COLLEGE OF PHARMACISTS OF MANITOBA
NEWSLETTER
SUMMER 2018

Low-Dose Codeine: From OTC to Prescription-Only Impact of Policy Change in Manitoba

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On February 1, 2016, the College of Pharmacists of Manitoba implemented a practice direction mandating that all low-dose codeine products, also known as exempted codeine preparations, require a prescription by either a pharmacist or other prescriber, as defined by the *Controlled Drugs and Substances Act*, as well as entry into the Drug Program Information Network (DPIN). Manitoba was one of the first Canadian jurisdictions to change low-dose codeine products to 'by prescription only' status with the goal of reducing the misuse and abuse of these products as part of a harm reduction strategy.

Analyses of the use of exempted codeine products before and after the policy change support the success of the practice direction since it came into effect.

Dramatic decrease in low-dose codeine products sold within one year

The number of low-dose codeine tablets sold in Manitoba (**Figure 1**) decreased by 94 per cent from 52.5 million tablets sold in the year prior to the policy change to 3.3 million in the year after. The prescribing of low-dose codeine products was split almost evenly among pharmacists and physicians.

Continuing decline in the prescribing of low-dose codeine products

The rate of prescribing low-dose codeine products after the policy change (in blue) showed a steady decline of 1.4 per cent per month from 300,000 to 260,000 tablets dispensed per month (**Figure 2**).

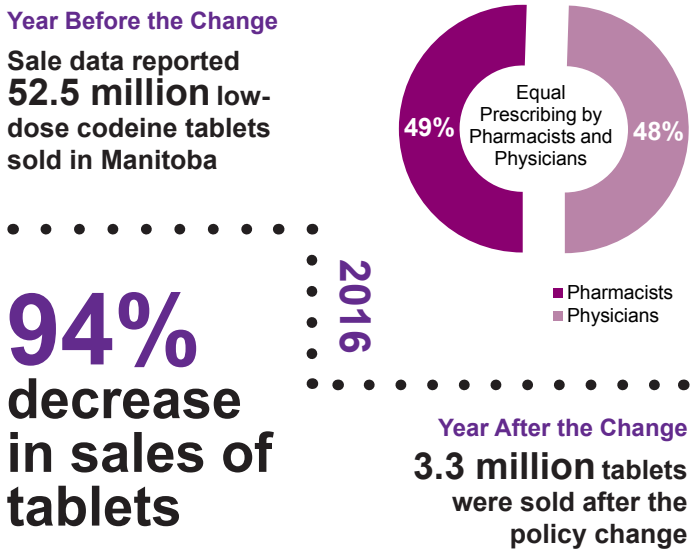

Figure 1

No increased use of higher-dose codeine, oxycodone combination products or tramadol products

The use of products containing higher doses of codeine, oxycodone combinations and tramadol was analyzed to address possible unintended increases resulting from this restriction. There was no substantial change observed in the prescribing rates before and after the policy change (**Figure 3**).

Positive impact of the Exempted Codeine Preparations Practice Direction

Manitoba's initiative in implementing the Exempted Codeine Preparations Practice Direction has resulted in positive changes as illustrated by the substantial decrease in the use of low-dose codeine products without an accompanying increase in the prescribing rates of higher-dose products. Following in Manitoba's footsteps as well as those of other countries, Health Canada is moving forward with a consultation on a proposal to enact a federal change requiring all codeine products to be sold by prescription only.

(Figure 2 and 3 are on pages 4 and 5)

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.

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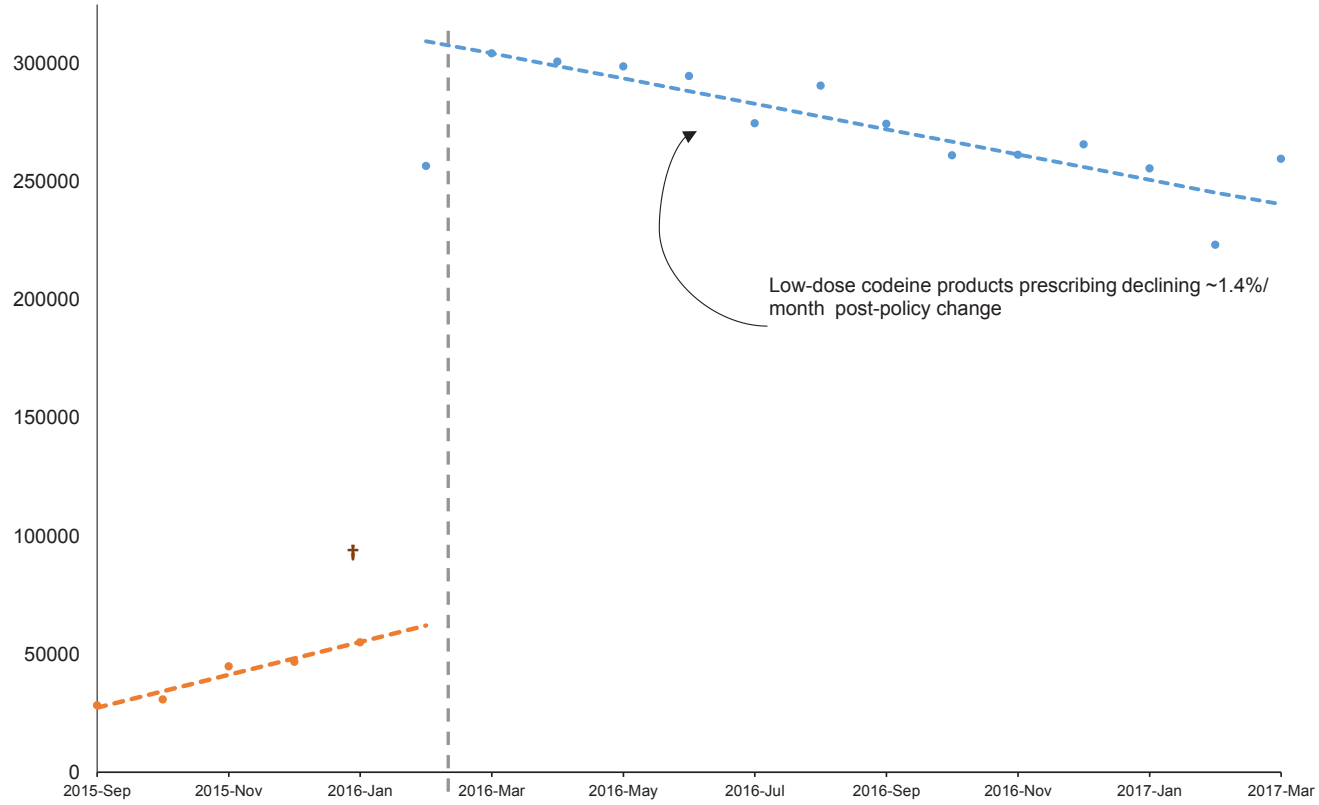
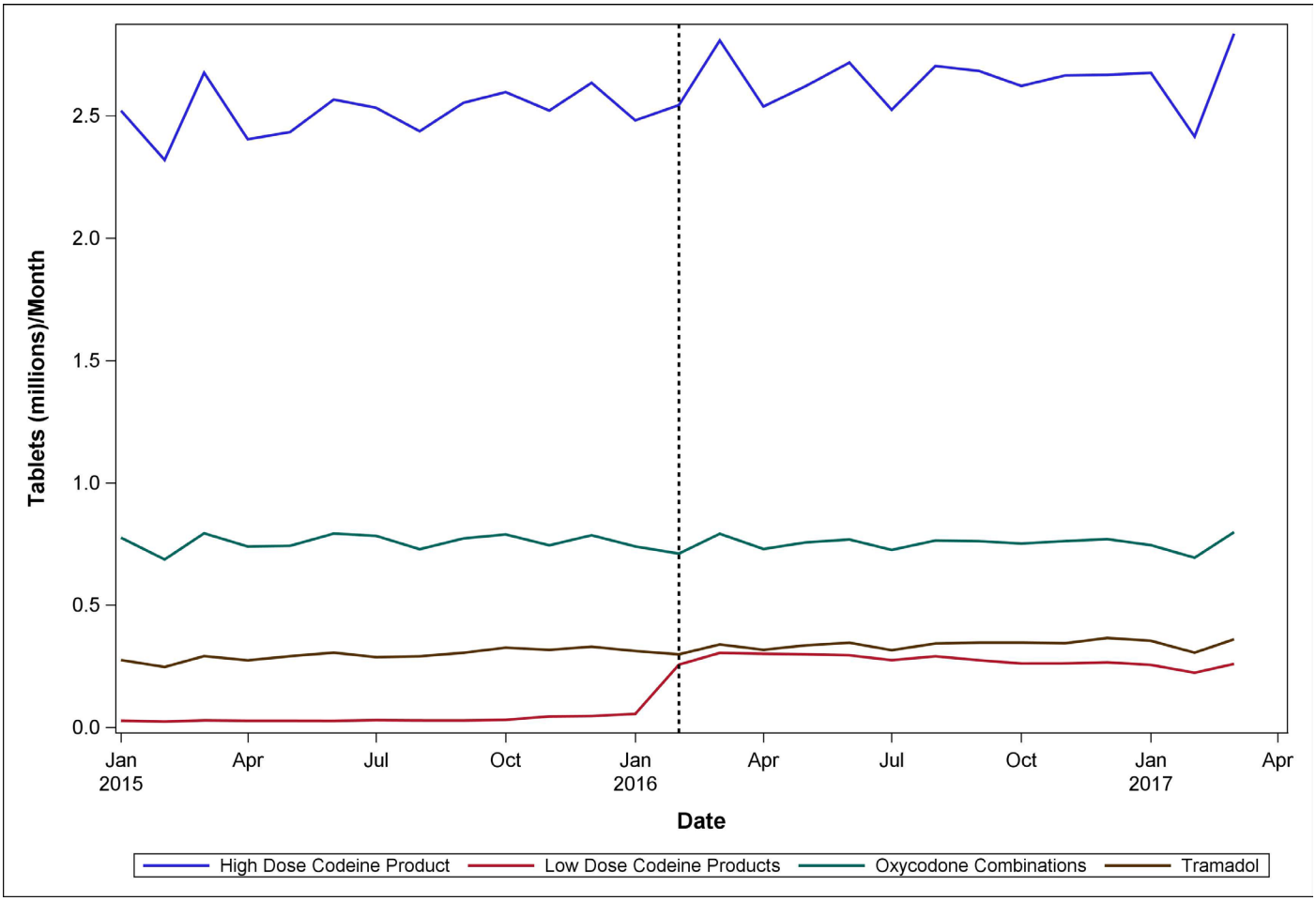
Figure 2: Low-Dose Codeine Product Units Dispensed per Month



†Pre-policy data only reflects low-dose codeine product prescriptions entered into DPIN

Figure 3: Total Units of Higher-Dose Codeine Products, Oxycodone Combination Products and Tramadol Products Dispensed per Month



President's Message

Dear Members,

I couldn't be more excited to write my very first message as President of the College of Pharmacists of Manitoba. Thank you to all the members who participated and voted in the (new) electronic College election process. It sure is a lot more convenient to vote electronically, rather than through regular mail.

