Since the late 1990’s, issuing prescriptions through facsimile transmission has been permitted between Manitoba prescribers and Manitoba pharmacies. As technology evolved, prescribers used other modes of electronic transmission for prescriptions, of which, some appeared to be “facsimile prescriptions”, but were not. These prescriptions did not comply with the joint statement on facsimile prescriptions so the pharmacist would contact the prescriber to confirm the order thereby making it a “verbal prescription”. The intent of the new joint statement entitled “Electronic Transmission of Prescriptions” is to address the other modes of electronic transmission of prescriptions to the pharmacy. It does not replace the joint statement for facsimile transmission, but enables other forms of electronic transmission to be valid. The updated Joint Statement on Facsimile Transmission of Prescriptions and the new Joint Statement on Electronic Transmission of Prescriptions are available on the MPhA website.

As with facsimile prescriptions, the Joint Statement on Electronic Transmission of Prescriptions requires that all prescriptions received in this manner are to be entered into the Drug Programs Information Network (DPIN). This joint statement clearly describes the shared responsibility between the prescriber and pharmacist to insure the confidentiality, authenticity, clarity and enhanced communication between parties. A Q and A: Electronic and Facsimile Transmission of Prescriptions has been developed and posted on the www.mpha.ca website to assist pharmacists with implementing this into their practice.

The Joint Statement on Electronic Transmission of Prescriptions was in effect on April 1st, 2013.
Save the Date:
2013 MPhA Golf Tournament
The MPhA Golf Tournament will be held September 12, 2013, at the Carman Golf & Curling Club in Carman, MB.
All surplus money raised will be donated to the Canadian Foundation for Pharmacy.

Pharmacy Student/Alumni Hockey Event
The pharmacy alumni and students would like to thank McKesson Canada and Shoppers Drug Mart #542 for their support of the annual hockey game. The game took place on March 10, 2013 at the MTS Ice Plex in Winnipeg. It was a “see-saw” battle that saw the students outscoring the “oldies” by a margin of 8 to 4. Congratulations to both teams for participating and their great team effort.

Welcome, Stacey Hjorleifson
Please join the MPhA in welcoming Mrs. Stacey Hjorleifson to the MPhA administrative staff. Stacey joined the MPhA as Administrative Secretary on February 11, 2013.

MPhA Annual General Meeting and Annual Report
The MPhA Annual General Meeting (AGM) will be held during the Manitoba Pharmacy Conference on Saturday, April 6, 2013, at the Winnipeg Convention Centre, 375 York Avenue in Winnipeg.

The meeting is scheduled to begin at 11:00 a.m. in Room 2GH. There is no preregistration for this meeting.

During this meeting, the MPhA will present the Annual Report. The AGM Order of Business and Rules of Procedure and MPhA Annual Report are also available on the MPhA website.

VISION
Creating the framework for excellence in Pharmacy Practice

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

VALUES
The MPhA activities are based on the following values and are the foundation of what we do:
- Integrity
- Respect
- Excellence
- Accountability
- Collaboration
- Life Long Learning
As I approach the second half of my two year term as president of the Manitoba Pharmaceutical Association (MPhA), I have had an opportunity to look back on the advancements that were made over the last year. Much of the work of the first year has focused on development and consultation on regulations for the 2006 Pharmaceutical Act. Recently, the first section of the draft regulations (Parts 1-11) and companion document were distributed to the membership and stakeholders for review.

To follow-up the release of these documents, the MPhA held a Special General Meeting on February 20, 2013, to review the draft regulations, companion document and several practice directions for member consultation. I would like to thank all that attended or have viewed the meeting on the website www.sbrc.tv, and once again stress that we are always open to comments and questions that members may have.

I encourage the membership to continue to review all communications from the MPhA office, as the MPhA Council and staff continue to work with representatives of Manitoba Health and Manitoba Justice to develop the rest of the regulations supporting the 2006 Pharmaceutical Act.

On another note, the Joint Statement on Electronic Transmission of Prescriptions will come into effect on April 1, 2013. Over the past few years, the MPhA collaborated with the College of Physicians and Surgeons of Manitoba (CPSM), the College of Registered Nurses of Manitoba (CRNM), The Manitoba Dental Association (MDA) and the Manitoba Veterinary Medical Association (MVMA) to create the new joint statement that will modernize the current prescribing system to allow for the electronic transmission of prescriptions. Please ensure that you read the Joint Statement, along with the Q and A sheet posted on the website.

Lastly, the MPhA and the University of Manitoba will be hosting the National Association of Boards of Pharmacy (NABP) District 5 Annual Meeting in Winnipeg from August 8-10, 2013. NABP is the American national pharmacy board, that consists of 8 districts. The MPhA is a member of District 5. The District 5 Annual Meeting presents a unique opportunity to address professional issues, educational development and to bring together members of the boards of pharmacy and regulatory bodies to discuss regional, national and international issues of mutual concern.

Looking over the past year with the current Council, it has been busy. The first sections of the regulations were completed, the priority practice directions were circulated to the members for consultation and we continue to work to release the balance of the regulations for the membership to review in the near future. It is my hope and expectation that we will move forward with a vote by the membership on the complete set of regulations in the second half of my term. I personally encourage all of you to participate in this historical path to enhance the role of the pharmacist in Manitoba, all the while ensuring and promoting safe and progressive pharmacy practice.

Kyle MacNair, BSc.Pharm, ACPR
President, Manitoba Pharmaceutical Association

“It is my hope and expectation that we will move forward with a vote by the membership on the complete set of regulations in the second half of my term. I personally encourage all of you to participate in this historical path to enhance the role of the pharmacist in Manitoba, all the while ensuring and promoting safe and progressive pharmacy practice.”
Disclosure of Personal Health Information

Pharmacists are obligated to protect the confidentiality of their patients’ personal health information in terms of security, use and disclosure. The MPhA often receives enquiries from pharmacists asking for guidance regarding situations involving disclosure of patient information without consent to third parties. Circumstances may involve providing information to a third party picking up a prescription, law enforcement or social agency or a parent of a minor. In any request for disclosure of patient information, it is imperative the pharmacist is knowledgeable about the restrictions and applies their professional judgment. Questions to consider would be – who is asking for the information, what is their relationship to the patient and why do they need the information?

