College of Pharmacists of British Columbia

Board Meeting
November 17, 2017
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
Anar Dossa, Outgoing Chair, District 6
Mona Kwong, Chair, District 1
Arden Barry, Vice-Chair, District 7
Ming Chang, District 2
Tara Oxford, District 3
Christopher Szeman, District 4
Frank Lucarelli, District 5
Sorell Wellon, District 8
Norman Embree, Public
Kris Gustavson, Public
Jeremy Walden, Public
George Walton, Public

Staff:
Bob Nakagawa, Registrar
David Pavan, Deputy Registrar
Mary O'Callaghan, Chief Operating Officer
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Doreen Leong, Director of Registration and Licensure
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Stephanie Kwok, Executive Assistant
Jon Chen, Communications Project Officer

Guests:
Michael Coughtrie, Dean, Faculty of Pharmaceutical Sciences, UBC
Alex Assumption, Pharmacy Undergraduate Society President, UBC

---

1. **WELCOME & CALL TO ORDER**
   Chair Dossa called the meeting to order at 11:15am on November 17, 2017.

2. **ELECTION OF CHAIR**
   In accordance with HPA bylaw 12(2) Board members at the November Board meeting must elect a Chair.

   Outgoing Chair Dossa called for nominations.

   - Mona Kwong was nominated.

After no further nominations were made, Mona Kwong was elected by acclamation as the new Board Chair for a one-year term to conclude at the start of the November 2018 Board meeting.

Mona Kwong assumed the Chair.

3. ELECTION OF VICE-CHAIR

Chair Kwong called for nominations, the following two names were put forward for consideration:

- Arden Barry
- Tara Oxford.

After 12 votes were electronically cast and tallied, Arden Barry was elected as the new Board Vice-Chair for a one-year term to conclude at the start of the November 2018 Board meeting.

Arden Barry assumed the Vice-Chair position.

4. AUDIT AND FINANCE COMMITTEE – APPOINTMENT OF CHAIR AND VICE-CHAIR

It was moved and seconded that the Board:

(1) Appoint Mona Kwong, Board Chair, as a member of the Audit and Finance Committee.

(2) Appoint Arden Barry, Board Vice-Chair, as a member of the Audit and Finance Committee.

CARRIED

5. CONSENT AGENDA

a) Items for further discussion

Item 5.b.vi *2018 Board Meeting Schedule* was removed from the consent agenda and placed onto the regular agenda under item 14.

Item 5.b.vii *Practice Review Committee – Phase 1 and 2 Update* was removed from the consent agenda and placed onto the regular agenda under item 8a for discussion as part of the committee updates.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as amended.

CARRIED

6. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the November 17, 2017 Draft Board Meeting Agenda as circulated.

CARRIED

7. COMMITTEE UPDATES

a) Audit and Finance Committee
George Walton, Chair of the Audit and Finance Committee, provided an update regarding the College's budget, expense and revenue to date. He reported that the College is overall on budget.

b) Discipline Committee
Jeremey Walden, Chair of the Discipline Committee reported that there are two current discipline files in progress.

c) Ethics Advisory Committee
Sorell Wellon, Chair of the Ethics Advisory Committee reported that the Committee met on October 18, 2017 via teleconference. The following decisions were made at the teleconference meeting:

- Alison Dempsey was voted and elected as Vice-Chair for the Committee;
- Going forward, meetings will be chaired quarterly or as needed;
- Name of Committee will remains as is; and
- Terms of reference will be amended to highlight the roles of the committee as it pertains to Patient Practitioner Relations
    - The Amendments will be considered at the February 2018 Board meeting.

d) Governance Committee
Norman Embree, Chair of the Governance Committee, provided an update under item 10a of the regular agenda.

e) Inquiry Committee
Ming Chang, Chair of the Inquiry Committee reported that the Committee panels met on several occasions since the last Board meeting. The current trends for complaint files that are reviewed by the Inquiry Committee are medication-related, competency issues, and/or about professional misconduct.

f) Jurisprudence Examination Subcommittee
Christopher Szeman, Chair of the Jurisprudence Examination (JE) Subcommittee reported that the Subcommittee met on November 8, 2017. The Committee reviewed statistical data and comments candidates provided and approved the JE results.

g) Legislation Review Committee
Jeremy Walden, Chair of the Legislation Review Committee, provided an update under item 8b of the regular agenda.

h) Practice Review Committee
Kris Gustavson, Chair of the Practice Review Committee, provided an update as well as answered questions related to item 5.b.vii *Practice Review Committee – Phase 1 and 2 Update*. Chair Gustavson reported that the Committee met 4 times a year and most recently in October 2017. The Practice Review Program question bank has been updated to include the new focus areas for pharmacy technicians in community practice and are currently being implemented.

i) Quality Assurance Committee
Frank Lucarelli, Chair of the Quality Assurance Committee, reported that the Professional Development and Assessment Program (PDAP) Mobile app is still waiting to be published on the Apple platform. At their last meeting, the Committee reviewed the referral policy based on registrants' feedback and decided at their last meeting that they will not conduct a learning needs survey at this time.

j) Registration Committee
Jeremy Walden, Chair of the Registration Committee reported that the Committee met twice in panels since the September Board meeting.

8. LEGISLATION REVIEW COMMITTEE (Appendix 3)

a) Mandatory Medical Error Reporting
Melissa Sheldrick, guest speaker presented via video conferencing.

It was moved and seconded that the Board:

Direct the Registrar to explore potential alternatives to the College's existing quality management requirements, including mandatory medication error reporting to an independent third party.

CARRIED

b) Committee Update
Jeremy Walden, Chair of the Legislation Review Committee, provided an update.

c) PODSA Bylaws – Owners (Filing)

It was moved and seconded that the Board:

(1) Approve the following resolution to amend the Pharmacy Operations and Drug Scheduling Act Bylaws, which operationalize recent amendments made to the Pharmacy Operations and Drug Scheduling Act and to approve consequential amendments to telepharmacy bylaws (including a form and schedules), to be effective with the

amendments to the Act:

RESOLVED THAT*, in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws (including forms and schedules) of the College of Pharmacists of British Columbia, as set out in the schedules attached to this resolution.*

(2) *Approve a new Professional Practice Policy 76 – Criminal Record History Vendor, to be effective at the same time as the bylaws come into force.*

(3) *Approve consequential amendments to the following Professional Practice Policies, to be effective at the same time as the bylaws come into force:*

- *PPP-3 Pharmacy References*
- *PPP-12 Prescription Hard Copy File Coding System*
- *PPP-46 Temporary Pharmacy Closures*
- *PPP-54 Identifying Patients for PharmaNet Purposes*
- *PPP-59 Pharmacy Equipment*
- *PPP-65 Narcotic Counts and Reconciliations*
- *PPP-73 Validate Identification and College Registration Status for New Pharmacy Hires*
- *PPP-74 Community Pharmacy Security*

CARRIED

d) HPA Bylaws – Board Terms of Office (Filing)

It was moved and seconded that the Board:

Approve the following resolution to amend the Health Professions Act Bylaws regarding the elected board member terms of office and election cycle:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

CARRIED

e) Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine

It was moved and seconded that the Board:

(1) Approve amendments to Professional Practice Policy (PPP) 66 Methadone Maintenance Treatment, to be effective on January 1, 2018.

(2) Approve the following two new PPP 66 Policy Guides, to be effective on January 1, 2018:

- *PPP 66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)*
- *PPP 66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)*

CARRIED

9. GOVERNANCE COMMITTEE

a) Committee Update

Norman Embree Chair of the Governance Committee reported the Committee met on October 17 2017 via teleconference.

b) Application Committee – Appointment of Members

It was moved and seconded that the Board:

(1) Approve the Terms of Reference to the Application Committee, as presented. **(Appendix 4)**

(2) To amend the motion by changing the word formation to membership to read: Approve the membership of Application Committee, as circulated. **(Appendix 5)**

CARRIED

c) Board Members as Chairs of all Committees (Appendix 6)

It was moved and seconded that the Board:

Remove the requirement for a Board member to Chair the Application, Inquiry, Discipline and Registration committees

CARRIED

10. CHANGE DAY BC 2017 (Appendix 7)

Gillian Vrooman, Director of Communications and Engagement, presented.

11. FRAMEWORK FOR PHARMACIST PRESCRIBING IN BC (Appendix 8)

- Alex Dar Santos & Derek Desrosiers from BC Pharmacy Association, presented and voiced support for the Pharmacist Prescribing in BC as a concept but outlined some concerns with the current framework.
- Sahil Ahuja & Michelle Ly from UBC Pharmacy Students Advancing Practice, presented.

- Dr. Greg Egan from Canadian Society of Hospital Pharmacists BC, presented.
- Gillian Vrooman, Director of Communications and Engagement, presented.

It was moved and seconded that the Board:

Direct the Registrar to submit a proposal for pharmacist prescribing in BC to the Minister of Health which would request amendments to the Pharmacists Regulation under the Health Professions Act and include the Framework for Pharmacist Prescribing in BC and the Engagement Report.

CARRIED

12. PODSA OWNERSHIP PROJECT – PRIVACY AND SECURITY UPDATE (Appendix 9)

Doreen Leong, Director of Registration & Licensure, presented.

13. IT COMPETITIVE BID UPDATE

Mary O'Callaghan, Chief Operating Officer, provided an update regarding the early termination of the existing IT Managed Services contract and the state of the current competitive IT bid to determine a new service provider.

14. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

a) Item 5.b.vi *2018 Board Meeting Schedule*
Possible scheduling conflicts were discussed regarding the June Board meeting dates.

The 2018 Board Meeting Schedule was approved as circulated.

ADJOURNMENT

Chair Kwong adjourned the meeting at 4:10pm.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5. Consent Agenda
b) Approval of Consent Items

DECISION REQUIRED

Recommended Board Motion:

Approve the Consent Agenda as circulated, or amended.

i. Chair's Report
ii. Registrar's Update
    a. Activity Report
    b. Action Items & Business Arising
iii. September 15, 2017 Draft Board Meeting Minutes **[DECISION]**
iv. Committee Updates (Links to Minutes)
v. Audit and Finance Committee – Finance Report – September Financials
vi. 2018 Board Meeting Dates **[DECISION]**
vii. Practice Review Committee: Phase 1 and 2 Update
viii. College of Pharmacists of BC Recordkeeping Policy **[DECISION]**
ix. College of Pharmacists of BC Risk Register
x. Proposed Amendments to the Health Professions Act

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.i. Chair's Report

INFORMATION ONLY

Since the September Board meeting, I have been involved in the following activities:

- Participated in regular meetings with the Registrar, Deputy Registrar and Vice-Chair regarding Board and College issues
- Participated in Certified Pharmacist Prescriber Public engagement session as a panel member
- Attended Canadian Society of Hospital Pharmacists Council meeting
- Discussed Certified Pharmacist Prescriber initiative
- Attended Governance Committee meetings as Vice-Chair
- Participated in the Registrar Evaluation Task Group

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.ii. Registrar's Update
a) Activity Report

INFORMATION ONLY

Since the September Board meeting, I have been involved in the following activities:

- Attended CPRC (as Chair) meetings
- Vacation (2 weeks)
- Co-chaired the NAPRA Ad Hoc Committee on Governance Implementation meetings
- Had regular meetings with the Board Chair, Vice Chair and Deputy Registrar
- Had meetings with Mitch Moneo, Acting ADM, MBPSD
- Attended Executive meetings at NABP
- Participated in the NAPRA interactive executive officer forum
- Participated in the .pharmacy executive meetings
- Participated in meetings with Health Canada – Veterinary Drugs Directorate, Controlled Substances Directorate, and the Therapeutic Products Directorate
- Attended the discipline hearings for Marigold Pharmacy
- Participated in the palliative kits discussion
- Attended the BCHR fall education day – cultural competency and safety
- Presented to the Pharm241 class on Innovative roles for pharmacists
- Planning for the management retreat
- Toured 2 SDM pharmacies and had discussions with their Associates
- Several discussions about OAT and iOAT with Health Authorities and the Ministry of Health

Excellence Canada Update:

- The Excellence Council and Project Teams continue to work on the identified Action Items, drafting policies, guidelines, investigating best practices, etc.
- The Executive Team holds monthly meetings with the Excellence Canada business coach, Catherine Neville.
- Catherine will be delivering a one day workshop for the Management Team on Change Management and Rewards and Recognition on November 27, 2017. She will follow that with a one day Coaching and Training session for the Excellence Council and key project team members on November 28, 2017. A focus of this session will be following up on the Business Process training held earlier this year, reinforcing that training.

Strategic Plan Update:

- Work on the Strategic Plan continues steadily.
- College staff will be receiving further training on the Strategic Planning software, Cascade, on November 9th. The training will include how to best reflect completion percentages and to generate a snapshot report that reflects the progress appropriately.
- In the meantime, this update will summarize the progress to date:
  - **Legislative Standards & Modernization**
    - The legislative focus has been on the PODSA Ownership changes and significant progress has been made. The necessary IT changes to the database (iMIS) are being tested for bug fixes and processes are being reviewed for privacy and security.
  - **Professional Excellence**
    - Hospital PRP launched on schedule and is being monitored.
    - The Methadone Action Plan inspections and undercover inspections work has been completed and the information obtained is being reviewed.
  - **Drug Therapy Access & Monitoring**
    - The draft framework for Pharmacist Prescribing is included in the Agenda for this Board meeting.
    - The work related to access to patient lab values will begin after PODSA Ownership is launched.
  - **Organizational Excellence**
    - Licensure business processes are being reviewed and changes implemented in preparation for the launch of the PODSA Ownership process. IT systems have been updated to reflect this and are being tested in order to be ready for launch.
    - The focus of the database (iMIS) revamp has been on Pharmacy Licensure, given the PODSA changes.
    - Practice Review Program software has been maintained only, given the resource requirements needed to be ready for PODSA's launch.
    - Data security, including identity and access management, has been reviewed and recommendations are being implemented.
    - Enterprise Content Management (electronic recordkeeping) will be an upcoming focus. In preparation for this the Recordkeeping Policy is included in this Board meeting agenda for approval.
    - The Organization Review recommendations are substantially implemented and being monitored.

Compliance Certificate:

- It was recommended by the Institute of Governance that the College provides its Board with a Compliance Certificate at each Board meeting.

Appendix	
1	CPBC Compliance Certificate

College of Pharmacists
of British Columbia

Compliance Certificate

We have reviewed the College's official records and financial reports and we certify that the College has met its legal obligations with respect to the following:

Annual Report - Filed June 27, 2017

Non-profit Tax Return – Filed August 23, 2017

Non-profit Information Return – Filed August 23, 2017

Employee statutory payroll deductions – remitted to Canada Revenue Agency – all remittances are current.

Employee pension plan remittances – all remittances are current.

WorkSafeBC BC assessments – all remittances are current.

Sales Taxes – all remittances are current.

Investments – invested as per policy

Insurance – all insurance policies are up to date

Signed by:

Registrar

Chief Operating Officer

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.ii. Registrar's Update
b) Action Items & Business Arising

INFORMATION ONLY

MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UDPATE
Motion: Direct the Registrar to take the following actions as outlined in the MMT Action Plan: • Develop, plan and implement new undercover investigations, • Conduct priority inspection of identified MMT dispensing pharmacies, • Continue to build and maintain collaborative relationships with key stakeholders, and • Provide recommendations to the Board to strengthen legislation and licensure requirements.	Jun 2015	IN PROGRESS
Motion: Pursue officially changing the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia.	Sep 2016	IN PROGRESS
Motion: Direct the Registrar to develop a proposal for pharmacist prescribing within collaborative practice settings – based on the amendment Draft Framework and results of the stakeholder engagement – to be brought to the Board for approval to submit to the Minister of Health for consideration.	NOV 2016	IN PROGRESS
Motion: Direct the Registrar to draft bylaws to adopt the *Model Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations and the Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations*, to be effective for May 2021, which will officially establish minimum requirements to be applied in compounding sterile preparations.	APR 2017	IN PROGRESS

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.iii. September 15, 2017 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the September 15, 2017 Draft Board Meeting Minutes as circulated.

Appendix	
1	http://library.bcpharmacists.org/2_About_Us/2-1_Board/Board_Meeting_Minutes-20170915.pdf

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.iv. Committee Updates (Minutes)

INFORMATION ONLY

Committees who have met and approved previous meeting minutes have submitted them to the Board for information purposes.

For confidentiality purposes, the Discipline Committee and Inquiry Committee have provided summaries of their meetings, but will not be submitting minutes.

Appendix – available on the Board Portal under 'Committee Minutes'	
1	Discipline Committee Update
2	Inquiry Committee Update
3	Legislation Review Committee Meeting Minutes
4	Practice Review Committee Meeting Minutes
5	Quality Assurance Committee Meeting Minutes

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.v. Audit and Finance Committee - Finance Report (September Financials)

INFORMATION ONLY

Purpose

To report on the highlights of the September 2017 financial reports.

Background

The September 2017 financial reports reflect **seven months** activity. Attached are the Statement of Financial Position, a summary Statement of Revenue and Expenditures and more detailed reports on Revenue and on Expenditures.

Statement of Financial Position

The College's cash position is well funded to meet payables with a balance of over $800,000. Investments at the end of July totalled more than $6 million.

Revenue

Licensure revenues continue to be under budget, but have improved somewhat since July, especially in the Pharmacy Technician fees category. *Other revenues* (PharmaNet, administrative fees, etc.) reflect a drop in PharmaNet revenues due to some technical difficulties at the Ministry of Health which slowed down processing of PharmaNet profiles. The issue was resolved in late May. As the contract is now completed this will remain under budget. In total, revenues are under budget by just under $225,000, so holding steady since July.

Expenses

Finance staff worked with our payroll processor, PayWorks, and with our new accounting and budget software and we are happy to be able to present the Financial Statements with salaries and benefits allocated by department.

Total Year to Date Actual expenditures are under budget by almost $500,000. As revenues will be under budget, we have be monitoring expenditures to ensure that they also remain under budget. See the variance analysis which follows for details. The net surplus has grown since July, which is normal over the summer due to a decrease in activities.

Variance analysis by department:

Department	Budget	Actual	Comment
Board & Registrar's Office	468,237	470,090	Unbudgeted Board consulting projects.
Grant distribution	135,449	67,962	Waiting for progress report for a grant.
Registration & Licensure	538,776	501,569	See also "Projects" re PODSA ownership process changes.
Quality Assurance	30,947	24,710	
Practice Review	830,331	772,786	Salaries and travel are under budget.
Complaints Resolution	908,787	686,457	Salaries due to gapping and legal fees due to timing.
Policy and Legislation	235,850	200,237	Legal fees due to timing.
Public Engagement	229,235	208,907	Timing of activities.
Finance and Administration	1,943,864	1,852,282	IT project priorities changed due to PODSA ownership requirements.
Projects (PODSA Ownership)	87,500	139,051	Legal and Project Management
Amortization	233,341	219,955	Timing – re IT development projects.
Total Expenses	5,642,318	5,144,008	

Appendix	
1	Statement of Financial Position
2	Statement of Revenue and Expenditures
3	Statement of Revenue
4	Statement of Expenses

College of Pharmacists of BC
Statement of Financial Position
As at September 30, 2017

ASSETS	
Current	
Cash and Cash Equivalents	823,787
Investments	6,096,506
Receivables	32,673
Prepaid and deposits	158,875
	7,111,841
Investment in College Place Joint Venture	1,579,468
Development costs	454,979
Property and Equipment	730,301
	2,764,748
Total Assets	**9,876,589**

LIABILITIES AND NET ASSETS	
Liabilities	
Current	
Payables and Accruals	572,142
Current portion of capital lease obligations	8,005
Deferred Revenue	3,785,520
Deferred Contributions	180,948
	4,546,616
Capital lease obligations	26,548
Total Liabilities	**4,573,164**
Net Assets	
Unrestricted Fund	441,915
Reserves - Capital Assets and Bldg	500,000
Reserves - Joint Venture	500,000
Reserves - Automation	750,000
Reserves - Legal	750,000
Reserves - Grants	500,000
Reserves - Operating	1,500,000
Retained Earnings	361,510
Total Net Assets	5,303,425
Total Liabilities and Net Assets	**9,876,589**

College of Pharmacists of BC
Statement of Revenue and Expenses
For the 7 months ending September 30, 2017

	Budget YTD Sept 2017	Actual YTD Sept 2017	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Licensure revenue	3,878,740	3,778,252	(100,488)	(3%)
Non-licensure revenue	1,063,499	939,477	(124,022)	(12%)
Transfer from Balance Sheet	787,789	787,789	-	0%
Total Revenue	**5,730,028**	**5,505,518**	**(224,510)**	(4%)
Total Expenditures Before Amortization	5,408,976	4,924,053	484,924	9%
Amortization	233,341	219,955	13,386	6%
Total Expenses Including Amortization	**5,642,318**	**5,144,008**	**498,310**	9%
Net Surplus/(Deficiency) of revenue over expenses after amortization expense	**87,710**	**361,510**	**273,800**	

College of Pharmacists of BC
Statement of Revenue and Expenses
For the 7 months ending September 30, 2017

	Budget YTD Sept 2017	Actual YTD Sept 2017	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Licensure revenue				
Pharmacy fees	1,371,262	1,368,566	(2,696)	(0%)
Pharmacists fees	2,099,900	2,057,602	(42,298)	(2%)
Technician fees	407,578	352,084	(55,494)	(14%)
	3,878,740	3,778,252	(100,488)	(3%)
Non-licensure revenue				
Other revenue	793,845	708,311	(85,534)	(11%)
Grant Revenue	69,700	11,250	(58,450)	(84%)
Investment income	54,120	79,916	25,795	48%
College Place joint venture income	145,833	140,000	(5,833)	(4%)
	1,063,499	939,477	(124,022)	(12%)
Transfer from Balance Sheet	787,789	787,789	-	0%
Total Revenue	**5,730,028**	**5,505,518**	**(224,510)**	(4%)

College of Pharmacists of BC
Statement of Revenue and Expenses
For the 7 months ending September 30, 2017

	Budget YTD Sept 2017	Actual YTD Sept 2017	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Expenses				
Board and Registrar's Office	468,237	470,090	(1,854)	(0%)
Finance and Administration	1,943,864	1,852,282	91,583	5%
Grant Distribution	135,449	67,962	67,487	50%
Registration, Licensure and Pharmanet	538,776	501,569	37,207	7%
Quality Assurance	30,947	24,710	6,237	20%
Practice Reviews	830,331	772,786	57,545	7%
Complaints Resolution	908,787	686,457	222,330	24%
Policy and Legislation	235,850	200,237	35,612	15%
Public Engagement	229,235	208,907	20,329	9%
Projects	87,500	139,051	(51,551)	(59%)
Total Expenses Before Amortization	5,408,976	4,924,053	484,924	9%
Amortization	233,341	219,955	13,386	6%
Total Expenses Including Amortization	**5,642,318**	**5,144,008**	**498,310**	9%

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.vi. 2018 Board Meeting Schedule

DECISION REQUIRED

Recommended Board Motion:

Approve the 2018 Board Meeting Schedule as circulated.

The Board Meeting Schedule for 2018 is:

Thursday, February 15, 2018
Friday, February 16, 2018

Thursday, April 19, 2018
Friday, April 20, 2018

Thursday, June 14, 2018
Friday, June 15, 2018

Thursday, September 13, 2018
Friday, September 14, 2018

Thursday, November 15, 2018
Friday, November 16, 2018
OR
Thursday, November 22, 2018
Friday, November 23, 2018

CPBC Annual General Meeting
Saturday, November 17, 2018
OR
Saturday, November 24, 2018
Please reserve the two dates, subject to consideration at a future Board meeting

College of Pharmacists of British Columbia

BOARD MEETING
November 17th, 2017

5.b.vii. Practice Review Committee: Phase 1 and 2 Update

INFORMATION ONLY

Purpose

To provide the Board with an update on the Practice Review Program (PRP).

Business Stream:

Update	Next Steps
General • Developed new Risk Register which includes risk identified for both Phase 1 and Phase 2	General • Monitor Risk Register to identify and track issues
Phase 1 – Community Practice • Conducted September and October reviews (Appendix 1) • Scheduled reviews for November and December reviews • Completed development of question sets for the new Pharmacy Professionals Review focus areas for pharmacy technicians (approved at the Board's June 2017 meeting) ○ Pre-populated non-compliance and action items • Determining program outcomes • Forecasting program cycle	Phase 1 – Community Practice • Schedule pharmacies for January 2018 reviews • Implement new Pharmacy Professionals Review focus areas for pharmacy technicians (see IT stream) • Develop Release 2 of Phase 1: Residential Care, packaging, compounding and other ancillary forms (contingent on resources)
Update	**Next Steps**

Phase 2 – Hospital Practice
• Conducted September and October reviews (Appendix 2)
• Scheduled pharmacies for November, December and January reviews
• Updated review forms
  ○ Pharmacy technician review
  ○ PODSA changes
• Trial to schedule 3 Pharmacy Professionals Reviews a day based on registrant feedback
	Phase 2 – Hospital Practice
	• Schedule pharmacies for February 2018 reviews
	• Continue to monitor and adjust policies and processes as needed

College of Pharmacists of British Columbia

BOARD MEETING
November 17th, 2017

Communications / Stakeholder Stream:

Update	Next Steps
Phase 1 – Community Practice • Drafting new PRP Insights articles	Phase 1 – Community Practice • Continue to draft and post monthly PRP Insights articles based on findings from reviews
Phase 2 – Hospital Practice • Developed new FAQs	Phase 2 – Hospital Practice • Begin drafting PRP Insights articles

Legislation Stream:

Update	Next Steps
General • Provided feedback on legislation based on findings from reviews	General • Continue to provide feedback on legislation based on findings from reviews

Enforcement Stream:

Update	Next Steps
General • Sharing PRP Information as needed • Working with Complaints Resolution team to review selected pharmacies (to prevent overlap)	General • Continue to share PRP information as needed • Continue to work with Complaints Resolution team to review selected pharmacies (to prevent overlap)

IT Stream:

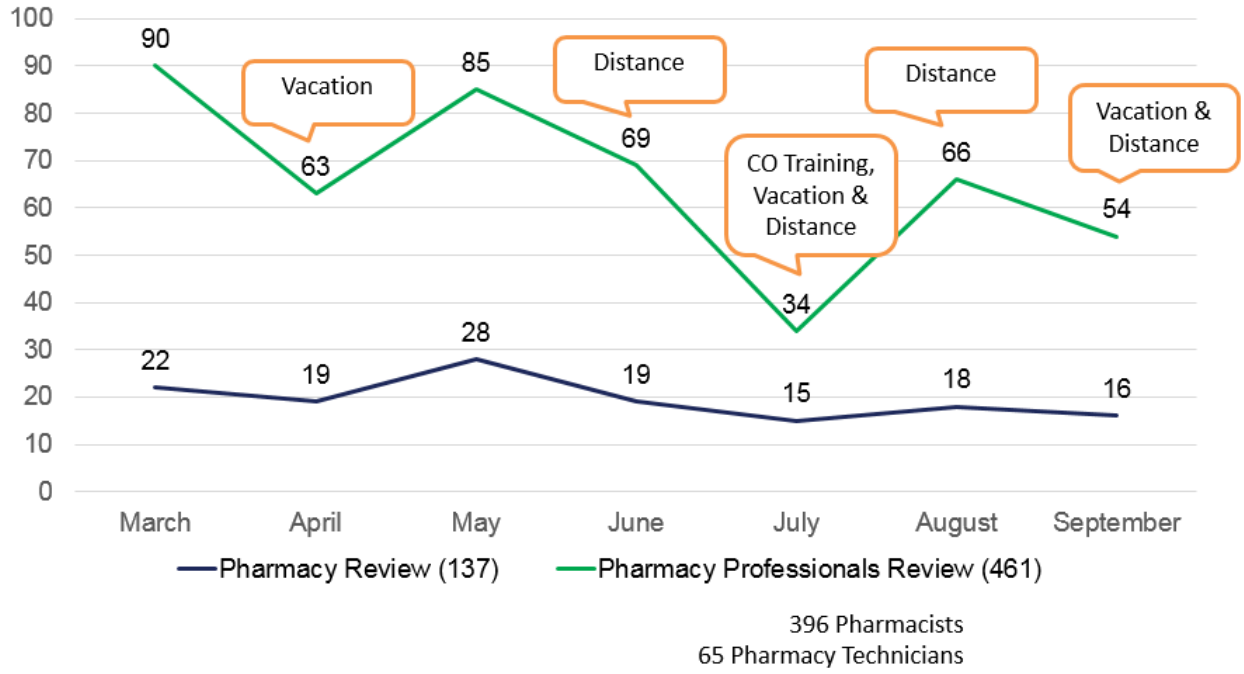
Update	Next Steps
Phase 1 – Community Practice • Fixing Question Bank module in PRP Application ○ Currently unable to add question sets for new pharmacy technician Focus areas • Updated Pharmacy Pre-Review hours and services to be consistent with online pharmacy renewals • Building functionality to extract data and reports (April 2016 reviews and onwards)	Phase 1 – Community Practice • Fix Question Bank module and add question sets for new pharmacy technician Focus Areas • User Acceptance Testing of reports module
Phase 2 – Hospital Practice • Provide support as needed	Phase 2 – Hospital Practice • Provide support as needed

Appendix	
1	Phase 1 – Community Practice Operational Statistics
2	Phase 2 – Hospital Practice Operational Statistics

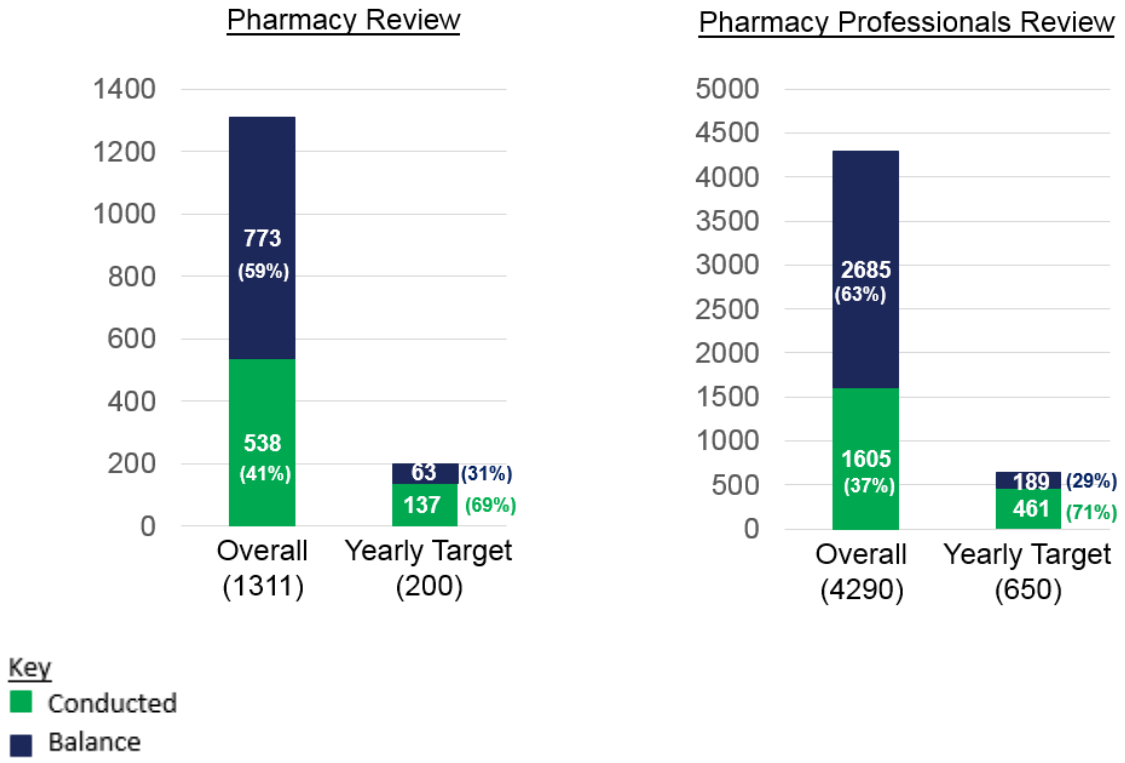
Appendix 1

PRP Phase 1: Community Practice Operational Statistics
2017-18 Fiscal Year: March 1st – September 30th, 2017

Fiscal Year Progress:



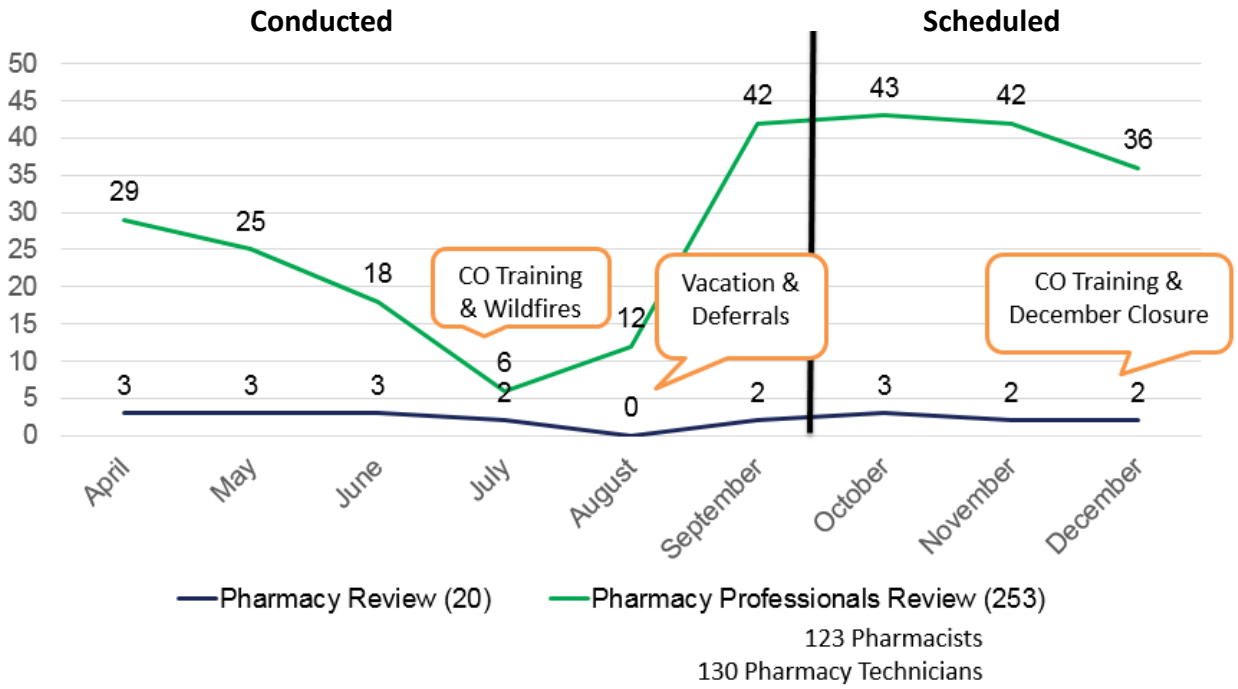
Overall and Fiscal Year Progress:



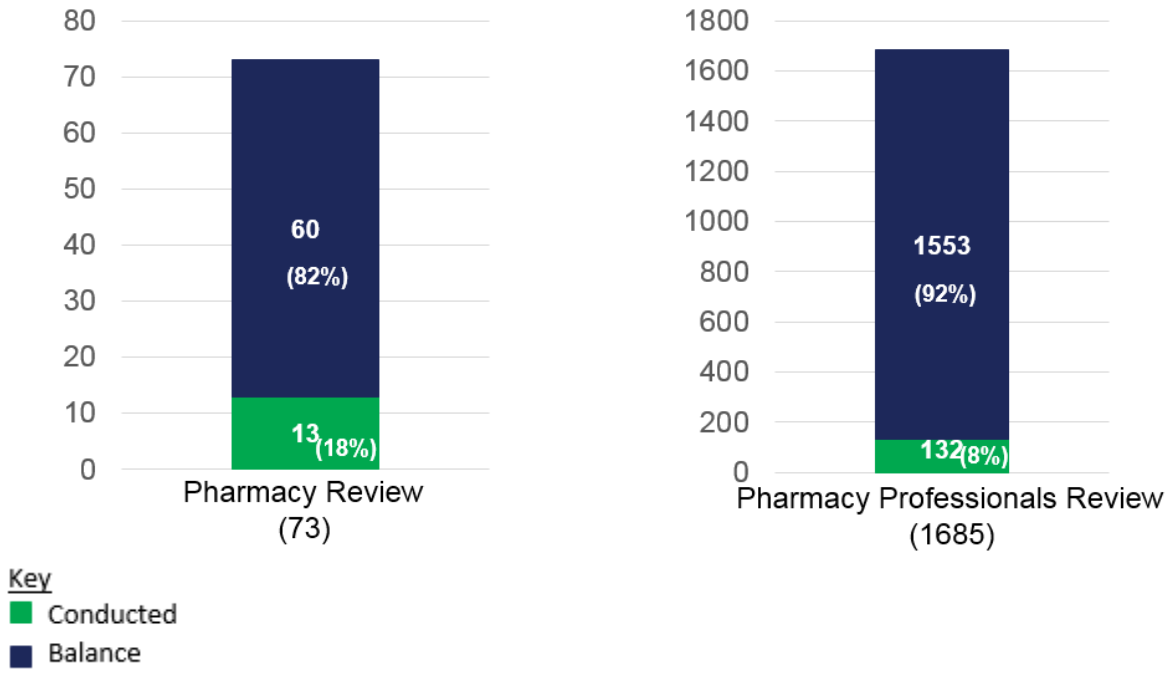
Appendix 2

PRP Phase 2: Hospital Practice Operational Statistics
2017-18 Fiscal Year: March 1st – September 30th, 2017

Fiscal Year Progress:



Overall Progress:



College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.viii. College of Pharmacists of BC Recordkeeping Policy

DECISION REQUIRED

Recommended Board Motion:

That the Board of the College of Pharmacists of BC approves the College of Pharmacists of British Columbia Recordkeeping Policy.

Purpose

To formalize the College's recordkeeping practices in a Recordkeeping Policy.

Background

It is considered best practices to have formal recordkeeping practices that set out the framework for Corporate recordkeeping, the nature and scope of the College's legislated and mandated recordkeeping responsibilities and to outline the various roles and responsibilities.

Discussion

Effective and efficient recordkeeping is essential to ensuring that official records and data with evidential value are created, acquired, captured, managed and secured in trustworthy and accountable repositories.

Successful implementation of this policy will require the development of procedures, guidelines, tips and tricks and will include regular formal and informal training of all involved.

The College has been working on the implementation of an Electronic Records Management software solution, Collabware (a SharePoint add-on) which will be gradually rolled out to all departments. This will automate some aspects of recordkeeping as well as making document searches simpler. It also improves privacy and access rights management.
However, this policy will apply to all recordkeeping, irrespective of format, software, etc.

Key recordkeeping issues addressed in the policy include:

- Identifying and maintaining repositories for records and data to be stored or preserved in a physical or electronic storage space;
- Establishing classification structures and file plans;
- Establishing and implementing retention periods for records and data;
- Managing all records and data with business or evidential value securely in the event of an emergency;
- Identifying and ensuring the appropriate protection and management of records and data containing personal information;
- Performing regular disposition activities for all records and data.

Recommendation

That the Board approves the attached Recordkeeping Policy.

Appendix	
1	College of Pharmacists of British Columbia Recordkeeping Policy

COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA	Policy number	
	Date in effect	
	Version	

Recordkeeping Policy

Approved by

Name(s)	Position(s)	Date Approved
[[to come]]	[[to come]]	[[2017-xx-xx]]

1.0 Overview

1.1 The College of Pharmacists of British Columbia believes that effective and efficient recordkeeping is essential to ensuring its official **records** and **data** with **business and evidential value** are created, acquired, captured, managed, and secured in trustworthy and accountable repositories so that they may be used as strategic assets and as core evidence for the College. The College believes that **information** and evidence are as important as financial or human resources to the successful execution of the College's duties and responsibilities.

1.2 Effective and efficient **recordkeeping** allows the College to: support **accountability** and **transparency** as well as facilitate effective decision making; manage College operations; facilitate the execution of programs and services; authorize and confirm actions, transactions, and decisions; ensure compliance with requirements for accountability, stewardship, evaluation, auditing, access to information, privacy, security, and policy implementation; and preserve the College's institutional memory.

1.3 Records are defined as any documentary material, regardless of form or medium, created or acquired to support the operations of the College. Information resources include textual records (memos, reports, invoices, contracts, etc.), electronic records (e-mails, databases, internet or intranet content, etc.), social media content (instant messages, Twitter messages, wikis, blogs, podcasts, etc.), publications (reports, books, magazines), films, sound recordings, photographs, documentary art, graphics, maps, and artefacts. Data with business and evidential value is included in the definition of records.

1.4 Recordkeeping is undertaken in order to ensure compliance with key government legislation, including but not limited to the Health Professions Act (HPA), Pharmacy Operations and Drug Scheduling Act (PODSA), the Freedom of Information and Protection of Privacy Act (FIPPA) and other laws, bylaws and regulations. Employees of the College will fulfill their legislated responsibilities through effective and accountable recordkeeping.

1.5 Effective and accountable recordkeeping principles and practices are undertaken irrespective of the form or medium of records. The College is responsible for determining the form in which records will be deemed official, whether analog, digital, or another form.

1.6 Information and records systems will be established for ensuring the adequate storage and preservation of accountable, authentic, and reliable information resources with business value, regardless of form or medium.

2.0 Purpose

2.1 The purpose of this policy is to define the nature and scope of the College's legislated and mandated recordkeeping responsibilities and to establish the framework for recordkeeping as an integral component of effective information resource management for the College.

3.0 Scope

3.1 This Recordkeeping Policy applies to all College employees, board and committee members, and consultants and contractors directly responsible for creating, collecting, using, sharing, or managing records or data (regardless of format or medium) with evidential value on behalf of the College.

3.2 Third-party organizations and individuals will abide by this and other College information management policies and recordkeeping requirements as articulated in contracts, agreements, or other instruments.

4.0 Principles

4.1 The College's records, data, and other information sources with business and evidential value will be managed according to internationally recognized recordkeeping standards that support:

- *Accountability:* records and data will be managed to ensure auditability of programs and services.
- *Integrity:* records and data will be guaranteed to be authentic and reliable.
- *Compliance:* records and data will allow the organization to comply with all legal, regulatory, or policy requirements.

- *Protection:* records and data will be securely housed and safe from unauthorized access.
- *Retention:* records and data will be kept for as long as needed for legal, regulatory, fiscal, operational, evidential, and historical requirements, as per approved **retention periods.**
- *Disposition:* records and data will be disposed of securely and in keeping with applicable laws, regulations, and policies.
- *Transparency:* records and information management processes will be documented so that they are understandable and available to all employees and to other appropriate parties.

4.2 To support these recordkeeping standards, the College's recordkeeping program will apply best practice recordkeeping policies, procedures, and systems – such as adhering to approved **classification** schemes, following established requirements for the **disposition** of records, and ensuring the secure storage and preservation of both physical and digital records and evidence – in order to create, acquire, capture, maintain, and protect accurate, authentic, and reliable records, data, and other information sources with business and evidential value for as long as they are required for the purposes of accountability, evidence, or information.

4.3 The College's institutional recordkeeping requirements will be applied consistently, irrespective of the form or medium in which information resources are created, received, used, and stored.

5.0 Policy

5.1 In order to ensure effective and accountable management of records, data, and other information sources with business and evidential value, the College will follow a consistent approach to recordkeeping, drawing on national and international standards and best practices, that is applicable irrespective of the form or medium in which information resources are created, received, used, and stored.

5.2 The College will implement and maintain a formal recordkeeping framework that includes clear well-defined, and accountable policies, procedures, and guidance.

5.3 The College will establish and manage recordkeeping programs and systems that comply with legislation, regulations, and organizational requirements.

5.4 The College's recordkeeping programs and system will include mechanisms for

- identifying, establishing, implementing, and maintaining repositories in which records and data with business or evidential value are stored or preserved in a physical or electronic storage space;
- establishing, using, and maintaining classification structures, file plans, and recordkeeping structures to facilitate the storage, search, and retrieval of records and data in appropriate formats;
- establishing, implementing, and monitoring retention periods for records and data, including retention requirements based on format if appropriate;
- identifying and ensuring the appropriate protection of **vital records** and data as evidence;
- managing all records and data with business or evidential value securely in the event of an emergency;
- identifying and ensuring the appropriate protection and management of records and data containing personal information;
- developing and implementing a formal disposition process for all records and data;
- performing regular disposition activities for all records and data, including documenting disposition decisions and actions as appropriate.

5.5 The College will establish realistic performance goals and effective monitoring and auditing programs for recordkeeping and information resource management.

5.6 The College will develop and disseminate recordkeeping awareness resources and training to provide active support and assistance to College employees.

5.7 The College will ensure its recordkeeping and information resource management programs align with other information management and information technology plans and programs within the College.

5.8 The College will educate all employees, board and committee members, and consultants and contractors about their legislative, regulatory, and organizational responsibilities for recordkeeping and information resource management.

5.9 The College will encourage the use of the most effective and accountable methods for creating, acquiring, and managing information resources, including, as appropriate, undertaking business process analysis or re-engineering to streamline operations, systems, and/or records, data, and information resources.

5.10 The College will document recordkeeping actions and decisions as appropriate in order to maintain accountability and transparency.

5.11 All College employees will manage official records according to the guidance and directives provided as part of the recordkeeping program, in order to comply with this recordkeeping policy.

6.0 Definitions

Item	Definition
Accountability	The state of being liable or answerable for actions, transactions, or decisions.
Business and evidential value	The value of records and data to ensure the successful completion of the organization's functions (business value) or to provide evidence of the organization's activities (evidential value). The ability to ensure records are authentic and reliable is essential to ensure they can be used to further the operations of the organization as well as serve as evidence of the organization's actions, functioning, policies, and/or structure.
Classification	The process of organizing and categorizing records and data according to established criteria, such as functions or activities, in order to manage information resources according to their business value and ensure their appropriate retention and disposition.
Data	One or more elements of raw content, such as letters, numbers or symbols that refer to or represent ideas, objects, events, concepts and things.
Disposition	The process of ensuring that the organization removes from its recordkeeping systems those records or data that no longer have operational value, either by permitting their destruction or by transferring them to archival custody within the College.

Evidential value	*See business and evidential value.*
Information	Data or knowledge that is communicated.
Information management	The discipline that directs and supports effective and efficient management of information in an organization, from planning and systems development to disposal or long-term preservation.
Information resources	Any documentary material produced in published and unpublished form regardless of communications source, information format, production mode, or recording medium. Information resources include textual records (memos, reports, invoices, contracts, etc.), electronic records (e-mails, databases, internet or intranet content, etc.), social media content (instant messages, Twitter messages, wikis, blogs, podcasts, etc.), publications (reports, books, magazines), films, sound recordings, photographs, documentary art, graphics, maps, and artefacts.
Record	Any documentary material, regardless of form or medium, created or acquired to support the operations of the College. Information resources include textual records (memos, reports, invoices, contracts, etc.), electronic records (e-mails, databases, internet or intranet content, etc.), social media content (instant messages, Twitter messages, wikis, blogs, podcasts, etc.), publications (reports, books, magazines), films, sound recordings, photographs, documentary art, graphics, maps, and artefacts. Data with evidential value is included in the definition of records.
Recordkeeping	The framework of accountability and stewardship in which records, data, and evidence are created, acquired, and managed as information assets and knowledge resources to support program and service delivery; foster informed decision making; facilitate accountability, transparency, and collaboration; and are protected and made available for the benefit of present and future generations.
Retention periods	The period of time that information resources should be kept before they can be disposed of legally. The period is established by the Records Management Committee in consultation with departments, and with the advice of external consultants or advisors as appropriate. The time is usually calculated based on the last administrative action performed on or using the information resource and is usually identified in years.

Transparency	The state of being honest and open in actions, transactions, and decisions, in order to bear public scrutiny.
Vital records	Records needed to support recovery after a disaster or emergency or essential to protecting the assets of the organization or demonstrating its responsibilities, protecting its employees, clients, and the public, and supporting the resumption or continuation of business as usual.

7.0 Roles and Responsibilities

Role or Position	Responsibilities
CPBC Board	• As leaders within the College, support the Executive's efforts to foster a culture of accountability across the College in order to support effective and accountable recordkeeping. • Support, approve, and help enforce actions that ensure recordkeeping requirements are incorporated into in the development of the College's priorities, strategic directions, and program objectives. • Support the provision of adequate funding for recordkeeping, in order to comply with legislative, regulatory, and organizational requirements. • As creators and owners of official records, fulfill all the obligations of recordkeeping identified for owners of information resources, including o accepting responsibility as the defined and accountable owners of information resources under their control. o ensuring the information resources under their control and custody are managed for efficiency, accountability, and transparency.

Recordkeeping Policy

Role or Position	Responsibilities
Executive Team	• Foster a culture of accountability across the College in order to support effective and accountable recordkeeping. • Address recordkeeping requirements during the development of the College's priorities, strategic directions, and program objectives. • Ensure adequate funding for institutional recordkeeping, in order to comply with legislative, regulatory, and organizational requirements.
Records Management Committee	• Ensure that recordkeeping policies, procedures, and practices are established, maintained, and updated as required to conform with the College's information management requirements • Report annually to the Registrar on the status of compliance with and implementation of this policy.
Chief Operating Officer	• Enforce and ensure compliance with this and related policies having to do with maintaining an effective, efficient, and accountable information management framework. • Implement recordkeeping policies and processes to ensure information resources are created, used, and managed in accordance with government requirements and national and international standards and best practice. • Define recordkeeping standards and requirements. • Communicate baseline recordkeeping requirements to all staff, board and committee members, and consultants and contractors. • Review all recordkeeping systems, methodologies, and operations for consistency and compliance with standards and requirements. • Ensure employees understand and effectively apply recordkeeping requirements in day-to-day operations and that these responsibilities are included in performance objectives. • Authorize the implementation of recordkeeping measures to ensure compliance with standards and requirements. • May delegate approval authority as appropriate.

Recordkeeping Policy

Role or Position	Responsibilities

Records Management and FOI Coordinator	• Establish and maintain recordkeeping standards, procedures, directives, guidelines, tools, and best practices, including
	  ○ classification structures, file plans, and recordkeeping structures;
	  ○ retention and disposal schedules and processes;
	  ○ identification and protection of vital records;
	  ○ identification and protection of records containing personal information; and
	  ○ formal records disposition processes.
	• Ensure physical and electronic storage spaces for official records comply with information and records management standards and requirements for security, access, and preservation.
	• Address recordkeeping requirements of the College's Business Continuity Plan.
	• Provide recordkeeping training, guidance, and support across the College.
	• Work closely with program and service delivery managers and information owners to ensure recordkeeping requirements are met across the College.
	• Monitor the College's compliance with legislative and regulatory requirements for recordkeeping, information management, and access and privacy administration.
	• Serve as the College's principal recordkeeping contact.

Role or Position	Responsibilities
Management Team	• Work with their staff to identify and manage recordkeeping requirements within their programs or services. • Confirm the ownership of information resources and the delegation of recordkeeping responsibilities within their department. • Incorporate recordkeeping duties into employee job descriptions and work plans to ensure satisfactory compliance with recordkeeping responsibilities. • Ensure employees comply with recordkeeping requirements. • Liaise with the Records Management and FOI Coordinator to address questions about staff compliance with or concerns about recordkeeping.
Owners of information resources	• Accept responsibility as the defined and accountable owners of information resources under their control. • Ensure the information resources under their control and custody are managed for efficiency, accountability, and transparency.
All staff	• Understand and fulfill their responsibilities for creating, managing, and protecting information resources as part of their position within the College. • Abide by the College's information and recordkeeping policies, procedures, and other related documentation. • Report any concerns or incidents affecting information resources to appropriate information management officials, normally through their immediate supervisor.

8.0 Monitoring

The Records Management and FOI Coordinator will report monthly to the Chief Operating Officer on the status of recordkeeping systems and any issues with compliance, and regular reports will be presented at Board meetings.

9.0 Compliance

Violation of this policy may result in disciplinary action, as outlined in Section 6.9 of the Employee Handbook.

10.0 Review and Update

This policy will be reviewed and updated annually, or more frequently if necessary, to ensure any changes to the College's organizational structure and business practices are properly reflected in the policy. College staff will be notified of policy changes.

11.0 Related Policies

Policy	Details
Information Management Policy	
Electronic Recordkeeping Policy	
Email Management Policy	
Archives Policy	
Information Security Policy	

12.0 Revision Log

Version	Date	Section/ Page	Revised By	Description of Change
v.2	2017-08-29	ALL	Laura Millar	Revised and edited for review by CPBC.
v.3	2017-09-25	ALL	Laura Millar	Revised based on inputs provided by the COO and RM/FOI Coordinator.
v.4	2017-10-17	ALL	Laura Millar	Revised based on inputs provided by CPBC staff.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

5.b.x. Proposed Amendments to the *Health Professions Act*

INFORMATION ONLY

Purpose

To outline the amendments to the *Health Professions Act* ("HPA").

Background

The *Health Professions Amendment Act, 2017* (Bill 10) came into force on November 2, 2017. The Act proceeded through the readings in the Legislature quite quickly. On October 24, 2017, it was introduced and first reading was completed.

The *Health Professions Amendment Act, 2017* contains amendments to the HPA, the legislation that provides a common regulatory framework for the governance of health professions in British Columbia, including pharmacists and pharmacy technicians. The HPA also authorizes the College of Pharmacists of British Columbia to create and enforce bylaws and standards of practice.

Discussion

The key amendments to the HPA are summarized as follows:

Allows for Amalgamation of Regulatory Colleges

The amendments allow for any of B.C.'s health profession colleges to amalgamate. The determination of whether to amalgamate colleges is made by the Minister of Health (the "Minister") at the request of a college or on the Minister's own initiative, and with or without an investigation. This change was prompted by a request from three nursing colleges (i.e., College of Registered Psychiatric Nurses of BC, College of Licensed Practical Nurses of BC and College of Registered Nurses of B.C.) to help streamline regulation by allowing them to amalgamate.

Allows for the Appointment of an Administrator for a Health Profession College

The amendments allow the Minister to appoint a public administrator to discharge the powers and duties of a board of a health profession college. This is intended to be a safeguard in the event that a college board is seen to be acting to protect the interest of the health profession instead of the patient. On the appointment of a public administrator, the members of the board cease to hold office unless otherwise ordered by the Minister. The Minister may specify the

powers, duties and responsibilities of a public administrator appointed under this section, or how a board will operate after the appointment of a public administrator has ended.

Allows Infection Control Breaches to be Reported to Public Health Officials in a Timely Manner

The amendments authorize a quality assurance committee, an assessor appointed by that committee or a person acting on behalf of that committee to disclose confidential information for the purpose of reporting to a public health official a significant risk of harm to the health or safety of the public or a group of people. This change is intended to support patient safety, as amendments will ensure that infection control breaches can be reported to public health officials in a timely manner. Currently, while any breach can be reported, it must first go through college investigation processes instead of directly to public health officials.

College of Pharmacists of British Columbia

Board Meeting

Friday, November 17, 2017

CPBC Office, 200-1765 West 8th Avenue, Vancouver

AGENDA

11:15am - 11:45am	30	**1.**	Welcome & Call to Order	Chair Dossa
		2.	Election of Chair **[DECISION]**	Chair
		3.	Election of Vice-Chair **[DECISION]**	Chair
		4.	Audit & Finance Committee - Appointment of Chair and Vice-Chair **[DECISION]**	Chair
		5.	Consent Agenda a) Items for Further Discussion b) Approval of Consent Items **[DECISION]**	Chair
		6	Confirmation of Agenda **[DECISION]**	Chair
11:45am - 12:15pm	30	**7.**	Committee Updates: a) Audit and Finance Committee b) Discipline Committee c) Ethics Advisory Committee d) Governance Committee (Update to included in item 10) e) Inquiry Committee f) Jurisprudence Examination Subcommittee g) Legislation Review Committee (Update to be included in item 8) h) Practice Review Committee i) Quality Assurance Committee j) Registration Committee	Committee Chairs: George Walton Jeremy Walden Sorell Wellon Norman Embree Ming Chang Christopher Szeman Jeremy Walden Kris Gustavson Frank Lucarelli Jeremy Walden
12:15pm - 1:00pm	45		***LUNCH***	
1:00pm - 2:15pm	75	**8.**	Legislation Review Committee: a) Mandatory Medication Error Reporting **[DECISION]** b) Committee Update c) PODSA Bylaws - Owners (Filing) **[DECISION]** d) HPA Bylaws - Board Terms of Office (Filing) **[DECISION]** e) Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine (Amendments to PPP-66) **[DECISION]**	Jeremy Walden Melissa Sheldrick
2:15pm - 2:35pm	20	**9.**	Governance Committee: a) Committee Update b) Application Committee - Appointment of Members **[DECISION]** c) Board Members as Chairs of all Committees **[DECISION]**	Norman Embree
2:35pm - 2:45pm	10		***BREAK***	
2:45pm - 3:00pm	15	**10.**	Change Day BC 2017	Gillian Vrooman
3:00pm - 4:00pm	60	**11.**	Framework for Pharmacist Prescribing in BC **[DECISION]**	Alex Dar Santos & Derek Desrosiers (BC Pharmacy Association) Sahil Ahuja & Michelle Ly (UBC Pharmacy Students Advancing Practice) Dr. Greg Egan (Canadian Society of Hospital Pharmacists) Gillian Vrooman (College of Pharmacists of BC)
4:00pm - 4:15pm	15	**12.**	PODSA Ownership Project - Privacy and Security Update	Doreen Leong
4:15pm - 4:25pm	10	**13**	IT Competitive Bid Update	Mary O'Callaghan
4:25pm - 4:30pm	5	**14.**	Items Brought Forward from Consent Agenda	
			CLOSING COMMENTS, ROUND TABLE EVALUATION OF MEETING, AND ADJOURNMENT	

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

8. Legislation Review Committee
a) Mandatory Medication Error Reporting

DECISION REQUIRED

Recommended Board Motion:

Direct the Registrar to explore potential alternatives to the College's existing quality management requirements, including mandatory medication error reporting to an independent third party.

Purpose

To determine whether the College of Pharmacists of British Columbia (the "College") should explore alternatives to its existing quality management requirements, including a standardized quality management program that includes mandatory error reporting to an independent third party.

Background

The second most common complaint received at the College are ones made in relation to medication dispensing errors by pharmacists.[1] In addition, recent high profile cases of medication errors have prompted the College to examine its existing quality management requirements for registrants.[2] In August 2017, Registrar Bob Nakagawa met with Melissa Sheldrick, an advocate whose son passed away due to a prescription drug dispensing error in Ontario.

[1] College of Pharmacists of B.C. 2015/2016 Annual Report
http://annualreport.bcpharmacists.org/ar2016/wp-content/uploads/2015/05/CPBC_Annual-Report_2016_FINAL_secure.pdf

[2] In March 2016, 8-year old Andrew Sheldrick died after taking a toxic dose of Baclofen that had been dispensed in error by an independent compounding pharmacy in Mississauga, Ontario.
http://www.cbc.ca/news/canada/toronto/go-public-sleep-medication-accidentally-switched-1.3811972;
In October 2016, a pharmacy in Saskatoon provided a 4-year old boy with an antipsychotic drug (Risperidone) that was 10 times the correct dose. The overdose went unchecked and undetected for months with each refill.
http://www.cbc.ca/news/canada/saskatoon/4-year-old-acting-like-a-slobbering-drunk-after-pharmacy-dispenses-wrong-dose-of-antipsychotic-drug-1.3801461

Several provinces in Canada have implemented, or are in the process of implementing, new quality management requirements that include mandatory error reporting to an independent third party. The error reports are submitted anonymously and are analyzed for the purposes of shared learning rather than discipline. Through anonymous reporting, it is hoped that pharmacists will be able to analyze medication incidents and learn about the possible causes of the incidents.

Discussion

Current State

Sections 10 and 14(1) of the Bylaws made under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") requires pharmacy managers of community and hospital pharmacies to develop, document and implement an ongoing quality management program that includes, among other things, a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies. The specific requirements of the program are left to the discretion of the pharmacy manager. The program may or may not include requirements for mandatory reporting of medication incidents to a third party. The College does not assess the adequacy of the program.

The College has some oversight over quality management through its Practice Review Program, an in-person review of pharmacy professionals' practices and the pharmacies where they work. The Practice Review Program is comprised of two components: the Pharmacy Review and the Pharmacy Professionals Review. During a practice review, compliance officers adjudicate compliance with College Bylaws and Professional Practice Policies. Compliance Officers record and document areas of compliance and non-compliance while observing pharmacy professionals throughout the review process. For areas of non-compliance action-items are assigned, if necessary. All pharmacies and pharmacy professionals will be reviewed under Practice Review Program on a cyclical basis.[3]

Interjurisdictional Scan

Several provinces in Canada have implemented, or are in the process of implementing, new quality management requirements that include mandatory error reporting to an independent third party such as the Institute of Safe Mediation Practices Canada ("ISMP"), an independent national not-for-profit organization focused on the advancement of medication safety in healthcare settings. An interjurisdictional comparison of the quality management requirements across Canada is summarized in Appendix 1. In provinces that have adopted new quality management requirements, those requirements are generally more prescriptive than the College's current requirements.

[3] http://www.bcpharmacists.org/practice-review-program

Currently, Nova Scotia is the only province that requires error reporting to an independent third party, ISMP. Saskatchewan and Ontario are proposing to implement new quality management requirements that include mandatory error reporting to an independent third party in 2018. Manitoba began a pilot project with ISMP in September 2017. New Brunswick completed a pilot project with ISMP in 2016, but has not implemented a mandatory error reporting program with an independent third party.

In Saskatchewan, Nova Scotia and New Brunswick, provinces that have completed pilot projects with ISMP, the feedback on this program appears to have been very positive.[4]

Pilot Projects

Nova Scotia

The first pilot project, SafetyNET-Rx, began in Nova Scotia in 2008. The first phase of the pilot project involved 13 community pharmacies in Nova Scotia. At the beginning of the pilot project, pharmacy staff were invited as continuous quality improvement ("CQI") facilitators to attend a training session about quality management, quality related events ("QREs"), and the SafetyNET-Rx program. The SafetyNET-Rx program also included the following: a central anonymous reporting tool to an independent third party database as part of an integrative information system that was used to identify, report, analyze and learn from QREs; quarterly staff meetings to discuss and learn from reported QREs as well as suggest changes to prevent recurrence; and an annual self-assessment tool for evaluating performance on a continual basis, the Medication Safety Self-Assessment. The pilot project covered a 12-month intervention period that ended in June 2009.

Following the completion of the pilot project, SafetyNET-Rx was expanded to 68 community pharmacies across the province, and then further expanded to all community pharmacies. The current program is based on the program used in the pilot project, with some adjustments. The off-site training of CQI facilitators, the self-assessment tool, and the quarterly meetings remained key components of the CQI program, however, changes were made to enhance the online reporting tool and an iPad application was created for the provincial pharmacy inspectors.

---

[4] SafetyNET-Rx: Insights and Lessons Learned From a Pilot Project
https://dalspace.library.dal.ca/bitstream/handle/10222/15805/Deal%2cHeidi%2cMAHSR%2cDec2012.pdf?sequence=1&isAllowed=y;
An Assessment of the COMPASS Quality Improvement Initiative: A Summary of Key Findings
https://scp.in1touch.org/uploaded/web/files/SCPP-COMPASS%20Report-2016-FINAL-%20PHARMV2.pdf;
The Business Case for A Standardized Continuous Quality Assurance Program in Saskatchewan Pharmacies – COMPASS by the Saskatchewan College of Pharmacy Professionals
http://saskpharm.ca/uploaded/web/site/COMPASS_Business_Case_20170206.pdf;
Multi-Incident Analysis on Incidents Involving Patients: Lessons Learned from Provincial Pilot Study
https://www.ismp-canada.org/download/PharmacyConnection/PC2016-LessonsLearnedProvincialPilotStudy.pdf

Saskatchewan

Saskatchewan has completed three phases of its pilot program, COMPASS, which began in 2013. Ten pharmacies participated in the first phase, 87 pharmacies participated in the second phase, and 119 pharmacies participated in the third phase. Program requirements included anonymous reporting of incidents (errors and near misses) to a central database (the Community Pharmacy Incident Reporting program developed by ISMP ("CPhIR")), and the biennial completion of a Medication Safety Self-Assessment. Other program requirements included discussing specific incidents and improvement strategies at continuous quality improvement meetings and designating at least one individual from pharmacy staff to be the quality improvement coordinator. Saskatchewan has proposed full implementation of a new quality management program based on COMPASS in 2018.

New Brunswick

A multi-incident analysis was performed on incidents reported from New Brunswick pharmacies to CPhIR from July 2015 to February 2016. Of the 223 pharmacies in New Brunswick, 82 were enrolled in a complimentary pilot project for the use of CPhIR. The objective of this multi-incident analysis was threefold; first, to understand how and why medication incidents occur; second, to identify the potential contributing factors of these incidents; and third, to provide recommendations to prevent future medication incidents. Based on the analysis, recommendations were developed to improve the medication workflow process, including inventory management, receiving/shelving, prescription order entry, dispensing, compliance packaging, and counselling/pick-up.

Service Providers

ISMP has developed the CPhIR Program to allow community pharmacies to document and analyze contributing factors that may lead to errors in the medication-use system.[5] CPhIR offers community pharmacies a systematic incident reporting tool, an analytical interface which allows users to compare their incident statistics with the national aggregate incident data, and a continuing professional development section dedicated to medication safety. A stated goal of the CPhIR Program is to analyze medication incident reports and develop recommendations for enhancing medication safety in all healthcare settings. Some B.C. pharmacies may already be voluntarily participating in this program.

Pharmapod is a company based in the U.K. and Ireland that provides software for tracking pharmacy medication incidents. Pharmapod states that its system enables pharmacists to systematically record medication-related incidents and risks in practice and carry out effective root-cause analysis. The system analyses the collated data and disseminates the learning back to the profession and to key stakeholders internationally, preventing recurrence of patient harm.

[5] www.cphir.ca

Both ISMP and Pharmapod have expressed interest in working with the College to run a pilot project in B.C.

Options

The Board should determine whether to explore alternatives to its existing quality management requirements. In making this determination, there are several factors to consider, including the following:

- The adequacy of the College's current quality management program.
- The effect of new requirements on pharmacies' and registrants' practices.
- The feasibility of a new quality management program from an operational perspective:
  - The College would need to devote resources into assessing, developing and implementing a new program.
  - If a mandatory error reporting system is implemented, the College may be subject to ongoing costs that must be budgeted for.
  - The College's compliance and investigations staff must determine how to enforce new requirements.

1. **Option 1**

   Do not explore alternatives to its existing quality management requirements at this time.

   <u>Advantages</u>

   - The College would not be required to devote additional resources to this issue, at this time.
   - Initial data from the Practice Review Program is being compiled and have indicated a positive impact on registrants' practice and compliance with College requirements. The College could focus on the development and further implementation of this program, as its key quality assurance program.

   <u>Disadvantages</u>

   - The College could appear to be unresponsive to emerging issues in patient safety.
   - The adequacy of quality management programs in the province may be limited and/or uneven.

2. **Option 2**

   Begin to explore alternatives to its existing quality management requirements.

   Advantages

   - The College will have an opportunity to assess its current requirements, and propose improvements, if necessary.
   - The College may have an opportunity to develop a program to reduce medication incidents and improve patient safety, consistent with its mandate.
   - The College would obtain a better understanding of the resources required for a new quality management program.
   - The College could also conduct engagement on the issue, to obtain a better understanding of stakeholder responses to such an initiative.

   Disadvantages

   - It is not a certainty that new quality management requirements would be an improvement over existing requirements.
   - There may be some negative response from stakeholders, as new quality management requirements might increase the workload for pharmacies and registrants.

Recommendation

The College recommends that the Board choose Option 2 for the following reasons:

- Due to the potentially serious consequences of medication errors, this topic warrants further consideration from College staff and the Board.
- The risk of taking this option is low, in that the College is not required to commit to any program that it explores. Conversely, the risk in not exploring this issue could be a lost opportunity to improve patient safety and respond to concerns from the public.

Appendix	
1	Interjurisdictional scan – Incident reporting

Appendix to Briefing Note – Mandatory Medication Error Reporting (November 17, 2017)

Interjurisdictional Scan – Incident Reporting

Jurisdiction	Provisions	Comments
British Columbia	**PODSA Bylaws** 10. A community pharmacy's manager must develop, document and implement an ongoing quality management program that (a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a community pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the Community Pharmacy Standards of Practice, and (c) **includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies**. 14. (1) A hospital pharmacy's manager must develop, document and implement an ongoing quality management program that (a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a hospital pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the Hospital Pharmacy Standards of Practice, (c) **includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies**, (d) documents periodic audits of the drug distribution process, (e) includes a process to review patient-oriented recommendations, (f) includes a process that reviews a full pharmacist's documentation notes in the hospital's medical records, (g) includes a process to evaluate drug use, and (h) regularly updates policies and procedures for drug use control and patient-oriented pharmacy services in collaboration with the medical and nursing staff and appropriate committees.	No mandatory error reporting to third party.
Alberta	**Standards of Practice for Pharmacists and Pharmacy Technicians** https://pharmacists.ab.ca/sites/default/files/StandardsOfPractice.pdf	No mandatory error reporting to third party.

Jurisdiction	Provisions	Comments
	1.9 Each pharmacist and pharmacy technician must participate in the quality assurance processes required by the Standards for the Operation of Licensed Pharmacies or another workplace quality assurance program applicable to the pharmacists' or the pharmacy technicians' practice. 1.10 A pharmacist who provides patient care in an environment where a quality assurance program does not exist or does not meet the minimum standards established under the Standards for the Operation of Licensed Pharmacies must implement a program that meets or exceeds the requirements outlined in the Standards for the Operation of Licensed Pharmacies. **Standards for the Operation of Licensed Pharmacies** https://pharmacists.ab.ca/sites/default/files/StandardsPharmacies.pdf Standard 6 – Implement a quality assurance program 6.3 A licensee must ensure that a quality assurance process is implemented and maintained in a licensed pharmacy. The quality assurance process should: a) **provide for reporting, investigating, documenting and evaluating drug incidents that occur in the pharmacy**; b) include regular review and feedback mechanisms to prevent drug incidents; and c) include a process or procedure for responding to complaints or concerns. (See detailed requirements in Standard 6)	
Saskatchewan	**The Business Case for a standardized continuous quality assurance program in Saskatchewan pharmacies – COMPASS** (December 2016) https://scp.in1touch.org/uploaded/web/site/COMPASS_Business_Case_20170206.pdf Appendix A Proposed program requirements: 1) **Requires anonymous reporting of quality related events (QREs) to an independent, objective third party organization**: for population of a national aggregate database from which learnings arising from trends and patterns can be communicated across the profession. 2) Requires completion of a medication safety self-assessment biennially.	3-phase pilot project with ISMP completed in 2016. Full implementation of mandatory error reporting to third party in 2018.