First of all, I must thank the preceding President, Jennifer Ludwig, for all her hard work. The dedication and care she put into this position is something I admire. While following her will be tough, I look forward to the challenge of being your President for the next two years. With change comes the loss of some council members whose hard work did not go unnoticed. They have provided a solid foundation for this council to build upon. Thanks must go out to Glenda Marsh who finished her term as Past President on Council. Thank you to Dinah Santos who had been on Council since 2010. She will continue as the College's PEBC representative.

Additionally, thank you to Geoff Namaka for his time and effort to improve patient safety on Council since 2012.

I look forward to working with the new councillors and public representatives that make up our Council for the 2018-2020 term.

We are currently working to build a strong strategic plan to guide our patient safety work over the next two years. We will announce the completed strategic plan to the membership in our usual publications following our first official Council meeting on July 23, 2018.

The Awards Luncheon on May 12th at The Manitoba Club was a great success. We celebrated the accomplishments of exceptional pharmacists in this province and honoured those who have put many years of service into this great profession. It was exceptional to see nine recipients of the 50 Year Pins and Certificates for half a century as members of the College. A few of these members still practice pharmacy and have shown great commitment to protecting the public.

Prior to the Awards Luncheon, we hosted the Annual General Meeting at The Manitoba Club, but we were unable to make quorum. Electronic voting has once again come in handy as a mechanism to ratify the business of the AGM.

I am especially excited about the approval and development of the Doctor of Pharmacy (PharmD) program at the University of Manitoba. This degree will replace the Bachelor of Science (Pharmacy) degree, proving the scope of practice for pharmacists continues to grow. We hope to see the University develop a bridging program in the future for practicing pharmacists to obtain this additional designation. The College would like to hear from you as practicing pharmacists on the type and format of these potential continuing education opportunities that would benefit you most. Please email your feedback to info@cphm.ca.

During my term as President, we must come together to make educated decisions that put public safety first.

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

Sincerely,

Kevin Hamilton
President

Professional Development Reminder

While summer is a time for leisure and slowing down to enjoy the company of friends and family, it an offer time for self-reflection and professional development (PD). The College provides a number of PD resources to support pharmacy professionals, including:

- a listing of upcoming live presentations and conferences;
- recorded PD programs and presentations;
- web-based PD programs.

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.

For more information on PD requirements for pharmacists, please visit the Learning Portfolio Requirements page of the College website.

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 additional information on the PD requirements for pharmacy technicians, visit the Pharmacy Technician page of the College website.

Pharmacy Technicians

Important Deadlines for Pharmacy Assistants and Pharmacy Technician Program Graduates

There are two pathways for individuals who wish to become pharmacy technicians in Manitoba:

Option A: For individuals who have graduated from a Canadian Council for Accreditation of Pharmacy Programs (CCAPP)-accredited pharmacy technician program.

Option B: For pharmacy assistants who have worked at least 2000 hours as a member of a pharmacy team within the last three years.

Each of these pathways have important upcoming deadlines.

Option A Deadlines

Students of a CCAPP-accredited pharmacy technician program who graduated before January 1, 2014, must be listed as a pharmacy technician with the College by January 1, 2019.

Students who graduated from a CCAPP-accredited pharmacy technician program after January 1, 2014, have **five years** immediately following their graduation to complete all of the steps required to be listed with the College as a pharmacy technician.

Within these time-frames, the graduate must successfully complete the

- Pharmacy technician-in-training application;
- Structured Practical Training Program;
- Jurisprudence Examination;
- PEBC Qualifying Examination Parts I and II; and
- Application to be listed as a pharmacy technician with the College.

If a graduate does not complete all of the components under Option A in the time-frame provided above, they will be required to complete a CCAPP-accredited pharmacy technician program **a second time** in order to pursue listing as a pharmacy technician in Manitoba.

It is important that graduates review all of the information for the Option A requirements as there are multiple obligations and deadlines to manage.

Option B Deadlines

Across Canada, pharmacy regulatory bodies have set deadlines for pharmacy assistants to become registered as pharmacy technicians through the PEBC Evaluating Exam and NAPRA National Pharmacy Technician Bridging Education Program (Option B pathway). On November 27, 2017, College Council set a deadline for the Option B pathway of **December 31, 2019**, with the following motion:

> **THAT** *Council approves December 31, 2019, as the deadline for individuals currently working as a pharmacy assistant to complete and submit all requirements for listing as a pharmacy technician in Manitoba. After December 31, 2019, all applicants wishing to become pharmacy technicians would be required to have graduated from an accredited pharmacy technician education program.*

This means that by the end of 2019, a pharmacy assistant in Manitoba who wants to become listed as a pharmacy technician through this transition pathway must successfully complete the

- PEBC Evaluating Examination;
- NAPRA National Pharmacy Technician Bridging Education Program;
- Pharmacy technician-in-training application;
- Structured Practical Training Program;

- Jurisprudence Examination;
- PEBC Qualifying Examination Parts I and II; and
- Application to be listed as a pharmacy technician with the College.

It is important that Option B candidates review all of the information for the Option B requirements as there are multiple obligations and deadlines to manage. For more information, please visit:

http://www.cphm.ca/site/pharmacytechnicians?nav=practice#steps

PEBC Deadlines

The last opportunity to write the Pharmacy Examining Board of Canada (PEBC) Evaluating Examination is in October 2018.The deadline for pharmacy assistants to apply to write The PEBC Evaluating Examination passed on June 22, 2018.

Pharmacy assistants who wish to be listed as pharmacy technicians, but do not pass the Evaluating Examination prior to December 31, 2018, will be required to complete a CCAPP-accredited pharmacy technician program to become pharmacy technicians. Please visit the CCAPP website for more information on accredited pharmacy technician programs.

Further, individuals who wish to become listed pharmacy technicians with the College through the PEBC Evaluating Examination and NAPRA Bridging Program must complete and submit all requirements for listing as a pharmacy technician by **December 31, 2019**, including the PEBC Qualifying Examinations.

The upcoming dates for the PEBC Pharmacy Technician Qualifying Examinations have not yet been posted by PEBC.

Applications must be received by the PEBC office no later than the application deadline. Please visit the PEBC website for complete information.

Expiry of PEBC and Jurisprudence Exams

On November 27, 2017, Council established expiry dates for PEBC exams and Jurisprudence Examination results for pharmacy technicians which match those expiry dates set for pharmacists. An expiry date of three years is in place on PEBC Qualifying Examination results and a two-year expiry date is in place for Jurisprudence Examination results.

NAPRA National Pharmacy Technician Bridging Education Program

In addition to completing the PEBC Evaluating Examination, pharmacy assistants who did not graduate from a CCAPP-accredited program must also complete the NAPRA National Pharmacy Technician Bridging Education Program. This bridging program allows experienced pharmacy assistants working in a pharmacy to become a listed pharmacy technician without enrolling in a full-time pharmacy technician program. Please visit the NAPRA website for more information.

A pharmacy assistant must complete **all** of the College of Pharmacists of Manitoba requirements to become listed as a pharmacy technician by **December 31, 2019.**

Courses that fulfill the education requirement for the NAPRA Bridging Education Program are available online through Selkirk College or in-class through Robertson College and the Manitoba Institute of Trades and Technology.

For more information on the steps to becoming a pharmacy technician, please see the Pharmacy Technician page of the College website or the Pharmacy Technician Resource Guide.

Pharmacy Technicians

Practicing to a Full Scope:
Pharmacy Technician Final Check Applications

The ability of a pharmacy technician to complete the final check of a prescription allows them to work to their full scope of practice and relieves pharmacists to complete other tasks. Pharmacy operations benefit due to improved work-flow and the additional time a pharmacist can spend on drug therapy management and patient interactions to enhance care and safety:

Under the Pharmaceutical Regulation, a pharmacy technician can perform the final check of a prescription under the following conditions:

- The pharmacy manager has submitted a Pharmacy Technician Final Check application to the College and has received approval for the drug packaging and preparation process;
- The prescription is prepared for dispensing by another pharmacy technician, student, intern or pharmacy assistant; and
- The pharmacist performs a therapeutic check of the prescription (new and refills) and approves the prescription for filling.

The College has approved a number of final check applications from hospital and community pharmacies wishing to further expand the role of pharmacy technicians within their pharmacies.

The Pharmacy Technician Final Check Application process requires pharmacy managers and staff to assess current dispensing processes to determine the policy and procedures required for a pharmacy technician to perform the final check safely and in compliance with legislation. Pharmacy managers submit their complete applications directly to the College for review and approval, based on criteria established by Council. College staff review the application and provide feedback to the pharmacy manager. Communication and collaboration with the pharmacy manager ensures the application and policy and procedure document meet the Council approved criteria for application approval.

Please refer to the Pharmacy Technician Final Check Information Sheet for additional information to help you complete the application and build your Pharmacy Technician Final Check policies and procedures.