If a patient sends someone to pick up their prescription, they are not necessarily giving consent to have their personal health information disclosed to that individual. It is essential that pharmacists use their professional judgment in these situations to ensure that patients are appropriately counselled on their medications while not compromising the security of their personal health information. In some cases it may be reasonable to provide counselling through the agent while in other instances it may be more appropriate for the pharmacist to contact the patient by phone to provide counselling on their medication. Providing relevant written drug information may be helpful in these cases but, it does not take the place of patient counselling. Documenting the manner in which patient counselling was provided to the patient is recommended.

In the case of a minor, subsection 60 (e) of the Personal Health Information Act (PHIA) states “The rights of an individual under this Act may be exercised by the parent or guardian of an individual who is a minor (under 18 years of age), if the minor does not have the capacity to make health care decisions”. In this scenario the pharmacist must make the judgment whether the minor is capable of making their healthcare decisions. In making this determination, great consideration should be given to the fact that the minor has made a personal decision to go to a physician and the physician has given that minor a prescription. It would then seem reasonable that the minor does have the capacity to make healthcare decisions and their personal health information should therefore only be released with their consent.

Patient information can be released without consent if it is necessary to comply with the law such as a subpoena, warrant or a rule of court requiring production of the personal health information. In some cases, a police officer may simply request patient information for an investigation; however, a court order is required in order to provide this personal health information.

A community pharmacist, as a trustee under PHIA, may disclose personal health information if it is necessary to prevent or lessen a serious and immediate threat to the health and safety of the individual or the public. An example may be if a person consumed another individual’s prescription and it is necessary to identify the drugs consumed, then a pharmacist can provide the personal health information to a police officer or emergency personnel.

Disclosure must be limited to the minimum amount of information necessary. Pharmacists must ensure proper documentation on the patient record including the name of person requesting the information, contact number, reason for the information request and details regarding the information provided. Each request for disclosure of personal health information must be considered individually and assessed as to whether it conforms to PHIA requirements. If a pharmacist is unsure, they may contact the MPhA (204-233-1411) or Manitoba Health (204-788-6612) for guidance in making their decision.
Exercising Your Professional Judgment

“Pharmacists that are registered and licensed with the Manitoba Pharmaceutical Association have met rigorous requirements to ensure they have the knowledge, skills and professional judgment necessary to provide quality pharmacy care.”

Using your professional judgment in practice means basing your patient care decisions on several factors including the patient’s needs and medical and medication history, your clinical or therapeutics knowledge and expertise, pharmacy practice legislation and standards of practice and the anticipated health benefit and safety of the patient. Professional judgment is not necessarily acquired through formal training but may be seen as analogous to the development of critical thinking skills and therefore improved through experience.

Patient safety is a key principle in professional judgment.

Does the decision put the patient’s safety at risk? What is the patient’s expected health outcome as a result of your decision? Is the decision made in the best health interests of the patient?

It is important to consider the patients’ needs when making decisions concerning their healthcare. Patient engagement helps to facilitate understanding and compliance with decisions. Speaking with patients about their healthcare needs and advising them of other important considerations in decisions about their medication therapy and overall healthcare will result in acceptance and agreement with decisions.

Consideration should also be given to whether your decision would seem reasonable and acceptable to one of your peers. A pharmacist should be able to justify their decision to other health professionals by detailing the reasoning behind their decision. An important component of professional judgment is documentation of your decision, your reasoning, your communication with patients and other professionals and any initial and on-going outcomes of your decision. Documentation shows the method you used to come to your decision and will facilitate review of your judgment and serve as a reference for others.

Clozapine - Protocol for Dispensing

Clozapine, used in the management of treatment-resistant schizophrenia, is associated with a significant risk of possible blood disorders such as agranulocytosis. Health Canada requires each clozapine manufacturer to establish a mandatory monitoring registry to reduce this risk and to also provide quick identification of adverse effects enabling timely intervention by the physician.

The patient, as well as the treating physician and dispensing pharmacist, must be enrolled in the drug manufacturer registry. The patient must undergo regular hematological tests prior to initiating therapy, during therapy and also upon discontinuation with the analyzed results forwarded to both the physician and pharmacist.

Although clozapine is on the Manitoba Drug Interchangeability Formulary, switching a patient from one brand of clozapine to another should not be done by a pharmacist unless the pharmacist obtains a new manufacturer-specific patient registration form completed by the prescribing physician. The physician is also required to obtain consent of the patient to allow the sharing of information between clozapine registries in order to ensure safe and continuous monitoring. The prescribing physician is ultimately responsible for verifying a patient’s hematological/non-rechallengable status and therefore must know the monitoring system in which the patient is registered.

Communication and collaboration among the patient, physician, pharmacist and the drug manufacturer’s monitoring program is essential to ensure the safety of the patient receiving clozapine. For more information, please see the Health Canada safety alert.
Dispensing Oral Chemotherapy for Use in the Home
What Pharmacists and Patients Need to Know

In recent years, as new oral therapies for the treatment of cancer have emerged, dispensing and administration of these hazardous medications has moved from the traditional hospital setting to the community. Oral chemotherapy treatments provide patients with greater convenience and independence, but also the responsibility for administration, monitoring of side effects and compliance. Safe and proper handling procedures should be followed within the pharmacy to prevent exposure and pharmacists need to communicate to patients and caregivers necessary safety precautions when using these medications in the home. Medication adherence is a major contributing factor in the overall efficacy of cancer therapies and pharmacists can provide ongoing support and intervention to improve patient compliance.

Safe Handling in the Pharmacy

Both cytotoxic agents (methotrexate, cyclophosphamide, etc) and non-cytotoxic agents (letrozole, tamoxifen, etc) pose a possible risk to pharmacy staff and patients in the event of exposure. The increased use of both cytotoxic and non-cytotoxic medications in the community setting requires knowledge and implementation of safe handling procedures. All pharmacy staff should be aware of all hazardous medications stocked in the pharmacy and these products should be clearly identified and properly labeled. When dispensing oral cytotoxic or non-cytotoxic medications, a designated counting tray and spatula should be used and medical quality gloves should be worn when handling these products. Pharmacy staff should ensure that gloves meet ASTM standards for handling contaminated materials and hands should be washed upon removal of gloves. Trays, spatulas and counter space should be properly cleaned after each use. Hazardous drugs should not have their dosage form compromised by splitting or crushing tablets as powder may be inhaled.

For more information please review the Winnipeg Regional Health Authority’s [WRHA] Hazardous Medication List and PowerPoint presentation on Safe Handling of Hazardous Medications.

Importance of Medication Adherence

Possible consequences of non-adherence with chemotherapy treatment regimens include an increased number of physician and hospital visits, treatment resistance, unnecessary treatment changes and disease progression. Additional adherence issues may be related to over-adherence whereby patients believe “more is better” leading to drug toxicities. Complex treatment regimens, poor understanding of therapy protocols, adverse drug effects and cognitive, memory or language deficits are all possible barriers to medication compliance.