Jurisdiction	Provisions	Comments
	3) Requires development and monitoring of the progress of an improvement plan at CQI meetings. 4) Requires CQI meetings to be held for the purpose of providing staff education, discussing of QRE's, completing of the MSSA, and developing and monitoring of the improvement plan. The number of CQI meetings held per year will be determined by the quality assurance coordinator and pharmacy manager in order to meet the above requirements. Recommended to meet no less than annually. 5) Requires documentation of quality improvements discussed at CQI meetings. Discussion and outcomes of the CQI meetings are to be documented using the quality improvement tool in CPhIR. 6) Requires each pharmacy to have designated at least one QI coordinator. Recommend to have two to be co-coordinators but will depend on the size of the safety workload within the pharmacy. Other components of the program: 7) Manages known, alleged and suspected medication errors that reach the patient consistent with the best practices for this activity. 8) Encourages open dialogue on QREs between pharmacy staff and management through review of the pharmacy's aggregate QRE data (e.g. total number of incidents, type of incidents, etc.). 9) Achieves the purposes of an effective CQI program through ongoing education of pharmacy staff on the current best practices in QRE management and adoption of these practices, with the goal of discouraging punitive identification or other approaches that is detrimental to reporting and learning. Service provider: ISMP Canada	
Manitoba	**Pilot Project: Safety Improvement in Quality (Safety IQ) (2017)** http://www.cphm.ca/uploaded/web/Newsletters/Spring%202017/College%20of%20Pharmacists%20of%20Manitoba%20Spring%20Newsletter%202017.pdf • Safety IQ is a standardized continuous quality improvement program that enables community pharmacies in Manitoba to **anonymously report medication errors and near misses, also known as quality related events (QREs) to ISMP Canada**.	One year pilot project with ISMP to begin in September 2017.

Jurisdiction	Provisions	Comments
	• 20 community pharmacies will be participating in pilot project beginning in September 2017.	
Ontario	**NAPRA Model Standards of Practice –** Adopted by Ontario (see provisions below under "NAPRA") **Proposed Continuous Quality Assurance Program** http://www.ocpinfo.com/library/consultations/download/Continuous_Quality_Assurance_Programs_in_Pharmacies.pdf http://www.ocpinfo.com/about/consultations/consultation/implementation-cqa/ • Enable and **require anonymous reporting of all medication incidents by pharmacy professionals to a specified independent, objective third-party organization** for population of an aggregate incident database to identify issues and trends to support patient safety improvement. • Require pharmacy professionals to document appropriate details of medication incidents and near misses in a timely manner to support the accurateness of information reported. • Document CQI plans and outcomes of staff communications and quality improvements implemented. • Necessitate that when a medication incident occurs pharmacy professionals analyze the error in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident. • Require completion of a medication safety self-assessment (MSSA) within the first year of implementation of the Standard, then at least every 2-3 years. The Designated Manager may determine an MSSA is required more frequently if a significant change occurs in the pharmacy. • Analyze individual and aggregate data to inform the development of quality improvement initiatives. • Require prompt communication of appropriate details of a medication incident to all pharmacy staff, including causal factors of the error and actions taken to reduce the likelihood of recurrence. • Ensure the scheduling of regular CQI communication with pharmacy staff to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete an MSSA, and develop and monitor quality improvement plans. • Support the development and monitoring of CQI plans, outcomes of CQI communications and quality improvements implemented. • To be implemented in 2 phases	Proposed standards for mandatory error reporting to third party posted for public comment. Propose full implementation by December 2018.

Jurisdiction	Provisions	Comments
	1st phase: • approximately six to eight months • would involve volunteer pharmacies that are representative of pharmacy practice across Ontario (e.g. independent, chain, rural, urban) and would provide an opportunity to assess the program requirements. 2nd phase: • expand by incorporating the changes and best practices identified by pharmacies in the first phase to improve successful incorporation into pharmacy workflow • full implementation in all pharmacies is expected by December 2018. **Feedback for Implementation of Continuous Quality Assurance for Medication Safety** http://www.ocpinfo.com/about/consultations/consultation/implementation-cqa/feedback/#read	
New Brunswick	**NAPRA Model Standards of Practice –** Adopted by New Brunswick (see provisions below under "NAPRA") **Regulations of the New Brunswick College of Pharmacists** https://nbcp.in1touch.org/document/1733/2015%2007%2023%20REGS%20bilingual.pdf 14.2 On or before December 31, 2015, the manager must implement a documented, ongoing quality management program that includes, but is not limited to, monitoring staff performance, equipment, facilities, and adherence to Standards of Practice, including the following: (a) **a process for documenting and reporting known, alleged and suspected medication errors, discrepancies, near misse**s and the steps taken to resolve the problem; (b) provisions to protect the confidentiality of information relating to clients. **Results of Pilot Study with ISMP Canada (2016)** https://nbcp.in1touch.org/document/1733/2015%2007%2023%20REGS%20bilingual.pdf	Pilot study with ISMP Canada completed in 2016. No mandatory error reporting to a third party.
Newfoundland and Labrador	**Standards of Pharmacy Practice – Standards for Hospital Pharmacies** http://www.nlpb.ca/media/SOPP-Hospital_Pharmacy-June2007.pdf 5.8.1 The pharmacy department shall participate in a medication incident and medication discrepancy reporting program.	No mandatory error reporting to third party.

Jurisdiction	Provisions	Comments
	5.8.2 **There shall be written policies and procedures to report, document, analyze and follow-up medication incidents and medication discrepancies**. 5.8.3 A written report shall be prepared for the designated hospital committee(s) describing medication incidents and medication discrepancies occurring in prescribing, dispensing or administration of a medication. **NAPRA Model Standards of Practice –** Adopted by N.L. (see provisions below under "NAPRA")	
Nova Scotia	**Pharmacy Practice Regulations made under Section 80 of the *Pharmacy Act*** https://novascotia.ca/just/regulations/regs/pharmprc.htm 22 (1) Every pharmacy manager shall establish and maintain a continuous, documented quality assurance program according to the standards of practice that monitors staff performance; adequacy of staff levels; equipment and facilities; and adherence to standards of practice. (2) The quality assurance program shall include a process for documenting, reporting and analyzing known, suspected, intercepted and corrected medication errors and discrepancies, and the steps taken to resolve the problems and prevent their recurrence. (3) The quality assurance program must demonstrate how the analysis of known, suspected, intercepted and corrected medication errors and discrepancies and regular pharmacy self-assessment has been acted upon to improve the quality of patient care. (4) The quality assurance program shall include provisions to protect the confidentiality of information relating to specific patients. **Standards of Practice: Continuous Quality Assurance Programs in Community Pharmacies** http://www.nspharmacists.ca/wp-content/uploads/2017/04/StandardsOfPractice_ContinuousQualityAssurance_Jan2010.pdf A CQI process that fulfills a pharmacy's legislated requirements as set out in the Practice Regulations achieves the following: 1) Monitors staff performance, equipment, facilities and adherence to standards of practice.	Currently, the only province with mandatory error reporting to third party.

Jurisdiction	Provisions	Comments
	2) Manages known, alleged and suspected medication errors that reach the patient consistent with the best practices for this activity undertaken by others in the profession, including: i. Taking appropriate and necessary action to optimize patient care, including prompt consultation with the patient's other health care provider(s) for determination of appropriate action to minimize negative impact on the patient. ii. Ensuring the management of error process is appropriately communicated to the patient. iii. Ensuring the management of error minimizes undue stress and frustration for the patient. iv. Ensuring the management of error should include an apology (as enabled by the Apology Act) in which the pharmacist acknowledges the negative impact to the patient, and commits to taking the steps appropriate to minimize the likelihood of recurrence of the incident. v. Promptly analyzing the error for causal factors. vi. Communicating to the patient the causal factors of the error when appropriate, and actions taken to reduce the likelihood of recurrence. vii. Documenting the details of the known, alleged or suspected error or discrepancy promptly and thoroughly, including statements from all pharmacy staff involved and the steps taken to resolve the problem. viii. Communicating to all pharmacy staff the appropriate details of the error, including the causal factors of the error and actions taken to reduce the likelihood of recurrence. 3) Enables and requires **anonymous reporting of quality related events (QREs) to an independent, objective third party organization** for population of a national aggregate database from which learnings arising from trends and patterns can be communicated across the profession. (NOTE: QREs include errors that reach the patient as well as those that are intercepted prior to dispensing. The extent to which intercepted errors are reported will be a professional judgment decision of the pharmacy manager in consideration of the nature of the intercepted error, its implication for patient safety and the extent to which it is recurring). 4) Encourages open dialogue on QREs between pharmacy staff and management through quarterly review of the pharmacy's aggregate QRE data (e.g. total number of incidents, type of incidents, etc.).	

Jurisdiction	Provisions	Comments
	5) Documents quality improvements made as a result of the quarterly CQI meetings of staff. 6) Requires completion of a medication safety self-assessment annually, and monitoring the progress of the resulting enhancement plan at quarterly CQI meetings. 7) Includes provisions to protect the confidentiality of information relating to specific patients. 8) Achieves the purposes of an effective CQI program as described at the beginning of this document through ongoing education of pharmacy staff on the current best practices in QRE management and adoption of these practices, with the goal of discouraging punitive identification or other approaches that are detrimental to reporting and learning. Service Provider: ISMP	
Prince Edward Island	**NAPRA Model Standards of Practice –** Adopted by P.E.I. (see provisions below under "NAPRA")	No mandatory reporting to third party.
NAPRA	**NAPRA Model Standards of Practice** http://napra.ca/Content_Files/Files/Model_Standards_of_Prac_for_Cdn_Pharm_March09_Final_b.pdf Part 3 Pharmacists regardless of the role they are fulfilling: 10. manage errors, incidents and unsafe practices (2.6) 11. promptly disclose alleged or actual errors, incidents and unsafe practices to those affected and in accordance with legal and professional requirements (2.6) 12. **record and report alleged and actual errors, incidents and unsafe practices in accordance with legal and professional requirements** (2.6) 13. adhere to applicable laws, regulations and policies applicable to pharmacy practice (3.1) Pharmacists, when providing patient care: 14. **report the occurrence of adverse events and close-calls** (2.6) (Close calls are defined by the Canadian Patient Safety Institute as events with the potential for harm that did not result in harm due to timely intervention or good fortune.) Pharmacists, when managing a pharmacy:	Standards require error reporting, but do not require error reporting to third party.

Jurisdiction	Provisions	Comments
	15. review errors and incidents to determine patterns and causal factors that contribute to patient risk (2.6) 16. develop and implement policies and procedures that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events and close-calls (2.6)	

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

8. Legislation Review Committee
b) Committee Update

INFORMATION ONLY

Purpose

For the Committee Chair to provide an update on the Legislation Review Committee.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

8. Legislation Review Committee
c) PODSA Bylaws - Owners (Filing)

DECISION REQUIRED

Recommended Board Motions:

(1) Approve the following resolution to amend the Pharmacy Operations and Drug Scheduling Act Bylaws, which operationalize recent amendments made to the Pharmacy Operations and Drug Scheduling Act and to approve consequential amendments to telepharmacy bylaws (including a form and schedules), to be effective with the amendments to the Act:

RESOLVED THAT, *in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws (including forms and schedules) of the College of Pharmacists of British Columbia, as set out in the schedules attached to this resolution.*

(2) Approve a new Professional Practice Policy 76 – Criminal Record History Vendor, to be effective at the same time as the bylaws come into force.

(3) Approve consequential amendments to the following Professional Practice Policies, to be effective at the same time as the bylaws come into force:

- PPP-3 Pharmacy References
- PPP-12 Prescription Hard Copy File Coding System
- PPP-46 Temporary Pharmacy Closures
- PPP-54 Identifying Patients for PharmaNet Purposes
- PPP-59 Pharmacy Equipment
- PPP-65 Narcotic Counts and Reconciliations
- PPP-73 Validate Identification and College Registration Status for New Pharmacy Hires
- PPP-74 Community Pharmacy Security

Purpose

To consider approval of the following:

- Amendments to the *Pharmacy Operations and Drug Scheduling Act* (PODSA) Bylaws (including forms and schedules) regarding pharmacy ownership and consequential amendments to previously filed telepharmacy bylaws (including a form and schedules), for filing with the Ministry of Health (MOH);
- A new Professional Practice Policy (PPP) 76 – Criminal Record History Vendor, which requires Board approval only; and,
- Consequential amendments to eight PPP's as a result of PODSA-Bylaw re-numbering, which requires Board approval only.

Background

In May 2016, the Provincial Government approved amendments to the *Pharmacy Operations and Drug Scheduling Act* (Bill 6)[1].

The amendments considerably change pharmacy ownership legislation. Some of the key changes include authorizing the College to:

- Identify pharmacy owners, including non-registrants;
- Determine pharmacy owners' suitability for pharmacy ownership; and
- Hold pharmacy owners accountable for providing safe and effective care, and ensuring that their pharmacies are compliant with legislative requirements.

To operationalize the amendments to the Act, the College developed corresponding bylaws. The proposed bylaws include licensure requirements for a new pharmacy licence application, renewal of a pharmacy licence and re-instatement of a licence.

Also included in the proposed bylaws are transitional provisions for all existing pharmacies to bring them into compliance with the new requirements.

During the drafting phase of the bylaws College staff engaged with pharmacy owners, managers, the BC Pharmacy Association (BCPhA), the Neighborhood Pharmacy Association, the MoH, hospitals and pharmacy education sites.

At their June 2017 meeting, the Board approved the public posting of the proposed bylaws for a 90-day period (See Appendix 1 for the June 2017 Board meeting note).

[1] https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/5th-session/bills/amended/gov06-2

Discussion

Public Posting of Proposed Bylaws

The proposed bylaws were publicly posted for a 90-day period on the College's website, which ended on September 23, 2017. During the public posting period, seven letters of feedback were received (See Appendix 2). These responses were from:

- BCPhA;
- Chain Drug Association of BC;
- London Drugs; and
- Four registrants.

Two of the letters of feedback received were related to the amendments to the Act and not the proposed bylaws. The content of the letters from the BCPhA, Chain Drug Association of BC and London Drugs were very similar.

Of the draft new or amended provisions within the proposed bylaws, comments were received on twelve provisions (see Appendix 3 for an overview of all feedback received and College responses[2]).

In general, the concerns with the proposed bylaws were minor in nature. A common concern, which was raised in the letters from London Drugs and a registrant, was regarding the scope of the criminal record history (CRH) check in the bylaws. The feedback indicated that the bylaws should list specific offences that would be considered in determining an owner's eligibility to hold a pharmacy licence.

The amendments to the Act determine that no direct owner, indirect owner or manager has within the previous 6 years have been convicted of an offence under the *Criminal Code*[3]. Furthermore, the amendments to the Act allow the College to determine what CRH information is considered relevant to pharmacy ownership[4]. However, staff do not recommend amendments to the proposed bylaws to set out a list of specific relevant offences at this time. The Application Committee is a new committee also created by the Act amendments, which has the authority to issue, renew and reinstate pharmacy licences referred to it, as well as attach limits and conditions to them, amongst other authorities. Developing a list of relevant offences that will impact a pharmacy licence would be pre-mature and limiting, as the Application Committee has not yet begun to carry out its duties. The College intends to monitor this issue

[2] Please note that the feedback from the two letters received, which were not related to the proposed bylaws, has not been included in Appendix 3.
[3] Section 3(f), https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/5th-session/bills/amended/gov06-2
[4] Section 5.1, https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/5th-session/bills/amended/gov06-2

and review the decisions of the Application Committee, once established. Staff intend to use this analysis to work with the Application Committee and develop a list of relevant offences which may impact a pharmacy licence.

Recommended Minor Amendments

The additional minor amendments recommended to the proposed bylaws, forms and schedules by staff are summarized in the sections below.

Recommended Minor Amendments to Bylaws:
The BCPhA, Chain Drug Association of BC and London Drugs recommended the addition of three definitions to the definitions section of the bylaws for additional clarity as well as some minor wording changes to the roles and responsibilities of direct owners, directors and officers. As a result, the definitions of "Central Securities Register", "British Columbia Company Summary" and "pharmacy" (from the Act) are included in the revised bylaws. Also, the roles and responsibilities of direct owners, directors and officers are amended to use language such as "ensure compliance" as opposed to "must comply with". Most of the minor language suggestions from the feedback were accepted, as they are in line with the oversight role that owners (direct and indirect) have in pharmacies (e.g., to ensure that certain things are done, etc.).

Recommended New Proposed Bylaws:
The letters from the BCPhA, Chain Drug Association and London Drugs raised an issue of "technical cancellations". For instance, under the amendments to the Act, a pharmacy licence could be cancelled and operation of the pharmacy prohibited if the manager or direct owner ceases to be eligible or if the location changes. In most cases, there will be time to provide notice and effectively make the changes required, but there could be instances were changes must occur without notice (e.g., a direct owner receives a criminal conviction and this is reported to the College).

In such instances, since there are no provisions in the Act or bylaws to address these situations where a direct owner ceases to be eligible within the 12 month licence period, the pharmacy would not be able to operate until the direct owners eligibility is assessed by the Application Committee. College staff and legal counsel reviewed this issue and drafted proposed bylaws to address the "technical cancellation" of a licence as this could impact the delivery of pharmacy services and continuity of care. The new proposed bylaws propose that, the Application Committee consider situations where the direct owner ceases to be eligible, to authorize the continued operation of the pharmacy in certain circumstances (e.g., if a criminal charge wasn't relevant to pharmacy ownership and there is no risk to public safety).

In the letter from London Drugs concerns were raised with the sensitivity of the information being collected by the College through the application/renewal process, with particular reference to criminal record history checks. In addition to privacy and security activities conducted by the College to ensure the security of information collected, new bylaws have also

been drafted to speak to the College's use, disclosure and retention of CRH information. Also, a definition of "criminal record history" has been drafted to provide transparency on the source of information collected in a CRH check.

Recommended Minor Amendments to Forms:
Minor changes are proposed to a number of forms resulting from staff review. These changes are informed by the on-going work of operationalizing changes (e.g., completing 'to-be' process flows, IT changes, etc.) needed to implement the new requirements.

A summary of these changes is included in the table below:

Recommended Change to Form(s)	Rationale
Amend all forms with "Proposed Opening Date" to "Proposed Licensure Date".	A proposed licensure date is a more static date as issued by the College whereas, a proposed opening date is more subject to change due to factors outside of the College's control.
Add a new field to forms related to community pharmacies to include the issued "Store # (if applicable)".	For pharmacy chains such as Shoppers Drug Mart, PharmaSave, London Drug etc. the operating name includes the store number. This field will prompt such pharmacies to include this number.
Add a new field to Form 8F- Application for Change of Location to include the "Expected Closing Date".	Knowing the "Expected Closing Date" of the pharmacy enables staff to advise the pharmacy that if there is a significant gap between the "Expected Closing Date" and "Expected Opening Date" all drugs and patient records must be secure in the interim.
Remove all bylaw references from Form 10- Pharmacy Pre-Opening Inspection Report.	To avoid duplicating bylaws in the Form.

Removal of Schedule "C" Community Pharmacy Diagram and Photos/Videos:
No feedback was received on the publicly posted schedules. However, as a result of staff and legal counsel review it is recommended that the proposed Schedule "C" be removed as this schedule is duplicative of existing bylaw and policy requirements. This was a new schedule that outlined applicable physical requirements already existing in bylaw and policy requirements which need to be included in pharmacy diagrams and photos/videos during the licensure process. Rather than file this schedule, staff recommend that it become an operational checklist which would be posted on the College's website as a resource tool for managers and owners. To capture the policy intent of the bylaws more clearly, staff and legal counsel have amended the proposed bylaws that previously referenced this schedule, to clarify that diagrams and photos/videos must demonstrate compliance with physical requirements in the bylaws and applicable policies.

Please see Appendices 4 and 5 for updated revised versions of the bylaws and forms.

College staff have liaised with the MoH on the above-noted minor and additional amendments, and understand that they do not require holding a second public posting. This is due to the changes being considered minor in nature and not deviating significantly from the original policy intent.

New Professional Practice Policy

The amendments to the Act, give the College bylaw making authority to determine the form (source) by which a CRH must be submitted. Accordingly, the proposed bylaw was drafted and publicly posted:

- A direct owner, indirect owner(s) and a manager must submit a criminal record history pursuant to section 5.1 of the Act, in the form approved by the board from time to time.

As noted in the June 2017 Board meeting materials, the College will use an external vendor, Sterling Talent Solutions, to conduct CRHs. Rather than adopt this vendor via bylaw, a new Professional Practice Policy (PPP) was drafted to adopt it. This PPP is included in this package for the Board's approval (see Appendix 6).

Adopting the vendor via PPP, rather than bylaw, allows for prompt changes if needed (for instance, if the vendor ceased to provide CRH services in the future, etc.) and will have minimal impact on the licensure process. This is because a bylaw change can take up to one year to complete whereas a PPP can be amended by the Board at any time.

Consequential Amendments to Existing PPP's, Filed Telepharmacy Bylaws, Schedules and Form

As there are a number of new bylaws that have been added to the existing PODSA bylaws document, and due to re-organizing existing requirements to align with the new licencing requirements in the amendments to the Act, the entire document has been re-numbered. Therefore, all existing PPP's, two filed schedules and one form to the bylaws, which reference PODSA bylaws were consequentially amended to reflect the new numbering of bylaws (see Appendix 7 and 8).

In addition, the telepharmacy bylaws approved by the Board at its September 2017 meeting, and are expected to be in effect on November 14, 2017, have been amalgamated into the proposed bylaws. The amalgamated bylaws required minor amendments in language for consistency purposes. For instance, changing "owner" to "direct owner" to reflect the amendments to the Act.

In future amendments to the PODSA bylaws, it is recommended that the telepharmacy Schedule "C" be repealed (requires public posting) and Schedule "E" and Form 11 be amended

as they duplicate existing bylaws. Schedule “C” should also become an operational resource tool for telepharmacy managers and operators.

Next Steps

Bylaws, Forms and Schedules:
As per section 21(4) of PODSA, bylaws must be filed with the Minister of Health. The amended bylaws will come into effect 60 days from the date the bylaws are sent to the MoH. The College has also been working closely with the MoH to align the effective dates of the Act changes and bylaws to be March 1, 2018 (subject to change). Therefore, if approved by the Board, these bylaws will not be sent to the MoH immediately as doing so would make the bylaws in effect sooner than the anticipated effective date of the Act. Instead the MoH will advise the College of the effective date of the Act (which requires Cabinet approval) once they are officially able to do so, and these bylaws will then be sent for filing accordingly.

PPP’s:
The Board has the authority to approve and amend PPPs. As such, if approved by the Board, PPP 76 – Criminal Record History Vendor and consequential amendments to the PPP’s, will also be in effect when the bylaws come into force.

Recommendation

The Legislation Review Committee recommends that the Board approve the amendments to the PODSA bylaws in Appendix 4, approve consequential amendments to filed telepharmacy bylaws (including a form and schedules) in Appendix 8 and approve the schedules to the resolutions in Appendix 9, all for filing with the MoH. Additionally, that the Board approves a new PPP 76 – Criminal Record History Vendor and consequential amendments to eight PPP’s (PPP- 3, 12, 46, 54, 59, 65, 73 and 74).

Appendix	
1	June 2017 Board Meeting Note (not including appendices)
2	Feedback Received During the Public Posting Period
3	Summary and Responses of Public Posting Feedback
4	Revised PODSA Bylaws
5	Revised Forms under PODSA Bylaws
6	PPP-76 Criminal Record History Vendor
7	Consequential Amendments to Existing PPP’s
8	Consequential Amendments to Telepharmacy Schedules “C”, “E” and Form 11
9	Schedules to the Resolution

College of Pharmacists of British Columbia

BOARD MEETING
June 23, 2017

6. Legislation Review Committee
a. PODSA Bylaws – Public Posting (Owners)

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 21(8) of the Pharmacy Operations and Drug Scheduling Act, the Board approve the proposed draft bylaws of the College of Pharmacists of British Columbia along with the related forms and schedules for public posting, which operationalize recent amendments made to the Pharmacy Operations and Drug Scheduling Act.

Strategic Plan Goal One: Legislative Standards and Modernization
The 2017 Strategic Plan includes a goal to modernize the suite of legislative requirements under the *Pharmacy Operations and Drug Scheduling Act* (PODSA) and the *Health Professions Act* (HPA). Phase one of this goal involves developing and implementing bylaws to operationalize the recent changes enacted by the Provincial Government regarding pharmacy ownership provisions under PODSA.

Purpose
To seek approval from the Board to publicly post draft amendments to the bylaws, forms and schedules under PODSA, as circulated, for a period of ninety days.

Background
In May 2016, the Provincial Government approved amendments to PODSA (Bill 6)[1]. The amendments include significant changes regarding pharmacy ownership provisions.

[1] https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/40th-parliament/5th-session/bills/amended/gov06-2

Specifically, the changes permit the College to know the identity of all pharmacy owners (including non-registrants), determine their suitability for pharmacy ownership, and hold them accountable for providing safe and effective care by ensuring their pharmacies are compliant with legislative requirements for pharmacies in BC.

The key amendments to PODSA include:

- Distinguishing between "direct owners" and "indirect owners";
- Broadening the meaning of "pharmacy" and "pharmacy licence";
- Harmonizing requirements and processes for issuing, renewing and reinstating a pharmacy licence;
- Setting eligibility requirements to hold a pharmacy licence;
- Establishing a new Application Committee to review licence applications that do not meet the requirements of the Act and bylaws;
- Clarifying that ownership of a pharmacy must be direct;
- Adding requirements for direct owners, indirect owners and managers to provide a Criminal Record History;
- Requiring direct owners, indirect owners and managers to comply with duties under PODSA and HPA; and
- Requiring direct owners, indirect owners and managers to give notice to the Registrar if certain events occur.

A more a detailed summary of the PODSA amendments can be found on the College website[2].

The PODSA amendments are not yet in force. The College has been working with the Ministry of Health (MoH) to align the effective date with the implementation of the corresponding bylaws. As a result, these new requirements and bylaws are scheduled to come into effect on March 1, 2018. This date has been communicated by both the Minister of Health and the Registrar of the College[3].

It is important to note that the amendments to PODSA are set by the Provincial Government and any further amendments to that Act would follow the standard provincial legislative process. The draft PODSA bylaws, which are included for the Board's approval for public posting purposes, aim to operationalize the amendments to the Act.

[2] The College developed a dedicated resource page on its website to assist managers, direct owners and indirect owners in understanding both the amendments and corresponding draft bylaws. This website can be accessed via the following link: http://www.bcpharmacists.org/ownership

[3] http://www.bcpharmacists.org/news/new-requirements-pharmacy-ownership-begin-march-1-2018

Discussion

As previously noted, College staff have been developing bylaws to operationalize the recent PODSA amendments. These bylaws are included in Appendix 1 for the Board's approval for public posting purposes.

Overview of the Proposed PODSA Bylaw Amendments

Licensure Requirements (New, Renewal and Reinstatement)

At their April 2017 Board meeting, a presentation provided the Board with the key amendments to PODSA. This presentation included the new licensure requirements that are set out in these proposed draft PODSA bylaws. This presentation is included in this briefing package attached in Appendix 2.

The PODSA amendments and the proposed changes to the PODSA bylaws will require that as of March 1, 2018, all managers, together with direct and indirect pharmacy owners, must meet new eligibility requirements (see section titled "Eligibility" below). The PODSA changes will also require the direct owner of the pharmacy to apply for a new pharmacy licence or pharmacy licence renewal, whereas in the past this was required to be completed by managers.

New Application

The changes to PODSA state that different individuals or organizations (e.g., a corporation, a health authority, a pharmacist, etc.) are permitted to be a direct owner of a pharmacy. The type of pharmacy ownership will determine what information will be required for a new pharmacy application, according to the proposed PODSA Bylaw amendments. For example, the most common direct owner of a pharmacy is a corporation. For corporations, a copy of the BC Company Summary (amongst other documents) will be required to provide the College with details of the corporation's ownership.

The draft bylaws also include other application requirements, such as photographs or videos, to confirm how the proposed site meets the College's pharmacy premise requirements. These other application requirements have been requested as operational documents in the past, but were not formal bylaw requirements. The College is now strengthening these requirements by incorporating them into the bylaws.

Renewal

The draft bylaws also set out the information required for pharmacy licence renewals.

A transitional provision has been incorporated to help ensure that existing pharmacies meet the new requirements. During the transition period, pharmacy renewals will require more thorough information (e.g., evidence of eligibility, etc.) from applicants. This process aligns with the regular annual pharmacy licence renewal process.

Following the transition period, the process for pharmacy licence renewals will be simplified. Post the transition period, direct owners, indirect owners and managers will only be required to review and update pharmacy ownership information that has changed, and attest to still meeting the eligibility requirements.

Reinstatement

Provisions regarding the reinstatement of a pharmacy licence have been introduced with the amendments to PODSA. A licence can now be reinstated if it has been expired for 90 days or less. Therefore, new bylaws regarding the information needed to process such applications have been drafted.

Eligibility

The amendments to PODSA define the eligibility criteria to hold a pharmacy licence. With these amendments, the College will have the authority to refuse to issue, renew or reinstate a pharmacy licence, or impose conditions on a licence if pharmacy owners or the pharmacy manager do not meet the eligibility criteria.

Below are some examples of the criteria that would make an ownership application ineligible, or may require that conditions be imposed:

- Owner/manager is subject to a limitation imposed by the discipline committee that precludes them from being an owner or manager
- Owner/manager within the previous 6 years, has been convicted of an offence under the Criminal Code
- Owner/manager within the previous 6 years, has been convicted of an offence prescribed under the *Pharmaceutical Services Act*,
- Owner/manager has been subject to an information or billing contravention,
- Owner/manager, within the previous 6 years, has had their registration as a pharmacist suspended or cancelled

If the Registrar deems that an applicant for a pharmacy licence does not meet the eligibility criteria, then the application must be referred to the Application Committee. The Application Committee will review and determine whether or not to issue, renew or reinstate a licence with

or without conditions. Bylaws establishing the Application Committee were approved by the Board at the April 2017 Board meeting for filing (see Appendix 3 for more information on this Committee).

Criminal Record History

The amendments to PODSA will require pharmacy owners to complete a criminal record history during the pharmacy licencing process. The amendments to PODSA require that no direct owner, indirect owner or manager has, within the previous 6 years, been convicted of an offence under the *Criminal Code* (Canada). In order to assess this, the College will be using an external vendor, Sterling Talent Solutions (formerly known as BackCheck), to conduct a criminal record history (CRH) check on applicants for a history of charges and convictions. This CRH will be valid for 5 years from the date it was last provided. After this time, another CRH will be required from the direct owner, indirect owner and manager.

The CRH is different from a criminal record check (CRC), which is a requirement under the *Criminal Records Review Act* (CRRA) for all registrants (pharmacists and pharmacy technicians) of a College under the *Health Professions Act*. Firstly, as noted above, the CRH is required for owners (pharmacists and non-pharmacists) and managers, whereas the CRC is only for registrants. Secondly, the CRC is a review of only specific sections of the *Criminal Code*, as specified in the CRRA. As a result, the scope of this CRC is narrower than the eligibility criteria in the PODSA amendments for direct owners, indirect owners and managers. Resulting from these differences, it is important to note that College registrants who are also pharmacy owners and managers, will be required to complete both a CRC and CRH.

Forms

A number of forms that are required in the draft bylaws have also been developed (see Appendix 4). These forms include the information required in the amendments to PODSA and the draft bylaws. These forms are subject to the legislated ninety-day public posting period.

Fee Schedule

The fee schedule in the PODSA bylaws has been amended to list fees referenced in the draft bylaws that are not already listed (see Appendix 5). The referenced fees that were added include a re-instatement fee and fees related to changes to the pharmacy premise, name and indirect owner or manager. The fee for each of these additions would be $0.00 for now, as the cost for administering the new requirements has been incorporated into the application fee (the application fee was previously increased in the 2017 budget).

PODSA requires that a new pharmacy licence is required, when a change to direct owner is made. So, the applicable fee for a new licence (i.e., an annual licence fee and application fee) was added to the 'Change of Direct Owner' line item in the fee schedule. While this is a new line item, the College previously required the applicable fee for a new licence, when ownership changes were made.

The above-noted proposed amendments to the fee schedule are subject to a legislated ninety-day public posting period.

Housekeeping Amendments

In addition to drafting new requirements pertaining to the amendments to PODSA, the existing licensure bylaws were re-organized and clarified to make them more coherent. For example, specific requirements for community and hospital pharmacy diagrams are outlined in two new schedules (see Schedule C and D in Appendix 6). As a result, the PODSA bylaws have significantly changed and during the filing stage of the bylaw amendment process, and the entire PODSA bylaws document will be repealed and replaced.

Linkages with the Ministry of Health

In developing these bylaws, College staff worked closely with the MoH as similar requirements regarding ownership were recently brought forward in the Provider Regulation under the *Pharmaceutical Services Act* (PSA). The Provider Regulation gives the MoH the authority to review applications for provider[4] enrollment with the provincial PharmaCare Program. As part of this process, all applications for provider enrollment are reviewed to determine the eligibility of an applicant based on set requirements and criteria in the legislation. The Pharmacare provider application process is similar to what the College will be required to do when the new PODSA amendments take effect. Further, some of the information that the College will be requesting from pharmacy applicants is currently being requested by MoH as part of the Pharmacare enrollment process. Given these similarities, efforts are underway to streamline the two processes, where synergies exist, through an Information Sharing Agreement (ISA) between the College and the MoH. This ISA has not yet been approved.

[4] A provider is a site (e.g., pharmacy, device provider) that is enrolled in PharmaCare for the purpose of receiving payment.

Legal Consultations

In addition to working with multiple College departments and external legal counsel, College staff also consulted with legal counsel with specific expertise in corporate matters. Legal counsel reviewed the corporate documents required in the draft bylaws to ensure that the documents noted are appropriate and capture the desired information. Furthermore, a privacy consultant, David Loukidelis, the former Information and Privacy Commissioner of BC, was also consulted. Mr. Loukidelis reviewed the College's existing privacy bylaws, privacy legislation and the information the College will be collecting through the draft bylaws, to provide advice and will further be developing a privacy impact assessment.

Stakeholder Consultations

To date, the College has engaged with pharmacy owners, managers, the BC Pharmacy Association, the Neighbourhood Pharmacy Association, Hospitals and Pharmacy Education Sites through workshops, discussions and an online survey to seek their feedback. Two in-person meetings (with teleconference availability) with the BC Pharmacy Association and Neighbourhood Pharmacy Association were held, and an in-person workshop (with teleconference availability) was held with pharmacy managers and owners. Additionally, an online survey was sent out to pharmacy managers and owners on the draft provisions. A report summarizing these engagements has been prepared and attached in Appendix 7.

Many of the comments received during these consultations were operational in nature and did not require modifications to the draft bylaws. However, the feedback has been very helpful in developing the operational processes and information technology enhancements for the new requirements, which are currently underway. For example, comments have been received regarding owners of multiple pharmacies, to see if they would be able to submit the new eligibility information at one time, instead of waiting for each pharmacy renewal date. These types of operational concerns are being considered by College staff, but do not require amendments to the bylaws.

College staff did make some revisions to the draft bylaws based on feedback received during the consultations. A key example of this is regarding the roles and responsibilities of direct and indirect owners. These responsibilities were revised to be more proportionate to the level of control/involvement they have in the day to day operations of a pharmacy.

Most commonly, stakeholders raised concerns about the new CRH process. At times, stakeholders were not sure which type of charges or convictions are covered under Canada's *Criminal Code*. The feedback suggested that the bylaws include a list of specific offences that

would result in a pharmacy licence application to be provided to the Application Committee (e.g., the owner or pharmacy manager would be considered ineligible to own or manage a pharmacy, respectively). However, the draft bylaws do not specify the exact list of charges and convictions, as the eligibility criteria is outlined in the PODSA amendments. The College is working to provide further clarification on this issue via communications tools.

Next Steps

College staff are continuing to work on the operational changes (e.g., completing 'to-be' process flows, IT changes, etc.) needed to implement the new requirements. In regards to the bylaw amendments, the next steps consist of the following:

- After the 90 day public posting period, review and analyze all feedback received;
- Draft any changes with legal counsel based on feedback received;
- Finalize the bylaws for filing with MoH;
- Seek Board approval for filing of final bylaws (targeting the November 2017 Board meeting);
- File the final bylaws with the MoH; and
- Work with College staff to develop an informational guide on the new requirements.

Recommendation

The Legislation Review Committee recommends that the Board approve the amendments to PODSA bylaws, related forms and schedules for public posting, as circulated.

Appendix	
1	Proposed Draft Bylaws for Public Posting (track changes)
2	April 2017 Presentation: Scope of PODSA Modernization – Phase 1
3	April 2017 Briefing Note: HPA Bylaws Application Committee
4	Draft Forms (track changes)
5	Draft Amendments to Fee Schedule – Schedule A (track changes)
6	Draft New Schedules – Schedule B, C and D (track changes)
7	Engagement Report

British Columbia Pharmacy Association
Suite 1530 - 1200 West 73rd Avenue
Vancouver, BC V6P 6G5
Tel: 604 261-2092 Fax: 604 261-2097
info@bcpharmacy.ca www.bcpharmacy.ca

British Columbia Pharmacy Association
A voice for community pharmacy

September 20, 2017

Christine Paramonczyk **BY EMAIL**: legislation@bcpharmacists.org
Director of Policy and Legislation
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC
V6J 5C6

And To:

Brian Westgate **BY EMAIL**: PROREGADMIN@gov.bc.ca
Director of Regulatory Initiatives, Professional Regulation and Oversight
Health Sector Workforce Division
Ministry of Health
1515 Blanshard Street
PO Box 9649 Stn Prov Govt
Victoria, BC
V8W 9P4

Dear Madam/Sir:

Re: PODSA Pharmacy Ownership Bylaw – Proposed Amendments

The BC Pharmacy Association thanks the College of Pharmacists of BC for the opportunity to provide comments on the proposed amendments to the bylaw enacted pursuant to the *Pharmacy Operations and Drug Scheduling Act* (the "Act" or "PODSA").[1]

BCPhA Position

The BCPhA supports the College's mandate to safeguard public safety by ensuring that the highest standards of practice and business operations exist in BC pharmacies. We strongly believe that when a member of the public enters a pharmacy, they have the right to expect safe and ethical care delivered by professionals who understand and adhere to their professional

[1] SBC 2003, C. 77. All references are to the Act as amended by Bill 6.

obligations. Accordingly, the public is best protected when the regulatory framework is consistent, fair and transparent.

The BCPhA appreciates the dialogue that has taken place regarding these draft bylaws. This dialogue has helped us better understand the scope of the challenge inherent in completing these changes to the College's systems, processes, and bylaws by March 1, 2018, when the Bill 6 amendments to PODSA come into force. Likewise, we hope that the College has more insight into the impact of these changes on registrants, and on direct and indirect owners. We are hopeful that some of the fundamental issues we have raised will be reconsidered and accordingly we must document those concerns here in the strongest terms. We welcome continued opportunities to work with the College toward the regulatory clarity and administrative fairness that will support British Columbians' continued access to the safe and ethical community pharmacy care they deserve.

A. Definitions

We note that the following words are not defined in the bylaw and recommend the following definitions be added, for clarity:

- "**Central Securities Register" means a central securities register within the meaning of the *Business Corporations Act* [SBC 2002] C. 57 as amended from time to time;**

- **"British Columbia Company Summary" means a summary issued by the BC Corporate Registry Services;**

- **"pharmacy" means a pharmacy within the meaning of the *Pharmacy Operations and Drug Scheduling Act* [SBC 2003] S. 77 as amended from time to time;**

B. Part II – All Pharmacies

Change of Manager – License cancellation

Subsection 14 and 15 set out the requirements for getting a new pharmacy license if a manager ceases to manage the pharmacy, the location changes or the direct owner changes. In the vast majority of cases these changes will occur with notice. However, from time to time, transitions in pharmacy management and ownership may occur without advance notice. In rare circumstances it may be appropriate for an owner to remove an employee from management or even terminate an employee without notice, or a direct owner/manager may suddenly become ill or die.

But ss. 14 and 15 don't account for the practical compliance problems that will now arise for both the College and registrants as a result of the amendments made in Bill 6. The combined operation of section 6 and ss. 7(2) of the Act is that the licence is automatically and immediately cancelled, and continued operation of the pharmacy is prohibited.

We believe this is an unintended consequence. Especially in light of the College's past practice of continuing a license until the College receives and processes a new manager appointment, then formally granting a new license effective as at the new manager's start date.

For clarity and to avoid creating the risk of such "technical cancellations," we recommend that Subsection 14(4) be amended to clearly authorize the College's existing practice of making the new pharmacy license effective on the date the manager changes. For consistency and efficiency, it makes sense that there should be similar clarity when there is a new direct owner (s. 14(1)), and when exercising the general licensing authority under s.2(1) of the bylaw.

Empowering the registrar to issue licenses with an effective date would have many advantages. First, it would enhance regulatory transparency, by articulating what is already the College's business practice. Second, it would enable the College to issue new licenses in advance of a change of ownership, which could improve efficiencies where the same direct owners will be associated with multiple pharmacies. Finally, it would also give the College sufficient flexibility to manage unforeseen delays that may arise from time to time in the ordinary course of the license renewal process.

Accordingly, we recommend adding similar language to ss.2(1), ss. 14(1) and ss. 14(4):

> **ss. 2(1) The registrar may issue a license <u>with an effective date as determined by the registrar,</u> for any of the following:**
>
> **(a) a community pharmacy;**
>
> **(b) a hospital pharmacy;**
>
> **(c) a pharmacy education site.**
>
> **ss. 14(1) If the direct owner changes, the registrar issue a new pharmacy license <u>with an effective date as determined by the registrar,</u> upon receipt of….**
>
> **ss. 14(4) If there is a change of manager, the registrar may issue a new pharmacy license<u>, with an effective date as determined by the registrar,</u> upon receipt of:….**

Although it is unlikely that the location of a pharmacy would change unexpectedly, for consistency it is appropriate for the registrar to have the same authority in those circumstances. As such, ss. 15(4) should also be amended as follows:

ss. 15(4) if there is a change in the location of the pharmacy, the registrar may issue a new pharmacy license with an effective date as determined by the registrar, upon receipt of….

Subsection 13(2) – Restrictions on an "unlicensed pharmacy"

Subsection 13(2) of the proposed bylaw provides that "Pursuant to section 7(3) of the *Act,* the registrar may authorize the direct owner, indirect owner or manager of an unlicensed pharmacy, or a full pharmacist to continue the operation of the pharmacy for a period not exceeding 90 days" but only "for the limited purpose of" transferring drugs and personal health information to another licensed pharmacy.

We have several concerns about this subsection.

First, in this context, we are not certain what is meant by "unlicensed pharmacy" because s. 7(3) of the Act doesn't deal with *unlicensed* pharmacies. Rather, it simply prohibits the *operation* of the pharmacy if the direct owner becomes ineligible to hold a license after the license has been issued.[2] There are two exceptions to this prohibition:

i. if that pharmacy's license authorizes that pharmacy to continue to operate despite the direct owner becoming ineligible during the term of the license; or

ii. if a bylaw permits continued operation of a pharmacy after a direct owner becomes ineligible.

It appears that there is nothing in the proposed bylaw that would permit the continued operation of a pharmacy after a direct owner becomes ineligible. Therefore, (unless the license specifically authorizes otherwise) when a direct owner becomes ineligible the pharmacy will *automatically* have to stop operating. The registrar *may* allow the pharmacy to operate for 90 days, but only in order to transfer its product and patients to another pharmacy.

This is a draconian outcome, especially because becoming ineligible doesn't trigger license cancellation; subsection 6 lists all the reasons why a license would be cancelled and ineligibility under s. 3 isn't among them. Rather, the inquiry and discipline processes under ss. 32-40 of the HPA apply and ss.20(3)(b) authorizes action to be taken – including suspension or cancellation of a pharmacy license - if the direct owner ceases to be eligible under section 3 to hold a pharmacy license.

The practical outcome of the proposed bylaw is that the pharmacy will automatically be out of business long before any decision is made about the license. It's important to remember that matters involving indirect owners could arise and be resolved by way of a plea of guilty and a

[2] Section 7(3) of the PODSA states: *"Unless authorized under a bylaw or by a pharmacy licence, a direct owner, an indirect owner and a manager must not operate or permit the operation of a pharmacy if the direct owner ceases to be eligible, under section 3, to hold a pharmacy licence.*

conviction within less than the 12 month term of a pharmacy license,[3] resulting in a direct owner becoming ineligible thereby forcing the pharmacy to close.

In light of this, we do not understand why the College has not proposed a bylaw to permit continued operation after a direct owner becomes ineligible, which is the purpose of s. 7(3) of the Act. Indeed, the very reason that section 7(3) of Bill 6 was amended on third reading was to enable the College to avoid automatically putting pharmacies out of business before determining whether the reason for ineligibility was relevant or a risk to the public.

Rules before and after license granted are inconsistent and unfair

At the application stage, if an applicant for a license isn't eligible under s. 3 of the Act, the issue is heard and decide by the Application Committee. That committee has broad authority to issue the license *despite* ineligibility, if it concludes that the convictions are irrelevant or there is minimal risk to the public. This discretionary power was given to the Application Committee in recognition of the fact that not every situation that makes a direct owner ineligible will be relevant to the operations of the pharmacy, or a risk to the public.

For that reason, the Act and the bylaws provide for an administrative process to take place prior to issuing the license, to hear and decide these key questions of *relevance* and *risk*.

Section 20 of the Act provides for a similar process if ineligibility arises *after* the license is issued. Subsection 20(1) extends the jurisdiction of the Inquiry and Discipline Committees to indirect owners "as if" they were a registrant. Those committees are authorized by ss. 20(3) to "take appropriate action" if the direct owner ceases to be eligible under section 3 to hold a license, and ss. 7(3) grants the College authority to draft a bylaw that would establish the conditions under which a pharmacy could continue to operate pending the outcome of a fair process.

If the proposed bylaw is not amended to properly account for this regulatory process, owners and managers will face the following dilemma: self-report during the license term in compliance with ss. 7.1(2)(c) of the Act and ss. 14(5) of the proposed bylaw, thereby triggering the application of s. 7(3) of the Act and s.13(2) of the bylaw, thus guaranteeing that they will be required to stop operating and likely be put out of business before any hearing on the merits. Instead, if they wait until the annual license renewal date and apply for renewal, the matter will be automatically referred to the Application Committee where the issues of *relevance* and *risk* will be heard and decided, in accordance with fundamental principles of procedural fairness.

Simply put, the proposed bylaw is unfair, and will punish the compliant while incentivizing non-compliance.

[3] For example a shoplifting charge, mischief or a DUI.

Since ss. 32-40 of the HPA apply in these circumstances, we suggest that the bylaw should specifically reference the HPA and provide the registrar with the discretion to authorize the pharmacy to continue to operate pending the outcome of that process. Those provisions of the HPA give the College Board sufficient flexibility to permit less serious matters to be disposed of by the registrar while more serious matters are reserved for the committees.

Accordingly, we recommend amending the section as follows:

> **ss. 13(2) Pursuant to s. 7(3) of the Act, <u>if the direct owner of a licensed pharmacy ceases to be eligible under section 3 of the Act to hold a license</u>, <u>the matter shall be treated in the same manner as a complaint under section 32-40 of the *Health Professions Act* and in addition,</u> the registrar may**
>
> **(a) <u>authorize the pharmacy to continue to operate pending the outcome of the process commenced pursuant to subsections 32-40 of the *Health Professions Act;* and</u>**
>
> **(b) <u>if the outcome results in the cancellation of the pharmacy license,</u> authorize the direct owner, indirect owner(s) or manager of an unlicensed pharmacy, or a full pharmacist to continue the operation of the pharmacy for a period of not exceeding 90 days, for the limited purpose of transferring drugs and personal health information on the premises to another licensed pharmacy.**

Subsection 16

Section 16 imposes duties directly onto owners, directors and officers to do certain things. In most other subsections the duty is to "ensure" that a thing be done, which makes more sense given that most owners, directors and officers have oversight roles. Accordingly, the following sections should be amended for consistency:

> **ss. 16(2)**
>
> **(g) <u>ensure that</u> ~~establish~~ policies and procedures <u>are established</u> to specify the duties to be performed by registrants and support persons;**
> **…**
>
> **(q) <u>ensure that</u> ~~establish and maintain~~ policies and procedures respecting pharmacy security <u>are established and maintained</u>**

> **ss. 16(8) A direct owner, directors and officers must do all of the following:…**
>
> **(c) ~~notify~~ <u>ensure that</u> the registrar <u>is notified</u> of any change of name, address, telephone number, electronic mail address or any other information previously provided to the registrar; and**

(d) in the event of a pharmacy closure under subsection 2(t), ~~notify~~ ensure that the registrar is notified in writing at least thirty days before the effective date of the proposed closure in Form 4.

Other Issues:

General Administration

We understand that all direct and indirect owners will be set up with an eServices account. Clarification is needed from the College whether this will permit single owners of multiple sites to administer changes, fee payments, renewals, etc. centrally through one eServices account. In a number of instances, the same direct and indirect owners will be associated with multiple pharmacies. It would seem to make sense to process the license applications for all of the locations for a specific owner at the same time in order to avoid duplication and increase efficiency.

Decisions of the Application Committee and Procedural Fairness

The authority to require criminal record background checks extends to cover many non-pharmacists, including individuals who are officers and directors of publicly traded corporations and individuals who may merely be passive shareholders in family-owned businesses (this will include ordinary business people, quite possibly spouses, children, and even grandchildren). We understand that it is the intention of the College to collect each individual's entire criminal record history. We note that section 4 of the Act provides that only convictions within the six years prior to the license application are relevant to eligibility and remain very concerned about the potential for irrelevant information to be improperly considered when making licensing decisions.

This leads us to our concern about the processes and transparency of the Application Committee. The Application Committee has very broad powers which will necessarily affect the livelihoods and property interests of individuals who are not members of the pharmacy profession. This power goes far beyond the ordinary mandate of a health professions College under the HPA, which is ordinarily restricted to governing the members of the health profession.

Given the serious responsibilities inherent in the administration of these individuals' rights and interests, it is imperative that the Application Committee adheres to fundamental principles of natural justice. This includes meeting the duties of procedural fairness which require a written explanation for the decision where a decision has important significant for the individual. The

law has long recognized that it is unfair for a person subject to a decision critical to their future not to be told why the result is reached.[4]

Moreover, the absence of written record of the Committee's analysis and conclusions will create uncertainty in the law.[5] The Application Committee is a new committee, and will be developing a new body of administrative law. It may meet in panels, comprised of different people at different times.[6] These panel members should have the guidance of precedents as they develop, to assist them in ensuring fairness and predictability as they consider the issues of *relevance* and *risk* in the context of eligibility for a pharmacy license.

It is therefore essential for their analysis and conclusions to be issued in written form to enable them to avoid "the possibility that different decision-makers may each reach opposing interpretations of the same provision, thereby creating "needless uncertainty in the law [in the sense that] individuals' rights [are] dependent on the identity of the decision-maker, not the law."[7]

Although administrative decision-makers aren't bound by the principle of *stare decisis* in the same way as the courts, our legal system is "based on a degree of consistency, equality and predictability in the application of the law" because consistency "enables regulated parties to plan their affairs in an atmosphere of stability and predictability. It impresses upon officials the importance of objectivity and acts to prevent arbitrary or irrational decisions. It fosters public confidence in the integrity of the regulatory process. It exemplifies common sense and good administration."[8] Certainty and predictability are "cardinal values" and "core principles of the rule of law,"[9] and their absence creates the risk of divergent application of the legal rules, which would "undermine the integrity of the rule of law."[10]

For all of these reasons it is essential that each panel of the Application Committee provides the parties with written reasons for their decisions. We would be pleased to consult with the College in developing a policy as to when and how to make the legal analysis and conclusions in such decisions available more broadly in a manner that protects the privacy rights of individuals

---

[4] *Baker v. Canada (Min. of Citizenship and Immigration)* [1999] 2 SCR 817 at para. 43

[5] See paragraph 84 of *Wilson v. Atomic Energy of Canada Ltd*., [2016] 1 SCR 770, 2016 SCC 29 (CanLII), <http://canlii.ca/t/gsh2f>

[6] See *Application Committee Terms of Reference*

[7] *Wilson v. Atomic Energy of Canada Ltd.,* [2016] 1 SCR 770, 2016 SCC 29 (CanLII), <http://canlii.ca/t/gsh2f>, at para. 81

[8] Per L'Heureaux-Dube J., *Domtar Inc v Quebec (Commission d'appel en matière de lésions professionnelles),* 1993 CanLII 106 (SCC), [1993] 2 SCR 756 at para. 59, and quoting Prof. MacLauchlan "Some Problems with Judicial Review of Administrative Inconsistency" (1984), 8 *Dalhousie L.J*. 435, at p. 446

[9] *Supra, Wilson*, at para. 86.

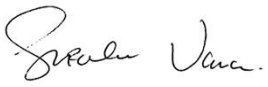
[10] per Rothstein J. in his concurring opinion in *Canada (Citizenship and Immigration) v. Khosa*, 2009 SCC 12 (CanLII), [2009] 1 S.C.R. 339, at para. 90.

while ensuring confidence in the College's adherence to these core principles of fundamental justice.[11]

The BCPhA thanks the College for the opportunity to provide these submissions.

A copy of this submission will be posted on the BCPhA website.

Yours Sincerely,



Geraldine Vance
CEO

cc: Bob Nakagawa, Registrar

[11] Some tribunals publish summaries of their decisions, making the decision itself only available to the parties. Others may choose to redact information that could identify individuals. See for example the *Guidelines on Electronic Publications of Administrative Tribunals* published by the Office of the Information and Privacy Commissioner for BC, available at: https://www.oipc.bc.ca/guidance-documents/1429

Chain Drug Association of British Columbia

September 20, 2017

Christine Paramonczyk
Director of Policy and Legislation
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC V6J 5C6

BY EMAIL: legislation@bcpharmacists.org

And To:

Brian Westgate
Director of Regulatory Initiatives, Professional Regulation and Oversight
Health Sector Workforce Division
Ministry of Health
1515 Blanshard Street
PO Box 9649 Stn Prov Govt
Victoria, BC
V8W 9P4

BY EMAIL: PROREGADMIN@gov.bc.ca

Dear Madam/Sir:

Re: Proposed Amendments to PODSA Bylaw – Pharmacy Ownership

The Chain Drug Association of British Columbia (CDABC) is an organization of pharmacy owners with the purpose of advocating on behalf of its members to promote and pursue policies and activities concerning and surrounding the profession of pharmacy which are in the interests of the profession and the public. To this end, CDABC is supportive of the College's efforts to ensure that members of the public receive pharmacy services from pharmacy operators who uphold the College's standards of practice and provide safe and ethical care. Upon review of the proposed bylaws, we do, however, have concerns with specific elements of the proposed bylaws and the operationalization of the same.

In the attached submission to the College and the Ministry, the British Columbia Pharmacy Association has outlined concerns regarding the following sections of the bylaws:

- Definitions
- Section 6 Change of Manager – license cancellation
- Subsection 13(2) Restrictions on an unlicensed pharmacy and rules before and after license granted
- Subsection 16 Duties on owners

CDABC has the same concerns about these sections and is fully aligned with the positions stated by the BCPhA in their submission.

BCPhA has also expressed concerns respecting the general administration of the renewal process, the criminal record history and potential for over-collection of information that is irrelevant to issues of eligibility as well as the need for transparency and procedural fairness in the operations of the Application Committee. Similarly, CDABC shares these concerns and agrees with the recommendations made by the BCPhA.

The Chain Drug Association of British Columbia appreciates the opportunity to provide feedback on the proposed amendments to the *Pharmacy Operations and Drug Scheduling Act* Bylaw pertaining to pharmacy ownership. We would welcome the opportunity for further discussions with the College about the operationalizing of the proposed licensing process to ensure as smooth an implementation period as possible for all.

Best regards,

Karen Sullivan
President, Chain Drug Association of British Columbia

Cc:
Geraldince Vance, CEO, British Columbia Pharmacy Association

Anu Sharma

From: CPBC Info
Sent: September-14-17 3:55 PM
To: Ownership
Subject: FW: Reminder: Feedback Invited on Draft Bylaws for New Pharmacy Ownership Requirements

Follow Up Flag: Follow up
Flag Status: Flagged

From: iraj@shawbiz.ca [mailto:iraj@shawbiz.ca]
Sent: September-14-17 3:46 PM
To: CPBC Info <Info@bcpharmacists.org>
Subject: Re: Reminder: Feedback Invited on Draft Bylaws for New Pharmacy Ownership Requirements

If I may I would like to offer my input with regard to new ownership requirements .

Please see my comments in bold and I 'd like to thank you in advance for spending time reading this.

The following would make an ownership application ineligible, or may require that conditions be imposed:

- *owner/manager is subject to a limitation imposed by the discipline committee that precludes them from being an owner or manager*

  This point seems to be fair because the history of CPBC indicates that limitations are imposed in extreme and serious cases but it lacks to define which "limitations"

- *owner/manager has, within the previous 6 years, been convicted of an offence under the Criminal Code*

  It is not clear what is exactly "an offence under the Criminal Code " which can affect the operation of a pharmacy and it is also unfair because it is retroactive .

- *owners/managers have, within the previous 6 years, been convicted of an offence under the Pharmaceutical Services Act*

  It is not clear what is exactly "an offence under the Pharmaceutical services Act" which can affect the operation of a pharmacy and it is also unfair because it is retroactive .

- *owner/manager has been subject to an information or billing contravention,*

  In my opinion this is the most important change because there is not a clear definition of what *is exactly* "an information or billing contravention.

  For example if a pharmacy gets audited by PharmaCare (or any other 3rd party payer like Blue Cross or other insurance companies) and Audit finds a handful of prescriptions that are missing some purely technical/bureaucratic information

  (for example if the total quantity of a prescription is written only in Numeric and not in Alphabetic) this will result in a hefty extrapolated fine , even though the patient received the correct drug and quantity.

  ## Is above example a "Billing Contravention"?

  If yes ,then all the pharmacies and pharmacists will be at total mercy of pharmaCare and insurance companies because pharmacists are also human beings and they will inevitably make mistakes.

  In my opinion there should be a clear distinction between innocent / technical errors (let's call them " Billing Errors") on one hand which can be rectified by more training and education and on the other hand "Billing Contraventions" which are the result of dishonesty, falsification and cheating in order to obtain more money.

This new requirement is extremely harsh too because it makes a pharmacist ineligible forever.

- *owner/manager has, within the previous 6 years, had their registration as a pharmacist suspended or canceled*

  This is also unfair because it is retroactive .

- *owner/manager has, within the previous 6 years, had a judgment entered against him or her in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related services within the meaning of the Pharmaceutical Services Act (See Section 4(3) and 4(4) of the amendments to Pharmacy Operations and Drug Scheduling Act)*

This is also unfair because it is retroactive .

****

If I may I would like to offer my input with regard to new ownership requirements .

Please see my comments in bold and I 'd like to thank you in advance for spending time reading this.

The following would make an ownership application ineligible, or may require that conditions be imposed:

- *owner/manager is subject to a limitation imposed by the discipline committee that precludes them from being an owner or manager*

  This point seems to be fair because the history of CPBC indicates that limitations are imposed in extreme and serious cases but it lacks to define which "limitations"

- *owner/manager has, within the previous 6 years, been convicted of an offence under the Criminal Code*

  It is not clear what is exactly "an offence under the Criminal Code " which can affect the operation of a pharmacy and it is also unfair because it is retroactive .

- *owners/managers have, within the previous 6 years, been convicted of an offence under the Pharmaceutical Services Act*

  It is not clear what is exactly "an offence under the Pharmaceutical services Act" which can affect the operation of a pharmacy and it is also unfair because it is retroactive .

- **This new requirement is extremely harsh too because it makes a pharmacist ineligible forever.**

- *owner/manager has, within the previous 6 years, had their registration as a pharmacist suspended or canceled*

This is also unfair because it is retroactive .

- *owner/manager has, within the previous 6 years, had a judgment entered against him or her in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related services within the meaning of the Pharmaceutical Services Act (See Section 4(3) and 4(4) of the amendments to Pharmacy Operations and Drug Scheduling Act)*

This is also unfair because it is retroactive .

****

These new ownership requirements are making the playing field even more uneven between smaller independent pharmacies on one hand and large corporations who own pharmacies among their various business activities on the other hand .

A shareholder of a publicly traded company could be a serious criminal or even a drug dealer but because they are not considered indirect owners they can continue making profit out of pharmacy business.

In my humble opinion CPBC should have continued to keep accountable the pharmacy managers by considering to suspend or cancel their licenses for a significant period of time for serious wrong doings . This would have kept the control of the profession of pharmacy in the hands of "pharmacists" and not headquarters, big corporations and insurance companies.

A pharmacy manager who knows he might loose his/her license and consequently his/her livelihood for a significant period of time would definitly stand up against unscrupulous owners.

-
- *owner/manager has been subject to an information or billing contravention,*

In my opinion this is the most important change because there is not a clear definition of what *is exactly* "an information or billing contravention.

For example if a pharmacy gets audited by PharmaCare (or any other 3rd party payer like Blue Cross or other insurance companies) and Audit finds a handful of prescriptions that are missing some purely technical/bureaucratic information

(for example if the total quantity of a prescription is written only in Numeric and not in Alphabetic) this will result in a hefty extrapolated fine , even though the patient received the correct drug and quantity.

Is above example a "Billing Contravention"?

If yes ,then all the pharmacies and pharmacists will be at total mercy of pharmaCare and insurance companies because pharmacists are also human beings and they will inevitably make mistakes.

In my opinion there should be a clear distinction between innocent / technical errors (let's call them " Billing Errors") on one hand which can be rectified by more training and education and on the other hand "Billing Contraventions" which are the result of dishonesty, falsification and cheating in order to obtain more money.

Regards,
Iraj Zehtab
R.Ph (07735)

On Mon, 11 Sep 2017 20:30:51 -0400 (EDT), College of Pharmacists of BC wrote:

Dear Iraj,

In June 2017, the College Board approved amendments to the bylaws, forms and schedules under the Pharmacy Operations and Drug Scheduling Act to support the new pharmacy ownership requirements for a public posting period of 90 days.

The amendments permit the College to know the identity of all pharmacy owners, determine their suitability for pharmacy ownership, and hold them accountable for providing safe and effective care by ensuring their pharmacies are compliant with legislative requirements for pharmacies in BC.

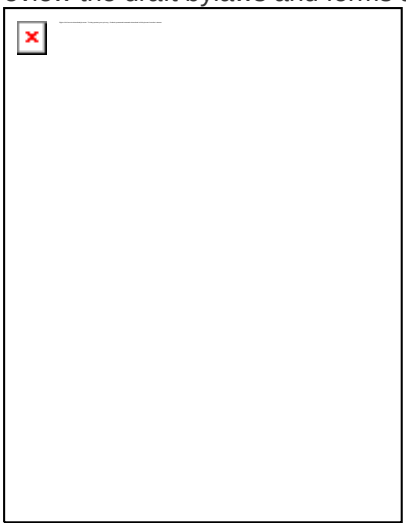
- Key amendments to the *Pharmacy Operations and Drug Scheduling Act* Bylaws include:
- Distinguishing between "direct owners" and "indirect owners."
- Broadening the meaning of "pharmacy" and "pharmacy license."
- Harmonizing requirements and processes for issuing, renewing and reinstating a pharmacy licence.
- Setting eligibility requirements to hold a pharmacy license.
- Establishing a new Application Committee to review licence applications that do not meet the requirements of the Act and bylaws.
- Clarifying that ownership of a pharmacy must be direct.
- Adding requirements for direct owners, indirect owners and managers to provide a Criminal Record History.
- Requiring direct owners, indirect owners and managers to comply with duties under the *Pharmacy Operations and Drug Scheduling Act* and *Health Professions Act*.
- Requiring direct owners, indirect owners and managers to give notice to the Registrar if certain events occur.

For a more detailed summary of the amendments and to learn more about the new pharmacy ownership requirements, visit bcpharmacists.org/ownership.

FEEDBACK INVITED

The proposed draft amendments to the*Pharmacy Operations and Drug Scheduling Act* bylaws have been posted for public comment until **September 20, 2017**.

Please take the opportunity to review the draft bylaws and forms and provide your feedback.



(Bylaws for Comment: PODSA Bylaws - New Pharmacy Ownership Requirements)

Once the public posting period has ended, the College will review and analyze the feedback received and update the draft bylaws as necessary. The amendments will be brought back to the College Board for a decision to file the bylaws with the Minister of Health. The College and Ministry of Health are working together to ensure that the bylaws and the amendments to the *Pharmacy Operations and Drug Scheduling Act* will come into effect at the same time.

QUESTIONS?

Questions about the new pharmacy ownership requirements can be directed to ownership@bcpharmacists.org.

College of Pharmacists of British Columbia

Feedback Form for Posted Draft Bylaws

Instructions

Thank you for providing your feedback on the College's draft Bylaws. To better facilitate the collation of feedback, please use the following form. The form is divided into 4 columns:

Column 1: Indicate which section, subsection or appendix of the Bylaws for which you are providing comments.

Column 2: Due to some sections carrying over multiple pages, please indicate the page number for ease of reference.

Column 3: Indicate the text for which you are provided suggested changes and include new or amended text.

Column 4: Indicate the reason for your suggested changes (e.g. scientific journal, published guidelines etc.). Please keep your explanations as brief as possible.

Example:

Section, Subsection or Appendix	Page #	Comment (provide current and new text when applicable)	Rationale
1.3 Sample Section	5	The requirements should include A, B and C…	The following reference supports this statement…

There is an opportunity to provide general comments on the draft Bylaws following the table.

PLEASE RETURN FEEDBACK FORM TO LEGISLATION@BCPHARMACISTS.ORG BY THE DATE INDICATED ON THE COLLEGE WEBSITE.

Note: Timelines are typically 60 or 90 day posting periods. Refer to College website for specific deadlines. Forms that are submitted after deadline will not be accepted.

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

Stakeholder Comments

Section, Subsection or Appendix	Page #	Comment (provide current and new text when applicable)	Rationale
Responsibilities of Pharmacy Manager, Direct Owners, Directors, Officers and Shareholders Section 16-8	13-17	A line should be added requiring the Direct Owners, Directors, etc. to declare any financial interest or relationship with prescribers or physician's offices.	Transparency is imperative in the pharmacist patient relationship. Currently, many physician's offices are constructed/managed and financed by pharmacy owners (e.g. owners will cover overhead costs for physicians or actually pay for/construct the primary care clinic premises or provide a monthly fee to physicians to do the same). This creates a real/apparent conflict of interest that the patient should be aware of.

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

General Comments

Comments submitted by:	
Name of individual	Sanjiv Khangura
Name of organization	
Date	September 15, 2017

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Anu Sharma

From: CPBC Info
Sent: September-14-17 12:59 PM
To: Ownership
Cc: CPBC Licensure
Subject: FW: Proposed College Bylaws on Pharmacy ownership requirements.

Follow Up Flag: Follow up
Flag Status: Flagged

From: Wesley C.R. Bedford [mailto:wesley.peachlandpharmacy@gmail.com]
Sent: September-14-17 11:41 AM
To: CPBC Info <Info@bcpharmacists.org>
Subject: Proposed College Bylaws on Pharmacy ownership requirements.

This I Wesley Bedford Jr. Lic#11337 (with Peachland Pharmacy). I am very concerned at the open ended wording of the proposed changes to the ownership eligibility criteria for pharmacy licence renewal.

I am all for Criminal record checks of share holders of pharmacies, but current pharmacists already have a criminal record checks and there is criteria relivant to Pharmacy. When a current record check is done it is ment to be protecting the public and is focused on Pharmacy practice and anything that may affect practice. The proposed Criminal record Check for Pharmacy share holders is worded as any Criminal Code Offense of any shareholder in the last 6 years regardless of relevance. Then an undisclosed board will review if it is relevant, and then could reject renewal of pharmacy license.

I feel the Criminal record Check should be focused (as current checks are) on specifics relating to practice with the goal of proctecting the public as it relates to pharmacy. These proposals make it so domestic disputes, speeding tickets, a single share holder with a 5 year old drunk driving charge, and many other things unrelated to practice and criminal violations that already have time served or fines paid by non-pharmacists not working in the pharmacy, could threaten license renewal. There is also mention of possible limits or conditions being imposed. This feels very open ended, and I don't see how it helps pharmacy as a whole. I would like to see some focus and criteria, as well as discription of possible conditions imposed.

Please note: No share holder of Peachland Pharmacy has a criminal record of any kind. I am just very concerned that this bylaw has a total lack of focus. The College mandate is to protect the public from pharmacists, and to make sure we are all following the rules. I feel the College should have a clear guide of how they preform these duties.

Thank you for your time.
Wesley Bedford

Anu Sharma

From: Sukh Mann <sukhmannbc@gmail.com>
Sent: September-20-17 3:02 PM
To: Ownership; PROREGADMIN@gov.bc.ca
Subject: COMMENTS ON PROPOSED CHANGES TO REGULATORY COLLEGE BYLAWS

To

Director of Policy & Legislation & Director of Regulatory Initiatives-Bob Nakagawa & Ministry of Health Director, Professional Regulation-Brian Westgate

Please find enclosed the following except from the Act.

Section, Subsection or Appendix

BILL 6 – 2016

PHARMACY OPERATIONS AND DRUG SCHEDULING AMENDMENT ACT, 2016

Eligibility for pharmacy licence

3 A direct owner is eligible to hold a pharmacy licence if all of the following apply:

(a) the ownership of the pharmacy complies with section 5 and the bylaws;

(b) no direct owner, indirect owner or manager is subject to a limitation imposed by the discipline committee that precludes him or her from being a direct owner, an indirect owner or a manager;

(c) the manager is a pharmacist, and that pharmacist will have responsibility for the actual management and operation of the pharmacy;

(d) no direct owner, indirect owner or manager is or has been the subject of an order or a conviction for an information or billing contravention;

(e) no direct owner, indirect owner or manager has, within the previous 6 years, been convicted of an offence prescribed under the *Pharmaceutical Services Act* for the purposes of section 45 (1) (a) (ii) of that Act;

(f) no direct owner, indirect owner or manager has, within the previous 6 years, been convicted of an offence under the *Criminal Code* (Canada), other than an offence to which paragraph (e) applies;

(g) no direct owner, indirect owner or manager has, within the previous 6 years, had a judgment entered against him or her in a court proceeding related to commercial or business activities that occurred in relation to the provision of

(i) drugs or devices, or

(ii) substances or related services within the meaning of the *Pharmaceutical Services Act*;

(h) no direct owner, indirect owner or manager has, within the previous 6 years, had his or her registration with one of the following bodies suspended or cancelled:

(i) the College of Pharmacists of British Columbia;

(ii) a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction;

(i) no direct owner, indirect owner or manager has, within the previous 6 years, had limits or conditions imposed on his or her practice of pharmacy as a result of disciplinary action taken by a body referred to in paragraph (h).

Comment (provide current and new text when applicable)

Rationale and Discussion

I am not a lawyer but his is my attempt to articulate the deficiencies in this Act as it relates to Natural Justice and Fairness.