For more information on pharmacy technician scope of practice and pharmacy technician final checks, please review the Pharmacy Technician Resource Guide and the Pharmacy Technician Final Check Application FAQ.

You can submit your application directly to the College office at 200 Taché Ave, by email to info@cphm.ca, or by fax to 204-237-3468.

If you have questions about the Pharmacy Technician Final Check Application process, please contact Ronda Eros, Practice Consultant, by email at reros@cphm.ca or by phone at 204-233-1411

Pharmacy Technician Listing Renewal: Updated Provisional Requirements

At the May 11, 2018, Council Meeting, a new policy was approved regarding the re-listing requirements for pharmacy technicians with insufficient practice hours or pharmacy technicians returning to work after an absence from practice.

The provisional renewal requirements outline the steps a pharmacy technician must complete if they do not meet the 600-hour practice requirement, but still wish to maintain their designation:

A pharmacy technician applicant who does not meet the 600-hour practice requirement may be listed with the condition they must practice under the **direct** *supervision of a pharmacist, until the 600-hour practice requirement is met.*

If a pharmacy technician upon renewal has not met the 600 hour practice requirement in the preceding three-year period, starting three years from being first listed, the technician's listing would be on condition until he/she meets the practice hour requirement by working under the **direct** *supervision of a pharmacist. The technician must provide the College with a letter signed by the technician and the pharmacy manager stating a reasonable timeline for completion of the outstanding practice hours. Once the hours have been completed, the technician must submit another letter signed by the pharmacy manager and the pharmacy technician stating the 600-hour practice requirement has been completed, along with a completed renewal application to be listed as a pharmacy technician.*

Council has also outlined the qualifying requirements for a pharmacy technician who does not renew their listing but later decides to return to practice. The requirements vary depending on the length of time the applicant has been absent from practice.

When a pharmacy technician has been unlisted for less than three years:

A pharmacy technician applicant that has not been listed in less than the previous three years, prior to the year of application, must practice under the direct supervision of a pharmacist until the 600-hour practice requirement is met.

When a pharmacy technician has been unlisted for three to six years:

A pharmacy technician applicant that has not been listed in the previous three years and not more than six years, prior to the year of application, must:

- *Successfully complete 240 hours of structured practical training under the direct supervision of a pharmacist;*
- *Successfully complete a Jurisprudence Examination and attain a passing grade of 70 per cent or more; and*
- *Complete three times the amount of professional development as required by Council.*

When a pharmacy technician has been unlisted for more than six years:

A pharmacy technician applicant that has not been listed for more than six years, prior to the year of application must:

- *Successfully complete the Pharmacy Examining Board of Canada OSCE Part II portion of the Qualifying Examination;*
- *Successfully complete 240 hours of structured practical training under the direct supervision of a pharmacist; and*
- *Successfully complete a Jurisprudence Examination and attain a passing grade of 70 per cent or more.*

Case Studies in Patient Safety

Trailing Zeros can Pose a Fatal Risk: HYDROmorph Contin Overdose in a Community Pharmacy

Case Description

A new patient presented to a Manitoba pharmacy with a prescription for "HYDROmorph Contin® (HYDROmorphone hydrochloride controlled release capsules) 6.0 mg", which was interpreted as "HYDROmorph Contin 60 mg". The prescription also indicated instructions to "hold Codeine Contin® (codeine controlled release tablets)", as the patient was switching therapy from Codeine Contin® to HYDROmorph Contin®.

Upon receiving the prescription, the pharmacist noted the higher dose of the medication and further assessed it for evidence of forgery. Drug Program Information Network (DPIN) processing revealed an active MY* code due to the patient's previous use of Codeine Contin®, but the amount released and days supply were not assessed. To ensure maximal dosing was not surpassed, the pharmacist consulted an appropriate reference which indicated that 60 mg of HYDROmorph Contin® twice daily was an acceptable therapeutic dose for an opiate tolerant patient. Due to the high dose, the pharmacist attempted to verify the integrity of the prescription by contacting the prescriber, but the prescriber was unavailable for the remainder of the day and the pharmacist made no further attempt to contact the prescriber. The pharmacist signed off on the prescription and provided counselling to the patient; however, the patient's previous dosage of Codeine Contin® was not discussed at this time. Directions provided to the patient stated: "Take 2 of the 30 mg capsules by mouth every 12 hours".

Several days later, the patient phoned the pharmacy expressing feeling unwell from the HYDROmorph Contin®. The pharmacist instructed the patient to halve the dose by taking only one capsule twice daily and to contact their prescriber immediately. The pharmacist made no additional contact with the patient after this phone conversation.

*If the same drug has been dispensed at a different pharmacy, the MY response code is returned from DPIN (DUPLICATE DRUG, OTHER PHARMACY)

Background

HYDROmorph Contin® is an opioid derivative that is classified as a potent centrally acting analgesic[1, 2]. It is indicated for relief of moderate to severe pain that requires continuous and long-term management on a daily basis[3]. Adverse effects associated with HYDROmorph Contin are similar to those of morphine and fentanyl, which include respiratory depression, central nervous system depression, and apnea[2, 3]. The major concern with overuse, however, is life-threatening respiratory depression that could eventually lead to death[3]. It is important to continuously monitor and evaluate this class of medication to prevent the patient from accidentally overdosing.

The Institute for Safe Medication Practices (ISMP) Canada found that opioids consistently rank in the top ten harmful medication incidents that are voluntarily reported to the organization[1].

Discussion

An in-depth analysis of this incident revealed several contributing factors that ultimately resulted in providing the patient medication with a ten-fold error in dosing:

- The prescription was written with a trailing zero after a decimal point.
- The pharmacist failed to assess previous narcotic therapy.
- The pharmacist failed in their responsibility to verify the dosafe of a potential narcotic with the prescriber

Medication errors are multi-factorial;[4] however, medication prescribing deficiencies are the primary cause of adverse drug events[4]. 'Ten-fold errors' can easily translate into 100-, or 1000-fold medication dosing errors. Common causes of a ten-fold error include trailing zeros or failure to place a leading zero before a decimal point[4]. These types of errors are especially prone during interpretation of a written prescription. In an 18-month longitudinal study conducted in a 631-bed tertiary-care teaching hospital, approximately two hundred cases of tenfold prescribing errors were detected (see Figure 1 below).

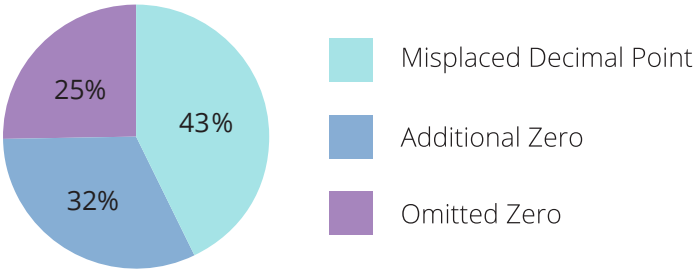


Figure 1: Tenfold Error Types

While a trailing zero was a major contributing factor in this medication incident, there were several other important missed steps that could have prevented the error.

The opportunity to assess previous narcotic therapy was missed on three occasions in this incident:

- Failure to fully assess DPIN regarding previous narcotic therapy.
- Failure to discuss previous narcotic therapy with the patient during the initial consultation.
- Follow-up conversation when patient callled several days after the perscription was filled.

Checking DPIN for previous narcotic therapy is outlined in Section 2.2 A of the Ensuring Patient Safety Practice Direction:

"*A licensed pharmacist must determine if there is an actual or potential drug related problem, specific to the patient and the drug therapy [...]*".

Section 2.3 of the Practice Direction states

"*where an actual or potential drug related problem has been identified, the licensed pharmacist must take the appropriate action to address the problem, collaborate with the patient, and the prescriber, where appropriate, to address the actual or potential drug related problem*".

Similarly, during patient counselling, if the dialogue between the pharmacist and patient would have met the Patient Counselling Practice Direction, the drug-therapy problem may have been identified.

Lastly, the breakdown of communication between the pharmacist and the prescriber presented an additional barrier to assessing the integrity of the prescription. Consultation with the prescriber is critical whenever the pharmacist has concerns. In this instance, additional attempts to contact the prescriber by various means, should have been attempted before release of this entire prescription.

(Continued on page 14)

Trailing Zeros (Cont'd)

How to prevent tenfold medication dosing errors

1. Always question whether a trailing zero may exist when reviewing dosages on prescriptions, especially narcotic perscriptions.

2. Display a printed version of the "Oral Opioid Analgesic Equivalence Table" where medications are prepared in the pharmacy. See Figure 2: Oral Opioid Analgesic Equivalence Table.

3. Establish a chart for narcotics that lists the maximum dose ranges for dangerous medications. The chart must be visible when preparing medications.

4. Implement rules regarding zeros in all medication related documentation, labeling, and communication such as:

   a) always place a zero before the decimal point for numbers,

   b) never place a trailing zero following a decimal point, and

   c) never use trailing zeros.

5. Require that doses of dangerous medications be independently double-checked by experienced staff.

6. Increase staff awareness of the risk of tenfold errors.

7. Obtain accurate patient medication histories through structured interviews.

8. Educate patients and families about the signs and symptoms of opioid toxicity.

9. Provide patients with a print copy of ISMP Canada's Opioid Information for Patients and Families handout.

Opioid	Equivalence to oral morphine 30 mg:	To convert to oral morphine equivalent multiply by:	To convert from oral morphine multiply by:
Morphine	30mg	1	1
Codeine *	200 mg	0.15	6.67
Oxycodone	20 mg	1.5	0.667
Hydromorphone	6 mg	5	0.2
Meperidine **	300 mg	0.1	10
Methadone	Morphine dose equivalence not reliably established.		
Tramadol *			
Transdermal fentanyl	60–134 mg morphine = 25mcg/h 180–224 mg = 50 mcg/h 225–269 mg = 62 mcg/h 270–314 mg = 75 mcg/h 315–359 mg = 87 mcg/h 360–404 mg = 100 mcg/h	**These estimates are conservative; therefore, DO NOT use these values for reverse conversion (e.g. fentanyl to morphine)**	

Figure 2: Oral Opioid Analgesic Equivalence Table.
From the Canadian Guideline for Safe and Effective Use of Opioids

References:

1. ISMP Canada. In: ISMP Canada Safety Bulletin. Decimal Point in New Strength of HYDROmorph Contin Leads to an Opioid Overdose. 14: 9; 2014. p. 1-6.