Community pharmacists can help improve patient adherence and therapeutic outcomes by providing education and support to patients, family members and care givers. Ensuring patients and family members understand the dosing schedule, the importance of reassessment prior to each cycle of chemotherapy, the monitoring and management of side effects, the benefits of therapy and the importance of following the treatment schedule will increase compliance. Pharmacists need to provide ongoing follow-up by enquiring about possible adverse effects and adherence issues and should work with patients, their families and caregivers to develop possible solutions. Encourage patients to maintain a diary or journal of side effects and/or symptoms to discuss with their healthcare team. Remind patients that the best way to improve outcomes and safety with chemotherapy is to ask questions whenever they are unsure.

To improve your knowledge of oral cancer treatments and appropriate pharmaceutical care of cancer patients, you can access the professional development previously recorded program: Oral Anti-Cancer Agents: Bridging the Gap on the MPhA PD Programs Webpage on www.mpha.ca.
Patient, Family and Caregiver Safety in the Home

Patients and caregivers need to receive training on the proper handling of oral chemotherapy medications and body wastes (that may be contaminated with these medications) in order to keep the home safe. All chemotherapy medications need to be properly labelled and stored securely and separate from other medications. Patients, family members and caregivers need to know which medications are hazardous and require special handling procedures. Medical quality examination gloves should be worn when administering these medications and hands should be washed afterwards. Tablets should not be split or crushed and capsules should not be opened as this may lead to inhalation of the powder from these hazardous medications. If a patient is having difficulty swallowing a chemotherapy medication, they should be instructed to contact the pharmacist or healthcare provider at the cancer clinic to provide advice on other ways to help swallow the medication. All unwanted, unused or expired chemotherapy medication should be returned to the pharmacy for safe disposal.

As small amounts of the medication can be found in the patient’s body fluids, special handling precautions are needed for clean-up and disposal of a patient’s contaminated waste. Patients should cover toilets before flushing and caregivers should wear medical quality examination gloves when cleaning up any body fluids including vomit. Soiled laundry should also be handled with gloves and washed separately from other clothes. Any soiled surfaces should be cleaned with soap and rinsed with large amounts of water while wearing gloves. Upon exposure to either medication or contaminated waste, the caregiver should wash the affected area with soap and running water as soon as possible and seek medical attention if necessary.

Please view CancerCare Manitoba’s Safe Management of Chemotherapy in the Home which is available on www.mpha.ca. This information is useful as a handout when counselling patients and their caregivers about the safe use of chemotherapy in the home.

Canadian Medication Incident Reporting and Prevention System (CMIRPS)

CMIRPS is a national voluntary medication incident and ‘near miss’ reporting program founded for the purpose of sharing the learning experiences from medication errors. Implementation of preventative strategies and system safeguards to decrease the risk for error-induced injury and thereby promote medication safety in healthcare is our collaborative goal.

Medication incidents (including near misses) can be reported to ISMP Canada:

(i) through the website: http://www.ismp-canada.org/err_report.htm or
(ii) by phone: 416-733-3131 or toll free: 1-866-544-7672.

ISMP Canada guarantees confidentiality and security of information received, and respects the wishes of the reporter as to the level of detail to be included in publications.

Institute for Safe Medication Practices Canada (ISMP Canada) 416-733-3131 or 1-866-544-7672 (1-866-54-ISMPC)
Email: info@ismp-canada.org
Website: www.ismp-canada.org

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 MPhA Newsletter.

2013 - ISMP Canada Safety Bulletins:
• Vol. 12 Issue 12 - Opioid-Related Incident in a Long-Term Care Home
• Vol. 12 Issue 11 - Usability Testing in Proactive Risk Assessments 2013 - SafeMedicationUse.ca Safety Newsletters and Alerts for Consumers
• ALERT: Canadian Adverse Reaction Newsletter Contains Important Information for Consumers with Allergies!
2012 - SafeMedicationUse.ca Safety Newsletters and Alerts for Consumers
• When It Comes to Your Medicines, Don’t Rely on Memory!
• Some Eye Drops and Nasal Sprays May Be Harmful if Swallowed!
• Reminder: Take Care with Clear Care!

All issues of the ISMP Canada Safety Bulletins, including those issued in previous years, are freely downloadable from the ISMP Canada website 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.

If you have made changes in your pharmacy, which focus on patient safety and that you would like to share with your colleagues, please contact Susan Lescard-Friesen at 204-233-1411.
Proper Handling of Medication Incidents

“I think you made a mistake with my prescription.”

As a pharmacist, this statement immediately causes a rush of anxiety. In spite of our best intentions, there are times when things can go very wrong and medication incidents occur. It is, however, the manner in which we respond to notification of a medication incident that can make the biggest difference in both the outcome for the patient and pharmacist involved.

Immediate, clear, open and continued communication with the patient is necessary to ensure the patient is safe. Steps are taken to determine why the medication incident occurred and changes are made to prevent a recurrence of the incident. It is a fact that most medication incidents are the result of a series of events that have failed and not the actions of one individual. It is vital that all pharmacy staff are aware of and follow proper policies and procedures so that medication incidents may be responded to promptly and with the patient’s health and safety a priority.

Steps to take to improve your response to a medication incident include:

1. When a patient presents a possible medication incident to the pharmacy, the pharmacist must give the patient their immediate attention. The safety of the patient is the pharmacist’s primary concern.

2. It is important to listen intently to the patient as they describe the situation and not interrupt even if you can immediately identify the reason for the concern. To ensure understanding, repeat or paraphrase what you have been told.

3. Acknowledge the distress and risk that the incident has caused the patient and express empathy and concern for the patient.

4. Determine if the patient is at possible risk of harm. Notify the prescriber of the medication incident and any other emergency personnel deemed necessary.

5. Apologize to the patient even if you are still unsure about the circumstances of how the medication incident occurred. Under the Apology Act in Manitoba, a healthcare worker can make an apology without it constituting admission of legal liability.

6. Determine the cause of the medication incident in a transparent and timely manner ensuring that changes are made in processes and systems that may have led to the medication incident.

7. Communicate this information to the patient so that they understand that steps have been taken to fully address the medication incident to prevent a recurrence.

8. Document and report the medication incident in accordance with the standards (see Medication Incidents and Discrepancies in MPhA Community Standards of Practice at www.mpha.ca).

