

PROFESSIONAL PRACTICE POLICY (Chronological):

POLICY FOCUS AREAS:

PPP-3	Pharmacy References
PPP-5	Pharmacy Security
PPP-12	Prescription Hard Copy File Coding System
PPP-15	Controlled Drug Substances Signing Authorizations
PPP-16	Glucose and Cholesterol Testing by Pharmacists
PPP-20	Prescription Refills
PPP-24	Depot Shipments of Prescriptions
PPP-25	Pharmacy Disaster Preparedness
PPP-26	Pharmacist Distribution of Alternative and Complementary Health Products
PPP-27	Registration Requirements for Pharm.D. Program Students
PPP-29	Triazolam Dispensing Guidelines
PPP-31	Emergency Prescription Refills
PPP-32	Dispensing Multidose Vials
PPP-35	Pharmacists' Refusal to Provide a Product or Service for Moral or Religious Reasons
PPP-39	Responsibility of the Pharmacist When Asked to Provide a Drug That May Harm the Patient
PPP-40	Repackaging Bulk Nonprescription Drugs
PPP-43	Automated Pharmacy Dispensing System
PPP-46	Temporary Pharmacy Closures
PPP-47	Operational Procedures for Complying with <i>Benzodiazepines and Other Targeted Substances Regulations</i>
PPP-50	Centralized Prescription Processing
PPP-54	Identifying Patients for PharmaNet Purposes
PPP-55	Telepharmacy
PPP-56	Standards for Pharmacy Technician Verification of Non-Sterile Products in Hospital Pharmacy Practice
PPP-57	Standards for Pharmacy Technician Verification of Sterile Products in Hospital Pharmacy Practice
PPP-58	Medication Management (Adapting a Prescription)
PPP-59	Pharmacy Equipment
PPP-60	Professional Liability Insurance
PPP-61	Hospital Pharmacy Published Standards
PPP-63	Hospital Pharmacist Role with Respect to Drug Distribution Systems, Drug Administration Devices, Products and Services
PPP-64	Guidelines to Pharmacy Compounding
PPP-65	Narcotic Counts and Reconciliations
PPP-1	RESCINDED Tobacco-free Pharmacies
PPP-2	RESCINDED Release of Prescription Information
PPP-4	RESCINDED Facsimile Transmission of Prescriptions
PPP-6	RESCINDED April 2004 Pharmacies in Private Membership Clubs
PPP-7	RESCINDED January 2004 - Pharmacy Database Uses
PPP-8	RESCINDED April 2004 HIV/Aids Prescription PharmaNet Records
PPP-9	RESCINDED Facsimile Transmission of Refill Authorizations in Community Pharmacies
PPP-10	RESCINDED Facsimile Transmission of Prescriptions in Long-term Care Facilities
PPP-11	RESCINDED Direct Communication with Practitioners in the Long-term Care Setting
PPP-13	RESCINDED June 1999-Pharmacist Purchases of Prescription Medications for Personal Use
PPP-14	RESCINDED January 2004 - Size, Shape and Colour of Pharmaceuticals
PPP-17	RESCINDED Proposed Bylaws of the Council of the College of Pharmacists of BC (Draft 10)
PPP-18	RESCINDED Vinca Alkaloids Warning Label
PPP-19	RESCINDED February 2007- Prescription Labeling
PPP-21	RESCINDED Accountability Procedures
PPP-22	RESCINDED Expiry Date
PPP-23	RESCINDED Hospital Pharmacy Licence Fee
PPP-28	RESCINDED Year 2000 Pharmacy Computer Software Compliance Policy
PPP-30	RESCINDED Direct Communication with Prescribers
PPP-33	RESCINDED Pharmacist-Patient Dialogue Bylaw Interpretation Guidelines
PPP-34	RESCINDED Pharmacist-to-Technician Ratio (Community Pharmacies)
PPP-36	RESCINDED April 2000-Exempted Codeine Product Sales
PPP-37	RESCINDED Mutual Recognition Agreement for the Profession of Pharmacy in Canada
PPP-38	RESCINDED February 2007 - Emergency Contraceptive Pills Collaborative Agreement Protocol
PPP-41	RESCINDED PharmaNet Patient Record Access and Use
PPP-42	RESCINDED February 2002-Return-to-Practice Requirements
PPP-44	RESCINDED Distribution of Medication Samples by Pharmacists
PPP-45	RESCINDED Shredding Confidential Material
PPP-48	RESCINDED Internet Pharmacy Standards
PPP-49	RESCINDED September 2002-Prescription Transmission from Prescriber's Computer to Pharmacy Fax Machine
PPP-51	RESCINDED Medical Marijuana
PPP-52	RESCINDED Medication Packaging for Facilities
PPP-53	RESCINDED Drug Interchangeability
PPP-62	RESCINDED Medication Management (Administration of Injections)

PROFESSIONAL PRACTICE POLICY (Alphabetical By Title):

POLICY FOCUS AREAS:

Automated Pharmacy Dispensing System	PPP-43
Centralized Prescription Processing	PPP-50
Depot Shipments of Prescriptions	PPP-24
Dispensing Multidose Vials	PPP-32
Emergency Prescription Refills	PPP-31
Glucose and Cholesterol Testing by Pharmacists	PPP-16
Guidelines to Pharmacy Compounding	PPP-64
Hospital Pharmacist Role with Respect to Drug Distribution Systems, Drug Administration Devices, Products and Services	PPP-63
Hospital Pharmacy Published Standards	PPP-61
Identifying Patients for PharmaNet Purposes	PPP-54
Medication Management	PPP-58
Narcotic Counts and Reconciliations	PPP-65
Controlled Drug Substances Signing Authorizations	PPP-15
Operational Procedures for Complying with <i>Benzodiazepines And Other Targeted Substances Regulations</i>	PPP-47
Pharmacist Distribution of Alternative and Complementary Health Products	PPP-26
Pharmacists' Refusal to Provide a Product or Service for Moral or Religious Reasons	PPP-35
Pharmacy Disaster Preparedness	PPP-25
Pharmacy Equipment	PPP-59
Pharmacy References	PPP-3
Pharmacy Security	PPP-5
Prescription Hard Copy File Coding System	PPP-12
Prescription Refills	PPP-20
Professional Liability Insurance	PPP-60
Registration Requirements for Pharm.D. Program Students	PPP-27
Repackaging Bulk Nonprescription Drugs	PPP-40
Responsibility of the Pharmacist When Asked to Provide a Drug That May Harm the Patient	PPP-39
Standards for Pharmacy Technician Verification of Non-Sterile Products in Hospital Pharmacy Practice	PPP-56
Standards for Pharmacy Technician Verification of Sterile Products in Hospital Pharmacy Practice	PPP-57
Telepharmacy	PPP-55
Temporary Pharmacy Closures	PPP-46
Triazolam Dispensing Guidelines	PPP-29
RESCINDED Accountability Procedures	PPP-21
RESCINDED Direct Communication with Prescribers	PPP-30
RESCINDED Distribution of Medication Samples by Pharmacists	PPP-44
RESCINDED Drug Interchangeability	PPP-53
RESCINDED Emergency Contraceptive Pills Collaborative Agreement Protocol	PPP-38
RESCINDED Expiry Date	PPP-22
RESCINDED Facsimile Transmission of Prescriptions in Long-term Care Facilities	PPP-10
RESCINDED Facsimile Transmission of Refill Authorizations in Community Pharmacies	PPP-9
RESCINDED April 2004 HIV/Aids Prescription PharmaNet Records	PPP-8
RESCINDED Hospital Pharmacy Licence Fee	PPP-23
RESCINDED Internet Pharmacy Standards	PPP-48
RESCINDED Medical Marijuana	PPP-51
RESCINDED Medication Management (Administration of Injections)	PPP-62
RESCINDED Medication Packaging for Facilities	PPP-52
RESCINDED Mutual Recognition Agreement for the Profession of Pharmacy in Canada	PPP-37
RESCINDED April 2004 Pharmacies in Private Membership Clubs	PPP-6
RESCINDED Pharmacist-Patient Dialogue Bylaw Interpretation Guidelines	PPP-33
RESCINDED PharmaNet Patient Record Access and Use	PPP-41
RESCINDED Prescription Labeling	PPP-19
RESCINDED Release of Prescription Information	PPP-2
RESCINDED Facsimile Transmission of Prescriptions	PPP-4
RESCINDED January 2004 - Pharmacy Database Uses	PPP-7
RESCINDED Direct Communication with Practitioners in the Long-term Care Setting	PPP-11
RESCINDED April 1999 – Pharmacist Purchases of Prescription Medications for Personal Use	PPP-13
RESCINDED January 2004 - Size, Shape and Colour of Pharmaceuticals	PPP-14
RESCINDED Proposed Bylaws of the Council of the College of Pharmacists of BC (Draft 10)	PPP-17
RESCINDED Vinca Alkaloids Warning Label	PPP-18
RESCINDED Year 2000 Pharmacy Computer Software Compliance Policy	PPP-28
RESCINDED Pharmacist-to-Technician Ratio (Community Pharmacies)	PPP-34
RESCINDED April 2000 – Exempted Codeine Product Sales	PPP-36
RESCINDED February 2002 – Return-to-Practice Requirements	PPP-42
RESCINDED September 2002 – Prescription Transmission from Prescriber's Computer to Pharmacy Fax Machine	PPP-49
RESCINDED Shredding Confidential Material	PPP-45
RESCINDED Tobacco-free Pharmacies	PPP-1