These regulations go into effect March 1, 2018. Not sure why the retroactive time period of 6 years is in place. It should start on March 1.2018 going forward . A law is always created at a specific point in time and is meant to be followed going from that point forward.

It is not fair that a registrant should be penalized for something they new was against the legislation when the legislation was not formulated at the time an infraction occurred.

The purpose of a legislation is to inform registrants and the public of all the bylaws.
Constitutionally it goes against the Charter of rights and Freedoms.

It goes against the principles Natural Justice and Procedural Fairness.

In English law, **natural justice** is technical terminology for the rule against bias (*nemo iudex in causa sua*) and the right to a fair hearing (*audi alteram partem*). While the term *natural justice* is often retained as a general concept, it has largely been replaced and extended by the general "duty to act fairly".

The basis for the rule against bias is the need to maintain public confidence in the legal system. Bias can take the form of actual bias, imputed bias or apparent bias. Actual bias is very difficult to prove in practice while imputed bias, once shown, will result in a decision being void without the need for any investigation into the likelihood or suspicion of bias. Cases from different jurisdictions currently apply two tests for apparent bias: the "reasonable suspicion of bias" test and the "real likelihood of bias" test. One view that has been taken is that the differences between these two tests are largely semantic and that they operate similarly

My suggestion is to remove all references to previous 6 years and replace it with wording that indicates any infraction against the bylaws after March1/2018 for points e,f,g,h,i. Legal advice should be sought for this. This should occur on all the forms in the application process that contains this language.

A registrant and the public is expected to know all the bylaws so they don't break them going forward. The purpose of any law is to create the parameters and guidelines so that they can be followed according to due process.. The law should be constricted fairly from the get go created from a time set forth not a time set prior to the regulation being created.

Yours Sincerely. If you need further clarification please do not hesitate to call or email me.

Sukh Mann

Comments submitted by:

Sukhbir Mann

BSc. Pharm

8093-162 B Street

Licence 7355

September 22, 2017

Christine Paramonczyk **BY EMAIL:** legislation@bcpharmacists.org
Director of Policy and Legislation
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC V6J 5C6

And To:

Brian Westgate **BY EMAIL:** PROREGADMIN@gov.bc.ca
Director of Regulatory Initiatives, Professional Regulation and Oversight
Health Sector Workforce Division
Ministry of Health
1515 Blanshard Street
PO Box 9649 Stn Prov Govt
Victoria, BC V8W 9P4

Dear Madams/Sirs:

Re: PODSA Bylaw – Proposed Amendments pertaining to Pharmacy Ownership ("Bylaw")

London Drugs is a privately held chain pharmacy retailer, with exactly 80 Canadian pharmacies, of which 51 are located in British Columbia. We are fully committed to providing our customers with outstanding pharmacy care services, in a safe and ethical manner and in accordance with the College's standards of practice. London Drugs understands the College has an overriding objective to safeguard public safety and is dedicated to ensuring no person can use corporate structures to avoid regulatory accountability, which London Drugs fully supports.

We have been provided with a copy of the submissions of the BC Pharmacy Association regarding the Bylaw dated September 20, 2017, and wish to advise the College and Ministry that London Drugs is in full agreement with the comments and concerns raised in those submissions.

In addition to those submissions, London Drugs has the following general comments:

Application of Bylaw to Indirect Owners: We are concerned about the extremely broad manner in which the Bylaw may apply to indirect owners, with particular reference to shareholders of non-public

companies who may be passive, and have no control or involvement in pharmacy operations whatsoever. We are not sure it is appropriate to hold a passive shareholder subject to and accountable for compliance with pharmacy laws/regulations/standards to the same degree as an actual pharmacy or pharmacist, who has been expressly trained and/or licensed to provide pharmacy services. Wording in Form 5 – Proof of Eligibility – requires Indirect Owners to declare in section 5 that they personally must comply will all duties under PODSA, Health Profession Act and College bylaws and regulations – even though that shareholder may have no actual involvement, control or knowledge of that pharmacy practice – that is problematic in our view. Proposed Bylaw 16(9) distinguishes between obligations of shareholders and other categories of owners by specifying that only subsections 2(d) and 8(c) of section 16 will apply, but no such comparable distinction is made in the Declaration of Form 5. We hope there will not be an overreaching by the College in the application of the Bylaw to indirect owners, otherwise questions of whether the College is properly acting with its sphere of governance could arise.

Application/ Renewal Process: We urge the College to greatest extent possible to adopt and continuously adopt processes that create efficiency and streamlining of the license application and renewal process, in order to avoid unnecessary administrative burden and costs which aren't needed to in order to achieve the College's important underlying objectives. For example, allowing information to be entered in the College database system once, rather than multiple times, where appropriate – especially in the case of a pharmacy owner like London Drugs with our 51 pharmacy locations which all contain identical ownership information, would be very helpful. We see there is a Form 9 proposed to list Multiple Pharmacies, which we assume is intended to facilitate this type of approach.

Criminal Record Checks: The highly sensitive information being collected by the College through the application/renewal process, with particular reference to criminal record checks, must be treated by the College with the utmost care, security and confidentiality. Principles of privacy laws dictate that only the minimum amount of personal information should be collected to achieve the reasonable purpose for which it is collected, personal information must only be provided to those with a direct need for it, it must be kept secure and not retained for any longer than necessary. Inadvertent release or misuse of this highly sensitive information could be enormously damaging and create significant liability for the College. We anticipate the College will engage in rigorous standards of security, limited access, appropriate retention and other appropriate safeguards. It appears to us there is potential for over-collection of information that is irrelevant to issues of pharmacy ownership eligibility. We urge the College to be extremely transparent and take a reasoned approach in what it considers to be 'relevant' criminal charges with respect to licensing and the practice of pharmacy.

We are not clear at this stage what the actual process will be for submitting criminal record checks, but would like to point out that obtaining criminal record checks is not without its challenges. Different police organizations have widely divergent practices and procedures around the form of the application they require; the actual record they will produce; to whom they will provide it; and the timeline on which they will produce same. We hope the College will be understanding that this process is not always straightforward to comply with from a practical standpoint.

Application Committee: Given the enormous responsibility the Application Committee holds in whether it approves, imposes conditions or denies license applications and renewals, communication of clear, fair and transparent guidelines on how the Committee will it make its determinations is essential. This will also help to ensure there can be no suggestion of bias, unfairness or discrimination by the College/Application Committee in its application of the Bylaws. Overall, the need for transparency and procedural fairness in the operations of the Application Committee cannot be understated.

Thank you for the opportunity to comment.

Sincerely,

LONDON DRUGS LIMITED

Chris Chiew
General Manager, Pharmacy

PODSA Ownership Bylaws - Public Posting Feedback		
Requirements	**Comments Received**	**Policy Decisions from Review of Feedback**
s.1 definitions	**BCPhA, Chain Drug Association of BC and London Drugs:** •add a new definition for "Central Securities Register" means a central securities within the meaning of the Business Corporations Act [SBC 2002] C.57 as amended from time to time; •add a new definition for "British Columbia Company Summary" means a summary issued by the BC Corporate Registry Services; •add a new definition for "pharmacy" means a pharmacy within the meaning of the	• Definition of "Central Securities Register" will be added to the bylaws. • Definition of "British Columbia Company Summary" will be added to the bylaws. • Definition of "Pharmacy" will be added to the bylaws.
s.2(1) The registrar may issue a licence for any of the following: (a) a community pharmacy; (b) a hospital pharmacy; (c) a pharmacy education site.	**BCPhA, Chain Drug Association of BC and London Drugs:** •Add "with an effective date as determined by the registrar". •Empowering the registrar to issue licenses with an effective date would have many advantages. First it would enhance regulatory transparency, by articulating what is already the College's business practice. Second, it would enable the College to issue new licenses in advance of a change of ownership, which could improve efficiencies where the same direct owners will be associated with multiple pharmacies. Finally, it would give the College sufficient flexibility to manage unforeseen delays that may arise from time to time in the ordinary course of the license renewal process.	• No change is proposed. • The authority for the registrar to establish effective dates is implied in the Act. • The College is changing the format of its licences. The new format will include effective dates. These effective dates will reflect changes such as a change of pharmacy manager and direct owner/name change. Note: As per section 4.1(5) of the amended Act, a pharmacy licence is valid for 12 months.
s.12 A direct owner, indirect owner(s) and a manager must submit a criminal record history pursuant to section 5.1 of the Act, in the form approved by the board from time to time.	**Wesley Bedford (registrant):** •Criminal record checks under the Act should be focused (like the CRC's under the CRRA) on specifics relating to practice with the goal of protecting the public as it relates to pharmacy. •These proposal make it so domestic disputes, speeding tickets, a single shareholder with a 5 year old drunk driving charge, and many other things unrelated to practice and criminal violations that already have time served or fines paid by non-pharmacists no working in the pharmacy, could threaten licence renewal. **London Drugs:** •We urge the College to be extremely transparent and take a reasoned approach in what it considers to be "relevant" criminal charges with respect to licensing and the practice of pharmacy.	• No change is proposed at this time. Currently, the scope of the CRH is not defined. The Application Committee is a new committee and no licences have been reviewed under the new criteria contained within the amendments to PODSA. Therefore, developing a list of relevant offences that will impact a pharmacy licence would be pre-mature and limit the authority of the Application Committee. The College intends to monitor this issue and review the decisions of the Application Committee, once established. College staff intend to work with the Application Committee to develop to establish a list of relevant offences which may impact a pharmacy licence.
s.12 A direct owner, indirect owner(s) and a manager must submit a criminal record history pursuant to section 5.1 of the Act, in the form approved by the board from time to time.	**London Drugs:** •The highly sensitive information being collected by the College through the application/renewal process, with particular reference to criminal record checks, must be treated by the College with utmost care, security and confidentiality. •Inadvertent release or misuse of this highly sensitive information could be enormously damaging and create significant liability for the College. •We anticipate that the College will engage in rigorous standards of security, limited access, appropriate retention and other appropriate safeguards.	• The College recognizes the importance of establishing and maintaining fulsome privacy and security requirements. To date, the privacy and security activities conducted by the College include: - IT security review of College systems has been conducted to ensure security of information; -A privacy officer has been established to handle any privacy related concerns; -A Privacy Impact Assessment has been drafted; and -A consultation with Office of the Information and Privacy Commission is being planned. • The College has drafted bylaws with legal counsel to speak to the College's use, disclosure and retention of criminal record history information. Including a definition of "criminal record history" to provide transparency around the source of the information collected for a criminal record history check.

Legend:
Yellow = Changes will be made to bylaws resulting from feedback received.
Red = No changes proposed to bylaws based on feedback received.

PODSA Ownership Bylaws - Public Posting Feedback		
Requirements	**Comments Received**	**Policy Decisions from Review of Feedback**
s.13(2) Pursuant to section 7(3) of the Act, the registrar may authorize the direct owner, indirect owner(s) or manager of an unlicensed pharmacy, or a full pharmacist to continue the operation of the pharmacy for a period not exceeding 90 days, for the limited purpose of transferring drugs and personal health information on the premises to another licenced pharmacy.	**BCPhA, Chain Drug Association of BC and London Drugs:** •We see several concerns with this subsection. •First we are uncertain what is meant by an "unlicensed pharmacy", because section 7(3) of the Act does not deal with unlicensed pharmacies. Rather it prohibits the operation of the pharmacy if the direct owner becoming ineligible to hold a licence after the licence has been issued. •It appears that there is nothing in the proposed bylaw that would permit the continued operation of a pharmacy after a direct owner becomes ineligible. •Therefore, (unless the licence specifically authorizes), when a direct owner becomes ineligible the pharmacy will automatically have to stop operating. •This is a draconian outcome, especially because becoming ineligible does not trigger a licence cancellation under subsection 6 of the Act. •Rather the inquiry and discipline processes under ss. 32-40 of the HPA apply and ss. 20(3)(b) of the Act authorizes actions to be taken - including suspension or cancellation of a pharmacy licence - if the direct owner ceases to eligible under section 3 to hold a pharmacy licence. •We do not understand why the College has not proposed a bylaw to permit continued operation after a direct owner becomes ineligible, which is the purpose of s.7(3) of the Act.	• The wording "unlicensed pharmacy" has been changed to "unlawful operation" to reflect the language used in the Act. • The College has drafted bylaws with legal counsel under subsection 7(3) of the Act, for the Application Commttee to allow a pharmacy to operate pending the committees review of the direct owners eligibility to hold a pharmacy licence under section 3 of the Act.
s.14(1) If a direct owner changes, the registrar may issue a new pharmacy licence upon receipt of the following from the new direct owner: (a) Form 8A; (b) the fee(s) specified in Schedule “A”; (c) a copy of the pharmacy’s current business licence issued by the municipality, if applicable; and (d) the documents listed in sections 3(3), 3(4) and 3(5) as applicable.	**BCPhA, Chain Drug Association of BC and London Drugs:** •section 14 does not account for the practical compliance problems that will arise for both the College and registrants as a result of the amendments in Bill 6. •The combined operation of section 6 and 7(2) of the Act is that a licence is automatically and immediately cancelled, and continued operation of the pharmacy is prohibited. •For clarity and to avoid creating the risk of such "technical cancellations", we recommend that 14(1) be amended to include "with an effective date as determined by the registrar"	• If the direct owner changes, the direct owner and indirect owner must give written notice to the registrar notice no later than 30 days before the direct owner changes. This timeline was drafted to allow for the new direct owner's eligibility to be assessed within the 30 days. • If the direct owner ceases to be eligible, the pharmacy must not operate. • The College has drafted bylaws with legal counsel under subsection 7(3) of the Act, for the Application Commttee to allow a pharmacy to operate pending the committees review of the direct owners eligibility to hold a pharmacy licence under section 3 of the Act.
s.14(4) If there is a change of manager, the registrar may issue a new pharmacy licence upon receipt of: (a) Form 8C submitted by the direct owner; (b) the fee(s) specified in Schedule “A”, and (c) proof of eligibility in Form 5 and a criminal record history in accordance with section 12 submitted by the new manager.	**BCPhA, Chain Drug Association of BC and London Drugs:** •section 14 does not account for the practical compliance problems that will arise for both the College and registrants as a result of the amendments in Bill 6. •The combined operation of section 6 and 7(2) of the Act is that a licence is automatically and immediately cancelled, and continued operation of the pharmacy is prohibited. •We believe this is an unintended consequence, especially in light of the College's past practice of continuing a licence until the College receives and processes a new manager appointment, then formally granting a new licence effective as the new manager's start date. •For clarity and to avoid creating the risk of such "technical cancellations", we recommend that 14(4) be amended to clearly authorize the College's existing practice of making the new pharmacy licence effective on the date the manager changes.	• No change is proposed. • If a manager changes, the direct owner and indirect owner must give written notice to the registrar notice no later than 7 days before the manager ceases to be a manager. Operationally, the College will allow an "interim" manager until the new manager's eligibility is assessed. • If a manager ceases to be eligible, then, consequentially the direct owner ceases to be eligible and the pharmacy must not operate. The new bylaw referred to in Rows 6 & 7 of this table, will address immediate changes in the direct owner.
s.15(4) If there is a change in location of the pharmacy, the registrar may issue a new pharmacy licence upon receipt of the following from the direct owner: (a) Form 8F; (b) the fee(s) specified in Schedule “A”; and (c) the requirements in section 3(2)(c), (d) and (e) for a community pharmacy, or (d) the requirements in section 6(2)(c) for a hospital pharmacy; and (e) a copy of the pharmacy’s current business licence issued by the municipality, if applicable.	**BCPhA, Chain Drug Association of BC and London Drugs:** •Although it is unlikely that the location of a pharmacy would change unexpectedly, for consistency it is appropriate for the registrar to have the same authority in those circumstances. As such, this section should also be amended by adding "with an effective date as determined by the registrar".	• No change is proposed. A change in location must occur within a prescribed timeline, set out in regulation. The College anticipates that the Ministry will be bringing forward a timeline regulation to come into effect with the Act changes.
s.16(2)(g) establish policies and procedures to specify the duties to be performed by registrants and support persons;	**BCPhA, Chain Drug Association of BC and London Drugs:** •Section 16 imposes duties directly onto owners, directors and officers to do certain things. •In most other subsections the duty is to "ensure" that a thing be done, which makes more sense given that most owners, directors and officers have oversight rules. •Accordingly, these requirements should be amended for consistency.	•The following amendment will be made to section 16(8)(a) ensure compliance with subsections 2(d), (e), (g), (j), (k), (p), (p.1), (q), (z) and (aa);

PODSA Ownership Bylaws - Public Posting Feedback		
Requirements	**Comments Received**	**Policy Decisions from Review of Feedback**
s.16(2)(q) establish and maintain policies and procedures respecting pharmacy security;	**BCPhA, Chain Drug Association of BC and London Drugs:** •Section 16 imposes duties directly onto owners, directors and officers to do certain things. •In most other subsections the duty is to "ensure" that a thing be done, which makes more sense given that most owners, directors and officers have oversight roles. •Accordingly, these requirements should be amended for consistency.	•The following amendment will be made to section 16(8)(a) ensure compliance with subsections 2(d), (e), (g), (j), (k), (p), (p.1), (q), (z) and (aa);
s.16(8) A direct owner, directors and officers must do all of the following:	**Sanjiv Khangura:** •A line should be added requiring direct owners, directors, etc. to declare any financial interest or relationship with prescribers or physician's offices.	• No change is proposed. The College does not have authority under the Act to collect this information.
s.16(8)(c) notify the registrar of any change of name, address, telephone number, electronic mail address or any other information previously provided to the registrar; and	**BCPhA, Chain Drug Association of BC and London Drugs:** •Section 16 imposes duties directly onto owners, directors and officers to do certain things. •In most other subsections the duty is to "ensure" that a thing be done, which makes more sense given that most owners, directors and officers have oversight rules. •Accordingly, these requirements should be amended for consistency.	• No change is proposed. The intent of this requirement is to require direct owners, directors and officers to notify the registrar of any changes to the information that they provide to the College.
s.16(8)(d) in the event of a pharmacy closure under subsection 2(t), notify the registrar in writing at least thirty days before the effective date of proposed closure in Form 4.	**BCPhA, Chain Drug Association of BC and London Drugs:** •Section 16 imposes duties directly onto owners, directors and officers to do certain things. •In most other subsections the duty is to "ensure" that a thing be done, which makes more sense given that most owners, directors and officers have oversight rules. •Accordingly, these requirements should be amended for consistency.	•No change is proposed. The intent of this requirement is to require notification to the registrar of a pharmacy closure from the pharmacy manager and direct owner. Form 4 is the mechanism for this notification. Where a direct owner is a corporation, the form allows for an authorized representative (directors or officers) to provide the notification on behalf of the direct owner.

Ownership Forms - Public Posting Feedback		
Form	**Comments Received**	**Policy Decisions from Review of Feedback**
Form 5 Manager/Direct Owner/Indirect Owner - Proof of Eligibility	**London Drugs:** •Form 5 requires indirect owners to declare in section 5 that they personally must comply with all duties under PODSA, HPA and College bylaws and regualtions - even though that shareholder may have no actual involvement, control or knowledge of that pharmacies practice - that is problematic in our view. •Bylaw 16(9) distinguishes between obligations of shareholders and other categories of owners by specifying that only subsection 2(d) and 8(c) apply, but no such comparable distinction is made in the declaration in Form 5.	•No change is proposed to the Form as legislation must be reviewed together. The declaration in Form 5 read alongside the Act (section 7.1(1)) and the bylaws (subsection 16(9)) means that shareholders must meet their duties (those applicable to them - bylaws).

Pharmacy Operations and Drug Scheduling Act - BYLAWS

Table of Contents

Commented [AK1]: Minor and additional changes made after the public posting period of the bylaws are highlighted in yellow. A number of these changes are consequential amendments made to previously filed telepharmacy bylaws, which were approved by the Board in June 2017 and are expected to be effective on November 14, 2017.

FORMS

1A. Application for New Pharmacy Licence – Community

1C. Application for New Pharmacy Licence – Hospital

1E. Application for Hospital Satellite

1F. Application for New Pharmacy Licence – Pharmacy Education Site

2. Application for New Telepharmacy Licence - Community

2A. Application for Pharmacy Licence Renewal – Community

2C. Application for Pharmacy Licence Renewal – Hospital

2F. Application for Pharmacy Licence Renewal – Pharmacy Education Site

3A. Application for Pharmacy Licence Reinstatement – Community

3C. Application for Pharmacy Licence Reinstatement – Hospital

3F. Application for Pharmacy Licence Reinstatement – Pharmacy Education Site

4. Application for Pharmacy Closure

5. Manager/Direct Owner/Indirect Owner – Proof of Eligibility

6. Manager/Direct Owner/Indirect Owner – Notice of Ineligibility

7. Indirect Owner – Email Contacts

8A. Application for Change of Direct Owner

8B. Application for Change of Indirect Owner(s)

8C. Application for Change of Manager

8D. Application for Change of Corporation Name

8E. Application for Change of Operating Name

8F. Application for Change of Location

8G. Application for Change of Layout

10. Pharmacy Pre-Opening Inspection Report – Community

11. ~~Telepharmacy~~ Pharmacy Pre-Opening Inspection Report – Community Telepharmacy

12. Application for Telepharmacy Licence Renewal - Community

~~New Pharmacy Application~~

~~Telepharmacy Services Application~~

~~a. Hospital Pharmacy Satellite Application~~

~~2. Community Pharmacy Licence Renewal Notice~~

~~3. Hospital Pharmacy Licence Renewal Notice~~

~~4. Education Site License Renewal Notice~~

Definitions

1. In these bylaws:

"*Act*" means the *Pharmacy Operations and Drug Scheduling Act*;

"attestation" means the attestation referred to in section 2(2)(d)(ii) of the *Act*;

"British Columbia Company Summary" means a summary issued by the BC Corporate Registry Services;

"central pharmacy" means a community pharmacy that holds one or more telepharmacy licences;

"Central Securities Register" means the register maintained under section 111(1) of the *Business Corporations Act* [SBC 2002] C.57 as amended from time to time;

"community pharmacy" means a pharmacy licensed to sell or dispense drugs to the public, but does not include a telepharmacy;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established under section 19-(1)-(k) of the *Health Professions Act* respecting community pharmacies;

"controlled drug substance" means a drug which includes a substance listed in the Schedules to the *Controlled Drugs and Substances Act* (Canada) or Part G of the *Food and Drug Regulations* (Canada);

"controlled prescription program" means a program approved by the board, to prevent prescription forgery and reduce inappropriate prescribing of drugs;

"criminal record history" means the results of a criminal record search of Royal Canadian Mounted Police and local police databases, in the form approved by the board from time to time;

"direct owner" has the same meaning as in section 1 of the *Act*;

"**direct supervision**" means real time audio and visual observation by a full pharmacist of pharmacy services performed at a telepharmacy consistent with a pharmacy manager's responsibilities as set out in subsection 18(2);

"dispensary" means the area of a community pharmacy or a telepharmacy that contains Schedule I and II drugs;

"drug" has the same meaning as in section 1 of the ~~Pharmacy Operations and Drug Scheduling Act~~*Act*;

"full pharmacist" means a member of the college who is registered in the class of registrants established in section 41(a) of the ~~*Health Professions Act*~~Bylaws under the *Health Professions Act*;

"health authority" ~~means~~ includes

(a) a regional health board designated under the *Health Authorities Act*, ~~or~~
(b) the Provincial Health Services Authority, ~~or~~
(c) First Nations Health Authority, and
~~(c)~~(d) Providence Health Care Society.~~;~~

"hospital" has the same meaning as in section 1 of the *Hospital Act*;

"hospital pharmacy" means a pharmacy licensed to operate in or for a hospital;

"hospital pharmacy satellite" means a physically separate area on or outside the hospital premises used for the provision of pharmacy services which is dependent upon support and administrative services from the hospital pharmacy;

"Hospital Pharmacy Standards of Practice" means the standards, limits and conditions for practice established under section 19(1)(k) of the *Health Professions Act* respecting hospital pharmacies;

"incentive" has the same meaning as in Part 1 of Schedule "F" of the bylaws of the college under the *Health Professions Act;*

"indirect owner" has the same meaning as in section 1 of the *Act*;

"manager" has the same meaning as in section 1 of the *Act*;

"outsource prescription processing" means to request another community pharmacy to prepare or process a prescription drug order;

"patient's representative" has the same meaning as in section 64 of the bylaws of the college under the *Health Professions Act*;

"personal health information" has the same meaning as in section 25.8 of the *Health Professions Act*;

"pharmacy" has the same meaning as in section 1 of the *Act*;

"pharmacy education site" means a pharmacy

(a) that has Schedule I, II and III drugs, but no controlled drug substances,
(b) that is licensed solely for the purpose of pharmacy education, and
(c) from which pharmacy services are not provided to any person.~~;~~

"pharmacy security" means

(a) measures to prevent unauthorized access and loss of Schedule I, IA, II and III drugs, and controlled drug substances;
(b) measures providing for periodic and post-incident review of pharmacy security;

(c) measures to protect against unauthorized access, collection, use, disclosure or disposal of personal health information.

"pharmacy services" has the same meaning as in section 1 of the bylaws of the college under the *Health Professions Act*;

"pharmacy technician" has the same meaning as in section 1 of the bylaws of the college under the *Health Professions Act*;

"prescription drug" means a drug referred to in a prescription;

"professional products area" means the area of a community pharmacy that contains Schedule III drugs;

"professional service area" means the area of a community pharmacy that contains Schedule II drugs;

"Residential Care Facilities and Homes Standards of Practice" means the standards, limits and conditions for practice established under section 19 (1) (k) of the *Health Professions Act* respecting residential care facilities and homes;

"**rural and remote community**" means a community set out in Schedule "H";

"Schedule I, Schedule IA, Schedule II, or Schedule III", as the case may be, refers to the drugs listed in Schedule I, IA, II or III of the *Drug Schedules Regulation*;

"support person" has the same meaning as in the *Act* except that it does not include a pharmacy technician;

"telepharmacy" means a pharmacy located in a rural and remote community that is licenced to provide pharmacy services;

"**Telepharmacy Standards of Practice**" means the standards, limits and conditions for practice established under subsection 19(1)(k) of the Health Professions Act respecting the operation of telepharmacies.

PART I – Pharmacy Licences

Licence Types

2. (1) The registrar may issue a licence for any of the following:

(a) a community pharmacy;

(b) a hospital pharmacy;

(c) a pharmacy education site; or

~~(a)~~(d) a telepharmacy.

New Community Pharmacy Licence

3 (1) Applicants for a new community pharmacy licence must submit an application consistent with the type of ownership under section 5(2) of the *Act*.

(2) A direct owner may apply for a new community pharmacy licence by submitting:

(a) an application in Form 1A;

(b) the fee(s) specified in Schedule "A";

(c) a diagram professionally drawn to a scale of ¼ inch equals 1 foot, including the measurements and entrances of the pharmacy, ~~confirming~~demonstrating compliance with ~~Schedule "C"~~the physical requirements in the bylaws and applicable policies;

(d) Form 10;

(e) photographs or video ~~confirming~~demonstrating compliance with the physical requirements in the bylaws and applicable policies~~Schedule "C"~~; and

(f) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable.

(3) In addition to the requirements in subsection (2), a direct owner described in section 5(2)(b) or (c) of the *Act* must submit:

(a) Form 7;

(b) a copy of the power(s) of attorney, if applicable;

(c) a copy of the Certificate of Incorporation, and

(d) a copy of the Notice of Articles, or

(e) a copy of the British Columbia Company Summary, whichever is current;

(f) a certified true copy of the Central Securities Register if a direct owner is or includes a corporation that is not traded publicly; and

(g) a certified true copy of the Central Securities Register for a parent corporation if a direct owner is a subsidiary corporation.

(4) If an indirect owner is a company incorporated under the *Company Act* or the *Business Corporations Act* that is not traded publicly, the following must be submitted for that company:

(a) a copy of the power(s) of attorney, if applicable;

(b) a copy of the Certificate of Incorporation, and

(c) a copy of the Notice of Articles, or

(d) a copy of the British Columbia Company Summary, whichever is current; and

(e) a certified true copy of the Central Securities Register.

(5) Proof of eligibility in Form 5 and a criminal record history in accordance with section 142 must be submitted by the following:

(a) any pharmacist who is a direct owner described in section 5(2)(a) of the *Act*;

(b) indirect owner(s); and

(c) the manager.

Community Pharmacy Licence -Renewal

4. (1) A direct owner may apply to renew a community pharmacy licence no later than 30 days prior to the expiry of the existing pharmacy licence by submitting:

(a) an application in Form 2A;

(b) the fee(s) specified in Schedule "A";

(c) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable; and

(d) a copy of the current British Columbia Company Summary, if a direct owner is or includes a corporation.

(2) At the time of the renewal application, an attestation in Form 5 must be submitted by:

(a) any pharmacist who is a direct owner described in section 5(2)(a) of the *Act*;

(b) indirect owner(s); and

(c) the manager.

(3) An application submitted later than 30 days prior to the expiry of the pharmacy licence is subject to the fee(s) specified in Schedule "A".

4.1. The first application to renew an existing licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act 2016* comes into force, is an application for a new community pharmacy licence under section 3 but the requirements in subsections 3(2)(c),(d) and (e) do not apply.

Community Pharmacy Licence Reinstatement

5. (1) A direct owner may apply to reinstate a community pharmacy licence that has been expired for 90 days or less by submitting:

(a) an application in Form 3A;

(b) the fee(s) specified in Schedule "A";

(c) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable; and

(d) a copy of the current British Columbia Company Summary, if the direct owner is or includes a corporation.

(2) At the time of the reinstatement application, an attestation in Form 5 must be submitted by:

(a) any pharmacist who is a direct owner described in section 5(2)(a) of the *Act*;

(b) indirect owner(s); and

(c) the manager.

5.1. The first application to reinstate an existing licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act 2016* comes into force, is an application for a new community pharmacy licence under section 3 but the requirements in subsections 3(2)(c),(d) and (e) do not apply.

New Hospital Pharmacy Licence

6. (1) Applicants for a new hospital pharmacy licence must submit an application consistent with the type of ownership under section 5(2) of the *Act*.

(2) A direct owner may apply for a new hospital pharmacy licence by submitting:

(a) an application in Form 1C;

(b) the fee(s) specified in Schedule "A"; and

(c) a diagram professionally drawn to a scale of ¼ inch equals 1 foot, including the measurements and entrances of the pharmacy, confirming compliance with Schedule "D".

(3) The manager must submit an attestation in Form 5 and a criminal record history in accordance with section 142.

(4) A pharmacy located in a hospital which dispenses drugs to staff, out-patients or the public and which is not owned or operated by a health authority, must be licenced as a community pharmacy.

Hospital Pharmacy Licence Renewal

7. (1) A direct owner may apply to renew a hospital pharmacy licence no later than 30 days prior to the expiry of the existing pharmacy licence by submitting:

(a) an application in Form 2C; and

(b) the fee(s) specified in Schedule "A".

(2) At the time of the renewal application, the manager must submit an attestation in Form 5.

(3) An application submitted later than 30 days prior to the expiry of the pharmacy licence is subject to the fee(s) specified in Schedule "A".

7.1. The first application to renew an existing hospital licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act 2016* comes into force, is an application for a new hospital pharmacy licence under section 6 but the requirement in subsection 6(2)(c) does not apply.

Hospital Pharmacy Licence Reinstatement

8. (1) A direct owner may apply to reinstate a pharmacy licence that has been expired for 90 days or less by submitting:

(a) an application in Form 3C; and

(b) the fee(s) specified in Schedule "A".

(2) At the time of the reinstatement application, the manager must submit an attestation in Form 5.

8.1. The first application to reinstate an existing licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act* 2016 comes into force, is an application for a new hospital pharmacy licence under section 6 but the requirement in subsection 6(2)(c) does not apply.

New Pharmacy Education Site Licence

9. (1) Applicants for a new pharmacy education site licence must submit an application consistent with the type of ownership under section 5(2) of the *Act*.

(2) A direct owner may apply for a new pharmacy education site licence by submitting:

(a) an application in Form 1F; and

(b) the fee(s) specified in Schedule "A".

(3) The manager must submit an attestation in Form 5 and a criminal record history in accordance with section 142.

Pharmacy Education Site Licence Renewal

10. (1) A direct owner may apply to renew a pharmacy education licence no later than 30 days prior to the expiry of the existing pharmacy licence by submitting:

(a) an application in Form 2F; and

(b) the fee(s) specified in Schedule "A".

(2) At the time of the renewal application, the manager must submit an attestation in Form 5.

(3) An application submitted later than 30 days prior to the expiry of the pharmacy licence is subject to the fee(s) specified in Schedule "A".

10.1. The first application to renew an existing licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act* 2016 comes into force, is an application for a new pharmacy education site licence under section 9.

Pharmacy Education Site Licence Reinstatement

11. (1) A direct owner may apply to reinstate a pharmacy education site licence that has been expired for 90 days or less by submitting:

(a) an application in Form 3F; and

(b) the fee(s) specified in Schedule "A".

(2) At the time of the reinstatement application, the manager must submit an attestation in Form 5.

11.1. The first application to reinstate an existing licence, submitted after the *Pharmacy Operations and Drug Scheduling Amendment Act* 2016 comes into force, is an application for a new pharmacy education site licence under section 9.

New Telepharmacy Licence

12. A direct owner of a community pharmacy may apply for a new telepharmacy licence by submitting:

(a) an ~~completed~~ application in Form 2;

(b) the ~~applicable~~ fee(s) specified in Schedule "A";

(c) a diagram professionally drawn to a scale of ¼ inch equals 1 foot, including the measurements and entrances of the telepharmacy, ~~and~~ confirming ~~that the telepharmacy meets the requirements listed in~~ compliance with Schedule~~s~~ "C" ~~and "E"~~;

(d) Form 11;

(e) photographs or video ~~in Form 11 of the requirements listed in~~confirming compliance with Schedules "C" and "E"~~,~~; and

(~~e~~f) if applicable, a copy of the telepharmacy's business licence issued by the jurisdiction in which the telepharmacy is located.

Telepharmacy Licence Renewal

13. ~~The registrar~~A direct owner may apply to renew a telepharmacy licence ~~upon receipt of the following~~no later than 30 days prior to the expiry of the existing telepharmacy licence by submitting:

(a) an application in Form 12;~~,~~

(b) the fee(s) ~~set out~~ specified in Schedule "A";~~,~~ and

(c) if applicable, a copy of the telepharmacy's business licence issued by the jurisdiction in which the telepharmacy is located.

Criminal Record History of Direct Owner, Indirect Owner(s) and Manager

14~~2~~. A direct owner, indirect owner(s) and a manager must submit a criminal record history pursuant to section 5.1 of the *Act*, in the form approved by the board from time to time.

~~Operating without a Pharmacy Licence~~Unlawful Operation

15~~3~~. (1) Pursuant to section 7(1) of the *Act*, persons listed in Schedule "B" are authorized under this bylaw to store, dispense or sell drugs or devices to the public.

(2) Pursuant to section 7(3) of the *Act*, the registrar may authorize the direct owner, indirect owner(s) or manager of an unlicensed pharmacy, or a full pharmacist to continue the operation of the pharmacy for a period not exceeding 90 days, for the limited purpose of transferring drugs and personal health information on the premises to another licenced pharmacy.

(3) On receiving a referral under section 16(6), the application committee may consider whether to authorize the operation of the pharmacy pursuant to section 7(3) of the *Act* pending a determination under section 4(4)(b) of the *Act* as to relevance or risk to the public.

PART I~~I~~ - All Pharmacies

Change in Direct Owner, Indirect Owner(s) or Manager

16~~4~~. (1) If a direct owner changes, the registrar may issue a new pharmacy licence upon receipt of the following from the new direct owner:

(a) Form 8A;

(b) the fee(s) specified in Schedule "A";

(c) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable; and

(d) the documents listed in sections 3(3), 3(4) and 3(5) as applicable.

(2) If there is a change of indirect owner(s) the following must be submitted:

(a) Form 8B;

(b) the fee(s) specified in Schedule "A";

(c) a Notice of Change of Directors, if applicable;

(d) a certified true copy of the Central Securities Register, if there is a change of shareholder(s) of a non-publicly traded corporation; and

(e) the documents listed in sections 3(3), 3(4) and 3(5), as applicable.

(3) If the change in subsection (2) includes a new indirect owner(s), proof of eligibility in Form 5 and a criminal record history in accordance with section 142 must be submitted by the new indirect owner(s).

(4) If there is a change of manager, the registrar may issue a new pharmacy licence upon receipt of:

(a) Form 8C submitted by the direct owner;

(b) the fee(s) specified in Schedule "A"; and

(c) proof of eligibility in Form 5 and a criminal record history in accordance with section 142 submitted by the new manager.

(5) In the event that a direct owner, indirect owner(s) or manager is no longer eligible under section 3 of the *Act*, the direct owner, indirect owner(s) or manager must submit a notice in Form 6.

(6) On receipt of a Form 6 under subsection (5), the Registrar must refer the matter to the application committee who may act under sections 4(3), 4(4), 4(5) of the *Act*.

Changes to the Pharmacy Premises and Name

175. (1) If there is a change in the name of a corporation that is a direct owner the following must be submitted:

(a) Form 8D;

(b) the fee(s) specified in Schedule "A";

(c) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable; and

(d) a copy of the Alteration to the Notice of Articles.

(2) If there is a change in the name of a corporation that is an indirect owner, the following must be submitted:

(a) Form 8D;

(b) the fee(s) specified in Schedule "A"; and

(c) a copy of the Alteration to the Notice of Articles.

(3) If there is a change in the operating name of the pharmacy, the following must be submitted:

(a) Form 8E;

(b) the fee(s) specified in Schedule "A"; and

(c) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable.

(4) If there is a change in location of the pharmacy, the registrar may issue a new pharmacy licence upon receipt of the following from the direct owner:

(a) Form 8F;

(b) the fee(s) specified in Schedule "A"; and

(c) the requirements in section 3(2)(c), (d) and (e) for a community pharmacy, or

(d) the requirements in section 6(2)(c) for a hospital pharmacy; and

(e) a copy of the pharmacy's current business licence issued by the jurisdiction, if applicable.

(5) If there is a change in layout of the pharmacy, the direct owner must submit the following:

(a) Form 8G;

(b) the fee(s) specified in Schedule "A"; and

(c) a diagram, photographs or video to demonstrate the changes in layout in accordance with section 3(2)(c),(d) and (e) for a community pharmacy, or

(d) a diagram to demonstrate the changes in layout in accordance with section 6(2)(c) for a hospital pharmacy.

~~**Application of Part**~~

~~2. This part applies to all pharmacies except pharmacy education sites.~~

Responsibilities of ~~Pharmacy~~ Manager, Direct Owners, Directors, Officers and Shareholders

~~(1)~~186~~.~~ (1) A full pharmacist may not act as manager of more than one pharmacy location, unless the pharmacy of which the full pharmacist is manager includes

(a) a telepharmacy,

(b) a hospital pharmacy,

(c) a hospital pharmacy satellite, or

(d) a pharmacy education site.

(2) A manager must do all of the following:

(a) actively participate in the day-to-day management of the pharmacy;

(b) confirm that the staff members who represent themselves as registrants are registrants;

(c) notify the registrar in writing of the appointments and resignations of registrants as they occur;

(d) cooperate with inspectors acting under section 17 of the *Act* or sections 28 or 29 of the *Health Professions Act*;

(e) ensure that

(i) registrant and support persons staff levels are sufficient to ensure that workload volumes and patient care requirements are met at all times in accordance with the bylaws, Code of Ethics and standards of practice, and

(ii) meeting quotas, targets or similar measures do not compromise patient safety or compliance with the bylaws, Code of Ethics or standards of practice;

(f) ensure that new information directed to the pharmacy pertaining to drugs, devices and drug diversion is immediately accessible to registrants and support persons;

(g) establish policies and procedures to specify the duties to be performed by registrants and support persons;

(h) establish procedures for

(i) inventory management,

(ii) product selection, and

(iii) proper destruction of unusable drugs and devices;

(i) ensure that all records related to the purchase and receipt of controlled drug substances are signed by a full pharmacist;

(j) ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present;

(k) ensure there is a written drug recall procedure in place for pharmacy inventory;

(l) ensure that all steps in the drug recall procedure are documented, if the procedure is initiated;

(m) ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status;

(n) notify the registrar as soon as possible in the event that he or she will be absent from the pharmacy for more than eight weeks;

(o) notify the registrar in writing within 48 hours of ceasing to be the pharmacy's manager;

(p) ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery;

(p.1) if the pharmacy is a central pharmacy, ensure the correct and consistent use of each telepharmacy operating name as it appears on the telepharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery associated with that telepharmacy;

(q) establish and maintain policies and procedures respecting pharmacy security;

(r) ensure that pharmacy staff are trained in policies and procedures regarding pharmacy security;

(s) notify the registrar of any incident of loss of narcotic and controlled drug substances within 24 hours;

(t) in the event of a pharmacy closure or relocation,

~~(i) notify the registrar in writing at least thirty days before the effective date of a proposed closure or relocation, unless the registrar determines there are extenuating circumstances,~~

~~(ii)~~(i) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances,

~~(iii)~~(ii) advise the registrar in writing of the disposition of all drugs and prescription records at the time of a closure,

~~(iv)~~(iii) provide the registrar with a copy of the return invoice and any other documentation sent to Health Canada in respect of the destruction of all controlled drug substances,

~~(v)~~(iv) arrange for the safe transfer and continuing availability of the prescription records at another pharmacy, or an off-site storage facility that is bonded and secure, and

(v) remove all signs and advertisements from the closed pharmacy premises;

(u) in the event that a pharmacy will be closed temporarily for up to 14 consecutive days,

(i) notify patients and the public of the temporary closure at least 30 days prior to the start of the temporary closure, and

(ii) make arrangements for emergency access to the pharmacy's hard copy patient records.

~~(i) ensure sample drugs are dispensed in accordance with the requirements in the Drug Schedules Regulation;~~

~~(u)~~(v) advise the registrar if the pharmacy is providing pharmacy services over the internet, and provide to the registrar the internet address of every website operated or used by the pharmacy;

~~(v)~~(w) ensure the pharmacy contains the reference material and equipment approved by the board from time to time;

~~(w)~~(x) require ~~all registrants, owners, managers, directors, pharmaceutical representatives, support persons and computer software programmers or technicians~~ anyone who will access the in-pharmacy computer system to sign an undertaking in a form approved by the registrar to maintain the confidentiality of patient personal health information;

(y) retain the undertakings referred to in paragraph (x) in the pharmacy for 3 years after employment or any contract for services has ended;

~~(x)~~(z) provide the registrar with access to the pharmacy premises in cases where a pharmacy licence has been cancelled or suspended due to loss of eligibility under section 3 of the *Act*;

~~(y) be informed of the emergency preparedness plan in the area of the pharmacy that he or she manages and be aware of his or her responsibilities in conjunction with that plan;~~

(aa) ensure that no incentive is provided to a patient or patient's representative for the purpose of inducing the patient or patient's representative to

(a) deliver a prescription to a particular registrant or pharmacy for dispensing of a drug or device specified in the prescription, or

(b) obtain any other pharmacy service from a particular registrant or pharmacy, and

(bb) notify the registrar of persistent non-compliance by ~~owners and directors~~a direct owner and indirect owner(s) with their obligations under the bylaws to the *Act*~~.~~; and

(cc) notify the registrar of any change of telephone number, fax number, electronic mail address or any other information previously provided to the registrar.

(3) Subsection (2)(p) does not apply to a hospital pharmacy, hospital pharmacy satellite, telepharmacy or a pharmacy education site.

(4) For the purpose of subsection (2)(t), a pharmacy closure includes a suspension of the pharmacy licence for a period of more than 30 days, unless otherwise directed by the registrar.

~~(4) Owners and directors must comply with subsection (2) (d), (e), (j), (p), (q), (t), (v), (w), (x) and (aa).~~

~~(5) An owner or director must appoint a manager whenever necessary, and notify the registrar in writing of the appointment and any resignation of a manager.~~

~~(6) Owners and directors must ensure that the requirements to obtain a pharmacy licence under the *Act* are met at all times.~~

~~(7) For the purpose of subsection (2)(t), a pharmacy closure includes a suspension of the pharmacy licence for a period greater than 30 days, unless otherwise directed by the registrar.~~

(5) Subsection (2)(aa) does not prevent a manager~~, or director, or an owner~~direct owner or indirect owner(s) ~~-~~from

(a) providing free or discounted parking to patients or patient's representatives,

(b) providing free or discounted delivery services to patients or patient's representatives, or

(c) ~~-~~accepting payment for a drug or device by a credit or debit card that is linked to an incentive.

~~3.2~~(6) Subsection (2)(aa) does not apply in respect of a Schedule III drug or an unscheduled drug, unless the drug has been prescribed by a practitioner.

(7) A pharmacy education site's manager must ensure that only registrants and instructors are present in the pharmacy education site and must also comply with subsections (2)(a), (d), (h), (o), (r) and (t)(i) and (ii).

(8) A direct owner, directors and officers must do all of the following:

(a) ~~comply~~ensure compliance ~~-~~with subsections 2(d), (e), (g), (j), (k), (p), (p.1), (q), (z) and (aa);

(b) ensure that the requirements to hold a pharmacy licence under the Act are met at all times;

(c) notify the registrar of any change of name, address, telephone number, electronic mail address or any other information previously provided to the registrar; and

(d) in the event of a pharmacy closure under subsection 2(t), notify the registrar in writing at least thirty days before the effective date of proposed closure in Form 4.

(9) Shareholders must comply with subsections 2(d) and 8(c).

Sale and Disposal of Drugs

4197. (1) Schedule I, II, and III drugs and controlled drug substances must only be sold or dispensed from a pharmacy.

(2) A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.

(3) If the manufacturer's expiry date states the month and year but not the date, the expiry date is the last day of the month indicated.

(4) Every registrant practising in a pharmacy is responsible for the protection from loss, theft or unlawful sale or dispensing of all Schedule I, II, and III drugs and controlled drug substances in or from the pharmacy.

(5) A registrant must not sell, dispense, dispose of or transfer a Schedule I drug except

(a) on the prescription or order of a practitioner,

(b) for an inventory transfer to a pharmacy by order of a registrant in accordance with the policy approved by the board,

(c) by return to the manufacturer or wholesaler of the drug, or

(d) by destruction, in accordance with the policy approved by the board.

(6) Drugs included in the controlled prescription program must not be sold or dispensed unless

(a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and

(b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug.

(7) A new prescription from a practitioner is required each time a drug is dispensed, except for

(a) a part-fill,

(b) a prescription authorizing repeats,

(c) a full pharmacist-initiated renewal or adaptation, or

(d) an emergency supply for continuity of care.

(8) Subsection (6) does not apply to prescriptions written for

(a) residents of a facility or home subject to the requirements of the *Residential Care Facilities and Homes Standards of Practice*, or

(b) patients admitted to a hospital.

Drug Procurement/Inventory Management

~~5~~2018. (1) A full pharmacist may authorize the purchase of Schedule I, II, or III drugs or controlled drug substances only from

(a) a wholesaler or manufacturer licensed to operate in Canada, or

(b) another pharmacy in accordance with the policy approved by the board.

(2) A registrant must record a transfer of drugs that occurs for any reason other than for the purpose of dispensing in accordance with a practitioner's prescription.

(3) All drug shipments must be delivered unopened to the pharmacy or a secure storage area.

(4) Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal.

(5) A full pharmacist must not purchase Schedule I, II and III drugs and controlled drug substances unless they are for sale or dispensing in or from a pharmacy.

Interchangeable Drugs

~~6~~1921. When acting under section 25.91 of the *Health Professions Act,* a full pharmacist must determine interchangeability of drugs by reference to Health Canada's Declaration of Equivalence, indicated by the identification of a Canadian Reference Product in a Notice of Compliance for a generic drug.

Returned Drugs

~~7~~202. No registrant may accept for return to stock or reuse any drug previously dispensed except in accordance with section 11(3) of the *Residential Care Facilities and Homes Standards of Practice* or section 5(2) of the *Hospital Pharmacy Standards of Practice.*

Records

~~8~~231. (1) All prescriptions, patient records, invoices and documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs and controlled drug

substances must be retained for a period of not less than three years from the date

(a) a drug referred to in a prescription was last dispensed, or

(b) an invoice was received for pharmacy stock.

(2) Registrants, support persons, managers, direct owners~~ors~~, and indirect owners must not, for commercial purposes, disclose or permit the disclosure of information or an abstract of information obtained from a prescription or patient record which would permit the identity of the patient or practitioner to be determined.

(3) Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices or documentation until the completion of any audit or investigation currently underway for which the registrant has received notice.

~~**Pharmacy Licences**~~

~~9. (1) The registrar may issue a licence for any of the following:~~

~~a community pharmacy;~~

~~a hospital pharmacy;~~

~~a pharmacy education site.~~

~~(2) An applicant for a pharmacy licence must submit the following to the registrar:~~

~~(a) a completed application in Form 1;~~

~~(b) a diagram to scale of ½ inch equals 1 foot scale including the measurements, preparation, dispensing, consulting, storage, professional service area, professional products area, entrances and packaging areas of the pharmacy;~~

~~(c) the applicable fee set out in Schedule "A";~~

~~(d) for a community pharmacy, proof in a form satisfactory to the registrar that the municipality in which the pharmacy is located has issued a business licence for the pharmacy to the pharmacy's owner or manager.~~

~~(3) The registrar may renew a pharmacy licence upon receipt of the following:~~

~~(a) a completed notice in Form 4, 5 or 6, as applicable, signed by the manager;~~

~~(b) the applicable fee set out in Schedule "A".~~

~~(4) A pharmacy's manager must submit to the registrar, in writing, any proposed pharmacy design changes or structural renovations together with a new pharmacy diagram for approval before the commencement of construction or other related activities.~~

~~(5) If a pharmacy will be closed temporarily for up to 14 consecutive days, the pharmacy's manager must~~

~~(a) obtain the approval of the registrar,~~

~~(b) notify patients and the public of the closure at least 30 days prior to the start of the closure, and~~

~~(c) make arrangements for emergency access to the pharmacy's hard copy patient records.~~

~~(6) A pharmacy located in a hospital which dispenses drugs to staff, out-patients or the public and which is not owned or operated by a health authority, must be licenced as a community pharmacy.~~

~~(7) Subsections (4) to (6) do not apply to a pharmacy education site.~~

PART II**I** – Community Pharmacies

Community **Pharmacy's** ~~Pharmacy~~ Manager – Quality Management

~~10~~242. (1) A community pharmacy's manager must develop, document and implement an ongoing quality management program that

(a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a community pharmacy,

(b) monitors staff performance, equipment, facilities and adherence to the *Community Pharmacy Standards of Practice*, and

(c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies.

(2) If a community pharmacy is a central pharmacy, the quality management program in subsection (1) must include all telepharmacies associated with the central pharmacy and must comply with the *Telepharmacy Standards of Practice.*

Community Pharmacy and Telepharmacy Premises

~~11~~253. (1) In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that

(a) the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage, and

(b) a sign reading "Medication Information" is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice.

(2) Subject to subsection (3), the dispensary area of a community pharmacy or a telepharmacy must

(a) be at least 160 square feet,

(b) be inaccessible to the public by means of gates or doors across all entrances,

(c) include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters,

(d) contain adequate shelf and storage space,

(e) contain a double stainless steel sink with hot and cold running water, ~~and~~

(f) contain an adequate stock of drugs to provide full dispensing services, and~~.~~

(g) contain a refrigerator.

(3) A telepharmacy that was authorized by the registrar to provide pharmacy services as a telepharmacy remote site as of January 1, 2017 is exempt from the requirements in subsections (2)(a) and (c) until such time as it commences a renovation of all or part of the premises.

(4) In all new and renovated community pharmacies or telepharmacies, an appropriate area must be provided for patient consultation that

(a) ensures privacy and is conducive to confidential communication, and

(b) includes, but is not limited to, one of the following:

(i) a private consultation room, or

(ii) a semiprivate area with suitable barriers.

(5) All new and renovated community pharmacies and telepharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.

Community Pharmacy and Telepharmacy Security

~~11.1~~264. (1) A community pharmacy or telepharmacy must:

(a) keep Schedule IA drugs in a locked metal safe that is secured in place and equipped with a time delay lock set at a minimum of five minutes;

(b) install and maintain a security camera system that:

(i) has date/time stamp images that are archived and available for no less than 30 days, and

(ii) is checked daily for proper operation; and

(c) install and maintain motion sensors in the dispensary.

(2) When no full pharmacist is present and the premise is accessible to non-registrants,

(a) the dispensary area must be secured by a monitored alarm, and

(b) Subject to subsection 2.1, schedule I and II drugs, controlled drug substances and personal health information, are secured by physical barriers.

(2.1) A community pharmacy or telepharmacy that exists on the date this provision comes into force and is not renovated during the period must comply with section ~~11~~264.~~1~~(2)(b) no later than three years after the date that provision comes into force.

(2.2) For the purposes of subsection (2), a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy.

(3) Subject to subsection (5), a community pharmacy and a telepharmacy must clearly display at all external entrances that identify the premises as a pharmacy, and at the dispensary counter signage provided by the College~~:~~.

(4) The ~~pharmacy~~ manager, direct~~r and~~ owner~~s~~ or indirect owner(s)~~directors~~ of a community pharmacy or telepharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises~~:~~.

(5) A pharmacy that is never open to the public and has no external signage identifying it as a pharmacy is exempt from the requirements in subsection (3).

Operation of a Community Pharmacy Without a Full Pharmacist

~~12~~275~~.~~ (1) Except as provided in subsection (2), a community pharmacy must not be open to the public unless a full pharmacist is present.

(2) A community pharmacy may operate without a full pharmacist present if all the following requirements are met:

(a) the registrar is notified of the hours during which a full pharmacist is not present;

(b) a security system prevents the public, support persons and other non-pharmacy staff from accessing the dispensary, the professional service area and the professional products area;

(c) a pharmacy technician is present and ensures that the pharmacy is not open to the public;

(d) Schedule I, II, and III drugs and controlled drug substances in a secure storage area are inaccessible to support persons, other non-pharmacy staff and the public;

(e) dispensed prescriptions waiting for pickup may be kept outside the dispensary if they are inaccessible, secure and invisible to the public and the requirements of section 12 of the *Community Pharmacy Standards of Practice* have been met; and

(f) the hours when a full pharmacist is on duty are posted.

(3) If the requirements of subsection (2) are met, the following activities may be performed at a community pharmacy by anyone who is not a registrant:

(a) requests for prescriptions, orders for Schedule II and III drugs and telephone requests from patients to order a certain prescription may be placed in the dispensary area by dropping them through a slot in the barrier;

(b) orders from drug wholesalers, containing Schedule I, II and III drugs, may be received but must be kept secure and remain unopened.

Outsource Prescription Processing

~~13~~286. (1) A community pharmacy may outsource prescription processing if

(a) all locations involved in the outsourcing are community pharmacies,

(b) all prescriptions dispensed are labeled and include an identifiable code that provides a complete audit trail for the dispensed drug, and

(c) a notice is posted informing patients that the preparation of their prescription may be outsourced to another pharmacy.

(2) The manager of an outsourcing community pharmacy must ensure that all applicable standards of practice are met in processing prescriptions at all locations involved in the outsourcing.

(3) In this section, "community pharmacy" includes a hospital pharmacy.

PART ~~III~~ IV – Hospital Pharmacies

Hospital Pharmacy's ~~Pharmacy~~ Manager – Quality Management

~~14~~297. (1) A hospital pharmacy's manager must develop, document and implement an ongoing quality management program that

(a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a hospital pharmacy,

(b) monitors staff performance, equipment, facilities and adherence to the *Hospital Pharmacy Standards of Practice*,

(c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies,

(d) documents periodic audits of the drug distribution process,

(e) includes a process to review patient-oriented recommendations,

(f) includes a process that reviews a full pharmacist's documentation notes in the hospital's medical records,

(g) includes a process to evaluate drug use, and

(h) regularly updates policies and procedures for drug use control and patient-oriented pharmacy services in collaboration with the medical and nursing staff and appropriate committees.

(2) If sample drugs are used within a hospital, the hospital pharmacy's manager must ensure that the pharmacy oversees the procurement, storage and distribution of all sample drugs.

After Hours Service

~~15~~3028. (1) If continuous pharmacy services are not provided in a hospital, the hospital pharmacy's manager must ensure that urgently needed drugs and patient-oriented pharmacy services are available at all times by

(a) providing a cabinet which must

(i) be a locked cabinet or other secure enclosure located outside of the hospital pharmacy, to which only authorized persons may obtain access,

(ii) be stocked with a minimum supply of drugs most commonly required for urgent use,

(iii) not contain controlled drug substances unless they are provided by an automated dispensing system,

(iv) contain drugs that are packaged to ensure integrity of the drug and labeled with the drug name, strength, quantity, expiry date and lot number, and

(v) include a log in which drug withdrawals are documented, and

(b) arranging for a full pharmacist to be available for consultation on an on-call basis.

(2) When a hospital pharmacy or hospital pharmacy satellite is closed, the premises must be equipped with a security system that will detect unauthorized entry.

PART ~~IV~~ V – Telepharmacy

Telepharmacy Licence

~~16~~3129. (1) The registrar must not issue a telepharmacy licence to a central pharmacy unless

(a) the proposed telepharmacy will be the only telepharmacy or community pharmacy located in the rural and remote community,

(b) the proposed telepharmacy is located at least 25 kilometers away from any other telepharmacy or community pharmacy,

(c) the proposed operating name of the telepharmacy includes the word "telepharmacy",

(d) except for a pharmacy located at an address listed in Schedule "F", the proposed telepharmacy does not have a licence as a community pharmacy,

(e) the central pharmacy applicant and the telepharmacy will have the same direct owner, and

(f) the central pharmacy is in compliance, and the telepharmacy will be in compliance, with the *Telepharmacy Standards of Practice.*

(2) A telepharmacy licence issued under subsection (1) is valid only for the location stated on the telepharmacy licence.

Telepharmacy Operation

31.1 (1) A telepharmacy must not remain open and prescriptions must not be dispensed without a full pharmacist physically present on duty at the telepharmacy, unless

(a) a full pharmacist at the central pharmacy is engaged in direct supervision of the telepharmacy in accordance with the *Telepharmacy Standards of Practice*, and

(b) subject to subsection (2), a pharmacy technician is physically present on duty at the telepharmacy.

(2) A telepharmacy located at an address listed in Schedule "G" is exempt from the requirements in subsection (1)(b).

(3) A telepharmacy must have a security system that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.

(4) Prescriptions and labels relating to prescriptions dispensed at a telepharmacy must identify the prescription as having been dispensed at that telepharmacy.

(4.1) Prescriptions and labels relating to prescriptions dispensed at a pharmacy listed in Schedule "F" must distinguish between those dispensed when it is operating as a telepharmacy from when it is operating as a community pharmacy.

(5) The manager of a central pharmacy, or a full pharmacist designated by the manager, must

(a) inspect and audit its telepharmacy at least 4 times each year, at intervals of not less than 2 months,

(b) record each inspection and audit in the prescribed form, and

(c) provide the inspection and audit records to the registrar immediately upon request.

(6) A telepharmacy located at an address listed in Schedule "G" must perform a monthly count of narcotics at the telepharmacy and retain a record of each monthly count signed by the supervising pharmacist for three years at both the central pharmacy and the telepharmacy location, and provide the signed record to the registrar immediately upon request.

(7) A telepharmacy must not continue to provide pharmacy services for more than 30 days after

(a) its location ceases to be a rural and remote community,

(b) a community pharmacy is established within the community, or

(c) a community pharmacy is established within 25 kilometers of the location of the telepharmacy.

(8) A telepharmacy must have a policy and procedure manual on site that outlines the methods for ensuring the safe and effective distribution of pharmacy products and delivery of pharmaceutical care by the telepharmacy.

(9) All transactions in PharmaNet must be distinguishable between the central pharmacy and telepharmacy.

~~**PART V – Pharmacy Education Sites**~~

~~**Pharmacy Education Site Manager**~~

~~17. (1) A pharmacy education site's manager must ensure that only registrants and instructors are present in the pharmacy education site.~~

~~(2) A pharmacy education site's manager must comply with section 3(2)(a), (d), (h), (o), (r) and (t)(ii) and (iii).~~

PART VI – PharmaNet

Application of Part

~~18~~320. This Part applies to every pharmacy that connects to PharmaNet.

Definitions

~~19~~331. In this Part:

"database" means those portions of the provincial computerized pharmacy network and database referred to in section 13 of the *Act*;

"in-pharmacy computer system" means the computer hardware and software utilized to support pharmacy services in a pharmacy;

"patient keyword" means an optional confidential pass code selected by the patient which limits access to the patient's PharmaNet record until the pass code is provided to the registrant;

"PharmaNet patient record" means the patient record described in section 11(2) of the *Community Pharmacy Standards of Practice* and in the PharmaNet Professional and Software Compliance Standards as the "patient profile";

"PharmaNet Professional and Software Compliance Standards" means the document provided by the Ministry of Health Services specifying the requirements of an in-pharmacy computer system to connect to PharmaNet;

"terminal" means any electronic device connected to a computer system, which allows input or display of information contained within that computer system.

Operation of PharmaNet

~~20~~342. A pharmacy must connect to PharmaNet and be equipped with the following:

(a) an in-pharmacy computer system which meets the requirements set out in the current PharmaNet Professional and Software Compliance Standards;

(b) a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which

(i) is only accessible to registrants and support persons,

(ii) is under the direct supervision of a registrant, and

(iii) does not allow information to be visible to the public, unless intended to display information to a specific patient; and

(c) the computer software upgrades necessary to comply with changes to the PharmaNet Professional and Software Compliance Standards.

Data Collection, Transmission of and Access to PharmaNet Data

~~21~~353. (1) A registrant must enter the prescription information and transmit it to PharmaNet at the time of dispensing and keep the PharmaNet patient record current.

(2) A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only

(a) to dispense a drug,

(b) to provide patient consultation, or

(c) to evaluate a patient's drug usage.

(3) A registrant may collect and transmit patient record information to PharmaNet or access a patient's PharmaNet record only for the purposes of claims adjudication and payment by an insurer.

(4) A registrant must revise information in the PharmaNet database pertaining to corrected billings for prescriptions billed to the patient or a payment agency other than PharmaCare and record the reason for the revision within 90 days of the original entry on PharmaNet.

(5) A registrant must reverse information in the PharmaNet database, for any drug that is not released to the patient or the patient's representative, and record the reason for the reversal no later than 30 days from the date of the original entry of the prescription information in PharmaNet.

(6) If a registrant is unable to comply with the deadlines in subsections (4) or (5), he or she must provide the information required to make the correction to the college as soon as possible thereafter.

(7) At the request of the patient, a registrant must establish, delete or change the patient keyword.

(8) Where a patient or patient's representative requests an alteration to be made to the PharmaNet information, the registrant must

(a) correct the information, or

(b) if the registrant refuses to alter the information, he or she must inform the person requesting the change of his or her right to request correction under the *Personal Information Protection Act*.

Confidentiality

~~22~~364. A registrant must take reasonable steps to confirm the identity of a patient, patient's representative, registrant or practitioner before providing any pharmacy service, including but not limited to

(a) establishing a patient record,

(b) updating a patient's clinical information,

(c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record,

(d) establishing, deleting, or changing a patient keyword,

(e) viewing a patient record,

(f) answering questions regarding the existence and content of a patient record,

(g) correcting information, and

(h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.

PART VII – College

Forms

375. The Registrar may establish forms for the purposes of the *Act*.

Use, Disclosure and Retention of Criminal Record History Information

38. (1) The College may disclose criminal record history information only for the purpose of licensing pharmacies or for the purpose of regulating registrants (including for the discipline of registrants).

(2) The College must retain criminal record history information only for so long as is permitted by the applicable College records retention and disposal provisions established by the College.

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

1. PHARMACY INFORMATION

Proposed Operating Name	**Store #/Identifier (if applicable)**	**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

3. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

4. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

5. PAYMENT INFORMATION

Proposed Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Hospital

Form 1C

1. PHARMACY INFORMATION

Proposed Operating Name		**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Software Vendor (for PharmaNet connection)	**PharmaNet Connection Required** ☐ Inpatient (Read-only access to patient records with ability to update clinical information and adverse reactions) ☐ Outpatient (PharmaCare adjudication of prescriptions and update of patient records) ☐ Inpatient & Outpatient (Inpatient and outpatient dispensing using the same software)

Manager Name	**Registration Number (BC)**

2. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

3. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health
☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Hospital

Form 1C

4. PAYMENT INFORMATION

Proposed Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

APPLICANT INFORMATION

Company name _____

Central pharmacy _____

Pharmacy manager _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal Code

PROPOSED REMOTE SITE

Remote site address, including name of pharmacy _____ Tel _____

_____ Fax _____

_____ Email _____

_____ _____

Postal Code

Hours of operation for Satellite _____

Pursuant to s.54(2) of the *Health Professions Act – Bylaws*, a registrant **must** notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and addresses of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

Registrants can update their contact information using the *eServices* section of our website.

I attest that:

- The Pharmacy is in compliance with the *Health Professions Act*, the *Pharmacy Operations and Drug Scheduling Act*, the *Pharmacists Regulation* and the *Bylaws* of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____
Name (please print) Signature

_____ _____
Position Date

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the *Pharmacy Operations and Drug Scheduling Act*, *Health Professions Act*, and *Freedom of Information and Protection of Privacy Act*. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 60 business days</u> prior to the planned operation of the hospital satellite.

Application must be approved PRIOR to commencement of hospital satellite service.

The following must be submitted together with this application:

- Diagram detailing the layout of the hospital pharmacy satellite

PharmaNet connection for both sites? ☐ Yes ☐ No

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

PAYMENT OPTION

Pharmacy Name _____

☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card # _____ Exp _____ /_____

Cardholder name _____

Cardholder signature _____

Initial licence fee	300.00
GST	15.00
Total	**$315.00**

GST # R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE

Pharmacy Education Site

Form 1F

1. EDUCATION SITE INFORMATION

Proposed Operating Name		**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

3. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) will not have controlled drug substances, 2) will be licensed solely for the purpose of pharmacy education, and 3) will not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Pharmacy Education Site

Form 1F

4. PAYMENT INFORMATION

Proposed Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$0.00
Initial licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

3. ADDITIONAL INFORMATION

Do you have other community pharmacies that are 1) owned by the same direct owner above and 2) due for pharmacy licence renewal this month? ☐ Yes – Also complete **Form 9** ☐ No

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

4. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**

Email Address	**Phone Number**	**Fax Number**

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**

Signature	**Sign Date**
	MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

5. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL

Hospital

Form 2C

1. PHARMACY INFORMATION

Operating Name		**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health

☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Hospital

Form 2C

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL

Pharmacy Education Site

Form 2F

1. EDUCATION SITE INFORMATION

Operating Name		**Pharmacy Licence Number**	
Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) does not have controlled drug substances, 2) is licensed solely for the purpose of pharmacy education, and 3) does not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Pharmacy Education Site

Form 2F

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Community

Form 3A

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Community

Form 3A

3. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.			
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Community

Form 3A

4. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Hospital

Form 3C

1. PHARMACY INFORMATION

Operating Name		**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health

☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Hospital

Form 3C

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Pharmacy Education Site

Form 3F

1. EDUCATION SITE INFORMATION

Operating Name		**Pharmacy Licence Number**	
Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) does not have controlled drug substances, 2) is licensed solely for the purpose of pharmacy education, and 3) does not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Pharmacy Education Site

Form 3F

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY CLOSURE

Form 4

1. INFORMATION OF CLOSING PHARMACY

Operating Name and Store #/Identifier (if applicable)	**Pharmacy Licence Number**	**Closing Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

PHARMACY MANAGER

Manager Name	**Registration Number (BC)**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section ~~16~~18(2)(t) of the *PODSA* Bylaws.

Signature of Pharmacy Manager	**Sign Date** MMM | DD | YYYY

DIRECT OWNER

Name of Authorized Representative	**Position/Title of Authorized Representative**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section ~~16~~18(8)(d) of the *PODSA* Bylaws.

Signature of Authorized Representative	**Sign Date** MMM | DD | YYYY

The first half of the following section must be completed by the closing pharmacy. If more than one receiving pharmacy is involved, complete a separate form for each receiving pharmacy to indicate the items that will be transferred to the receiving pharmacy.

2. INFORMATION OF RECEIVING PHARMACY

Operating Name and Store #/Identifier (if applicable) ☐ Community ~~Pharmacy~~ – ☐ Hospital ~~Pharmacy~~ – ☐ ~~Education Site~~ ☐ Other: _____		**Manager Name**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Items that will be transferred to the receiving pharmacy

☐ Prescription drugs (including controlled drug substances)
☐ Non-prescription drugs (including exempted codeine products)
☐ Medical devices
☐ Patient medication records and prescription records

The subsection below can be completed and submitted later by the receiving pharmacy manager upon receipt of the items.

☐ I have received all the items checked above on (received date): _____.

☐ I have faxed a copy of the inventory of narcotics, controlled drugs, targeted substances and benzodiazepines received to the College.

Manager Name	**CPBC Registration Number**
Signature of Manager from the Receiving Pharmacy	**Sign Date** MMM | DD | YYYY

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - PROOF OF ELIGIBILITY

FORM 5

The pharmacy manager and each direct/indirect owner applying/renewing for a pharmacy license must complete this form. Only one form is required per person per pharmacy.

1. PHARMACY INFORMATION

[Proposed] Operating Name	**Pharmacy Licence Number (if issued)**

Your Relationship to the Pharmacy Named above (Select all that apply):

- ☐ Pharmacy Manager
- ☐ Direct Owner – Sole Proprietor (Single pharmacist, unincorporated)
- ☐ Direct Owner – Pharmacist Partner (≥2 pharmacists, unincorporated)
- ☐ Indirect Owner – Director of Corporation
- ☐ Indirect Owner – Officer of Corporation
- ☐ Indirect Owner – Shareholder of Corporation
- ☐ Indirect Owner – Director of PARENT Corporation
- ☐ Indirect Owner – Officer of PARENT Corporation
- ☐ Indirect Owner – Shareholder of PARENT Corporation

2. PERSONAL INFORMATION

☐ **Dr** ☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss**	**Last Name**		**Date of Birth (MMM/DD/YYYY)**	
First Name		**Middle Name**	**Informal Name (if any)**	
Address ☐ Home ☐ Mailing		**City**	**Province**	**Postal Code**
Email Address		**Phone Number**	**Fax Number**	

Registration Class

Are you a PHARMACIST or PHARMACY TECHNICIAN registered in BC, another province, or a foreign jurisdiction?

☐ Yes – Complete ALL sections below

☐ No – Provide the following information and complete ALL sections below EXCEPT Section 3

a) If you have a CPBC eServices ID, enter here: _____

b) Identification document

i) Type of government issued ID (select ANY one of the following):

- ☐ Canadian citizenship card/certificate
- ☐ Passport (Country issued if outside Canada: _____)
- ☐ Canadian driver's licence (Province issued if outside BC: _____)
- ☐ BC Identification Card

ii) Document number of the selected document above: _____

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - PROOF OF ELIGIBILITY

FORM 5

3. ATTESTATION FOR PHARMACISTS AND PHARMACY TECHNICIANS ONLY

Registration Information

I am a: ☐ Pharmacist ☐ Pharmacy Technician

Registered in: ☐ BC ☐ Other province: _____ ☐ Foreign jurisdiction: _____

Registration/Licence Number: _____

I attest that, within the previous 6 years:

☐	I have never been suspended nor has my registration been cancelled by the College of Pharmacists of British Columbia, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.
☐	No limits or conditions have been imposed on my practice of pharmacy as a result of disciplinary action taken by the College of Pharmacists of British Columbia, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.