9. Ensure information about the medication incident is communicated to all dispensary staff.

10. Report medication incidents and near misses or good catches to the Institute for Safe Medication Practices – Canada at www.ismp-canada.org. Medication incidents and near misses/good catches can be reported anonymously. Remember, everyone can learn from medication incidents when they are reported.
Accountability of Drugs Covered Under the Controlled Drugs and Substances Act

Inventory counts for expired and returned narcotics and controlled drugs

The pharmacy manager is accountable for all narcotic and controlled drug inventory covered by the Controlled Drugs and Substances Act (CDSA) including those drugs which have expired and have been returned for destruction by patients. As there is often a time lag between when the drug expires or is returned and the time of destruction, each pharmacy must maintain an inventory count of these drugs until the time of destruction. The pharmacy manager will be responsible for completing and recording a physical count of these drugs at least once every three months.

The inventory records of expired and returned CDSA drug stock should include the date of entry into the expired narcotic inventory and quantity of the drug. A physical inventory count will compare the stock on hand with the count from the expired and returned CDSA drug inventory sheet. Any discrepancies are to be investigated by the pharmacy manager. By tracking expired and returned CDSA drug inventory, possible diversion of these medications can be prevented.

Narcotic and controlled drugs covered under the CDSA to be destroyed shall receive prior authorization from Health Canada and, at the time of destruction, shall be witnessed and documented by two health care professionals. Destruction will be noted on the expired and returned CDSA drug inventory log sheet and the count adjusted. Please review the template of an Expired and Returned CDSA Drug Inventory Count Form.

Azathioprine + Allopurinol or Febuxostat Interaction

Always verify with prescriber before dispensing

Azathioprine is an inactive pro-drug used in a wide variety of clinical settings such as inflammatory bowel disease, solid organ transplant, rheumatology, oncology, dermatology, and nephrology. Xanthine oxidase is the enzyme involved in the metabolism of azathioprine to an active metabolite (6-TGN) which is responsible for its immune suppressant action but also bone marrow suppression at high concentrations. Co-administration of xanthine oxidase inhibitors, allopurinol or febuxostat, often leads to severe bone marrow suppression with resulting pancytopenia. Prolonged hospitalizations and patient deaths have occurred.(1,2)

Azathioprine has been used in vastly reduced doses (50-75% dose reduction required) with low dose Allopurinol 100 mg daily in the treatment of IBD patients who overproduce the 6-MMP metabolite of azathioprine which is associated with hepatotoxicity. However, this combination should only be prescribed by a GI specialist who can closely monitor the thiopurine metabolites.(2) The use of this combination with other disease states has not been studied and is not recommended.

Febuxostat received approval under Part 3 coverage as of Jan. 21, 2013 to lower serum uric acid levels in patients with symptomatic gout who have documented hypersensitivity to allopurinol. This drug is contraindicated with azathioprine.

Practice Points:
- Do not dispense azathioprine in patients receiving allopurinol or febuxostat until the prescriber is contacted. The reverse is also true, i.e. do not dispense allopurinol or febuxostat if patient is already receiving azathioprine.
- Contact the prescriber and describe the seriousness of this drug interaction. In most instances, this drug combination is absolutely contraindicated.
- The DPIN system upgraded the level of this drug interaction from intermediate (ME2 code) to most significant (ME1 code) on December 27, 2012.
- This same interaction applies to 6-mercaptopurine (used in oncology) as it is also metabolized by xanthine oxidase.


References:
Pharmacists Awarded Certificates of Life Long Learning

The following pharmacists have been awarded a MPhA Certificate of Life Long Learning in Pharmacy in recognition of their outstanding participation in professional development activities during the 2012 PD Year. Recognition is provided each year to pharmacists who have participated in a minimum of 50 hours of professional development activities, of which, a minimum of 30 hours involves participation in accredited learning activities.

The MPhA congratulates the following pharmacists on their achievement:

- Murvin Abas
- Karam Abd El Nour
- Ahmed Abdel Hadi
- Albassiouny
- Elizabeth Arauz-Tijerino
- Robert Ariano
- Marian Atta
- Joanna Ayotte
- Manjit Bains
- Linda Barnes
- Eugene Baron
- Kristin Bartram
- Melvin Baxter
- Allison Bell
- B. Marie Berry
- Angel Bhathal
- Anwar Bhojani
- Mona Docter
- Brent Booker
- Jacinte Bosc
- Marnie Boyle
- Jasvir Brar
- Corinne Brockman
- Alysha Buck
- Shawn Bugden
- Dayna Catrysse
- William Cechvala
- Miro Cerqueti
- Ryan Chan
- Lengim Chen Ingram
- Kelly Cheung
- Arnold Chew
- Harjot Chohan
- Julie Choy
- Janice Coates
- Lilanie Cruz
- Marcin Cychowski
- Pritpal Dhanjal
- Melissa Dowd
- Terry Dubyts
- Erica Dueck
- Ingrid Dueck
- Drena Dunford
- Ronald Elder
- Crystal Evans
- Rowena Fernando
- Evelyn Fletcher
- Linda Foley
- Christin Franken
- Julie Funk
- Medhat Geloa
- Jennifer Gibson
- M. Claire Gillis
- Kathryn Gorber
- Ruby Grymonpre
- Kimi Guibert
- Saminder Gujral
- Rebecca Hamilton
- Ashraf Hanna
- Kari Hanneson
- Krysten Harder
- Jennifer Hayward
- Lorraine Hilderman
- Peter Hirmina
- Tara Hoop
- Curtis Hughes
- Shannon Hunter
- David Huston
- Bassem Ibrahim
- Randa Istafoanous
- Melissa Jacobs
- Russel Jose
- Komal Kaler
- Kerry Kent
- Cheryl Kessler
- Rhonda Kitchen
- Nancy Kleiman
- Meghan Klowak
- Elmer Kuber
- Linda Kuber
- Britt Kural
- Florence Kwok
- Tannis Kyrzyk
- Carey Lai
- Jana Lane
- Alan Lawless
- Gwen Lawson
- Danny Lee
- Lindsay Lemanski Filz
- Christine Leong
- Wilfird Lessak
- Susan Lessard-Friesen
- Katherine Lewis
- Thomas Ling
- Juguin Lodha
- Abe Loewen
- Beverly Loewen
- Christopher Louizos
- Melvin Love
- Dora Ma
- Janice Macalino
- Janice Magnusson
- Mary Makarios
- Amarjeet Makkar
- Tara Maltman-Just
- Kristopher Markowsky
- Julie Mark
- Amy Marriott
- Nicole Mathe
- Margo McCrae
- Scott McDougall
- Kimberly McIntosh
- David McKay
- Suzanne McKay
- Meghan McKechnie
- Anokhi Mehta-Sachdev
- Martha Mikulak
- Arlene Nabong
- Nicole Nakatsu
- Geoffryy Namaka
- Michael Namaka
- Sheila Ng
- Thanh Nguyen
- Debra Nolan
- Jamie Nolan
- Olga Norrie
- Amanda Nunn
- Olasumbo Ojo
- Amy Oliver
- Robin Oliver
- Virendrakumar Patel
- Kristine Petasko
- Siegfried Pfahl
- Mathilda Prinsloo
- Sonal Bachu Purohit
- Noureen Qamar
- Erin Ramahlo
- Colin Repchinsky
- Derek Risbey
- Janine Risteyn
- Michael Rizkalla
- Gayle Romanetz
- Brenda Rosenthal
- Ligy Russel
- Venkateswaren Saja
- Tatiana Sandhurst
- Dinah Santos
- Charles Scebro
- Chris Schellenberg
- Gerri Scott
- Shawnna Secord
- Advit Shah
- Adel Shenoda
- Trevor Shewfelt
- Marilyn Sidhu
- Robert L.J. Sitarz
- Glenda Sloane
- Timothy Smith
- Suzanne Sobel
- Alice Studney
- Roger Tam
- Sylvia Tang
- Jennifer Thackeray
- Meera Thadhani
- Tinu Thomas
- Iwana Thordarson
- Michael Tomiak
- Chris Tsang
- Sheryl Tymchynshyn
- Julia Walker
- Jennifer Wallace
- Ashley Wallus
- Michael Watts
- Sonya Wight
- Brooke Wilson
- Elizabeth Wilson
- Gwen Wischnewski
- Donna Wolochuck
- Dennis Wong
- Horst Wuerfel
- Amany Younan
- Amanda Young
- Amir Youssef
- Irene Yu
- Cindy Yap-Wong
- Osama Zaki
- Sheryl Zelenitsky