POLICY STATEMENT(S):

All community pharmacies are required to have the most current versions of the BC Pharmacy Practice Manual. The CPBC *ReadLinks* is an exception, as only the most recent three years must be retained.

An updated copy of the *Revision Dates of Legislation* is provided when documents are amended, and it is available on the CPBC web site. Please ensure that all documents are current and readily accessible within the dispensary.

To obtain copies of these documents, please contact the College office for an order form or access our web site at www.bcpharmacists.org.

Electronic Database References

Electronic database references are acceptable for any of the authorized choices within any of the required categories, provided that they are as comprehensive as the printed version and meet the same updating requirements.

Residential Care Homes and Facilities References

Pharmacies providing service to licensed residential care facilities and homes must obtain a minimum of one reference applicable to geriatric residents or to psychiatric care residents, as appropriate to the pharmacy's service area.

Suppliers / Sources

Pharmacy reference texts can be obtained from several sources. The College is aware of the following suppliers of the required references:

BC Drug & Poison Information Centre (DPIC)
Tel: 604.682.2344 Ext. 62126

BC Pharmacy Association
Tel: 604.261.2092
Toll Free: 800.663.2840
Website: www.bcpharmacy.ca

Canadian Pharmacists Association
Toll Free: 800.917.9489
Website: www.pharmacists.ca

Harcourt Canada
Tel & Fax: 416.255.4491
Toll Free: 800.387.7278
Website: www.harcourt.com

Login Bros. Canada
Tel: 403.246.1963
Toll Free: 800.665.1148
Website: www.lb.ca

Pharma Systems Inc.
Toll Free: 888.475.2500
Website: www.pharmasystems.com

Therapeutic Research Facility
Tel: 209.472.2240
Website: www.naturaldatabase.com

UBC Health Sciences Bookshop
Tel: 604.875.5588
Toll Free: 800.665.7119
Website: www.hsb.bookstore.ubc.ca

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-3
Pharmacy References

All community pharmacies at a minimum must have one of the following authorized library references in each of the categories listed as per PODSA Bylaw 2(2)(w).

CATEGORY	VERSION	TEXT	ELECTRONIC FORMATS
COMPENDIUM	Current year	1. Compendium of Pharmaceuticals and Specialties	1. www.pharmacists.ca - e-CPS
COMPLEMENTARY / ALTERNATIVE	Within the last 4 years	1. Stockley's Herbal Medicines Interactions 2. Natural Medicines Comprehensive Database 3. Herbal Medicines – Pharmaceutical Press - MedicinesComplete.com	1. www.MedicinesComplete.com 2. www.naturaldatabase.com 3. www.lexi.com - Lexi-Naturals 4. www.ipharmacist.com 5. www.Micromedex.com - AltMedDex
DISPENSATORY	Within last 9 years	1. Martindale - The Complete Drug Reference. (Published every 3 years)	1. www.MedicinesComplete.com 2. www.lexi.com Lexi-drugs 3. www.ipharmacist.com
DRUG INTERACTIONS	In its entirety every 2 years, or continual updates	1. Stockley's Drug Interactions 2. Hansten and Horn's Drug Interactions Analysis and Management. St. Louis: Facts and Comparisons; continual updates 3. Drug Interaction Facts (Tatro). St. Louis: Facts and Comparisons	1. www.MedicinesComplete.com 2. www.factsandcomparisons.com 3. www.lexi.com - Lexi-Interact 4. www.ipharmacist.com 5. www.Micromedex.com – Drug-Reax
NONPRESCRIPTION MEDICATION * Both references required	Most current issue	1. Patient Self-Care. (PSC). Ottawa: Canadian Pharmacists Association 2. Compendium of Self-Care Products. (CSCP). Ottawa: Canadian Pharmacists Association	1. www.pharmacists.ca - e-Therapeutics (suite)
MEDICAL DICTIONARY * Those listed or any equivalent professional medical dictionary	Within the last 15 years	1. Dorland's Illustrated Medical Dictionary 2. Dorland's Pocket Medical Dictionary 3. Stedman's Medical Dictionary 4. Stedman's Medical Dictionary-Health Professions and Nursing 5. Tabor's Medical Dictionary	1. www.dorlands.com 2. www.ipharmacist.com
PREGNANCY AND LACTATION	Within the last 3 years	1. Drugs in Pregnancy and Lactation by Briggs 2. Drugs during Pregnancy and Lactation by Christof Schaefer 3. Medications and Mother's Milk by Thomas Hale	1. www.lexi.com - Lexi-Pregnancy and Lactation 2. www.ipharmacist.com
PEDIATRICS	Within the last 4 years	1. Pediatric Dosage Handbook. (Taketomo) Hudson: Lexi-Comp Inc. 2. British Columbia's Children's Hospital Pediatric Drug Dosage Guidelines. (Vancouver)	1. www.lexi.com - Lexi-Pediatric Drugs 2. http://edreg.cw.bc.ca/BookStore/public/bookstore/ 3. www.ipharmacist.com
THERAPEUTICS	Within last 4 years	1. Therapeutic Choices. Ottawa: Canadian Pharmacists Association	1. www.pharmacists.ca – e-Therapeutics

POLICY STATEMENT(S):

All hospital pharmacies and hospital pharmacy satellites must be equipped with a reference library of current references relevant to medication compounding, dispensing and/or preparation of medication orders, and current patient-oriented references for the provision of patient-oriented pharmacy services.

POLICY STATEMENT(S):

1. Each pharmacy manager must create and document a pharmacy security policy and procedure statement which demonstrates compliance with existing bylaws regarding patient record confidentiality and drug inventory security.

2. The following procedures must be followed when the store premises are occupied by nonpharmacist personnel after normal hours of operation:
 - (a) All dispensary area access points will be protected by locked doors, grillwork or similar secure barriers. (For emergency access, a key may be stored on the premises in a sealed envelope, provided that the pharmacy manager is notified each time emergency access to the dispensary is made.)