NOTE: Failure to attest to any of the above would result in my application being sent to the Application Committee. The Application Committee may request additional information.

4. ATTESTATION

I attest that:

☐	I am not authorized by an enactment to prescribe drugs (not applicable to pharmacists).
☐	I have never been subject to a limitation imposed by the College's discipline committee that precludes me from being a direct owner, an indirect owner, or a manager.
☐	I have never been the subject of an order or a conviction for an information or billing contravention.

I also attest that, within the previous 6 years:

☐	I have not been convicted of an offence prescribed under section 45(1)(a)(ii) of the *Pharmaceutical Services Act*.
☐	I have not been convicted of an offence under the *Criminal Code* (Canada).
☐	I have not had a judgment entered against me in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related services.

NOTE: Failure to attest to any of the above would result in my application being sent to the Application Committee. The Application Committee may request additional information.

5. DECLARATION

☐	I understand that I must comply with all applicable duties imposed under the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, the *Health Professions Act*, the regulations and the bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts and any subsequent amendments.
☐	I declare the facts set out herein to be true.

Applicant Signature	**Applicant Position/Title**	**Sign Date**
Witness Signature	**Witness Name**	**Witness Date**

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - NOTICE OF INELIGIBILITY

Form 6

1. REASON FOR COMPLETING THIS FORM (Select all that apply)

☐	To report that the person named below is no longer eligible to be the **manager** of the pharmacy named below.
☐	To report that the person named below is no longer eligible to be a **direct** or **indirect owner** of the pharmacy/corporation named below.

2. INFORMATION OF THE PERSON IN SECTION 3

☐ **Dr** ☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss**	**Last Name**		
First Name		**Informal Name**	**Date of Birth (MMM/DD/YYYY)**
Name of Affiliated Organization: ☐ Pharmacy Operating Name ☐ Corporation Name			

3. ADDITIONAL INFORMATION RELATED TO THE PERSON NAMED ABOVE

Matter related to a(n):

- ☐ Order or conviction **FOR/UNDER**:
  - ☐ Information contravention
  - ☐ Billing contravention
  - ☐ Section 45(1)(a)(ii) of the *Pharmaceutical Services Act*
  - ☐ *Criminal Code* (Canada)
  - ☐ Other – Specify: _____
- ☐ Suspension or cancellation of registration as a pharmacy technician or pharmacist;
- ☐ Limits or conditions being imposed on (select one):
  - ☐ Practice of pharmacy
  - ☐ Being a direct owner, indirect owner, or a manager of a pharmacy
- ☐ Judgement issued in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related device
- ☐ Other – Specify: _____

Description of the events that resulted in the matter above.	
Date/period of the above events occurred.	

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

Name of the entity/court/governing body that: • Issued the order or conviction • Suspended/cancelled billing privileges or registration as a pharmacist or pharmacy technician; OR • Imposed limits or conditions	
Date (or period, when specified) of: • Order or conviction; • Suspension (period) or cancellation of billing privileges or registration as a pharmacist or pharmacy technician; OR • Limits or conditions being imposed	
Disposition of charge including details of penalty-imposed (e.g. fine, imprisonment, limits and conditions imposed)	
Extenuating circumstances you wish taken into account for your application.	
Other	

*Attach a separate sheet if you need more space

☐ **I understand that I may have to provide additional information if requested by the Application Committee, the Discipline Committee or the Inquiry Committee, within the time requested.**

4. INFORMATION OF THE PERSON WHO COMPLETED THIS FORM

Name	**Signature**	**Sign Date**
Email	**Phone Number**	**Fax Number**

Relationship to the Pharmacy: ☐ Direct/Indirect Owner ☐ Pharmacy Manager ☐ Other: _____

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists
of British Columbia

INDIRECT OWNER – EMAIL CONTACTS

Form 7

Instructions to complete *Form 5: Manager/Direct Owner/Indirect Owner – Proof of Eligibility* and the *Criminal Record History* will be sent to the email address of each indirect owner provided below. Ensure that the information is current, correct and legible. On page 1, list all the indirect owners of the corporation that is the direct owner. If applicable, complete page 2 for each shareholder which is a corporation that is not publicly traded. Make a copy of any of these two pages if you need more space.

1. INFORMATION OF THE CORPORATION THAT IS THE DIRECT OWNER

Name of Company on *Notice of Articles/BC Company Summary*	BC Incorporation Number

INFORMATION OF EACH INDIRECT OWNER (INDIVIDUALS) UNDER THIS CORPORATION

Type of Indirect Owner	BC Pharmacist (Y/N)	Last Name	First Name	Email Address
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**

***if known**

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

H9001 Rev. 13/10/2017 10:49:00 AM DRAFT

If a shareholder is a corporation, complete the information below for EACH corporation that is a shareholder. Make a copy of this page if you need more space or there are more than one corporation that is a shareholder.

2. INFORMATION OF THE CORPORATION THAT IS A SHAREHOLDER

Name of Company/Corporation as Provided in Incorporation Document(s)	Incorporation Number

INFORMATION OF EACH INDIRECT OWNER (INDIVIDUALS) UNDER THIS CORPORATION

Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**

***if known**

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF DIRECT OWNER

Form 8A

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. NEW OWNERSHIP INFORMATION

Effective Date of Change (MMM-DD-YYYY)

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

3. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF DIRECT OWNER

Form 8A

4. ADDITIONAL INFORMATION

As a result of this change (direct owner):

a)	Will the **manager** also be changed at the same time?	☐ Yes – Also complete **Form 8C**	☐ No
b)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
c)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
d)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional[⌘])	☐ No

[⌘]You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Form 9 to include other pharmacies.

5. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

6. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

Form 8B

1. CURRENT PHARMACY INFORMATION

Operating Name	Store #/Identifier (if applicable)	Pharmacy Licence Number	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. DEPARTING INDIRECT OWNER(S)

Type	Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change (MMM-DD-YYYY)
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	

*If known

3. NEW INDIRECT OWNER(S)

Type	Corporation Name	Indirect Owner	Pharmacist (Y/N)	Effective Date of Change (MMM-DD-YYYY)
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	

*If known

4. ADDITIONAL INFORMATION

As a result of this change (indirect owner):

a)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
b)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
c)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional⌘)	☐ No

⌘You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Fform 9 to include other pharmacies.

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF MANAGER

Form 8C

1. CURRENT PHARMACY INFORMATION

Operating Name	Store #/Identifier (if applicable)	Pharmacy Licence Number	
Pharmacy Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	

2. MANAGER INFORMATION

DEPARTING MANAGER		
Last Name	First Name	Registration Number (BC)
NEW MANAGER		
Last Name	First Name	Registration Number (BC)
Effective Date of Change (MMM-DD-YYYY)		

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	Position/Title of Authorized Representative	
Email Address	Phone Number	Fax Number
Signature	Sign Date MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF CORPORATION NAME

Form 8D

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Type of Change ☐ Name of the Corporation that is the Direct Owner – Complete sections 2, 4 and 5 ☐ Name of the Corporation that is a Shareholder – Complete sections 3, 4 and 5		**Effective Date of Change** MMM | DD | YYYY	

2. DIRECT OWNER INFORMATION

FORMER CORPORATION NAME	
Name of Company on *Notice of Articles/BC Company Summary*	**BC Incorporation Number***
NEW CORPORATION NAME	
Name of Company on *Notice of Articles/BC Company Summary*	**BC Incorporation Number***

*If the numbers are different, DO NOT submit this form but complete Form 8A (Change of Direct Owner) instead.

3. SHAREHOLDER INFORMATION

FORMER CORPORATION NAME	
Name of Company/Corporation as Provided in Incorporation Document	**Incorporation Number****
NEW CORPORATION NAME	
Name of Company/Corporation as Provided in Incorporation Document	**Incorporation Number****

**If the numbers are different, DO NOT submit this form but complete Form 8B (Change of Indirect Owner) instead.

4. ADDITIONAL INFORMATION

As a result of this change (corporation name):

a)	Will the **indirect owner(s)** also be changed at the same time?	☐ Yes – Also complete **Form 8B**	☐ No
b)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
c)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
d)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional⌘)	☐ No

⌘You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Form 9 to include other pharmacies.

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF CORPORATION NAME

Form 8D

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF OPERATING NAME

Form 8E

1. PHARMACY INFORMATION

Current Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
PROPOSED NEW OPERATING NAME			
Proposed Operating Name	**Store #/Identifier (if applicable)**	**Effective Date of Change** MMM | DD | YYYY	

2. OTHER TYPES OF CHANGES

As a result of this change (operating name):

a) Will the **manager** also be changed at the same time? ☐ Yes – Also complete **Form 8C** ☐ No

b) Will the **pharmacy layout** also be changed at the same time? ☐ Yes – Also complete **Form 8G** ☐ No

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF LOCATION

Form 8F

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Manager Name		**Registration Number (BC)**	
CURRENT INFORMATION			
Current Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website	**Software Vendor (for dispensing)**	**Expected Closing Date** MMM | DD | YYYY	
RELOCATION INFORMATION			
New Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address ☐ No Change	**Phone Number** ☐ No Change	**Fax Number** ☐ No Change	
Website ☐ No Change	**Software Vendor** ☐ No Change	**Expected Opening Date** MMM | DD | YYYY	

2. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF LAYOUT

Form 8G

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. RENOVATION INFORMATION

PharmaNet Router

☐ No change ☐ Moving/disconnection required – Distance of router move: _____

Expected Completion Date

MMM | DD | YYYY

Areas Affected by Renovation

☐ External to the Dispensary (up to 25 feet from the dispensary) ☐ Dispensary area

☐ Other area(s) on the premises – Specify: _____

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

MULTIPLE PHARMACIES

Form 9

1. LIST OF ALL PHARMACIES

Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

PHARMACY PRE-OPENING INSPECTION REPORT

COMMUNITY

1. PHARMACY INFORMATION				
Operating Name	**Store #/Identifier (if applicable)**	**PharmaCare Code**		**Proposed Licensure ~~Opening~~ Date** MMM | DD | YYYY
Pharmacy Address	**City**	**Province** BC	**Postal Code**	**Software Vendor (for dispensing)**
Email Address	**Phone Number**	**Fax Number**		**Website**

~~2. PHARMACY SERVICES~~						
~~TYPE~~	~~YES~~	~~NO~~	~~TYPE~~	~~YES~~	~~NO~~	~~IF "YES", PROVIDE PHAR~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

						MAGYNAME(S) INVOLVED
Methadone (Pain)			Contracts - BC Transplant			
Methadone (Maintenance)			Contracts - Center for Excellence			
Compounding (Specialty)			Other - Delivery			
Compounding (Sterile Product)			Other - Internet			
Compliance Packaging			Other - Drive Thru			
Clinical - Injection Drug Administration			Residential Care Services			
Clinical - Medication Management/Review			Centralized Prescription Processing Services			provided

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Clinical - Education Clinics			Outsourced Prescription Processing Services			
Contracts - Renal Agencies			Telepharmacy Services (Central Pharmacy)			

2. PHARMACY SERVICES

TYPE	SUBTYPE	YES	NO	TYPE	YES	NO	If "YES", PROVIDE ADDITIONAL INFORMATION
OPIOID ADDICTION THERAPY	Methadone (Maintenance)			RESIDENTIAL CARE SERVICES			Facility Name & Number of Beds:
	Oral Morphine						
	Buprenorphine & Naloxone (Suboxone)						
COMPOUNDING	Non-Sterile Preparation			CENTRALIZED PRESCRIPTION			Provide the name(s) of the pharmacy(ies) that your pharmacy prepares/processes prescriptions/drug orders for:
	Non-Hazardous Sterile						

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

	Hazardous Sterile			PROCESSING SERVICES PROVIDED TO			
OTHER	Injection & Intranasal Drug Administration			OUTSOURCED PRESCRIPTION PROCESSING SERVICES RECEIVED FROM			Provide the name(s) of the pharmacy(ies) that prepare/process prescriptions/drug orders for your pharmacy:
	No Public Access						
	Schedule 1A drugs On-Site						
	Internet Pharmacy						

3. HOURS OF OPERATION

TYPE	SUN	MON	TUE	WED	THU	FRI	SAT
Pharmacy Hours							
Lock & Leave Hours							

4. PHARMACY ROSTER

STAFF	REGISTRATION #	FIRST NAME/INFORMAL NAME	LAST NAME	REGISTRATION CLASS
Pharmacy Manager				☒ Pharmacist ☐ Pharmacy Technician
Staff #1				☐ Pharmacist ☐ Pharmacy Technician
Staff #2				☐ Pharmacist ☐ Pharmacy Technician
Staff #3				☐ Pharmacist ☐ Pharmacy Technician
Staff #4				☐ Pharmacist ☐ Pharmacy Technician
Staff #5				☐ Pharmacist ☐ Pharmacy Technician
Staff #6				☐ Pharmacist ☐ Pharmacy Technician
Staff #7				☐ Pharmacist ☐ Pharmacy Technician

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Staff #8				☐ Pharmacist ☐ Pharmacy Technician
Staff #9				☐ Pharmacist ☐ Pharmacy Technician
Staff #10				☐ Pharmacist ☐ Pharmacy Technician

5. PRE-OPENING INSPECTION

Confirm whether your new pharmacy currently complies with each of the following requirements.

- **If compliant, mark "✓" under the "Compliant" column and submit digital evidence (e.g. photos/videos) along with this form. Refer to the Licensure Guide for further details.**
- **If not applicable, enter "N/A" under the "Compliant" column and provide the reason in the comment field.**

External to Dispensary

#	Item	Compliant	Comment	CPBC Use
1a	**External view of the pharmacy (street view including the external signage)**			
1b	**Hours of operation sign**			
1c	**Professional products area for schedule 3 drugs** **(+ Lock-and-Leave barriers if the premise is open for business while the pharmacy is closed)** **OR N/A**			
1d	**Signage at 25 feet from dispensary** **OR N/A**			
1e	**"Medication Information" Sign** **OR N/A**			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Dispensary

#	Item	Compliant	Comment	CPBC Use
2a	Dispensary area			
2b	Gate/door at the entrance into the dispensary			
2c	Placeholder for College license			
2d	Professional service area for Schedule 2 drugs			
2e	Patient consultation area			
2f	Dispensing counter and service counter			
2g	Computer terminals for prescription processing			
2f	Shelving			

Security

#	Item	Compliant	Comment	CPBC Use
3a	Secure storage space			
3b	☐ Locked metal safe OR ☐ Safe declaration			
3c	Security camera system AND Surveillance signage			
3d	Motion sensors			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
3e	**Monitored alarm** **OR N/A**			
3f	**Physical barriers** **OR N/A**			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Equipment and References

#	Item	Compliant	Comment	CPBC Use
4a	**Double stainless steel sink**			
4b	**Equipment:** 1. Telephone 2. Refrigerator 3. Rx filing supplies 4. Rx balance 5. Metric weights 6. Glass graduates 7. Mortar 8. Pestle 9. Spatulas 10. Funnels 11. Stirring rods 12. Ointment slab/ parchment paper 13. Counting tray 14. Disposable drinking cups 15. Soap dispenser 16. Paper towel dispenser 17. Plastic/metal garbage containers 18. Plastic lining 19. Fax machine			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~ ~~G~~ ~~H~~ ~~I~~ ~~J~~ ~~K~~ ~~L~~ ~~M~~ ~~O~~ ~~P~~ ~~Q~~
4c	**Equipment (Cold Chain)** 1. Thermometer 2. Temperature log			~~TMM~~ ~~TLOG~~
4d	**Equipment (Methadone)** 1. Calibrated device 2. Auxiliary labels 3. Containers for daily dose 4. Patient/Rx Log			~~DEV~~ ~~AUX1~~ ~~AUX 2~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
	OR N/A			~~DOSE~~ ~~MLOG~~
4e	**References (CPBC)** **1. BC Pharmacy Practice Manual** **2. ReadLinks** ~~2.~~			~~BPPM~~ ~~RL~~
4f	**References (General)** **1. Compendium** **2. Complementary/ Alternative** **3. Dispensatory** **4. Drug Interactions** **5. Nonprescription Medication (2x)** **6. Medical Dictionary** **7. Pregnancy and Lactation** **8. Pediatrics** **9. Therapeutics**			~~CPS~~ ~~ALT~~ ~~DIS~~ ~~DI~~ ~~OTC1~~ ~~OTC2~~ ~~MD~~ ~~P/L~~ ~~PED~~ ~~TH~~
4g	**References (if applicable)** ☐ **Veterinary** ☐ **Psychiatric** ☐ **Geriatric** ☐ **Specialty compounding** ☐ **Methadone** o **PPP-66** o **CSPBC** o **CAMH** o **Monograph** **OR N/A**			~~VET~~ ~~PSY~~ ~~GER~~ ~~CMP~~ ~~MET1~~ ~~MET2~~ ~~MET3~~ ~~MET4~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Prescription

#	Item	Compliant	Comment	CPBC Use
5a	**Prescription hardcopy (i.e. the label/paper attached to the original prescription, which contains prescription information generated after transmitting to PharmaNet)**			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Confidentiality

#	Item	Compliant	Comment	CPBC Use
6a	☐ Shredder OR ☐ Contract with a document destruction company			
6b	Offsite storage contract OR N/A			

Inventory Management

#	Item	Compliant	Comment	CPBC Use
7a	Drug receiving area			
7b	Drugs			
7c	Storage area for non-usable and expired drugs			

Dispensed Products

#	Item	Compliant	Comment	CPBC Use
8a	Prescription product label 1. Single entity product ~~2.~~ Multiple-entity product 2.			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~ ~~G~~ ~~A~~ ~~B~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
				~~A~~ ~~B~~
8b	**Filling supplies (e.g. vials and bottles including caps)**			

Pharmacy Manager's Responsibilities

#	Item	Compliant	Comment	CPBC Use
9a	**Name badge**			
9b	**Policy & procedure manual**			~~R/PA~~ ~~INV~~ ~~SEL~~ ~~DES~~ ~~R/C~~ ~~SEC~~ ~~QMP~~ ~~BRE~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

6. INFORMATION OF THE PERSON WHO COMPLETED THE PRE-OPENING INSPECTION

Last Name	First Name	Completion Date

Relationship of the Named Person above to the Pharmacy

☐ Pharmacy Manager ☐ Owner (Registrant) ☐ Owner (Non-Registrant) ☐ College Inspector

Email Address of the Person Named above	Phone Number of the Person Named above	Fax Number of the Person Named above

☐ I hereby declare that the information provided above including the accompanying digital evidence is true and correct to the best of my knowledge. If any of the above information is found to be false, untrue, misleading or misrepresenting, I am aware that I may be referred to the Inquiry Committee and the pharmacy licence may not be issued.

Signature	Sign Date
	MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

This policy provides guidance to direct owners, indirect owners and managers of pharmacies in British Columbia on submitting a criminal record history for the purpose of pharmacy licensure to the College as required in the *Pharmacy Operations and Drug Scheduling Act* sections 3(f), 5.1 and 21(1)(d.1) and *Pharmacy Operations and Drug Scheduling Act* – Bylaws sections 1 and 14.

POLICY STATEMENT:

The Board of the College of Pharmacists of BC adopts the vendor Sterling Talent Solutions (formerly known as BackCheck) for all criminal record history (CRH) checks.

BACKGROUND:

The *Pharmacy Operations and Drug Scheduling Amendment Act*, *2016* considerably changed pharmacy ownership legislation. Some of the key changes included authorizing the College to:

- Identify pharmacy owners, including non-registrants;
- Determine pharmacy owners' suitability for pharmacy ownership; and
- Hold them accountable for providing safe and effective care and ensuring that their pharmacies are compliant with legislative requirements.

The Act and Bylaws set out requirements for pharmacy licensure, including a CRH. The approved vendor will administer the criminal record check and will provide the results to the College for review in accordance with the legislation.

First approved: **17/11/2017** **PPP-76**
Revised:
Reaffirmed:

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.

Please ensure that all documents are current and readily accessible within the dispensary.

To obtain copies of the BC Pharmacy Practice Manual and CPBC ReadLinks, please contact the College office for an order form or access our website 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: **PROFESSIONAL PRACTICE POLICY-3**
POLICY FOCUS: **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 ~~3~~18(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. Therapeutic Choices For Minor Ailments (formerly called Patient Self-Care) 2. Products for Minor Ailments (formerly called Compendium of Self-Care Products).	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
DISCLAIMER	In addition to the above list, pharmacies must be equipped with references relevant to their practices. (e.g. Veterinary, Psychiatric, Geriatric.)		

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-3**
POLICY FOCUS: **Pharmacy References**

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.

First approved: 02 May 1997
Revised: 11 Oct 2000 / 2 Nov 2001 / 22 Nov 2002 / 20 Jun 2003 / 09 Feb 2007 / 27 Mar 2009 / 18 Jun 2010 / 15 Apr 2011 / 15 Feb 2013 / 21 Feb 2014
Reaffirmed: 18 Jun 2010

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-12**
POLICY FOCUS: **Prescription Hard Copy File Coding System**

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 registrants 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 ~~8(1)~~23(1).

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-46**
POLICY FOCUS: **Temporary Pharmacy Closures**

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 ~~9(5)~~18(2)(u).

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-54**
POLICY FOCUS: **Identifying patients for PharmaNet purposes**

POLICY STATEMENT(S):

1. Registrants 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 registrant the registrant may positively identify the patient. In cases where the patient is not known to the registrant, 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
- Permanent Resident Card issued by the Government of Canada
- B.C. Services Card

SECONDARY IDENTIFICATION:

- Care card issued by the Province of B.C.
- Birth Certificate
- Canadian Citizenship Card
- Record of Landing of Permanent Residency
- Work/Visitor/Study Permit issued by the Government of Canada
- 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 ~~22~~ 36 which requires that registrants must take reasonable steps to positively identify a patient, patient's representative, registrant or a practitioner before providing any pharmacy service, including but not limited to:

(a) establishing a patient record,

(b) updating a patient's clinical information,

(c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record,

(d) establishing, deleting, or changing a patient keyword,

(e) viewing a patient record,

(f) answering questions regarding the existence and content of a patient record,

(g) correcting information, and

(h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.

First approved: 2 May 2003 **PPP-54**
Revised: 25 Sep 2008 / 21 Nov 2008 / 15 Apr 2011 / 12 Apr 2012 / 8 Jan 2015
Reaffirmed: 27 Mar 2009

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-59**
POLICY FOCUS: **Pharmacy Equipment**

POLICY STATEMENT(S):

1. The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw ~~3~~18(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 glass 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.

3. 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.

Formatted: Tab stops: 6.5", Right + Not at 1"

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-65**
POLICY FOCUS: **Narcotic Counts and Reconciliations**

The pharmacy manager must ensure that narcotic counts and reconciliations are completed for the pharmacy, pharmacy satellites and all areas of a facility where narcotics are stored:

- at a minimum of every 3 months,
- after a change of pharmacy manager,
- after a break and enter or robbery,
- after an identified drug diversion,
- when a pharmacy closes and ceases to operate its business, and
- after any event where the security of the narcotic drugs may have been compromised.

REQUIRED PROCEDURES:

The narcotic counts and reconciliations must consist of the following four components, and must be verified and signed off by the pharmacy manager after each completion:

1. Perpetual Inventory[1]

a) Pharmacies must maintain a separate perpetual inventory for each narcotic drug.
b) The perpetual inventory must include entries for:
   i. purchases,
   ii. transfers,
   iii. losses,
   iv. purchases returned, expired, or destroyed,
   v. quantities dispensed, and
   vi. a running balance.
c) Any manual adjustments to the perpetual inventory must be documented, including:
   i. the reason for the adjustment,
   ii. the date adjusted, and
   iii. the identity of the person who made the adjustment.
d) If a pharmacy does not have a computerized perpetual inventory, then a manual perpetual inventory must be maintained. (Note: A sample Perpetual Inventory Record can be found on the CPBC website).

2. Physical Inventory Counts

a) A physical inventory count must be done at a minimum of every 3 months.
b) All narcotics must be counted, including:
   i. active inventory,
   ii. compounded mixtures, and
   iii. expired inventory.
c) When completing the narcotic count, the following information must be documented:

   i. the name, strength, quantity, and DIN/brand of the drug counted,
   ii. the date and signature of the person(s) who completed the count, and
   iii. the date and signature of the responsible pharmacist

[1]**Perpetual Inventory:** A book record of every inventory kept continuously up to date by detailed entries for all incoming and outgoing items. (Merriam-Webster Dictionary)

d) The count must not be conducted by the same person who enters narcotic purchases into the records.

3. Reconciliation[2]

a) Perpetual inventory, physical inventory counts, and purchase invoices must be reconciled and documented.
b) Discrepancies must be investigated, addressed, and documented on a narcotic incident report and maintained at the pharmacy for a period of not less than 3 years.

4. Documentation Requirements

a) The inventory counts and reconciliation documentation must be kept in chronological order in a separate and dedicated record that is retained for 3 years.
b) Within 10 days of the discovery of a loss or theft of a narcotic, the pharmacy manager must:
   i. report the loss or theft to the local police and to the appropriate office at Health Canada. (Note: Shortages which cannot be accounted for must also be reported to the appropriate office at Health Canada.)
   ii. forward to the College a copy of any report sent to the appropriate office at Health Canada. (Note: Please refer to PPP-74 Community Pharmacy Security)

BACKGROUND:

The above policy statement is supplemental to PODSA Bylaw ~~3~~ 18 and ~~4~~19, PPP-74 Community Pharmacy Security, and the *Narcotic Control Regulations*.

APPENDIX:

Sample – Perpetual Inventory Form

[2]**Reconciliation:** To check (example a financial account) against another for accuracy (Merriam Webster Dictionary)

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-73**
POLICY FOCUS: **Validate Identification and College Registration Status for New Pharmacy Hires**

POLICY STATEMENT(S):

Pharmacy owners, directors and managers must establish and implement a written policy and procedure to verify the identity and registration status of individuals applying for pharmacist or pharmacy technician positions prior to employment.

The Policy and Procedure Must Include the Following Steps that the Pharmacy Manager Must Take:

1. **Confirm Applicant Identification**

   The pharmacy manager must confirm identification of the applicant by viewing a valid and current source of picture identification, such as a Canadian driver's licence, passport or Canadian citizenship card.

2. **Confirm Registration Status with the College of Pharmacists of BC**

   The pharmacy manager must access the online registry on the College website to:

   - Confirm the applicant's registration status as pharmacist or pharmacy technician.
   - Review any limits and/or conditions on practice published for the pharmacist or pharmacy technician.
   - Confirm whether the pharmacist is authorized to administer injections.

3. **Confirm that the College Registration Number Provided by the Pharmacist Matches the Registration Number on PharmaNet**

   The pharmacy manager must use the practitioner ID look up function 'P1' on their local pharmacy system to verify that the pharmacist registration number provided by the applicant matches the College registration number and pharmacist name returned by PharmaNet.

Note: **Once a pharmacist has been hired and has created a profile on the local pharmacy software, the pharmacy manager must verify the information created by the pharmacist by confirming the registration number and name matches the information returned by the practitioner ID look up function 'P1' on PharmaNet.**

BACKGROUND:

This policy supplements Pharmacy Operations and Drug Scheduling Act (PODSA) Bylaws Part 1 - All Pharmacies, Section ~~3~~18(2)(b) a manager must confirm that staff members who represent themselves as registrants are registrants.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 74**
POLICY FOCUS: **Community Pharmacy Security**

This policy provides guidance to community pharmacies for complying with community pharmacy security requirements. *Pharmacy Operations and Drug Scheduling Act ("PODSA")* Bylaws section 1, section ~~3~~18(2)(q), section ~~3~~18(2)(r), section ~~3~~18(2)(s), section ~~3~~18(2)(bb), section ~~3(4)~~18(8) and section ~~11.1~~ 26 address community pharmacy security.

POLICY STATEMENT(S):

1. Written Policies and Procedures Regarding Pharmacy Security
Pharmacy security policies and procedures should be included in the pharmacy's policy and procedure document. The policies and procedures should contain information on the following:

- Training,
- Pharmacy security equipment,
- Emergency responses,
- Incident review, and
- Pharmacy security evaluation,

Additionally, pharmacy owners and directors should ensure that critical stress debriefing and stress counseling is offered as soon as possible following an incident.

2. Staff Training on Pharmacy Security Policies and Procedures

Pharmacy managers should ensure that staff members are retrained at least annually to maintain knowledge of pharmacy security policies and procedures.

Staff training is critical both to prevent and respond effectively to security breaches. Training includes initial training and periodic review/refresher of skills. Training should include instruction on:

- Operation of security-related equipment, such as security camera, alarms, safes, etc.,
- What to do in the event of a pharmacy security breach, and
- How to handle potential precursors to robbery (e.g., the presence of suspicious customers and phishing style phone calls, etc.).

3. Notification Procedures

As outlined in PODSA bylaws section ~~3~~18(2)(s), pharmacy managers notify the registrar of any incident of loss of narcotic and controlled drug substances within 24 hours. This notification should occur through the Robbery Prevention Portal located in e-Services under the "report an incident" tab. Incidents to be reported include but are not limited to any of the following:

a. Robbery (armed/unarmed) or attempted robbery
b. Break and enter
c. Forgery
d. Theft
e. Drug loss (unexplained or adulterated)

Additionally, pharmacy managers should provide the College Registrar, within 10 days of an occurrence, with a copy of the mandatory Health Canada report **(Form HC 4010 or HC 4004)** via the Robbery Prevention Portal located in e-Services containing the complete inventory of drugs (including the drug count) that were taken or diverted.

Pharmacy managers should notify the pharmacy owner(s) and director(s) immediately as soon as the manager becomes aware that they are unable to meet the minimum pharmacy security requirements (as defined in PODSA bylaws section ~~11.1~~26). If compliance is not achieved within a reasonable amount of time, then the pharmacy manager must notify the registrar of any persistent non-compliance by the pharmacy owner(s) and director(s) with community pharmacy security bylaws and/or this policy as required in PODSA bylaws section ~~3~~18(2)(bb). The CPBC Complaints Resolution Department via the complaints line **778-330-0967** should be used for this notification.

4. Pharmacy Security Equipment

Safe

The safe must be an actual metal safe, a "narcotics cabinet" is not sufficient. The safe must be securely anchored in place, preferably to the floor. The safe should only be open when items are being placed into or removed from the safe. ***It is never appropriate for the safe to be left open; this would defeat the purpose of the time-delay lock security measure*.**

Security Camera System

It is important to ensure that images captured by the security camera system are sufficient to enable law enforcement to identify the criminals. In order to identify a person, specific individual features must be distinguishable.

Experts advise that camera systems are rated on frame rates per second and resolution. The higher the frame rate and resolution the better for detection and identification.

Under the *Personal Information Protection Act* (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras. Guidance on the use of cameras, including security arrangements and policies can be found on the Office of Information Privacy Commissioner's site.

Motion Sensors

Security experts recommend that 360 degree motion detectors be installed on the ceiling as wall mounted motion detectors are vulnerable to blind spots.

Monitored Alarms Systems

Independent alarms for the dispensary **are optional**, when a full pharmacist is present **at all times and the premise is accessible by non-registrants.**

Physical Barriers

Physical barriers provide an additional layer of security and deter:

1. Unauthorized access to drugs, including but not limited to:
    - All Schedule I, and II and, controlled drug substances and personal health information.

2. Unauthorized access to personal health information, including but not limited to:
    - Hard copies of prescriptions,
    - Filled prescriptions waiting to be picked up, and/or
    - Labels, patient profiles, and any other personal health information documents waiting for disposal.

Physical barriers can be tailored to the needs and structure of the particular community pharmacy. Examples of physical barriers include: locked gates, grillwork, locked cabinets, locked doors, and locked shelving units. The physical barriers should prevent access.

As per section ~~11.1~~26(2.1), existing community pharmacies have 3 years (from the date that the bylaws are in force) to implement physical barriers. All new pharmacies must have physical barriers. Pharmacies that are renovated within this 3 year period must include physical barriers in the renovations.

When a full pharmacist is present at all times, physical barriers **are optional**.

Signage

The College will send signs to all new pharmacies at the time of licensure approval. In addition, signs can also be ordered via the e-Services portal. Signage provides a consistent province-wide deterrent message that additional layers of security are in place. It is critical that all pharmacies comply with this requirement to ensure that their pharmacy does not become a “soft target”.

For pharmacies that do not stock IA drugs, the declaration attesting this can be provided using the self-declaration template in Appendix 1 of this policy.

5. Emergency Response Kit

An emergency response kit should include a step-by-step guide on what to do in the event of a robbery or break and enter and be available to all pharmacy staff.

Pharmacy robberies and break and enters can be very stressful and traumatic events for pharmacy staff. Having an accessible and plain language step-by-step guide on what do if such an event occurs can help pharmacy staff take the steps necessary to appropriately respond to the situation.

6. Incident Review

Incident reviews should be conducted annually to determine concerns about pharmacy security and/or activity trends.

Policies and procedures should be in place regarding a privacy breach response plan consistent with s. 79 of the *Health Professions Act* Bylaws. The plan should provide for notification of affected individuals and other health care providers in appropriate cases. It should also include notification to the College and the Office of the Information and Privacy Commissioner of British Columbia.

7. Pharmacy Security Evaluation

Pharmacy security evaluations should be conducted on an annual basis to identify areas of risk and needed improvements.

Appendix 1: Safe Declaration Template

NO SCHEDULE 1A DRUGS ON-SITE DECLARATION

I ,_____, the _____(position title) of _____(legal pharmacy name), declare that,

1. Schedule 1A drugs are **never** stocked or dispensed at the above identified pharmacy, and I understand that non-compliance with this declaration may result in referral to the Inquiry Committee of the College of Pharmacists of BC.

2. In the event that the terms of the declaration above are no longer valid, I will notify the Registrar immediately and take action in advance to ensure that pursuant to sections ~~11.1~~26 (1)(a) and ~~11.1~~26 (3) of the *Pharmacy Operations and Drug Scheduling Act* Bylaws, a safe will be installed and signage will be displayed.

_____ _____

Date (MM/DD/YYYY) Signature

College of Pharmacists of B.C.

~~COMMUNITY PHARMACY AND~~ TELEPHARMACY DIAGRAM AND PHOTOS/VIDEOS

PODSA Bylaw "Schedule C"

ITEMS

Indicate the location of the following items on the diagram and/or submit photos or videos of the following items with Form 10/Form 11:

Category	Item	Reference & Requirements		Diagram	Photo/Video
External to Dispensary	**External View of the Pharmacy (Street view including the External Signage)**	**Community Pharmacy: *PODSA Bylaws* s.183(2)(p)** The manager must ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery.	**Telepharmacy: *PODSA Bylaws* s.183(2)(p.1)** The manager must, if the pharmacy is a central pharmacy, ensure the correct and consistent use of each telepharmacy operating name as it appears on the telepharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery associated with that telepharmacy. **Telepharmacy: *PODSA Bylaws* s.3116(1)(c)** The registrar must not issue a telepharmacy licence to a central pharmacy unless the proposed operating name of the telepharmacy includes the word "telepharmacy".	(Entrance to the pharmacy)	✓
	Hours of operation sign	***PODSA Bylaws* s.2712(2)(f)** The hours when a full pharmacist is on duty are posted.			✓
	Professional products area for schedule 3 drugs (+ Lock and Leave barriers if the premises is opened for business while the pharmacy is closed) **OR N/A**	***PODSA Drug Schedule Regulations* s.2(3)** Schedule III drugs may be sold by a pharmacist to any person from the self-selection Professional Products Area of a licensed pharmacy. ***PODSA Bylaws* s.2511(1)(a)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage. ***PODSA Bylaws* s.183(2)(j)** The manager must ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present.		✓	✓
	Signage at 25 feet from dispensary OR N/A	***PODSA Bylaws* s.2511(1)(a)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy must ensure that the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage.		✓	✓
	"Medication Information" Sign **OR N/A**	***PODSA Bylaws* s.2511(1)(b)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy must ensure that a sign reading "Medication Information" is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice.		✓	✓
Dispensary	**Dispensary area**	***PODSA Bylaws* s.2511(2)(a)** The dispensary area of a community pharmacy or a telepharmacy must be at least 160 square feet. **Telepharmacy: *PODSA Bylaws* s.2511(3)** A telepharmacy that was authorized by the registrar to provide pharmacy services as a telepharmacy remote site as of January 1, 2017 is exempt from the requirements in subsections (2)(a) and (c) until such time as it commences a renovation of all or part of the premises.			✓
	Gate/door at the entrance into the dispensary	***PODSA Bylaws* s.2511(2)(b)** The dispensary area of a community pharmacy or a telepharmacy must be inaccessible to the public by means of gates or doors across all entrances.		✓	✓
	Placeholder for College license	***PODSA* s.2(4)** The manager must display the licence issued under subsection (1) in a place within the pharmacy where it is conspicuous to the public.			✓
	Professional Service Area for Schedule 2 drugs	***PODSA Drug Schedule Regulations* s.2(3)** Schedule II drugs may be sold by a pharmacist on a non-prescription basis and which must be retained within the Professional Service Area of the pharmacy where there is no public access and no opportunity for patient self-selection.		(Shelving)	✓
	Patient consultation area	***PODSA Bylaws* s.2511(4)** In all new and renovated community pharmacies or telepharmacies, an appropriate area must be provided for patient consultation that		✓	✓

Category	Item	Reference & Requirements	Diagram	Photo/Video
		(a) ensures privacy and is conducive to confidential communication, and (b) includes, but is not limited to, one of the following: (i) a private consultation room, or (ii) a semiprivate area with suitable barriers.		
	Dispensing counter and service counter	***PODSA Bylaws* s.2511(2)(c)** The dispensary area of a community pharmacy or a telepharmacy must include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters. **Telepharmacy: *PODSA Bylaws* s.2511(3)** A telepharmacy that was authorized by the registrar to provide pharmacy services as a telepharmacy remote site as of January 1, 2017 is exempt from the requirements in subsections (2)(a) and (c) until such time as it commences a renovation of all or part of the premises.	✓	✓
	Computer terminals for prescription processing	***PODSA Bylaws* s.3420(b)** A pharmacy must connect to PharmaNet and be equipped with a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which (i) is only accessible to registrants and support persons, (ii) is under the direct supervision of a registrant, and (iii) does not allow information to be visible to the public, unless intended to display information to a specific patient.	✓	✓
	Shelving	***PODSA Bylaws* s.2511(2)(d)** The dispensary area of a community pharmacy or a telepharmacy must contain adequate shelf and storage space.	✓	✓
Security	**Secure storage space**	***PODSA Bylaws* s.2511(5)** All new and renovated community pharmacies and telepharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.	✓	✓
	Locked Metal Safe **OR** **Safe Declaration**	***PODSA Bylaws* s.2611.1(1)(a)** A community pharmacy or telepharmacy must keep Schedule IA drugs in a locked metal safe that is secured in place and equipped with a time delay lock set at a minimum of five minutes. ***PPP-74 Policy Statement #4*** The safe must be an actual metal safe, a "narcotics cabinet" is not sufficient. The safe must be securely anchored in place, preferably to the floor. ***PODSA Bylaws* s.2611.1(4)** The ~~pharmacy~~ manager, direct ~~and~~ owner~~s~~ or indirect owners (s)~~directors~~ of a community pharmacy or a telepharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises.	✓	✓
	Security camera system AND Surveillance signage	***PODSA Bylaws* s.2611.1(1)(b)** A community pharmacy or telepharmacy must install and maintain a security camera system that: (i) has date/time stamp images that are archived and available for no less than 30 days, and (ii) is checked daily for proper operation. ***PPP-74 Policy Statement #4*** Under the Personal Information Protection Act (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras.		✓
	Motion sensors	***PODSA Bylaws* s.2611.1(1)(c)** A community pharmacy or telepharmacy must install and maintain motion sensors in the dispensary.		✓
	Monitored alarm OR N/A	***PODSA Bylaws* s.2611.1(2)(a)** When no full pharmacist is present and the premise is accessible to non-registrants, the dispensary area must be secured by a monitored alarm. ***PPP-74 Policy Statement #4*** Independent alarms for the dispensary are optional, when a full pharmacist is present at all times and the premise is accessible by non-registrants. **Telepharmacy (in addition to the above):** ***PODSA Bylaws* s.2611.1(2.2)** For the purposes of subsection (2), a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy. ***PODSA Bylaws* s.3116.1(3)** A telepharmacy must have a security system that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.		✓
	Physical barriers OR N/A	***PODSA Bylaws* s.2611.1(2)(b)** When no full pharmacist is present and the premise is accessible to non-registrants, subject to subsection ~~(~~2.1~~)~~,schedule I and II drugs, controlled drug substances and personal health information, are secured by physical barriers. ***PPP-74 Policy Statement #4*** Physical barriers provide an additional layer of security and deter: 1. Unauthorized access to drugs, including but not limited to: • All Schedule I, and II and, controlled drug substances and personal health information. 2. Unauthorized access to personal health information, including but not limited to:	✓	✓

Category	Item	Reference & Requirements	Diagram	Photo/Video
		• Hard copies of prescriptions, • Filled prescriptions waiting to be picked up, and/or • Labels, patient profiles, and any other personal health information documents waiting for disposal. Physical barriers can be tailored to the needs and structure of the particular community pharmacy. Examples of physical barriers include: locked gates, grillwork, locked cabinets, locked doors, and locked shelving units. When a full pharmacist is present at all times, physical barriers are optional.		
		Telepharmacy (in addition to the above): ***PODSA Bylaws* s.2611.1(2.2)** For the purposes of subsection (2), a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy. ***PODSA Bylaws* s.3116.1(3)** A telepharmacy must have a security system that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.		
Equipment & Reference	**Double stainless steel sink**	***PODSA Bylaws* s.2511(2)(e)** The dispensary area of a community pharmacy or a telepharmacy must contain a double stainless steel sink with hot and cold running water. ***PPP-59* Policy Statement #1** The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw 183(2)(w): (n) double sink with running hot and cold water;	✓	✓
	Equipment (basic): **1. Telephone** **2. Refrigerator** **3. Rx filing supplies** **4. Rx balance** **5. Metric weights** **6. Glass graduates** **7. Mortar** **8. Pestle** **9. Spatulas** **10. Funnels** **11. Stirring rods** **12. Ointment slab/ parchment paper** **13. Counting tray** **14. Disposable drinking cups** **15. Soap dispenser** **16. Paper towel dispenser** **17. Plastic/metal garbage containers** **18. Plastic lining** **19. Fax machine**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-59* Policy Statement #1**; The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw 183(2)(w): (a) telephone; (b) refrigerator; (c) prescription filing supplies; ***PPP-12* Policy Statement #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. (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 glass 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; (o) soap dispenser and paper towel dispenser; (p) plastic or metal garbage containers to be used with plastic liners; (q) fax machine ***HPA Bylaws Schedule F Part 1 s. 7(1)(b)*** The facsimile equipment is located within a secure area to protect the confidentiality of the prescription information	✓ Fridge only	✓
	Equipment (Cold Chain) **1. Thermometer** **2. Temperature log**	***PPP-68* Policy Statement:** The Board of the College of Pharmacists of BC adopts the BCCDC guidelines on the Cold Chain Management of Biologicals. Refer to BCCDC's Communicable Disease Control Immunization Program: Section VI – Management of Biologicals. ***Communicable Disease Control Immunization Program Section VI – Management of Biologicals (2015)* s.3.3.2** Use a constant temperature-recording device or digital minimum/maximum thermometer (with probe) to monitor both the current refrigerator temperature and the minimum/maximum temperatures reached. At the start and end of each work day, record the minimum and maximum temperatures reached since the last monitoring, on the Temperature Form. On the Temperature Log, record the date, time and three temperatures (the current refrigerator temperature, the minimum temperature reached since last check, and the maximum temperature reached since last check.) Also record the refrigerator dial setting.		✓
	Equipment (Methadone) **1. Calibrated device** **2. Auxiliary labels** **3. Containers for daily dose**	***PPP-66 Policy Guide MMT (2013)* Principle 3.3.1** Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 ml. ***PPP-66 Policy Guide MMT (2013)* Principle 3.3.1 Guidelines** All devices used to measure the methadone 10 mg/ml solutions should be distinctive and recognizable and must be used only to measure methadone solutions. Devices must be labeled with a "methadone only" label and a "poison" auxiliary label with the international symbol of the skull and cross bones.		✓

Category	Item	Reference & Requirements	Diagram	Photo/Video
	4. Patient/Rx Log **OR N/A**	***PPP-66 Policy Guide MMT (2013)* Principle 4.1.6** With respect to take-home doses the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion with all subsequent take-home doses dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. ***PPP-66 Policy Guide MMT (2013)* Principle 4.1.6 Guidelines** Each dose must be dispensed in an individual, appropriately sized, child-resistant container. ***PPP-66 Policy Guide MMT (2013)* Principle 4.1.3** Prior to releasing a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/ prescription-specific log.		
	References (CPBC) **1. BC Pharmacy Practice Manual** **2. ReadLinks**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Policy Statement 1st Paragraph** All community pharmacies are required to have the most current versions of the BC Pharmacy Practice Manual. The CPBC Read Links is an exception, as only the most recent three years must be retained.		✓
	References (General) **1. Compendium** **2. Complementary/ Alternative** **3. Dispensatory** **4. Drug Interactions** **5. Nonprescription Medication (2x)** **6. Medical Dictionary** **7. Pregnancy and Lactation** **8. Pediatrics** **9. Therapeutics**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Page 2** 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 183(2)(w). [which are: 1. Compendium (current year); 2. Complementary/Alternative (within the last 4 years); 3. Dispensatory (within last 9 years); 4. Drug Interactions (in its entirety every 2 years, or continual updates); 5. Nonprescription Medication (most current issue of BOTH references required); 6. Medical Dictionary (within the last 15 years); 7. Pregnancy and Lactation (within the last 3 years); 8. Pediatrics (within the last 4 years); 9. Therapeutics (within last 4 years)]		✓
	References (if applicable) • **Veterinary** • **Psychiatric** • **Geriatric** • **Specialty compounding** • **Methadone** ○ **PPP-66** ○ **CSPBC** ○ **CAMH** ○ **Monograph** **OR N/A**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Page 2** In addition to the above list, pharmacies must be equipped with references relevant to their practices (e.g. Veterinary, Psychiatric, Geriatric). ***PPP-66* Required References** In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following: (1) CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions, (2) most recent version of the CPSBC Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder, (3) most current edition of Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders, and (4) product monographs for the commercially available 10mg/ml methadone oral preparations.		✓
Prescriptions	**Prescription hardcopy (i.e. the label/paper attached to the original prescription, which contains prescription information generated after transmitting to PharmaNet)**	***HPA Bylaws Schedule F Part 1 s.6(4)(a) to (f)*** At the time of dispensing, a prescription must include the following additional information: (a) the address of the patient; (b) the identification number from the practitioner's regulatory college; (c) the prescription number; (d) the date on which the prescription was dispensed; (e) the manufacturer's drug identification number or the brand name of the product dispensed; (f) the quantity dispensed.		✓

Category	Item	Reference & Requirements	Diagram	Photo/Video
		Telepharmacy (in addition to the above): ***PODSA Bylaws* s.3116.1(4)** Prescriptions and labels relating to prescriptions dispensed at a telepharmacy must identify the prescription as having been dispensed at that telepharmacy. ***PODSA Bylaws* s.3116.1(4.1)** Prescriptions and labels relating to prescriptions dispensed at a pharmacy listed in Schedule "F" must distinguish between those dispensed when it is operating as a telepharmacy from when it is operating as a community pharmacy.		
Confidentiality	**Shredder OR** **Contract with a Document Destruction Company**	***HPA Bylaws* s.75** A registrant must ensure that records referred to in section 74 are disposed of only by (a) transferring the record to another registrant, or (b) effectively destroying a physical record by utilizing a shredder or by complete burning, or by (c) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the information cannot be reconstructed. ***HPA Bylaws* s.78** A registrant must ensure that, if personal information about patients is transferred to any person or service organization for processing, storage or disposal, a contract is made with that person which includes an undertaking by the recipient that confidentiality and physical security will be maintained.		✓
	Offsite Storage Contract **OR N/A**	***HPA Bylaws* s.74(b)** A registrant must ensure that all records pertaining to his or her practice, and containing personal information about patients are safely and securely stored off site.		✓
Inventory Management	**Drug Receiving Area**	***PODSA Bylaws* s.205(3)** All drug shipments must be delivered unopened to the pharmacy or a secure storage area.	✓	✓
	Drugs	***PODSA Bylaws* s.2511(2)(f)** The dispensary area of a community pharmacy or a telepharmacy must contain an adequate stock of drugs to provide full dispensing services.		✓
	Storage area for non-usable and expired drugs	***PODSA Bylaws* s.205(4)** Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal.		✓
Dispensed Products	**Prescription product label** **1. Single entity product** **2. Multiple-entity product**	***HPA Bylaws Schedule F Part 1* s.9(2)** The label for all prescription drugs must include (a) the name, address and telephone number of the pharmacy, (b) the prescription number and dispensing date, (c) the full name of the patient, (d) the name of the practitioner, (e) the quantity and strength of the drug, (f) the practitioner's directions for use, and (g) any other information required by good pharmacy practice. ***HPA Bylaws Schedule F Part 1* s.9(3)** For a single-entity product, the label must include (a) the generic name, and (b) at least one of (i) the brand name, (ii) the manufacturer's name, or (iii) the drug identification number (DIN). ***HPA Bylaws Schedule F Part 1* s.9(4)** For a multiple-entity product, the label must include (a) the brand name, or (b) all active ingredients and at least one of (i) the manufacturer's name or (ii) the drug identification number (DIN).		✓
		Telepharmacy (in addition to the above): ***PODSA Bylaws* s.3116.1(4)** Prescriptions and labels relating to prescriptions dispensed at a telepharmacy must identify the prescription as having been dispensed at that telepharmacy. ***PODSA Bylaws* s.3116.1(4.1)** Prescriptions and labels relating to prescriptions dispensed at a pharmacy listed in Schedule "F" must distinguish between those dispensed when it is operating as a telepharmacy from when it is operating as a community pharmacy.		
	Filling supplies (e.g. vials and bottles including caps)	***HPA Bylaws Schedule F Part 1* s.10(4)** All drugs must be dispensed in a container that is certified as child-resistant unless….		✓

Category	Item	Reference & Requirements	Diagram	Photo/Video
Pharmacy Manager's Responsibilities	**Name Badge**	***PODSA Bylaws* s.183(2)(m)** A manager must ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status.		✓
	Police & Procedure Manual	***PODSA Bylaws* s.183(2)(g)** A manager must establish policies and procedures to specify the duties to be performed by registrants and support persons. ***PODSA Bylaws* s.183(2)(h)** A manager must establish procedures for (i) inventory management, (ii) product selection, and (iii) proper destruction of unusable drugs and devices. ***PODSA Bylaws* s.183(2)(k)** A manager must ensure there is a written drug recall procedure in place for pharmacy inventory. ***PODSA Bylaws* s.183(2)(q)** A manager must establish and maintain policies and procedures respecting pharmacy security. ***PPP-74 Policy Statement #1*** Pharmacy security policies and procedures should be included in the pharmacy's policy and procedure document. The policies and procedures should contain information on the following: • Training, • Pharmacy security equipment, • Emergency responses, • Incident review, and • Pharmacy security evaluation ***PPP-74 Policy Statement #5*** An emergency response kit should include a step-by-step guide on what to do in the event of a robbery or break and enter and be available to all pharmacy staff. ***PODSA Bylaws* s.2410(1)(c)** A community pharmacy's manager must develop, document and implement an ongoing quality management program that includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies ***HPA Bylaws* s.79** A registrant must take appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal information about patients under this Part as soon as possible after the breach is discovered.		✓ (or document file)
		Telepharmacy (in addition to the above): ***PODSA Bylaws* s.3116.1(8)** A telepharmacy must have a policy and procedure manual on site that outlines the methods for ensuring the safe and effective distribution of pharmacy products and delivery of pharmaceutical care by the telepharmacy.		

College of Pharmacists of B.C.

TELEPHARMACY ADDITIONAL PHOTOS/VIDEOS

PODSA Bylaw "Schedule E"

ITEMS

Submit photos or videos of the following items with Form 11:

Category	Item	Reference and Requirements
Prescriptions	**Marked prescription (sample)**	***HPA Bylaws Schedule F Part 6 s.5(2)*** An original physical prescription may be submitted to a telepharmacy and, upon receipt, must be marked with the date of receipt and the name of the telepharmacy.
Central Pharmacy	**Tool/technology enabling direct supervision on dispensary activities**	***PODSA Bylaws* s.3116.1(1)(a)** A telepharmacy must not remain open and prescriptions must not be dispensed without a full pharmacist physically present ~~and~~ on duty at a telepharmacy, unless a full pharmacist at the central pharmacy is engaged in direct supervision of the telepharmacy in accordance with the *Telepharmacy Standards of Practice*. ***PODSA Bylaws Definitions*** "direct supervision" means real time audio and visual observation by a full pharmacist of pharmacy services performed at a telepharmacy consistent with a pharmacy manager's responsibilities as set out in subsection 183(2). ***HPA Bylaws Schedule F Part 6* s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(3)** A supervising pharmacist must be able to engage in direct supervision of the provision of pharmacy services at a telepharmacy independent of any action of or request by persons performing those services.
	Tool/technology used for transmitting prescription and personal health information between sites	***HPA Bylaws Schedule F Part 6* s.6(2)** Each telepharmacy and central pharmacy must maintain a secure connection to the central pharmacy for transmission of prescription and personal health information.
	Tool/technology used for processing prescriptions at the central pharmacy for prescriptions received at the telepharmacy	***HPA Bylaws Schedule F Part 6* s.6(1)** All prescription processing must occur at the central pharmacy unless a full pharmacist is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.6(2)** Each telepharmacy and central pharmacy must maintain a secure connection to the central pharmacy for transmission of prescription and personal health information.
	Tool/technology enabling direct supervision on product final check	***PODSA Bylaws* s.3116.1(1)(a)** A telepharmacy must not remain open and prescriptions must not be dispensed without a full pharmacist physically present ~~and~~ on duty at the telepharmacy, unless a full pharmacist at the central pharmacy is engaged in direct supervision of the telepharmacy in accordance with the *Telepharmacy Standards of Practice*. ***HPA Bylaws Schedule F Part 6* s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(2)(a)** A supervising pharmacist must be readily available at all times when a telepharmacy is open to provide direction and support to persons performing pharmacy services at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(4)** Subject to subsection (5), telepharmacy staff may only perform the activities described in s. 4(1) of the Pharmacists Regulation while under direct, continuous real-time audio and visual observation and direction of a supervising pharmacist. ***HPA Bylaws Schedule F Part 6* s.4(5)** Direct supervision does not require the supervising pharmacist to conduct real-time observation of a pharmacy technician performing work within his or her scope of practice.
	Tool/technology enabling direct pharmacist/patient consultation	***HPA Bylaws Schedule F Part 6* s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(2)(b)** A supervising pharmacist must be readily available at all times when a telepharmacy is open to provide pharmacist/patient consultation. ***HPA Bylaws Schedule F Part 6* s.7** Unless a full pharmacist is physically present on duty at the telepharmacy, the supervising pharmacist must provide full pharmacist/patient consultation by real-time audio and visual link and otherwise in accordance with the requirements of Part 1 of Schedule F of the *Health Professions Act Bylaws*.

Category	Item	Reference and Requirements
	Policy and procedure manual (document file acceptable)	***PODSA Bylaws* s.~~2410~~(2)** If a community pharmacy is a central pharmacy, the quality management program in subsection (1) must include all telepharmacies associated with the central pharmacy and must comply with the *Telepharmacy Standards of Practice.*

College of Pharmacists of British Columbia

PHARMACY PRE-OPENING INSPECTION REPORT

TELEPHARMACY (COMMUNITY)

1. TELEPHARMACY INFORMATION				
Operating Name		**PharmaCare Code**		**Proposed Opening Date** MMM | DD | YYYY
Telepharmacy Address	**City**	**Province** BC	**Postal Code**	**Software Vendor (for dispensing)**
Email Address	**Phone Number**	**Fax Number**		**Website**

2. CENTRAL PHARMACY INFORMATION				
Operating Name				**PharmaCare Code**
Pharmacy Address	**City**	**Province** BC	**Postal Code**	**Software Vendor (for dispensing)**
Email Address	**Phone Number**	**Fax Number**		**Website**

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

3. PHARMACY SERVICES

TYPE	YES	NO	TYPE	YES	NO	If "YES", PROVIDE PHARMACY NAME(S) INVOLVED
Methadone (Pain)			Contracts - BC Transplant			
Methadone (Maintenance)			Contracts - Center for Excellence			
Compounding (Specialty)			Other - Delivery			
Compounding (Sterile Product)			Other - Internet			
Compliance Packaging			Other - Drive Thru			
Clinical - Injection Drug Administration			Residential Care Services			
Clinical - Medication Management/Review			Centralized Prescription Processing Services			Provided to:
Clinical - Education Clinics			Outsourced Prescription Processing Services			Received from:
Contracts - Renal Agencies						

4. HOURS OF OPERATION

TYPE	SUN	MON	TUE	WED	THU	FRI	SAT
TELEPHARMACY							
Telepharmacy Hours							
Pharmacy Hours							
Lock & Leave Hours							
CENTRAL PHARMACY							
Pharmacy Hours							
Lock & Leave Hours							

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

5. TELEPHARMACY ROSTER*				
STAFF	**REGISTRATION #**	**FIRST NAME/INFORMAL NAME**	**LAST NAME**	**REGISTRATION CLASS**
Pharmacy Manager				☒ Pharmacist ☐ Pharmacy Technician
Staff #1				☐ Pharmacist ☐ Pharmacy Technician
Staff #2				☐ Pharmacist ☐ Pharmacy Technician
Staff #3				☐ Pharmacist ☐ Pharmacy Technician
Staff #4				☐ Pharmacist ☐ Pharmacy Technician
Staff #5				☐ Pharmacist ☐ Pharmacy Technician
Staff #6				☐ Pharmacist ☐ Pharmacy Technician
Staff #7				☐ Pharmacist ☐ Pharmacy Technician

*Include all registrant staff who may be providing pharmacy services or performing inspections/audits at the telepharmacy at any time

6. PRE-OPENING INSPECTION

Confirm whether your new telepharmacy currently complies with each of the following requirements.

- **If compliant, mark "✓" under the "Compliant" column and submit digital evidence (e.g. photos/videos) along with this form. Refer to the Licensure Guide for further details.**
- **If not applicable, enter "N/A" under the "Compliant" column and provide the reason in the comment field.**

External to Dispensary

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
1a	**External view of the pharmacy (street view including the external signage)**	***PODSA Bylaws* s.183(2)(p.1)** The manager must, if the pharmacy is a central pharmacy, ensure the correct and consistent use of each telepharmacy operating name as it appears on the telepharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery associated with that telepharmacy. ***PODSA Bylaws* s.3116(1)(c)** The registrar must not issue a telepharmacy licence to a central pharmacy unless the proposed operating name of the telepharmacy includes the word "telepharmacy".			
1b	**Hours of operation sign**	***PODSA Bylaws* s.2712(2)(f)** The hours when a full pharmacist is on duty are posted.			

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
1c	**Professional products area for schedule 3 drugs** **(+ Lock-and-Leave barriers if the premise is open for business while the pharmacy is closed)** **OR N/A**	***PODSA Drug Schedule Regulations* s.2(3)** Schedule III drugs may be sold by a pharmacist to any person from the self-selection Professional Products Area of a licensed pharmacy. ***PODSA Bylaws* s.~~25~~11(1)(a)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage. ***PODSA Bylaws* s.~~18~~3(2)(j)** The manager must ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present.			
1d	**Signage at 25 feet from dispensary** **OR N/A**	***PODSA Bylaws* s.~~25~~11(1)(a)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage.			
1e	**"Medication Information" Sign** **OR N/A**	***PODSA Bylaws* s.~~25~~11(1)(b)** In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that a sign reading "Medication Information" is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice.			

Dispensary

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
2a	**Dispensary area**	***PODSA Bylaws* s.~~25~~11(2)(a)** The dispensary area of a community pharmacy or a telepharmacy must be at least 160 square feet. ***PODSA Bylaws* s.~~25~~11(3)** A telepharmacy that was authorized by the registrar to provide pharmacy services as a telepharmacy remote site as of January 1, 2017 is exempt from the requirements in subsections (2)(a) and (c) until such time as it commences a renovation of all or part of the premises.			
2b	**Gate/door at the entrance into the dispensary**	***PODSA Bylaws* s.~~25~~11(2)(b)** The dispensary area of a community pharmacy or a telepharmacy must be inaccessible to the public by means of gates or doors across all entrances.			
2c	**Placeholder for College license**	***PODSA* s.2(4)** The manager must display the licence issued under subsection (1) in a place within the pharmacy where it is conspicuous to the public.			
2d	**Professional service area for Schedule 2 drugs**	***PODSA Drug Schedule Regulations* s.2(3)** Schedule II drugs may be sold by a pharmacist on a non-prescription basis and which must be retained within the Professional Service Area of the pharmacy where there is no public access and no opportunity for patient self-selection.			
2e	**Patient consultation area**	***PODSA Bylaws* s.~~25~~11(4)** In all new and renovated community pharmacies or telepharmacies, an appropriate area must be provided for patient consultation that			

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
		(a) ensures privacy and is conducive to confidential communication, and (b) includes, but is not limited to, one of the following: (i) a private consultation room, or (ii) a semiprivate area with suitable barriers.			
2f	**Dispensing counter and service counter**	***PODSA Bylaws* s.2511(2)(c)** The dispensary area of a community pharmacy or a telepharmacy must include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters. ***PODSA Bylaws* s.2511(3)** A telepharmacy that was authorized by the registrar to provide pharmacy services as a telepharmacy remote site as of January 1, 2017 is exempt from the requirements in subsections (2)(a) and (c) until such time as it commences a renovation of all or part of the premises.			
2g	**Computer terminals for prescription processing**	***PODSA Bylaws* s.3420(b)** A pharmacy must connect to PharmaNet and be equipped with a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which (i) is only accessible to registrants and support persons, (ii) is under the direct supervision of a registrant, and (iii) does not allow information to be visible to the public, unless intended to display information to a specific patient.			
2f	**Shelving**	***PODSA Bylaws* s.2511(2)(d)** The dispensary area of a community pharmacy or a telepharmacy must contain adequate shelf and storage space.			

Security

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
3a	**Secure storage space**	***PODSA Bylaws* s.2511(5)** All new and renovated community pharmacies and telepharmacies must have a separate and distinct area consisting of at least 40 square feet reserved as secure storage space.			
3b	☐ **Locked metal safe** **OR** ☐ **Safe declaration**	***PODSA Bylaws* s.2611.1(1)(a)** A community pharmacy or telepharmacy must keep Schedule IA drugs in a locked metal safe that is secured in place and equipped with a time delay lock set at a minimum of five minutes. ***PPP-74 Policy Statement #4*** The safe must be an actual metal safe, a "narcotics cabinet" is not sufficient. The safe must be securely anchored in place, preferably to the floor. ***PODSA Bylaws* s.2611.1(4)** The manager, direct owner or indirect owner(s) of a community pharmacy or telepharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises.			
3c	**Security camera system** **AND** **Surveillance signage**	***PODSA Bylaws* s.2611.1(1)(b)** A community pharmacy or telepharmacy must install and maintain a security camera system that: (i) has date/time stamp images that are archived and available for no less than 30 days, and (ii) is checked daily for proper operation. ***PPP-74 Policy Statement #4*** Under the Personal Information Protection Act (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras.			SCS SS

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
3d	**Motion sensors**	***PODSA Bylaws* s.2~~611.1~~(1)(c)** A community pharmacy or telepharmacy must install and maintain motion sensors in the dispensary.			
3e	**Monitored alarm** **OR N/A**	***PODSA Bylaws* s.2~~611.1~~(2)(a)** When no full pharmacist is present and the premise is accessible to non-registrants, the dispensary area must be secured by a monitored alarm. ***PPP-74 Policy Statement #4*** Independent alarms for the dispensary are optional, when a full pharmacist is present at all times and the premise is accessible by non-registrants. ***PODSA Bylaws* s.2~~611.1~~(2.2)** For the purposes of subsection (2), a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy. ***PODSA Bylaws* s.3~~116~~.1(3)** A telepharmacy must have a security system that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.			
3f	**Physical barriers** **OR N/A**	***PODSA Bylaws* s.2~~611.1~~(2)(b)** When no full pharmacist is present and the premise is accessible to non-registrants, subject to subsection ~~(~~2.1~~)~~, schedule I and II drugs, controlled drug substances and personal health information, are secured by physical barriers. ***PODSA Bylaws* s.2~~611.1~~(2.2)** For the purposes of subsection (2), a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy. ***PPP-74 Policy Statement #4*** Physical barriers provide an additional layer of security and deter: 1. Unauthorized access to drugs, including but not limited to: • All Schedule I, and II and, controlled drug substances and personal health information. 2. Unauthorized access to personal health information, including but not limited to: • Hard copies of prescriptions, • Filled prescriptions waiting to be picked up, and/or • Labels, patient profiles, and any other personal health information documents waiting for disposal. Physical barriers can be tailored to the needs and structure of the particular community pharmacy. Examples of physical barriers include: locked gates, grillwork, locked cabinets, locked doors, and locked shelving units. When a full pharmacist is present at all times, physical barriers are optional. ***PODSA Bylaws* s.3~~116~~.1(3)** A telepharmacy must have a security system that prevents the public and non-pharmacy staff from accessing the professional services area and the dispensary area, including any area where personal health information is stored.			

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Equipment and References

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
4a	**Double stainless steel sink**	***PODSA Bylaws* s.~~25~~11(2)(e)** The dispensary area of a community pharmacy or a telepharmacy must contain a double stainless steel sink with hot and cold running water. ***PPP-59* Policy Statement #1** The dispensary of all community pharmacies and telepharmacies at a minimum must have the following equipment as per PODSA Bylaw 18~~3~~(2)(w): (n) double sink with running hot and cold water;			
4b	**Equipment:** **1. Telephone** **2. Refrigerator** **3. Rx filing supplies** **4. Rx balance** **5. Metric weights** **6. Glass graduates** **7. Mortar** **8. Pestle** **9. Spatulas** **10. Funnels** **11. Stirring rods** **12. Ointment slab/ parchment paper** **13. Counting tray** **14. Disposable drinking cups** **15. Soap dispenser** **16. Paper towel dispenser** **17. Plastic/metal garbage containers** **18. Plastic lining** **19. Fax machine**	***PODSA Bylaws* s.18~~3~~(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-59* Policy Statement #1**; The dispensary of all community pharmacies and telepharmacies at a minimum must have the following equipment as per PODSA Bylaw 18~~3~~(2)(w): (a) telephone; (b) refrigerator; (c) prescription filing supplies; ***PPP-12* Policy Statement #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. (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 glass graduates (a selection, including 10 ml size); (g) mortar and pestle; (h) Spatulas (metal and non-metallic); (i) funnels (glass or plastic); (j) stirring rods (glass or plastic); (k) ointment slab or parchment paper; (l) counting tray; (m) disposable drinking cups; (o) soap dispenser and paper towel dispenser; (p) plastic or metal garbage containers to be used with plastic liners; (q) fax machine ***HPA Bylaws Schedule F Part 1 s. 7(1)(b)*** The facsimile equipment is located within a secure area to protect the confidentiality of the prescription information			A B C D E F G H I J K L M O P Q

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
4c	**Equipment (Cold Chain)** **1. Thermometer** **2. Temperature log**	***PPP-68* Policy Statement:** The Board of the College of Pharmacists of BC adopts the BCCDC guidelines on the Cold Chain Management of Biologicals. Refer to BCCDC's Communicable Disease Control Immunization Program: Section VI – Management of Biologicals. ***Communicable Disease Control Immunization Program Section VI – Management of Biologicals (2015)* s.3.3.2** Use a constant temperature-recording device or digital minimum/maximum thermometer (with probe) to monitor both the current refrigerator temperature and the minimum/maximum temperatures reached. At the start and end of each work day, record the minimum and maximum temperatures reached since the last monitoring, on the Temperature Form. On the Temperature Log, record the date, time and three temperatures (the current refrigerator temperature, the minimum temperature reached since last check, and the maximum temperature reached since last check.) Also record the refrigerator dial setting.			TMM TLOG
4d	**Equipment (Methadone)** **1. Calibrated device** **2. Auxiliary labels** **3. Containers for daily dose** **4. Patient/Rx Log** **OR N/A**	***PPP-66 Policy Guide MMT (2013)* Principle 3.3.1** Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 ml. ***PPP-66 Policy Guide MMT (2013)* Principle 3.3.1 Guidelines** All devices used to measure the methadone 10 mg/ml solutions should be distinctive and recognizable and must be used only to measure methadone solutions. Devices must be labeled with a "methadone only" label and a "poison" auxiliary label with the international symbol of the skull and cross bones. ***PPP-66 Policy Guide MMT (2013)* Principle 4.1.6** With respect to take-home doses the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion with all subsequent take-home doses dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. ***PPP-66 Policy Guide MMT (2013)* Principle 4.1.6 Guidelines** Each dose must be dispensed in an individual, appropriately sized, child-resistant container. ***PPP-66 Policy Guide MMT (2013)* Principle 4.1.3** Prior to releasing a methadone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/ prescription-specific log.			DEV AUX1 AUX 2 DOSE MLOG
4e	**References (CPBC)** **1. BC Pharmacy Practice Manual** **2. ReadLinks**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Policy Statement 1st Paragraph** All community pharmacies are required to have the most current versions of the BC Pharmacy Practice Manual. The CPBC Read Links is an exception, as only the most recent three years must be retained.			BPPM RL

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
4f	**References (General)** **1. Compendium** **2. Complementary/ Alternative** **3. Dispensatory** **4. Drug Interactions** **5. Nonprescription Medication (2x)** **6. Medical Dictionary** **7. Pregnancy and Lactation** **8. Pediatrics** **9. Therapeutics**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Page 2** In addition to the above list, pharmacies must be equipped with references relevant to their practices (e.g. Veterinary, Psychiatric, Geriatric). [which are: 1. Compendium (current year); 2. Complementary/Alternative (within the last 4 years); 3. Dispensatory (within last 9 years); 4. Drug Interactions (in its entirety every 2 years, or continual updates); 5. Nonprescription Medication (most current issue of BOTH references required); 6. Medical Dictionary (within the last 15 years); 7. Pregnancy and Lactation (within the last 3 years); 8. Pediatrics (within the last 4 years); 9. Therapeutics (within last 4 years)]			CPS ALT DIS DI OTC1 OTC2 MD P/L PED TH
4g	**References (if applicable)** ☐ **Veterinary** ☐ **Psychiatric** ☐ **Geriatric** ☐ **Specialty compounding** ☐ **Methadone** ○ **PPP-66** ○ **CSPBC** ○ **CAMH** ○ **Monograph** **OR N/A**	***PODSA Bylaws* s.183(2)(w)** The manager must ensure the pharmacy contains the reference material and equipment approved by the board from time to time. ***PPP-3* 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. ***PPP-3* Page 2** In addition to the above list, pharmacies must be equipped with references relevant to their practices (e.g. Veterinary, Psychiatric, Geriatric). ***PPP-66* Required References** In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following: (1) CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions, (2) most recent version of the CPSBC Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder, (3) most current edition of Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders, and (4) product monographs for the commercially available 10mg/ml methadone oral preparations.			VET PSY GER CMP MET1 MET2 MET3 MET4

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Prescription

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
5a	**Prescription hardcopy (i.e. the label/paper attached to the original prescription, which contains prescription information generated after transmitting to PharmaNet)**	***HPA Bylaws Schedule F Part 1 s.6(4)(a) to (f)*** At the time of dispensing, a prescription must include the following additional information: (a) the address of the patient; (b) the identification number from the practitioner's regulatory college; (c) the prescription number; (d) the date on which the prescription was dispensed; (e) the manufacturer's drug identification number or the brand name of the product dispensed; (f) the quantity dispensed. ***PODSA Bylaws* s.~~3116~~.1(4)** Prescriptions and labels relating to prescriptions dispensed at a telepharmacy must identify the prescription as having been dispensed at that telepharmacy. ***PODSA Bylaws* s.~~3116~~.1(4.1)** Prescriptions and labels relating to prescriptions dispensed at a pharmacy listed in Schedule "F" must distinguish between those dispensed when it is operating as a telepharmacy from when it is operating as a community pharmacy.			A B C D E F TPY
5b	**Marked prescription (sample)**	***HPA Bylaws Schedule F Part 6 s.5(2)*** An original physical prescription may be submitted to a telepharmacy and, upon receipt, must be marked with the date of receipt and the name of the telepharmacy.			