2. Opioids monograph. In: Repchinsky C, editor-in-chief. Compendium of Pharmaceuticals and Specialties. Ottawa (ON): Canadian Pharmacists Association; 2012. p. 1896-1898.

3. CPS [Internet]. Ottawa (ON): Canadian Pharmacists Association; c2016 [updated 2015 July 22; cited 2018 May 9]. Hydromorph Contin [product monograph]. Available from: http://www.e-therapeutics.ca. Also available in paper copy from the publisher.

4. S Lesar, Timothy. (2003). Tenfold Medication Dose Prescribing Errors. The Annals of Pharmacotherapy. 36. 1833-9. 10.1345/aph.1C032.

5. National Opioid Use Guideline Group. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Available at http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf. Accessed May 10th, 2018.

Return-to-Stock Medication: A Community Pharmacy Mix-Up Causes Patient Harm

Introduction to the Case

The case presented below is an incident that occurred in a Manitoba community pharmacy as a result of a medication being returned to an incorrect manufacturer stock bottle. The medication error resulted in patient harm resulting in a hospital stay.

Case Description

A long-time patient that was known to the pharmacy came to refill a prescription to treat their hypertension. A refill was made for irbesartan 300 mg, with directions for the patient to take the medication once daily. The prescription was verified by the pharmacist and counselling was offered to the patient.

The patient took their first dose of this medication the following morning. Shortly after taking the medication, the patient felt unwell and extremely weak. The patient suspected a potential stroke at the time of the incident, and an ambulance was called.

Upon arrival at the emergency room and a subsequent medical assessment, the patient received a diagnosis indicating "medication toxicity". Upon further investigation, it was determined that the patient had ingested a tablet containing a high dose of the antipsychotic medication, quetiapine.

Upon discharge from the hospital, the patient was given a new prescription for irbesartan 300 mg. The vial containing quetiapine, rather than irbesartan, was returned to the dispensing pharmacy for the purpose of incident analysis.

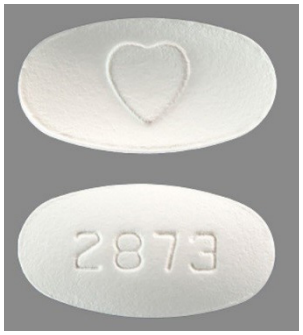
Background

Irbesartan is an angiotensin II receptor antagonist and is prescribed for the chronic treatment of mild to moderate hypertension[1]. Irbesartan is supplied in 75 mg, 150 mg, or 300 mg dose strengths. Each tablet is white to off-white, biconvex, oval-shaped, and uncoated in appearance[1].

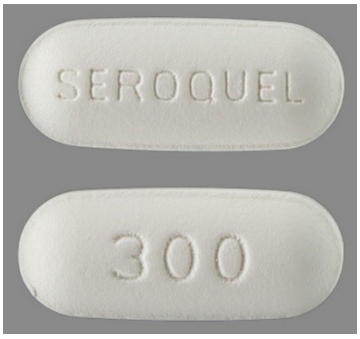
(Continued on page 16)

Quetiapine, an antipsychotic medication, is indicated for the management of manifestations of schizophrenia or acute management of manic or depressive episodes in bipolar disorder[2]. Immediate release tablets come in 25 mg, 100 mg, 200 mg, or 300 mg dose strengths[2].

Though each individual dose strength has a different overall appearance, the 300 mg immediate-release tablet more closely resembles a 300 mg irbesartan tablet; it appears as a white, capsule-shaped, biconvex, film-coated tablet[2]. The images are presented below:



Avapro - irbesartan 300 mg oral tablet.



Seroquel - quetiapine 300 mg oral tablet.

Following a review of this incident, it was determined that the contributing factors that led to this medication error were as follows:

1. A vial of return-to-stock quetiapine tablets was incorrectly poured into an irbesartan manufacturer stock bottle.

2. The two medications looked alike.

3. Reliance on technology. The pharmacy assistant scanned and counted the medication, however, the pharmacist did not visually verify the contents of the vial.

4. "Show and tell" was not conducted by the pharmacist at the time of patient counselling.

Discussion

The Pharmaceutical Regulation outlines the following under "Returning drugs to inventory" Section 85(1):

A drug must not be returned to inventory if it has been previously dispensed, unless the following conditions are met:

a) The lot numbers and expiry dates of the drug, where applicable, are directly attached to the dispensed container;

b) The drug has not expired;

c) Where each dose of the drug of the container is sealed, the seal is intact when the drug is returned to the pharmacy;

d) The patient or agent has not been in possession of the dispensed drug;

e) The conditions under which the drug has been stored between the time of the dispensing and the time of the return are known and appropriate;

f) It is reasonably safe to do so.

"Show-and-tell" is a valuable process for both the pharmacist and the patient (or caregiver) at time of pick-up.

How to prevent return to stock medication errors

A pharmacy manager should develop Return to Stock (RTS) processes in their pharmacy to prevent incidents involving return to stock medications. Strategies to consider include:

1. Do not return a drug into the manufacturer stock bottle;

2. Before placing a drug in the dispensed container back on the shelf, ensure that:

    a. BOTH the lot number and expiry dates are clearly indicated, and

    b. Patient- and physician-identifying information has been obscured on the pharmacy label;

3. If available within the pharmacy software, generate a RTS label, which includes the drug name and strength;

4. Develop organizational policies for recording and monitoring of expiration dates on RTS products[3].

5. Perform a final visual check of the medication. Although many pharmacies in the province scan stock bottles for accuracy prior to counting patients' medications, it is always important for a pharmacist or pharmacy technician performing the final check of the medication to visually verify that the correct medication is in the vial.

6. Make 'show and tell' part of the patient counselling process. "Show-and-tell" is a valuable process for both the pharmacist and the patient (or caregiver) at time of pick-up. "Show-and-tell" provides an opportunity for the pharmacist to perform a final visual verification that the correct medication is in the vial. It is also an opportunity for the patient to inform the pharmacist if a refilled medication looks different than they expect, which facilitates a discussion about the medication before it leaves the pharmacy.

References:

1. CPS [Internet]. Ottawa (ON): Canadian Pharmacists Association; c2016 [updated 2015 July 22; cited 2018 June 15]. Angiotensin II Receptor Antagonists [product monograph]. Available from: http://www.e-therapeutics.ca. Also available in paper copy from the publisher.

2.CPS [Internet]. Ottawa (ON): Canadian Pharmacists Association; c2016 [updated 2015 July 22; cited 2018 June 15]. Seroquel [product monograph]. Available from: http://www.e-therapeutics.ca. Also available in paper copy from the publisher.

3. ISMP Medication Error Safety Briefs. The Pharmacy Times. Available at https://www.pharmacytimes.com/publications/issue/2017/december2017/ismp-medication-error-safety-briefs. Accessed June 15th, 2018.

Important Update to the Food and Drug Regulations Regarding the Sale of Opioids

On April 23, 2018, the Government of Canada announced the *Regulations Amending the Food and Drug Regulations* (*Opioids*) that directly affect pharmacists dispensing opioids. These changes will come into effect in October 2018. Health Canada, as part of their strategy to reduce opioid overuse, addiction and overdose, will require patients to receive additional information about the safe use of opioids. These changes are intended to mitigate the current public health crisis by educating patients about the inherent risks associated with prescription opioids. The *Regulations Amending the Food and Drug Regulations (Opioids)* involve altering the terms and conditions required for pharmacists to sell an opioid. The following two requirements have been added to the Food and Drug Regulations for the sale of any Class A opioid (see Table 1: Part A – Opioids subject to prescription labelling provisions):

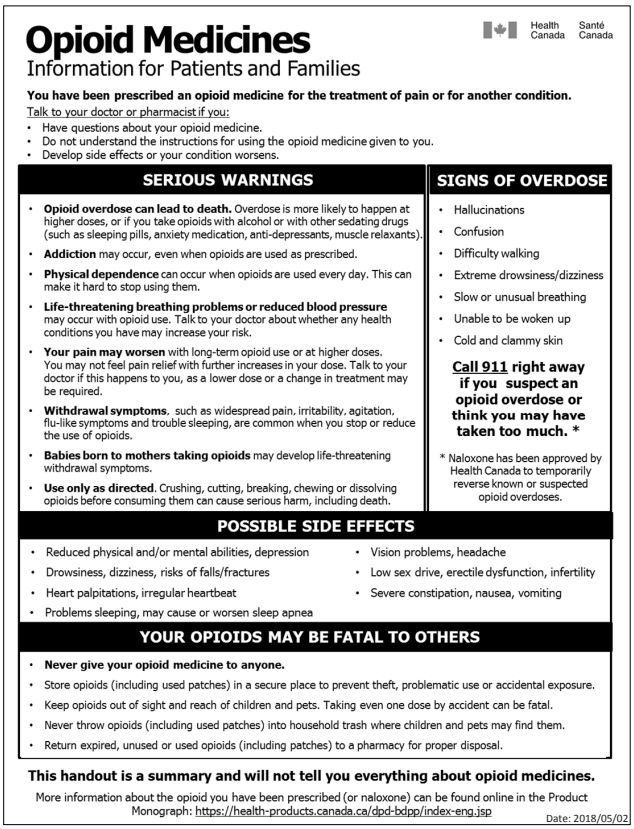
C.01.005.1 (1) No pharmacist or practitioner shall sell a Class A opioid — including one that is compounded by a pharmacist under a prescription or by a practitioner — unless

(a) the drug's package has a warning sticker applied to it that meets the specifications set out in the source document; and

(b) the drug is accompanied by a patient information handout that meets the specifications set out in the source document.