Please note that several new graduates and pharmacists involved in recognized, accredited, post-graduate studies, who did not qualify for a Life Long Learning Certificate, were sent a certificate in error. These individuals were erroneously included on the list of Life Long Learning Recipients in the Annual Report. The MPhA sincerely apologizes for the error.
Videoconferencing

Videoconferencing is an expensive technology for program delivery owing to the high degree of technical support necessary. One way in which costs may be reduced is to have volunteer videoconference site coordinators trained to operate equipment and serve as the contact person to coordinate activities at the far-end site.

We were very fortunate to have the following pharmacists agree to serve as our videoconference site coordinators for 2012. To each of them, we extend our sincere thanks and appreciation for their time and effort, which has allowed us to provide educational programs through videoconferencing to pharmacists in rural Manitoba.

Kathy Adriaansen – Neepawa
Jay Boschman – Portage la Prairie/Brandon
Blaire Cairns - Grandview
Lise Durand – Notre Dame de Lourdes
Victor Eyolfson - Arborg
Claire Gillis - Gimli
Joey Gwozdz – Steinbach
Brent Havelange – Russell
Chris Johnson – Killarney
Russ Keeler - Ashern
Christine Klimuk - Swan River
Ken Marek – Portage la Prairie
Martin Michaeels - Hodgson
Whitney Mitchell - Roblin
Real Mulaire – St. Pierre
Spencer Reavie – Russell
Derrick Sanderson - The Pas
Trevor Shewfelt - Dauphin
Jennifer Thackery – Thompson
Corey Thompson - Flin Flon
Jeff Wooster – Morden/Winkler

Dr. Daniel Sitar retires from the Professional Development Committee after Sixteen Years

Dan Sitar has been an active volunteer member of the Professional Development (PD) Committee since 1996. He is retiring after serving on the Committee for approximately sixteen years. The Manitoba Pharmaceutical Association and the PD Committee appreciate his valuable contribution to meeting the educational needs of pharmacists in Manitoba and thank him for his many years of guidance and service to the PD Committee.

Thank You to Michael Giannuzzi

The MPhA was pleased to have fourth year pharmacy student, Michael Giannuzzi, spend a seven week rotation with us as part of his PHRM 4800 Electives Program. During this time, Michael was involved in conducting a literature search and developing a survey to gather members’ input on ways to improve the MPhA Quality Assurance (QA)/Continuous Quality Improvement (CQI) Program.

Thank you to Michael for all of his hardwork and to all of our members who participated in this survey!

MIPS Call for Applications for 2013 Dr. John Wade Research Award

MIPS released an official call for applications for the 2013 Dr. John Wade Research Award. This award is open to premier members of MIPS, which includes MPhA members. Dr. John Wade was instrumental in the creation of the Manitoba Institute for Patient Safety. MIPS established an award in his name to recognize local excellence in the important work of patient safety.

The MPhA may submit up to three applications from our membership for the Dr. John Wade Research Award. Submission deadline is Tuesday, April 30, 2013, at noon. To view the guidelines and criteria for submissions, as well as to download the application, please go to www.mbips.ca/wadeaward. Those who are interested in submitting an application are asked to please notify the MPhA office by calling Lita Hnatiuk at 204-233-1411 or emailing info@mpha.mb.ca.
The Manitoba Pharmaceutical Association
2013 Award Presentations

<table>
<thead>
<tr>
<th>Award</th>
<th>Recipient</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Pharmacist of the Year</td>
<td>Mr. Grant Lawson</td>
<td>Brandon, Manitoba</td>
</tr>
<tr>
<td>Bonnie Schultz Memorial Award For Practice Excellence</td>
<td>Mr. Jamison Falk</td>
<td>Winnipeg, Manitoba</td>
</tr>
<tr>
<td>Pfizer Consumer Healthcare Bowl of Hygeia</td>
<td>Mr. Lothar Dueck</td>
<td>Vita, Manitoba</td>
</tr>
<tr>
<td>Patient Safety Award</td>
<td>Ms. Susan Lessard-Friesen</td>
<td>Winnipeg, Manitoba</td>
</tr>
</tbody>
</table>

This award is presented annually to a Manitoba Pharmacist who, in the opinion of his or her peers, has made a significant contribution to the profession during his or her career.

The Bonnie Schultz Memorial Award for Practice Excellence is given on occasion to a pharmacist or a group of pharmacists who demonstrate outstanding excellence in optimizing patient care, serve as a role model, demonstrate superior communication skills, display compassion, empathy and concern.