Confidentiality

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
6a	☐ **Shredder** **OR** ☐ **Contract with a document destruction company**	***HPA Bylaws* s.75** A registrant must ensure that records referred to in section 74 are disposed of only by (a) transferring the record to another registrant, or (b) effectively destroying a physical record by utilizing a shredder or by complete burning, or by (c) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the information cannot be reconstructed. ***HPA Bylaws* s.78** A registrant must ensure that, if personal information about patients is transferred to any person or service organization for processing, storage or disposal, a contract is made with that person which includes an undertaking by the recipient that confidentiality and physical security will be maintained.			
6b	**Offsite storage contract** **OR N/A**	***HPA Bylaws* s.74(b)** A registrant must ensure that all records pertaining to his or her practice, and containing personal information about patients are safely and securely stored off site.			

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Inventory Management

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
7a	**Drug receiving area**	***PODSA Bylaws* s.205(3)** All drug shipments must be delivered unopened to the pharmacy or a secure storage area.			
7b	**Drugs**	***PODSA Bylaws* s.2511(2)(f)** The dispensary area of a community pharmacy or a telepharmacy must contain an adequate stock of drugs to provide full dispensing services.			
7c	**Storage area for non-usable and expired drugs**	***PODSA Bylaws* s.205(4)** Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal.			

Dispensed Products

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
8a	**Prescription product label** **1. Single-entity product** **2. Multiple-entity product**	***HPA Bylaws Schedule F Part 1* s.9(2)** The label for all prescription drugs must include (a) the name, address and telephone number of the pharmacy, (b) the prescription number and dispensing date, (c) the full name of the patient, (d) the name of the practitioner, (e) the quantity and strength of the drug, (f) the practitioner's directions for use, and (g) any other information required by good pharmacy practice. ***HPA Bylaws Schedule F Part 1* s.9(3)** For a single-entity product, the label must include (a) the generic name, and (b) at least one of (i) the brand name, (ii) the manufacturer's name, or (iii) the drug identification number (DIN). ***HPA Bylaws Schedule F Part 1* s.9(4)** For a multiple-entity product, the label must include (a) the brand name, or (b) all active ingredients and at least one of (i) the manufacturer's name or (ii) the drug identification number (DIN). ***PODSA Bylaws* s.3116.1(4)** Prescriptions and labels relating to prescriptions dispensed at a telepharmacy must identify the prescription as having been dispensed at that telepharmacy. ***PODSA Bylaws* s.3116.1(4.1)** Prescriptions and labels relating to prescriptions dispensed at a pharmacy listed in Schedule "F" must distinguish between those dispensed when it is operating as a telepharmacy from when it is operating as a community pharmacy.			A B C D E F G A B --- A B

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
8b	**Filling supplies (e.g. vials and bottles including caps)**	***HPA Bylaws Schedule F Part 1*** **s.10(4)** All drugs must be dispensed in a container that is certified as child-resistant unless….			

Pharmacy Manager's Responsibilities

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
9a	**Name badge**	***PODSA Bylaws*** **s.183(2)(m)** A manager must ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status.			
9b	**Policy & procedure manual**	***PODSA Bylaws*** **s.183(2)(g)** A manager must establish policies and procedures to specify the duties to be performed by registrants and support persons. ***PODSA Bylaws*** **s.183(2)(h)** A manager must establish procedures for (i) inventory management, (ii) product selection, and (iii) proper destruction of unusable drugs and devices. ***PODSA Bylaws*** **s.183(2)(k)** A manager must ensure there is a written drug recall procedure in place for pharmacy inventory. ***PODSA Bylaws*** **s.183(2)(q)** A manager must establish and maintain policies and procedures respecting pharmacy security. ***PPP-74 Policy Statement #1*** Pharmacy security policies and procedures should be included in the pharmacy's policy and procedure document. The policies and procedures should contain information on the following: • Training, • Pharmacy security equipment, • Emergency responses, • Incident review, and • Pharmacy security evaluation ***PPP-74 Policy Statement #5*** An emergency response kit should include a step-by-step guide on what to do in the event of a robbery or break and enter and be available to all pharmacy staff. ***PODSA Bylaws*** **s.2410(1)(c)** A community pharmacy's manager must develop, document and implement an ongoing quality management program that includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies. ***PODSA Bylaws*** **s.2410(2)** If a community pharmacy is a central pharmacy, the quality management program in subsection (1) must include all telepharmacies associated with the central pharmacy and must comply with the *Telepharmacy Standards of Practice.* ***HPA Bylaws*** **s.79** A registrant must take appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal information about patients under this Part as soon as possible after the breach is discovered.			R/PA INV SEL DES R/C SEC QMP1 QMP2 BRE

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Comment	CPBC Use
		PODSA Bylaws **s.3116.1(8)** A telepharmacy must have a policy and procedure manual on site that outlines the methods for ensuring the safe and effective distribution of pharmacy products and delivery of pharmaceutical care by the telepharmacy.			TPY

Central Pharmacy

#	Item	Reference and Requirements	Compliant	Details (Mandatory field)	CPBC Use
10a	**Tool/technology enabling direct supervision on dispensary activities**	***PODSA Bylaws*** **s.3116.1(1)(a)** A telepharmacy must not remain open and prescriptions must not be dispensed without a full pharmacist physically present and on duty at a telepharmacy, unless a full pharmacist at the central pharmacy is engaged in direct supervision of the telepharmacy in accordance with the *Telepharmacy Standards of Practice*. ***PODSA Bylaws Definitions*** "direct supervision" means real time audio and visual observation by a full pharmacist of pharmacy services performed at a telepharmacy consistent with a pharmacy manager's responsibilities as set out in subsection 183(2). ***HPA Bylaws Schedule F Part 6*** **s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6*** **s.4(3)** A supervising pharmacist must be able to engage in direct supervision of the provision of pharmacy services at a telepharmacy independent of any action of or request by persons performing those services.		**Name of tool/technology:** **Describe in details how compliance is met:**	
10b	**Tool/technology used for transmitting prescription and personal health information between sites**	***HPA Bylaws Schedule F Part 6*** **s.6(2)** Each telepharmacy and central pharmacy must maintain a secure connection to the central pharmacy for transmission of prescription and personal health information		**Name of tool/technology:** **Describe in details how compliance is met:**	
10c	**Tool/technology used for processing prescriptions at the central pharmacy for prescriptions received at the telepharmacy**	***PODSA Bylaws*** **s.3116.1(9)** ~~A telepharmacy must connect to PharmaNet independently of the central pharmacy with which it is associated.~~All transactions in PharmaNet must be distinguishable between the central pharmacy and telepharmacy. ***HPA Bylaws Schedule F Part 6*** **s.6(1)** All prescription processing must occur at the central pharmacy unless a full pharmacist is physically present on duty at the telepharmacy.		**Name of tool/technology:** **Describe in details how compliance is met:**	

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Reference and Requirements	Compliant	Details (Mandatory field)	CPBC Use
10d	**Tool/technology enabling direct supervision on product final check**	***PODSA Bylaws* s.3116.1(1)(a)** A telepharmacy must not remain open and prescriptions must not be dispensed without a full pharmacist physically present ~~and~~ on duty at a telepharmacy, unless a full pharmacist at the central pharmacy is engaged in direct supervision of the telepharmacy in accordance with the *Telepharmacy Standards of Practice*. ***HPA Bylaws Schedule F Part 6* s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(2)(a)** A supervising pharmacist must be readily available at all times when a telepharmacy is open to provide direction and support to persons performing pharmacy services at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(4)** Subject to subsection (5), telepharmacy staff may only perform the activities described in s. 4(1) of the Pharmacists Regulation while under direct, continuous real-time audio and visual observation and direction of a supervising pharmacist. ***HPA Bylaws Schedule F Part 6* s.4(5)** Direct supervision does not require the supervising pharmacist to conduct real-time observation of a pharmacy technician performing work within his or her scope of practice.		**Name of tool/technology:** **Describe in details how compliance is met:**	
10e	**Tool/technology enabling direct pharmacist/patient consultation**	***HPA Bylaws Schedule F Part 6* s.3** "supervising pharmacist" means (a) the manager of a central pharmacy, (b) a full pharmacist employed at the central pharmacy responsible for providing direct supervision of pharmacy services in a telepharmacy, or (c) a full pharmacist who is physically present on duty at the telepharmacy. ***HPA Bylaws Schedule F Part 6* s.4(2)(b)** A supervising pharmacist must be readily available at all times when a telepharmacy is open to provide pharmacist/patient consultation. ***HPA Bylaws Schedule F Part 6* s.7** Unless a full pharmacist is physically present on duty at the telepharmacy, the supervising pharmacist must provide full pharmacist/patient consultation by real-time audio and visual link and otherwise in accordance with the requirements of Part 1 of Schedule F of the *Health Professions Act Bylaws*.		**Name of tool/technology:** **Describe in details how compliance is met:**	

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

7. INFORMATION OF THE PERSON WHO COMPLETED THE PRE-OPENING INSPECTION

Last Name	**First Name**	**Pre-Opening Inspection Completion Date**

Relationship of the person named above to the telepharmacy: ☐ Pharmacy Manager ☐ Owner (Registrant) ☐ Owner (Non-Registrant) ☐ College Inspector

Email address of the person named above	**Phone number of the person named above**	**Fax number of the person named above**

☐ I hereby declare that the information provided above including the accompanying digital evidence is true and correct to the best of my knowledge. If any of the above information is found to be false, untrue, misleading or misrepresenting, I am aware that I may be referred to the Inquiry Committee and the pharmacy licence may not be issued.

Signature	**Date**
	MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the *Pharmacy Operations and Drug Scheduling Act*, *Health Professions Act*, and *Freedom of Information and Protection of Privacy Act*. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by repealing and replacing the *Pharmacy Operations and Drug Scheduling Act* -Bylaws.

SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by repealing and replacing the following Forms: 1A, 1C, 1E, 1F, 2A, 2C and 2F and adding the following new Forms: 3A, 3C, 3F, 4, 5, 6, 7, 8A, 8B, 8C, 8D, 8E, 8F, 8G, 9 and 10.

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

1. PHARMACY INFORMATION

Proposed Operating Name	**Store #/Identifier (if applicable)**	**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

3. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

4. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Community

Form 1A

5. PAYMENT INFORMATION

Proposed Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Hospital

Form 1C

1. PHARMACY INFORMATION

Proposed Operating Name		**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Software Vendor (for PharmaNet connection)	**PharmaNet Connection Required** ☐ Inpatient (Read-only access to patient records with ability to update clinical information and adverse reactions) ☐ Outpatient (PharmaCare adjudication of prescriptions and update of patient records) ☐ Inpatient & Outpatient (Inpatient and outpatient dispensing using the same software)

Manager Name	**Registration Number (BC)**

2. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

3. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health
☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Hospital

Form 1C

4. PAYMENT INFORMATION

Proposed Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

APPLICANT INFORMATION

Company name _____

Central pharmacy _____

Pharmacy manager _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal Code

PROPOSED REMOTE SITE

Remote site address, including name of pharmacy _____ Tel _____

_____ Fax _____

_____ Email _____

_____ _____

Postal Code

Hours of operation for Satellite _____

Pursuant to s.54(2) of the *Health Professions Act – Bylaws*, a registrant **must** notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and addresses of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

Registrants can update their contact information using the *eServices* section of our website.

I attest that:

- The Pharmacy is in compliance with the *Health Professions Act*, the *Pharmacy Operations and Drug Scheduling Act*, the *Pharmacists Regulation* and the *Bylaws* of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____
Name (please print) Signature

_____ _____
Position Date

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the *Pharmacy Operations and Drug Scheduling Act*, *Health Professions Act*, and *Freedom of Information and Protection of Privacy Act*. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 60 business days</u> prior to the planned operation of the hospital satellite.

Application must be approved PRIOR to commencement of hospital satellite service.

The following must be submitted together with this application:

- Diagram detailing the layout of the hospital pharmacy satellite

PharmaNet connection for both sites? ☐ Yes ☐ No

College of Pharmacists of British Columbia

APPLICATION FOR HOSPITAL SATELLITE

PAYMENT OPTION

Pharmacy Name _____

☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card # _____ Exp _____ /_____

Cardholder name _____

Cardholder signature _____

Initial licence fee	300.00
GST	15.00
Total	**$315.00**

GST # R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE

Pharmacy Education Site

Form 1F

1. EDUCATION SITE INFORMATION

Proposed Operating Name		**Proposed ~~Opening~~ Licensure Date** MMM | DD | YYYY	
Address	**City**	**Province** BC	**Postal Code**
Mailing Address (if different from above)	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

3. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) will not have controlled drug substances, 2) will be licensed solely for the purpose of pharmacy education, and 3) will not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR NEW PHARMACY LICENCE
Pharmacy Education Site

Form 1F

4. PAYMENT INFORMATION

Proposed Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$0.00
Initial licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

3. ADDITIONAL INFORMATION

Do you have other community pharmacies that are 1) owned by the same direct owner above and 2) due for pharmacy licence renewal this month? ☐ Yes – Also complete **Form 9** ☐ No

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

4. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**

Email Address	**Phone Number**	**Fax Number**

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**

Signature	**Sign Date**
	MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Community

Form 2A

5. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL

Hospital

Form 2C

1. PHARMACY INFORMATION

Operating Name		**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health

☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Hospital

Form 2C

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL

Pharmacy Education Site

Form 2F

1. EDUCATION SITE INFORMATION

Operating Name		**Pharmacy Licence Number**	
Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) does not have controlled drug substances, 2) is licensed solely for the purpose of pharmacy education, and 3) does not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE RENEWAL
Pharmacy Education Site

Form 2F

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Community

Form 3A

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website		**Software Vendor (for dispensing)**	
Manager Name		**Registration Number (BC)**	

2. OWNERSHIP INFORMATION

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Community

Form 3A

3. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.			
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Community

Form 3A

4. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Hospital

Form 3C

1. PHARMACY INFORMATION

Operating Name		**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. APPLICANT (DIRECT OWNER) INFORMATION

Hospital Name			
Hospital Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Health Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health

☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare ☐ Other: _____

☐ I have reviewed the hours of operation and the roster for this pharmacy on eServices and confirmed that the information is correct and up- to-date.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Hospital

Form 3C

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$2,250.00
GST	$112.50
Total	**$2,362.50**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT

Pharmacy Education Site

Form 3F

1. EDUCATION SITE INFORMATION

Operating Name		**Pharmacy Licence Number**	
Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
Program Coordinator Name		**Registration Number (BC)**	

Program Offered

☐ CCAPP Accredited Pharmacy Program (Pharmacists) ☐ CCAPP Accredited Pharmacy Technician Program

2. APPLICANT (DIRECT OWNER) INFORMATION

Type of Ownership

☐ Public Post-Secondary Education Institution ☐ Private Post-Secondary Education Institution

Institution Name			
Institution Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

☐ I attest that this pharmacy education site 1) does not have controlled drug substances, 2) is licensed solely for the purpose of pharmacy education, and 3) does not provide pharmacy services to any person.

Name of Authorized Representative	**Position/Title of Authorized Representative**
Signature	**Sign Date** MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY LICENCE REINSTATEMENT
Pharmacy Education Site

Form 3F

3. PAYMENT INFORMATION

Operating Name
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Reinstatement fee	$0.00
Licence fee	$550.00
GST	$27.50
Total	**$577.50**
GST #	R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____

College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY CLOSURE

Form 4

1. INFORMATION OF CLOSING PHARMACY

Operating Name and Store #/Identifier (if applicable)	**Pharmacy Licence Number**	**Closing Date** MMM | DD | YYYY	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

PHARMACY MANAGER

Manager Name	**Registration Number (BC)**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section ~~16~~18(2)(t) of the *PODSA* Bylaws.

Signature of Pharmacy Manager	**Sign Date** MMM | DD | YYYY

DIRECT OWNER

Name of Authorized Representative	**Position/Title of Authorized Representative**

☐ I have read and understand my duties and responsibilities for closing my pharmacy described in section ~~16~~18(8)(d) of the *PODSA* Bylaws.

Signature of Authorized Representative	**Sign Date** MMM | DD | YYYY

The first half of the following section must be completed by the closing pharmacy. If more than one receiving pharmacy is involved, complete a separate form for each receiving pharmacy to indicate the items that will be transferred to the receiving pharmacy.

2. INFORMATION OF RECEIVING PHARMACY

Operating Name and Store #/Identifier (if applicable) ☐ Community ~~Pharmacy~~ – ☐ Hospital ~~Pharmacy~~ – ☐ ~~Education Site~~ ☐ Other: _____		**Manager Name**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	

Items that will be transferred to the receiving pharmacy

☐ Prescription drugs (including controlled drug substances)
☐ Non-prescription drugs (including exempted codeine products)
☐ Medical devices
☐ Patient medication records and prescription records

The subsection below can be completed and submitted later by the receiving pharmacy manager upon receipt of the items.

☐ I have received all the items checked above on (received date): _____.

☐ I have faxed a copy of the inventory of narcotics, controlled drugs, targeted substances and benzodiazepines received to the College.

Manager Name	**CPBC Registration Number**
Signature of Manager from the Receiving Pharmacy	**Sign Date** MMM | DD | YYYY

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - PROOF OF ELIGIBILITY

FORM 5

The pharmacy manager and each direct/indirect owner applying/renewing for a pharmacy license must complete this form. Only one form is required per person per pharmacy.

1. PHARMACY INFORMATION

[Proposed] Operating Name	**Pharmacy Licence Number (if issued)**

Your Relationship to the Pharmacy Named above (Select all that apply):

- ☐ Pharmacy Manager
- ☐ Direct Owner – Sole Proprietor (Single pharmacist, unincorporated)
- ☐ Direct Owner – Pharmacist Partner (≥2 pharmacists, unincorporated)
- ☐ Indirect Owner – Director of Corporation
- ☐ Indirect Owner – Officer of Corporation
- ☐ Indirect Owner – Shareholder of Corporation
- ☐ Indirect Owner – Director of PARENT Corporation
- ☐ Indirect Owner – Officer of PARENT Corporation
- ☐ Indirect Owner – Shareholder of PARENT Corporation

2. PERSONAL INFORMATION

☐ **Dr** ☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss**	**Last Name**		**Date of Birth (MMM/DD/YYYY)**	
First Name		**Middle Name**	**Informal Name (if any)**	
Address ☐ Home ☐ Mailing		**City**	**Province**	**Postal Code**
Email Address		**Phone Number**	**Fax Number**	

Registration Class

Are you a PHARMACIST or PHARMACY TECHNICIAN registered in BC, another province, or a foreign jurisdiction?

☐ Yes – Complete ALL sections below

☐ No – Provide the following information and complete ALL sections below EXCEPT Section 3

a) If you have a CPBC eServices ID, enter here: _____

b) Identification document

i) Type of government issued ID (select ANY one of the following):

- ☐ Canadian citizenship card/certificate
- ☐ Passport (Country issued if outside Canada: _____)
- ☐ Canadian driver's licence (Province issued if outside BC: _____)
- ☐ BC Identification Card

ii) Document number of the selected document above: _____

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - PROOF OF ELIGIBILITY

FORM 5

3. ATTESTATION FOR PHARMACISTS AND PHARMACY TECHNICIANS ONLY

Registration Information

I am a: ☐ Pharmacist ☐ Pharmacy Technician

Registered in: ☐ BC ☐ Other province: _____ ☐ Foreign jurisdiction: _____

Registration/Licence Number: _____

I attest that, within the previous 6 years:

☐	I have never been suspended nor has my registration been cancelled by the College of Pharmacists of British Columbia, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.
☐	No limits or conditions have been imposed on my practice of pharmacy as a result of disciplinary action taken by the College of Pharmacists of British Columbia, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.

NOTE: Failure to attest to any of the above would result in my application being sent to the Application Committee. The Application Committee may request additional information.

4. ATTESTATION

I attest that:

☐	I am not authorized by an enactment to prescribe drugs (not applicable to pharmacists).
☐	I have never been subject to a limitation imposed by the College's discipline committee that precludes me from being a direct owner, an indirect owner, or a manager.
☐	I have never been the subject of an order or a conviction for an information or billing contravention.

I also attest that, within the previous 6 years:

☐	I have not been convicted of an offence prescribed under section 45(1)(a)(ii) of the *Pharmaceutical Services Act*.
☐	I have not been convicted of an offence under the *Criminal Code* (Canada).
☐	I have not had a judgment entered against me in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related services.

NOTE: Failure to attest to any of the above would result in my application being sent to the Application Committee. The Application Committee may request additional information.

5. DECLARATION

☐	I understand that I must comply with all applicable duties imposed under the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, the *Health Professions Act*, the regulations and the bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts and any subsequent amendments.
☐	I declare the facts set out herein to be true.

Applicant Signature	**Applicant Position/Title**	**Sign Date**
Witness Signature	**Witness Name**	**Witness Date**

College of Pharmacists of British Columbia

MANAGER/DIRECT OWNER/INDIRECT OWNER - NOTICE OF INELIGIBILITY

Form 6

1. REASON FOR COMPLETING THIS FORM (Select all that apply)

☐	To report that the person named below is no longer eligible to be the **manager** of the pharmacy named below.
☐	To report that the person named below is no longer eligible to be a **direct** or **indirect owner** of the pharmacy/corporation named below.

2. INFORMATION OF THE PERSON IN SECTION 3

☐ **Dr** ☐ **Mr** ☐ **Ms** ☐ **Mrs** ☐ **Miss**	**Last Name**		
First Name		**Informal Name**	**Date of Birth (MMM/DD/YYYY)**
Name of Affiliated Organization: ☐ Pharmacy Operating Name ☐ Corporation Name			

3. ADDITIONAL INFORMATION RELATED TO THE PERSON NAMED ABOVE

Matter related to a(n):

- ☐ Order or conviction **FOR/UNDER**:
  - ☐ Information contravention
  - ☐ Billing contravention
  - ☐ Section 45(1)(a)(ii) of the *Pharmaceutical Services Act*
  - ☐ *Criminal Code* (Canada)
  - ☐ Other – Specify: _____
- ☐ Suspension or cancellation of registration as a pharmacy technician or pharmacist;
- ☐ Limits or conditions being imposed on (select one):
  - ☐ Practice of pharmacy
  - ☐ Being a direct owner, indirect owner, or a manager of a pharmacy
- ☐ Judgement issued in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related device
- ☐ Other – Specify: _____

Description of the events that resulted in the matter above.	
Date/period of the above events occurred.	

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

Name of the entity/court/governing body that: • Issued the order or conviction • Suspended/cancelled billing privileges or registration as a pharmacist or pharmacy technician; OR • Imposed limits or conditions	
Date (or period, when specified) of: • Order or conviction; • Suspension (period) or cancellation of billing privileges or registration as a pharmacist or pharmacy technician; OR • Limits or conditions being imposed	
Disposition of charge including details of penalty-imposed (e.g. fine, imprisonment, limits and conditions imposed)	
Extenuating circumstances you wish taken into account for your application.	
Other	

*Attach a separate sheet if you need more space

☐ **I understand that I may have to provide additional information if requested by the Application Committee, the Discipline Committee or the Inquiry Committee, within the time requested.**

4. INFORMATION OF THE PERSON WHO COMPLETED THIS FORM

Name	**Signature**	**Sign Date**
Email	**Phone Number**	**Fax Number**

Relationship to the Pharmacy: ☐ Direct/Indirect Owner ☐ Pharmacy Manager ☐ Other: _____

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

College of Pharmacists of British Columbia

INDIRECT OWNER – EMAIL CONTACTS

Form 7

Instructions to complete *Form 5: Manager/Direct Owner/Indirect Owner – Proof of Eligibility* and the *Criminal Record History* will be sent to the email address of each indirect owner provided below. Ensure that the information is current, correct and legible. On page 1, list all the indirect owners of the corporation that is the direct owner. If applicable, complete page 2 for each shareholder which is a corporation that is not publicly traded. Make a copy of any of these two pages if you need more space.

1. INFORMATION OF THE CORPORATION THAT IS THE DIRECT OWNER

Name of Company on *Notice of Articles/BC Company Summary*	BC Incorporation Number

INFORMATION OF EACH INDIRECT OWNER (INDIVIDUALS) UNDER THIS CORPORATION

Type of Indirect Owner	BC Pharmacist (Y/N)	Last Name	First Name	Email Address
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			
☐ Director ☐ Officer ☐Shareholder	☐ Y – Registration #: _________ ☐ N – eService ID*: __________			

***if known**

If a shareholder is a corporation, complete the information below for EACH corporation that is a shareholder. Make a copy of this page if you need more space or there are more than one corporation that is a shareholder.

2. INFORMATION OF THE CORPORATION THAT IS A SHAREHOLDER

Name of Company/Corporation as Provided in Incorporation Document(s)	Incorporation Number

INFORMATION OF EACH INDIRECT OWNER (INDIVIDUALS) UNDER THIS CORPORATION

Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**
Type of Indirect Owner ☐ Director ☐ Officer ☐Shareholder	**BC Pharmacist (Y/N)** ☐ Y – Registration #: _________ ☐ N – eService ID*: __________	**Last Name**	**First Name**	**Email Address**

***if known**

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF DIRECT OWNER

Form 8A

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. NEW OWNERSHIP INFORMATION

Effective Date of Change (MMM-DD-YYYY)

Type of Ownership

☐ *Sole Proprietorship (Single pharmacist, unincorporated)* –

a) Pharmacist's legal name: (First name) _____ (Last name) _____ Registration number (BC): _____

b) Registered business name (if applicable): _____

☐ *Partnership of Pharmacists (≥2 pharmacists, unincorporated)* – Total number of partners: _____

a) Each pharmacist's full legal name and registration number (BC): _____

_____

b) Registered business name (if applicable): _____

☐ *Corporation* – BC Incorporation Number: _____ Incorporation Date: _____

"Name of Company" on *Notice of Articles/BC Company Summary*: _____

a) Is your corporation publicly traded or not? Select one below:

☐ Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____

☐ Not Publicly Traded – Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

b) Is the corporation named above a **subsidiary corporation**? ☐ Yes – complete (c) below ☐ No – go to section 3

c) Is the parent corporation **publicly traded?** ☐ Yes – go to section 3 ☐ No – complete (d) below

d) Parent corporation - Incorporation Number: _____ Incorporation Date: _____

Name of company/corporation as provided in incorporation document(s): _____

Total number of: ☐ Directors: _____ ☐ Officers: _____ ☐ Shareholders: _____

☐ *Health Authority/Organization* – Select one: ☐ FHA ☐ IHA ☐ NHA ☐ VCH ☐ VIHA ☐ PHSA ☐ FNHA ☐ PHC

☐ *Other* – Specify: _____

3. PRIMARY CONTACT PERSON

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF DIRECT OWNER

Form 8A

4. ADDITIONAL INFORMATION

As a result of this change (direct owner):

a)	Will the **manager** also be changed at the same time?	☐ Yes – Also complete **Form 8C**	☐ No
b)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
c)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
d)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional[⌘])	☐ No

[⌘]You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Form 9 to include other pharmacies.

5. APPLICANT (DIRECT OWNER) INFORMATION

Mailing Address of Direct Owner ☐ Check this box if lawyer/accountant's address	**City**	**Province**	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Name of Authorized Representative	**Position/Title of Authorized Representative**		
Signature	**Sign Date** MMM | DD | YYYY		

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

6. PAYMENT INFORMATION

Operating Name and Store #/Identifier (if applicable)
(Auto-populate)

Method of Payment: ☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card Number	**Expiry Date (MM/YY)**
Cardholder Name	
Cardholder Signature	

Application fee	$550.00
Initial licence fee	$2,250.00
GST	$140.00
Total	**$2,940.00**
GST #	R106953920

For office use ONLY

iMIS ID: Finance stamp:

Lic initials:

Date to Finance:

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

Form 8B

1. CURRENT PHARMACY INFORMATION

Operating Name	Store #/Identifier (if applicable)	Pharmacy Licence Number	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. DEPARTING INDIRECT OWNER(S)

Type	Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change (MMM-DD-YYYY)
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	

*If known

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

Form 8B

3. NEW INDIRECT OWNER(S)

Type	Corporation Name	Indirect Owner	Pharmacist (Y/N)	Effective Date of Change (MMM-DD-YYYY)
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	

*If known

4. ADDITIONAL INFORMATION

As a result of this change (indirect owner):

a)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
b)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
c)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional⌘)	☐ No

⌘You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Fform 9 to include other pharmacies.

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF MANAGER

Form 8C

1. CURRENT PHARMACY INFORMATION

Operating Name	Store #/Identifier (if applicable)	Pharmacy Licence Number	
Pharmacy Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	

2. MANAGER INFORMATION

DEPARTING MANAGER		
Last Name	First Name	Registration Number (BC)
NEW MANAGER		
Last Name	First Name	Registration Number (BC)
Effective Date of Change (MMM-DD-YYYY)		

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	Position/Title of Authorized Representative	
Email Address	Phone Number	Fax Number
Signature	Sign Date MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF CORPORATION NAME

Form 8D

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Type of Change ☐ Name of the Corporation that is the Direct Owner – Complete sections 2, 4 and 5 ☐ Name of the Corporation that is a Shareholder – Complete sections 3, 4 and 5		**Effective Date of Change** MMM | DD | YYYY	

2. DIRECT OWNER INFORMATION

FORMER CORPORATION NAME	
Name of Company on *Notice of Articles/BC Company Summary*	**BC Incorporation Number***
NEW CORPORATION NAME	
Name of Company on *Notice of Articles/BC Company Summary*	**BC Incorporation Number***

*If the numbers are different, DO NOT submit this form but complete Form 8A (Change of Direct Owner) instead.

3. SHAREHOLDER INFORMATION

FORMER CORPORATION NAME	
Name of Company/Corporation as Provided in Incorporation Document	**Incorporation Number****
NEW CORPORATION NAME	
Name of Company/Corporation as Provided in Incorporation Document	**Incorporation Number****

**If the numbers are different, DO NOT submit this form but complete Form 8B (Change of Indirect Owner) instead.

4. ADDITIONAL INFORMATION

As a result of this change (corporation name):

a)	Will the **indirect owner(s)** also be changed at the same time?	☐ Yes – Also complete **Form 8B**	☐ No
b)	Will the **pharmacy operating name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
c)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 8G**	☐ No
d)	Will **other pharmacies** be affected by the same change?	☐ Yes – Also complete **Form 9** (optional⌘)	☐ No

⌘You may fill this form for each pharmacy being affected by this change, or fill this form only once for one of the pharmacies plus Form 9 to include other pharmacies.

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF CORPORATION NAME

Form 8D

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF OPERATING NAME

Form 8E

1. PHARMACY INFORMATION

Current Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	
PROPOSED NEW OPERATING NAME			
Proposed Operating Name	**Store #/Identifier (if applicable)**	**Effective Date of Change** MMM | DD | YYYY	

2. OTHER TYPES OF CHANGES

As a result of this change (operating name):

a) Will the **manager** also be changed at the same time? ☐ Yes – Also complete **Form 8C** ☐ No

b) Will the **pharmacy layout** also be changed at the same time? ☐ Yes – Also complete **Form 8G** ☐ No

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF LOCATION

Form 8F

1. PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Manager Name		**Registration Number (BC)**	
CURRENT INFORMATION			
Current Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Website	**Software Vendor (for dispensing)**	**Expected Closing Date** MMM | DD | YYYY	
RELOCATION INFORMATION			
New Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address ☐ No Change	**Phone Number** ☐ No Change	**Fax Number** ☐ No Change	
Website ☐ No Change	**Software Vendor** ☐ No Change	**Expected Opening Date** MMM | DD | YYYY	

2. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF LAYOUT

Form 8G

1. CURRENT PHARMACY INFORMATION

Operating Name	**Store #/Identifier (if applicable)**	**Pharmacy Licence Number**	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Registration Number (BC)**	

2. RENOVATION INFORMATION

PharmaNet Router

☐ No change ☐ Moving/disconnection required – Distance of router move: _____

Expected Completion Date

MMM | DD | YYYY

Areas Affected by Renovation

☐ External to the Dispensary (up to 25 feet from the dispensary) ☐ Dispensary area

☐ Other area(s) on the premises – Specify: _____

3. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Sign Date** MMM | DD | YYYY	

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

MULTIPLE PHARMACIES

Form 9

1. LIST OF ALL PHARMACIES

Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**
Operating Name	Store #/Identifier (if applicable)	**Pharmacy Licence Number**

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

College of Pharmacists of British Columbia

PHARMACY PRE-OPENING INSPECTION REPORT

COMMUNITY

1. PHARMACY INFORMATION				
Operating Name	**Store #/Identifier (if applicable)**	**PharmaCare Code**		**Proposed Licensure ~~Opening~~ Date** MMM | DD | YYYY
Pharmacy Address	**City**	**Province** BC	**Postal Code**	**Software Vendor (for dispensing)**
Email Address	**Phone Number**	**Fax Number**		**Website**

~~2. PHARMACY SERVICES~~						
~~TYPE~~	~~YES~~	~~NO~~	~~TYPE~~	~~YES~~	~~NO~~	~~IF "YES", PROVIDE PHAR~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

						MAGYNAME(S) INVOLVED
Methadone (Pain)			Contracts - BC Transplant			
Methadone (Maintenance)			Contracts - Center for Excellence			
Compounding (Specialty)			Other - Delivery			
Compounding (Sterile Product)			Other - Internet			
Compliance Packaging			Other - Drive Thru			
Clinical - Injection Drug Administration			Residential Care Services			
Clinical - Medication Management/Review			Centralized Prescription Processing Services			provided

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Clinical - Education Clinics			Outsourced Prescription Processing Services			
Contracts - Renal Agencies			Telepharmacy Services (Central Pharmacy)			

2. PHARMACY SERVICES

TYPE	SUBTYPE	YES	NO	TYPE	YES	NO	If "YES", PROVIDE ADDITIONAL INFORMATION
OPIOID ADDICTION THERAPY	Methadone (Maintenance)			RESIDENTIAL CARE SERVICES			Facility Name & Number of Beds:
	Oral Morphine						
	Buprenorphine & Naloxone (Suboxone)						
COMPOUNDING	Non-Sterile Preparation			CENTRALIZED PRESCRIPTION			Provide the name(s) of the pharmacy(ies) that your pharmacy prepares/processes prescriptions/drug orders for:
	Non-Hazardous Sterile						

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

	Hazardous Sterile			PROCESSING SERVICES PROVIDED TO			
OTHER	Injection & Intranasal Drug Administration			OUTSOURCED PRESCRIPTION PROCESSING SERVICES RECEIVED FROM			Provide the name(s) of the pharmacy(ies) that prepare/process prescriptions/drug orders for your pharmacy:
	No Public Access						
	Schedule 1A drugs On-Site						
	Internet Pharmacy						

3. HOURS OF OPERATION

TYPE	SUN	MON	TUE	WED	THU	FRI	SAT
Pharmacy Hours							
Lock & Leave Hours							

4. PHARMACY ROSTER

STAFF	REGISTRATION #	FIRST NAME/INFORMAL NAME	LAST NAME	REGISTRATION CLASS
Pharmacy Manager				☒ Pharmacist ☐ Pharmacy Technician
Staff #1				☐ Pharmacist ☐ Pharmacy Technician
Staff #2				☐ Pharmacist ☐ Pharmacy Technician
Staff #3				☐ Pharmacist ☐ Pharmacy Technician
Staff #4				☐ Pharmacist ☐ Pharmacy Technician
Staff #5				☐ Pharmacist ☐ Pharmacy Technician
Staff #6				☐ Pharmacist ☐ Pharmacy Technician
Staff #7				☐ Pharmacist ☐ Pharmacy Technician

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Staff #8				☐ Pharmacist ☐ Pharmacy Technician
Staff #9				☐ Pharmacist ☐ Pharmacy Technician
Staff #10				☐ Pharmacist ☐ Pharmacy Technician

5. PRE-OPENING INSPECTION

Confirm whether your new pharmacy currently complies with each of the following requirements.

- **If compliant, mark "✓" under the "Compliant" column and submit digital evidence (e.g. photos/videos) along with this form. Refer to the Licensure Guide for further details.**
- **If not applicable, enter "N/A" under the "Compliant" column and provide the reason in the comment field.**

External to Dispensary

#	Item	Compliant	Comment	CPBC Use
1a	**External view of the pharmacy (street view including the external signage)**			
1b	**Hours of operation sign**			
1c	**Professional products area for schedule 3 drugs** **(+ Lock-and-Leave barriers if the premise is open for business while the pharmacy is closed)** **OR N/A**			
1d	**Signage at 25 feet from dispensary** **OR N/A**			
1e	**"Medication Information" Sign** **OR N/A**			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Dispensary

#	Item	Compliant	Comment	CPBC Use
2a	Dispensary area			
2b	Gate/door at the entrance into the dispensary			
2c	Placeholder for College license			
2d	Professional service area for Schedule 2 drugs			
2e	Patient consultation area			
2f	Dispensing counter and service counter			
2g	Computer terminals for prescription processing			
2f	Shelving			

Security

#	Item	Compliant	Comment	CPBC Use
3a	Secure storage space			
3b	☐ Locked metal safe OR ☐ Safe declaration			
3c	Security camera system AND Surveillance signage			
3d	Motion sensors			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
3e	**Monitored alarm** **OR N/A**			
3f	**Physical barriers** **OR N/A**			

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Equipment and References

#	Item	Compliant	Comment	CPBC Use
4a	**Double stainless steel sink**			
4b	**Equipment:** 1. Telephone 2. Refrigerator 3. Rx filing supplies 4. Rx balance 5. Metric weights 6. Glass graduates 7. Mortar 8. Pestle 9. Spatulas 10. Funnels 11. Stirring rods 12. Ointment slab/ parchment paper 13. Counting tray 14. Disposable drinking cups 15. Soap dispenser 16. Paper towel dispenser 17. Plastic/metal garbage containers 18. Plastic lining 19. Fax machine			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~ ~~G~~ ~~H~~ ~~I~~ ~~J~~ ~~K~~ ~~L~~ ~~M~~ ~~O~~ ~~P~~ ~~Q~~
4c	**Equipment (Cold Chain)** 1. Thermometer 2. Temperature log			~~TMM~~ ~~TLOG~~
4d	**Equipment (Methadone)** 1. Calibrated device 2. Auxiliary labels 3. Containers for daily dose 4. Patient/Rx Log			~~DEV~~ ~~AUX1~~ ~~AUX 2~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
	OR N/A			~~DOSE~~ ~~MLOG~~
4e	**References (CPBC)** **1. BC Pharmacy Practice Manual** **2. ReadLinks** ~~2.~~			~~BPPM~~ ~~RL~~
4f	**References (General)** **1. Compendium** **2. Complementary/ Alternative** **3. Dispensatory** **4. Drug Interactions** **5. Nonprescription Medication (2x)** **6. Medical Dictionary** **7. Pregnancy and Lactation** **8. Pediatrics** **9. Therapeutics**			~~CPS~~ ~~ALT~~ ~~DIS~~ ~~DI~~ ~~OTC1~~ ~~OTC2~~ ~~MD~~ ~~P/L~~ ~~PED~~ ~~TH~~
4g	**References (if applicable)** ☐ **Veterinary** ☐ **Psychiatric** ☐ **Geriatric** ☐ **Specialty compounding** ☐ **Methadone** o **PPP-66** o **CSPBC** o **CAMH** o **Monograph** **OR N/A**			~~VET~~ ~~PSY~~ ~~GER~~ ~~CMP~~ ~~MET1~~ ~~MET2~~ ~~MET3~~ ~~MET4~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Prescription

#	Item	Compliant	Comment	CPBC Use
5a	**Prescription hardcopy (i.e. the label/paper attached to the original prescription, which contains prescription information generated after transmitting to PharmaNet)**			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

Confidentiality

#	Item	Compliant	Comment	CPBC Use
6a	☐ Shredder OR ☐ Contract with a document destruction company			
6b	Offsite storage contract OR N/A			

Inventory Management

#	Item	Compliant	Comment	CPBC Use
7a	Drug receiving area			
7b	Drugs			
7c	Storage area for non-usable and expired drugs			

Dispensed Products

#	Item	Compliant	Comment	CPBC Use
8a	Prescription product label 1. Single entity product ~~2.~~ Multiple-entity product 2.			~~A~~ ~~B~~ ~~C~~ ~~D~~ ~~E~~ ~~F~~ ~~G~~ ~~A~~ ~~B~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

#	Item	Compliant	Comment	CPBC Use
				~~A~~ ~~B~~
8b	**Filling supplies (e.g. vials and bottles including caps)**			

Pharmacy Manager's Responsibilities

#	Item	Compliant	Comment	CPBC Use
9a	**Name badge**			
9b	**Policy & procedure manual**			~~R/PA~~ ~~INV~~ ~~SEL~~ ~~DES~~ ~~R/C~~ ~~SEC~~ ~~QMP~~ ~~BRE~~

tel 604.733.2440 800.663.1940 fax 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

6. INFORMATION OF THE PERSON WHO COMPLETED THE PRE-OPENING INSPECTION

Last Name	First Name	Completion Date

Relationship of the Named Person above to the Pharmacy

☐ Pharmacy Manager ☐ Owner (Registrant) ☐ Owner (Non-Registrant) ☐ College Inspector

Email Address of the Person Named above	Phone Number of the Person Named above	Fax Number of the Person Named above

☐ I hereby declare that the information provided above including the accompanying digital evidence is true and correct to the best of my knowledge. If any of the above information is found to be false, untrue, misleading or misrepresenting, I am aware that I may be referred to the Inquiry Committee and the pharmacy licence may not be issued.

Signature	Sign Date
	MMM | DD | YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

tel 604.733.2440 800.663.1940 *fax* 604.733.2493 800.377.8129 200 / 1765 WEST 8TH AVE VANCOUVER BC V6J 5C6 BCPHARMACISTS.ORG

SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by adding a new schedule: Schedule “B”.

College of Pharmacists of B.C.

Exemptions to Act

PODSA Bylaw "Schedule B"

1. **The following Health Professions under the *Health Professions Act* are exempted from section 7(1) of the *Pharmacy Operations and Drug Scheduling Act*:**

Dental Hygienists
Dentists
Dietitians
Medical Practitioners
Midwives
Naturopathic Physicians
Licenced Practical Nurses
Registered Nurses and Nurse Practitioners
Registered Psychiatric Nurses
Optometrists
Podiatrists
Speech and Hearing Pathologists
~~**Traditional Chinese Medicine Practitioners and Acupuncturists Regulation**~~

2. **The following persons are exempted from section 7(1) of the *Pharmacy Operations and Drug Scheduling Act*:**

"veterinary drug dispenser" under the *Veterinary Drugs Act*
“emergency medical assistants” under the *Emergency Health Services Act*

SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by adding a new schedule: Schedule “D”.

College of Pharmacists of B.C.

HOPSITAL PHARMACY DIAGRAM

PODSA Bylaw "Schedule D"

ITEMS

Indicate the location of the following items on the diagram:

1. Medication refrigerator(s)
2. Narcotic storage equipment, and
3. Any of the following where applicable:
    a. Automated dispensing cabinet(s) or unit(s);
    b. Packaging area;
    c. Consultation area;
    d. Bulk or batch packaging area;
    e. Non-sterile compounding area;
    f. Sterile compounding (hazardous and non-hazardous) area; and/or
    g. Hazardous drugs storage area.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

8. Legislation Review Committee
d) HPA Bylaws - Board Terms of Office (Filing)

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution to amend the Health Professions Act Bylaws regarding the elected board member terms of office and election cycle:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

Purpose

To approve amendments to the *Health Professions Act* (HPA) Bylaws, for filing with the Ministry of Health, regarding elected Board member terms of office and election cycle.

Background

At their November 2016 meeting, the Board directed, *"…the Registrar to pursue a bylaw amendment that would change the term of office for elected Board members from two years to three years, and from a maximum of 3 consecutive terms to a maximum of 2 consecutive terms."* As noted at the June 2017 Board meeting, amendments to the HPA Bylaws to change the term length and maximum number of consecutive terms of elected Board members, requires consequential amendments regarding the Board election cycle (see Appendix 1 for the June 2017 briefing note).

At their June 2017 meeting, the Board approved two motions regarding elected Board member terms of office and election cycles:

- Provided policy direction to amend the HPA Bylaws to implement a change to the Board election cycle whereby elections for four electoral districts are held in each of the first two years, and in the third year, no election is held. This included changes to the elected Board member term length and maximum consecutive terms, as discussed above.

- Approved publicly posting the corresponding proposed bylaws to implement the above-noted policy direction.

Discussion

The proposed bylaws were subsequently posted for the ninety day public posting period on the College's website. The public posting period ended on September 20, 2017. No comments were received during this time. Therefore, no further amendments are being proposed at this time (see Appendix 2 for a "track change" version of the proposed bylaw amendments).

Next Steps

As per section 19(3) of HPA, the next step required to finalize the bylaws is to file them with the Minister of Health. Once filed, the bylaws will come into effect sixty days from the filing request date to the Ministry of Health. If approved by the Board, the bylaw amendments will be made effective by mid-January 2018, and implemented for the 2018 election.

It is important to note that the above-noted HPA amendments limiting the number of consecutive terms to two terms, would also prohibit some of the existing elected Board members to serve up to six years on the Board. An overview of this impact was provided to the Board at their June 2017 meeting, and has been included in Appendix 3.

Recommendation

The Board approve the amendments to the HPA bylaws (by approving the schedule to the resolution in Appendix 4), regarding elected Board member terms of office and election cycle.

Appendix	
1	June 2017 Briefing Note on Board Terms of Office (appendices removed)
2	Proposed HPA Bylaw Amendments
3	Overview of Impact of HPA Bylaw Amendments on Current Board Members
4	Schedule to the Resolution

College of Pharmacists of British Columbia

Board Meeting
June 23, 2017

6. Legislation Review Committee
b. HPA Bylaws – Public Posting (Board Terms of Office)

DECISIONS REQUIRED

Recommended Board Motions:

(1) Amend the Health Professions Act – Bylaws, to implement a change to the board election cycle whereby elections for four electoral districts are held in each of the first two years, and in the third year, no election is held.

(2) Approve the following resolution:

"RESOLVED THAT, in accordance with the authority established in section 19(1)(6.2) of the Health Professions Act, the board approve the proposed draft bylaws of the College of Pharmacists of British Columbia, regarding elected board member terms of office and the board election cycle, for public posting as circulated."

Purpose

To seek Board approval on, (1) policy direction on changing Board terms of office as well as the Board election cycle; and, (2) approval to publicly post the corresponding proposed bylaws to implement the Board term and election cycle decision.

Background

Currently, elected College Board members are drawn from eight geographical districts and, according to s. 7(1) of the *Health Professions Act* (HPA) – Bylaws, are elected for two-year terms. Section 7(2) of the HPA Bylaws limits elected Board members' tenure to three consecutive terms.

On November 18, 2016, as recommended by the Governance Committee, the Board directed, "*the Registrar to pursue a bylaw amendment that would change the term of office for elected Board members from two years to three years, and from a maximum of three consecutive terms to a maximum of two consecutive terms*."

At the February 2017 Board meeting, a status update on the terms of office project was provided in the consent agenda. In that update, it was noted that a change to the Board member terms of office would not be feasible for the 2017 election. More specifically, it was noted that:

- The HPA requires that any amendments to the bylaws (subject to limited exemptions, such as fee amendments, etc.) must include a 90-day public posting period, along with a 60-day filing period with the Minister of Health.
- The planning and operational processes for annual elections begins in mid-summer.
- Given the above-noted legislative timelines along with the operational capacity and time needed to organize elections, it is not feasible for the Board member term of office amendments to take effect for the 2017 elections.

As such, the options outlined below assume that any proposed Board term of office and election schedule changes will be made effective for the 2018 election.

Discussion

An amendment to ss. 7(1) and 7(2) of the HPA Bylaws to change the term length and maximum number of consecutive terms of elected Board members, is a straightforward amendment. However, such changes impact s.7(3) of the HPA Bylaws regarding the Board election cycle.

Currently, s.7(3) of the HPA Bylaws states that the terms of elected Board members from odd-numbered electoral districts must commence and end in odd-numbered years, and the terms of elected Board members from even-numbered electoral districts must commence and end in even-numbered years. Amending the terms of office of elected Board members from two to three years, will require an amendment to s.7(3), as it would not be possible to meet the timeline requirements set out in that section.

In order to seek a bylaw amendment to s.7(3), a policy decision is first required with respect to the election cycle process. The following three potential options have been identified:

- The College holds an election every three years (i.e., the whole Board is elected, and no staggering of elections is permitted).
- The College holds an election each year (i.e., an election for three districts is held in each of the first two years, and an election for two districts is held in the third year).
- The College holds an election in each of two years, and in the third year there is no election held (i.e., elections for four districts is held in each of first two years, and then there is a year without elections).

With respect to the above-noted options, the first option was not considered suitable, as all elected Board members would be up for election at the same time. This could significantly limit consistency in decision-making and the ability of more experienced elected Board members to provide mentorship to new members. As such, College staff have explored the other two options.

Options

Option One: The College Holds an Election Each Year

- In this option, the Board elections would follow a three year cycle: an election for three districts is held in each of the first two years, and an election for two districts is held in the third year.
- Districts 2, 4, and 6 would begin the cycle, as those districts are due for election in 2018. As such, commencing in 2018, elections for districts 2, 4 and 6 would be held in the first year of the cycle, and elections for districts 1, 3 and 5 would be held in the second year of the cycle. Elections for districts 7 and 8 would be held in the third year of the cycle.
- In order to have districts 7 and 8 track to the correct schedule of elections, transition elections would be needed for those districts. The election for district 8 would be held in November 2018 to elect a member from that district to a two-year term and an election for district 7 would be held in November 2019 to elect a member from that district to a one-year term. The election cycle is further outlined in Appendix 1.
- Limiting the number of consecutive terms to two consecutive terms, would limit the ability of existing Board members to serve up to six years on the Board. An overview, which assumes that all existing Board members will seek re-election and be re-elected, is attached in Appendix 1.
- Draft bylaws outlining this option are attached in Appendix 2.

Pros:

- Addresses the Board's direction to change the terms to three years.
- Allows for election staggering, so that all elected Board members are not elected at one time.
- Consistent with s.4(1) of the HPA Bylaws that requires an election to be held every year.

Cons:

- This option does result in a more complex election schedule, due to the short-term need for a transition period for two electoral districts.
- Would limit the ability of current Board members, who are eligible to seek re-election, from serving on the Board for six years. However, newer Board members would not face these same restrictions.

Option Two: The College Holds an Election in Each of Two Years; No Election is Held in the Third Year

- Elections would be on a three year cycle, with elections for four districts being held in each of first two years, and in the third year, no election is held.
- Commencing with the November 2018 elections, Board members from even-numbered electoral districts (i.e., districts 2, 4, 6 and 8) would be elected in the first year of the cycle, and Board members from odd-numbered electoral districts (i.e., districts 1, 3, 5, and 7) would be elected in the second year of the cycle. No election would be held in the third year of the cycle. The election cycle is further outlined in Appendix 3.
- The provisions limiting the number of consecutive terms to two terms, would also limit the ability of existing Board member to serve up to six years on the Board. An overview, which assumes that all existing Board members will seek re-election and be re-elected, is attached in Appendix 3.
- This option will require a further amendment to s.4(1) of the HPA-Bylaws that requires an election to be held every calendar year.

- Draft bylaws outlining this approach are attached in Appendix 4.

  Pros:
  - Addresses the Board's direction to change the terms to three years.
  - Allows for staggering of elections, so that all elected Board members are not elected at one time.
  - Fairly consistent with the current election schedule, where four districts are elected at one time.
  - A less complex election schedule than outlined in Option 1, as no transition election is required.

  Cons:
  - Would limit the ability of current Board members, who are eligible to seek re-election, from serving on the Board for six years. However, newer Board members would not face these same restrictions.
  - Would require an additional amendment to s.4(1) of the HPA Bylaws that requires an election to be held every calendar year. However, that is not expected to raise significant stakeholder concerns.

Other Considered Options

Staff considered other potential options to implement the requested changes, including:

- Appointing existing Board members who complete two terms, but not six years of service on the Board. This would be done so that these members could serve six years on the Board. However, staff recommend not proceeding with this option. While the Board is able, under s.10(1) of the HPA-Bylaws, to appoint a member due to a position vacancy, the Board would be appointing a majority of the Board membership. This approach may receive negative stakeholder reaction, as a democratic Board election process is expected by registrants.
- Removing the requirement for maximum of consecutive *terms*, and instead, inserting a maximum number of consecutive *years* that a member can serve on the Board. However, staff recommend not proceeding with this option. Such an approach makes it very difficult to have a consistent election schedule, as a number of Board appointments may be needed.
- Delaying the implementation date of the term and election schedule changes to 2020 or 2021. This option could limit the impact on existing Board members (assuming all elected Board members who are eligible to run for election, do run, and are elected). However, this option is not recommended. Should Board membership change prior to 2020 or 2021, newly elected Board members, who did not vote in support of the change, would be impacted. See Appendix 5 for further information.

Recommendation

It is recommended that the Board choose Option 2 for the following reasons:

- Addresses the Board's direction to amend the terms of office for elected Board members, from two to three years, and to a maximum of two consecutive terms.
- Fairly consistent with the current election schedule, whereby four electoral districts are "up" for election at one time.

- Does not require a transition schedule for specific electoral districts, and as such, is a more straightforward and consistently applied approach.

Appendix	
1	Overview of Option 1
2	HPA Bylaws – Track Changes Outlining Option 1
3	Overview of Option 2
4	HPA Bylaws – Track Changes Outlining Option 2
5	Overview of Delayed Implementation (i.e., 2020 or 2021)

Health Professions Act – BYLAWS

Table of Contents

10. Registration Renewal Notice
11. Application for Reinstatement
12. Order to Attend a Discipline Committee Hearing
13. Application for Certification – Drug Administration

Definitions

1. In these bylaws:

"*Act*" means the *Health Professions Act*;

"appointed board member" means

(a) a person appointed to the board under section 17(3)(b) of the *Act,* or

(b) prior to the first election referred to in section 17(2)(a) of the *Act*, a person appointed under section 17(2)(a) of the *Act* to represent the public on the first board;

"ballot" means an electronic ballot;

"board" means the board of the college;

"board member" means an appointed board member or an elected board member;

"chair" means the chair of the board elected under section 12;

"child-resistant package" means a package that complies with the requirements of the Canadian Standards Association Standard CAN/CSA-Z76.1-06, published in 2006 as amended from time to time;

"controlled drug substance" means a drug which includes a controlled substance listed in Schedule I, II, III, IV or V of the *Controlled Drugs and Substances Act* (Canada);

"college" means the College of Pharmacists of British Columbia continued under section 15.1(4) of the *Act*;

"deliver" with reference to a notice or other document, includes mail by post or electronically to, or leave with a person, or deposit in a person's mailbox or receptacle at the person's residence or place of business;

"director" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"dispense" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act;*

"drug" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"elected board member" means a full pharmacist board member or a pharmacy technician board member;

"examination" means an examination, given orally or in writing, or a practical examination, or any combination of these, and includes a supplemental examination;

"full pharmacist" means a member of the college who is registered in the class of registrants established in section 41(a);

"full pharmacist board member" means

(a) a full pharmacist elected to the board under section 17(3)(a) of the *Act* or appointed to the board under section 10, or

(b) prior to the first election referred to in section 17(2)(a) of the *Act*, a person appointed under section 17(2)(a) of the *Act* to represent the health profession on the first board;

"hospital" has the same meaning as in section 1 of the *Hospital Act*;

"in good standing" in respect of a registrant means

(a) the registration of the registrant is not suspended under the *Act*, and

(b) no limits or conditions are imposed on the registrant's practice of pharmacy under section 20(2.1), 20(3), 32.2, 32.3, 33, 35, 36, 37.1, 38, 39, or 39.1 of the *Act*;

"limited pharmacist" means a member of the college who is registered in the class of registrants established in section 41(b);

"manager" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"medication" has the same meaning as "drug";

"non-practising pharmacist" means a member of the college who is registered in the class of registrants established in section 41(f);

"owner" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"personal information" means "personal information" as defined in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*;

"pharmacy assistant" has the same meaning as "support person" in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"pharmacy services" means the services a registrant is authorized under the *Act* to provide;

"pharmacy technician" means a member of the college who is registered in the class of registrants established in section 41(e);

"pharmacy technician board member" means a pharmacy technician elected to the board under section 17(3)(a) of the *Act* or appointed to the board under section 10;

"practising pharmacist" means a full pharmacist, limited pharmacist, temporary pharmacist or student pharmacist;

"practitioner" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"prescription" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act*;

"public representative" means a person who

(a) is not a registrant or former registrant, and

(b) has no close family or business relationship with a registrant or former registrant,

and includes an appointed board member;

"quality assurance assessor" means an assessor appointed under section 26.1(4) of the *Act*;

"record" means a "record" as defined in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*;

"Regulation" means the Pharmacists Regulation, B.C. Reg. 417/2008;

"student pharmacist" means a member of the college who is registered in the class of registrants established in section 41(d);

"temporary pharmacist" means a member of the college who is registered in the class of registrants established in section 41(c);

"vice-chair" means the vice-chair of the board elected under section 12 of the *Act*.

PART I – College Board, Committees and Panels
Composition of Board

2. The board consists of

(a) 7 full pharmacist board members,

(b) 1 pharmacy technician board member, and

(c) the appointed board members.

Composition of the Board – Transitional

2.1 Despite section 2, until the start of the November 2010 board meeting, the board consists of

(a) 7 full pharmacist board members, and

(b) the appointed board members

Electoral Districts

3. (1) For the purpose of elections of full pharmacist board members under section 17(3)(a) of the *Act*, electoral districts are established as follows:

(a) the province of British Columbia is divided into 7 electoral districts, the boundaries of which are set out in Schedule "B";

(b) the number of full pharmacist board members elected from each electoral district is 1;

(c) electoral district boundaries described in paragraph (a) may be changed only by special resolution amending Schedule "B";

(d) a full pharmacist who has only 1 place of practice which is not a hospital must be assigned to an electoral district from among Districts 1 to 5, according to the location of the full pharmacist's place of practice;

(e) a full pharmacist who has only 1 place of practice which is a hospital must be assigned to District 6 or 7, according to the location of the hospital;

(f) a full pharmacist who practices in more than 1 electoral district must be assigned to the electoral district in which the full pharmacist's primary place of practice is located;

(g) a full pharmacist who does not practice must be assigned to the electoral district within which he or she resides.

(2) For the purpose of election of pharmacy technician board members under section 17(3)(a) of the *Act*, the electoral district is the province of British Columbia.

Notice of Election

4. (1) An election under section 17(3)(a) of the *Act* must be held ~~in each calendar year,~~ by electronic means approved by the registrar, at a date determined by the registrar that is at least 21 days prior to the date of the November board meeting in ~~that~~ each year that an election is held.

(2) The registrar must deliver a notice of election in Form 1 to every full pharmacist and pharmacy technician assigned to the electoral districts which are to elect board members in the election, at least 60

days prior to the election date.

(3) The accidental omission to deliver notice of an election to, or the non-receipt of such a notice, by any person entitled to receive notice does not invalidate the election, any proceedings in relation thereto, or the results thereof.

Eligibility and Nominations

5. (1) To be eligible for election to the board under section 17(3)(a) of the *Act*, a registrant must be

(a) a full pharmacist or pharmacy technician,

(b) in good standing, and

(c) assigned to the electoral district in which he or she is nominated.

(2) A full pharmacist or pharmacy technician is not eligible to be elected to the board if he or she is employed by the college or is engaged in a contract or assignment providing goods or services to the college.

(3) A nomination for a full pharmacist board member must be endorsed by 3 full pharmacists who are in good standing and are assigned to the electoral district in which the nominee is standing for election.

(4) A nomination for a pharmacy technician board member must be endorsed by 3 pharmacy technicians who are in good standing.

(5) A nomination must be delivered to the registrar at least 45 days prior to the election date.

(6) A nomination must be in Form 2.

Election Procedure

6. (1) If there is only 1 nominee for a vacant position at the close of nominations, the nominee for that position is elected by acclamation.

(2) Only full pharmacists and pharmacy technicians, who are in good standing, are eligible to vote in an election under section 17(3)(a) of the *Act.*

(3) A full pharmacist or pharmacy technician eligible to vote under subsection (2) is eligible to vote only in the electoral district to which he or she is assigned for an election.

(4) The registrar must deliver to each full pharmacist and pharmacy technician who is eligible to vote the instructions for voting electronically in the election at least 30 days prior to the election date.

(5) Each full pharmacist and pharmacy technician who is eligible to vote is entitled to 1 ballot and may vote in favour of 1 candidate for the vacant position.

(6) A ballot does not count unless it is cast no later than 5:00 p.m. Pacific Time on the election date.

(7) The candidate for a vacant position receiving the most votes on the return of the ballots is elected.

(8) In the case of a tie vote, the registrar must select the successful candidate by random draw.

(9) In the event that there are no nominees for a vacant position, the board may fill the vacant position in accordance with section 10.

(10) The registrar must supervise and administer all elections under section 17(3)(a) of the *Act* and may establish additional procedures consistent with these bylaws for that purpose.

(11) The registrar may determine any dispute or irregularity with respect to any nomination, ballot or election.

(12) The registrar must use Form 3 to certify newly elected members of the board under section 17.1(1) of the *Act*.

(13) If there is an interruption of electronic service during the nomination period or election, the registrar may extend the deadline for delivery of nominations or casting of ballots for such period of time as the registrar considers necessary in the circumstances.

Terms of Office

7. (1) The term of office for an elected board member is 3~~2~~ years, commencing at the start of the November board meeting following that board member's election.

(2) An elected board member may serve a maximum of 2~~3~~ consecutive terms.

~~(3) The terms of office of the elected board members from odd-numbered electoral districts must commence and end in odd-numbered years, and the terms of office of elected board members from even-numbered electoral districts must commence and end in even-numbered years.~~

~~(4)~~ (3) Subsections (1) and~~to~~ (2~~3~~) do not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

Election Cycle

7.1 Commencing with the 2018 elections, elections shall follow a three-year cycle, pursuant to which board members from even-numbered electoral districts are elected in the first year of the cycle, board members from odd-numbered electoral districts are elected in the second year of the cycle, and no election is held in the third year of the cycle.

Ceasing to Hold Office as a Board Member

8. (1) An elected board member ceases to hold office if he or she

(a) ceases to be a full pharmacist or pharmacy technician, in good standing,

(b) submits a written resignation to the chair,

(c) becomes an employee of the college or engaged in a contract or assignment providing goods or services to the college,

(d) is removed by a special resolution of the board, if notice of the proposal to remove the elected board member has been included with the notice of the board meeting, or

(e) is absent from 3 or more consecutive board meetings for reasons which the board finds unacceptable.

(2) Subsection (1) does not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

First Election and Terms of Office

9. Despite section 7(1) and (3), the term of office for the first elected full pharmacist board members from Districts 2, 4 and 6 is 1 year, commencing at the start of the November 2009 board meeting.

Vacancy

10. (1) In the event of a vacancy in an elected board member position, the board may, by special resolution, appoint a full pharmacist or pharmacy technician, as applicable, eligible under section 5 for election to fill the position until the next election.

(2) Subsection (1) does not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

Remuneration of Board and Committee Members

11. All board members and committee members are equally entitled to be

(a) remunerated for time spent on business of the college in the amount approved by the board from time to time, and

(b) reimbursed by the college for reasonable expenses necessarily

incurred in connection with the business of the college.

Chair and Vice-Chair

12. (1) The chair must

(a) preside at all board meetings,

(b) sign certificates, diplomas and other instruments executed on behalf of the college as required, and

(c) act in accordance with the requirements of his or her office for the proper carrying out of the duties of the board.

(2) At the November board meeting in each calendar year, the board members must elect a chair by a majority vote in accordance with the following procedure:

(a) the acting chair for the meeting must call for nominations;

(b) if there is only 1 nominee, he or she is elected by acclamation;

(c) if there is more than 1 nominee, an election must be held by secret ballot, and the person with the most votes is elected;

(d) if there is a tie vote, there must be a second vote immediately following the first vote;

(e) if there is a second tie vote, the new chair must be selected by random draw.

(3) The chair's term of office as chair is 1 year, commencing at the election of the vice-chair under subsection (4), and ending at the start of the November board meeting in the next calendar year.

(4) Immediately following the election of the chair under subsection (2), the board members must elect a vice-chair by a majority vote in accordance with the procedure set out in subsection (2).

(5) The vice-chair's term of office as vice-chair is 1 year, commencing at his or her election under subsection (4), and ending at the start of the November board meeting in the next calendar year.

(6) The vice-chair must perform the duties of the chair in the chair's absence.

(7) In the absence of both the chair and the vice-chair, an acting chair for a board meeting must be elected by a majority vote of the board members present.

(8) Despite subsections (2) to (5), the board members must elect a chair and vice-chair in accordance with the procedure set out in subsection (2), each to serve a term ending at the start of the November 2009

board meeting.

Board Meetings

13. (1) The board must meet at least 4 times in each calendar year, including one meeting in November, and must provide reasonable notice of board meetings to board members, registrants and the public.

(2) The accidental omission to deliver notice of a board meeting to, or the non-receipt of a notice by, any person entitled to receive notice does not invalidate proceedings at that meeting.

(3) Despite subsection (1), the chair or registrar may call a meeting of the board without providing notice to registrants or the public if necessary to conduct urgent business.

(4) The registrar must call a board meeting at the request of the chair or any 3 board members.

(5) The registrar must provide the following to members of the public on request:

(a) details of the time and place of a board meeting;

(b) a copy of the agenda;

(c) a copy of the minutes of any preceding board meeting.

(6) Subject to subsection (7), board meetings must be open to registrants and the public.

(7) The board may exclude any person from any part of a board meeting if it is satisfied that

(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public,

(b) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced,

(c) personnel matters or property acquisitions will be discussed,

(d) the contents of examinations will be discussed,

(e) communications with the Office of the Ombudsman will be discussed, or

(f) instructions will be given to or opinions received from legal counsel for the college, the board, or a committee.

(8) If the board excludes any person from a part of a board meeting, it

must have its reasons for doing so noted in the minutes of the meeting.

(9) The registrar must ensure that minutes are taken at each board meeting and retained on file, and must publish them on the college website.

(10) A majority of the total number of board members constitutes a quorum.

(11) The chair is entitled to vote on all motions, and is also entitled to speak in debate, but not in preference to other board members.

(12) A written resolution signed by all board members is valid and binding and of the same effect as if such resolution had been duly passed at a board meeting.

(13) In case of an equality of votes the chair does not have a casting or second vote in addition to the vote to which he or she is entitled as a board member and the proposed resolution does not pass.

(14) The board may meet and conduct business using video-conferencing or tele-conference connections or by other electronic means when some or all of the board members are unable to meet in person.

(15) Except as otherwise provided in the *Act*, the regulations, or these bylaws, the most recent edition of Robert's Rules of Order governs the procedures at meetings of the board.

Registration Committee

14. (1) The registration committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the registration committee must consist of public representatives, at least one of whom must be an appointed board member.

Inquiry Committee

15. (1) The inquiry committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the inquiry committee must consist of public representatives, at least one of whom must be an appointed board member.

Practice Review Committee

15.1 (1) The practice review committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the practice review committee must consist of public representatives, at least one of whom must be an appointed board member.

(3) The practice review committee is responsible for monitoring standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants.

(4) The practice review committee may receive reports made to the registrar, inquiry committee or discipline committee in respect of

(a) matters specified in section 17(1) of the *Pharmacy Operations and Drug Scheduling Act,* including without limitation reports under section 18 of that Act, and

(b) matters specified in section 28(1) of the *Health Professions Act*, including without limitation reports under section 28(3) of that Act.

(5) Upon receipt of a report described in subsection (4), the practice review committee may

(a) review the report, and

(b) as it considers appropriate in the circumstances, refer a matter arising from that review to the inquiry committee, quality assurance committee or registrar.

Application Committee

15.2 (1) The application committee within the meaning of section 1 of the *Pharmacy Operations and Drug Scheduling Act [SBC 2003] c.77* is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the application committee must consist of public representatives, at least one of whom must be an appointed board member.

Discipline Committee

16. (1) The discipline committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the discipline committee must consist of public representatives, at least one of whom must be an appointed board member.

Quality Assurance Committee

17. (1) The quality assurance committee is established consisting of at least 6 persons appointed by the board.

(2) At least 1/3 of the quality assurance committee must consist of public representatives, at least one of whom must be an appointed board member.

Drug Administration Committee

18. (1) The drug administration committee is established consisting of at least 4 and no more than 7 persons appointed by the board.

(2) The committee must include

(a) one full pharmacist,

(b) one medical practitioner confirmed by the College of Physicians and Surgeons of British Columbia as suitable for membership on the committee,

(c) one registered nurse confirmed by the College of Registered Nurses of British Columbia as suitable for membership on the committee, and

(d) one person nominated by the Ministry of Health Services.

(3) The drug administration committee

(a) must review, develop and recommend to the board standards, limits and conditions respecting the performance by practising pharmacists of restricted activities under section 4(1) (c.1) of the Regulation for the purposes of preventing diseases, disorders and conditions, and

(b) may

(i) review the role of practising pharmacists in regard to the performance of restricted activities under section 4(1) (c.1) of the Regulation, and

(ii) make recommendations to the board, for submission to the Ministry of Health Services, respecting the standards, limits and conditions for practice and any other requirements it considers necessary or appropriate to support the performance by practising pharmacists of restricted activities under section 4(1) (c.1) of the Regulation for the purposes of treating diseases, disorders and conditions.

