam	May 11, 2019	2 mg	500	100	Dr. A	ABC Pharmacy
Acetaminophen/ Codeine	May 14, 2019	300/30 mg	30	3	Dr. A	ABC Pharmacy
Diltiazem	Apr 22, 2019 Apr 22, 2019 Feb 28, 2019 Feb 28, 2019	360 mg 180 mg 360 mg 180 mg	90 90 60 60	90 90 60 60	Dr. A	ABC Pharmacy
Gabapentin	Apr 22, 2019 Apr 3, 2019 Feb 28, 2019	100 mg	40 60 60	40 60 60	Dr. A	ABC Pharmacy
Hydromorphone (Controlled Release)	May 5, 2019 Apr 26, 2019 Apr 14, 2019 Apr 2, 2019 Mar 15, 2019 Mar 2, 2019 Feb 18, 2019 Feb 18, 2019	3 mg 6 mg 12 mg 18 mg 24 mg 30 mg 12 mg 24 mg	28 28 28 28 28 14 28 28	14 14 14 14 14 14 14 14	Dr. A	ABC Pharmacy
Lorazepam	May 27, 2019 May 5, 2019 Apr 31, 2019 Apr 21, 2019 Apr 14, 2019 Apr 1, 2019 Mar 15, 2019 Mar 1, 2019 Feb 25, 2019 Feb 18, 2019	1 mg	84 84 42 84 84 84 84 84 28 56	14 14 7 14 14 14 14 14 7 14	Dr. A	ABC Pharmacy
Paroxetine	Mar 1, 2019	20 mg	180	90	Dr. A	ABC Pharmacy
Quetiapine	Apr 3, 2019	25 mg	90	90	Dr. A	ABC Pharmacy
Zopiclone	May 10, 2019	5 mg	180	90	Dr. A	ABC Pharmacy

Discussion

BC was rapidly tapered off hydromorphone-controlled release (CR) over the span of 13 weeks. Based on recommendations from the 2017 Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain [1], initial dose reductions in the range of 5-10% of the total daily morphine equivalent dose (MED) every 2-4 weeks are reasonable, with frequent follow-up [2]. Once a dose of approximately 1/3 of the original dose is reached, smaller dose reductions (e.g., 5% every 4-8 weeks) may be more suitable and more likely to result in a successful taper [3].

BC's original dose of 72 mg/day of hydromorphone-CR (360 mg/day MED) [4], was decreased to 30 mg/day (150mg MED) on March 2. BC's original hydromorphone-CR dose of 72 mg/day should have been reduced by 5 -10%, equating roughly to 3 – 7 mg/day (18 – 36 mg/day MED) for 2-4 weeks. However, as the DPIN history shows, her dose was reduced by 42 mg/day (210mg MED) for 2 weeks, which is roughly 60% of her total daily MED. After a brief dose re-escalation on March 15th, her dose was tapered further to 50%, 33%, 16%, and then 8% of her original daily MED dose at two-week intervals for the subsequent 8 weeks, before being completely tapered off.

The 2017 Guideline states that rapidly decreasing the dose over a few days or weeks can lead to severe withdrawal symptoms and should be carried out in a medically supervised withdrawal centre with an interdisciplinary approach [1]. According to a study by Mark et al., each additional week of tapering time was associated with a 7% reduction in the probability of an emergency department visit or hospitalization secondary to opioid poisoning or substance use disorder ($p < 0.01$) [5], meaning that slower opioid tapering schedules were associated with improved safety. In 2019, the U.S. Food and Drug Administration (FDA) has released a statement that indicated patients who are given sudden and rapid dose reductions and are physically dependent on opioids can experience serious withdrawal symptoms, uncontrolled pain, psychological distress, and potentially suicide [6].

It is also critical to note that sudden discontinuation of opioids may cause vulnerable individuals to resort to illicit, harmful drugs to alleviate their withdrawal symptoms, which may elevate the risk of accidental overdose when opioid tolerance is lowered [7] [8]. Tapering should be done slowly to minimize this risk. In this case, BC was at an increased risk for unintentional overdose, as she had a history of suicidal ideation, a previous suicide attempt, and non-prescription fentanyl exposure.

A crucial strategy in tapering opioids would be to engage in active discussions with the patient to establish realistic goals, that include but are not limited to, improvement in mood and function, pain control, reduction in adverse events, and better quality of life. Moreover, a detailed plan must be discussed and should include a set schedule of dose reductions, frequent follow-up visits (e.g., weekly check-ins) and strategies to manage withdrawal symptoms and emerging pain. As pharmacists can assist physicians and patients with scheduling dose reductions, it is vital for the pharmacist and physician to collaborate closely to construct an optimal and personalized opioid tapering strategy that best meets the patient's needs [9]. The patient should be informed of the increased risk for overdose if they quickly return to a previously prescribed higher dose or seek other opioids.