The Pfizer Consumer Healthcare Bowl of Hygeia is in recognition of the time and personal sacrifice devoted by pharmacists to the welfare of their respective community. This award was established in 1958 and awarded to a pharmacist for outstanding community service.

The Manitoba Pharmaceutical Association’s award recipients, Mr. Grant Lawson, Mr. Jamison Falk, Mr. Lothar Dueck, and Ms. Susan Lessard-Friesen will be presented with these prestigious awards at the Awards Banquet of The Manitoba Pharmacy Conference, held at The Delta Hotel, 350 St. Mary’s Avenue, in Winnipeg, Manitoba, on Saturday, April 6, 2013, at 6:00 p.m. Tickets for the Awards Banquet are available by calling 204.956.6688.

In Memoriam

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Melville Waddell</td>
<td>December 21, 2012</td>
</tr>
<tr>
<td>Sharon Moncek</td>
<td>February 6, 2013</td>
</tr>
<tr>
<td>Ronald Connors</td>
<td>February 21, 2013</td>
</tr>
</tbody>
</table>

Mrs. Irene Lewis
Mrs. Irene Lewis passed away at age 91 on February 23, 2013. Mrs. Lewis was the sister of Dr. Roman Bilous, a professor at the Faculty of Pharmacy for many years. Mrs. Lewis was very well known and respected at the University of Manitoba, Faculty of Pharmacy and the Manitoba Pharmaceutical Association and many will remember her for her philanthropic work donating funds and creating scholarships in the memory of Dr. Bilous.

Mrs. Margaret Larcombe
Mrs. Margaret Larcombe passed away on January 16, 2013. During her career she was employed for many years by the University of Manitoba, Faculty of Pharmacy as an Administrative Assistant to the Dean and Faculty. She enjoyed her career with the U of M, and particularly the everyday contact she had with all of the students. Mrs. Larcombe was the main contact for many years between the MPhA and the Faculty. Her knowledge and assistance was a great asset to both organizations.
March 2013

Please make all necessary changes on your copies of the National Drug Schedules and applicable Federal Legislation. Updated copies of these documents are available on the NAPRA website at www.napra.ca

NAPRA National Drug Schedules Notice Board

National Drug Schedules: Final Recommendation for Dimeticone 100 cSt, 50% w/w as a topical treatment of scalp hair in case of infestation with head lice (pediculosis capitis).
January 08, 2013

The Initial Recommendation made by the National Drug Scheduling Advisory Committee (NDSAC) on December 6, 2012 for the scheduling of:

- Dimeticone 100 cSt solution, 50% w/w as a topical treatment of scalp hair in case of infestation with head lice (pediculosis capitis) – Schedule III

was finalized effective January 8, 2013. Final approval of the initial recommendation(s) was made by NAPRA's Executive Committee, in consideration of comments received during the 30-day review period. The National Drug Schedules will be revised accordingly.

NDSAC Initial Recommendation on bisacodyl 5mg tablets and 10mg suppositories
March 07, 2013

A meeting of the National Drug Scheduling Advisory Committee (NDSAC) was held on March 4, 2013 with the following Initial Recommendation made:

- That bisacodyl and its salts in all forms and strengths be retained in Schedule III

Any objection to this Initial Recommendation must be received by the NAPRA office by April 6, 2013. Questions or comments should be directed to the Manager, Professional and Regulatory Affairs, Sarah Marshall, via email at smarshall@napra.ca.

March 2013
For a complete listing of the most recent changes to the National Drug Schedules, visit the Drug Schedules Notice Board at www.napra.ca
Get Better Together! is a free workshop designed to help Manitobans with ongoing health conditions take control of their life. Get Better Together is the name for the highly successful Chronic Disease Self-Management Program developed and licensed by Stanford University Patient Education Centre.

Get Better Together! is a six week workshop offered in-person or online to help participants learn strategies to control pain, deal with fatigue and frustration, start a basic exercise program, handle stress, and eat well to live well. Personal goal setting and problem-solving help patients build confidence for successful self-management.

The program has been well studied and shown to improve compliance with medications and lifestyle change prescriptions, reduce hospitalization and ER visits, and improved communication with healthcare professionals.

The program is led by a combination of health care staff and trained peer leaders. Research on the peer-led model demonstrates that when the program is led by peer leaders with health conditions, participants do even more to make positive changes to their health habits.

Programs are offered across Manitoba, throughout Winnipeg and online. To refer patients, simply direct them to call (204) 632-3927 or to www.getbettertogether.ca. If you would like brochures for your Pharmacy, or more information about the program, please contact us.

Get Better Together Manitoba Program
Phone: (204) 632-3927
Email: gbt@wellnessinstitute.ca
Website: www.getbettertogether.ca

What participants are saying …

“This program helped me out of a depressed slump I was in. Everyone is shocked to see how well I’m doing now”

“I think this program is great for everybody that has some kind of illness”
Dear Pharmacist;

RE: Regional Pulmonary Rehabilitation Program and Action Plan Prescriptions

I am pleased to inform you that three Pulmonary Rehabilitation Programs have been augmented across the Winnipeg Regional Health Authority. The programs at Seven Oaks/Wellness Institute and Misericordia Health Centre have been expanded and enhanced, and a new program located at Deer Lodge Centre has been added to improve access for community-dwelling patients. These programs were developed to assist adults with a diagnosis of Chronic Obstructive Lung Disease, Asthma, Pulmonary Fibrosis, Bronchiectasis, and Restrictive Disease.

All three locations will offer eight week programs that clients attend twice weekly to help them:
- Understand Lung disease
- Prevent Infection
- Improve breathing through individualized exercise programs
- Learn breathing and relaxation techniques
- Learn energy conservation strategies
- Use medications and inhalers effectively
- Eat well to live well

Pulmonary Rehabilitation Programs are both education and exercise programs with four major components, which are: Exercise, Self-Management, Smoking Cessation, and Patient-Centred Care. The program will be provided by a team of health care professionals consisting of Respirologists, Physiotherapists/Kinesiologists, Respiratory Therapists, Pharmacists, Clinical Dietitians, Occupational Therapists, and Social Workers.

There is one Pulmonary Rehabilitation Central Intake telephone number (204-831-2181) and fax number (204-940-8633) to receive and distribute all referrals to the appropriate location based on the client’s home address. Please click here for the referral to copy and use as required.

As a pharmacist, you are welcome to initiate the referral process for any patients that you identify that may benefit from this program. You may assist your patient in completing the form and then they may take it to their doctor to have the bottom portion of the form completed. For those pharmacists with access to charts, please feel free to forward the additional tests information over to our intake coordinator to speed up the referral process time for your patient.