(4) The committee may consult, as it considers necessary or appropriate, with registrants or other individuals who have expertise relevant to drug administration or on any other matter considered by the committee.

Committees

19. (1) A person appointed to a committee established under these bylaws

(a) serves for a term determined by the board not exceeding 2 years, and

(b) is eligible for reappointment but may not serve more than 3 consecutive terms.

(2) A committee member may be removed by a majority vote of the board.

(3) The board must appoint a committee chair and a committee vice-chair from among the members of the committee.

(4) Each committee must submit a report of its activities to the board annually or as required by the board.

(5) The registrar is an ex officio non-voting member of the committees established under these bylaws.

(6) The chair is a non-voting ex-officio member of all committees, except in respect of a committee to which he or she has been appointed under these bylaws, in which case he or she has the right to vote.

Committee Panels

20. (1) The registration committee, inquiry committee, practice review committee, application committee, discipline committee and quality assurance committee may meet in panels of at least 3 but not more than 5 persons, and each panel must include at least 1/3 public representatives.

(2) The chair of a committee referred to in subsection (1) must appoint the members of a panel and must designate a chair of the panel.

(3) A panel of a committee referred to in subsection (1) may exercise any power or perform any duty of that committee.

Meetings of a Committee or Panel

21. (1) A majority of a committee constitutes a quorum.

(2) All members of a panel constitute a quorum.

PART II – College Administration
Registrar/Deputy Registrar

22. (1) The registrar is authorized to establish, by bylaw, forms for the purposes of the bylaws, and to require the use of such forms by registrants.

(2) If a deputy registrar is appointed by the board,

(a) the deputy registrar is authorized to perform all duties and exercise all powers of the registrar, subject to the direction of the registrar, and

(b) if the registrar is absent or unable to act for any reason, the deputy registrar is authorized to perform all duties and exercise all powers of the registrar.

Seal

23. (1) The board must approve a seal for the college.

(2) The seal of the college must be affixed, by those persons designated by the board, to the documents determined by the board.

Fiscal Year

24. The fiscal year of the college commences on March 1st and ends on the last day of February of the following year.

Banking

25. The board must establish and maintain such accounts with a chartered bank, trust company or credit union as the board determines to be necessary from time to time.

Payments and Commitments

26. The board must approve an operating and capital budget for each fiscal year, and may amend the approved budget from time to time.

Investments

27. The board may invest funds of the college in accordance with the board's investment policy which must be consistent with sections 15.1 and 15.2 of the *Trustee Act.*

Auditor

28. (1) The board must appoint a chartered accountant or a certified general accountant to be the auditor.

(2) The registrar must submit the financial statement to the auditor within 60 days of the end of the fiscal year.

(3) A copy of the auditor's report must be included in the annual report.

Legal Counsel

29. The board or, with the approval of the registrar, a committee or panel, may retain legal counsel for the purpose of assisting the board, a

committee or a panel in exercising any power or performing any duty under the *Act*.

General Meetings

30. (1) General meetings of the college must be held in British Columbia at a time and place determined by the board.

(2) The first annual general meeting must be held before October 1, 2010, and after that an annual general meeting must be held at least once in every calendar year and not more than 20 months after the holding of the last preceding annual general meeting.

(3) The following matters must be considered at an annual general meeting:

(a) the financial statements of the college;

(b) the annual report of the board;

(c) the report of the auditor.

(4) Every general meeting, other than an annual general meeting, is an extraordinary general meeting.

(5) The board

(a) may convene an extraordinary general meeting by resolution of the board, and

(b) must convene an extraordinary general meeting within 60 days after receipt by the registrar of a request for such a meeting signed by at least ten percent of all full pharmacists and pharmacy technicians, who are in good standing.

Notice of General Meetings

31. (1) The registrar must deliver notice of an annual or extraordinary general meeting to every board member and registrant at least 21 days prior to the meeting.

(2) Notice of a general meeting must include

(a) the place, day and time of the meeting,

(b) the general nature of the business to be considered at the meeting,

(c) any resolutions proposed by the board, and

(d) any resolutions proposed under section 32 and delivered to the registrar prior to the mailing of the notice.

(3) The accidental omission to deliver notice of a general meeting to, or

the non-receipt of a notice by, any person entitled to receive notice does not invalidate proceedings at that meeting.

(4) General meetings must be open to the public.

(5) The registrar must

(a) provide reasonable notice of each general meeting to the public, and

(b) provide to members of the public on request a copy of the notice given under subsection (1) in respect of the meeting.

Resolutions

32. Any 3 full pharmacists or pharmacy technicians, who are in good standing, may deliver a written notice to the registrar at least 60 days prior to the date of an annual or an extraordinary general meeting requesting the introduction of a resolution.

Voting at a General Meeting

33. (1) A full pharmacist or pharmacy technician present at a general meeting is entitled to 1 vote at the meeting.

(2) In case of an equality of votes the chair of the general meeting does not have a casting or second vote in addition to the vote to which he or she is entitled as a full pharmacist or pharmacy technician, if any, and the proposed resolution does not pass.

(3) Except as these bylaws otherwise provide, the most recent edition of Robert's Rules of Order governs the procedures at an annual or extraordinary general meeting.

(4) A resolution passed at an annual or extraordinary general meeting is not binding on the board.

Proceedings at General Meetings

34. (1) Quorum is 25 registrants consisting of full pharmacists or pharmacy technicians, or both.

(2) No business, other than the adjournment or termination of the meeting, may be conducted at a general meeting at a time when a quorum is not present.

(3) If at any time during a general meeting there ceases to be a quorum present, business then in progress must be suspended until there is a quorum present.

(4) In the case of a general meeting other than an extraordinary general meeting under section 30(5)(b),

(a) if there is no quorum within 30 minutes from the time appointed for the start of the meeting, or

(b) if there is no quorum within 30 minutes from any time when there is no quorum during the meeting,

the meeting must be adjourned to one month later, at the same time and place, and those full pharmacists and pharmacy technicians who attend that later meeting will be deemed to be a quorum for that meeting.

(5) In the case of an extraordinary general meeting under section 30(5)(b),

(a) if there is no quorum within 30 minutes from the time appointed for the start of the meeting, or

(b) if there is no quorum within 30 minutes from any time when there is no quorum during the meeting,

the meeting must be adjourned and cancelled and no further action may be taken in respect of the request under section 30(5)(b) for that meeting.

(6) In the absence of both the chair and the vice-chair of the board, an acting chair for a general meeting must be elected by a majority vote of the full pharmacists and pharmacy technicians present.

(7) A general meeting may be adjourned from time to time and from place to place, but no business may be transacted at an adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place.

(8) When a meeting is adjourned in accordance with subsection (4) or by resolution, notice of the rescheduled meeting must be delivered in accordance with section 31.

Notice to Public Representatives

35. Every notice or mailing to registrants must also be provided to public representatives serving on the board or a committee.

PART III – College Records
Body Responsible for Administering the *Freedom of Information and Protection of Privacy Act*

36. (1) The registrar is the “head” of the college for the purposes of the *Freedom of Information and Protection of Privacy Act.*

(2) The registrar may authorize the deputy registrar, a person employed by the college or a person who has contracted to perform services for the college to perform any duty or exercise any function of the registrar that arises under the *Freedom of Information and Protection*

of Privacy Act.

Fees for Information Requests

37. Subject to section 75 of the *Freedom of Information and Protection of Privacy Act*, an applicant who requests access to a college record under section 5 of the *Freedom of Information and Protection of Privacy Act* must pay the fees set out in the Schedule of Maximum Fees in B.C. Reg. 323/93 for services required to comply with the information request.

Disclosure of Annual Report

38. The registrar must make each annual report under section 18(2) of the *Act* available electronically and free of charge on the college website, must notify registrants that the report is available, and must provide a paper copy of the report to any person on request upon payment of the fee set out in Schedule "D".

Disclosure of Registration Status

39. (1) If an inquiry about the registration status of a person is received by the board or the registrar, the registrar must disclose, in addition to the matters required by section 22 of the *Act*,

(a) whether the discipline committee has ever made an order relating to the person under section 39 of the *Act* and the details of that order,

(b) whether the person has ever consented to an order under section 37.1 of the *Act* and the details of that order, and

(c) whether the person has ever given an undertaking or consented to a reprimand under section 36 of the *Act* and the details of that undertaking or reprimand.

(2) When acting under subsection (1), the registrar must not release the name of, or information which might enable a person to identify

(a) a patient, or

(b) another person, other than the registrant, affected by the matter,

except with the consent of the patient or the other person.

Manner of Disposal of College Records Containing Personal Information

40. The board must ensure that a college record containing personal information is disposed of only by

(a) effectively destroying a physical record by utilizing a shredder or by complete burning,

(b) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the

information cannot be reconstructed,

(c) returning the record to the person the information pertains to, or

(d) returning the record to the registrant who compiled the information.

PART IV – Registration
Classes of Registrants

41. The following classes of registrants are established:

(a) full pharmacist;

(b) limited pharmacist;

(c) temporary registrant;

(d) student pharmacist;

(e) pharmacy technician;

(f) non-practising registrant.

Full Pharmacist Registration

42. (1) For the purposes of section 20(2) of the *Act*, the requirements for full pharmacist registration are

(a) graduation with a degree or equivalent qualification from a pharmacy education program recognized by the board for the purpose of full pharmacist registration and specified in Schedule "C",

(b) successful completion of the jurisprudence examination required by the registration committee,

(c) successful completion of an English language proficiency examination acceptable to the registration committee, if the person has not graduated from a pharmacy education program in Canada or the United States accredited by the Canadian Council for Accreditation of Pharmacy Programs or the Accreditation Council for Pharmacy Education,

(d) successful completion of the structured practical training required by the registration committee, if any,

(e) successful completion of the Pharmacy Examining Board of Canada Evaluating Examination, if the person has not graduated from a pharmacy education program in Canada or the United States accredited by the Canadian Council for Accreditation of Pharmacy Programs or the Accreditation Council for Pharmacy Education,

(f) successful completion of the Pharmacy Examining Board of

Canada Qualifying Examination - Part I and Part II,

(g) evidence satisfactory to the registration committee that the person is of good character and fit to engage in the practice of pharmacy, and

(h) receipt by the registrar of

(i) a signed application for full pharmacist registration in Form 4,

(ii) the application fee specified in Schedule "D",

(iii) a notarized copy, or other evidence satisfactory to the registration committee, of the person's degree or equivalent qualification, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) if applicable, the fee for the jurisprudence examination specified in Schedule "D",

(vi) a criminal record check authorization in the form required by the *Criminal Records Review Act*,

(vii) if the person has engaged in the practice of pharmacy or another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(viii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession,

(ix) a certified passport size photograph of the person taken within one year prior to the date of application,

(x) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada, and

(xi) proof of professional liability insurance as required under section 81.

(1.1) If an applicant for registration does not complete the requirements for full registration in subsection (1) within 12 months from the date of application, the applicant must provide

(a) a letter or certificate, in a form satisfactory to the registration

committee and dated within three months prior to the date of full registration, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession, and

(b) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) Despite subsection (1), the person may be granted full pharmacist registration if he or she

(a) is registered in another Canadian jurisdiction as the equivalent of a full pharmacist and has provided notarized evidence, or other evidence satisfactory to the registration committee, of such registration and that he or she is the person named therein, and

(b) meets the requirements established in subsection (1)(g) and (h)(i) to (iv) and (vi) to (xi).

(3) Despite subsection (1), the registration committee has discretion, in satisfying itself under section 20 of the *Act* that the person meets the conditions or requirements for registration as a full pharmacist member of the college, to consider whether the person's knowledge, skills and abilities are substantially equivalent to the standards of academic or technical achievement and the competencies or other qualifications established in subsection (1)(a), and to grant full pharmacist registration on that basis, if the person also meets the requirements established in subsection (1)(b) to (h).

(4) A full pharmacist may use only the abbreviation "R.Ph.".

(5) A full pharmacist must not

(a) delegate any aspect of practice to a pharmacy technician, or

(b) authorize a pharmacy technician to perform or provide any aspect of practice under supervision.

Certification of Practising Pharmacists for Drug Administration

43. (1) A practising pharmacist may apply to the registrar under this section for certification that the practising pharmacist is qualified and competent to perform a restricted activity under section 4(1) (c.1) of the Regulation.

(2) The registrar must grant certification under this section if the practising pharmacist has

(a) provided evidence satisfactory to the registrar that the practising pharmacist has

(i) successfully completed within the year prior to application an education program in drug administration, approved by the board for the purposes of section 4.1(c) of the Regulation and specified in Schedule “C”,

(ii) a current certificate in cardiopulmonary resuscitation from a program approved by the board and specified in Schedule “C”, and

(iii) a current certificate in first aid from a program approved by the board and specified in Schedule “C”,

(b) submitted a signed application for certification in Form 13, and

(c) paid the fee specified in Schedule “D”.

(3) If certification is granted under this section, the registrar must enter a notation of certification for drug administration in the register in respect of the practising pharmacist.

(4) To maintain certification under this section, a practising pharmacist must declare upon registration renewal

(a) that he or she has successfully completed a continuing education program in drug administration approved by the board and specified in Schedule “C” if an injection has not been administered in the preceding three years, and

(b) that he or she has successfully completed a continuing education program in administering a drug by intranasal route approved by the board and specified in Schedule “C” if a drug has not been administered by intranasal route in the preceding three years, and

(c) maintain current certification in cardiopulmonary resuscitation from a program approved by the board and specified in Schedule “C”, and

(d) maintain current certification in first aid from a program approved by the board and specified in Schedule “C”.

(5) The registrar must remove a practising pharmacist’s notation of certification from the register if the practising pharmacist fails to meet any of the requirements in subsection (4), and the practising pharmacist must not again perform a restricted activity under section 4(1) (c.1) of the Regulation until

(a) the requirements in subsection (4) are met to the satisfaction of the registrar, and

(b) the registrar has re-entered a notation of certification for drug

administration in the register in respect of the practising pharmacist.

Intranasal Drug Administration

43.1 A practising pharmacist who has been certified under section 43(1) must complete the program specified in Schedule C on intranasal drug administration prior to administering an intranasal drug.

Limited Pharmacist Registration

44. (1) An applicant under section 42 or 52 may be granted limited pharmacist registration for a period of up to one year if

(a) the applicant

(i) does not meet the requirements established in section 42(1)(b)(c)(e) and (f) or (3), or section 52(2)(a) and (c), as applicable,

(ii) meets the requirements established in section 42(1)(d), or section 52(2)(b), as applicable, and

(iii) is capable, in the opinion of the registration committee, of practising as a limited pharmacist without any risk to public health and safety, or

(b) the applicant

(i) meets the requirements established in section 42(1)(b)(c)(e) and (f) or (3), or section 52(2)(a) and (c), as applicable,

(ii) does not meet the requirements established in section 42(1)(d), or section 52(2)(b), as applicable, and

(iii) is capable, in the opinion of the registration committee, of practising as a limited pharmacist without any risk to public health and safety.

(2) Limited pharmacist registration may be renewed twice, but in any case, the total period of registration in this class must not exceed 3 years.

(3) Full pharmacist registration may be granted to a limited pharmacist who has met all the requirements in section 42(1) or (3), or section 52, as applicable.

(4) A limited pharmacist may provide pharmacy services as if he or she is a full pharmacist, but only under the supervision of a full pharmacist approved by the registration committee for that purpose.

(5) A limited pharmacist must not delegate any aspect of practice.

(6) A limited pharmacist may use only the title “pharmacist (limited)” and must not use any abbreviations.

Temporary Registration

45. (1) Despite sections 42 and 47, a person may be granted temporary pharmacist registration or temporary pharmacy technician registration, for a period of up to 90 days, if

(a) an emergency has been declared by the registrar in accordance with criteria established by the board,

(b) the person

(i) is registered in another jurisdiction in Canada or the United States as the equivalent of a full pharmacist or a pharmacy technician, and

(ii) has provided notarized evidence, or other evidence satisfactory to the registration committee, of such registration and that the person is the person named therein.

(2) The registration of a temporary pharmacist or temporary pharmacy technician may be renewed once for an additional period of up to 90 days.

(3) A temporary pharmacist may provide services as if he or she is a full pharmacist, and may apply for certification, and be certified, under section 43.

(4) A temporary pharmacy technician may provide services as if he or she is a pharmacy technician,

(5) A temporary pharmacist may use only the title “pharmacist (temporary)” and must not use any abbreviations.

(6) A temporary pharmacy technician may use only the title “pharmacy technician (temporary)” and must not use any abbreviations.

Student Pharmacist Registration

46. (1) A person may be granted student pharmacist registration if the person

(a) is enrolled as a student in a pharmacy education program recognized by the board for the purpose of full pharmacist registration and specified in Schedule ”C”,

(b) provides evidence satisfactory to the registration committee that the person is of good character and fit to engage in the practice of pharmacy, and

(c) has delivered to the registrar

(i) a signed application for registration in Form 6,

(ii) the application fee specified in Schedule "D",

(iii) a notarized copy, or other evidence satisfactory to the registration committee of the person's enrolment and educational standing, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) a criminal record check authorization in the form required under the *Criminal Records Review Act*,

(vi) if the person has engaged in the practice of pharmacy or another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(vii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession,

(viii) a certified passport size photograph of the person taken within one year prior to the date of application, and

(ix) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) A person described in subsection (1)(a) must be registered under this section

(a) within 6 months of their enrolment as a student in the pharmacy education program, and

(b) before undertaking a period of structured practical training or providing pharmacy services.

(3) A person who is enrolled as a student in a pharmacy education program that is not recognized by the board for the purpose of registration may be granted student registration if the applicant meets all requirements established in subsection (1)(b) and (c).

(4) A person described in subsection (3) must be registered under this section before undertaking a period of structured practical training, or

providing pharmacy services.

(5) A student pharmacist may only provide pharmacy services while under the supervision of a full pharmacist

(5.1) Despite subsection (5), a student pharmacist may only perform a restricted activity under section 4(1)(c.1) of the Regulation while under the supervision of

(a) a full pharmacist who is certified under section 43, or

(b) a person who is

(i) not a member of the college,

(ii) registered as a member of another college established or continued under the Act, and

(iii) authorized under the Act to perform the restricted activity in the course of practising the designated health profession for which the other college is established or continued.

(6) The registration of a student pharmacist may be renewed if he or she

(a) remains enrolled in a pharmacy education program described in subsection 1(a),

(b) applies in writing in a form acceptable to the registration committee,

(c) pays any outstanding fine, fee, debt or levy owed to the college, and

(d) pays the fee specified in Schedule "D".

(7) A student pharmacist must not delegate any aspect of practice.

(8) A student registrant may use only the title "pharmacist (student)" and must not use any abbreviations.

Pharmacy Technician Registration

47. (1) For the purposes of section 20(2) of the *Act,* the requirements for pharmacy technician registration are

(a) graduation with a diploma or certificate from a pharmacy technician education program recognized by the board for the purpose of pharmacy technician registration and specified in Schedule "C",

(b) successful completion of the jurisprudence examination required by the registration committee,

(c) successful completion of an English language proficiency examination acceptable to the registration committee, if the person has not graduated from a pharmacy technician education program in Canada accredited by the Canadian Council for Accreditation of Pharmacy Programs.

(d) successful completion of the structured practical training required by the registration committee, if any,

(e) successful completion of the Pharmacy Examining Board of Canada Evaluating Examination, if the person has not graduated from a pharmacy technician education program in Canada accredited by the Canadian Council for Accreditation of Pharmacy Programs.

(f) successful completion of the Pharmacy Examining Board of Canada Pharmacy Technician Qualifying Examination – Part I and Part II,

(g) evidence satisfactory to the registration committee that the person is of good character and fit to engage in practice as a pharmacy technician, and

(h) receipt by the registrar of

(i) a signed application for registration in Form 7,

(ii) the application fee specified in Schedule "D",

(iii) a notarized copy, or other evidence satisfactory to the registration committee, of the person's diploma, certificate or equivalent qualification, and that he or she is the person named therein,

(iv) a statutory declaration in Form 5,

(v) if applicable, the fee for the jurisprudence examination specified in Schedule "D",

(vi) a criminal record check authorization in the form required by the *Criminal Records Review Act*,

(vii) if the person has practised as a pharmacy technician or in another health profession in another jurisdiction, an authorization for a criminal record check in that jurisdiction,

(viii) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of the application, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to practise as a pharmacy

technician or in another health profession,

(ix) a certified passport size photograph of the person taken within one year prior to the date of application,

(x) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada, and

(xi) proof of professional liability insurance as required under section 81.

(1.1) If an applicant for registration does not complete the requirements for full registration in subsection (1) within 12 months from the date of application, the applicant must provide

(a) a letter or certificate, in a form satisfactory to the registration committee and dated within three months prior to the date of full registration, of the person's good standing from each body responsible for the regulation of the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction where the person is, or has been, authorized to engage in the practice of pharmacy or another health profession, and

(b) a notarized copy, or other evidence satisfactory to the registration committee, of the person's Canadian citizenship or authorization to work in Canada.

(2) Despite subsection (1), the person may be granted pharmacy technician registration if he or she

(a) is registered in another Canadian jurisdiction as the equivalent of a pharmacy technician and has provided evidence, satisfactory to the registration committee, of such authorization and that he or she is the person named therein, and

(b) meets the requirements established in subsection (1)(g) and (h)(i) to (iv) and (vi) to (xi).

(3) Despite subsection (1), the registration committee has discretion, in satisfying itself under section 20 of the *Act* that the person meets the conditions or requirements for registration as a pharmacy technician member of the college, to consider whether the person's knowledge, skills and abilities are substantially equivalent to the standards of academic or technical achievement and the competencies or other qualifications established in subsection (1)(a), and to grant full pharmacy technician registration on that basis, if the person also meets the requirements established in subsection (1)(b) to (h).

(4) Despite subsection (1), the person may be granted pharmacy technician registration if he or she

(a) applies on or before December 31, 2015,

(b) has worked for at least 2000 hours as the equivalent of a pharmacy assistant in the 3 year period immediately preceding the date of application,

(c) has

(i) successfully completed the Pharmacy Examining Board of Canada Evaluating Examination, or

(ii) been certified as the equivalent of a pharmacy technician in the Province of Ontario or Province of Alberta prior to January 1, 2009, or in another jurisdiction recognized by the registration committee, or

(iii) successfully completed an accredited pharmacist degree program in Canada or in the continental United States,

(d) has successfully completed the pharmacy technician bridging programs, and

(e) meets the requirements in subsection (1)(b) to (d) and (f) to (h).

(5) A pharmacy technician must not

(a) perform a restricted activity under section 4(1)(a) or (c.1) of the Regulation,

(b) act under section 25.92 of the *Act,* or

(c) be appointed as a pharmacy manager.

(6) A pharmacy technician may use only the title "pharmacy technician" and may use only the abbreviation "R.Ph.T.".

Non-Practising Registration

48. (1) A full pharmacist or pharmacy technician may be granted non-practising registration if the registrar has received

(a) a signed application for non-practising registration in Form 8,

(b) the registration fee specified in Schedule "D",

(c) a statutory declaration in Form 5, and

(d) a criminal record check authorization in the form required under the *Criminal Records Review Act*.

(2) A non-practising registrant must not provide pharmacy services in British Columbia.

(3) A non-practising registrant who was formerly a full pharmacist may use only the title "pharmacist (non-practising)" and must not use any abbreviations.

(4) A non-practising registrant who was formerly a pharmacy technician

may use only the title “pharmacy technician (non-practising)” or “technician (non-practising)” and must not use any abbreviations.

Certificate of Registration and Registration Card

49. (1) The registrar must issue a certificate in Form 9 to a person who is granted full pharmacist or pharmacy technician registration.

(2) A registration card must be issued to a person who is granted registration, and is valid from the date issued until the date shown on the card.

Examinations

50. (1) An applicant who fails a required examination under this Part, may write the examination again to a maximum of 4 times except where the Pharmacy Examining Board of Canada for its examinations, determines otherwise.

(2) If an invigilator has reason to believe that an applicant has engaged in improper conduct during the course of an examination, the invigilator must make a report to the registration committee, and may recommend that the registration committee take one or more of the following courses of action:

(a) fail the applicant;

(b) pass the applicant;

(c) require the applicant to rewrite the examination;

(d) disqualify the applicant from participating in any examination for a period of time.

(3) After considering a report made under subsection (2), the registration committee may take one or more of the courses of action specified in subsection (2).

(4) An applicant disqualified under subsection 2(d) must be provided with written reasons for disqualification.

Registration Renewal

51. (1) To be eligible for a renewal of registration, a registrant must

(a) provide the registrar with a completed Form 10,

(b) pay the registration renewal fee specified in Schedule “D”,

(c) pay any other outstanding fine, fee, debt or levy owed to the college,

(d) attest that he or she is in compliance with the *Act*, the regulations, and these bylaws, and is in compliance with any

limits or conditions imposed on his or her practice under the *Act*,

(e) meet all applicable requirements of the quality assurance program under Part V,

(f) if certified under section 43, meet all applicable requirements of section 43(4),

(g) provide proof of professional liability insurance as required under section 81, and

(h) provide an authorization for a criminal record check in the form required under the *Criminal Records Review Act*, if the college does not have a valid authorization on file.

(2) Form 10 must be delivered to each registrant no later than 30 days before the registration renewal date and must describe the consequences of late payment and non-payment of fees.

(3) Each registrant must submit the monies required under subsection (1) and a completed Form 10 to the college on or before the registration expiry date.

(4) On receipt of the monies required under subsection (1) and a completed Form 10, the registrar must issue a receipt stating that the registrant is, subject to his or her compliance with the *Act*, the regulations, and the bylaws, entitled to practice the profession of pharmacy or practise as a pharmacy technician, as applicable, in the Province of British Columbia as a member of the college.

(5) If a registrant fails to submit the monies required under subsection (1) and a completed Form 10 on or before the registration expiry date, he or she ceases to be registered.

(6) In this section, ”registrant” does not include a student pharmacist.

Reinstatement

52. (1) The registration of a former registrant or a non-practising registrant, whose registration is not suspended or cancelled under the *Act* and who has been out of practice for more than 90 days but less than 6 years must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant or non-practising registrant

(a) has met all the applicable requirements of the quality assurance program approved by the board, and

(b) has delivered to the registrar

(i) a signed application for reinstatement in Form 11,

(ii) a statutory declaration in Form 5,

(iii) an authorization for a criminal record check in the form required by the *Criminal Records Review Act*, and

(iv) the registration reinstatement fee and transfer fee, if applicable, specified in Schedule "D".

(2) The registration of a former registrant or a non-practising registrant, whose registration is not suspended or cancelled under the *Act* and who has been out of practice for 6 years or more must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant or non-practising registrant

(a) successfully completes the jurisprudence examination required by the registration committee,

(b) successfully completes the structured practical training required by the registration committee,

(c) successfully completes the Pharmacy Examining Board of Canada Qualifying Examination - Part II, and

(d) has delivered to the registrar

(i) a signed application for reinstatement in Form 11,

(ii) a statutory declaration in Form 5,

(iii) an authorization for a criminal record check in the form required by the *Criminal Records Review Act*, and

(iv) the registration reinstatement and transfer fee, if applicable specified in Schedule "D".

Reinstatement Following Late Registration Renewal

53. The registration of a former registrant who ceased to be registered under section 51(5) must, subject to sections 20 and 39 of the *Act*, be reinstated by the registration committee if the former registrant

(a) applies for reinstatement in Form 11 not later than 90 days following the expiry of his or her registration,

(b) meets the requirements of section 52(1),

(c) is not in contravention of the *Act*, the regulations, or these bylaws, and

(d) pays the registration reinstatement and late registration renewal fees specified in Schedule "D".

Registration Information

54. (1) For the purposes of section 21(2)(f) of the *Act*, the registrar must enter and maintain on the register the most recent electronic mail

address for each registrant.

(2) A registrant must notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and addresses of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

PART V – Quality Assurance
Quality Assurance Program

55. (1) In this Part, **"program"** means the quality assurance program established by the board in accordance with this section.

(2) The program consists of the following:

(a) continuing professional development;

(b) assessment of professional performance.

Continuing Professional Development

56. (1) Each full pharmacist and pharmacy technician must complete learning activities for the purpose of continuing professional development, in accordance with the policy approved by the board.

(2) Each full pharmacist and pharmacy technician must

(a) keep records in a form satisfactory to the quality assurance committee of the learning activities that the full pharmacist or pharmacy technician undertakes for the purpose of meeting the requirement established in subsection (1), and

(b) provide, on the request of and in accordance with the direction of the quality assurance committee, copies of the records referred to in paragraph (a).

(3) The quality assurance committee may conduct a review of the records provided under subsection 2(b).

Assessment of Professional Performance

56.1 (1) The quality assurance committee may require a full pharmacist or pharmacy technician to undergo an assessment of professional performance

(a) upon referral from the practice review committee under section 15.1(5), or

(b) if the quality assurance committee determines an assessment is appropriate in the circumstances upon a review of records conducted under section 56(3).

(2) For the purpose of an assessment under subsection (1) the quality assurance committee or an assessor appointed by the quality assurance committee may do one or more of the following:

(a) conduct an interview of the full pharmacist or pharmacy technician;

(b) assess the practice competency of the full pharmacist or pharmacy technician;

(c) require the full pharmacist or pharmacy technician to undergo any other type of assessment determined by the quality assurance committee to be appropriate in the circumstances.

PART VI – Inquiries and Discipline
Consent Orders

57. The record of an undertaking or consent given under section 36 of the *Act*, a consent order under section 37.1 of the *Act*, or an agreement under section 32.2(4)(b) or 32.3(3)(b) of the *Act*, must

(a) include any consent to a reprimand or to any other action made by the registrant under section 32.2(4)(b), 32.3(3)(b), 36 or 37.1 of the *Act*,

(b) include any undertaking made by the registrant under section 36 of the *Act*,

(c) specify the length of time that an undertaking specified in paragraph (b) is binding on the registrant,

(d) specify the procedure that the registrant may follow to be released from an undertaking specified in paragraph (b), and

(e) subject to sections 22 and 39.3 of the *Act* and sections 39(1) and 60(1), specify which limits or conditions of the undertaking, consent order or agreement may be published, disclosed to the public, or both.

Notice of Disciplinary Committee Action Under Section 39.1 of *Act*

57.1 The discipline committee must deliver notice to a registrant not fewer than 14 days before making an order under section 39.1 of the *Act* in respect of the registrant.

Citation for Disciplinary Hearing

58. (1) On the direction of a panel of the discipline committee, the registrar may join one or more complaints or other matters which are to be the subject of a discipline hearing in one citation as appropriate in the circumstances.

(2) On the direction of a panel of the discipline committee, the registrar

may sever one or more complaints or other matters which are to be the subject of a discipline hearing as appropriate in the circumstances.

(3) On the direction of a panel of the discipline committee, the registrar may amend a citation issued under section 37 of the *Act*.

(4) If a citation is amended under subsection (3) prior to a discipline hearing, the amended citation must be delivered to the respondent by personal service or sent by registered mail to the respondent at the last address for the respondent recorded in the register not fewer than 14 days before the date of the hearing.

(5) If a citation is amended under subsection (3) prior to a discipline hearing, and the amended citation changes the date, time or place of the hearing, the registrar must notify any complainant of the amendment not fewer than 14 days before the date of the hearing.

Hearings of Discipline Committee

59. (1) No person may sit on the discipline committee while he or she is a member of the inquiry committee.

(2) No member of the discipline committee may sit on the panel hearing a matter in which he or she:

(a) was involved as a member of the inquiry committee, or

(b) has had any prior involvement.

(3) Information about the date, time and subject matter of the hearing must be provided to any person on request.

(4) The discipline committee must provide notice by registered mail or by personal service to a person who is required to attend a hearing under section 38(6) of the *Act* in Form 12.

(5) All discipline hearings must be recorded and any person may obtain, at his or her expense, a transcript of any part of the hearing which he or she was entitled to attend.

Notice of Disciplinary Decision

60. (1) In addition to any notification required under section 39.3 of the *Act* with respect to any of the actions referred to in section 39.3(1)(a) to (e) of the *Act*, the registrar

(a) must notify all registrants,

(b) must notify the regulatory bodies governing the practice of pharmacy or the services of pharmacy technicians in every other Canadian jurisdiction, and

(c) may notify any other governing body of a health profession inside or outside of Canada.

(2) Notification provided to all registrants under subsection (1)(a)

(a) must include all information included in the public notification under section 39.3 of the *Act*, and

(b) unless otherwise directed by the inquiry committee or the discipline committee, as the case may be, must exclude any information withheld from the public notification under section 39.3(3) or (4) of the *Act*.

(3) Unless otherwise directed by the inquiry committee or the discipline committee, as the case may be, notification provided to other regulatory or governing bodies under subsection (1)(b) or (c) may include information that has been withheld from the public notification under section 39.3(3) or (4) of the *Act*.

Retention of Discipline Committee and Inquiry Committee Records

61. Records of the inquiry committee and discipline committee must be retained permanently.

Registrant Under Suspension

62. (1) If the registration of a registrant is suspended, the registrant must

(a) not engage in the practice of pharmacy or provide the services of a pharmacy technician,

(b) not hold himself or herself out as a registrant,

(c) not hold office in the college,

(d) not be a manager,

(e) not make appointments for patients or prospective patients,

(f) remove the registrant's name and any sign relating to the registrant's practice from any premises where the registrant practiced pharmacy or provided the services of a pharmacy technician and any building in which any such premises are located,

(g) not contact or communicate with patients or prospective patients, except for the following purposes:

(i) to advise a patient or a prospective patient of the fact and duration of the suspension, and

(ii) to advise a patient or prospective patient that another registrant will continue to act or provide services in the

suspended registrant's place, or

(iii) to refer a patient or prospective patient to another registrant, who is in good standing.

(h) pay any fee required by the college when due in order to remain a registrant and any other outstanding fine, fee, debt or levy owed to the college, and

(i) immediately surrender his or her registration card to the registrar.

(2) No registrant or former registrant is entitled to any refund of any fine, fee, debt or levy paid to the college solely on the basis that it was paid during or in relation to a period of suspension from practice.

(3) During the period of suspension,

(a) a suspended full pharmacist may permit another full pharmacist in good standing to practice pharmacy, and

(b) a suspended pharmacy technician may permit a full pharmacist or another pharmacy technician, in good standing, to provide pharmacy services,

in the premises where the full pharmacist or pharmacy technician formerly practiced pharmacy or provided pharmacy services, as applicable.

Fines

63. The maximum amount of a fine that may be ordered by the discipline committee under section 39(2)(f) of the *Act* is $100,000.

PART VII –Registrant Records
Definitions

64. In this Part, **"patient's representative"** means

(a) a "committee of the patient" under the *Patient's Property Act*,

(b) the parent or guardian of a patient who is under 19 years of age,

(c) a representative authorized by a representation agreement under the *Representation Agreement Act* to make or help in making decisions on behalf of a patient,

(d) a decision maker or guardian appointed under section 10 of the *Adult Guardianship Act*, or

(e) a temporary substitute decision maker chosen under section 16 of the *Health Care (Consent) and Care Facility (Admission) Act*.

Purpose for which Personal Information may be Collected

65. No registrant may collect personal information regarding a patient without the patient's consent unless

(a) the information relates directly to and is necessary for providing health care services to the patient or for related administrative purposes, or

(b) the collection of that information is expressly authorized by or under an enactment.

Source of Personal Information

66. (1) A registrant must collect personal information about a patient directly from the patient, unless the patient otherwise consents.

(2) Despite subsection (1), a registrant may collect personal information about a patient from another person if he or she has reasonable grounds to believe

(a) that the patient has been made aware of the matters set out in section 67(1) and has authorized collection of the personal information from another person,

(b) that the patient is unable to give his or her authority and the registrant, having made the patient's representative aware of the matters set out in section 67(1), collects the information from the representative or the representative authorizes collection from another person,

(c) that compliance with subsection (1) would:

(i) prejudice the best interests of the patient,

(ii) defeat the purpose or prejudice the use for which the information is collected, or

(iii) prejudice the safety of any person,

(d) that compliance with subsection (1) is not reasonably practicable in the circumstances of the particular case,

(e) that the collection is for the purpose of assembling a family or genetic history of a person and is collected directly from that person,

(f) that the information is publicly available,

(g) that the information:

(i) will not be used in a form in which the patient concerned is identified, or

(ii) will be used for statistical or research purposes and will not be published in a form that could reasonably be expected

to identify the patient.

(h) that non-compliance with subsection (1) is necessary if the information is about law enforcement or anything referred to in sections 15(1) or (2) of the *Freedom of Information and Protection of Privacy Act*.

Collection of Personal Information

67. (1) If a registrant collects personal information directly from a patient, or from a patient's representative, the registrant must take such steps as are, in the circumstances, reasonable to ensure that the patient or patient's representative is aware of

(a) the fact that the personal information is being collected,

(b) the purpose for which the personal information is being collected,

(c) the intended recipients of the personal information,

(d) whether or not the supply of the personal information is voluntary or mandatory and, if mandatory, the legal authority for collecting the personal information,

(e) the consequences, if any, for that patient if all or any part of the requested personal information is not provided, and

(f) the rights of access to personal information provided in section 80.

(2) The steps referred to in subsection (1) must be taken before the personal information is collected or, if that is not practicable, as soon as practicable after the personal information is collected.

(3) A registrant is not required to take the steps referred to in subsection (1) in relation to the collection of personal information from a patient, or the patient's representative, if the registrant has taken those steps in relation to the collection, from the patient or patient's representative, of the same information or information of the same kind for the same or a related purpose, on a recent previous occasion.

(4) Despite subsection (1), a registrant is not required to comply with subsection (1) if the registrant believes on reasonable grounds

(a) that non-compliance is authorized by the patient concerned,

(b) that compliance would:

(i) prejudice the interests of the patient concerned, or

(ii) defeat the purpose or prejudice the use for which the information is collected,

(c) that compliance is not reasonably practicable in the circumstances of the particular case, or

(d) that the information is about law enforcement or anything referred to in sections 15(1) or (2) of the *Freedom of Information and Protection of Privacy Act*.

Manner of Collection of Personal Information

68. Personal information must not be collected by a registrant

(a) by unlawful means, or

(b) by means that in the circumstances intrude to an unreasonable extent upon the personal affairs of the patient concerned.

Accuracy of Personal Information

69. The registrant must make every reasonable effort to ensure that personal information collected about patients is current and is legibly, accurately and completely recorded.

Right to Request Correction of Personal Information

70. (1) A person who believes there is an error or omission in a record containing his or her personal information may request that the registrant having the record in his or her custody or control correct the information.

(2) If, after receiving a request for correction under subsection (1), the registrant disagrees that there is an error or omission in the record, the registrant must note the request in the record with particulars of the correction that was sought.

Use of Personal Information

71. A registrant may use personal information about a patient only

(a) for the purpose of providing health care services to, or performing health, care services for, the patient, or for a related administrative purpose, or

(b) for a use or disclosure consistent with a purpose specified in paragraph (a)

(i) if the patient has consented to the use, or

(ii) for a purpose for which that information may be disclosed by the registrant under section 72 or otherwise under the *Act*.

Disclosure of Personal Information

72. A registrant must maintain confidentiality of personal information

about a patient, and may disclose personal information about a patient only

(a) if the patient concerned has consented to the disclosure,

(b) for the purpose of providing health care services to, or performing health care services for, the patient, or for a related administrative purpose, or for a disclosure consistent with either purpose,

(c) for the purpose of complying with an enactment of, or an arrangement or agreement made under an enactment of, British Columbia or Canada,

(d) for the purpose of complying with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of information,

(e) to an employee of, or contractor providing services to, the registrant, if the information is necessary for the performance of the duties of, or for the protection of the health or safety of, the employee or contractor,

(f) to a lawyer acting for the registrant, for use in civil or criminal proceedings involving the registrant,

(g) if necessary to comply with the *Coroners Act*,

(h) if necessary to comply with the *Ombudsman Act*,

(i) for the purposes of

(i) collecting a debt or fine owing by a patient to the registrant, or

(ii) making a payment owing by the patient to a registrant,

(j) to an auditor, the college or any other person or body authorized by law, for audit purposes,

(k) if the registrant believes on reasonable grounds that there is a risk of significant harm to the health or safety of any person and that the use or disclosure of the information would reduce that risk,

(l) so that the next of kin or a friend of an injured, ill or deceased individual may be contacted,

(m) in accordance with the *Act*, the regulation, or these bylaws, or

(n) as otherwise required by law.

Definition of Consistent Purpose

73. A use or disclosure of personal information is consistent with the purposes of providing health care services to a patient or related

administrative purposes under sections 71 and 72 if the use or disclosure has a reasonable and direct connection to either purpose.

Storage of Personal Information

74. A registrant must ensure that all records pertaining to his or her practice, and containing personal information about patients are safely and securely stored

(a) at the pharmacy, or

(b) off site.

Manner of Disposal of Records

75. A registrant must ensure that records referred to in section 74 are disposed of only by

(a) transferring the record to another registrant, or

(b) effectively destroying a physical record by utilizing a shredder or by complete burning, or

(c) erasing information recorded or stored by electronic methods on tapes, disks or cassettes in a manner that ensures that the information cannot be reconstructed.

Registrant Ceasing to Practice

76. (1) Except where records must be retained for the purpose of Part 3 of the *Act* and Part 3 of the *Pharmacy Operations and Drug Scheduling* Act, in any case where a pharmacy is closed or a registrant ceases to practise, for any reason, the records referred to in section 74 must be transferred in accordance with this Part, and the college must be notified and provided with a written summary of the steps taken to transfer those records.

(2) A registrant must make appropriate arrangements to ensure that, in the event that the registrant dies or becomes unable to practise for any reason and is unable to dispose of records referred to in section 74 those records will be safely and securely transferred to another registrant.

(3) A registrant who transfers records containing personal information about a patient transferred in accordance with subsection (1) or (2) must notify the patient.

Protection of Personal Information

77. (1) A registrant must protect personal information about patients by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal.

(2) A registrant must take reasonable measures to ensure that a third party, including a volunteer, employee or contractor of the registrant, or a limited pharmacist does not access, collect, use, disclose, store or dispose of personal information about patients except in accordance with this Part.

Contracts for Handling Personal Information

78. A registrant must ensure that, if personal information about patients is transferred to any person or service organization for processing, storage or disposal, a contract is made with that person which includes an undertaking by the recipient that confidentiality and physical security will be maintained.

Remedying a Breach of Security

79. A registrant must take appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal information about patients under this Part as soon as possible after the breach is discovered, including

(a) taking steps to recover the personal information or to ensure its disposal if it cannot be recovered,

(b) taking steps to ensure that any remaining personal information is secured,

(c) notifying

(i) anyone affected by the unauthorized access including patients and other health care providers,

(ii) the college, and

(iii) law enforcement officials, if criminal action may have contributed to the unauthorized action, and

(d) modifying existing security arrangements to prevent a re-occurrence of the unauthorized access.

Patient Access to Personal Information

80. (1) For the purposes of this section, **"**access to" means the opportunity to examine or make copies of the original record containing personal information about a patient.

(2) If a patient or a patient's representative makes a request for access to personal information about the patient, the registrant must comply as soon as practical but not more than 45 days following the request by

(a) providing access to the patient or patient's representative,

(b) providing access to the remainder of the personal information if

that information excepted from disclosure under subsection (3) can reasonably be severed, or

(c) providing written reasons for the refusal of access to the personal information or to any portion thereof.

(3) The registrant may refuse to disclose personal information to a patient or a patient's representative

(a) if there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient,

(b) if there is a significant likelihood of harm to a third party, or

(c) if the disclosure could reasonably be expected to disclose personal information regarding another individual.

(4) If a patient or a patient's representative requests a copy of an original record containing personal information about the patient to which a registrant has given the patient or patient's representative access, a copy must be provided if it can reasonably be reproduced.

(5) A registrant may charge a reasonable fee for the reproduction of personal information which does not exceed the fee specified in Schedule "G".

(6) Subject to subsection (3), a patient under 19 years of age may have access to a record if, in the opinion of the registrant, the patient is capable of understanding the subject matter of the record.

(7) Except if authorized by the patient, a registrant must not provide access to the records of a patient who is under 19 years of age to the guardian or parent of the patient if the subject matter of the record is health care which was provided without the consent of a parent or guardian in accordance with the requirements of section 17 of the *Infants Act.*

Part VIII – General
Liability Insurance

81. (1) Each registrant, other than a student registrant or a non-practising registrant, must obtain and at all times maintain professional liability insurance coverage with a limit of liability not less than $2,000,000 insuring against liability arising from an error, omission or negligent act of the registrant.

(2) Each registrant, other than a student registrant or a non-practising registrant, must obtain and at all times maintain professional liability insurance coverage with a limit of liability not less than $2,000,000 insuring against liability arising from an error, omission or negligent act of an employee of the registrant.

Part IX – Marketing and Advertising

Definitions

82. In this Part:

"advertisement" means the use of space or time in a public medium, or the use of a commercial publication such as a brochure or handbill, to communicate with the general public, or a segment thereof, for the purpose of promoting professional services or enhancing the image of the advertiser;

"marketing" includes

(a) an advertisement,

(b) any publication or communication in any medium with any patient, prospective patient or the public generally in the nature of an advertisement, promotional activity or material, a listing in a directory, a public appearance or any other means by which professional services are promoted, and

(c) contact with a prospective client initiated by or under the direction of a registrant.

Marketing and Advertising

83. (1) When advertising pharmacy services that are required by legislation, the statement, “Required in all British Columbia Pharmacies”, must accompany the advertising and must be of the same size and prominence as all other print in the advertising.

(2) Schedule I drug price advertising must include

(a) the proprietary (brand) name, if any, for the drug and/or the device,

(b) the drug product’s generic name and the manufacturer’s name,

(c) the dosage form and strength,

(d) total price for a specific number of dosage units or quantity of the drug product, and

(e) the phrase “only available by prescription”.

(3) Where Schedule I drug price advertising includes direct or indirect reference to a professional fee charged, the total prescription price must also be incorporated into the advertisement, and both figures must be featured equally.

(4) Schedule I drug price advertising must not include any reference to the safety, effectiveness or indications for use of the advertised prescription drug products or compare the fees charged by the

registrant with those charged by another registrant.

(5) Any marketing undertaken or authorized by a registrant in respect of his or her professional services must not be

(a) false,

(b) inaccurate,

(c) reasonably expected to mislead the public, or

(d) unverifiable.

(6) Marketing violates subsection (5) if it

(a) is calculated or likely to take advantage of the weakened state, either physical, mental or emotional, of the recipient or intended recipient,

(b) is likely to create in the mind of the recipient or intended recipient an unjustified expectation about the results which the registrant can achieve,

(c) implies that the registrant can obtain results

(i) not achievable by other registrants,

(ii) by improperly influencing a public body or official, or any corporation, agency or person having any interest in the welfare of the recipient,

(iii) by any other improper means, or

(d) compares the quality of services provided with those provided by another registrant, or a person authorized to provide health care services under another enactment, or another health profession.

(7) The home page of any pharmacy that advertises on a website must clearly show

(a) that the pharmacy is licensed in British Columbia,

(b) the contact information for the college,

(c) a notice to patients that pharmacy practice issues may be reported to the college,

(d) the physical location of the pharmacy operation,

(e) the 10 digit pharmacy telephone number, and

(f) the name of the pharmacy's manager.

Part X – Patient Relations

Patient Relations Program

84. (1) The board must establish a patient relations program to seek to prevent professional misconduct, including professional misconduct of a sexual nature.

(2) For the purposes of the patient relations program, the board must

(a) establish and maintain procedures by which the college deals with complaints of professional misconduct of a sexual nature,

(b) monitor and periodically evaluate the operation of procedures established under subsection (a), and

(c) develop guidelines for the conduct of registrants with their patients.

(3) The registrar must provide information to the public regarding the college's complaint, investigation, and discipline processes.

(4) In this section, "**professional misconduct of a sexual nature**" means

(a) sexual intercourse or other forms of physical sexual relations between the registrant and the patient,

(b) touching of a sexual nature, of the patient by the registrant, or

(c) behavior or remarks of a sexual nature by the registrant towards the patient,

but does not include touching, behavior and remarks by the registrant towards the patient that are of a clinical nature appropriate to the service being provided.

Part XI – Standards of Practice

Community Pharmacy, Hospital Pharmacy, Residential Care Facilities and Homes

85. Standards, limits, and conditions for the practice of the health profession of pharmacy and the provision of pharmacy technician services by registrants, referred to in section 19(1)(k) of the *Act* are established in Parts 1 to 3 of Schedule "F".

Drug Administration

86. Standards, limits, and conditions respecting practising pharmacists and drug administration, referred to in section 19(1)(k) of the *Act*, are established in Part 4 of Schedule "F".

Part XII – Standards of Professional Ethics
Code of Ethics

87. Standards of professional ethics for registrants, including standards

for the avoidance of conflicts of interest, referred to in section 19(1)(l) of the *Act,* are established in Schedule "A".

Appendix 3: Overview of Impact of Proposed HPA Bylaw Amendments on Current Board Members

Proposed Changes:

- **Two years with elections and one without (e.g., four districts in each of first two years, and then a year without elections).**
- **Elected Board members' term length is three years, and maximum consecutive terms is two terms.**

Proposed Corresponding Election Cycle

Election Calendar									
Electoral District	**2017**	**2018****	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
District 1	X		X			X			X
District 2		X			X			X	
District 3	X		X			X			X
District 4		X			X			X	
District 5	X		X			X			X
District 6		X			X			X	
District 7	X		X			X			X
District 8		X			X			X	

** X indicates an election*

*** Beginning of the new Board term of office cycle*

Potential Impact on Existing Board Members*

	Current Term Information			Years									
Elected Board Member	**Start**	**End**	**On Term #**	**2017**	**2018****	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**Total Maximum Years Served**
Mona Kwong (District 1)	21-Nov-15	20-Nov-17	1	X		***X***							Served 4 years (two terms)
Ming Chang (District 2)	21-Nov-14	20-Nov-18	2		***X***								Served 4 years (two terms)
Tara Oxford (District 3)	21-Nov-15	20-Nov-17	1	X		***X***							Served 4 years (two terms)
Christopher Szeman (District 4)	18-Nov-16	17-Nov-18	1		X			***X***					Served 5 years (two terms)
Frank Lucarelli (District 5)	21-Nov-15	20-Nov-17	1	X		***X***							Served 4 years (two terms)
Anar Dossa (District 6)	16-Nov-12	14-Nov-18	3		***X***								Served 6 years (three terms)
Arden Barry (District 7)	21-Nov-15	20-Nov-17	1	X		***X***							Served 4 years (two terms)
Sorell Wellon (District 8)	4-Apr-16	18-Nov-18	1		X			***X***					Served 5 years (two terms)

** Assumes that eligible elected Board members run for election and become elected.*

*** Beginning of the new Board term of office cycle*

X *Indicates the final year that the elected Board member would be eligible to serve*

SCHEDULE OF AMENDMENTS

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended to extend the term of office of elected board members as follows:

1. Section 4.(1) is repealed and replaced with the following:

   An election under section 17(3)(a) of the *Act* must be held by electronic means approved by the registrar, at a date determined by the registrar that is at least 21 days prior to the date of the November board meeting in each year that an election is held.

2. Section 7.(1) is repealed and replaced with the following:

   The term of office for an elected board member is 3 years, commencing at the start of the November board meeting following that board member's election.

3. Section 7.(2) is repealed and replaced with the following:

   An elected board member may serve a maximum of 2 consecutive terms.

4. Section 7.(3) is repealed and replaced with the following:

   Subsections (1) and (2) do not apply prior to the first election referred to in section 17(2)(a) of the *Act*.

5. Section 7.(4) is repealed.

6. The following new subsection has been added after section 7.(3):

   Election Cycle

   7.1 Commencing with the 2018 elections, elections shall follow a three-year cycle, pursuant to which board members from even-numbered electoral districts are elected in the first year of the cycle, board members from odd-numbered electoral districts are elected in the second year of the cycle, and no election is held in the third year of the cycle.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

8. Legislation Review Committee
e) Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine (Amendments to PPP-66)

DECISION REQUIRED

Recommended Board Motions:

(1) Approve amendments to Professional Practice Policy (PPP) 66 Methadone Maintenance Treatment, to be effective on January 1, 2018.

(2) Approve the following two new PPP 66 Policy Guides, to be effective on January 1, 2018:

- PPP 66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)
- PPP 66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)

Purpose

To approve the following policy changes to be effective on January 1, 2018:

- Amendments to PPP-66 Methadone Maintenance Treatment
- PPP-66 Policy Guide Buprenorphine/Naloxone Maintenance Treatment (2018)
- PPP-66 Policy Guide Slow Release Oral Morphine Treatment (2018)

Background

The BC Centre on Substance Use (BCCSU) is a new provincially networked organization with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction. As of June 5, 2017, the BCCSU is responsible for the educational and clinical care guidance activities for all health care professionals who are prescribing medications to treat opioid addiction (e.g., methadone, buprenorphine/naloxone, slow release oral morphine).

In June 2017, the BCCSU released, *"A Guideline for the Clinical Management of Opioid Use Disorder"*[1] (the 2017 BCCSU Guideline), which is the new provincial clinical practice guideline for all clinicians who wish to prescribe oral opioid agonist treatments (OAT) (i.e., methadone,

[1] BCCSU guideline, http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

buprenorphine/naloxone, slow release oral morphine) for treatment of patients with opioid use disorder. This guideline replaces the previous provincial guideline released by the College of Physicians and Surgeons of BC, *"Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder".*

The new guideline aims to help address the provincial opiate drug overdose crisis.

Discussion

The College has requirements in place for methadone when used as an OAT drug. However, with the release of the BCCSU guidelines, a gap in policy exists in which there are no specific requirements regarding the two other OAT drugs – slow release oral morphine (SROM) and buprenorphine/naloxone (commonly known as Suboxone). These OAT medications are currently being prescribed and dispensed. And, the absence of requirements for safe dispensing of these drugs can lead to patient safety concerns. Therefore, staff have been establishing minimum requirements for dispensing SROM and buprenorphine/naloxone to complement the existing methadone requirements.

It is important to note that methadone requirements were not revised as part of the development of the new SROM and buprenorphine/naloxone requirements. Updating the methadone policy is on the College's current operational plan, and more time is required before these polices can be revised.

In establishing the minimum requirements for safe dispensing of SROM and buprenorphine/naloxone, College staff reviewed the existing policy and policy guide for methadone. The goal was to identify which existing methadone requirements should apply to SROM and buprenorphine/naloxone. Staff also reviewed the 2017 BCCSU Guideline. Stemming from this review, an initial draft of SROM and buprenorphine/naloxone requirements was produced.

The College also contracted a subject matter expert, Dr. Ahmad Ghahary, to support the development of the new requirements regarding SROM and buprenorphine/naloxone. Dr. Ghahary provided advice on what the new practice requirements should include, reviewed the initial draft to identify any gaps, and recommended additional requirements (See Appendix 1 for Dr. Ahmad's biography).

The draft policies included many requirements from the methadone policy requirements with the following noted differences:

- Duplicative requirements from existing legislation were not included (e.g. privacy and confidentiality requirements which are already requirements in the *Health Professions Act Bylaws, Schedule F-Standards of Practice, Part 1- Community Pharmacy*);

- The regular Controlled Prescription Form will be required, and not the Methadone Controlled Prescription Form (which is specific to methadone);
- Faxed Controlled Prescription forms are not accepted with SROM and buprenorphine/naloxone, in accordance with the Controlled Prescription Program; and,
- Alterations to the Controlled Prescription forms are not accepted with SROM and buprenorphine/naloxone, in accordance with the Controlled Prescription Program.

Consultations

After Dr. Ghahary's review, the following groups reviewed and provided input on them:

- BCCSU;
- The College's Community Pharmacy Advisory Committee (CPAC); and
- The BC Pharmacy Association.

During the consultations, positive feedback was received on the requirements from all three groups along with feedback requesting minor changes.

SROM

During the consultations, a few concerns were raised by the BCCSU regarding existing requirements of the Controlled Prescription Program (CPP). The first concern was related to *Health Professions Act Bylaws, Schedule F-Standards of Practice, Part 1- Community Pharmacy* bylaws[2] which states that faxed CPP prescriptions cannot be accepted. The second concern was related to the CPP requirement, which states that all CPP prescriptions are "void after 5 days" [3]. This means that the prescription cannot be honoured after midnight of the fifth day following the date of issue. Therefore, a prescription written on January 10th can be accepted for filling or logging on until midnight January 15th.

Staff advised the BCCSU that a steering committee for the CPP has recently been established, consisting of all CPP participants (i.e., relevant Colleges). Both of the BCCSU's concerns will be taken to the next steering committee meeting for discussion. This committee may find it appropriate to review the CPP faxing prohibition and "void after 5 days" requirement, in the future.

Buprenorphine/Naloxone

Some changes were also proposed to the requirements for buprenorphine/naloxone during the consultations. For example, it was initially determined that daily witness ingestion of buprenorphine/naloxone would be required; however, through the feedback received during

---

[2] Section 7(3) of the *Health Professions Act Bylaws, Schedule F-Standards of Practice, Part 1- Community Pharmacy*: A registrant must not dispense a prescription authorization received by facsimile transmission for a drug referred to on the Controlled Prescription Drug List.

[3] CPP, http://library.bcpharmacists.org/6_Resources/6-4_Drug_Distribution/5015-ControlledPrescriptionProgram.pdf

consultations, this requirement was amended to require daily dispensing unless otherwise determined by the prescriber. The reasoning for this is due to the relatively low risk for misuse and adverse events associated with buprenorphine/naloxone. The 2017 BCCSU Guideline recommends daily witnessed ingestion of buprenorphine/naloxone; however, it also states that data of improved outcomes associated with daily witnessed ingestion of buprenorphine/naloxone is lacking and some data suggests that more flexible take-home dosing improved adherence and retention[4]. During the consultation with the BCCSU, they supported daily dispensing of this drug instead of daily witnessed ingestion. As a result, buprenorphine/naloxone prescriptions will not be required to be daily witnessed. If a prescriber orders daily witnessed ingestion, then the pharmacist must directly observe the patient placing the medication under his/her tongue. As a guideline, pharmacists should give patients instructions on how to take the dose (e.g., instruct the patient to place and hold the tablet under their tongue until it fully dissolves, advising them that this may take up to 10 minutes). The patient can leave the pharmacy once the pharmacist has directly observed the patient placing the medication under his/her tongue.

Policy vs Bylaw

Given the public safety risk associated with SROM and buprenorphine/naloxone being dispensed in the absence of specific requirements for safe dispensing of these drugs, the College felt it important to develop a position on this issue as soon as possible. As such, the existing PPP-66 Methadone Maintenance Treatment has been amended to include both the two new OAT drugs and the policy has been renamed to Opioid Agonist Treatment (see Appendix 2).

The final requirements for both drugs are in the form of two policy guides – Professional Practice Policy # 66 Policy Guide: Slow Release Oral Morphine Maintenance Treatment (2018) and Professional Practice Policy # 66 Policy Guide: Buprenorphine/Naloxone Maintenance Treatment (2018) (see Appendix 3 and 4). Both these policy guides are referenced in the revised PPP-66.

The policy and policy guides will be transitioned to bylaws as per the College's Operational Plan.

Next Steps

- Communicate and implement new policy requirements for January 1, 2018.
- Revise the Methadone Maintenance Treatment additional resources webpage on the internet with the Communications Department. [5]
- Transitioning the OAT requirements to bylaws.

[4] Page 54 of BCCSU guideline, http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

[5] Methadone Maintenance Treatment Webpage, http://www.bcpharmacists.org/methadone-maintenance-treatment-mmt

Recommendation

The Legislation Review Committee recommends that the Board approve the amendments to PPP-66 and approve two new accompanying policy guides, PPP # 66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018) and PPP # 66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018), all to be effective on January 1, 2018.

Appendix	
1	Dr. Ahmad Ghahary's Biography
2	Amended PPP-66 Opioid Agonist Treatment (track changes and clean)
3	New PPP # 66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)
4	New PPP # 66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)

Dr. Ahmad Ghahary's Biography

Dr. Ahmad Ghahary is a community pharmacist with 6 years of experience working in the area of mental health and addictions in Vancouver's Downtown Eastside. Dr. Ahmad's educational credentials include a BSc.Pharm and Community Pharmacy Residency from the University of British Columbia and a Pharm.D from the University of Toronto. Dr. Ghahary also owns a community pharmacy, 'Community Apothecary' and works with the PHS Community Services Society.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

Effective January 1, 2018:

1. Buprenorphine/Naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The College of Pharmacists of British Columbia (CPBC) Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to buprenorphine/naloxone maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Buprenorphine Maintenance Treatment Policy Guide (2018) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*A Guideline for the Clinical Management of Opioid Use Disorder"*,
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

Effective February 1, 2014:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation. ***Note: Refer to the transition period requirements.***

2. The CPBC Methadone Maintenance Treatment Policy Guide (2013) is in force.

3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to methadone maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Methadone Maintenance Treatment Policy Guide (2013) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of College of Physicians and Surgeons of BC's (CPSBC) Methadone Maintenance Handbook,
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs
    d) successfully complete the mandatory CPBC MMT training program (2013),
    e) record self-declaration of training completion in eServices prior to dispensing the 10mg/ml preparation.

4. Upon completion of the mandatory CPBC MMT training program pharmacy managers must educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to methadone maintenance treatment. (Note: documentation forms that confirm the education of individual non-pharmacist staff members must be signed and dated by the community pharmacy manager and the non-pharmacist staff member and retained in the pharmacy files).

Implementation Timeline
Effective February 1, 2014:
All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to MMT must:

- have successfully completed the mandatory CPBC MMT training program, and
- have implemented all necessary practice requirements identified in the CPBC Methadone Maintenance Treatment Policy Guide (2013).

Transition Period
February 1, 2014 – February 28, 2014:
During this period, pharmacists must:

- transition their patients from 1mg/ml to the commercially available 10mg/ml methadone oral preparation, obtain new MMT prescriptions from physicians,
- educate patients about safety concerns (eg.10 times concentration),
- educate patients about appropriate security and storage (eg. does not require refrigeration and must be stored securely because of increased strength), and
- manage inventory, create a plan and document appropriate methadone powder return. Documentation must be available for review by College inspectors.

Effective March 1, 2014

- All methadone maintenance treatment prescriptions must be dispensed with the commercially available 10mg/ml methadone oral preparation.

The Methadone Maintenance Policy Statements must be read in conjunction with PPP-71 Delivery of Methadone Maintenance Treatment.

Required References

In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions
- The most recent version of the CPSBC Methadone Maintenance Handbook

- Most current edition of Methadone Maintenance: A Pharmacist's Guide to Treatment, Centre for Addiction and Mental Health
- Product monographs for the commercially available 10mg/ml methadone oral preparations

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

Effective January 1, 2018:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths.
2. The College of Pharmacists of British Columbia (CPBC) Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to slow release oral morphine maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*A Guideline for the Clinical Management of Opioid Use Disorder"*,
    c) be familiar with the information included in the product monographs of approved, commercially available strengths.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

Effective January 1, 2018:

1. Buprenorphine/Naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The College of Pharmacists of British Columbia (CPBC) Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to buprenorphine/naloxone maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Buprenorphine Maintenance Treatment Policy Guide (2018) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*A Guideline for the Clinical Management of Opioid Use Disorder*",
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENT~~(~~S~~)~~:

Effective February 1, 2014:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation. ***Note: Refer to the transition period requirements.***

2. The ~~College of Pharmacists of British Columbia (~~CPBC~~)~~ Methadone Maintenance Treatment Policy Guide (2013) is in force.

3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to methadone maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Methadone Maintenance Treatment Policy Guide (2013) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of College of Physicians and Surgeons of BC's (CPSBC) Methadone Maintenance Handbook,
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs
    d) successfully complete the mandatory CPBC MMT training program (2013),
    e) record self-declaration of training completion in eServices prior to dispensing the 10mg/ml preparation.

4. Upon completion of the mandatory CPBC MMT training program pharmacy managers must educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to methadone maintenance treatment. (Note: documentation forms that confirm the education of individual non-pharmacist staff members must be signed and dated by the community pharmacy manager and the non-pharmacist staff member and retained in the pharmacy files).

Implementation Timeline
Effective February 1, 2014:
All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to MMT must:

- have successfully completed the mandatory CPBC MMT training program, and
- have implemented all necessary practice requirements identified in the CPBC Methadone Maintenance Treatment Policy Guide (2013).

Transition Period
February 1, 2014 – February 28, 2014:
During this period, pharmacists must:

- transition their patients from 1mg/ml to the commercially available 10mg/ml methadone oral preparation, obtain new MMT prescriptions from physicians,
- educate patients about safety concerns (eg.10 times concentration),
- educate patients about appropriate security and storage (eg. does not require refrigeration and must be stored securely because of increased strength), and
- manage inventory, create a plan and document appropriate methadone powder return. Documentation must be available for review by College inspectors.

Effective March 1, 2014

- All methadone maintenance treatment prescriptions must be dispensed with the commercially available 10mg/ml methadone oral preparation.

Th~~is~~e Methadone Maintenance P~~p~~olicy Statements must be read in conjunction with PPP-71 Delivery of Methadone Maintenance Treatment.

Required References

In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions
- The most recent version of the CPSBC Methadone Maintenance Handbook

- Most current edition of Methadone Maintenance: ~~-~~A Pharmacist's Guide to Treatment, Centre for Addiction and Mental Health
- Product monographs for the commercially available 10mg/ml methadone oral preparations

~~**BACKGROUND:**~~

~~Opioid dependence is a health concern with implications for the individual and the public. Methadone maintenance treatment has a proven track record for managing opioid dependency. Effective delivery of methadone maintenance treatment reduces non-medical opioid use, other problematic substance use, criminal activity, mortality, injection-related risks and transmission of blood-borne disease. Additional positive results are improvement in physical and mental health, social functioning, quality of living and pregnancy outcomes.~~

~~The purpose of the policy requirements is to ensure that:~~

- ~~Patients have access to standardized methadone treatment pharmacy services~~
- ~~Patients experience reduced risk potential while receiving methadone maintenance treatment services~~
- ~~Pharmacists have up-to-date knowledge and information to meet their patients' needs~~
- ~~Pharmacies have adequate resources and capacity~~
- ~~Communities accept and value pharmacies' methadone treatment programs~~

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

Effective January 1, 2018:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths.
2. The College of Pharmacists of British Columbia (CPBC) Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to slow release oral morphine maintenance treatment must:

    a) know and apply the principles and guidelines outlined in the CPBC Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018) and all subsequent revisions,
    b) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*A Guideline for the Clinical Management of Opioid Use Disorder*",
    c) be familiar with the information included in the product monographs of approved, commercially available strengths.

College of Pharmacists of British Columbia

Professional Practice Policy #66

Policy Guide

Slow Release Oral Morphine (SROM) Maintenance Treatment (2018)

Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide

All pharmacy managers, staff and relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to SROM maintenance treatment must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC's (CPBC) SROM Maintenance Treatment Policy Guide (2018) and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily witness ingestion or daily dispense (i.e. 7 days per week) the pharmacy hours of service need to accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for SROM maintenance treatment from 'daily witness' to a 'take-home' dose.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take SROM. SROM pellets must be swallowed whole. Crushing, chewing, or dissolving slow-release oral morphine capsules or pellets can cause rapid release and absorption of a potentially fatal dose of morphine sulfate.

See Principle 4.1.4 for detailed administration requirements.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, craving, and/or non-medical opioid use.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the new guideline to the BCCSU website. Recommend completion of online training through the Provincial Opioid Addiction Treatment Support Program (https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program).

2.0 Receiving SROM Prescriptions

2.1 Controlled Prescription Program Forms – Overview

Principle 2.1.1 SROM prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting SROM prescriptions, the pharmacist must ensure that the Controlled Prescription Program Form is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) SROM Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 SROM for maintenance must be dispensed in approved, commercially available strengths. Capsule contents cannot be split.

Guideline: Only the once-daily, 24-hour formulation of SROM has been studied in clinical trials for the treatment of opioid use disorder. Other formulations of oral morphine, such as twice-daily, 12-hour sustained- or extended-release formulations, have not been empirically studied in this context and are not recommended.

Principle 3.1.2 Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient, to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g. weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Pharmacists and pharmacy technicians must correctly identify the product as prescribed for "pain" or "Opioid Agonist Treatment (OAT)" by using the appropriate Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

Guideline: Effective June 5, 2017, PharmaCare established new PINs for the use of Kadian® SROM as OAT. These PINs are to be used when submitting claims for the various dosing strengths through PharmaNet. Similar to methadone, the current Drug Identification Numbers (DINs) will be used by pharmacists exclusively for claims for analgesia, and the new PINs will be used for claims for OAT.

Prescriptions for Kadian® should specify whether it is designated for analgesia or OAT (i.e., "for OAT" or "for opioid agonist treatment" is to be indicated on the prescription). If there is a question as to whether the prescription is for OAT (i.e., indicated by the dose strength, directions to "open and sprinkle" capsules for daily witnessed ingestion, or other elements of the prescription), but the prescription lacks the explicit indication "for OAT", the pharmacist should contact the prescriber to confirm the intended use prior to dispensing the medication and properly document any alteration of the prescription.

The claim entered into PharmaNet should match the prescription written by the prescriber. If a claim marked "for OAT" has been entered under the DIN rather than under the new PIN for Kadian® for OAT, it must be reversed, following the full standard procedure for reversing a claim entered under the wrong DIN or PIN. Only after a claim has been reversed can it then be re-entered with the correct PIN.

Principle 3.2.2 As with all medications a pharmacist must review each individual PharmaNet patient record, as stated in HPA Bylaws (Schedule F Part 1), and resolve any drug-related problems prior to dispensing any SROM prescription. This step is particularly critical for SROM for OAT prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system **does not include SROM for OAT**.

Pharmacists providing SROM for OAT maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to SROM.

Guideline: A PharmaNet patient record review should be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of SROM and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the SROM maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the SROM maintenance program. Co-ingestion of SROM with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing SROM for OAT Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the SROM prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a SROM prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a SROM prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *SROM Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

Principle 4.1.4 With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

Guideline: SROM has a high risk of diversion, even when administered as witnessed doses (e.g., intact capsules can be 'cheeked' or 'palmed').

To reduce the risk of diversion, daily witnessed ingestion doses should be prepared by opening the capsule(s) and sprinkling the enclosed pellets for immediate ingestion. The patient should be instructed that pellets must not be chewed or crushed.

Pellets may be sprinkled into a 30 mL medicine cup or small cup followed by at least 30 mL of water to ensure that all pellets have been swallowed.

Immediately following observing the patient's ingestion of the medication, the pharmacist should ensure that the entire dose has been swallowed. This may include: engaging the patient in short conversation, asking the patient if there are pellets remaining in their teeth or gums, offering additional water for rinsing, or inspecting the inside of the patient's mouth.