All dispensed medications (new or refills) listed in Part A MUST contain a Health Canada approved warning sticker affixed to the label. The warning sticker is standardized:

In addition, all practitioners and/or pharmacists dispensing a Class A opioid MUST provide the following patient information handout to the patient, every time an opioid is sold:



Opioid Medicines

Information for Patients and Families

Health Canada / Santé Canada

You have been prescribed an opioid medicine for the treatment of pain or for another condition.

Talk to your doctor or pharmacist if you:

- Have questions about your opioid medicine.
- Do not understand the instructions for using the opioid medicine given to you.
- Develop side effects or your condition worsens.

SERIOUS WARNINGS

- **Opioid overdose can lead to death.** Overdose is more likely to happen at higher doses, or if you take opioids with alcohol or with other sedating drugs (such as sleeping pills, anxiety medication, anti-depressants, muscle relaxants).
- **Addiction** may occur, even when opioids are used as prescribed.
- **Physical dependence** can occur when opioids are used every day. This can make it hard to stop using them.
- **Life-threatening breathing problems or reduced blood pressure** may occur with opioid use. Talk to your doctor about whether any health conditions you have may increase your risk.
- **Your pain may worsen** with long-term opioid use or at higher doses. You may not feel pain relief with further increases in your dose. Talk to your doctor if this happens to you, as a lower dose or a change in treatment may be required.
- **Withdrawal symptoms**, such as widespread pain, irritability, agitation, flu-like symptoms and trouble sleeping, are common when you stop or reduce the use of opioids.
- **Babies born to mothers taking opioids** may develop life-threatening withdrawal symptoms.
- **Use only as directed.** Crushing, cutting, breaking, chewing or dissolving opioids before consuming them can cause serious harm, including death.

SIGNS OF OVERDOSE

- Hallucinations
- Confusion
- Difficulty walking
- Extreme drowsiness/dizziness
- Slow or unusual breathing
- Unable to be woken up
- Cold and clammy skin

Call 911 right away if you suspect an opioid overdose or think you may have taken too much. *

* Naloxone has been approved by Health Canada to temporarily reverse known or suspected opioid overdoses.

POSSIBLE SIDE EFFECTS

- Reduced physical and/or mental abilities, depression
- Drowsiness, dizziness, risks of falls/fractures
- Heart palpitations, irregular heartbeat
- Problems sleeping, may cause or worsen sleep apnea
- Vision problems, headache
- Low sex drive, erectile dysfunction, infertility
- Severe constipation, nausea, vomiting

YOUR OPIOIDS MAY BE FATAL TO OTHERS

- **Never give your opioid medicine to anyone.**
- Store opioids (including used patches) in a secure place to prevent theft, problematic use or accidental exposure.
- Keep opioids out of sight and reach of children and pets. Taking even one dose by accident can be fatal.
- Never throw opioids (including used patches) into household trash where children and pets may find them.
- Return expired, unused or used opioids (including patches) to a pharmacy for proper disposal.

This handout is a summary and will not tell you everything about opioid medicines.

More information about the opioid you have been prescribed (or naloxone) can be found online in the Product Monograph: https://health-products.canada.ca/dpd-bdpp/index-eng.jsp

Date: 2018/05/02

This warning sticker and patient information sheet can be found on the Health Canada website:

https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/applications-submissions/policies/warning-sticker-opioid-patient-information-handout.html

An exception to these requirements is when an opioid is being administered directly to the patient under the supervision of a practitioner, or when an opioid product is sold from one pharmacist or practitioner to another. Please be reminded that pharmacy-to-pharmacy sales of opioids are only permitted in emergency situations.

Table 1: Part A – Opioids subject to prescription labelling provisions

Drugs intended for human use containing any of the following active ingredients	Including (but not limited to)	Qualifier
Buprenorphine	Buprenorphine Hydrochloride	n/a
Butorphanol	Butorphanol Tartrate	Except for those products referred to in subsection 36(1) of the Narcotic Control Regulations.
Codeine	Codeine Phosphate	n/a
Fentanyl	Fentanyl Citrate	n/a
Hydrocodone	Hydrocodone Bitartrate	n/a
Hydromorphone	Hydromorphone Hydrochloride	n/a
Meperidine	Meperidine Hydrochloride	n/a
Methadone	Methadone Hydrochloride	n/a
Morphine	Morphine Hydrochloride; Morphine Sulfate	n/a
Normethadone	Normethadone Hydrochloride	n/a
Opium	Opium and Belladonna	n/a
Oxycodone	Oxycodone Hydrochloride	n/a
Oxymorphone	Oxymorphone Hydrochloride	n/a
Pentazocine	Pentazocine Hydrochloride; Pentazocine Lactate	n/a
Tapentadol	Tapentadol Hydrochloride	n/a
Tramadol*	Tramadol Hydrochloride	n/a

* Tramadol is not classified as a controlled substance, however, Health Canada has decided to include it on this list because, pharmaceutically, it is an opioid.

Gabapentin, Pregabalin, and Duloxetine
Listing Changes and Considerations

Cymbalta® (duloxetine), Lyrica® (pregabalin), and Neurontin® (gabapentin) are now all Part 1 benefits on the Manitoba Drug Benefits and Interchangeability Formulary (Formulary) making them eligible for Pharmacare benefits under all prescribed circumstances. On January 25, 2018, Cymbalta® and generic formulations were moved from a restricted Part 3 listing to a Part 1 benefit on the Formulary; and Lyrica® and generic formulations were added to the Formulary as Part 1 benefits.

Amendments to the Formulary are documented in Bulletins, and may be accessed through the "Information for Health Professionals" page of the Manitoba Health website: https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html.

This change comes amidst reports of gabapentin becoming a significant drug of abuse in recent years. Although therapeutically useful when prescribed appropriately, it is well known that gabapentin, due to its possible psychoactive effects, is commonly diverted and overused along with other prescription drugs such as opioids and benzodiazepines.

It is important to note that there is data suggesting that pregabalin may also have abuse potential, although this has not been a major issue in Manitoba to date. This may be, at least in part, due to this drug's past restricted Part 3 EDS status. Health care practitioners should be alert to the potential abuse or misuse of gabapentin and pregabalin.

The Part 1 listing of duloxetine and pregabalin gives health care providers more options for treatment of pain and pain related conditions. The length of clinical trials associated with these drugs varies from 10 months to greater than 1 year depending on the drug and indication, therefore the use of these drugs for the management of chronic pain conditions must be monitored appropriately and be patient-specific.

Gabapentin is indicated for the management of epilepsy but is commonly used for treatment of neuropathic pain. Gabapentin, duloxetine and pregabalin are all generically available and vary little in price.

These medications have a defined place in therapy, and it is the responsibility of the healthcare professionals caring for these patients to ensure that they are using the best quality evidence currently available in formulating treatment plans. It is important that prescribers become familiar with the indications, dosing, adverse effects and drug interactions for these three drugs. Appropriate monitoring parameters should be considered when starting any of these medications. Practitioners should refer to current literature, drug monographs, guidelines and evidence based reviews such as those provided by the Canadian Agency for Drugs and Technologies in Health (CADTH): https://cadth.ca/evidence-bundles/pain-evidence-bundle/browse-evidence.

Collaborative care is a vital part of health care because it creates better health outcomes for patients. As medication experts, pharmacists are ideally positioned to optimize prescribing by providing suggestions and advice on drug therapy, including:

- Dose adjustments for patients with or without renal or hepatic failure.
- Suggestions to minimize poly-pharmacy.
- Assessment of patient compliance or overuse,.
- Monitoring for drug interactions or adverse effects.

Collaboration between all health care practitioners is key to improving patient outcomes and increasing patient safety.

This information was developed by a interprofessinal ad hoc working group consisting of representatives from the College of Pharmacists of Manitoba, the College of Physicians and Surgeons of Manitoba, the College of Registered Nurses of Manitoba, and the Manitoba Dental Association. Manitoba Health tasked the ad hoc working group with creating a unified and coordinated approach to communications on the use, risks, benefits and monitoring of gabapentin, pregabalin, and duloxetine in prescribing and dispensing.

Learning from Our Mistakes: Resources for Continuous Quality Improvement

The ground-breaking report, *To Err is Human: Building a Safer Health System* (1999), published by the Institute of Medicine, demonstrated that medical errors are a leading cause of patient harm and death in the US. *The Canadian Adverse Event Study* (2004) came to similar conclusions and noted that 24 per cent of all preventable adverse events in hospitals are related to medication errors.

These reports have prompted healthcare organizations to re-assess and restructure their approaches to medical and medication errors to encourage blame-free reporting of errors and shared learning to prevent recurrence. In 2006, legislation was introduced in Manitoba that made blame-free reporting of critical incidents mandatory in regional health authorities, hospitals, personal care homes, land and air ambulances, the Selkirk Mental Health Centre, Cancer Care Manitoba, and Diagnostic Services Manitoba. The outcomes and recommendations of the critical incidents investigations are posted online by Manitoba Health, Seniors and Active Living and contain valuable information on error prevention including medication incidents:

https://www.gov.mb.ca/health/patientsafety/psla.html

To focus exclusively on medication incidents and error prevention, pharmacy professionals should also sign-up to receive the Institute for Safe Medication Practices (ISMP) Canada Safety Bulletins:

ISMP CANADA

Institute for Safe Medication Practices Canada
REPORT MEDICATION INCIDENTS
Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672

A KEY PARTNER IN
CMIRPS SCDPIM

ISMP Canada Safety Bulletin

Volume 18 · Issue 5 · June 27, 2018

Safe Storage and Disposal of Medications

- *Engage in conversation with patients about the safe storage of medications in the home and about the safe disposal of unnecessary or expired medications.*
- *Share online and written resources about safe medication storage and disposal.*
- *Determine whether practices, such as removal of unnecessary medications by a home-visiting pharmacist or return of medications to a pharmacy, are available in your area, and advise patients accordingly.*

Improper storage and disposal of medications in the home have resulted in medication errors, accidental poisonings, inappropriate use, and diversion.[1-3] Children in Canada continue to experience harm through accidental ingestion of improperly stored or discarded medications and poisons, despite the implementation of child-resistant packaging.[4]

ISMP Canada, with the support of the Canadian Patient Safety Institute (CPSI) and partners, has developed key messages to guide both clinicians and patients on the safe storage and disposal of medications in the community.