If you have any questions, or would like more information about making a referral, please contact the Pulmonary Rehabilitation Central Intake Coordinator at (204) 831-2181.
IMPORTANT:
You may also notice Action Plan Prescriptions coming to you at the pharmacy that may have been initiated by our interdisciplinary team. Please note that there are currently two versions in circulation. The new and improved 2012 version has just been released and consists of two forms rather than just one. Please see documents attached. Both types of Action Plan Prescriptions (the old version and part 2 of the new version) are in triplicate format: one for the patient, one for the physician, and one for the pharmacist.

It is important to know that patients may bring these Action Plan Prescriptions to you to be put ‘on file’ in the pharmacy for when they feel they are getting a lung infection. The purpose of this is to help improve patient self-management, decrease ER visits and prevent hospitalizations. Many of these patients will have undergone the Pulmonary Rehab Program and will have been taught how to use this plan.

Furthermore, the action plan indicates the components that need to be met for a COPD flare up in order to fill the prescription (i.e. increased shortness of breath, changes in sputum over 48 hours). The new 2012 Action Plan allows for the prescriptions to be filled two times each, as needed, for 1 year. According to the Canadian Thoracic Society (CTS) guidelines, if the patient requires a 2nd round of antibiotics within a 3 month period, it should be switched to an alternative type of antibiotic, as indicated on the plan. Ideally, pharmacists should be pulling the ‘first fill’ prescriptions and would see during the checking process that this is an action plan prescription along with the details. It may also be helpful for the pharmacist to add the words ‘Action Plan Prescription’ to the sig so they know they can refer back to this form during the refill process. For the new 2012 version, the patient may only bring Part 2 (prescription) to the pharmacy. You may want to keep Part 1 on file for reference.

CTS is currently finalizing a fillable PDF version of the Action Plan and this will be available at www.respiratoryguidelines.ca and should be available soon. For now, pharmacists can use the old one which is available here http://www.respiratoryguidelines.ca/sites/all/files/COPD-actionplan_1.pdf

For more information about the COPD action plan or guidelines, please refer to the sbrc.tv presentation from Dec 6th, 2012 entitled ‘What’s new in COPD’ or call our Regional Pulmonary Educator at (204) 833-1717. Reminder: To access the sbrc.tv program please go to http://www.sbrc.tv/1/page/Published.aspx and under the MPhA file, be sure to enter the case sensitive password ‘MPhA’. Please note that the program only discussed the older version of the action plan prescription.

Thank you for your time. Our teams look forward to working with you to provide the best outcomes for our patients.

Sincerely,

Marlene Graceffo, MSc (Rehab)  
Regional Rehabilitation & Geriatrics Program Director

Kristine Petrasko, BScPharm, CRE  
Regional Pulmonary Educator
2012 COPD Action Plan Instructions

The goal of a COPD Action Plan is to help those with COPD prevent and manage exacerbations in conjunction with the healthcare professional team (the physician*, the certified respiratory educator and the pharmacist). With the patient, the healthcare professional team should complete/review the following information:

- a list of persons to contact when he/she needs help
- a list of baseline symptoms and the actions to be taken to stay well (green zone)
- the symptoms indicating worsening COPD and the actions to be taken to manage the exacerbation (yellow zone)
- the symptoms which require urgent treatment (red zone)

Early and appropriate intervention helps to prevent or minimize the impact of an acute exacerbation.

The COPD Action Plan is a tool to facilitate communication between the person with COPD and his/her healthcare professional team. Once completed, the Action Plan should be brought to each follow-up visit, reviewed on a regular basis and modified as necessary. Follow-up should include a discussion of past exacerbations and how the person manages flare-ups.

When possible, a certified respiratory educator should discuss and review the document with the person with COPD to ensure he/she:

- has a clear understanding of how to recognize worsening COPD symptoms; and
- is confident in knowing when and what actions are to be taken based on the severity of symptoms, including when to fill the prescription for additional medications.

The COPD Action Plan consists of two parts:

Part I includes written instructions on what actions should be taken by the person with COPD based on symptoms (sputum and shortness of breath) in the green, yellow and red zones. It includes a copy for the patient, the physician and the respiratory educator. Any member of the healthcare professional team can begin the process for completing the Action Plan.

Part II includes a prescription for medications to be initiated in the case of sustained worsening symptoms. It is completed by a physician. It includes a copy for the patient, the physician and the pharmacist.

**Warning:** Since both parts are carbon copied, ensure that when the first part is being completed, the second part is not directly underneath, as the information will be transferred to the second part of the Action Plan.

*or nurse practitioner
This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are _____________________________.

My support contacts are _____________________________.

<table>
<thead>
<tr>
<th>My Symptoms</th>
<th>I Feel Well</th>
<th>I Feel Worse</th>
<th>I Feel Much Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have sputum.</td>
<td>My usual sputum colour is:</td>
<td>Changes in my sputum, for at least 2 days.</td>
<td>My symptoms are not better after taking my flare-up medicine for 48 hours.</td>
</tr>
<tr>
<td>I feel short of breath.</td>
<td>When I do this:</td>
<td>More short of breath than usual for at least 2 days.</td>
<td>I am very short of breath, nervous, confused and/or drowsy, and/or I have chest pain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Actions</th>
<th>Stay Well</th>
<th>Take Action</th>
<th>Call For Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use my daily puffers as directed.</td>
<td>If I checked ‘Yes’ to one or both of the above, I use my prescriptions for COPD flare-ups.</td>
<td>I will call my support contact and/or see my doctor and/or go to the nearest emergency department.</td>
<td></td>
</tr>
<tr>
<td>If I am on oxygen, I use ______ L/min.</td>
<td>I use my daily puffers as usual. If I am more short of breath than usual, I will take ___ puffs of ______ up to a maximum of ___ times per day.</td>
<td>I will dial 911.</td>
<td></td>
</tr>
</tbody>
</table>

Notes: _____________________________.

Important information: I will tell my doctor, respiratory educator, or case manager within 2 days if I had to use any of my flare-up prescriptions. I will also make follow-up appointments to review my COPD Action Plan twice a year.
This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are ___________________________________________.

My support contacts are ________________________________ and ________________________________

(Name & Phone Number) (Name & Phone Number)

Prescriptions for COPD flare-up (Patient to take to pharmacist as needed for symptoms)

These prescriptions may be refilled two times each, as needed, for 1 year, to treat COPD flare-ups. Pharmacists may fax the doctor’s office once any part of this prescription has been filled.