Important Safety Notice: SROM pellets must be swallowed whole. Crushing, chewing, or dissolving slow-release oral morphine capsules or pellets can cause rapid release and absorption of a potentially fatal dose of morphine sulphate.

Principle 4.1.5 If take home doses (carries) are prescribed, the first dose must be a witnessed ingestion. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Note that the majority of prescriptions for slow-release oral morphine will be for daily witnessed ingestion (DWI). In exceptional cases, patients may be transitioned to take-home dosing schedules. If a patient's prescription indicates transition to a take-home dosing schedule for SROM, it is best practice to call and confirm with the prescriber.

Compliance packaging (e.g. blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy still needs to ensure that the medications are provided in child-resistant packaging.

Patients should be reminded that SROM should be stored out of the reach of children, preferably in a locked cupboard or small lock box.

5.0 Responding to SROM Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any SROM prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up SROM doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses (unless a specified number of missed doses has been indicated by the prescriber) before the next witnessed ingestion. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication Form* (Appendix 2) can be used for this purpose.

Principle 5.1.4 If a patient misses 2 or more consecutive doses, the prescription must be cancelled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to 'Appendix 2: Induction and dosing guidelines for Slow Release Oral Morphine' of the BCCSU's 'A Guideline for the Clinical Management of Opioid Use Disorder'.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The Pharmacist-Prescriber Communication Form (Appendix 2) can be used for the documentation and communication.

The SROM Part-Fill Accountability Log (Appendix 1) can be used for the Part-Fill Accountability Log.

5.3 Vomited Doses

Principle 5.3.1 If a patient reports that they vomited their dose, a replacement dose cannot be provided. The pharmacist must notify the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Lost or Stolen Doses

Principle 5.4.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.5 Tapering

Principle 5.5.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/ prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication form* (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

SROM Part-Fill Accountability Log

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their buprenorphine/naloxone dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

College of Pharmacists of British Columbia

College of Pharmacists
of British Columbia

Professional Practice Policy #66

Policy Guide

Buprenorphine/Naloxone Maintenance Treatment (2018)

Buprenorphine/Naloxone Maintenance Treatment Policy Guide

All pharmacy managers, staff and relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to Buprenorphine/Naloxone maintenance treatment (BMT) must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC's (CPBC) Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018) and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily dispense (i.e. 7 days per week) the pharmacy hours of service need to accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for Buprenorphine/Naloxone maintenance treatment from 'daily dispense' to a 'take-home' dose.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take Buprenorphine/Naloxone tablets.

Guideline: For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. Avoid swallowing, talking, eating, drinking, and smoking.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, cravings, and/or non-medical opioid use. Educate on risks of precipitated withdrawal during Buprenorphine/Naloxone induction. Educate patients on the inclusion of naloxone in Buprenorphine/Naloxone formulations and its purpose to deter use in a manner not intended as prescribed.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the new guideline to the BCCSU website. Recommend completion of online training through the Provincial Opioid Addiction Treatment Support Program (https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program).

2.0 Receiving Buprenorphine/Naloxone Prescriptions

2.1 Controlled Prescription Program Forms - Overview

Principle 2.1.1 Buprenorphine/Naloxone prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting Buprenorphine/Naloxone prescriptions, the pharmacist must ensure that the Controlled Prescription Program Form is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) Buprenorphine/Naloxone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Buprenorphine/Naloxone for maintenance must be dispensed to patients as an approved, commercially available formulation.

Guideline: Buprenorphine/Naloxone is currently available in multiple strengths of sublingual formulations. Tablets can be halved and/or combined to achieve target doses.

Principle 3.1.2 Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g. weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily dispense, take-home doses), including the specific days of the week for each dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of Buprenorphine/Naloxone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the Buprenorphine/Naloxone maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the Buprenorphine/Naloxone maintenance program. Co-ingestion of Buprenorphine/Naloxone with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing Buprenorphine/Naloxone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the Buprenorphine/Naloxone prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a Buprenorphine/Naloxone prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a Buprenorphine/Naloxone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *Buprenorphine/Naloxone Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

Principle 4.1.4 If a prescriber orders the Buprenorphine/Naloxone for daily dispense, the pharmacist is not required to observe the patient ingesting the dose. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: If the prescription states daily dispense, the patient may ingest the dose without pharmacist observation.

Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. Avoid swallowing, talking, eating, drinking, and smoking.

Principle 4.1.5 If a prescriber orders the Buprenorphine/Naloxone to be dispensed as a "Daily Witnessed Ingestion" or "DWI", the pharmacist must directly observe the patient placing the medication under the tongue. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves - this may take up to 10 minutes. Avoid swallowing, talking, eating, drinking, and smoking.

The patient is not required to remain in the pharmacy once the pharmacist has directly observed the patient placing the medication under the tongue.

Principle 4.1.6 If take home doses (carries) are prescribed, the first dose does not need to be witnessed, unless ordered by the prescriber. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Compliance packaging (e.g. blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy must still ensure that the medications are provided in child-resistant packaging.

Patients should be reminded that Buprenorphine/Naloxone should be stored out of the reach of children, preferably in a locked cupboard or small lock box.

5.0 Responding to Buprenorphine/Naloxone Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any Buprenorphine/Naloxone prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up Buprenorphine/Naloxone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses (unless a specified number of missed doses has been indicated by the prescriber) before the next witnessed ingestion. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The Pharmacist-Prescriber Communication Form (Appendix 2) can be used for this purpose.

Principle 5.1.4 If a patient misses 6 or more consecutive days, the prescription must be canceled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to 'Appendix 2: Induction and dosing guidelines for Buprenorphine/Naloxone' of the BCCSU's 'A Guideline for the Clinical Management of Opioid Use Disorder'.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The Pharmacist-Prescriber Communication Form (Appendix 2) can be used for the documentation and communication.

The Buprenorphine/Naloxone Part-Fill Accountability Log (Appendix 1) can be used for the Part-Fill Accountability Log.

5.3 Lost or Stolen Doses

Principle 5.3.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Tapering

Principle 5.4.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/ prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The Pharmacist-Prescriber Communication form (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

Buprenorphine/Naloxone Part-Fill Accountability Log

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their buprenorphine/naloxone dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

College of Pharmacists of British Columbia

College of Pharmacists of British Columbia

8. Legislation Review Committee

Jeremy Walden

Chair, Legislation Review Committee

College of Pharmacists of British Columbia

8 a) Mandatory Medication Error Reporting

Presentation to Council, College of Pharmacists of British Columbia

Friday November 17, 2017

Canada | Toronto

GO PUBLIC | Parents find son's lifeless body after pharmacy switches sleep medication for toxic dose of another drug

Boy's mother wants legislation that would force pharmacies to make prescription errors public

By Rosa Marchitelli, CBC News Posted: Oct 20, 2016 5:00 AM ET | Last Updated: Oct 21, 2016 9:20 AM ET

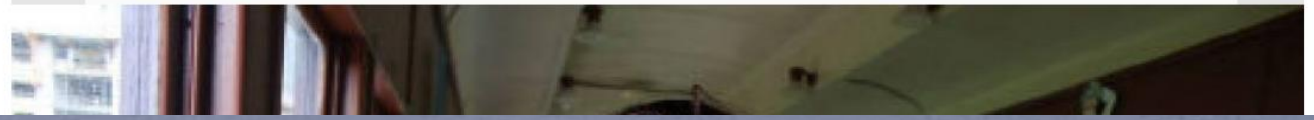
October/November 2016

thestar.com

News · Canada

Ontario health minister vows increased transparency for pharmacy errors

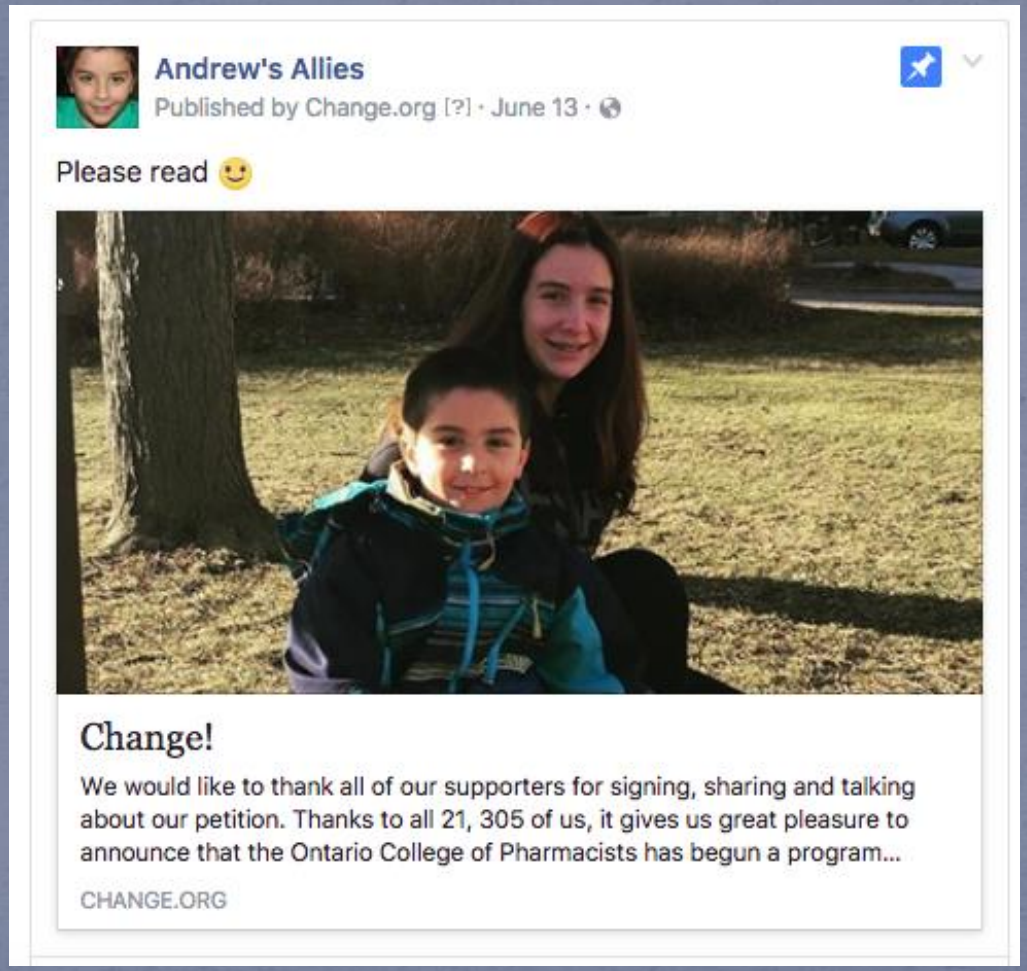
Mother of boy who died after allegedly being administered wrong drug says she's encouraged by meeting



News / Canada

Mother of boy who died from wrong medication calls for better reporting of pharmacy errors

My Campaign for Change in Ontario



Petition on Change.org began in September 2016 and garnered more than 21 000 signatures from Canada, the U.S. and across the world.

Why a CQI?

"There needs to be a greater focus on reporting errors and using that information to learn and improve."

Sandi Kossey, Sr. Director at CPSI

"We don't have good data to define how big the problem is yet…The optimal next step is to see the Nova Scotia model spread across Canada so we can get a national picture of prescription error reporting."

Sylvia Hyland, Sr. Director with ISMP

Who is Andrew?

Andrew John Sheldrick

June 19, 2007 – March 13, 2016

Andrews Allies

@melshel73

College of Pharmacists of British Columbia

Background

- There have been recent high profile cases of medication errors in Canada.
- Several provinces are implementing new quality management requirements, including mandatory error reporting.
- Mandatory error reporting involves submitting error reports anonymously to an independent third party.
- Error reports are analyzed for shared learning instead of discipline.

College of Pharmacists of British Columbia

Current State

- The PODSA Bylaws require community and hospital pharmacies to have:
  - An ongoing quality management program, including a process for reporting, documenting and following up errors.
- The requirements of the program are left to the discretion of the pharmacy manager.
- The College does have oversight over quality management through the PRP.

College of Pharmacists of British Columbia

Interjurisdictional Scan

Province	Status
Nova Scotia	The only province that has mandatory error reporting.
Saskatchewan	In 2018, is expected to implement new quality management requirements, including mandatory error reporting.
Ontario	In 2018, is expected to implement new quality management requirements, including mandatory error reporting.
Manitoba	In 2017, began a pilot project that includes mandatory error reporting.
New Brunswick	In 2016, completed a pilot project that analyzed mandatory error reporting.

College of Pharmacists of British Columbia

Potential Service Providers

- Institute of Safe Medication Practices Canada (ISMP Canada) is an independent national not-for-profit organization focused on the advancement of medication safety in healthcare settings.
- Pharmapod is a U.K. and Ireland based company based that provides software for tracking pharmacy medication incidents.
- Both companies have expressed an interest in working with the College on a pilot project in B.C.

College of Pharmacists of British Columbia

8 a) Mandatory Medication Error Reporting

Motion:

Direct the Registrar to explore potential alternatives to the College's existing quality management requirements, including mandatory medication error reporting to an independent third party.

College of Pharmacists of British Columbia

8 b) Committee Update

College of Pharmacists of British Columbia

Committee Update

October 18, 2017 Meeting

- Reviewed and recommended two items for Board approval:
  - Mandatory Medication Error Reporting (Board approval)
  - PODSA Bylaws – Owners (Filing)
  - HPA Bylaws - Board Terms of Office (Filing)
  - Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine (Amendments to PPP-66) (Board approval)
- Reviewed and discussed the Legislation Operational Plan.

College of Pharmacists of British Columbia

Committee Update, continued

Key Upcoming Committee Work

- Review draft bylaws regarding electronic documentation (e.g., document scanning) in 2018.
- Potential recommendation for Board approval at their February 2018 meeting.

College of Pharmacists of British Columbia

8 c) PODSA Bylaws – Owners (Filing)

College of Pharmacists of British Columbia

Amendments to *Pharmacy Operations and Drug Scheduling Act* (PODSA)

Background

- On May 19, 2016, amendments to PODSA were given Royal Assent.
- These amendments:
  - Apply to pharmacy ownership;
  - Allow the College to require information about pharmacy owners;
  - Allow the College determine their suitability for pharmacy ownership; and
  - Hold owners accountable for providing safe and effective care by ensuring their pharmacies are compliant with legislative requirements for pharmacies in BC.

College of Pharmacists of British Columbia

Proposed Ownership Amendments

- Amendments to the PODSA Bylaws (including forms and schedules) have been made to operationalize the new Act changes.
- The Board approved the proposed bylaws for a 90-day legislated public posting period at the June 2017 Board meeting. This public posting period ended on September 23, 2017.

College of Pharmacists of British Columbia

Public Posting

- During the public posting period, seven responses were received from:
  - The BC Pharmacy Association (BCPhA);
  - Chain Drug Association of BC;
  - London Drugs; and
  - Four registrants.
- In general, the concerns with the proposed bylaws were minor in nature.
- College and Ministry of Health staff reviewed all feedback received.
- Some minor revisions are recommended, stemming from feedback and further staff review.

College of Pharmacists of British Columbia

Recommended Amendments to Bylaws

Feedback	Staff Review / Recommendation
Include definitions of “Central Securities Register”, “British Columbia Company Summary” and “pharmacy”.	Recommend changes to bylaws to include these definitions for clarity.
Amend the roles and responsibilities of direct owners, directors and officers to use language such as “ensure compliance” as opposed to “must comply with”.	Recommend changes to bylaws regarding the roles and responsibilities of direct owners, directors and officers to reflect the oversight role of owners (direct and indirect).
Bylaws should be drafted to prevent the “technical cancellation” of a pharmacy licence if a direct owner ceases to be eligible under the Act and Bylaws.	Recommend new bylaws to address instances when a change in direct owner occurs without notice (e.g., received a criminal conviction), which would allow the Application Committee to authorize the continued operation of the pharmacy in certain circumstances (e.g., if a criminal charge wasn’t relevant to pharmacy ownership and there is no risk to public safety).

College of Pharmacists of British Columbia

Recommended Amendments to Bylaws

Feedback	Staff Review / Recommendation
Highly sensitive information is being collected by the College (particularly for criminal record history checks). It is anticipated that the College will engage in rigorous standards of security, limited access, appropriate retention.	New bylaws about the College's use, disclosure and retention of criminal record history information were drafted. Includes a definition of "criminal record history" which is recommended to provide transparency about the source of the criminal record history information.

College of Pharmacists of British Columbia

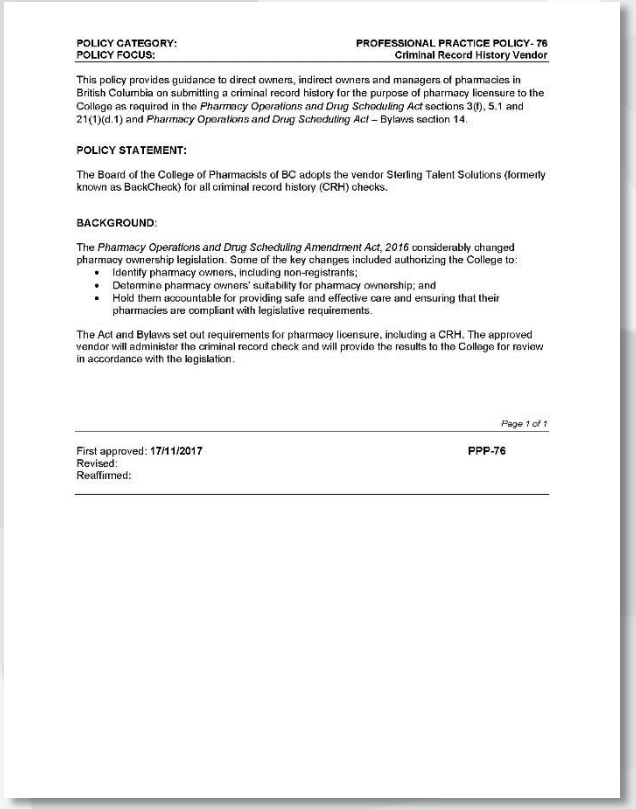
Recommended Additional Amendments to Forms and Schedules

Recommended Change to Form(s) / Schedules	Rationale
Change “Proposed Opening Date” to “Proposed Licensure Date”.	A proposed licensure date is a more static date.
Add a new field to all community pharmacy related forms, to include the store number.	For pharmacy chains, such as Shoppers Drug Mart, the operating name includes the store number.
Add a new field to *Form 8F- Application for Change of Location* to include the “Expected Closing Date”.	The College can determine if there is a significant gap between the “Expected Closing Date” and “Expected Opening Date”. If so, all drugs and patient records must be secured in the interim.
Remove all bylaw references from *Form 10- Pharmacy Pre-Opening Inspection Report*.	To avoid duplicating bylaws in the Form.
Remove Schedule *“C” – Community Pharmacy Diagram and Photos/Videos* and transition it to an operational checklist.	To avoid duplicating bylaws and policies.

College of Pharmacists of British Columbia

New Professional Practice Policy (PPP- 76 Criminal Record History Vendor)

New



POLICY CATEGORY: PROFESSIONAL PRACTICE POLICY- 76
POLICY FOCUS: Criminal Record History Vendor

This policy provides guidance to direct owners, indirect owners and managers of pharmacies in British Columbia on submitting a criminal record history for the purpose of pharmacy licensure to the College as required in the *Pharmacy Operations and Drug Scheduling Act* sections 3(f), 5.1 and 21(1)(d.1) and *Pharmacy Operations and Drug Scheduling Act* – Bylaws section 14.

POLICY STATEMENT:

The Board of the College of Pharmacists of BC adopts the vendor Sterling Talent Solutions (formerly known as BackCheck) for all criminal record history (CRH) checks.

BACKGROUND:

The *Pharmacy Operations and Drug Scheduling Amendment Act, 2016* considerably changed pharmacy ownership legislation. Some of the key changes included authorizing the College to:

- Identify pharmacy owners, including non-registrants;
- Determine pharmacy owners' suitability for pharmacy ownership; and
- Hold them accountable for providing safe and effective care and ensuring that their pharmacies are compliant with legislative requirements.

The Act and Bylaws set out requirements for pharmacy licensure, including a CRH. The approved vendor will administer the criminal record check and will provide the results to the College for review in accordance with the legislation.

Page 1 of 1

First approved: **17/11/2017** **PPP-76**
Revised:
Reaffirmed:

- The PODSA amendments give the College bylaw making authority to determine the form in which a CRH must be submitted.
- This new PPP will adopt Sterling Talent Solutions as the vendor to conduct CRH checks.
- The policy will be effective when the Act and bylaws come into force.

College of Pharmacists of British Columbia

Consequential Amendments to Existing PPP's

- A number of new PODSA bylaws have been added and existing bylaws have been re-organized.
- The following PPP's have been amended to reflect the new numbering of bylaws:
  - PPP-3 Pharmacy References
  - PPP-12 Prescription Hard Copy File Coding System
  - PPP-46 Temporary Pharmacy Closures
  - PPP-54 Identifying Patients for PharmaNet Purposes
  - PPP-59 Pharmacy Equipment
  - PPP-65 Narcotic Counts and Reconciliations
  - PPP-73 Validate Identification and College Registration Status for New Pharmacy Hires
  - PPP-74 Community Pharmacy Security

College of Pharmacists of British Columbia

Consequential Amendments to Telepharmacy Bylaws

Telepharmacy Bylaws, Form and Schedules:

- In September 2017, the Board approved filing of amendments to PODSA Bylaws (including forms and schedules) related to telepharmacies.
- These bylaw amendments are now in effect.
- Minor amendments are needed for consistency purposes:
  - E.g., the term “owner” is changed to “direct owner”.
- Consequential amendments were also required to a form and two schedules to reflect the new numbering of bylaws.

College of Pharmacists of British Columbia

Next Steps

Bylaws, Forms and Schedules:

- College staff are working with the Ministry of Health (MoH) to align the effective dates of the Act changes and bylaws.
- If approved by the Board, these bylaws will be held until the MoH advises the College of the effective date of the Act, which requires Cabinet approval.
- The bylaws (including forms and schedules) will then be sent to the MoH for the legislated 60-day filing period.

PPP's:

- The Board has the authority to approve PPP's.
- If approved by the Board, the new PPP and consequential amendments to existing PPP's will come into effect with the bylaws.

College of Pharmacists of British Columbia

8 c) PODSA Bylaws – Owners (Filing)

MOTION 1:

Approve the following resolution to amend the Pharmacy Operations and Drug Scheduling Act Bylaws, which operationalize recent amendments made to the Pharmacy Operations and Drug Scheduling Act and to approve consequential amendments to telepharmacy bylaws (including a form and schedules), to be effective with the amendments to the Act:

RESOLVED THAT, *in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws (including forms and schedules) of the College of Pharmacists of British Columbia, as set out in the schedules attached to this resolution.*

College of Pharmacists of British Columbia

8 c) PODSA Bylaws – Owners (Filing)

MOTION 2:

Approve a new Professional Practice Policy 76 – Criminal Record History Vendor, to be effective at the same time as the amendments to the Pharmacy Operations and Drug Scheduling Act Bylaws come into force.

College of Pharmacists of British Columbia

8 c) PODSA Bylaws – Owners (Filing)

MOTION 3:

Approve consequential amendments to the following Professional Practice Policies, to be effective at the same time as the amendments to the Pharmacy Operations and Drug Scheduling Act Bylaws come into force:

PPP-3 Pharmacy References

PPP-12 Prescription Hard Copy File Coding System

PPP-46 Temporary Pharmacy Closures

PPP-54 Identifying Patients for PharmaNet Purposes

PPP-59 Pharmacy Equipment

PPP-65 Narcotic Counts and Reconciliations

PPP-73 Validate Identification and College Registration Status for New Pharmacy Hires

PPP-74 Community Pharmacy Security

College of Pharmacists of British Columbia

8 d) HPA Bylaws - Board Terms of Office (Filing)

College of Pharmacists of British Columbia

Background

- The HPA-Bylaws sets out requirements for elected Board members' term length and maximum number of consecutive terms.
- In November 2016, the Board directed a change to elected Board members' terms from 2 to 3 years, and from a maximum of 3 consecutive terms to a maximum of 2 consecutive terms.
- Amending the term length provisions to 3 years requires an additional bylaw amendment:
  - Currently, the terms of elected Board members from odd-numbered districts must start and end in odd-numbered years (and vice-versa for even-numbered districts). It is not possible to meet this requirement if the term length is 3 years.

College of Pharmacists of British Columbia

June 2017 Board Decision

Election Cycle Change:

- An election to be held in each of two years; no election held in the third year.
  - Three year cycle: Elections for four districts are held in each of first two years, and in the third year, no election is held.
    - Even-numbered Districts (i.e., 2, 4, 6 and 8) would begin election cycle in 2018.
    - Odd-numbered Districts (i.e., 1, 3, 5, and 7) would "be up" for election in the second year of the cycle.
    - No election would be held in the third year of the cycle.
  - Would limit the ability of existing Board member to serve up to six years on the Board.

College of Pharmacists of British Columbia

June 2017 Board Decision, continued

Start of new election cycle

Board Election Calendar								
District	2018	2019	2020	2021	2022	2023	2024	2025
1		X			X			X
2	X			X			X	
3		X			X			X
4	X			X			X	
5		X			X			X
6	X			X			X	
7		X			X			X
8	X			X			X	

X = an Election

College of Pharmacists of British Columbia

HPA Bylaws - Board Terms of Office

Pubic Posting:

- Proposed bylaws were publicly posted for a 90-day period.
- No feedback was received, and no further changes are recommended.

Next Steps:

- Once approved by the Board, the bylaws will be sent to the Ministry of Health for filing.
- The amendments will be in effect after a legislated 60 day filing period.
- The new provisions would be in place for the 2018 Board election.

College of Pharmacists of British Columbia

8 d) HPA Bylaws - Board Terms of Office (Filing)

Motion:

Approve the following resolution to amend the Health Professions Act Bylaws regarding the elected board member terms of office and election cycle:

RESOLVED THAT, in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

College of Pharmacists of British Columbia

8 e) Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine (Amendments to PPP-66)

College of Pharmacists of British Columbia

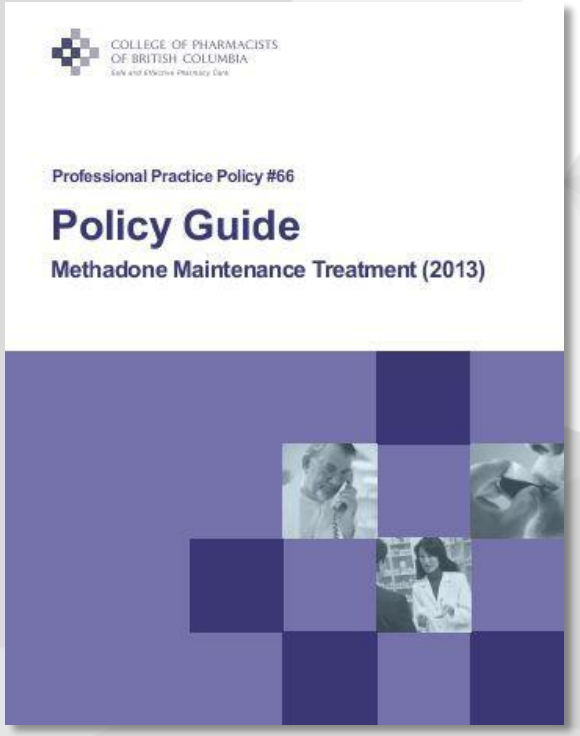
Opioid Agonist Therapy (OAT)

Background

- In 2016, a state of public health emergency was declared in BC, due to the sharp increase in drug-related overdoses and deaths.
- OAT is an effective treatment for addiction to opioid drugs such as heroin, oxycodone, fentanyl and Percocet.
- The therapy involves taking opioid agonists such as methadone (Methadose), buprenorphine/naloxone (Suboxone) or slow release oral morphine (Kadian).
- These medications work to prevent withdrawal and reduce cravings for opioid drugs.
- People who are addicted to opioid drugs can take these medications to help stabilize their lives and to reduce the harms related to their drug use.

College of Pharmacists of British Columbia

Current State – Methadone for OAT



- Methadone maintenance treatment is a recognized treatment for opioid dependency.
- The College has requirements in place for methadone when used for OAT.
- These requirements are in a Professional Practice Policy (PPP) – 66 Methadone Maintenance Treatment and its accompanying guide.

College of Pharmacists of British Columbia

BC Centre on Substance Use & New Guideline

- BC Centre on Substance Use (BCCSU), is a new provincial organization with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction.
- In June 2017, the BCCSU released, *"A Guideline for the Clinical Management of Opioid Use Disorder"*.
- The new guideline is for all clinicians who prescribe OAT drugs (i.e., methadone, slow release oral morphine and buprenorphine/naloxone) for treatment of patients with opioid use disorder.
- This guideline will replace the existing guideline, "*Methadone and Buprenorphine: Clinical Practice Guideline for Opioid Use Disorder*".

College of Pharmacists of British Columbia

Buprenorphine/Naloxone

BCCSU Guideline:

- Buprenorphine/Naloxone is the preferred first-line OAT for treating patients with an opioid use disorder.
- Buprenorphine/Naloxone is a 4:1 combined formulation of buprenorphine and naloxone administered as a sublingual tablet(s).

College of Pharmacists of British Columbia

Slow Release Oral Morphine (SROM)

BCCSU Guideline:

- OAT with SROM (24 hour formulation) prescribed as once-daily witnessed doses.
- May be considered for patients who have not benefited from treatment with first and second-line treatment options (i.e., buprenorphine/naloxone and methadone).

College of Pharmacists of British Columbia

Gap in Requirements: Buprenorphine/Naloxone and SROM

- These OAT medications are currently being prescribed and dispensed.
- There is a gap in dispensing requirements for SROM and buprenorphine/ naloxone.
- Absence of requirements for safe dispensing can lead to patient safety concerns.
- College staff have been working on developing dispensing requirements for both drugs.

College of Pharmacists of British Columbia

Policy Development

- College staff reviewed the BCCSU Guideline and the College's existing policy and policy guide for methadone.
- The draft policy amendments included many of the College's methadone requirements, with the following noted differences:
  - Removal of duplicative requirements from existing legislation (e.g. privacy and confidentiality requirements from bylaws);
  - Requiring the regular Controlled Prescription Form, and not the Methadone Controlled Prescription Form; and
  - Removal of exceptions to the Controlled Prescription Program's requirements (i.e., faxing Controlled Prescriptions forms and alterations to Controlled Prescription forms are not accepted).

College of Pharmacists of British Columbia

Subject Matter Expert – Dr. Ahmad Ghahary

- Dr. Ahmad Ghahary is a community pharmacist and pharmacy owner, with six years of experience working in the area of mental health and addictions in the Downtown Eastside.
- Dr. Ghahary holds a Bachelor of Science degree in Pharmacy and earned a Doctor of Pharmacy Degree.

College of Pharmacists of British Columbia

Subject Matter Expert's Role:

- Dr. Ghahary supported the development of the new dispensing requirements for buprenorphine/naloxone and SROM.
- He provided advice on the new practice requirements, reviewed initial drafts to identify any gaps, and recommended additional requirements.

College of Pharmacists of British Columbia

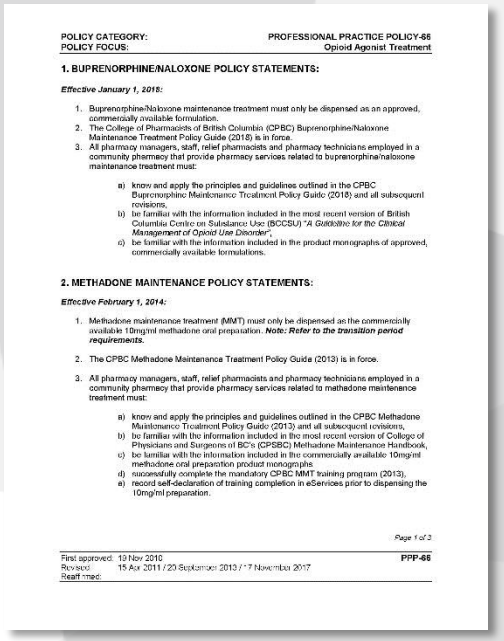
Consultations

- The following groups reviewed and provided input on the new policy requirements:
  - BCCSU;
  - The College's Community Pharmacy Advisory Committee (CPAC); and
  - The BC Pharmacy Association.
- Positive feedback was received on the requirements from all three groups along with feedback requesting minor changes.

College of Pharmacists of British Columbia

New OAT Policy (Amendment to PPP-66) and Guides

Amendment



POLICY CATEGORY: PROFESSIONAL PRACTICE POLICY-66
POLICY FOCUS: Opioid Agonist Treatment

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

Effective January 1, 2018:

1. Buprenorphine-Naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The College of Pharmacists of British Columbia (CPBC) Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to buprenorphine/naloxone maintenance treatment must:
   a) know and apply the principles and guidelines outlined in the CPBC Buprenorphine Maintenance Treatment Policy Guide (2018) and all subsequent revisions,
   b) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) *"A Guideline for the Clinical Management of Opioid Use Disorder"*,
   c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

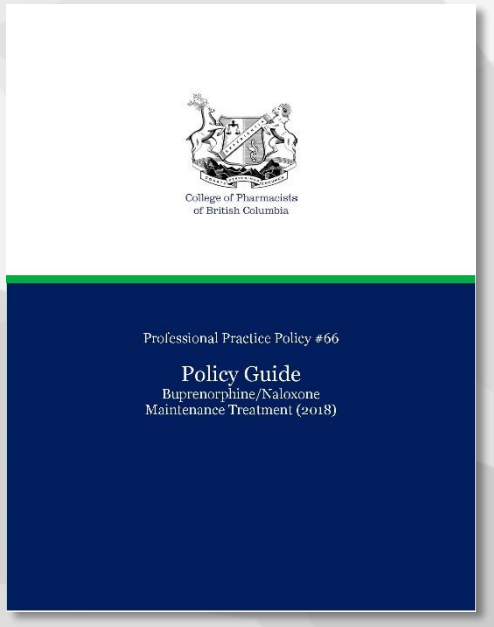
Effective February 1, 2014:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation. ***Note: Refer to the transition period requirements.***
2. The CPBC Methadone Maintenance Treatment Policy Guide (2013) is in force.
3. All pharmacy managers, staff, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to methadone maintenance treatment must:
   a) know and apply the principles and guidelines outlined in the CPBC Methadone Maintenance Treatment Policy Guide (2013) and all subsequent revisions,
   b) be familiar with the information included in the most recent version of College of Physicians and Surgeons of BC's (CPSBC) Methadone Maintenance Handbook,
   c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs
   d) successfully complete the mandatory CPBC MMT training program (2013),
   e) record self-declaration of training completion in eServices prior to dispensing the 10mg/ml preparation.

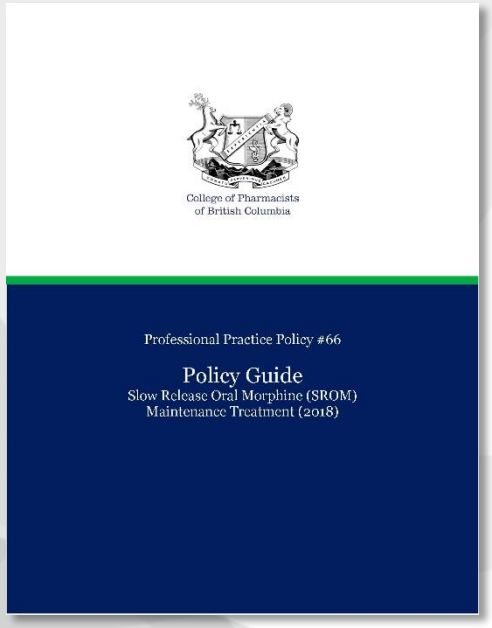
Page 1 of 3

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 September 2013 / 7 November 2017
Reaffirmed:

New



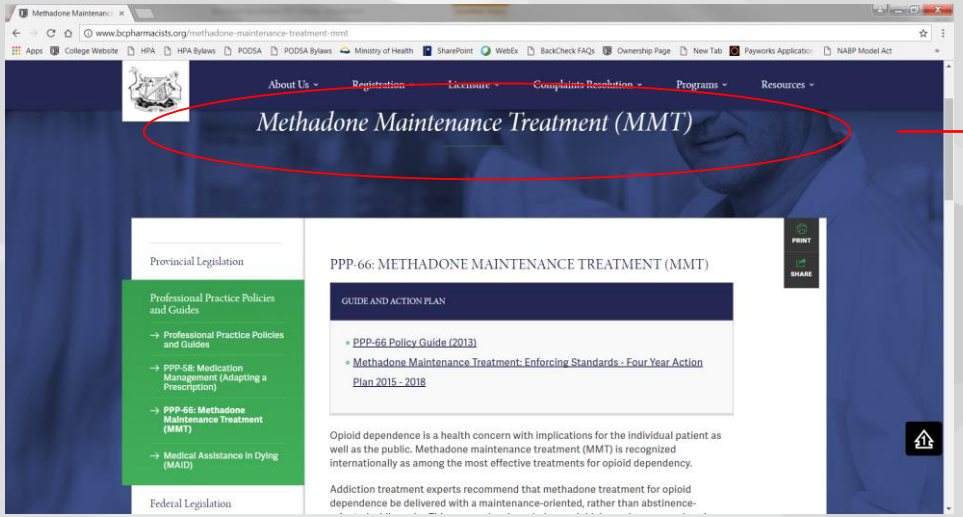
New



College of Pharmacists of British Columbia

Next Steps

- Communicate and implement new policy requirements for January 1, 2018 effective date.
- Revise the Methadone Maintenance Treatment webpage to OAT treatment.
- Transitioning the OAT policies to bylaws.



Opioid Agonist Treatment

College of Pharmacists of British Columbia

8 e) Policies on Buprenorphine/Naloxone and Slow Release Oral Morphine (Amendments to PPP-66)

MOTION 1:

Approve amendments to Professional Practice Policy (PPP) 66 Methadone Maintenance Treatment, to be effective on January 1, 2018.

MOTION 2:

Approve the following two new PPP 66 Policy Guides, to be effective on January 1, 2018:

- PPP 66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)
- PPP 66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)

APPLICATION COMMITTEE

Background

The Board is required to establish an Application Committee.

Authority

Health Professions Act (HPA) sections 19(1)(t) and HPA Bylaws sections 15.2, 19 and 20.
Pharmacy Operations and Drug Scheduling Act (PODSA) sections 1, 4(2), 4(3), 4(4), 4(5), 4.1 and 5.1(b).

Mandate

To review pharmacy licence applications that have been referred to the committee and determine whether to issue, renew or reinstate a licence with or without conditions.

Responsibilities

- Review applications for a pharmacy licence as referred by the Registrar that do not meet the eligibility criteria defined in PODSA.
- Request additional information or evidence, if required to make a decision.
- Issue, renew or reinstate a pharmacy licence, with or without conditions, to applicants who satisfy the Application Committee they are eligible to hold a pharmacy licence.
- Refuse to issue, renew or reinstate a pharmacy licence, to applicants who do not satisfy the Application Committee that they are eligible to hold the pharmacy licence.
- Develop conditions with respect to issuing, renewing and reinstating a pharmacy licence.
- Establish sub-committees and ad hoc working groups for Board appointment, to review, develop, administer and establish requirements for the purposes of the application process.
- Inform applicants, about the results of the licensure decision made by the Application Committee.

Reporting relationship

The committee as a whole reports through the chair to the Board. The committee must submit a report of its activities to the Board annually, or as required by the Board.

Membership

- At least six full pharmacists or pharmacy technicians appointed by the Board (there must be representation from both groups of registrants).
- At least 1/3 of its members must consist of public representatives, at least one of whom must be an appointed Board member.

Panels

- The committee may meet in panels of at least 3 persons but not more than 5 persons, and each panel must include at least 1/3 public representatives.
- The chair of the Application Committee must appoint the members of a panel and must designate a chair of the panel.
- The panel may exercise any power, duty or function of the Application Committee.

Term of appointment

- Appointments are determined by the Board and will not exceed 3 years. Appointees are eligible for reappointment by the Board but may not serve more than 6 consecutive years.
- A registrant appointed to the committee ceases to be a member if they are no longer a full pharmacist or pharmacy technician in good standing or if they become a College employee.
- Any committee member may resign upon written notification to the registrar. Committee members who are absent for more than three committee meetings per year automatically forfeit membership on the committee. The chair has the discretion to approve, in advance, an extended absence of any committee member.

Committee officers

Board appoints a committee chair and vice-chair from among the members of the committee.

Voting rights

Each member, including each public representative, is entitled to one vote on all matters coming before the committee or a panel of the committee.

Meeting procedures

Schedule:	At least three times annually.
Format:	In person, by teleconference, or by videoconference.
Agenda:	Developed by College staff in consultation with the committee chair with input from committee members.
Panels:	The committee chair, who also designates the panel chair, must appoint panel members. A panel of a committee may exercise any power, duty or function of that committee.
Attendees:	Only Application Committee members and College staff are entitled to attend committee and panel meetings, unless specifically invited by the committee or panel chair as a guest.
Quorum:	A majority of the committee or all members of a panel.
Minutes:	Drafted by College staff for review and approval at next committee meeting; filed at the College office.
Secretariat Support:	Provided by the College, including meeting coordination, preparation and distribution of materials and drafting meeting minutes.

Conflict-of-interest disclosure

Members must declare conflicts of interest prior to the discussion of individual files or at any time a conflict of interest or potential conflict of interest arises.

A conflict of interest refers to situations in which personal, occupational or financial considerations may affect or appear to affect the objectivity or fairness of decisions related to the committee activities. A conflict of interest may be real, potential or perceived in nature. Individuals must declare potential conflicts to the chair of the committee and must either absent themselves from the discussion and voting, or put the decision to the committee on whether they should absent themselves.

Confidentiality

Each committee member must sign a confidentiality agreement at the time of each appointment indicating their agreement to maintain the confidentiality, security and integrity of all materials during and after their term on the committee.

Remuneration

Committee members may claim honouraria and expense reimbursement in accordance with the Board's policy and guidelines for claiming committee expenses.

Amendment to terms of reference

The Board may amend committee terms of reference at any time and from time to time.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

9. Governance Committee
b) Application Committee – Appointment of Members

DECISION REQUIRED

Recommended Board Motion:

Approve the formation of Application Committee with the terms of reference as presented.

Background

As the College and the Ministry work to establish new ownership requirements and the PODSA amendments to support this change, the establishment of an Application Committee was required.

A key component of establishing an Application Committee is the development of Terms of Reference for that committee. College staff have drafted Terms of Reference, which are attached in Appendix 2.

The College has requested applications and the Governance Committee has populated members to serve on this committee, which are attached in Appendix 3. The committee will become active once the PODSA ownership changes come into effect in April.

Application Committee Members

Name	Type	Term Dates	Term Length (Yrs)	
Doreen Leong	Staff			
Wellon, Sorell	Chair/Board/RPT	TBD	3	NEW
Walton, George	Public/Board	TBD	1	NEW
Antler, Christine	Pharmacist	TBD	1	NEW
Beever, John	Pharmacist	TBD	2	NEW
Zhou, Mark	Pharmacist	TBD	3	NEW
Park, Terry	Pharmacist	TBD	1	NEW
Lee, Derek	Pharmacist	TBD	2	NEW
Budd, George	Pharmacist	TBD	3	NEW
Braun, Neil	Pharmacist	TBD	1	NEW
Cunningham, Diane	Public	TBD	2	NEW
Lewis, Robert	Public	TBD	2	NEW
Ly, Kevin	Public	TBD	3	NEW
Singh, Surbhi	Public	TBD	3	NEW

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

9. Governance Committee
c) Board Members as Chairs of all Committees

DECISION REQUIRED

Recommended Board Motion:

Remove the requirement for a Board member to Chair the Application, Inquiry, Discipline and Registration committees.

Background

Many of the statutory committees of the College have independent decision making authority. That is, they do not make recommendations or report to the Board. Specifically, these committees are: Application, Inquiry, Discipline and Registration.

The Board previously established an informal policy to appoint Board members as the chair of each College committee to ensure strong lines of communication between committees and the Board. This is not necessary for the above-noted statutory committees as they do not report to the Board.

It is recommended that the requirement for the Application, Inquiry, Discipline and Registration Committees be chaired by a Board Member, be removed.

The committees still required to be chaired by Board Members are:

- Community Pharmacy Advisory Committee;
- Ethics Advisory Committee;
- Hospital Pharmacy Advisory Committee; and
- Residential Care Advisory Committee.

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

10. Change Day BC 2017

INFORMATION ONLY

Gillian Vrooman, the College's Director of Communications and Engagement will provide a presentation to the Board on Change Day BC 2017, encouraging Board Members, Staff and other health professionals in attendance to make pledges to improve patient care in British Columbia.

Change Day BC is on November 17, 2017 and is organized by the BC Patient Safety and Quality Council.

As an official Organizational Partner of Change Day BC, the College is helping to build awareness by encouraging BC's registered health professionals to join the movement and make a pledge to drive positive change within BC's health system.

Change Day started with England's National Health Service in 2013 and has since grown to include countries from all over the world with over one million pledges worldwide! Change Day first came to British Columbia in 2015, garnering nearly 8000 pledges from health care professionals across the province.

What is a Pledge?

A pledge is a voluntary personal commitment to changing healthcare in BC for the better. Past pledges have included:

- Talking about mental health;
- Spending a day in a patient gown;
- Working to increase cultural safety for Indigenous people seeking health services; and
- Acknowledging the work of fellow healthcare professionals.

Pledges can be submitted at ChangeDayBC.ca/PLEDGE before end-of-day November 17, 2017.

Appendix	
1	Change Day Pledge Card
2	Change Day Pamphlet

I pledge to...

CHANGE DAY BC
17.11.17

My name

My Twitter handle

My email

My job

What I do

My city/town

CHANGE DAY BC
17.11.17

BC Patient Safety & Quality Council

201-750 Pender St W
Vancouver, BC
V6C 2T7

17.11.17

@changedaybc #changeday changedaybc.ca changeday@bcpsqc.ca

WHY CHANGE DAY BC?

We believe that individual acts of change – regardless of their size – can add up to significant improvements for British Columbians and the health, social and community care system. We know that every one of us has the power and passion to affect change that leads to better care. We want to harness this potential and support improvements in our system.

TOP 5 REASONS TO PARTICIPATE:

1. *You have an idea that you're eager to try and Change Day BC is the perfect excuse.*
2. *You want to spread your idea by having others join your pledge.*
3. *You want to inspire others to make their own pledges.*
4. *The team around you needs a lift and Change Day BC is a great energy boost.*
5. *You want to do something for yourself by committing to staying well.*

WHAT IS A PLEDGE?

A pledge is something that you commit to doing, changing or improving in health or social care. It's that simple!

When you are considering your pledge, think about something that you are passionate about. What is something that you have always wanted to change, improve and/or transform? What someone pledges, and how they do it, is entirely up to them.

WHO CAN MAKE A PLEDGE?

Anyone can make a pledge. Regardless of where you work or volunteer, whether you are a patient, resident, client, family member or someone working in the care system, we invite you to join the movement to improve health and social care in our province.

HOW DO I MAKE A PLEDGE?

Pledges can be made online at www.changedaybc.ca or by completing and mailing in a pledge postcard. Don't have a pledge postcard? Contact changeday@bcpsqc.ca and we will send you some!

HOW DO I PROMOTE CHANGE DAY BC?

We've developed some resources to help raise awareness about Change Day BC. Buttons, post-it notes, posters and more are free and available to order at www.changedaybc.ca/resources or by giving us a call at 604.668.8223.

HERE ARE SOME EXAMPLE PLEDGES FROM CHANGE DAY 2015

- *wearing a patient gown and spending a day in hospital attached to an IV pole;*
- *encouraging patients to ask questions;*
- *remembering to acknowledge my colleagues' hard work;*
- *talking about my mental health;*
- *wearing and using, adult incontinence products for a day; and*
- *working to increase cultural safety for Indigenous people seeking health services.*

FOR EXAMPLE, Amy Horrock, a dietitian in Northern Health pledged to spend a day eating only pureed foods and drinking only thickened fluids. Amy's pledge had a rippled effect and inspired the NH board to also try pureed food. In both cases, it allowed people to better empathize with patients on a restricted diet.

WHAT HAPPENS ON 17.11.17?

On 17.11.17, we invite you to acknowledge and celebrate Change Day BC pledges and actions.

Plan a local celebration or event and watch for more details about provincial activities.

WANT TO GET MORE INVOLVED?

Change Day BC is the result of partnerships with organizations and individuals across the province. We can't possibly do this alone. If you aren't already a partner for Change Day BC, we invite you to join us!

You can also connect with others by becoming a volunteer Change Day BC Ambassador. There are no requirements or expectations around being an Ambassador, other than being an enthusiastic supporter.

Email changeday@bcpsqc.ca or call 604.668.8223.

WHAT DREW YOU TO HEALTH, SOCIAL OR COMMUNITY CARE?

WHAT IGNITES YOUR PASSION?

WHAT STEP – BIG OR SMALL – COULD YOU TAKE TO MAKE YOUR SYSTEM BETTER FOR BRITISH COLUMBIANS?

THIS IS WHAT IT'S ALL ABOUT! Change Day BC is November 17, 2017 (17.11.17). Between now and then, we invite anyone involved in health, social and community care to commit to making a change or trying something new. And we mean anyone! Patients, residents, clients, and those working in the system are invited to make a new pledge or join an existing pledge on changedaybc.ca.

*Make or join pledges at **www.changedaybc.ca***
*Questions? Email us at **changeday@bcpsqc.ca***
*Share your thoughts! Tweet us **@changedaybc***
#changeday

CHANGE DAY BC
17.11.17

BC PATIENT SAFETY & QUALITY COUNCIL
Working Together. Accelerating Improvement.

1 DAY. 5000 PLEDGES. UNLIMITED POSSIBILITIES.

CHANGE DAY BC
17.11.17


College of Pharmacists
of British Columbia
CHANGE
DAY BC
17.11.17
One small act can make a huge difference.

College of Pharmacists of British Columbia

What is Change Day BC?

1 DAY. 5000 PLEDGES. UNLIMITED POSSIBILITIES.

CHANGE DAY BC 17.11.17

Change Day is a celebration of the power of any person – patients, caregivers, health care providers, students, volunteers – to have a positive impact on the health system.

College of Pharmacists of British Columbia

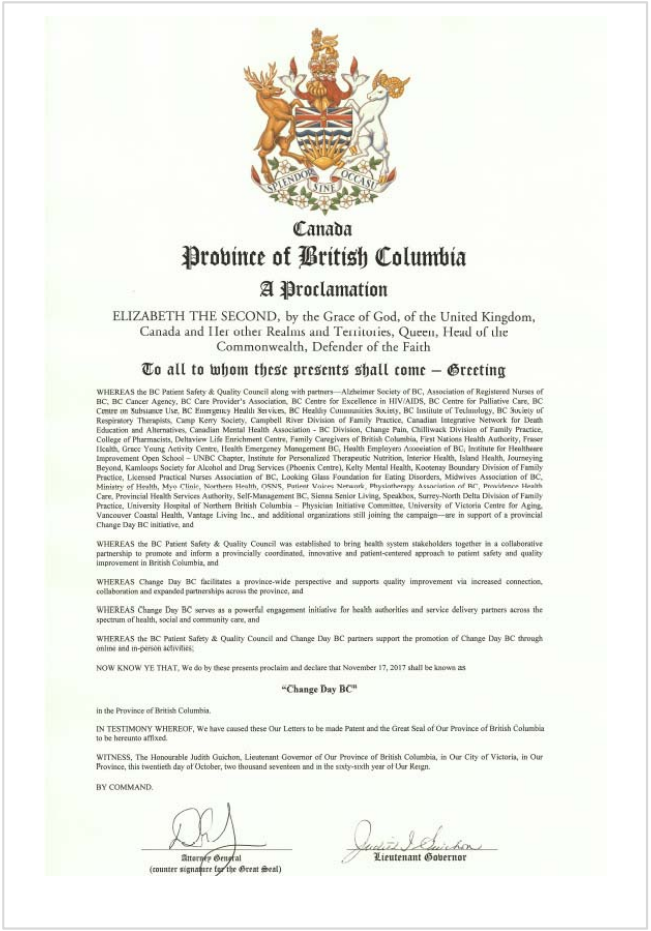
17.11.17 @changedaybc #changeday changedaybc.ca

Change Day BC

- BC Patient Safety & Quality Council and partners across BC first launched Change Day BC in February 2015
- Clinicians, patients, caregivers, executives, students, volunteers, and everyone in between are invited to participate by making a pledge to improve the quality of care
- Pledges can be big or small; single acts or sustained efforts; group activities or solo endeavours

College of Pharmacists of British Columbia

Province of British Columbia has proclaimed November 17, 2017 to be “Change Day BC”



Canada

Province of British Columbia

A Proclamation

ELIZABETH THE SECOND, by the Grace of God, of the United Kingdom, Canada and Her other Realms and Territories, Queen, Head of the Commonwealth, Defender of the Faith

To all to whom these presents shall come – Greeting

WHEREAS the BC Patient Safety & Quality Council along with partners—Alzheimer Society of BC, Association of Registered Nurses of BC, BC Cancer Agency, BC Care Provider's Association, BC Centre for Excellence in HIV/AIDS, BC Centre for Palliative Care, BC Centre on Substance Use, BC Emergency Health Services, BC Healthy Communities Society, BC Institute of Technology, BC Society of Respiratory Therapists, Camp Kerry Society, Campbell River Division of Family Practice, Canadian Integrative Network for Death Education and Alternatives, Canadian Mental Health Association - BC Division, Change Pain, Chilliwack Division of Family Practice, College of Pharmacists, Dehaview Life Enrichment Centre, Family Caregivers of British Columbia, First Nations Health Authority, Fraser Health, Grace Young Activity Centre, Health Emergency Management BC, Health Employers Association of BC, Institute for Healthcare Improvement Open School – UNBC Chapter, Institute for Personalized Therapeutic Nutrition, Interior Health, Island Health, Journeying Beyond, Kamloops Society for Alcohol and Drug Services (Phoenix Centre), Kelty Mental Health, Kootenay Boundary Division of Family Practice, Licensed Practical Nurses Association of BC, Looking Glass Foundation for Eating Disorders, Midwives Association of BC, Ministry of Health, Myo Clinic, Northern Health, ONNS, Patient Voices Network, Physiotherapy Association of BC, Providence Health Care, Provincial Health Services Authority, Self-Management BC, Sienna Senior Living, SpeakNow, Surrey-North Delta Division of Family Practice, University Hospital of Northern British Columbia – Physician Initiative Committee, University of Victoria Centre for Aging, Vancouver Coastal Health, Vantage Living Inc., and additional organizations still joining the campaign—are in support of a provincial Change Day BC initiative, and

WHEREAS the BC Patient Safety & Quality Council was established to bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative and patient-centered approach to patient safety and quality improvement in British Columbia, and

WHEREAS Change Day BC facilitates a province-wide perspective and supports quality improvement via increased connection, collaboration and expanded partnerships across the province, and

WHEREAS Change Day BC serves as a powerful engagement initiative for health authorities and service delivery partners across the spectrum of health, social and community care, and

WHEREAS the BC Patient Safety & Quality Council and Change Day BC partners support the promotion of Change Day BC through online and in-person activities;

NOW KNOW YE THAT, We do by these presents proclaim and declare that November 17, 2017 shall be known as

"Change Day BC"

in the Province of British Columbia.

IN TESTIMONY WHEREOF, We have caused these Our Letters to be made Patent and the Great Seal of Our Province of British Columbia to be hereunto affixed.

WITNESS, The Honourable Judith Guichon, Lieutenant Governor of Our Province of British Columbia, in Our City of Victoria, in Our Province, this twentieth day of October, two thousand seventeen and in the sixty-sixth year of Our Reign.

BY COMMAND.

Attorney General
(counter signature for the Great Seal)

Lieutenant Governor

College of Pharmacists of British Columbia

17.11.17 @changedaybc #changeday changedaybc.ca

College of Pharmacists of British Columbia

College of Pharmacists of BC is proud to be a Change Day Partner

1 DAY. 5000 PLEDGES. UNLIMITED POSSIBILITIES.

CHANGE DAY BC 17.11.17

Over 60 Change Day partners in BC

17.11.17 @changedaybc #changeday changedaybc.ca

College of Pharmacists of British Columbia

Make a Pledge

1 DAY. 5000 PLEDGES. UNLIMITED POSSIBILITIES.

CHANGE DAY BC
17.11.17

Top 5 Reasons to Participate

1. You have an idea that you're eager to try and Change Day BC is the perfect excuse

2. You want to spread your idea by having others join your pledge

3. You want to inspire others to make their own pledges

4. The team around you needs a lift and Change Day BC is a great energy boost

5. You want to do something for yourself by committing to staying well

College of Pharmacists of British Columbia

What is a Pledge?

A pledge is a voluntary personal commitment to changing healthcare in BC for the better

Examples

- talking about mental health
- spending a day in a patient gown
- working to increase cultural safety for Indigenous people seeking health services
- acknowledging the work of fellow healthcare professionals.

College of Pharmacists of British Columbia

College of Pharmacists of British Columbia

Change Day BC Results

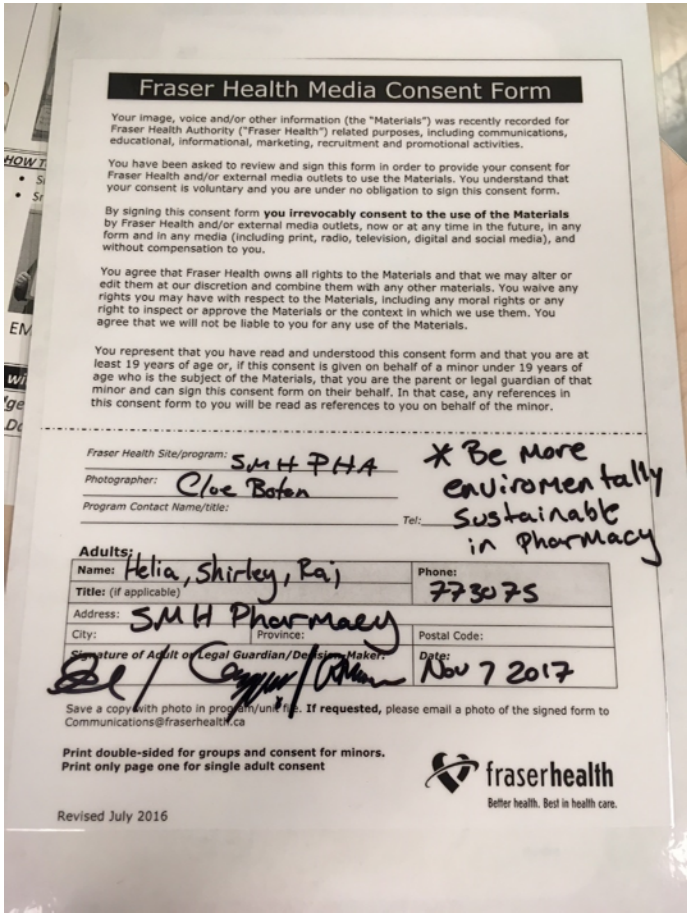
CHANGE DAY BC 17.11.17

College of Pharmacists of British Columbia

We asked pharmacy professionals and College staff to make a Change Day pledge

1 DAY. 5000 PLEDGES. UNLIMITED POSSIBILITIES.

CHANGE DAY BC 17.11.17



Fraser Health Media Consent Form

Your image, voice and/or other information (the "Materials") was recently recorded for Fraser Health Authority ("Fraser Health") related purposes, including communications, educational, informational, marketing, recruitment and promotional activities.

You have been asked to review and sign this form in order to provide your consent for Fraser Health and/or external media outlets to use the Materials. You understand that your consent is voluntary and you are under no obligation to sign this consent form.

By signing this consent form **you irrevocably consent to the use of the Materials** by Fraser Health and/or external media outlets, now or at any time in the future, in any form and in any media (including print, radio, television, digital and social media), and without compensation to you.

You agree that Fraser Health owns all rights to the Materials and that we may alter or edit them at our discretion and combine them with any other materials. You waive any rights you may have with respect to the Materials, including any moral rights or any right to inspect or approve the Materials or the context in which we use them. You agree that we will not be liable to you for any use of the Materials.

You represent that you have read and understood this consent form and that you are at least 19 years of age or, if this consent is given on behalf of a minor under 19 years of age who is the subject of the Materials, that you are the parent or legal guardian of that minor and can sign this consent form on their behalf. In that case, any references in this consent form to you will be read as references to you on behalf of the minor.

Fraser Health Site/program: SMH PHA

Photographer: Cloe Boten

Program Contact Name/title: * Be more environmentally sustainable in Pharmacy

Tel:

Adults:

Name: Helia, Shirley, Raj	**Phone:** 773075
Title: (if applicable)	
Address: SMH Pharmacy	
City:	**Province:** **Postal Code:**
Signature of Adult or Legal Guardian/Decision-Maker:	**Date:** Nov 7 2017

Save a copy with photo in program/unit file. **If requested,** please email a photo of the signed form to Communications@fraserhealth.ca

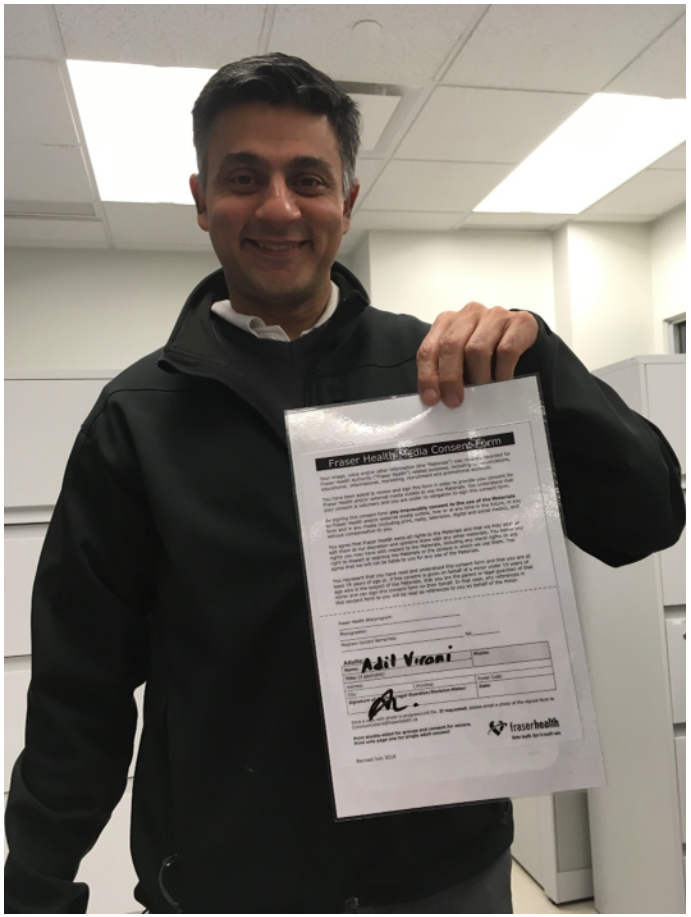
Print double-sided for groups and consent for minors.
Print only page one for single adult consent

fraserhealth
Better health. Best in health care.

Revised July 2016

College of Pharmacists of British Columbia

17.11.17 @changedaybc #changeday changedaybc.ca



College of Pharmacists of British Columbia

17.11.17 @changedaybc #changeday changedaybc.ca

I pledge to:

help discharge patients safely and contact their community pharmacy and physician

- **Emma (Fraser Health), Surrey**

advocate for pharmacy prescribing rights

- **Alex, New Westminster**

College of Pharmacists of British Columbia

I pledge to:

increase implementation of effective and safe medication use practices across our health authority by applying evidence-based behaviour change interventions.

- **Sean (Interior Health), Kelowna**

remember the patient at the core of every medication order I process in pharmacy

- **Mary Lou (Interior Health), Kelowna**

I pledge to:

be more involved with my patients- to talk not just about medications but other things to help improve their lives

- **Anonymous, Vancouver**

take my meds all week

- **Mike (Island Health), Victoria**

make patient experience simple and easy in and out of pharmacy

- **Pratik, Vancouver**

I pledge to:

understand things from others point of view before I jump to conclusions.

- **Kaitlin (College of Pharmacists), BC**

take a moment to relax and refocus on what's important and why I'm doing something during times of intensity/stress.

- **Gillian (College of Pharmacists), Vancouver**

I pledge to:

provide culturally competent care for LGBTQ patients and promote LGBTQ cultural competency in pharmacy practice and health care

- **Arden (Fraser Health), Chilliwack**

consider cultural sensitivity and humility in pharmacy practice and regulatory issues.

- **Bob (College of Pharmacists), Vancouver**

College of Pharmacists of British Columbia

What's Your Pledge?

College of Pharmacists of British Columbia


1 DAY. 5000 PLEDGES.
UNLIMITED POSSIBILITIES.
CHANGE DAY BC
17.11.17

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

11. Framework for Pharmacist Prescribing in BC

DECISION REQUIRED

Recommended Board Motions:

Direct the Registrar to submit a proposal for pharmacist prescribing in BC to the Minister of Health which would request amendments to the Pharmacists Regulation under the Health Professions Act and include the Framework for Pharmacist Prescribing in BC and the Engagement Report.

Purpose

To review the Framework for Pharmacist Prescribing Engagement Report and determine the next steps for moving forward with a proposal for pharmacist prescribing in BC.

Background

The College of Pharmacists of BC is in the final stages of developing a Framework for Pharmacist Prescribing in BC which aims to help protect patient safety and improve patient outcomes. Development of a framework and proposal for pharmacist prescribing dates back to 2010 when the Board first decided to move forward with a feasibility study. The initial Draft Framework was approved for stakeholder engagement by the College Board at the November 2015 Board meeting, and used to help facilitate an initial stakeholder engagement conducted from February to August 2016.

After reviewing the results of the engagement, the College Board made the decision to amend the initial draft framework by narrowing the scope of pharmacist prescribing to within collaborative practice.

2017 Engagement

The second engagement on pharmacist prescribing was conducted through June to October 2017 and sought feedback on the new Framework for Pharmacist Prescribing in BC.

This report consolidates all the feedback received through the second engagement under four key themes:

- Confidence in Pharmacist Prescribing
- Collaboration
- Improving Patient Care
- Support for Pharmacist Prescribing

The online consultation ran from September 21 through to October 8, 2017 and sought feedback from registered pharmacy professionals, patients and other health professionals. The College also hosted 3 live engagement sessions with patients and pharmacy professionals.

The College completed its second engagement on pharmacist prescribing, including analyzing the extensive feedback received, and has prepared a report on the results of the engagement which will be published on the College's website following the November 2017 Board meeting.

Discussion

Overall, most stakeholder groups had confidence in pharmacist prescribing in BC. Feedback indicated strong support for implementing pharmacist prescribing to help care for patients from pharmacists, pharmacy technicians, pharmacy students and members of the public. Physicians illustrated strong resistance, while others (such as nurses and nurse practitioners) indicated support for pharmacist prescribing. This pattern was apparent across the four key themes of confidence in pharmacists prescribing, collaboration, improving patient care, and support for pharmacist prescribing.

Feedback was significantly more supportive for pharmacist prescribing compared to earlier feedback in 2016 on the initial draft framework. While previously members of the public were divided over their confidence and interest in pharmacist prescribing, the public responded positively across the areas of confidence in pharmacists prescribing, collaboration and communication, improving patient care, and support for pharmacist prescribing. This is a significant and important change towards the new Framework for Pharmacist Prescribing and its focus on collaborative practice relationships.

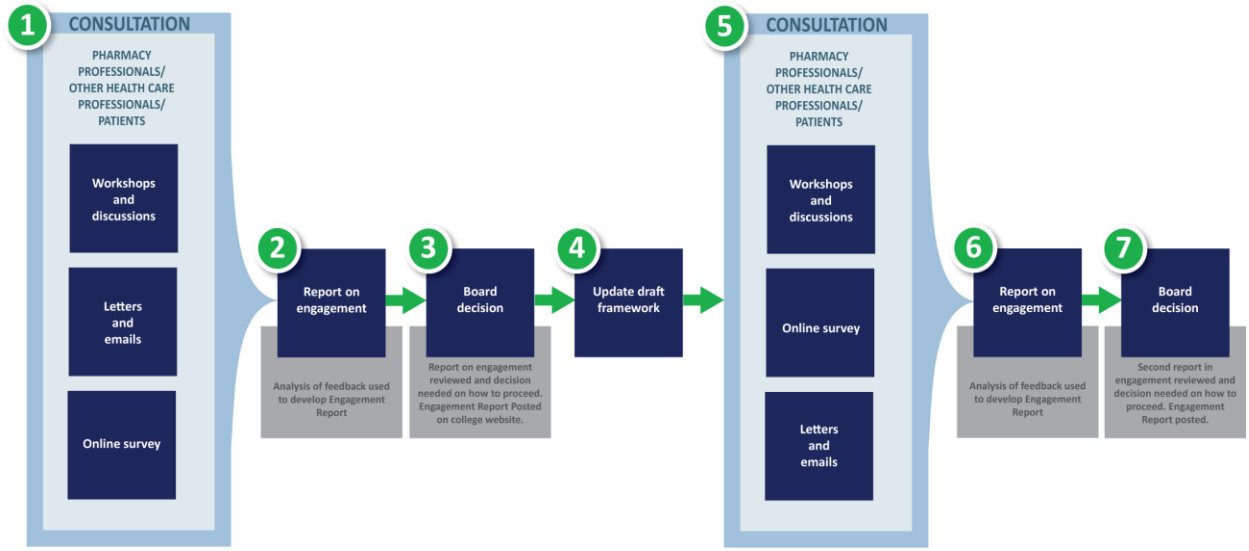
While most physicians continued to disagree with pharmacist prescribing, the level of disagreement was less compared to earlier feedback in 2016 on the initial draft framework. There was also strong division between responses from physicians and others in the same category (such as nurses and nurse practitioners). Other health care professionals (excluding physicians) demonstrated support for pharmacist prescribing across their responses. There were also points on which general practitioners demonstrated less disagreement than physician specialists, such as being open to collaborating with a pharmacist prescriber.

The greatest convergence across stakeholder groups surrounded the opportunities for greater collaboration in caring for patients as well as the ability to help protect patient safety and improve patient outcomes. In particular respondents noted that pharmacist prescribing would be beneficial for chronic disease management as well as minor ailments and prescription renewals and increased monitoring and management of drug therapy.

Engagement Overview

Consultation Process

The College followed the International Association for Public Participation (IAP2) best practices in planning and executing the second pharmacist prescribing engagement. The engagement process was communicated to stakeholders, including identifying how the feedback received would be used and how the results of the engagement would be shared – this is part of an effective and transparent engagement strategy and follows IAP2 Core Values.



The 2017 Pharmacist Prescribing Engagement ran from June to October 2017. Feedback was collected through an online survey as well as 3 live engagement sessions.
The College's Online Engagement Survey ran from September 21st to October 8th, 2017, inviting pharmacy professionals, patients and other health professionals to provide feedback on pharmacist prescribing in BC.