 - (b) The dispensary area will be protected by an alarm system separate from the balance of the premises, and only the pharmacist staff may possess the alarm code. (For emergency access, the alarm code may be stored on the premises in a sealed envelope, provided that the pharmacy manager is notified each time emergency access to the dispensary is made.)

 - (c) If the dispensary area is not protected by locked doors or similar barriers at all entry points or if it is not protected by a separate alarm system, a system must be established to prevent access to the dispensary area without the knowledge and consent of the pharmacy manager.

POLICY STATEMENT(S):

1. Prescriptions must be retained for a period of three years after their most recent activity, including refill transactions.
2. Prescription files must be organized chronologically by date and sequentially by prescription number or transaction number.
3. All prescription hard copies are to be bundled, pegged or otherwise grouped into manageable groups of prescriptions, and are to be enclosed within a jacket or cover.
4. The exterior storage carton for the prescription files must be labelled with the date range and the prescription number range or transaction number range.
5. Prescriptions containing controlled drug substances must be filed separately from Schedule F drug prescriptions, either as completely separate files/books or as two sections within one jacket. If files/books contain two sections, a distinctive divider card should be employed.
6. If the prescription files are stored in cartons, the exterior of the carton must be labeled with the prescription number range or the transaction number range and the date range of the prescription copies contained therein. The books, files or cartons of hard copy prescriptions must be organized in chronological order and be stored in an accessible, clean and secure storage area. The storage area must be within the building in which the pharmacy premises are licensed.
7. Hard copy prescriptions must be readily available to all pharmacists on staff, regardless of the storage site, for a three-year period.
8. Hard copy prescription files shall be available at all reasonable times for audit or inspection by authorized inspectors of the Health Canada, the College of Pharmacists of British Columbia and other authorized individuals and agencies.

BACKGROUND:

The above policy statements are supplementary to PODSA Bylaw 7(1).

POLICY STATEMENT(S):

Any pharmacist registered under the full pharmacist registration category will be permitted to sign controlled drug substances orders, provided that the order is invoiced and delivered to a licensed pharmacy. The delegation of controlled drug substances signing authority is not required.

BACKGROUND:

Manufacturers and wholesalers who sell controlled drugs have been urged to purchase the *Registered Pharmacists Directory* to ensure that the signing pharmacist is, in fact, registered in our province.

As long as a pharmacist is registered with the College under the full pharmacist registration category, he or she may sign controlled drug substances orders for any pharmacy in which he or she is practising, and may sign for orders in more than one pharmacy.

Pharmacy managers may exercise their business management authority to develop corporate or individual pharmacy policies and procedures to limit the employee pharmacists who may order controlled drug substances. It is not necessary to register this information with the College.

Although College staff will not be required to check that a signing pharmacist has been reported as being an employee of the pharmacy to which the drugs are to be shipped, -pharmacists must still notify the College of their employment sites as they change, in compliance with the Health Professions Act Bylaw 52.

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-16
Glucose and Cholesterol Testing by Pharmacists

POLICY STATEMENT(S):

A pharmacist may conduct, administer or interpret a diagnostic test for demonstration purposes only, but may supervise the performance and interpretation by the patient of a diagnostic test performed in the pharmacy.

First approved: 26 Sep 1997
Revised: 20 Jun 2003
Reaffirmed: 27 Mar 2009

PPP-16

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-20
Prescription Refills

POLICY STATEMENT(S):

Refill prescription authorizations may be added to the original prescription instead of creating a new prescription when:

1. A computerized transaction log is maintained, or
2. A new prescription number is assigned and a new hard copy prescription is prepared.

Also see PPP-31

First approved: April 1990
Revised: 29 Sep 1999 / 20 Jun 2003
Reaffirmed: 27 Mar 1998 / 27 Mar 2009

PPP-20

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-24
Depot Shipments of Prescriptions

POLICY STATEMENT(S):

Pharmacists are not permitted to deliver prescriptions to depots for subsequent dispersal to or retrieval by individual patients.

First approved: Nov 1993
Revised: 20 Jun 2003
Reaffirmed: 27 Mar 1998 / 27 Mar 2009

PPP-24

POLICY STATEMENT(S):

1. Notwithstanding the provisions of *The Health Professions Act, the Pharmacy Operations and Drugs Scheduling Act, the Regulation and the bylaws* of the College of Pharmacists of BC made pursuant to these Acts or any other provision of law, a pharmacist in good faith may furnish a drug without prescription in reasonable quantities during a declared state of emergency to further the health and safety of the public.
2. If a drug is provided in accordance with point 1 above, a record containing the date, name and address of the person to whom the drug is furnished, and the name, strength and quantity of the drug furnished must be maintained. The pharmacist shall communicate this information to the patient's prescriber as soon as possible.
3. The Registrar may waive pharmacy licensure requirements (pertaining to minimum equipment, minimum space, sanitary facilities or any other licensing requirements) and issue a temporary pharmacy licence to a licensed pharmacy required to relocate because of a declared state of emergency.
4. It is the responsibility of each pharmacy manager to approach regional emergency preparedness coordinators and be aware of and participate in local plans. Pharmacy managers should develop more detailed individual disaster plans for their own pharmacies (beyond the regional plans).

POLICY CATEGORY:

PROFESSIONAL PRACTICE POLICY-26

POLICY FOCUS: Pharmacist Distribution of Alternative and Complementary Health Products

POLICY STATEMENT(S):

1. Pharmacists who elect to sell or distribute natural, herbal, homeopathic and other alternative or complementary products must understand the indications, contraindications, risks and expected outcomes of the products offered to the public.
2. Pharmacists shall advise purchasers to inform their physicians of decisions to add to or replace current therapies.
3. Pharmacists shall have the necessary competence to recognize the need for intervention and/or referral to a physician.

First approved: 12 Jun 1998
Revised: 2 Nov 2001 / 20 Jun 2003
Reaffirmed: 27 Mar 2009

PPP-26

POLICY STATEMENT(S):

1. While acting in the capacity of a pharmacist, a person enrolled in the Pharm.D. Program in the Faculty of Graduate Studies at the University of British Columbia must either:
 - Be registered with the College of Pharmacists of BC under the full pharmacist registration category, or
 - Be under the full, direct supervision of a registered pharmacist preceptor.

BACKGROUND

In June 1998 Council reviewed correspondence from the BC Branch of the Canadian Society of Hospital Pharmacists, expressing concerns about nonpharmacists or nonpractising registrants performing pharmacist duties in hospital settings.

Subsequently, the Registrar corresponded with all hospital pharmacy managers to emphasize that they must ensure that activities listed in the definition of the “practice of pharmacy” are performed or directly supervised by individuals registered under the *Health Professions Act Bylaw Section 41*. All functions which involve direct individual patient care must be performed or directly supervised by a pharmacist registered under the full pharmacist registration category. Professional practice decisions which indirectly affect individual patient care must also be made by pharmacists registered under the full pharmacist registration category.

As a result of this communication, the Registrar received a query about the level of supervision required for Pharm.D. students on rotations through in-patient and out-patient pharmacy service areas. The October 1998 Council meeting discussion resulted in the interpretation policy noted above.