Safe Storage

Medications, including those in compliance packaging, should be stored out of sight and out of reach of children. The ideal medication storage location provides easy accessibility for the intended user while preventing or discouraging inappropriate access and accidental ingestion by anyone else, especially children. Most unintentional pediatric ingestion occurs at home and involves medications stored at a height within easy reach of a toddler or child. A locking device is strongly suggested, either for the medication container or for the cabinet in which medications are stored.[4,5]

Safe Disposal

Patients and their caregivers may need to dispose of prescription and nonprescription medications for various reasons, such as failure to complete a course of therapy; change in treatment, dose, or clinical condition; or product expiry. The ideal method of medication disposal should be easy to perform, should minimize risk for diversion, should not impose a financial burden, and should be environmentally sound. Taking unused medications to a community pharmacy for proper disposal meets all of these criteria and is therefore recommended.

Disposing of medications in the trash is not acceptable, because home garbage containers are

ISMP Canada Safety Bulletin – www.ismp-canada.org/ISMPCSafetyBulletins.htm 1 of 6

The ISMP Canada Safety Bulletins feature real medication incidents and analysis of data collected through the Canadian Medication Incident Reporting and Prevention System.

Focus on Patient Safety

The Institute for Safe Medication Practices Canada is an independent national not-for-profit organization committed to the advancement of medication safety in all healthcare settings. ISMP Canada works collaboratively with the healthcare community, regulatory agencies and policy makers, provincial, national and international patient safety organizations, the pharmaceutical industry and the public to promote safe medication practices. ISMP Canada's mandate includes analyzing medication incidents, making recommendations for the prevention of harmful medication incidents, and facilitating quality improvement initiatives.

ISMP Newsletter Subscriptions

ISMP Canada Safety Bulletins are designed to disseminate timely, targeted information to reduce the risk of medication incidents. The purpose of the bulletins is to confidentially share the information received about medication incidents which have occurred and to suggest medication system improvement strategies for enhancing patient safety. The bulletins will also share alerts and warnings specific to the Canadian market place. The following ISMP Canada Safety Bulletins have been issued since the last issue of the Newsletter:

ISMP Canada Safety Bulletins for Practitioners, 2018 - Volume 18:

- Reaffirming the "Do Not Use: Dangerous Abbreviations, Symbols and Dose Designations" List
- Deprescribing: Managing Medications to Reduce Polypharmacy

SafeMedicationUse.ca Newsletters and Alerts for Consumers, 2018 - Volume 9:

- Keep Your Medications Organized
- Using Your Own Medications While in Hospital
- Do NOT Delay Starting Certain Medications

All issues of the ISMP Canada Safety Bulletins, including those issued in previous years, are freely downloadable from the ISMP Canada website at www.ismp-canada.org. ISMP Canada is pleased to distribute The Medication Safety Alert! (US) newsletters along with ISMP Canada Safety Bulletins to Canadian practitioners and corporations.

To subscribe and for more information on all ISMP Canada's publications, events and services visit the ISMP Canada website at www.ismp-canada.org.

CMIRPS Canadian Medication Incident Reporting and Prevention System

SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

The Canadian Medication Incident Reporting and Prevention System (CMIRPS) is a collaborative pan-Canadian program of Health Canada, the Canadian Institute for Health Information (CIHI), the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The goal of CMIRPS is to reduce and prevent harmful medication incidents in Canada.

Report medication incidents (including near misses):

Online: www.ismp-canada.org/err_index.htm
Phone: 1-866-544-7672 ISMP Canada strives to ensure confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

Sign up:

To receive this publication or other medication safety publications, sign up at: www.ismp-canada.org/subscription.htm

For more information, visit CMIRPS, call 1-866-544-7672, or email cmirps@ismp-canada.org.

Multi-Dose Beyond-Use Dating

Beyond-use dating not only applies to hospitals and compounding pharmacies, but also to community pharmacies. There are medications dispensed by a community pharmacy where beyond-use dating (BUD) applies such as ampoules and multi-use vials.

When a multiple dose container (e.g. vial) is dispensed, the BUD must be taken into consideration.

The National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Hazardous, and of Non-Hazardous, Sterile Preparations outline the expectations for BUD including the use of multi-dose containers:

6.1.2 Beyond-use dates for commercially available products according to type of container (single-dose vial or multiple-dose container)

6.1.2.3 Multiple-dose container (e.g., vial)

- A multiple-dose container will be labeled as such by the manufacturer.
- Multiple-dose containers usually contain a preservative.
- The BUD is 28 days unless otherwise specified by the manufacturer.
- If there is visible contamination before 28 days (or the manufacturer's expiry date), the container must be discarded.

When dispensing a multi-use vial, the days' supply must take into account the BUD of 28 days.

Use of Filter Needles

A filter needle is a syringe needle with a glass filtering device. A filter needle cannot be used to both withdraw and inject. It is a one-way device and can only be pushed or pulled in one direction. A filter needle is used to withdraw from the ampoule and a non-filter needle must be placed on the syringe prior to injection.

When medication is drawn from an ampoule, a filter needle should be used to draw it up in order to decrease the risk of glass particle contamination to the patient. The community pharmacy may not be involved in drawing up the medication from the ampoule, but the proper filter needles and education about using a filter needle should be available to the patient who is using the medication.

The use of a filter needle is not always possible or advisable in emergency situations such as naloxone administration.

SMART Medication Safety Agenda: Drug Shortage


Community Pharmacy Incident Reporting (CPhIR)
May 2018
SMART Medication Safety Agenda
Drug Shortage
SMART Medication Safety Agenda
How to Use the SMART Medication Safety Agenda
Table 1.
Effectiveness and Feasibility

The Institute for Safe Medication Practices Canada (ISMP Canada) has introduced the SMART Medication Safety Agenda to share learnings on common medication incidents reported to them through the Community Pharmacy Incident Reporting (CPhIR) program. The Safety IQ Pilot pharmacies have been contributing to CPhIR since September 2017. Important data reported to CPhIR from across Canada has formed the foundation for continuous quality improvement (CQI) resources like SMART Medication Safety Agenda to support pharmacy practice enhancements for patient safety.

What is the SMART Medication Safety Agenda?

The SMART Medication Safety Agendas feature anonymously reported medication incidents from across Canada through the (CPhIR) program. Potential contributing factors and recommendations are provided in each issue for pharmacy teams to discuss and encourage collaboration toward continuous quality improvement. By putting together an action plan and monitoring its progress, the SMART Medication Safety Agenda can help raise awareness regarding similar incidents at a pharmacy.

How do I use the SMART Medication Safety Agenda?

The following YouTube video (4:16 minutes) is a step-by-step guide for pharmacy professionals to learn how to use the SMART Medication Safety Agenda:

https://youtu.be/zFTwL-mt0Xw

A series of SMART Medication Safety Agendas will be published on a quarterly basis and College members will be notified through the College's regular communications, Friday Five and Newsletter. Pharmacy professionals can access this resource on the Safety IQ homepage and the Practice Resource page of the College website.

The second of 2018's SMART Medication Safety Agenda is about Drug Shortage and can be found below:

SMART Medication Safety Agenda: Drug Shortages

NAPRA Releases Model Standards for Compounding of Non-Sterile Preparations

On March 28, 2018, the National Association of Pharmacy Regulatory Authorities (NAPRA) completed its suite of pharmacy compounding model standards with the release of the *Model Standards for Pharmacy Compounding of Non-Sterile Preparations*. NAPRA has also published a *Guidance Document for Pharmacy Compounding of Non-sterile Preparations* (Guidance Document) to provide implementation support to pharmacies engaged in non-sterile compounding. These documents were prepared by the NAPRA National Advisory Committee on Pharmacy Practice following robust consultation with experts and stakeholders and with the aim of protecting patient and personnel safety in the compounding of non-sterile drugs.

College Council has established an ad-hoc committee to review and provide provincial recommendations regarding *The Model Standards for Pharmacy Compounding of Non-sterile Preparations.* An implementation schedule will be determined by Council following a review of the ad-hoc committee's member recommendations and stakeholder consultation. For now, the College encourages members engaged in non-sterile compounding of drugs to review the Model Standards for Pharmacy Compounding of Non-sterile Preparation and its supporting Guidance Document to begin their own gap analysis between the current practices and the updated standards.

Dr. John Wade Patient Safety Initiatives Grant 2017:
Continuing Dr. Wade's Legacy with the Just/Safe Toolkit

In November 2017, the Manitoba Institute for Patient Safety (MIPS) generously awarded the College a Dr. John Wade Patient Safety Initiatives Grant. The grant funds are supporting the development of a toolkit to help pharmacy professionals, managers, and owners enhance or develop just and safe cultures in their workplaces.

The idea for the toolkit was born in July 2017 following the results of the Pre-Safety IQ survey that was administered to practicing pharmacists and pharmacy technicians in Manitoba. This survey demonstrated that pharmacy professionals face significant barriers to medication incident and near miss reporting including the fear of reprimand and a lack of resources. Fear of reprimand for discussing or reporting medication incidents and near misses is a frequent symptom of blame-and-shame culture—a deeply ingrained set of pathological attitudes that persist across all healthcare professions.

We recognized the need for a resource that could support pharmacy professionals, managers, and owners to identify any elements of blame-and-shame culture in their workplaces and make the shift to a generative approach to patient/medication safety: just-and-safe culture.

The Just/Safe Toolkit will help pharmacy professionals to work toward a culture that balances a safety and just culture to support and encourage reporting, discussing, sharing, and developing solutions to preventable medication harm to improve patient safety.