Given the patient's history of overdose, this patient may have benefited from daily dispensing of medication. Additionally, according to the Canadian national consensus guidelines for naloxone prescribing by pharmacists by Tsuyuki et. al [10], all patients receiving an opioid should be dispensed take-home naloxone and counselled by a pharmacist.

Providing patients with resources on accessing services for addiction and suicide is recommended, including the following:

- Rapid Access to Addictions Medicine Clinic (RAAM) located across Manitoba is a drop-in clinic for individuals seeking help with high-risk substance use and addictions. Not for individuals needing urgent medical attention. See the website here for more information and locations.
- Crisis Response Centre (CRC) located at 817 Bannatyne Avenue is a 24/7 drop-in for adults experiencing a mental health crisis.
- Mobile Crisis Service (204-940-1781) is a 24/7 phone service assisting individuals experiencing a mental health crisis.

To summarize, the pharmacist is primarily responsible for prioritizing patient safety. Pharmacists must ensure they complete a thorough revision of each prescription, as well as address and correct potential issues before the medication is dispensed. All members are reminded of their professional obligation and must take measures 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. [1] J. Busse, S. Craigie, D. Juurlink, N. Buckley, L. Wang, R. Couban, T. Agoritsas, A. Carrasco-Labra, L. Cooper, C. Cull, B. Da Costa, J. Frank, G. Grant, A. Iorio, N. Persaud, S. Stern, P. Tugwell, P. Vandvik and G. Guyatt, "Guideline for Opioid Therapy and Chronic Noncancer Pain," Canadian Medical Association Journal, pp. 189:E659-66, 2017.

2. [2] L. Murphy, R. Babaei-Rad, D. Buna, P. Isacc, A. Murphy, K. Ng, L. Reiger, N. Steenhof, M. Zhang and B. Sproule, "Guidance on opioid tapering in the context of chronic pain: Evidence, practical advice and frequently asked questions," Canadian Pharmacists Journal (CPJ), p. 151(2): 114–120, 2018.

3. [3] RxFiles Academic Detailing, "Tapering Opioids How to Explore and Pursue the Option for Patients Who Stand to Benefit," Spring 2018. [Online]. Available: https://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Tapering-Newsletter-Compilation.pdf. [Accessed August 2021].

4. [4] Centre For Effective Practice, "Opioid Tapering Template," February 2018. [Online]. Available: https://cep.health/media/uploaded/CEP_Opioid_Tapering_Template_2018.pdf. [Accessed August 2021].

5. [5] T. L. Mark and W. Parish, "Opioid medication discontinuation and risk of adverse opioid-related health care events," Journal of Substance Abuse Treatment, vol. 103, no. August, pp. 58-63, 2019.

6. [6] U.S. Food and Drug Administration (FDA), "FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering: FDA Drug Safety Communication," 9 April 2019. [Online]. Available: https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes. [Accessed August 2021].

7. [7] S. Darke and W. Hall, "Heroin Overdose: Research and Evidence-Based Intervention," Journal of Urban Health: Bulletin of the New York Academy of Medicine, vol. 80, no. No. 2, pp. 189-200, June 2003.

8. [8] A. Agnoli, G. Xing, D. J. Tancredi, E. Magnan, A. Jerant and J. Fenton, "Association of Dose Tapering With Overdose or Mental Health Crisis Among Patients Prescribed Long-term Opioids," The Journal of the American Medical Association (JAMA), vol. 326, no. 5, pp. 411-419, August 3, 2021.

9. [9] Canadian Institute for Health Information (CIHI), "Opioid Prescribing in Canada: How Are Practices Changing?," Canadian Institute for Health Information, Ottawa, 2019.

10. [10] R. Tsuyuki, V. Arora, M. Barnes, M. A. Beazely, M. Boivin, A. Christofides, H. Patel, J. Laroche, A. Sihota and R. So, "Canadian national consensus guidelines for naloxone prescribing by pharmacists," Canadian Pharmacist Journal (CPJ) , vol. 153, no. 6, pp. 347-351, 2020.

2022 COLLEGE AWARDS

Call For Award Nominations

The College is now accepting nominations for the 2022 College Awards. If you or a pharmacist you know has made a noteworthy contribution to patient care and safety or the practice of pharmacy, please consider submitting a nomination or application for one of the awards listed in the College Awards brochure.

The College has created award submission guidelines for your consideration prior to forwarding your nomination to the Awards & Nominating Committee.

Young Leader Awards

The Young Leader Awards celebrate the efforts of up to ten leaders in pharmacy practice. The recipients will receive a plaque to commemorate their contributions to the pharmacy profession and a $500 cash prize.