POLICY STATEMENT(S):

1. Pharmacists must provide each patient with a patient package insert every time a triazolam prescription is dispensed (including refills) in order to reinforce the information relating to the identified adverse reactions of triazolam. Special 7-tablet unit-of-use packaging, with an attached patient package insert is available.
2. Verbal counselling must supplement written information for patients, particularly for patients inquiring about any signs or symptoms of potential adverse effects (memory disturbances, behavioural changes, confusion, anxiety, restlessness or depression).
3. The prescriber must be consulted when new prescriptions for quantities greater than a 14-day supply or for daily dosages greater than 0.25 mg are received, in order to ascertain the prescriber's rationale and exercise appropriate judgment.
4. In cases where the prescriber has been previously consulted regarding the quantity or dosage and a decision has been made to dispense the prescription without modification, continue to monitor refill patterns, and communicate with the prescriber should increases in frequency or quantity of refills occur, again exercising appropriate judgment based on information provided by the prescriber.

Drug dependence experts recognize that withdrawal from benzodiazepines is difficult and potentially dangerous. Expert help may be required, and the continued use of triazolam may be necessary until the patient can be evaluated. For some patients, particularly geriatrics, withdrawal may not be practical.

5. For residents of facilities, similar discussions should be undertaken by the medication safety and advisory committee and with the individual prescribers when triazolam prescriptions are received or requested for refill.
6. Using the reverse of the original hard copy or a special record book, document the outcome of any consultations with either the patient or the prescriber, which result in an unusual outcome.

BACKGROUND:

The above policy statements supplement Health Canada's 1992 announcement regarding triazolam prescribing guidelines, particularly relating to prescriptions for quantities greater than the recommended 14-day maximum duration.

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-31
Emergency Prescription Refills

POLICY STATEMENT(S):

Pharmacists may exercise professional judgment in the provision of emergency prescription refill supplies of a medication to ensure continuity of patient treatment until the physician can be contacted for authorization. This practice is *the exception to the rule and not the normal practice*.

Pharmacists must use their pharmacist identification numbers (diploma numbers) in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.

Also see PPP-20

First approved: 29 Jan 1999
Revised: 20 Jun 2003
Reaffirmed: 27 Mar 2009

PPP-31

POLICY STATEMENT(S):

1. Multidose injectables must remain in the physician's office and never be returned to the pharmacy once they have been distributed to the physician's office.
2. The preferred method of handling the prescription is to sell the multidose vial to the physician's office. The physician's office can then charge each patient for an individual injection.

POLICY STATEMENT(S):

1. A pharmacist is permitted to object to the provision of a certain pharmacy product or service if it appears to conflict with the pharmacist's view of morality or religious beliefs and if the pharmacist believes that his or her conscience will be harmed by providing the product or service. Objections should be conveyed to the pharmacy manager, not to the prescriber or to the patient. When the concerned pharmacist is the pharmacy manager, objections should be conveyed to the employer.
2. A pharmacist who objects to providing a certain pharmacy service as a matter of conscience must inform his or her manager and employer of the objection before they accept employment to enable the pre-planning of alternate arrangements to facilitate patient access to required pharmacy services. If the belief is formed after employment is accepted, the pharmacy manager must be informed at the earliest opportunity in the pharmacist's term of employment.
3. A pharmacy manager or employer must provide reasonable accommodation of a pharmacist's right of conscience, including the development of alternate arrangements to enable another pharmacist to provide the pharmacy products or service to the patient. Any alternate means must avoid unnecessary inconvenience or suffering to the patient or patient's agent.
4. Should the alternate means developed by the pharmacy manager or employer fail to operate to provide the product or service to the patient in a timely fashion or should the pharmacy manager or employer fail to provide alternate means, the pharmacist has a duty to the patient to provide the service or product.

BACKGROUND:

Pharmacists shall hold the health and safety of the public to be their first consideration in the practice of their profession. Pharmacists who object, as a matter of conscience, to providing a particular pharmacy product or service must be prepared to explain the basis of their objections. Objecting pharmacists have a responsibility to participate in a system designed to respect a patient's right to receive pharmacy products and services.

POLICY STATEMENT(S):

1. The standard of care when dispensing a drug that may harm the patient includes a duty to inform the patient and respect for autonomy.
2. The pharmacist respects the autonomy of the patient to make informed decisions. This requires informed consent where the pharmacist is satisfied that the patient possesses sufficient information and mental capacity to understand the risks and benefits in order to voluntarily accept or reject the treatment. During the process, the pharmacist is obliged to accurately disclose the material risks and benefits that are reasonably known, or can be reasonably expected under the circumstances.

BACKGROUND:

“In common law, the standard of care for a pharmacist would be what a responsible pharmacist would do, that is the standard of the profession. Courts look towards expert witnesses, legislation and standards of practice accepted by regulatory bodies as evidence of standard of care.”

M. Berry, “Canadian Pharmacy Law”, August 1998, paragraph 5.251

In this document, “standard of care” means the level of professional service that a reasonably prudent pharmacist would provide in caring for the patient in order to provide reasonable protection of the patient from harm.

Ethically, pharmacists are obliged to hold the health and safety of the public or patient to be of first consideration. Should the pharmacist not be satisfied that the patient has made an informed decision, the pharmacist may compromise respect for autonomy and exercise professional judgement in a manner which will reduce what the pharmacist believes might be an unsafe consequence for the patient to an acceptable level.

As professionals, pharmacists have an obligation to meet the standards of the profession, including the standard described in this statement. Failure to meet the standards can be misconduct for which the pharmacist is accountable to his provincial or territorial regulatory authority. Failure can also lead to liability, especially when it is shown that the conduct below the standard of the profession is related to harm against the patient or the patient’s property.

POLICY STATEMENT(S):

1. Repackaged nonprescription drugs must not be sold from the Professional Products Area of licensed pharmacies.
2. Repackaged nonprescription drugs may be sold from the Professional Service Area of licensed pharmacies under the following conditions:
 - The package labelling should include the name of the medication, appropriate expiry date, lot number, the classification of the drug (laxative, anti-allergenic, etc.), and at a minimum common directions.
 - The medication should be repackaged in a child-resistant container when possible.
3. There must be pharmacist-patient consultation for all repackaged drugs, with particular emphasis on contraindications for use of the drug.

POLICY STATEMENT(S):

1. An automatic counting device that is capable of recording data and producing printed reports may be replenished without completely emptying the container only under the following criteria:
 - The dispensing device records all lot numbers and expiry dates and is capable of printing a report of that information for a pharmacist's review.
 - The pharmacy manager ensures that all appropriate reports are printed and reviewed at least monthly to ensure that inventory is well within the "use-by" date.
 - The reports are filed and available for review for one year.
 - If a drug recall occurs, the entire contents of the affected drug's cassette are removed and returned or destroyed if the affected lot number has been used at any time since the last complete emptying and cleaning of the cassette.

2. An automated dispensing device that is not capable of recording data and printing reports must be operated and replenished under the following conditions:
 - The cell or cassette must be identified with the drug name, strength, Drug Identification Number (DIN), lot number and expiry date of the stock currently contained in the cell.
 - The replenishment of the cells and cassettes must occur only when they are completely empty of stock before having stock added to them (no "topping up").
 - The replenishment of cells and cassettes must be checked by a pharmacist. An accountability record must be maintained, including the replenishment date for each cell and the handwritten identification of the pharmacist who checked the stock.

POLICY STATEMENT(S):

1. It is permissible for a licensed pharmacy to be closed temporarily for up to 14 consecutive days without surrendering its operating license, provided that the following provisions are performed:
 - Contact all prepared prescription recipients to advise of the closure and given them the opportunity to obtain their prepared prescription prior to the temporary closure start date. Any prepared prescriptions remaining in the pharmacy at the time of the temporary closure must be returned to inventory and reversed on the patients' PharmaNet record.
 - Post notices to the public at least 30 days prior to the temporary closure start date.
 - Post signage at the store entrance and provide a telephone answering machine message advising the public about the closure, its duration, the location of the nearest licensed pharmacy, and other information to assist with obtaining necessary pharmacy services during the closure period.
 - Make alternate arrangements with local prescribers.