Patient’s Name

Patient Identifier (e.g. DOB, PHN)

1. (A) If the colour of your sputum CHANGES, start antibiotic ______________________________ Dose: _____ pills: _____
   How often___________ for #days: ______

   (B) If the first antibiotic was taken for a flare-up in the last 3 months, use this different antibiotic instead:
   Start antibiotic ______________________________ Dose: _____ #pills: _____
   How often___________ for #days: ______

   AND/OR

2. If you are MORE short of breath than usual, start prednisone ______________________________ Dose: _____ #pills: _____
   How often: ___________ for #days: ______

Once I start any of these medicines, I will tell my doctor, respiratory educator, or case manager within 2 days.

Doctor’s Name

Doctor’s Fax

Doctor’s Signature

License

Date

PART II 2012

Produced in collaboration with the COPD & Asthma Network of Alberta (CANA), The Canadian Thoracic Society (CTS) acknowledges the past contributions of Living well with COPD and the Family Physician Airways Group of Canada.
Pharmacological Treatment
1. Short-acting (beta_2-agonists and anticholinergic) bronchodilators to treat wheeze and dyspnea. Continue all of your long acting bronchodilators or inhaled steroids as prescribed.
2. Prednisone (oral) → 25-50 mg once daily for 10 days for patients with moderate to severe COPD.
3. Antibiotic choice is prescribed based upon the presence of risk factors as below.
4. Severe AECOPD complicated by acute respiratory failure is a medical emergency. Consider consultation with an emergency specialist or respirologist.

Antibiotic Treatment Recommendations for Acute COPD Exacerbations

<table>
<thead>
<tr>
<th>Group</th>
<th>Probable Pathogens</th>
<th>First Choice</th>
<th>Alternatives for Treatment Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, Simple Smokers FEV1 &gt; 50% ≤ 3 exacerbations per year</td>
<td>H. influenzae M. catarrhalis S. pneumoniae</td>
<td>Amoxicillin, 2nd or 3rd generation cephalosporin, doxycycline, extended spectrum macrolide, trimethoprim sulfamethoxazole (in alphabetical order).</td>
<td>Fluoroquinolone β-lact/β-lactamase inhibitor</td>
</tr>
<tr>
<td>II, Complicated, as per I, plus at least one of the following should be present: FEV1&lt;50% predicted; ≥4 exacerbations/year; ischemic heart disease; use home oxygen or chronic oral steroids; antibiotic use in the past 3 months.</td>
<td>As in group I, plus: Klebsiella spp. and other Gram-negative bacteriaIncreased probability of β-lactam resistance.</td>
<td>Fluoroquinolone β-lact/β-lactamase inhibitor (in order of preference).</td>
<td>May require parenteral therapy. Consider referral to a specialist or hospital.</td>
</tr>
<tr>
<td>III, Chronic Suppurative II, plus: Constant purulent sputum; some have bronchiectasis; FEV1 usually &lt;35% predicted; chronic oral steroid use; multiple risk factors.</td>
<td>As in group II, plus: P. aeruginosa and multi-resistant Enterobacteriaceae.</td>
<td>Ambulatory - tailor treatment to airway pathogen; P. aeruginosa is common (ciprofloxacin). Hospitalized - parenteral therapy usually required.</td>
<td></td>
</tr>
</tbody>
</table>

General Recommendations for the Pharmacist
- Patients need to be instructed to call or visit their treating physician if symptoms persist or worsen after 48 hrs in spite of patient-initiated treatment. Please instruct patients to notify their doctor, respiratory educator, or case manager within 2 days of filling any of their prescriptions for a COPD flare-up.
- Prescriptions for antibiotics and prednisone can be refilled twice each, as needed, for 1 year. Even if you have any concerns to discuss with the doctor, please fill at least the minimum quantity of the appropriate prescription based on the patient’s symptoms.
- To reduce the risk of antibiotic resistance, if more than one treatment is required over 3 months, the class of antibiotics should be changed on subsequent courses of therapy.
- Review with your patient some general measures to prevent future COPD exacerbations including smoking cessation, annual influenza vaccination, pneumococcal vaccination and appropriate use of inhaled daily medications.


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As of February 4, 2013, the *Natural Health Products (Unprocessed Product Licence Applications) Regulations* (NHP-UPLAR) were repealed. These Regulations were promulgated two and a half years ago to address unprocessed natural health product applications.

During the period of August 4, 2010 to February 3, 2013, the Regulations allowed for the sale of a category of products for which Health Canada (HC) had not yet issued a product license but had completed an initial assessment to ensure that information supporting the safety, efficacy and quality of the product had been provided and that specific safety criteria had been met. These products received an Exemption Number (EN).

With the repeal of the NHP-UPLAR, Exemption Numbers will no longer be used. However, it is possible that some products that still display an EN may have received a NPN or DIN-HM because the change in labelling of the product has not been completed. Health Canada offered a period of transition (until September 2014) to retailers to phase out their stock of approved products with non-compliant labeling.

When presented with a product with an EN number, pharmacists should verify its status by searching for the product on Health Canada’s Natural Health Products Exempted Products Database. Once the product information is displayed, pharmacists should verify the status field for that product. Below is a chart outlining how to interpret the information provided on the Exempted Products Database.

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**EN Products**

- **Input the product’s EN number into the HC EN Database and click “search”**
- **Verify the status field for the product**

- **NOT VALID**
  - Product’s application for an NPN or DIN-HM has been refused or cancelled
  - **Product is NOT approved**

- **VALID**
  - Product is still under review by Health Canada. HC may decide to issue a licence or may deny the application
  - **Product is approved**

- **LICENCE ISSUED**
  - Product has received an NPN or DIN-HM but has not yet updated its labelling to show its new number
  - **Product is approved**
The following are links to Health Canada’s Databases for natural health products:

**Natural Health Products (NHP) Exempted Products Database** (for products with EN)

**Licensed Natural Health Products (NHP) Database** (for products with NPN or DIN-HMs)
http://webprod3.hc-sc.gc.ca/lnhpdbdpsnh/index-eng.jsp

Pharmacists are reminded that only products that have received a market authorization or product licence from Health Canada are approved for sale in Canada. Authorized products in Canada will bear a Drug Identification Number (DIN), a Natural Product Number (NPN) or a Homeopathic Medicine Number (DIN-HM).

If you are unsure about the status of a product you may want to contact Health Canada at 1-800-OCANADA (1-800-622-6232) to obtain clarification.