While the Just/Safe Toolkit is still under development, the Dr. John Wade Patient Safety Initiatives Grant funded the foundational elements of the toolkit, including:

- Safety Attitudes Questionnaire
- Continuing education resources focused on medication safety in older adults (Age Friendly Pharmacy Practice)
- MedSecret – a safety culture focused mobile application for health care professionals
- Culture Shift 101: Safety and Just Culture in Community Pharmacy

Blame-and-Shame Culture

Blame-and-shame culture is a significant barrier to improving medication safety because people are afraid to talk about mistakes. By extension, this also means that people do not talk about solutions. *Blame-and-shame* culture is characterized by the following elements and beliefs:

- Health care workers should never make mistakes
- People are to blame when a mistake happens
- Punishment is an effective way to motivate carefulness
- With the hard work of individuals, things will improve
- Errors happen because of a few 'bad apples'

Safety Attitudes Questionnaire:

Measuring Safety Culture in Manitoba's Community Pharmacies

The Safety Attitudes Questionnaire (SAQ) is a validated measurement of safety culture in community pharmacies and examines six key topics:

- Teamwork
- Safety Culture
- Job Satisfaction
- Stress Recognition
- Perception of Management
- Working Conditions

This element of the Just/Safe Toolkit determines a baseline measurement of safety culture in community pharmacies in Manitoba and also serves as a needs assessment for tailoring the Just/Safe Toolkit. In May 2018, the College issued the SAQ on behalf of ISMP Canada to 1635 pharmacy professionals in Manitoba. The survey outcomes will support the College in developing the resources and relationships that are needed for Manitoba community pharmacies to make the shift from *blame-and-shame* to *just-and-safe* cultures.

SAQ Methods

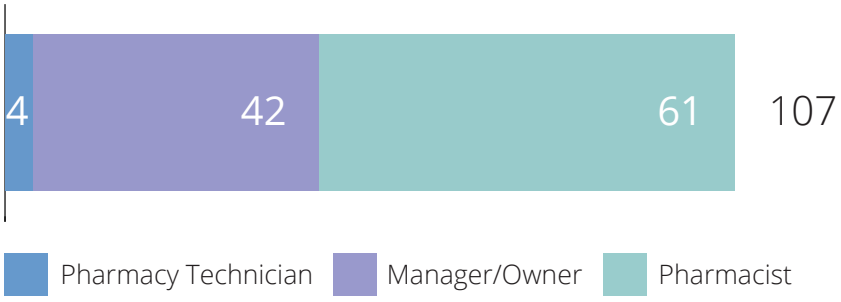
1635 pharmacy professionals receive a SAQ invitation.

SAQ consists of a 40 item online questionnaire based on a five-point Likert Scale.

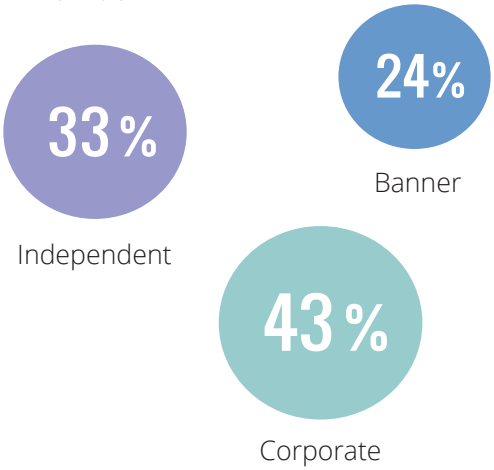
ISMP Canada performs an analysis on the data collected.

SAQ Demographics

Pharmacy Team Role



Pharmacy Type



SAQ Results

Subject	Mean	100 point scale score*
Teamwork	4.40	85.09
Safety Culture	4.41	85.29
Job Satisfaction	4.14	78.62
Stress Recognition	4.08	76.89
Perception of Management	3.96	74.05
Working Conditions	3.97	74.26

*100 point score=(mean-1) * 25

> Constant head office cutbacks require our pharmacy to do the same amount of work with less support staff and less pharmacist hours. This leaves less time to complete tasks and interact with my patients.

> A lot of our part-time technicians had to quit to find other jobs which resulted in constant training of new staff who don't receive adequate training due to hour cuts.

Key Recommendations

1. Streamline new staff training procedures
2. Recognize the impact of fatigue on patient safety
3. Review staffing level to balance productivity and safety

Age-Friendly Pharmacy Practice:

Resources to Encourage Safe Medication Use in Older Adults

The Canadian population is aging. While Canadians are enjoying longer and more mature life expectancies, medication use becomes inherently more complex because of:

- physiological changes related to aging;
- increased likelihood of chronic illnesses; and
- use of multiple chronic medications.

There are also large bodies of evidence that suggest a significant impact of polypharmacy (taking a high number of prescription medications) on medication errors in the senior population.

The Institute for Safe Medication Practices Canada (ISMP Canada) developed a suite of resources to support pharmacists in adapting their knowledge and skill sets to facilitate an "age-friendly environment" for seniors by developing a more robust medication safety culture involving medication use in older adults.

For more information about how you can enhance your practice to create an age-friendly environment and empower older adults to use medication safely, please visit: http://www.cphm.ca/site/age_friendly_pharmacy_practice.

MedSecret:

A Technological Solution for Psychological Safety

We know that up to 50 per cent of healthcare practitioners experience severe psychological impacts when they are involved in an error. This is known as 'Second Victim Syndrome' and the symptoms can be similar to post-traumatic stress disorder (PTSD) with healthcare practitioners experiencing debilitating fear, guilt, anger, and shame. Second Victim Syndrome can be seen as an extension, or even an outcome of, a blame-and-shame culture in which individuals bear sole responsibility for errors often in secret and alone.

In addition to blame-and-shame attitudes, barriers such as time and financial constraints, and inadequate technology can prevent the development of a safety culture in healthcare settings. The College once more partnered with ISMP Canada to develop a solution.

MedSecret is a mobile/web-based application designed to serve as a platform where pharmacy professionals can openly discuss and share medication incidents and provide peer support to one another.

To read about one pharmacist's experience with Second Victim Syndrome and how you can seek or provide support, please see ISMP Canada Safety Bulletin, The Second Victim: Sharing the Journey toward Healing.

Culture Shift 101:
Safety and Just Culture in Community Pharmacy

On May 29, 2018, the College hosted a professional development event for pharmacy professionals to introduce the concepts of safety and just culture and to offer practical steps they can take to enhance or develop their workplace culture. The main learning objectives include:

- Define the characteristics of just-and-safe vs. blame-and-shame cultures
- Describe the current safety culture in Manitoba community pharmacies
- Engage strategies to improve the safety culture of your pharmacy through the experience of a community pharmacist
- Understand the emotional impacts of medication errors on healthcare professionals and the supports available

Four presenters provided an overview of *just-and-safe culture* in both hospital and community pharmacy settings, the outcomes of the Safety Attitude Questionnaire, the impacts of 'Second Victim Syndrome,' and the pilot test version of MedSecret:

Barbara Sproll, B.Sc. Pharm
Medication Safety Pharmacist
WRHA Regional Pharmacy Program

Dr. Certina Ho, RPh, BScPhm, MISt, MEd, PhD
Project Lead, ISMP Canada
Lecturer, Experiential Education Coordinator
Leslie Dan Faculty of Pharmacy, University of Toronto

Shannon Trapp, B.Sc., BA., B.Sc. Pharm
Community Pharmacy Manager

Adrian Boucher, B.Sc. (Hon.), PharmD
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Culture Shift 101: Safety and Just Culture in Community Pharmacy is now available on the College website and is accredited by the College of Pharmacists of Manitoba for 2.00 CEU.

Safety and Just Culture

A *safety culture* is the shared belief and the practice of healthcare providers that makes safety the first priority when providing care to patients. *Safety culture* is characterized by the following elements and beliefs:

- Risks and failure are inherent to complex systems
- People make mistakes no matter how hard they try not to
- Errors are approached with a blame-free attitude
- Focus on systems rather than individuals
- People are preoccupied with safety

A just culture ensures that dangerous, malicious, or neglectful acts are dealt with appropriately by managers, owners, and regulators. A just culture encourages accountability across an entire organization and aims achieve the following foundational elements and beliefs:

- Systems are designed to be resilient so that it can anticipate and prevent errors
- People are held accountable for deliberately risky or neglectful behaviour
- People can trust that their organization will deal fairly with them when something goes wrong

Advancing Patient Safety: The Future of the Just/Safe Toolkit

The College will continue its work developing the Just/Safe Toolkit until it's release in early 2019. Here's what will happen next:

The College of Pharmacists of Manitoba will continue to develop the Just/Safe Toolkit into a comprehensive document and website elements. The next stages of development will focus on:

- Consultation with patient safety experts and advocates including patients and healthcare professionals who have experienced medication errors
- Literature review to ensure our toolkit is evidence based and focused on best practices
- Writing, design, and dissemination of the toolkit

Acknowledgments

The College is grateful to the Manitoba Institute for Patient Safety for their generous support of the Just/Safe Toolkit via the Dr. John Wade Patient Safety Initiatives Grant. We also thank ISMP Canada for their excellent work helping us to develop the Just/Safe Toolkit.

Manitoba Institute for Patient Safety

ismp CANADA

Institute for Safe Medication Practices Canada
Institut pour la sécurité des médicaments aux patients du Canada

Honouring Excellence in Pharmacy Practice:

The College of Pharmacists of Manitoba Awards Recipients

Each year, the College provides pharmacists and members of the public an opportunity to recognize excellence in pharmacy practice in Manitoba by nominating a pharmacist for one of its prestigious awards. On Saturday, May 12, 2018, award recipients were honoured during the annual Awards Luncheon hosted by the College of Pharmacists at the Manitoba Club.

Congratulations to all the pharmacists who went above and beyond their duties to advance the pharmacy profession for their patients and colleagues in 2017.

Pharmacist of the Year

Grazia Prochazka

The Pharmacist of the Year Award is presented annually to a Manitoba Pharmacist deemed among his or her peers as having significantly contributed to the profession through election to provincial and/or national pharmacy organizations, committee involvement, practice achievements, and mentorship.