BACKGROUND:

These policy statements supplement PODSA Bylaw 8(6).

POLICY STATEMENT(S):

1. Notwithstanding provincial rules permitting the advertising of drugs, Targeted Substances cannot be advertised to the general public.
2. Any loss or theft of Targeted Substances must be reported to the federal Minister of Health within ten days of discovery with a copy of the report forwarded to the College. Loss and theft reporting forms are available through the federal Office of Controlled Substances, Compliance, Monitoring and Liaison Division, Address Locator 3502B, or by telephone at (613) 954-1541 or by fax at (613) 957-0110.
3. Pharmacists receiving Targeted Substances from a licensed dealer, another pharmacy or hospital must keep a record (either in a register or an invoice record system) showing the brand name, quantity (where applicable including package size and number of packages), strength, the name and address of the supplier, and the date it was received. The record must be kept for a minimum of three years.

In the hospital setting, only a pharmacist or practitioner practising in the hospital and authorized by the person in charge of the hospital may order a Targeted Substance on behalf of the hospital.

4. Targeted Substances received by the community pharmacy, hospital pharmacy department or nursing unit must be stored in a secure environment.
5. Pharmacists are required to keep on file all written prescriptions and a written record of verbal prescriptions for three years from the last dispensing date. Prescriptions for Targeted Substances may be filed in the regular prescriptions and not in the separate file created for narcotic and controlled medications.

The Regulations do not specifically require that, in hospitals:

- (a) all issues of Targeted Substances to and returns from nursing units be recorded
- (b) the receiving nursing unit signs for the receipt of Targeted Substances
- (c) the recording of administered doses to patients be on a document other than the Medication Administration Record (MAR)
- (d) a dose which is not administered to the patient, but returned to stock, be documented

However, the person in charge of the hospital may wish to implement additional controls should these be required in that particular setting.

6. The pharmacist can refill a prescription for a Targeted Substance where refills are authorized by the practitioner and the pharmacist makes documentation at the time of the refill. Refills must be provided in accordance with the interval that may be specified on the prescription.

A prescription cannot be refilled one year after the date on the prescription regardless of remaining refills.

7. With Targeted Substances, a pharmacist may transfer the remaining refills of a prescription to another pharmacist in another pharmacy. Section 54 prohibits the further transfer of the prescription once it has been received at a second pharmacy. The pharmacist receiving the transferred prescription may not further transfer any remaining refills.
8. Only a licensed medical, dental or veterinary practitioner can prescribe Targeted Substances.
9. If the pharmacist deems it appropriate to destroy Targeted Substances, prior approval from Health Canada is not required. However, records including the name, strength per unit, and quantity of the Targeted Substance destroyed must be kept for three years.

The destruction must render the product unusable and it must be witnessed by another health care professional. An exemption is made for hospital practice where a hospital employee who is a health care professional, may destroy an opened ampoule containing amounts of a Targeted Substance without a witness.

10. As described in Section 4 of the *Controlled Drug and Substance Act*, "double-doctoring" and rules for possession apply for Targeted Substances.
11. The regulations prohibit the exportation of Targeted Substances by pharmacists, including through the mail, pursuant to a prescription for a patient residing outside Canada.

POLICY STATEMENT(S):

1. The parties performing or contracting for centralized prescription processing services must maintain a policy and procedures manual, along with documentation that implementation is occurring in a manner that shall be made available for inspection and review upon request and that includes, but is not limited to, the following:
 - (a) A description of how the parties will comply with federal and provincial laws and regulations
 - (b) The maintenance of appropriate records to identify the responsible pharmacist(s) in the various stages of the pharmaceutical care and drug product preparation processes
 - (c) The maintenance of a mechanism for tracking the prescription drug order during each step in the pharmaceutical care and drug product preparation processes
 - (d) The maintenance of a mechanism to identify on the prescription label all pharmacies involved in dispensing the prescription drug order
 - (e) The provision of adequate security to protect the confidentiality and integrity of patient information
 - (f) The maintenance of a quality assurance program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

POLICY STATEMENT(S):

1. Pharmacists must ensure that only one PharmaNet patient record is created and maintained for each person and that only one Personal Health Number (PHN) is assigned to each person. By viewing and confirming appropriate identification documents, duplicate PHNs and patient records can be avoided.
2. Where a patient is personally known to the pharmacist for a period of two years or longer, the pharmacist may positively identify the patient. In cases where the patient is not known to the pharmacist, positive identification is best achieved by viewing one piece of primary identification or two pieces of secondary identification.

PRIMARY IDENTIFICATION:

- Drivers License
- Passport
- Provincial Identity card issued by the Province of BC
- Police Identity Card issued by RCMP or Municipality
- Certificate of Indian Status Card

SECONDARY IDENTIFICATION:

- Care card issued by the Province of B.C.
- Birth Certificate
- Canadian Citizenship Card
- Landed Immigrant Status papers
- Naturalization Certificate
- Marriage certificate
- Change of Name Certificate
- Identification or Discharge Certificate from External Affairs Canada or Canadian Armed Forces
- Consular Identity Card

BACKGROUND:

The above policy statements supplement PODSA Bylaw 21(2) which requires that pharmacists take reasonable steps to positively identify a patient, patient's representative, pharmacist or a practitioner before providing any pharmacy service, including but not limited to:

- Obtaining prescription services for the first time in each pharmacy.
- Transmitting requests to the College office for a printed PharmaNet patient record.
- Updating clinical information on a patient record.
- Establishing, deleting or changing a keyword.

POLICY STATEMENT(S):

1. There must be a policy and procedure manual which outlines specific telepharmacy operations are in place to ensure the safe and effective distribution of pharmaceutical products and delivery of the required pharmaceutical care including, but not limited to:
 - The process by which the pharmacy assistant at the remote site receives and processes the prescription.
 - The process for discussing drug related problems with the prescriber.
 - The management of prescription transfers, both into the remote site and out to another pharmacy.
 - The management of over-the-counter drugs.
 - The procedure for extemporaneous compounding of prescriptions.
 - The procedure for supplying compliance packaging.
 - The contingency plan in the event of an interruption in data, video, or audio link to the central pharmacy.
 - The contingency plans to ensure continuous pharmacy service is available in the event that either or both the pharmacy technician/pharmacist are unavailable for work on short notice.
 - The maintenance of patient privacy and confidentiality during all communication with the patient.

2. A copy of the policy and procedure manual must be submitted with the application to establish a telepharmacy operation.

BACKGROUND:

Telepharmacy is the provision of pharmacy services to ensure that British Columbians only in rural and remote communities have access to the pharmacy care they need, when they need it and, as much as possible, without having to leave their communities. Telepharmacy means a central pharmacy with one or more remote sites in which all sites are connected via computer, video and audio link.

The above policy statements supplement PODSA Bylaw 15.

POLICY STATEMENT(S):

1. Technical functions specified in the Hospital Pharmacy Standards of Practice, section 10 may be delegated to pharmacy technicians in accordance with the *Standards for Delegation of Technical Functions to Pharmacy Technicians*.
2. The pharmacist may delegate the function of verifying medication container contents to a pharmacy technician under the following conditions:
 - the pharmacist is responsible for ensuring that the verification procedure has the sensitivity and accuracy to detect all possible errors.
 - the pharmacy must have established written policies and procedures for all aspects of medication container verification, including quality assurance procedures and checks, procedures if an error occurs, and documentation records.
3. A pharmacy technician may verify the medication contents of non-patient specific medication containers (e.g. prepackaging) or patient-specific medication containers (e.g. refill drawers, cards or vials). A pharmacy technician may only verify medication containers prepared by another technician.
4. The pharmacist at the telepharmacy central site may delegate the function of verifying medication container contents to a pharmacy technician certified to verify medication container contents. A hospital policy and procedure for all aspects of the medication verification process must be established. The policy must include quality assurance procedures and checks, procedures if an error occurs and copies of all documentation.
5. The verification process may occur between central/remote sites or between remote/remote sites.
6. A pharmacy technician may not verify his or her own work.