The Young Leader Awards are open to recently licensed pharmacists (practicing one to five years post-graduation) and to pharmacy students (interns) in their final year of study who have made a professional contribution to patient care, the pharmacy profession or amongst their colleagues and peers at the University of Manitoba's College of Pharmacy.

If you or someone you know meet these criteria, please submit a nomination or application package including the nominee or applicant's Curriculum Vitae and a summary of their activities and contributions within pharmacy practice or within the College of Pharmacy, University of Manitoba. Awards will be presented during the 2022 Awards Presentation in May 2022.

Submissions

Please submit all nominations or applications to the College of Pharmacists of Manitoba by regular mail or email.

Mail: College of Pharmacists of Manitoba

Attention: The Awards & Nominating Committee – Young Leader Awards

200 Taché Avenue Winnipeg,
MB R2H 1A7

Email: info@cphm.ca with the subject line: "Attention: The Awards & Nominating Committee – Young Leader Awards"

The deadline for nominations or applications is Friday, January 14, 2022.

In Case You Missed It

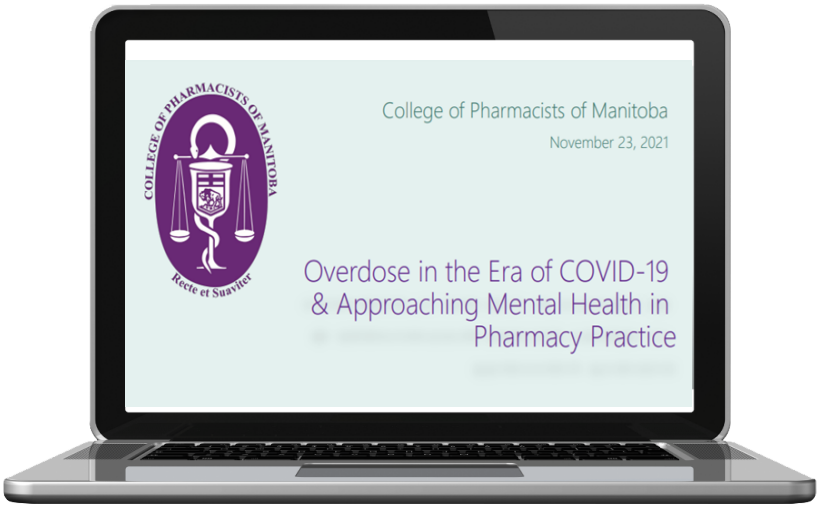
On November 23, 202, the College hosted its third annual Medical Examiner Professional Development (PD) event, entitled ***Overdose in the Era of COVID-19 & Approaching Mental Health in Pharmacy Practice.***

The first program segment was presented by Dr. Marina Reinecke MBCHB, CCFP(AM), ISAM, Medical Consultant, Prescribing Practices Program, College of Physicians and Surgeons of Manitoba. Dr. Reinecke covered historic and recent trends in Manitoba overdose death data reported by substance, shifting overdose death data trends in the context of the pandemic, and proposed an appropriate health system response to address the overdose crisis by applying accepted evidence-based interventions.

The second program segment was presented by Dr. Christine Leong B.Sc. (Gen), B.Sc (Pharm), Pharm.D., Assistant Professor, College of Pharmacy, Rady Faculty of Health Sciences, University of Manitoba. Dr. Leong's presentation focused on recognizing the signs and symptoms of someone experiencing a mental health crisis and described the pharmacist's role in helping patients experiencing a mental health crisis.

If you were unable to attend the live PD event, the recording is now available on the College website under the Recorded PD Programs section. Answers to questions that were not answered during the live session due to time constraints will be posted in the coming weeks. To receive your statement of participation for 1.5 CEUs, please fill out the evaluation form and submit it to Hazel Suh at HSuh@cphm.ca.

The College would like to extend its sincere gratitude and thanks to the presenters, as well as those who participated in the program.



IN MEMORIUM

In loving memory,

Cathy Mok, December 1, 2021

Iqbal Riyaz, December 2021

HOLIDAY GREETING

Season's Greetings from the College of Pharmacists of Manitoba

As the pandemic continues into a New Year, your continued valuable efforts through this challenging environment remain fully recognized and noted. Your continued dedication to ensure safe patient care during the holiday season and throughout the year is gratefully appreciated.

The conscientious and determined contributions by all pharmacy professionals in the delivery of safe healthcare for all Manitoba patients has made significant impacts on meeting patient needs and improved health outcomes over this past highly challenging year. Your professional commitment to ongoing patient care and compassion are observed, inspiring, and celebrated.

On behalf of Council and staff at the College of Pharmacists of Manitoba, best wishes for a happy and safe holiday season are extended to you and your families. May you all celebrate joy, laughter, and good health with your close circles this season with the New Year bringing continued health, happiness and prosperity.