Past President, Lois Cantin (left), presents Grazia Prochazcha with the 2017 Pharmacist of the Year Award

Grazia has been in hospital pharmacy since graduation, and has worked at HSC, Misericordia, and now Deer Lodge Centre. She has provided care excellence to her patients as a hospital pharmacist for over 25 years.

Grazia is also involved in many committees in the province, including acting as President for the Canadian Society of Hospital Pharmacists - Manitoba Branch.

As a preceptor, Grazia is a role model for students and greatly assists in their development as pharmacists. One student recently voted Grazia as the Preceptor of the Year for Hospital Pharmacy stating:

"Grazia is an amazing preceptor. She has guided me in my learning experience.....and is always available for questions..... (she) is the type of pharmacist I aspire to be."

As more evidence of her excellent care for patients, Grazia was awarded the Bonnie Schultz Award for Practice Excellence in 2006.

Grazia's commitment to patient-centred care and quality practice is exemplified in what she does and the College is proud to recognize her as the 2017 Pharmacist of the Year.

News and Events

Past President Award

Jennifer Ludwig

The Canadian Foundation for Pharmacy presents the Past President Award in recognition of a past Council President's dedication to pharmacy practice and commitment to protecting the health and well-being of the public during their tenure as President of the College of Pharmacists of Manitoba.

During her tenure as President, Jennifer focused on enhancing public and patient safety with pharmacy practice innovation. She led the College and Council through the implementation phase of the exempted codeine products practice direction taking important steps to help reduce the use, misuse, and abuse of low-dose codeine products by restricting public access to these products by requiring a prescription.

In April 2017, Council approved the Safety IQ Pilot Project to advance patient safety and safety culture in community pharmacies within Manitoba. The project enables community pharmacies to anonymously report, analyze, and share learnings about medication incidents and near misses through the Institute for Safe Medication Practices Canada, an independent third-party institution, to educate pharmacy professionals and improve systems across the province.

Past-President to Past-President: Jennifer Ludwig receives the Past President Award from Raymond Biglow.

Patient Safety Award

2014 - 2016 Council

The Patient Safety Award recognizes those that have made a significant and lasting contribution to improving patient safety and health care quality through a specific initiative or project.

This year's award was presented in recognition of the 2014-2016 Council's efforts to implement the Practice Direction on Exempted Codeine Preparations to support pharmacists to reduce the misuse, and abuse of low-dose codeine products.

Brent Booker	Travis Giavedoni	Kyle MacNair	Petr Prochazka
Neal Davies	Kevin Hamilton	Glenda Marsh	Derrick Sanderson
Donna Forbes	Jennifer Ludwig	Geoff Namaka	Dinah Santos

Bonnie Schultz Memorial Award for Pharmacy Practice Excellence

Nora Kaye

The Bonnie Schultz Memorial Award for Pharmacy Practice Excellence is awarded to a pharmacist who demonstrates outstanding excellence in optimizing patient care.

Nora spent more than 47 years practicing pharmacy in Manitoba. After graduating from the University of Manitoba in 1969 as the Gold Medalist of her class, she went on to work over 25 years at the Victoria General Hospital. Following her time there, she worked at CancerCare Manitoba in a pediatric oncology pharmacy position before moving to Neepawa to practice in a rural hospital pharmacy setting.

Nora is commended by her peers for her leadership and caring. Nora's dedication to the pharmacy profession is demonstrated in her commitment to preceptorship, continuous learning, and excellent patient care.

College Registrar, Susan Lessard-Friesen (right), presents Nora Kaye (Left) with the Bonnie Schultz Memorial Award for Pharmacy Practice Excellence.

Pfizer Consumer Healthcare Bowl of Hygeia

Patrick Fitch

The Pfizer Consumer Healthcare Bowl of Hygeia is awarded annually to a pharmacist who has compiled an outstanding record of community service. This award has tremendous history and has been presented in all ten Canadian provinces since 1967.

Past President, Ron Eros (right), presents Patrick Fitch (left) with the Pfizer Consumer Healthcare Bowl of Hygeia award.

Patrick has proven to be a national leader for pharmacists. With his representation in the Canadian Society of Hospital Pharmacists (CSHP) since 1994, Patrick continues to uphold the practice of pharmacy to its highest standards while being innovative and responsive to current and future patient needs. Patrick is currently the Presidential Officer with CSHP National where he ensures CSHP stays true to its mission to advancing safe, effective medication use in hospitals and other collaborative healthcare settings

Patrick is currently a staff pharmacist at the Victoria General Hospital.

Honorary Life Memberships

Honorary Life Memberships are presented to pharmacists who have made a significant contribution to the profession of pharmacy in Manitoba and at the national level.

Dr. Daniel N. Sitar

While Dr. Sitar has extensive research and teaching accomplishments, Dan is simply a pharmacist at heart, working to the best of his abilities towards improving the health outcomes of his patients. Dr. Sitar, as a long-time member of the College, was a very active member of the Professional Development (PD) Committee for 16 years. During his tenure on the committee, we saw the development and launch of the then MPhA Learning Portfolio.

The College and specifically the PD Committee have benefited greatly from Dr. Sitar's participation and the unique perspective on the practice pf pharmacy that he brought to the work of the committees.

Dr. Shawn Bugden

Shawn has extensive experience as both a retail and hospital pharmacist, and helped to establish PrISM (Prescription Information Services of Manitoba). Initially elected to the College Council in 2006, Shawn has served as an Executive Committee Member as the Vice President (2008-2010), President (2010 – 2012) and Past President (2012-2014).

Shawn is a graduate of the Faculty of Pharmacy at the University of Manitoba and has taken further post-graduate training at Oxford University, the University of Manitoba, and the University of Washington. Shawn is currently the Dean of the Faculty of Pharmacy at Memorial University.

Honorary Member

Raymond Joubert

An Honorary Membership is given to worthy individuals who are not registered pharmacists in Manitoba, but have provided valuable and notable service to the profession of pharmacy.

As the Registrar of the Saskatchewan College of Pharmacy Professionals, Ray has served as a vital support and sounding board for the work of our college and has fostered a close and mutually beneficial relationship between the College of Pharmacists of Manitoba and the Saskatchewan College of Pharmacy Professionals.

Ray and former Registrar Stewart Wilcox were founding members of NAPRA and helped to lay the foundation for the development of national standards of practice and harmonization of the practice of pharmacy across jurisdictions in an effort to provide a consistent level of quality pharmacy care across Canada.

Young Leader Awards

Young Leader Awards are given to recently licensed pharmacists (practicing 1 to 5 years post-graduation) and to pharmacy students 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 College Of Pharmacy.

Congratulations to the following Young Leaders:

Tommy Barr

Tyler Campbell

Jasmine Duthie

Hailey Lincoln

Alia Marcinkow

25 Year Silver Pins and Certificates

Charlotte Baumgart

Marnie Boyle

Shannon Cattani

Derek Chan

Jennifer Countess

Shelley Cowie

Ryan Douglas

Kerri Drosdowech

Darren Hall

Patricia Hallonquist

Dieu Huynh

Darren King

Colleen Kizuik

Beata Kozak

Margaret Kozak

Jane Lamont

Quan Mai

Anokhi Mehta-Sachdev

Todd Mereniuk

Thuy Mui

Di Van Ngo

Tuyet-Ngoc Nguyen

Tiffany Pankratz

Tamara Peters

Norma Pittman

Gary Pomeroy

Connie Richard

Dinah Santos

Kelly Senkiw

Judy Skaritko

Candace Spewak

Julia Walker

Brian Whitby

50 Year Pins and Certificates

50 Year Pin and Certificate recipients (Left to Right): Grant Lawson, Jocelyn March, Ernest Stefanson, Yvonne Skura, and Greg Skura.

WIlliam Balacko

Louis Blanaru

Ken Bowman

Grant Lawson

Patricia Liddle

Greg Skura

Yvonne Skura

Ernest Stefanson

Raymond Wolanin

Welcome to the Profession:
Celebrating the College of Pharmacy Class of 2018

On June 2, 2018, the University of Manitoba, College of Pharmacy and the College of Pharmacists of Manitoba welcomed the Class of 2018 to the profession of pharmacy. The students were presented with their mortar and pestles during the event.

University of Manitoba, College of Pharmacy Class of 2018

Jennifer Ludwig, outgoing College President, presents Lane Sokolwski, with the College of Pharmacists of Manitoba Gold Medal for her hard work and dedication.

The College of Pharmacists of Manitoba congratulates all the students of the Class of 2018 for their hard work and celebrates the following award recipients on their accomplishments:

Lane Sokolwski
College of Pharmacists of Manitoba Gold Medal

Devyn Swark
College of Pharmacists of Manitoba Silver Medal

Christine Fogg
College of Pharmacists of Manitoba President's Prize

Bi-Annual Election Results

On April 11, 2018, the College sent notice to all voting members of the following 2018 Council elections outcome:

Electoral District #1	Electoral District #2
Todd Mereniuk	Wendy Clark
Nicole Nakatsu	Kevin Hamilton
Petr Prochazka	Kurt Schroeder
Sonal Bachu Purohit	Derrick Sanderson

The new Executive Committee was decided at the 2017 AGM:

Kevin Hamilton, President

Petr Prochazka, Vice-President

Wendy Clark, Executive Treasurer

Jennifer Ludwig, Past President

The College thanks all those who ran for a Council position in Electoral District #1 and Electoral District #2, and congratulates those members forming the new Council of the College and Executive Committee.

Staff Updates

The College welcomes David Fuss as the Summer Student Apprentice

David just finished his first year at the College of Pharmacy, Rady Faculty of Health Sciences.

Welcome to the team!

Farewell to Megan Noonan, Office Assistant, for her hard work over the last eight months.

We also must say farewell to Rachel Carlson, Communications and Quality Assurance Coordinator. Rachel's contribution and commitment to the successful implementation of the Safety IQ pilot has been immeasurable and we wish her and Megan all the very best in their future endeavors.

In Memoriam

John Steele - July 16, 2018

Jud Scales - July 23, 2018