Qualifications:

7. In order to verify medication container contents, a pharmacy technician must:
 - be a graduate of a recognized pharmacy technician training course or have an equivalent of two years experience in a hospital pharmacy setting, and
 - work sufficient hours to maintain competence in the function, as determined by the hospital pharmacy manager, and
 - complete a standard departmental training program on verifying medication container contents, and
 - demonstrate, on an ongoing basis, a commitment to exemplary accuracy in verifying the contents of medication containers, as determined by the hospital pharmacy manager.

Training

8. A pharmacist with relevant expertise must ensure that the required knowledge and skills are appropriately taught. The required knowledge and skills must be acquired through a combination of educational modules, in-service programs and work experience with the opportunity for repeated practice of the skills under supervision. Work experience must be at the site where the verifying will be done.

Initial Certification

9. Pharmacy technicians must be trained and assessed prior to becoming certified to verify medication container contents. The supervising pharmacist may grant certification if the technician achieves an accuracy rate of 100%**. (see Appendix A)

Quality Control

10. The certifying technician must maintain an accuracy rate of 100%.
- (a) If an error occurs during day-to-day checking activities, the institutions must have written procedures to address this situation.
 - (b) The accuracy of all pharmacy technicians who verify medication containers must be audited at least annually and if possible conducted without the technician's knowledge. The results of the audit must be discussed with the audited technician. A technician who is certified to verify both non-sterile and sterile products may be audited on a balanced combination of the two types of products to achieve the audit quantity.

Decertification

11. If the accuracy rate of a checker falls below the established standard on one occasion, perform a re-audit shortly after the first failed audit. If the pharmacy technician fails to meet the minimum standard on re-audit, s/he must be decertified and removed from the verifying function.
12. The pharmacy manager or supervisory pharmacist for the area may decertify a technician at any time if there is any reason to believe that the technician is not capable of safely carrying out the delegated function. The technician may be recertified only if the problem is resolved to the satisfaction of the pharmacy manager.
13. A decertified checker must reenter and complete the training and initial certification process prior to being reassigned to verify medication containers.

Documentation

14. The supervising pharmacist must maintain a log or record showing the training, certification and quality assurance audits for each pharmacy technician who verifies medication container contents. The identification of the pharmacy technician who prepares or verifies medication container contents must be documented. This record must be retained for at least three years.

Continuous Quality Improvement

15. An ongoing process of continuous quality improvement must be implemented to prevent or eliminate system errors. Documentation of the continuous quality improvement process must be retained for at least three years.

BACKGROUND:

The expected outcome of every medication distribution system is that 100% of medication doses will be correct when administered to the patient. Recognizing that "human failure" may create errors in any segment of the system, the medication distribution system processes must be designed with numerous checks to identify and remove potential errors prior to dispensing. Errors and other potential problems must be constantly identified and eliminated through a process of continuous quality improvement (CQI).

Medication distribution system processes include both technical functions and cognitive or professional functions.

Examples of professional functions, which may **NOT** be delegated to a pharmacy technician, are:

- checking the accuracy of a transcription of a written medication order into the computer,
- checking a new medication order against the patient medication profile for therapeutic appropriateness,
- approving the calculations for a new product or formula.

Examples of technical functions, which may be delegated to a pharmacy technician, are*

- verifying the label and content of a compounded or prepackaged product prepared in a batch
- verifying the medication container contents against a patient-specific label or fill list.

**These functions relate to Framework of Professional Practice (March 2006), Role 2: Produce and Distribute Drug Preparations and Products, and Role 3: Contribute to the Effective Operation of the Pharmacy.*

*** This document is meant as a guide to institutions to enable them to establish a tech-check program to meet their specific needs. Each institution should set certification and audit numbers that will reflect a measurement that is logistically feasible to ensure a level of acceptable performance and is reflective of all order types.*

Patient-Specific Medication Containers

Patient-specific medication containers generally consist of individually labelled medication containers or exchange drawers containing a one to 35 day supply of medication. Patient-specific medication containers are filled according to a refill or pick list or from labels generated from the patients' computerized medication profile.

Verification of the patient-specific medication containers against a list or label will include a check to ensure:

- correct patient name
- correct patient location, if applicable
- correct medication
- correct strength
- correct dosage form
- correct number of doses or units in container
- medication is within expiry date
- correct auxiliary label(s) applied, if applicable

Non-Patient Specific Medication Containers

Non-patient specific medication containers are usually prepared in batches in anticipation of individual medication orders. Non-patient specific medication containers may include compounded medications, wardstock medications, prepackaging or crash cart trays. Each medication container batch must be documented with a compounding / prepackaging worksheet or record.

Verification of medication container batches against the compounding / prepackaging record must include a check to ensure correct:

- medication
- number of doses or units in container
- ingredient or medication expiry date(s) and lot number(s) documented
- expiry date and lot number for the batch or prepackaging
- labelling
- integrity of final product

POLICY STATEMENT(S):

1. Technical functions as specified in the Hospital Pharmacy Standards of Practice, section 10 may be delegated to pharmacy technicians in accordance with the *Standards for Delegation of Technical Functions to Pharmacy Technicians*.
2. The pharmacist may delegate the function of verifying sterile products to a pharmacy technician under the following conditions:
 - the pharmacist is responsible for ensuring that the verification procedure has the sensitivity and accuracy to detect all possible errors.
 - the pharmacy must have established written policies and procedures for all aspects of the verification of sterile products, including quality assurance procedures and checks, procedures if an error occurs, and documentation records.
3. A pharmacy technician may verify either the medication contents of patient specific compounded sterile products against a label or pick-list (e.g. refills) or the medication contents of a compounded sterile batch products against an approved written procedure or compounding record. A pharmacy technician may only verify another technician's preparation of compounded sterile products.
4. The pharmacist at the telepharmacy central site may delegate the function of verifying patient specific compound sterile products against a label or pick-list (eg. refills) or the medication contents of a compounded sterile batch products against an approved written procedure or compounding record to a pharmacy technician certified to verify compounded sterile products. A hospital policy and procedure for all aspects of the sterile product verification process must be established. The policy must include quality assurance procedures and checks, procedures if an error occurs and copies of all documentation.
5. The verification process may occur between central/remote sites or between remote/remote sites.
6. A pharmacy technician may not verify his or her own work.

Prior to verifying sterile products, the pharmacy technician must be trained and certified in the delegated function.

Qualifications

7. In order to verify compounded sterile products, a pharmacy technician must:
 - be a graduate of a recognized pharmacy technician training course or have an equivalent of two years experience in a hospital pharmacy setting, and
 - work sufficient hours to maintain competence in the function, as determined by the hospital pharmacy manager, and
 - be trained in aseptic technique and qualified to prepare sterile products, and
 - complete a standard departmental training program on verifying compounded sterile products, and
 - demonstrate, on an ongoing basis, a commitment to exemplary accuracy in verifying compounded sterile products, as determined by the hospital pharmacy manager.

Training

8. A pharmacist with relevant expertise must ensure that the required knowledge and skills are appropriately taught. The required knowledge and skills may be acquired through a combination of educational modules, inservice programs and work experience with the opportunity for repeated practice of the skills under supervision. Work experience must be at the site where the verifying will be done but didactic educational programs or inservices may be conducted either in-house or at another hospital pharmacy.

Initial Certification

9. Pharmacy technicians must be trained and assessed prior to becoming certified to verify compounded sterile products. The supervising pharmacist may grant certification if the technician achieves an accuracy rate of 100%** (See Appendix A).

Quality Control

10. The certifying technician must maintain an accuracy rate of 100%.
 - (a) If an error occurs during the day-to-day checking activities, the institution must have written procedures to address this situation.
 - (b) The accuracy of all pharmacy technicians who verify medication containers must be audited at least annually and if possible conducted without the technician's knowledge. The results of the audit must be discussed with the audited technician. A technician who is certified to verify both non-sterile and sterile products may be audited on a balanced combination of the two types of products to achieve the audit quantity.

Decertification

11. If the accuracy rate of a verifying technician falls below the established standard, a minimum of 2 re-audits will be performed shortly after the first failed audit. If the pharmacy technician fails to meet the minimum standard on any re-audit, s/he must be decertified and removed from the verifying function.
12. The pharmacy manager or supervisory pharmacist for the area may decertify a technician at any time if there is any reason to believe that the technician is not capable of safely carrying out the delegated function. The technician may be recertified only if the problem is resolved to the satisfaction of the pharmacy manager.
13. A decertified checker must reenter and complete the training and certification process prior to being reassigned to verify compounded sterile products.

Documentation

14. The supervising pharmacist must maintain a log or record showing the training, certification and quality assurance for each pharmacy technician who verifies compounded sterile products. The identification of the pharmacy technician or any other person who prepares or compounded sterile products must be documented. This record must be retained for at least three years.

Continuous Quality Improvement

15. An ongoing process of continuous quality improvement must be implemented to prevent or eliminate system errors. Documentation of the continuous quality improvement process must be retained for at least three years.

BACKGROUND:

The expected outcome of every sterile preparation and distribution system is that 100% of the parenteral medication doses will be correct when administered to the patient. Recognizing that "human failure" may create errors in any segment of the process, the processes of compounding and labelling sterile products must be designed with numerous checks to identify and remove potential errors prior to dispensing. Errors and other potential problems must be constantly identified and eliminated through a process of continuous quality improvement (CQI).

Compounding and labelling sterile products involves both technical functions and cognitive or professional functions.

Examples of professional functions, which may **not** be delegated to a pharmacy technician, are:

- checking the accuracy of a transcription of a written medication order into the computer,
- checking a new medication order against the patient medication profile for therapeutic appropriateness,
- approving the stability or compatibility information or calculations for a new product or formula.

Examples of technical functions, which may be delegated to a pharmacy technician, are*:

- verifying diluents and volumes of reconstituted sterile medications according to an approved procedure,
- verifying the label and content of a compounded sterile product prepared in a batch,
- verifying the medication container contents against a patient-specific label or fill list.

**These functions relate to Role 2: Produce and Distribute Drug Preparations and Products, and Role 3: Contribute to the Effective Operation of the Pharmacy from the Framework of Professional Practice (April 2003).*

** This document is meant as a guide to institutions to enable them to establish a tech-check program to meet their specific needs. Each institution should set certification and audit numbers that will reflect a measurement that is logistically feasible to ensure a level of acceptable performance and is reflective of all order types.

Patient-Specific Sterile Products

Patient-specific sterile products generally consist of a 24-hour supply of individually labelled compounded or purchased sterile product. These sterile products are labelled according to a refill or pick list or from labels generated from the patients' computerized medication profiles.

Verification of the individual sterile product units against a label or list will include a check to ensure correct:

- patient name,
- patient location,
- medication,
- amount added,
- solution and volume,
- dosage form,
- number of doses or units,
- ingredients are within expiry dates,
- compounded sterile product expiry date,
- auxiliary label(s), if applicable,
- integrity of the final product.

Compounded Sterile Product Batches

Compounded sterile products are usually prepared in non-patient specific batches, in anticipation of individual patient medication orders. Each batch must be documented with a compounding worksheet or record.

Verification of compounded sterile product batches against the compounding record will include a check to ensure correct:

- medication,
- amount added,
- solution and volume,
- admixture devices,
- number of units,
- ingredient expiry dates and lot numbers documented,
- compounding expiry date and lot number for the batch,
- labelling,
- integrity of the final product.

POLICY STATEMENT(S):

A pharmacist may dispense a drug contrary to the terms of a prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets **all** of the following elements of a protocol to adapt a prescription:

1. Individual competence

- a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

2. Appropriate information

- a. Pharmacist has sufficient information about the specific client's health status to ensure that adapting the prescription will maintain or enhance the effectiveness of the drug therapy and will not put the client at increased risk.

3. Prescription

- a. Pharmacist has a prescription that is current, authentic, and appropriate.

4. Appropriateness

- a. Pharmacist determines whether adapting the prescription is appropriate in the circumstances.

5. Informed consent

- a. Pharmacist must obtain the informed consent of the client or client's representative before undertaking any adapting activity.

6. Documentation

- a. Pharmacist must document in the client's record any adaptation of the prescription, the rationale for the decision, and any appropriate follow-up plan.

7. Notification of other health professionals

- a. Pharmacist must notify the original prescriber (and the general practitioner if appropriate) as soon as reasonably possible (preferably within 24 hours of dispensing) and this must be recorded in the client's record or directly on the prescription hard copy.

Note: PPP-58 is not a stand-alone document and must be read with the Orientation Manual and the Amendment to the Orientation Manual. For a pharmacist to use PPP-58 they will be required to sign the PPP-58 Declaration Form.

BACKGROUND:

Protocol for medication management (adapting a prescription)

This professional practice policy enables pharmacists to maximize their full educational and professional competencies by providing authorization to adapt existing prescriptions. This policy is not mandatory and the decision whether to adapt a prescription is at the discretion of the individual pharmacist.

To guide decisions with respect to adapting a prescription, where a specific hospital board - or College of Pharmacists of BC - Board approved protocol does not exist, the pharmacist must refer to all applicable legislation and standards. This includes, but is not limited to, the Health Professions Act, Pharmacy Operations and Drug Scheduling Act, the Regulation and Bylaws of the College of Pharmacists of BC made pursuant to these Acts, the Health Care (Consent) and Care Facility (Admission) Act, the Framework of Professional Practice, the Code of Ethics and Professional Practice Policies. This specific policy (PPP-58) does not apply to controlled drug substances and cancer chemotherapy agents.

The Framework of Professional Practice (FPP) is the standards of pharmacy practice in British Columbia. In adapting a prescription the pharmacist must follow the FPP Role 1 *Provide pharmaceutical care*. Role 1 elements include:

- Function A – Assess the client's health status and needs
- Function B – Develop a care plan with the client
- Function C – Support the client to implement the care plan
- Function D – Support and monitor the client's progress with the care plan
- Function E – Document findings, follow-ups recommendations, information provided and client's outcomes

Benefits of professional practice policy

The benefits to clients are to:

- a) Optimize drug therapy leading to improved client health outcomes
 - 1) Better therapeutic responses.
 - 2) Reduced drug errors.
 - 3) Fewer adverse drug reactions/interactions.
- b) Have an effective and efficient health care system
 - 1) Minimize delays in initiating and changing drug therapy.
 - 2) Make the best use of human resources in the health care system.
- c) Expand the opportunities to identify people with significant risk factors.
- d) Encourage collaboration among health care providers.

Supporting documents

- [Amendment to PPP-58](#)
- [Orientation Guide – Declaration Form](#)
- [PPP-58 Orientation Guide](#)
- [Pharmacist Prescription Adaptation Documentation and Notification Form](#)
- [Sample letter/fax introducing PPP-58](#)
- [Quick Reference Guide](#)

First approved: 21 Sept 2007

Revised:

Reaffirmed: 27 March 2009

Page 2 of 2

PPP-58

POLICY STATEMENT(S):

1. The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw 2(2)(w).
 - (a) Telephone
 - (b) Refrigerator
 - (c) Prescription filing supplies
 - (d) Prescription balance having a sensitivity rating of 0.01
 - (e) Metric weights (10 mg to 50 g) for balances requiring weights or instruments with equivalent capability
 - (f) Metric scale graduates (a selection, including 10 ml size)
 - (g) Mortar and pestle
 - (h) Spatulas (metal and nonmetallic)
 - (i) Funnels (glass or plastic)
 - (j) Stirring rods (glass or plastic)
 - (k) Ointment slab or parchment paper
 - (l) Counting tray
 - (m) Disposable drinking cups
 - (n) Double sink with running hot and cold water
 - (o) Soap dispenser and paper towel dispenser, and
 - (p) Plastic or metal garbage containers to be used with plastic liners
 - (q) Fax machine

2. All community pharmacies must have a dedicated high-speed internet connection.

POLICY STATEMENT(S):

1. All hospital pharmacies and hospital pharmacy satellites must be adequately equipped to provide safe and proper medication compounding, dispensing and/or preparation of medication orders, and for the provision of patient-oriented and administrative pharmacy services.

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-60
Professional Liability Insurance

POLICY STATEMENT(S):

1. The professional liability insurance coverage must meet the following criteria:
 - a) The policy provides occurrence-based coverage or claims made coverage with an extended reporting period of at least three years, and
 - b) If not issued in the pharmacist's name, the group policy covers the pharmacist as an individual.
2. Each pharmacist is responsible to ensure their individual or group plan meets the minimum criteria.

BACKGROUND:

The above policy statements are supplemental to HPA Bylaw 82.

First approved: 21 Nov 2008
Revised:
Reaffirmed: 27 Mar 2009

PPP-60

POLICY STATEMENT(S):

Sterile products must be prepared in accordance with the published standards noted below:

1. CSHP Official publications – Guidelines for Preparation of Sterile Products in Pharmacies
2. CSHP Official Publications – Handling and Disposal of Hazardous Pharmaceuticals (including cytotoxic drugs)

Hazardous drugs must be handled and prepared in accordance with the requirements for the Safe Handling of Antineoplastic Agents in Health Care Facilities published by WorkSafe BC and the published standards noted below:

3. CSHP Official Publications – Handling and Disposal of Hazardous Pharmaceuticals (including cytotoxic drugs)

POLICY STATEMENT(S):

A hospital pharmacy manager must have in place:

1. Organization-specific policies and procedures to ensure patient safety and effectiveness of drug delivery systems, drug administration devices, products and services.
2. Organization-specific policies, procedures, training and certification as appropriate, to ensure safety and effectiveness of persons assuming responsibilities for the provision of drug delivery systems, drug administration devices, products and services.
3. A system to monitor and evaluate the safety and effectiveness of drug delivery systems, drug administration devices, products, personnel and services. Quality assurance checks should be conducted and documented.
4. A system to investigate unsafe practices in accordance with professional requirements. Practices resulting in actual or potential risks are to be stopped immediately.

BACKGROUND:

The intent of this policy is to provide direction for hospital pharmacy managers to minimize practice errors, omissions and unsafe practices in hospital pharmacy as it relates to drug delivery systems, drug administration devices, products and services.

Pharmacists bear a substantial responsibility for ensuring optimal clinical outcomes from drug therapy and should participate in organizational and clinical decisions with regard to drug distribution systems, drug administration systems, products and services.

POLICY STATEMENT(S):

1. The Board of the College of Pharmacists of BC adopts the NAPRA Guidelines to Pharmacy Compounding as the Standard of Practice:

http://www.napra.org/Content_Files/Files/Guidelines_to_Pharmacy_Compounding_Oct2006.pdf

BACKGROUND:

In 2005, the National Association of Pharmacy Regulatory Authorities (NAPRA) formed the Compounding Guidelines Task Force (CGTF). The task force was comprised of pharmacists from across Canada experienced in the area of compounding preparations. The task force members recognized that compounding is an essential part of pharmacy practice, and the guidelines reflect the knowledge they felt was required to prepare a safe and appropriate product.

Once the draft guidelines were completed, they were reviewed by NAPRA's National Advisory Committee on Pharmacy Practice, the Council of Pharmacy Registrars of Canada, and NAPRA's Executive Committee. The guidelines also underwent an extensive external review.

These guidelines, referred to as the Guidelines to Pharmacy Compounding

http://www.napra.org/Content_Files/Files/Guidelines_to_Pharmacy_Compounding_Oct2006.pdf are intended to enhance the standards of practice area addressing compounding (in BC, Role 2 of the Framework of Professional Practice).

The guidelines apply to pharmacists or their delegates in the preparation of all extemporaneous products. The guidelines are based on the following performance indicators for pharmacists fulfilling this role:

- Have accurate knowledge and expertise to compound preparations
- Confirm the need for a compounded product
- Maintain access to contemporary equipment
- Use of quality ingredients and procedures
- Appropriate labeling
- Suitable containers for each unique product
- Safe and acceptable storage
- Documentation to ensure accurate checking, duplicating, and tracing

The key elements of good compounding include qualified and trained personnel, adequate premises and space, approved compounding procedures and instructions, suitable equipment, labels and containers, and accurate documentation.

For reference, the following definitions differentiate between the activities of “compounding” and “manufacturing”:

Compounding - Pharmaceutical preparation of components into drug products that:

- Are considered to be within the professional practice of pharmacy, regulated by provincial regulatory authorities in accordance with guidelines and standards that ensure the quality and safety of pharmaceuticals.
- Involve a relationship that can be demonstrated to exist between a patient and / or a regulated health care professional or a practitioner.
- Do not circumvent regulatory requirements including the Food and Drugs Act and the Food and Drug Act Regulations, the National Drug Schedules, or intellectual property legislation.
- Provide a customized therapeutic solution to improve patient care without duplicating a commercially available, approved product.

Manufacturing - Preparation of products:

- Are subject to all the appropriate divisions and sections of the Food and Drugs Act and Regulations, including all applicable standards and guidelines.
- Require a Drug Identification Number (DIN) and / or Notice of Compliance (NOC) to be sold in Canada.
- Are produced independently of the demonstrated regulated health care professional-patient relationship or valid pharmacist-veterinarian-client-patient relationship.
- Are required to obtain an Establishment License (EL) (Division 1A of the Food and Drugs Act and Regulations) and meet the appropriate sections of Division 2 Good Manufacturing Practices (GMP).

The NAPRA Guidelines to Pharmacy Compounding have been adopted by five other provincial pharmacy regulatory authorities (NB, NL, NS, ON and SK).

POLICY STATEMENT(S):

The pharmacy manager must ensure that narcotic counts and reconciliations are completed:

- a) at a minimum of every 3 months and
- b) after a change of manager and
- c) after a break-in or robbery.

BACKGROUND:

Federal Narcotic Control Regulations state that a pharmacist must report to the Federal Minister any loss or theft of narcotic within 10 days of discovery. Shortages which cannot be accounted for must be reported to Health Canada as per federal legislation.

DEFINITION:

Reconciliation: means the quantity of narcotics on hand must equal the quantity received (as shown on invoices) minus those dispensed (as shown on the narcotic report) over a specified time period.

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Revised:
Reaffirmed:

PPP-65