Live engagement sessions included a Pharmacist Prescribing Patient Session on September 21, 2017, as well as sessions with the College's Advisory Committees, Canadian Society of Hospital Pharmacists BC Branch and Health Authority Pharmacy Directors.

Who we heard from

The College reached out to patients, pharmacy professionals, pharmacy students and other health professionals as part of the engagement on pharmacist prescribing. Like the initial engagement in 2016, the College continued to receive significant participation during the second engagement on pharmacist prescribing.

We would like to thank everyone who provided feedback during the consultation period, as well as those who helped build awareness of the opportunity to provide input.
Feedback was collected in the following ways:

- 1,122 completed responses through an online survey
- 3 live engagement sessions
- 10 letters

During the course of the online consultation period there were more than 3,700 visits to the Pharmacist Prescribing Engagement Page on the College`s website.

The College also used its social media channels (Twitter, Facebook, Instagram) to share information about the Framework for Pharmacist Prescribing, encouraged participation in the online survey and invited people to an in-person patient engagement session.

The College reached an estimated 58,000 through Facebook and received over 470 reactions (with more than 90% positive reactions including likes and loves). The College also reached over 5,800 on Instagram and over 2,800 on twitter.

Over 1,120 completed the online survey providing over 10,364 comments to a range of questions on pharmacist prescribing.

Online Survey Engagement Demographics

The College asked survey respondents to identify if they were a pharmacist, pharmacy technician, pharmacy student, member of the public or other healthcare professional.
While the majority of responses came from registered pharmacists (54%), the College received many responses from both members of the public (14%) and other health professionals (11%). Pharmacy students also made significant contributions to the survey (15%).

Purpose of Engagement
The purpose of this engagement was to give patients, pharmacy professionals and other health professionals an opportunity to provide their input and share their thoughts on how pharmacist prescribing in collaborative practice relationships could work to help care for patients in BC.

Appendix	
1	Framework for Pharmacist Prescribing in BC
2	Framework for Pharmacist Prescribing in BC Engagement Report
3	BC Cancer Agency, letter
4	BC Pharmacy Association, letter
5	Canadian Society of Hospital Pharmacists – BC Branch, position statement
6	Doctors of BC, letter
7	Fraser Health Authority, letter
8	Provincial Health Services Authority, letter
9	Specialists of BC, letter
10	University of British Columbia, Faculty of Pharmaceutical Sciences, letter
11	University of British Columbia, Pharmacists Clinic, letter
12	Providence Health Care

College of Pharmacists of British Columbia

DRAFT

CERTIFIED PHARMACIST PRESCRIBER

FRAMEWORK FOR PHARMACIST PRESCRIBING IN BRITISH COLUMBIA

September 2017

CONTENTS

1. EXECUTIVE SUMMARY

This Certified Pharmacist Prescriber initiative is focused on preventing patient harm by reducing preventable drug-related problems and providing safer transitions in care through increased involvement of pharmacists, as medication experts in the delivery of patient-centred collaborative care. Improving medication management and reducing preventable drug-related hospitalizations protects public safety and will improve patient outcomes.

This initiative will require amendments to the Pharmacists Regulation under the *Health Professions Act*. Amendments to College bylaws will also be needed.

Risks to patient safety as a result of drug-related problems or poor patient outcomes are a growing concern. An aging population, multi-medication use, transfers in care, chronic disease management, and increasing complexity in patient care all increase the risk of drug related problems and put patient safety at risk. These factors together with the challenges in providing timely access to care, effect patient health outcomes.

As a result, medication experts play an important role in navigating the increasing complex care involved in providing patients with the care they need. Pharmacist-led drug therapy management improves clinical outcomes for patients, contributes to health care cost savings, and receives high satisfaction ratings from patients.

However, there are gaps in a pharmacist's authority to use their medication expertise to prevent drug-related problems and help improve patient health outcomes. Currently, pharmacists in BC do not have the level of involvement in prescribing decisions or the ability to initiate, monitor and adjust a patient's drug-therapy in a timely way that is needed to help manage these risks and better care for patients. What results without the authority to prescribe is often a redundant and time-consuming process, where pharmacists make recommendations to other health care professionals who are asked to approve them.

Reduced risk factors for chronic disease, improved blood glucose, improved blood pressure, improved lipid levels, and reduced risk for major cardiovascular events are all examples of pharmacist prescribing in collaborative relationships preventing harm and improving patient outcomes in recent studies. These opportunities to improve patient outcomes and prevent patient harm through pharmacist prescribing cannot be ignored when considering patient safety.

While the College does not advocate for changes to scope of practice for the advancement of the pharmacy profession, it does consider changes to pharmacy practice that are in the best interests of patients by increasing public safety and improving patient outcomes. Like the expansion of the pharmacists' role in drug administration, the College is proposing regulation of Certified Pharmacist Prescribers to help pharmacists better care for their patients and protect them from preventable drug related problems.

Pharmacist prescribing is needed in British Columbia to:

- improve patient outcomes,
- prevent drug-related problems,
- reduce unnecessary emergency room visits and hospitalizations,
- improve timely access to drug therapy, and
- improve continuity of care.

Framework for Pharmacist Prescribing in British Columbia

The Framework for Pharmacist Prescribing in British Columbia has been developed to establish regulation for Certified Pharmacists Prescribers across the Province. It includes requirements for collaboration with other health professionals, an education, training and evidence based qualification process, information access requirements and protection from conflict of interest among other standards limits and conditions designed to protect patient safety.

Collaboration

For the purpose of the framework, the College is requiring collaborative practice relationships.

Collaborative practice relationships involve developing a relationship with a regulated health professional who has the authority to prescribe to:

- Facilitate communication
- Determine mutual goals of therapy that are acceptable to the patient
- Share relevant health information
- Establish the expectations of each regulated health professional when working with a mutual patient

Collaborative practice relationships are not tied to a specific environment or practice setting, but set requirements for what must be established to prescribe through working with others on a patient's care team. In collaborative practice relationships, the diagnosis is still provided by physicians and nurse practitioners (or other regulated health professionals with prescribing authority). Some environments may be more easily be able support the

requirements for collaborative relationships, such as hospitals or urgent care centers. However, collaborative relationships can still take place in other environments where pharmacists are able to effectively communicate and securely share relevant health information with other health professionals on a patient's care team.

Separating Prescribing from Dispensing

Pharmacist prescribing would be separated from dispensing. Pharmacist Prescribers would be restricted from dispensing medications they prescribed for a patient. This prevents the potential business conflict of interest – a frequent point of concern for respondents.

Eligibility

The application process to become a Certified Pharmacist Prescriber will involve both an evidence based competency evaluation and completion of an educational program.

The College will use an evidence based competency evaluation to assess the competency of applicants to prescribe in collaborative practice. Applicants will need to submit information on their clinical background as well as patient care cases documenting the pharmacist's clinical involvement to demonstrate knowledge, skills and abilities under each one of the competency indicators.

The education program for Certified Pharmacist Prescribers will include a course series on the responsibilities of pharmacist prescribing. The series will focus on fundamental knowledge all Certified Pharmacist Prescribers require to effectively and safely prescribe in collaborative practice. The College will also recommend (but not require) a series of preparatory courses based on topics that support pharmacist prescribing in collaborative relationships.

Renewal requirements for a Certified Pharmacist Prescriber includes proof of an additional 15 units of continuing education and an annual self-declaration.

Access to Relevant Health Information

Pharmacists must be able to effectively share and review relevant health information in order to be able to prescribe and effectively manage drug therapy. This ranges from access to patient medical records (electronic or offline), PharmaNet, and laboratory test results, to specific input from the patient and others on the health care team, especially the most responsible practitioner. Access to health information from the patient, PharmaNet, patient medical records, and information from others on the patient care team are required for pharmacist prescribing.

Patient Education

The College will develop a patient education plan and a communications strategy to build awareness and understanding of pharmacist prescribing in BC.

2. PURPOSE OF THIS FRAMEWORK

The College's mandate is to serve and protect the public with a vision to provide better health through excellence in pharmacy. This framework proposes the path forward to protecting patient safety through the regulation of Certified Pharmacist Prescribers in collaborative practice relationships.

This Certified Pharmacist Prescriber initiative is focused on preventing patient harm by reducing preventable drug-related problems and providing safer transitions in care through increased involvement of pharmacists, as medication experts in the delivery of patient-centred collaborative care. Improving medication management and reducing preventable drug-related hospitalizations protects public safety and will improve patient outcomes.

Pharmacists are medication management experts and can identify, resolve and prevent drug therapy problems. They take complete and accurate medication histories and monitor drug therapy to prevent patient harm from drug-related problems. They make recommendations to the patient's family physician and others involved in the patient's care when changes to drug therapy are required to prevent drug-related problems, including initiation of a new drug, discontinuation of a drug and a switch in drug therapy. More closely involving pharmacists in a patient's care team and prescribing decisions allows pharmacists to contribute their medication expertise more effectively and better protect patients from the risks involved in drug therapy.

Collaborative practice relationships involve a Certified Pharmacist Prescriber and a regulated health professional who has the authority to prescribe developing a relationship and working together to establish expectations for caring for a mutual patient, facilitate communication, share relevant health information, and determine mutual goals of therapy with the patient.

Certified Pharmacist Prescribers would work in collaboration with the patient and other members of the patient's care team on drug therapy plans, and would be authorized to prescribe drug therapy, including initiating, discontinuing and or changing drug therapy to improve outcomes and prevent drug-related problems.

Certified Pharmacist Prescribers would be regulated by the College through specific standards, limits and conditions in addition to the College's *Code of Ethics* and existing bylaws and professional practice policies. An education program and evidence based cases would also be part of the certification process.

This initiative will require amendments to the Pharmacists Regulation under the *Health Professions Act*. Amendments to College bylaws will also be needed.

3. BACKGROUND

The development of a framework for pharmacist prescribing stretches back to 2010 when the College of Pharmacists of British Columbia Board first decided to move forward with a feasibility study to assess how pharmacist prescribing could help better prevent patient harm and improve patient outcomes. It was later included as an initiative in the College's 2014/15 – 2016/17 Strategic Plan and continues to be part of the College's strategic plan for 2017/18 – 2019/20.

In May 2015, the College developed "Establishing Advanced Practice Pharmacists in British Columbia" which proposed moving forward with obtaining pharmacist prescribing authority, in response to the Ministry of Health's call for feedback on several cross-sector policy discussion papers. In response to the College's submission, the Ministry of Health requested additional information on societal need, eligibility criteria, and managing perverse incentives to prescribe in addition to further stakeholder engagement.

As a result, the College developed an initial Certified Pharmacist Prescriber Draft Framework which included information on societal need, proposed eligibility criteria and standards limits and conditions, as well as practical use cases. The framework was based on full independent prescribing, similar to the pharmacist prescribing authority that exists in the Province of Alberta, where pharmacist prescribers initiate and manage drug therapy for patients when they have the knowledge, skills and abilities to safely prescribe.

The initial Draft Framework was used to facilitate stakeholder engagement on pharmacist prescribing in BC. Stakeholder engagement was conducted through a series of consultations in Spring/Summer 2016.

The level of participation during the Certified Pharmacists Prescriber Engagement was one of the largest the College has ever experienced. The College held over 15 different workshops discussions and meetings and heard from over heard from and over 25 different stakeholder groups. The College also received over 11,400 comments through its online survey. The detailed report on the results of the engagement was published on the College's website after being reviewed by the College Board in November 2016.

After reviewing the results of the engagement, the College Board made the decision to amend the Certified Pharmacist Prescriber Draft Framework by narrowing the scope of pharmacist prescribing to within collaborative practice.

Stakeholder Feedback

The College used feedback from patients, pharmacists and other prescribers to revised and build on the framework for pharmacist prescribing in BC.

Overall, stakeholder groups were quite divided in their level of confidence in independent pharmacists. Feedback indicated overwhelming support from pharmacists and pharmacy technicians, but strong resistance from other prescribers, while the public was divided with both support and concern.

The greatest convergence across stakeholder groups surrounded the opportunity pharmacist prescribing could have in providing greater access to care, especially for minor ailments, emergency situations, continuity of care and for patients without a primary care provider. Feedback from pharmacists and other prescribers also highlighted that pharmacist prescribing might work best in interdisciplinary team-based settings where access to more patient information and lab test results, and having a physician or nurse practitioner available to provide a diagnosis, provided respondents with greater confidence in pharmacist prescribing.

The Engagement Report with stakeholder feedback on the initial framework for independent prescribing can be found at bcpharmacists.org/certified-pharmacist-prescriber.

Collaborative Practice Pharmacist Prescribing

Pharmacist prescribing within collaborative practice would take place through interdisciplinary team-based care where physicians and nurse practitioners would continue to be responsible for the diagnosis, and access to health records and diagnostics, including lab tests, would be facilitated. Certified Pharmacist Prescribers would also be restricted from dispensing medications they prescribed for a patient.

Reasons for restricting pharmacist prescribing to collaborative practice

- **Interdisciplinary team-based settings**
  Collaborative practice settings involve working closely in an interdisciplinary team to care for patients. In this setting, physicians or nurse practitioners provide the diagnosis – an area many other prescribers felt pharmacist prescribers would not have the expertise to do.
- **Access to patient health information and lab tests**
  Pharmacists working in collaborative practice settings already have access to patient health information and lab tests. Lack of access to patient information, and diagnostic tests (including lab tests) outside of interdisciplinary settings was a key point of concern identified by many pharmacists and other prescribers.
- **Conflict of Interest**
  Separating pharmacist prescribing from dispensing and business interests removes the concern for a potential business conflict of interest – a frequent point of concern for respondents.

Developing a Framework for Pharmacist Prescribing in Collaborative Practice Relationships

Based on the College Board's direction, the College has developed a framework for pharmacist prescribing within collaborative practice. Pharmacist prescribing is proposed to take place through interdisciplinary team-based care where physicians and nurse practitioners would continue to be responsible for the diagnosis, and access to health records and diagnostics, including lab tests, would be facilitated. Certified Pharmacist Prescribers would also be restricted from dispensing medications they prescribed for a patient.

In developing a new Draft Framework for Pharmacist Prescribing in Collaborative Practice Relationships, the elements in the initial Draft Framework were adjusted to reflect the revised scope and collaborative requirements. Feedback on other areas, such as eligibility requirements and patient education, were also used to inform this framework.

The new Draft Framework for Pharmacist Prescribing in Collaborative Practice Relationships also focuses more closely on the benefit to patient care by identifying specific opportunities to prevent patient harm and improve patient outcomes. More recent evidence and case studies demonstrating the benefits of pharmacist prescribing in patient care have also been released and were important to include.

While many of the standards, limits and conditions may remain the same, some changes were also needed to narrow the scope of the framework to pharmacist prescribing in collaborative relationships. This included outlining how pharmacist prescribing would operate within a collaborative approach and defining what would be required as part of a collaborative practice relationship.

4. EXISTING PATIENT SAFETY RISKS

Risks to patient safety as a result of drug-related problems or poor patient outcomes are growing. There are many risks inherently involved in providing drug-therapy as part of patient care and medication experts play an important role in navigating the increasing complex care involved in providing patients with the care they need. An aging population, multi-medication use, transfers in care, chronic disease management, and increasing complexity in patient care all increase the risk of drug related problems and put patient safety at risk. These factors together with the challenges in providing timely access to care, also affect patient health outcomes.

While the risks can be managed through the involvement of medication experts in a patient's care team, there are still gaps in a pharmacist's ability to reduce these risks and contribute to improving patient health outcomes. Currently, pharmacists in BC do not have the level of involvement in prescribing decisions or the ability to initiate, monitor and adjust a patient's drug-therapy in a timely way that is needed to help manage these risks and better care for patients.

4.1 DRUG RELATED PROBLEMS ARE A GROWING CONCERN

Drug related problems are a growing concern and pose a serious risk to patients that can result in poor patient outcomes, hospitalizations or even death. Incidents occur both within hospital and residential care settings as well as within the community. However, many can be prevented when medication experts are involved in the prescribing process and can intervene to address drug-related problems.

Drug-related problems

A drug-related problem is defined as an event or circumstance that involves a patient's drug treatment that actually, or potentially, interferes with the achievement of an optimal outcome.

- Need for additional drug therapy (i.e. untreated indications)
- Unnecessary drug therapy (i.e. drug use without indication)
- Wrong drug (i.e. improper drug selection)
- Dosage is too low
- Dosage is too high
- Adverse drug reaction (actual and potential)
- Drug interactions
- Compliance problem
- Failure to receive drugs (i.e. dose omissions and delay in treatment)[1]

While many of the factors that increase the risk for drug-related problems are inherit in the health care system and cannot be avoided, in many cases, drug-related problems are still preventable. This makes it important to recognize the ongoing risks and involve medication experts in helping to mitigate the risk for patients.

Drug-related problems have a significant impact on morbidity and mortality and they will continue to increase as BC's population ages and more people use prescription medications, over the counter drugs and natural supplements to treat their conditions.

[1] Adusumilli, P.K., Adepu, R. (2014). Drug Related Problems: An Over View of Various Classification Systems. *Asian J Pharm Clin Res*, Vol 7, Issue 4

Elements of patient care that contribute to drug-related problems

- Increased use of medications
- Multiple chronic diseases or conditions (comorbidities)
- Polypharmacy (where patients are on five or more medications)
- Transitions in care (such as discharge from Hospital back into the community)

Approximately 5-10% of hospital admissions are due to drug-related problems, of which 50% were preventable.[2] The Canadian Adverse Events Study[3] reported drug and fluid-related events were the second most common type of adverse events in Canadian hospitals, and accounted for 23.6% of the adverse events. In a BC study, more than 1 in 9 emergency department visits at Vancouver General Hospital were due to drug-related adverse events, and 68% of them were preventable.[4] In addition, 20% of patients discharged experienced some sort of adverse problem and of those, 66% are drug related.[5]

Increases to preventable drug-related problems leads to more hospital admissions and readmissions. As a result, in addition to the patient harm drug-related problems cause, they also add a burden on the health system which unnecessarily takes resources away from patient care.

The total cost of preventable drug-related hospitalizations in Canada is estimated at $2.6 billion per year[6]. Inappropriate prescriptions for seniors aged 65 and older is also estimated at $400 million annually to the Canadian healthcare costs and reaches $1.4 billion when the impact of drug-induced falls, fractures and hospitalizations are included.[7]

[2] Nelson, K.M., Talbert, R.M. Drug-related hospital admissions. Pharmacotherapy, 16 (1996), pp. 701-707

[3] Baker, G. R., P. G. Norton, V. Flintoft, R. Blais, A. Brown, J. Cox, E. Etchells, et al. 2004. The Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada. CMAJ 170 (11): 1678-86.

[4] Zed,P et al incidence, severity and preventability of medication-related visits to the emergency depart: a prospective study, CMAJ 2008 June 3:178(12) 1563-9

[5] Forster, A.J., Murff, H.J., Peterson, J.F., Gandhi, T.K., Bates, D.W. (2003). The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*, 4,138(3), 161-7

[6] Hohl, C.M., Nosyk, B., Kuramoto, L., Zed, P.J., Burbacher, J.R., Abu-Laban, R.B., et al. (2011). Outcomes of emergency department patients presenting with adverse drug events. Ann Emerg Med, 58(3), 270-279.

[7] S.G. Morgan , J. Hunt , J. Rioux , J. Proulx , D. Weymann , & C Tannenbaum . (2016). Frequency and cost of potentially inappropriate prescribing for older adults: A cross-sectional study. *CMAJ Open*, 4(2). doi: 10.9778/cmajo.20150131

4.2 TRANSITIONS IN CARE INVOLVE RISKS FOR PATIENTS

Transitions in care are a normal and necessary occurrence in the health system as patients move between different locations and partners in their care team. However, they present an increased risk for patients, primarily from preventable drug-related problems.

Patients are particularly vulnerable during transitions, a time when they are most likely to experience drug-related problems. Transitions of Care involve patients moving between different health care locations, health care professionals, or different levels of care within the same location as their conditions or care needs change.

Factors that contribute to delay or omission of medications during transitions of care

- intention to prescribe but not prescribed new or routine drug therapy
- inadequate follow-up of problematic orders
- incomplete handoffs between health professionals
- gaps in high quality medication reconciliation[8] [9]

Approximately 40% of medications used upon admission are not continued at hospital discharge which has the potential to cause patient harm.[10] In addition, the first doses of medications to be administered can be delayed when patients are transferred between acute care and primary care or residential care. The timely administration of certain medications is crucial to prevent patient harm and death (e.g. antibiotics, antifungals, anticoagulants, insulin and Parkinson's drug therapy[11]).

[8] National Patient Safety Agency. Rapid Response Report NPSA/2010/RRROO9: Reducing harm from omitted and *delayed medicines in hospital.* NPSA 2010 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=66720

[9] ISMP Canada Safety Bulletin, Delayed Treatment after Transitions in Care: A Multi-Incident Analysis, October 2016

[10] Nickerson, A, MacKinnon, NJ, robers, N, Saulnier, L. Drug-therapy problems, inconsistencies and omissions identified during a medication reconciliation and seamless care service. *Healthcare Quarterly*. 2005;8:65-72

[11] Parkinson's patients may lose their ability to walk without their medication in the hospital

Taking a complete and accurate medication history is an important step involved in transfers of care and occur in both hospital and community practice settings. When incomplete or inaccurate medication history is taken, it increases the risk of drug related problems and puts the patient's safety at risk. Pharmacists have the medication expertise to conduct thorough medication histories. However, they do not have the authority to initiate or adjust drug-therapy which can result in delays in discharge, or not enough involvement in the prescribing decisions and insufficient drug-therapy adjustments.

Incomplete or inaccurate medication histories frequently occur during hospital admissions or discharge. This can lead to unwanted duplication of drugs, drug interactions, discontinuation of long-term medications and failure to detect drug-related problems[12] – all of which put patient safety at risk and negatively affect health outcomes.

Incomplete or inaccurate medication histories also occur outside of hospitals in primary care. This can lead to continuing drugs that are not needed or no longer needed, not using drugs that are needed to prevent adverse drug reactions, using drugs or drug doses that interact with existing medical conditions, using drugs or drug doses that interact with existing drug therapy and inconsistent monitoring.[13]

[12] Medication errors: the importance of an accurate drug history 2009

[13] High-risk prescribing and monitoring in primary care: how common is it, and how can it be improved? 2012

4.3 TIMELY ACCESS TO CARE CAN'T KEEP UP WITH PATIENT DEMAND

Challenges with timely access to care increase the risks for drug-related problems for patients in BC. Lack of access to timely care also negatively impacts patient outcomes.

Canadians report longer wait times for physicians and emergency department visits than adults in comparable countries. Only 43% were able to get a same or next day appointment at their regular place of care.[14] Canadians also visit emergency departments more often than people in other countries, and have longer waits. More than 40% of Canadians said that the last time they visited an emergency department, it was for a condition that could have been treated by their regular providers if they had been available. [15]

In BC, many large emergency departments are congested and emergency visits continue to increase each year. Seniors, and patients who have chronic conditions or severe mental illness and/or substance use are most affected by access to care and wait times.[16] People living in rural and remote areas in BC also face additional challenges as they tend to have poorer health status and limited access to health care services.[17]

Many Canadians do not have access to a regular medical doctor which presents challenges for patients to receive timely access to care and presents risks to patient health. Over 4.5 million Canadians are without a regular medical doctor.[18]

Being without a regular medical doctor is associated with fewer visits to general practitioners or specialists, who can play a role in the early screening and treatment of medical conditions.

Patients without a regular medical doctor receive services through a walk-in clinic or ER and may not be well connected to the additional primary care services that would improve their health status.[19]

As a result, physicians are seeking support from pharmacists and other healthcare providers to help manage the workload of more and more complex patients.[20]

---

[14] Canadian Institute for Health Information. How Canada Compares: Results From The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries – Accessible Report. Ottawa, ON: CIHI; 2017

[15] Canadian Institute for Health Information. Commonwealth Fund Survey 2016. https://www.cihi.ca/en/commonwealth-fund-survey-2016

[16] Ministry of Health, British Columbia. Setting Priorities for B.C. Health. http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-priorities/setting-priorities-for-bc-health

[17] Ministry of Health of British Columbia. 2015. Rural Health Services in BC: A Policy Framework to Provide a System.

[18] Statistics Canada. Access to a regular medical doctor, 2014. http://www.statcan.gc.ca/pub/82-625-x/2015001/article/14177-eng.htm

[19] Ministry of Health of British Columbia. Primary and Community Care in BC: A Strategic Policy Framework. http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf

[20] Society of General Practitioners of BC 2007. Submission to the BC Ministry of Health "Conversation on Health"

4.4 AN AGING POPULATION, POLYPHARMACY AND INCREASED COMPLEXITY IN PATIENT CARE

An aging population increases the complexity in providing care for patients. With many seniors managing multiple chronic diseases and conditions and needing multiple medications, the risks for drug-related problems and poor patient outcomes are increased.

Across Canada, patient demographics have changed, resulting in a greater number of seniors needing care. There are now more seniors than children in Canada according to the 2016 Stats Canada Census.[21]

This is especially relevant in BC. According to the Ministry of Health, BC has the fastest growing population of seniors in Canada with almost 17% being age 65 or older and this is expected to double in the next 25 years.[22]

As people get older, they need more health care, more medications, and their care becomes increasingly complex and at higher risk for drug-related problems. Nearly two-thirds of seniors over 65 use 5 or more drugs and more than one-quarter use 10 or more drugs. Medication use can lead to serious patient harm, especially in older adults with multiple chronic diseases or conditions (comorbidities) and on multiple medications. More than one-third of seniors are using also inappropriate medications[23]. As a result, seniors are at a greater risk for adverse drug reactions and are five times more likely to be hospitalized as a result.[24]

Half of British Columbians are taking one or more prescription medications and medication use is higher in individuals with chronic conditions of medium or high complexity.[25] [26] Multiple medication use can lead to polypharmacy, the use of inappropriate medications, or more medications than clinically indicated.

Polypharmacy is associated with adverse drug-related events, nonadherence, increased risk of cognitive impairment, impaired balance and falls, increased risk of morbidity, hospitalization, and death.[27]

[21] Statistics Canada. An aging population. http://www.statcan.gc.ca/pub/11-402-x/2010000/chap/pop/pop02-eng.htm

[22] Ministry of Health of British Columbia. 2014. 2014/15 - 2016/7 Service Plan.

[23] CIHI 2014 Drug Use Among Seniors on Public Drug Programs in Canada

[24] Canadian Institute for Health Information. 2014. Adverse drug reaction- related hospitalizations among seniors 2006 to 2011.

[25] Health Council of Canada. 2014. Where You Live Matters: Canadian Views on Health Care Quality.

[26] Ministry of Health of British Columbia. 2015. Primary and Community Care in BC: A Strategic Policy Framework.

[27] Kwan D, Farrell B. Polypharmacy: Optimizing medication use in elderly patients. Can Geriatr J. 2014;4(1):21–7.

There is an also increasing complexity involved in the skills and knowledge required to provide comprehensive care to an aging demographic. This makes it more difficult for any single health professional to be able to meet all the complex needs of patients. Team work, where health professionals work collaboratively to deliver care and draw on the expertise of each health professional in the team, is being emphasized as a strategy by the Province of BC and others for addressing the increasing complexity.[28, 29]

[28] Ministry of Health, British Columbia. Setting Priorities for B.C. Health. http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-priorities/setting-priorities-for-bc-health

[29] Team work is used interchangeably with interdisciplinary, Interprofessional, multiprofessional, and multidisciplinary throughout Setting Priorities for B.C. Health policy papers.

5. PHARMACIST'S EVOLVING ROLE IN THE PATIENT'S CARE TEAM

At one time, prescribing was limited largely to physicians. However, an increasing focus on an interprofessional collaborative approach in the delivery of healthcare services, especially with chronic diseases, have led to expansion of prescribing rights for other healthcare professionals including pharmacists.

Greater recognition of pharmacists' ability to prevent drug-related problems and improve drug therapy outcomes through their medication expertise has also led to greater involvement in prescribing decisions across Canada and internationally. Growing pressure on the health care system from an increasing senior population, complexities in patient care, and limited access to primary care services have also been factors in expanding pharmacists' scope of practice to provide better care for patients.

5.1 PHARMACISTS OPTIMIZE DRUG THERAPY AS MEDICATION EXPERTS

Medication management involves patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams.[30]

Pharmacists' Role in Medication Management

- Assess patients and their medication-related needs and identify actual or potential drug therapy problems
- Formulate and implement care plans to prevent and/or resolve drug therapy problems
- Recommend, adapt or initiate drug therapy where appropriate
- Monitor, evaluate and document patients' response to therapy
- Collaborate and communicate with other health care providers, in partnership with patients

With greater involvement in prescribing drug therapy, pharmacist prescribers working in collaborative practice relationships will be able to use their medication expertise to more effectively manage drug therapy, prevent drug-related problems and improve patient outcomes.

Pharmacist-led drug therapy management improves clinical outcomes for patients, contributes to health care cost savings, and receives high satisfaction ratings from patients.[31] For example, preventable adverse drug events were reduced by two-thirds and 99% of the pharmacist recommendations were accepted by physicians during rounds with a pharmacist in ICU[32].

[30] This definition was collaboratively defined by the Canadian Pharmacists Association, Canadian Society of Hospital Pharmacists, Association of Faculties of Pharmacy of Canada and Institute for Safe Medication Practices Canada. https://www.pharmacists.ca/education-practice-resources/professional-development/medication-management/

[31] Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. *J Manag Care Pharm.* 2010;16(3):185-95.

[32] Leape LL, Cullen DJ, Clapp MD, et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. *JAMA*. 1999;282:267-270

Pharmacist prescribing optimizes the pharmacist's role in medication management and has the potential to improve continuity of care by decreasing the number of steps a patient must take to obtain the optimal medication regimen for their condition.[33]

Pharmacists with varying levels of undergraduate, postgraduate and specific on-the-job training related to the disease or condition achieved comparable health outcomes to physicians when the pharmacists prescribed medications to manage a range of conditions[34].

What results without the authority to prescribe is often a redundant and time-consuming process, where pharmacists make recommendations to other health care professionals who are asked to approve them. This causes delays and inefficiencies that are not in the interest of patient care or safety, especially in cases of adverse effects or lack of therapeutic response, and does not improve the overall quality of therapeutic decision-making. Further, it requires patients to visit multiple healthcare practitioners and constrains the time that prescribers (e.g., physicians and nurse practitioners, etc.) have to provide other care within their scopes of practice. Prescribing authority provides pharmacists with an important tool to contribute to the optimization of medication use and improve patient health outcomes.

Lack of continuity and prescribing errors at transitions of care from community to hospital and hospital to community are major causes of morbidity, readmission, inefficiency, and patient dissatisfaction with care.[35] [36] [37] [38] This has become a major priority of health authorities and is a focus of accreditation standards for hospitals.[39] Pharmacists in hospital and the community have a critical role in reconciling and optimizing drug therapy through these transitions. Prescribing is a key to doing this effectively and pharmacist prescribing would contribute greatly to achieving the goal of seamless care delivery.

[33] Pearson, Glen et al. An Information Paper on Pharmacist Prescribing Within a Facility. The Canadian Journal of Hospital Pharmacy, [S.l.], v. 55, n. 1, May 2009.

[34] Cochrane Review 2016 Weeks G, George J, Maclure K, Stewart D. Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD011227. DOI: 10.1002/14651858.CD011227.pub2 http://www.cochrane.org/CD011227/EPOC_prescribing-roles-health-professionals-other-doctors

[35] Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med 2003;138:161–7

[36] Kwan JL, Kwan JL, Lo L, Lo L, Sampson M, Sampson M, et al. Medication Reconciliation During Transitions of Care as a Patient Safety Strategy. Ann Intern Med 2013;158:397–403

[37] Rennke S, Nguyen OK, Shoeb MH, Magan Y, Wachter RM, Ranji SR. Hospital-initiated transitional care interventions as a patient safety strategy: a systematic review. Ann Intern Med 2013;158:433–40

[38] Hesselink G, Schoonhoven L, Barach P, Spijker A, Gademan P, Kalkman C, et al. Improving patient handovers from hospital to primary care: a systematic review. Ann Intern Med 2013;158:417–28

[39] American College of Clinical Pharmacy, Hume AL, Kirwin J, Bieber HL, Couchenour RL, Hall DL, et al. Improving care transitions: current practice and future opportunities for pharmacists. Pharmacotherapy 2012;32:e326–37 https://accreditation.ca/medication-management-standards

5.2 EXPANDING ROLE OF PHARMACISTS IN THE PATIENT CARE TEAM

Pharmacists' scope of practice has evolved in BC to better meet the needs of patients. Risks to patient care and opportunities to improve outcomes are key drivers in expanding pharmacists' scope of practice.

In 2009, pharmacists were given the authority to continue and adapt prescriptions written by authorized prescribers, as well as administer injections.[40] This was an important step, and expansion of the pharmacist's scope of practice, to help protect patients in BC from the H1N1 influenza. Pharmacists now play an important role in delivering influenza vaccinations every flu season and are better prepared to protect patients from future influenza pandemics.[41] [42]

Pharmacists were also previously granted the authority to prescribe an emergency supply of prescription medications. In addition, pharmacists may prescribe Schedule IV drugs[43] for emergency contraception (4 norgestrol). Pharmacists have also been assessing patients and prescribing Schedule II and III drugs[44] for several years.

These changes helped address risks to patients that could result in drug-related problems or poor patient outcomes, such as timely access to care. However, initiating Schedule I Drugs in collaboration with the patients' care team is not within a pharmacist' scope of practice, unlike many other provinces in BC.

[40] College of Pharmacists of BC. Pharmacists Preparing to Provide Immunizations. Vol 34 no 4, Jul-Aug-Sep 09. http://library.bcpharmacists.org/6_Resources/6-7_ReadLinks/ReadLinks-JulAugSep2009.pdf

[41] BC Centre for Disease Control. Communicable Disease Control Immunization Program. http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization

[42] The role of pharmacists in the delivery of influenza vaccinations. https://www.ncbi.nlm.nih.gov/pubmed/15161077/

[43] Schedule IV drugs are those prescribed by a pharmacist and include "drugs which may be prescribed by a pharmacist in accordance with guidelines approved by the Board". Drug Schedules Regulation http://www.bclaws.ca/civix/document/id/complete/statreg/9_98#Schedules)

[44] Schedule II drugs may be sold by a pharmacist on a nonprescription basis and which must be retained within the Professional Service Area of the pharmacy where there is no public access and no opportunity for patient self-selection. Schedule III drugs may be sold by a pharmacist to any person from the self-selection Professional Products Area of a licensed pharmacy. Drug Schedules Regulation. http://www.bclaws.ca/civix/document/id/complete/statreg/9_98#Schedules

Patient safety was protected by the College of Pharmacists of BC as pharmacist practice expanded. Methods of regulation related to the new area of practice and ranged from specific training, certification programs, to new requirements in College bylaws and policies (see Appendix 5).

5.3 OTHER JURISDICTIONS IMPROVING PATIENT CARE THROUGH PHARMACIST PRESCRIBING

Pharmacists have become more involved in protecting patient safety and improving outcomes through different models of collaborative prescribing across Canada and other international jurisdictions.

A recent review of pharmacists' scope of practice across Canada shows that initiating prescriptions is possible in all Canadian provinces except BC.[45] Other international jurisdictions including the UK, parts of the USA, and New Zealand have also implemented pharmacist prescribing (see Appendix 3).

These jurisdictions established pharmacist prescribing with goals focused on protecting patient safety and improving patient outcomes.

Goals of Implementing Pharmacist Prescribing [46] [47]

- improve access to primary care
- improve timely access to medications
- make better use of pharmacists knowledge and skills
- increase drug-therapy monitoring
- reduce ER visits and hospitalizations
- improve continuity of care
- improve patient outcomes

[45] Pharmacists' Expanded Scope of Practice. December 2016. http://www.pharmacists.ca/pharmacy-in-canada/scope-of-practice-canada/

[46] Department of Health. Improving Patients' Access to Medicines: A Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England. London: Department of Health; 2006.

[47] MacLeod-Glover, N. (2011), An explanatory policy analysis of legislative change permitting pharmacists in Alberta, Canada, to prescribe. International Journal of Pharmacy Practice, 19: 70–78. doi: 10.1111/j.2042-7174.2010.00074.x

5.4 PRESCRIBING DECISIONS IN PHARMACY PROGRAMS

Pharmacists are already being trained to make prescribing decisions. Pharmacy education programs are training pharmacists to be medication therapy experts who will have the knowledge, skills and abilities to initiate and manage drug therapy and effectively collaborate with other health professionals to deliver patient-centred team-based care.

Canadian universities, including the Faculty of Pharmaceutical Sciences at UBC, are transitioning the professional pharmacy degree program from a bachelor of science to a doctor of pharmacy degree with an added focus on prescribing and monitoring of drug therapy, and interprofessional team-based primary care. They will also complete almost twice the amount of experiential learning – caring for patients under the supervision of practicing professionals – than the previous BSc Program.

Universities have also begun to offer opportunities where students across health faculties train together to develop collaborative relationships that prepare them for collaborative practice.

The Pharmacy Examining Board of Canada which assesses the qualifications and competence of candidates for licensing of pharmacists across Canada already includes requirements that support pharmacist prescribing in collaborative practice relationships. “Patient Care” has the highest overall weighting, including for Objective Standardized Clinical Examination. “Communication and Education”, and “Intra- and Inter-Professional Collaboration” are more highly weighted as part of the clinical examination. [48]

Pharmacy residencies[49] and other PharmD programs such as the UBC Graduate PharmD degree[50] and Flex PharmD degree[51] also provide already practicing pharmacists with the knowledge skills and abilities to prescribe.

[48] Pharmacy Examining Board of Canada. http://www.pebc.ca/index.php/ci_id/3139/la_id/1.htm

[49] Pharmacy Practice Residency, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/pharmacy-practice-residency

[50] Graduate PharmD degree, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/graduate-pharmd-degree

[51] Flex PharmD degree, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/flex-pharmd-degree

5.5 INCREASED COLLABORATION BETWEEN HEALTH PROFESSIONALS

Collaboration and team-based care is growing between health professionals both nationally and internationally.[52] [53] Research showing that a team-based approach can improve efficiency and effectiveness is a key driver in expanding collaborative practice.[54] Jurisdictions, including BC, have taken measures to support and increase interprofessional collaboration.[55]

Principles of interprofessional collaboration

- work together with patients in response to their needs
- collaborate with other providers
- understand the roles of other providers
- develop trust and respect for others
- value the input of other providers
- communicate effectively
- seek direction and guidance from other providers when aspects of care are beyond their individual competence, scope of practice and scope of employment

Currently, pharmacists in BC participate in interprofessional collaboration through working on care teams and recommending drug therapy plans to other prescribers involved in the patient's care.

[52] Steglitz J, Buscemi J, Spring B. Developing a patient-centered medical home: Synopsis and comment on "Patient preferences for shared decisions: a systematic review." Transl Behav Med 2012;2:260-261.

[53] Canadian Health Services Research Foundation, Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada – Policy Synthesis and Recommendations. June, 2006.

[54] Health Canada. Health care system. Accessed 2 March 2015. www.hc-sc.gc.ca/hcs-sss/prim/about-apropros-eng.php

[55] Health Professions Regulatory Advisory Council. Interprofessional Collaboration. http://www.hprac.org/en/projects/resources/hprac-collaboration.JurisdictionReviewENFINAL.feb1208.pdf

6. PREVENTING PATIENT HARM AND IMPROVING HEALTH OUTCOMES

Pharmacist prescribing has an important opportunity to prevent harm and improve outcomes for patients across BC.

Patient needs are growing with of the rising number of patients with chronic diseases and multiple conditions in addition to a growing senior population. To meet these needs, Pharmacists need to be able to contribute more as part of the patient care team.

Pharmacist prescribing is needed to:

- improve patient outcomes,
- prevent drug-related problems,
- reduce unnecessary emergency room visits and hospitalizations,
- improve timely access to drug therapy, and
- improve continuity of care.

Many patients recognize the value pharmacists provide in providing timely access to care and would like to see more health services provided by pharmacists. More than 4 in 5 Canadians, 82%, say allowing pharmacists to do more for patients will both improve health outcomes and reduce health care costs.[56]

Studies show that pharmacist prescribing benefits patients by preventing drug-related problems and unnecessary hospitalizations and deaths, improving outcomes for patients with chronic diseases and complex conditions, providing safer transfers in care and providing more timely access to care. Reduced risk factors for chronic disease, improved blood glucose, improved blood

[56] Abucus Data. 2017. Pharmacists in Canada – A national survey of Canadians on their perceptions and attitudes towards pharmacists.

pressure, improved lipid levels, and reduced risk for major cardiovascular events are all examples of pharmacist prescribing in collaborative relationships preventing harm and improving patient outcomes in recent studies.[57] [58] [59] [60] [61] [62] [63] [64]

It has also been shown that pharmacists achieve comparable health outcomes to physicians when they managed a range of conditions with the authority to prescribe.[65]

[57] Al Hamarneh YN, Charrois T, Lewanczuk R, et al. Pharmacist intervention for glycaemic control in the community (the RxING study). *BMJ Open* 2013;3:e003154.

[58] McAlister FA, Majumdar SR, Padwal RS, et al. Case management for blood pressure and lipid level control after minor stroke: PREVENTION randomized controlled trial. *CMAJ* 2014;186:577-84

[59] Cochrane for Clinicians (2013). Appropriate use of polypharmacy for older patients. *Am Fam Physician*. 2013Apr1;87(7):483-484.

[60] Tsuyuki R, Houle S, Charrois T, et al. A randomized trial of the effect of pharmacist prescribing on improving blood pressure in the community: the Alberta clinical trial in optimizing hypertension (RxACTION). *Can Pharm J (Ott)* 2014;147:S18.

[61] Rosenthal M, Tsuyuki R. A community-based approach to dyslipidemia management: pharmacist prescribing to achieve cholesterol targets (RxACT Study). *Can Pharm J (Ott)* 2014;147(4):S20

[62] Al Hamarneh Y, Sauriol L, Tsuyuki R. Economic analysis of the RxING study. *Can Pharm J (Ott)* 2014;147:S47

[63] Dole EJ, Murawski MM, Adolphe AB, et al. Provision of Pain Management by a Pharmacist with Prescribing Authority. AM J Health- Syst Pharm. 2007; 64: 85- 89.

[64] Finley PR, Rens HR, Pont JT, et al. Impact of a Collaborative Pharmacy Practice Model on the Treatment of Depression in Primary Care. Am J Health- Syst Pharm. 2002; 59(16): 1518- 1526.

[65] Cochrane Review 2016 Weeks G, George J, Maclure K, Stewart D. Non-medical prescribing versus medical prescribing for acute and chronic disease management in primary and secondary care. Cochrane Database of Systematic Reviews 2016, Issue 11. Art. No.: CD011227. DOI: 10.1002/14651858.CD011227.pub2 http://www.cochrane.org/CD011227/EPOC_prescribing-roles-health-professionals-other-doctors

6.1 PHARMACISTS PREVENT DRUG-RELATED PROBLEMS

Pharmacists have unique drug therapy focused knowledge and skills, making them medication experts. This makes them the most effective member of a health care team in identification, prevention and resolution of drug-related problems. Through collaborating with other health professionals and the patient, pharmacists have a great opportunity to help protect patient safety and improve patient outcomes through a more active role in initiating and managing drug therapy.

Currently, pharmacists in BC can recommend drug therapy plans to a physician or other prescriber on the patient's care team. This collaborative role already plays an important role in preventing drug-related problems. However, without the ability to make prescribing decisions, pharmacists cannot always intervene to prevent drug-related problems.

A pharmacist prescriber has the ability to effectively manage a patient's drug therapy through initiating, monitoring and adjusting medications. With their medication expertise and accessibility to patients, they can play an important role on the patient's care team in managing drug therapy and provide more opportunities for improved drug therapy monitoring, patient follow up, and adjustments as needed.

They are also more easily able to quickly intervene to address or prevent adverse effects from drug-related problems. Time delays for patients when a prescriber, such as a physician or a nurse practitioner is not readily accessible, can result in delayed interventions and delayed access to treatment which puts patient safety at risk and contributes to poor health outcomes. In addition, the pharmacist may not have ongoing overall involvement in the patient's drug therapy plan to monitor, adjust and follow up with patients and members of the care team.

Studies have also shown that pharmacists on hospital rounds identify, resolve, and prevent drug therapy problems through their management and initiation of drug therapy.

6.2 PHARMACIST PRESCRIBERS IMPROVE TIMELY ACCESS TO PATIENT CARE

For many patients, the first point of contact with the health system is through the most accessible health professional, the pharmacist – this is particularly relevant when other health professionals are unavailable or are unable to see patients in a timely manner. As a valuable member of the patients' care team, pharmacists can work with patients on achieving the best drug therapy outcomes, avoiding drug-related problems, and providing accessible and timely care.

Patients in BC want better, faster access to health care and have specifically identified pharmacists and nurses as key professionals best qualified to assist in alleviating physicians' workload.[66] Patients also believe an expanded scope of practice will allow health professionals to provide a level of care more reflective of their qualifications, while increasing the efficiency and accessibility of BC's health care system.[67]

Pharmacists frequently see patients with poorly controlled high blood pressure (about 30-90% uncontrolled in the community). They also frequently see patients with abnormal amounts of lipids in their blood (about 50% in the community). These cases, among many, present opportunities for pharmacists to work closely with their patients, and others on the patient care team to help improve health outcomes. The pharmacists' accessibility to the patient and their ability to assess, monitor and prescribe and adjust drug therapy allows for timely care to be provided. This can be especially beneficial for many chronic diseases and complex conditions where ongoing monitoring and frequent follow-ups and drug therapy adjustments may be needed.

[66] Geoffrey Appleton, MB. The consensus? There is no consensus. BCMJ, Vol. 50, No. 1, January, February, 2008, page(s) 10 — President's Comment.

[67] Ministry of Health of British Columbia. 2007. Input on the Conversation on Health.

Improved blood pressure[68] [69] (RxACTION Study)

Pharmacist assessment of blood pressure, cardiovascular risk, patient education, prescribing of antihypertensive medications, laboratory monitoring, monthly follow-up based on the Canadian hypertension guidelines improves blood pressure in poorly controlled patients.

- The pharmacist prescriber established a collaborative relationship with the patient's family physician, established drug therapy goals together with the patient and physician to improve the patient's blood pressure, and ensured information and updates could be effectively shared between the physician and the pharmacist prescriber.
- The pharmacist prescribing decisions included: initiation of new antihypertensive drugs, dose changes, deprescribing of antihypertensive drugs, addition of low-dose acetylsalicylic acid and initiation of a statin.
- This resulted in improved blood pressure in poorly controlled patients.
- Pharmacist prescribers communicated all the assessment results and drug therapy changes in the patient's medication management with the patient's family physician in person or by fax.

[68] Tsuyuki R, Houle S, Charrois T, et al. A randomized trial of the effect of pharmacist prescribing on improving blood pressure in the community: the Alberta clinical trial in optimizing hypertension (RxACTION). *Can Pharm J (Ott)* 2014;147:S18.

[69] McAlister FA, Majumdar SR, Padwal RS, et al. Case management for blood pressure and lipid level control after minor stroke: PREVENTION randomized controlled trial. *CMAJ* 2014;186:577-84

Improved lipid levels[70] [71] (RxACT Study)

Pharmacist prescribing helps patients improve lipid levels and achieve cholesterol targets to reduce cardiovascular risk.

- The pharmacist prescriber established a collaborative relationship with the patient's family physician, established drug therapy goals together with the patient and physician to improve the patient's lipid levels, and ensured information and updates could be effectively shared between the physician and the pharmacist prescriber.
- The pharmacist prescriber's medication management and prescribing decisions included: completing assessment of cardiovascular risk, reviewing lipid levels, developing a care plan, providing education/counseling to the patient, prescribing/titration of lipid-lower medications, ordering lab tests to monitor efficacy and safety, assessing of drug tolerability (i.e. myalgia), and following-ups based on the Canadian dyslipidemia guidelines.
- This resulted in improved lipid levels in poorly controlled patients.
- Pharmacist prescribers communicated all the assessment results and drug therapy changes in the patient's medication management with the patient's family physician.

[70] Rosenthal M, Tsuyuki R. A community-based approach to dyslipidemia management: pharmacist prescribing to achieve cholesterol targets (RxACT Study). *Can Pharm J (Ott)* 2014;147(4):S20

[71] Cochrane for Clinicians (2013). Appropriate use of polypharmacy for older patients. *Am Fam Physician*. 2013Apr1;87(7):483-484.

Involving pharmacists more closely in prescribing drug therapy within a collaborative practice relationship can ease some of the pressure on access to primary care for patients in BC. Pharmacists would also be able to collaborate more efficiently with other health providers in hospital settings, for example in providing more timely access to the health professional and medication expertise needed to provide safe transitions in care.

Pharmacist prescribing will allow pharmacist to take on a larger role in medication management, initiating, adapting and monitoring a patients' drug therapy while collaborating with others on the patient's care team to ensure the best possible health outcomes. This additional prescriber on a patients' care team has the potential to both provide more-timely access to drug therapy and improve medication management to reduce risks and improve outcome for patients.

6.3 PHARMACIST PRESCRIBERS HELP PREVENT PATIENT HARM DURING TRANSITIONS IN CARE

Patients are at an increased risk for drug-related problems during transitions in care. However, these risks can be reduced with increased involvement of pharmacists in initiating, managing and deprescribing drug therapy during transitions in care.

Medication reconciliation, an important step in transitions in care, is proven to be especially effective in preventing patient harm and improving patient outcomes.[72]

Canadian Medication Reconciliation Outcomes

- Using a nurse-pharmacist led process, medication reconciliation was able to potentially avert 81 adverse drug events for every 290 patients.
- Over a six month period, implementation of a formal medication reconciliation process upon transfer out of the Intensive Care Unit (ICU) decreased the number of sampled patients found to have a medication error from 94% to nearly 0%.
- Long-term care (LTC) residents, who had medication reconciliation completed upon return to LTC from acute care, were less likely to have a discrepancy-related adverse event as compared to residents who did not have medication reconciliation completed.

Gaps in high quality medication reconciliation[73] [74] during admission and discharge from hospital can be addressed by pharmacist prescribers, with collaborative relationships that involve others on the patient's care team both in the hospital and in primary care.

[72] Medication Reconciliation in Canada: Raising the Bar Progress to date and the course ahead. https://accreditation.ca/sites/default/files/med-rec-en.pdf

[73] National Patient Safety Agency. Rapid Response Report NPSA/2010/RRROO9: Reducing harm from omitted and *delayed medicines in hospital.* NPSA 2010 http://www.nrls.npsa.nhs.uk/alerts/?entryid45=66720

[74] ISMP Canada Safety Bulletin, Delayed Treatment after Transitions in Care: A Multi-Incident Analysis, October 2016

For example, pharmacist-led medication reconciliation [75] during a hospital discharge can help ease the transition of care back into the community. The Pharmacist prescriber would complete a best possible medication history[76] as part of the medication reconciliation, and facilitate a safe handoff of the medication changes, including initiation, adaption or deprescribing of drug therapy through working with the patient's family physician and community pharmacy together with the patient and others involved in the patient's care team.

As a result, pharmacist prescribers have a valuable opportunity to improve the timeliness of transfers of care through quality medication reconciliations and initiation of drug therapy during hospital discharge. This is also an opportunity to improve patient outcomes and prevent drug-related problems by ensuring the appropriate drug-therapy is prescribed at discharge and patients are not delayed in stating their therapy. Effective communication between pharmacist prescribers in hospital or urgent care centers and pharmacists in community also supports effective continuity of care during a transfer. The College of Physicians and Surgeons of BC also specifically identified the opportunity for pharmacist to make appropriate prescribing decisions during hospital discharges.[77]

"It seems entirely appropriate for hospital pharmacists to provide prescriptions at time of discharge, having been engaged in the medication optimization and management during the patient's stay." – Letter from the College of Physicians and Surgeons of British Columbia

Medication reconciliation by pharmacist prescribers during admissions and emergency room visits – including initiating and adjusting drug therapy – has also demonstrated positive results for patient outcomes.

[75] Lo L, Kwan J, Fernandes OA, et al. Medication Reconciliation Supported by Clinical Pharmacists (NEW) In: Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Mar. (Evidence Reports/Technology Assessments, No. 211.) Chapter 25. Available from: https://www.ncbi.nlm.nih.gov/books/NBK133408/

[76] The 'Best Possible Medication History' (BPMH) constitutes the cornerstone for medication reconciliation. The BPMH is more comprehensive than a routine primary medication history, as it involves "(1) a systematic process for interviewing the patient/family; and (2) a review of at least one other reliable source of information (e.g., review of a central medication database, inspection of medication vials, or contact with the community pharmacy) to obtain and verify patient medications (prescribed and non-prescribed)." (Institute for Safe Medication Practices Canada. Medication Reconciliation).

[77] College of Pharmacists of BC. Certified Pharmacist Prescriber Engagement Report. November 2016. Page 23. http://library.bcpharmacists.org/5_Programs/5-5_CPP/1046-Certified_Pharmacist_Prescriber_Engagement_Report.pdf

In the UK, a pharmacist prescriber completed systematic medicine reconciliation in the accident and emergency department and initiated an inpatient prescription chart. In these cases, medicine reconciliation completed within 24 hours of admission increased from 50% to 100% and prescription chart initiation in the accident and emergency department increased from 6% to 80%. The prescribing error rate was reduced from 3.3 errors to 0.04 errors per patient.[78]

[78] Mills PR, McGuffie AC. Formal medicine reconciliation within the emergency department reduces the medication error rates for emergency admissions. Emerg Med J 2010;27(12):911-915. Featured in The Health Foundation, Evidence Scan: Reducing prescribing errors. April 2012. http://www.health.org.uk/sites/health/files/ReducingPrescribingErrors.pdf

6.4 PHARMACIST PRESCRIBERS IMPROVE OUTCOMES FOR PATIENTS WITH CHRONIC DISEASES AND COMPLEX CARE NEEDS

As patients' needs become more complex with multiple conditions and complex drug therapy plans, collaborative relationships become increasingly important. Patients with multiple chronic diseases or conditions are especially vulnerable to drug-related problems. They are also among the patients most affected by access to care and wait times.[79]

Increasing specialization within health professions and a fragmentation in specialist expertise results in no one healthcare professional being able to meet all the complex needs of their patients. As a result, patients with chronic diseases and multiple conditions or other complex issues require a team approach where pharmacists can use their medication expertise to initiate and manage the patient's complex drug therapy while consulting with others on the patient's care team.

While in this more involved prescribing role, pharmacist prescribers also better prevent drug-related problems and unnecessary hospitalizations or deaths.[80] [81] Greater access to a health professional that can initiate, monitor and adjust drug therapy while consulting with and informing other members of the patient's care team can also benefit patients and help address challenges with timely access to care.

In particular, a recent study showed the benefit of using pharmacist prescribing to help improve the health outcomes of patients with type 2 diabetes. Pharmacists frequently see patients with type 2 diabetes that have poorly controlled blood glucose (about 50% uncontrolled in the community).

[79] Ministry of Health, British Columbia. Setting Priorities for B.C. Health. http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-priorities/setting-priorities-for-bc-health

[80] Kwan D, Farrell B. Polypharmacy: Optimizing medication use in elderly patients. Can Geriatr J. 2014;4(1):21–7.

[81] Hughes CM, Lapane KL. Pharmacy interventions on prescribing in nursing homes: from evidence to practice. *Therapeutic Advances in Drug Safety*. 2011;2(3):103-112.

Improved blood glucose[82] (RxING Study)

Prescribing by pharmacists of oral medications and insulin for patients with poorly controlled 2 diabetes that included titration and patient follow-ups that was based on the Canadian Diabetes Guidelines showed improved glycemic control. This also revealed that the pharmacist prescribers achieved similar improvements in controlling blood glucose as previous physician-led studies.

- The pharmacist prescriber established a collaborative relationship with the patient's family physician, established drug therapy goals together with the patient and physician to improve the patient's glycemic control, and ensured information and updates could be effectively shared between the physician and the pharmacist prescriber.
- The pharmacist prescribing decisions included: a switch to another oral diabetes medication, the deprescribing of an oral diabetes medication, the initiation of an oral diabetes medication and the initiation of insulin. The pharmacist provided ongoing care and checked: adherence to the medication, blood glucose, HbA1c, insulin dose and titration, and adverse events.
- The patient's family physician was well informed of the pharmacist prescribing decisions and patient's progress with the medications prescribed.

Pharmacists also frequently see patients with high risk for major cardiovascular events. In particular, patients with chronic diseases are at high risk for cardiovascular events – this includes patients with diabetes, chronic kidney disease, established atherosclerotic vascular disease as well as those with multiple risk factors (such as poorly controlled blood glucose/blood pressure/lipids and current smokers).

Patient care through pharmacist prescribing has been shown to reduce the risk for future cardiovascular events, as well as improve blood pressure, lipids, blood glucose and help patients quit smoking. Pharmacist prescribers are also able to help patients undergo cardiovascular risk assessments. Many patients report not having undergone an assessment despite the guideline recommendation to use this assessment to guide prevention and management. Pharmacists' medication expertise together with their accessibility to the patient are key to improving patient outcomes through this kind of care.

[82] Al Hamarneh YN, Charrois T, Lewanczuk R, et al. Pharmacist intervention for glycaemic control in the community (the RxING study). *BMJ Open* 2013;3:e003154.

Reduced risk for major cardiovascular events [83] (RxEACH Study)

Pharmacist prescribing and care reduced the risk for future cardiovascular events, as well as improved blood pressure, lipids, blood glucose and smoking cessation. The reductions in cardiovascular risk were achieved on top of (not instead of) usual physician care.

- The pharmacist prescriber completed a training program based on current Canadian guidelines and included modules on case finding (identifying at risk patients), cardiovascular risk calculation, and patient communication of cardiovascular risk, chronic kidney disease, hypertension, dyslipidemia, diabetes, smoking cessation, diet and lifestyle management, and documentation of care plans.
- The pharmacist prescriber established a collaborative relationship with the patient's family physician, established drug therapy goals together with the patient and physician to reduce the patient's risk for major cardiovascular events, and ensured information and updates could be effectively shared between the physician and the pharmacist prescriber.
- The pharmacist prescriber conducted patient assessment including blood pressure measurement, waist circumference, weight and height measurements. They also completed laboratory assessment (HbA1c, fasting cholesterol profile, estimated glomerular filtration rate, albumin-to-creatinine ratio).
- The pharmacist prescriber developed an individualized assessment of cardiovascular risk and provided the patient with education about the risk, prescribed drug therapy to meet lipid, blood pressure and blood glucose targets, and started the patient on smoking cessation.
- The pharmacist prescriber also established regular follow-ups with the patient to monitor effectiveness of therapy.

  The pharmacist prescriber communicated regularly with the patient's family physician after each contact with the patient, sharing prescribing decisions and results from patient follow-ups and drug-therapy monitoring.

To meet the needs of the rising number of patients with chronic diseases and multiple conditions, especially in senior populations, many health strategies include new models of care that emphasize interprofessional collaborative practice aiming to maximize the expertise and scope of practice of all qualified healthcare professionals.[84] Pharmacist prescribing in collaborative relationships supports the team-based approach needed in the health care system to care for the growing number of patients with multiple chronic diseases.

---

[83] Tsuyuki RT, Al Hamarneh YN, Jones CA, Hemmelgarn BR. The effectiveness of pharmacist interventions on cardiovascular risk: the multicenter randomized controlled RxEACH trial. J Am Coll Cardiol 2016;67(24):2846-54.

[84] Healthcare Priorities in Canada: A Backgrounder 2014 Canadian Foundation for Healthcare Improvement www.cfhi-fcass.ca

6.5 PHARMACIST PRESCRIBERS IN COLLABORATIVE PRACTICE CAN PREVENT PATIENT HARM AND IMPROVE OUTCOMES

Collaborative relationships between health professionals on a patient's care team is a well-established practice for improving patient outcomes and providing more timely access to health services.

It's clear that the factors that increase the risks for drug-related problems will continue to exist and increase with an aging population and increasing complexity of patient care. Greater involvement of medication experts in prescribing drug therapy and medication management as part of a team based approach are needed to reduce preventable drug-related hospitalizations and deaths in addition to the unnecessary burden on the health system.

As we prepare to care for more and more patients while improving patient outcomes and reducing preventable drug-related problems, it will be important for BC to build capacity for patient-centred collaborative care in the health system. Pharmacist prescribing supports greater collaboration between health professionals, allowing pharmacists to play a bigger role on the patient's care team.

Drawing on each health professionals' expertise provides better patient-centred care

Pharmacists and physicians recognize that shared care should be patient-centred and delivered through collaboration.[85] The importance of trust and mutual recognition of each other's expertise optimizes the application of each health professional's specific training and knowledge in the provision of patient care.

Improvements to patient safety and health outcomes can be found when pharmacists and physicians work together to help patients meet their care goals. For example, a physician makes a diagnosis and decides together with the patient whether or not treatment is appropriate. The Pharmacist prescriber initiates and manages drug therapy which includes monitoring, modification, and discontinuation as needed of appropriate medication. Monitoring and follow up with the patient together with ongoing updates and discussions with the physician helps with ongoing medication management, prevent drug-related problems and helping the patient meet their drug therapy goals.

With many opportunities for collaboration to improve patient outcomes, the Ministry of Health is seeking strategies for pharmacists to work together with physicians and other healthcare providers to improve the optimal use of drug therapy[86]. Enabling pharmacists to prescribe in

[85] Donald, M., King-Shier, K., Tsuyuki, R. T., Al Hamarneh, Y. N., Jones, C. A., Manns, B., … Hemmelgarn, B. R. (2017). Patient, family physician and community pharmacist perspectives on expanded pharmacy scope of practice: a qualitative study. CMAJ Open, 5(1), E205–E212. http://doi.org/10.9778/cmajo.20160135

[86] Ministry of Health BC. 2017. 2017/18 – 2019/20 Service Plan

collaborative relationships will be an important step in maximizing the clinical effectiveness and efficiencies pharmacists offer as medication experts that can provide timely and easily accessible patient-centred collaborative care.

Collaborative Relationships help provide access to shared information

Better communication through electronic health records is needed to facilitate real-time and reciprocal relay of information about the provision of care by Pharmacist Prescribers and physicians, especially between family physician practices and community pharmacies. It is much more difficult for pharmacists working in community pharmacies and family physician offices to relay timely information to each other about the provision of patient care. The communication is mainly through fax and telephone.

However, those working in collaborative relationships will have developed a plan to facilitate communication and share relevant health information.

The transfer of information (verbal, written and electronic) already readily takes place between pharmacists and physicians working at the same practice site including hospital, team-based primary care clinics and co-located pharmacists at family physician offices. Communication tools that support collaboration are expected to increase as more physicians begin to use PharmaNet and other secure information sharing platforms.

Effective and shared communication between Pharmacist Prescribers and physicians enables physicians to be notified about modifications or initiation of drug therapy, and similarly for pharmacists to be aware of changes to the patient's health status and drug therapy as provided by the physician. Other members of a patient care team, such as nurse practitioners and specialists, would also be involved in collaboration and communication as needed. For example, a specialist's ability to review and discuss the results of the increased drug-therapy monitoring managed by the pharmacist.

6.6 PHARMACIST PRESCRIBING SUPPORTS THE HEALTH SYSTEM IN CARING FOR PATIENTS

Pharmacist prescribing in collaborative relationships supports the health care system in providing better care for patients. There is tremendous opportunity to improve patient care, in addition to improving the overall health of populations and reduce cost through pharmacist prescribing in collaborative relationships. Pharmacist prescribers are able to intervene to prevent drug-related problems, and address poor health outcomes, inappropriate medication use, polypharmacy in high-risk populations and poor transitions in care.

These opportunities for improvements to patient care, in addition to reducing cost through reducing preventable drug-related problems and unnecessary hospitalizations, support the Triple Aim approach to improving BC's health care system

The Ministry of Health's Triple Aim is:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

This is not attainable without interprofessional collaboration[87] and using a pharmacist's medication expertise to reduce preventable drug-related problems that put patient safety at risk and add an unnecessary burden to the health care system.

Table 1 outlines key ways pharmacist interventions through pharmacist prescribing in collaborative relationships are improving patient care. Improving overall health of populations and reducing costs are also identified benefits. However, these benefits are secondary to (and largely a result of) the opportunity to prevent patient harm and improve patient outcomes.

[87] World Health Organization. Framework for action on interprofessional education & collaborative practice. Geneva: World Health Organization. http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf. Published 2010

Table 1: Pharmacist interventions improve care, improve health and reduce cost				
Issue	Pharmacist Intervention	Improve Care	Improve Health	Reduce Cost
Poor patient outcomes	Pharmacist Prescribers manage and initiate drug therapy to improve patient outcomes (e.g. improve blood glucose, blood pressure, lipids and reduce future risk of CVD events).**Error! Bookmark not defined. Error! Bookmark not defined. Error! Bookmark not defined.**	✓	✓	✓
Poor handoffs during transitions in care	Pharmacist-led Medication Reconciliation [88] at hospital discharge that includes a best possible medication history[89], and a safe handoff of the medication changes (includes initiation of drug therapy) to the patient's family physician and community pharmacy.	✓	✓	✓
Preventable adverse drug events that cause patient harm in acute care	Pharmacists on hospital rounds identify, resolve, and prevent drug therapy problems through the management and initiation of drug therapy**Error! Bookmark not defined.**.	✓	✓	✓
Preventable adverse drug events that cause patient harm in residential care	Pharmacist-led medication reviews identify, resolve and prevent drug therapy problems through the management and initiation of drug therapy.	✓	✓	✓
Preventable adverse drug events that cause patient harm in the frail elderly	Pharmacist-led medication reviews for the elderly[90] identify, resolve and prevent drug therapy problems through the management and initiation of drug therapy. Pharmacists are involved in multi-disciplinary home monitoring programs for high-risk patients discharged from hospital.	✓	✓	✓
Preventable adverse drug events that cause patient harm in primary care patients with chronic diseases	Pharmacist-led medication reviews**Error! Bookmark not defined.** in team-based primary care practice identify, resolve and prevent drug therapy problems through the management and initiation of drug therapy.	✓	✓	✓
Polypharmacy and inappropriate medication use	Pharmacist-led deprescribing – Pharmacists provide evidence-based approaches to reducing potentially harmful medication burdens. [91]	✓	✓	✓

[88] Lo L, Kwan J, Fernandes OA, et al. Medication Reconciliation Supported by Clinical Pharmacists (NEW) In: Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Mar. (Evidence Reports/Technology Assessments, No. 211.) Chapter 25. Available from: https://www.ncbi.nlm.nih.gov/books/NBK133408/

[89] The 'Best Possible Medication History' (BPMH) constitutes the cornerstone for medication reconciliation. The BPMH is more comprehensive than a routine primary medication history, as it involves "(1) a systematic process for interviewing the patient/family; and (2) a review of at least one other reliable source of information (e.g., review of a central medication database, inspection of medication vials, or contact with the community pharmacy) to obtain and verify patient medications (prescribed and non-prescribed)." (Institute for Safe Medication Practices Canada. Medication Reconciliation).

[90] Hughes CM, Lapane KL. Pharmacy interventions on prescribing in nursing homes: from evidence to practice. *Therapeutic Advances in Drug Safety*. 2011;2(3):103-112.

[91] Farrell B, Shamji S, Monahan A, et al. Clinical vignettes to help you deprescribe medications in elderly patients: Introduction to the polypharmacy case series. Can Fam Physician 2013;59:1257-1258.

7. REGULATION OF CERTIFIED PHARMACIST PRESCRIBERS

The College of Pharmacists of BC has identified that pharmacist prescribing in collaborative relationships can help prevent patient harm and better protect patient safety. Pharmacist prescribing also has the opportunity to improve outcomes for patients in BC, an important element in the College's vision to provide better health through excellence in pharmacy.

As described in this framework, pharmacist prescribers in collaborative relationships have the important opportunity to prevent patient harm by reducing preventable drug-related problems, providing safer transitions in care, improving medication management, and providing more timely access to drug therapy. The opportunity to reduce preventable drug-related adverse events, hospitalizations and deaths while improving patient outcomes cannot be overlooked.

While the College does not advocate for changes to scope for the advancement of the pharmacy profession – a role belonging to pharmacy associations – it does consider changes to pharmacy practice that are in the patients best interests by increasing public safety and improving patient outcomes. Like the expansion of pharmacists role in drug administration, the College is proposing regulation of Certified Pharmacist Prescribers to help pharmacists better care for their patients and protect them from preventable drug related problems.

The framework has been developed to establish regulation for Certified Pharmacist Prescribers. It includes requirements for collaboration with other health professionals, an education, training and evidence based qualification process, information access requirements and protection from conflict of interest among other standards limits and conditions designed to protect patient safety.

7.1 COLLABORATIVE PRACTICE RELATIONSHIPS

Collaboration is an essential component of the framework for pharmacist prescribing in BC. There are many different types of collaboration described within different health strategies and policies, research studies, educational programs and regulatory frameworks ranging from collaborative practice environments to intra- and inter-professional collaboration.

For the purpose of the framework for Certified Pharmacist Prescribers, the College is requiring collaborative practice relationships.[92]

A collaborative relationship involves developing a relationship with a regulated health professional who has the authority to prescribe to:

- Facilitate communication
- Determine mutual goals of therapy that are acceptable to the patient
- Share relevant health information
- Establish the expectations of each regulated health professional when working with a mutual patient

Collaborative practice relationships are not tied to a specific environment or practice setting, but set requirements for what must be established to prescribe through working with others on a patient's care team. In collaborative practice relationships, the diagnosis is still provided by physicians and nurse practitioners (or other regulated health professionals with prescribing authority).

Some environments may be able support the requirements for collaborative relationships more easily, such as hospitals or urgent care centers. However, collaborative relationships can still take place in other environments where pharmacists are able to effectively communicate and securely share relevant health information with other health professionals on a patient's care team.

[92] Collaborative relationships were defined by the Alberta College of Pharmacists in their Standards of Practice for Pharmacists and Pharmacy Technicians to set clear requirements for collaboration in pharmacy practice. https://pharmacists.ab.ca/sites/default/files/StandardsOfPractice.pdf

7.2 SHARING RELEVANT HEALTH INFORMATION

Pharmacists must be able to effectively share and review relevant health information in order to be able to prescribe and effectively manage drug therapy. This ranges from access to patient medical records (electronic or offline), PharmaNet, and laboratory test results, to specific input from the patient and others on the health care team, especially the most responsible practitioner.

This information is required to take a complete and accurate medication history, an essential step as part of the prescribing process. Access to this information is necessary for a pharmacist prescriber to effectively initiate and manage a patient's drug therapy in collaboration with other health professionals. Communication will also play an important role in ensuring an accurate and complete medication history is available. For example, a pharmacist prescriber may need to review the number of doses taken by a patient with a patient's primary health care practitioner, and others involved in their care to confirm the accuracy of patient's medication history, or discuss the patient's drug therapy goals and history of effectiveness in meeting those goals.

Establishing how to communicate and share relevant health information as part of the collaborative practice relationship will be an important step in pharmacist prescribing.

Access to Relevant Health Information

Information from the patient

- Current medication list including over-the-counter drugs and natural remedies (herbal and vitamins)
- Medications taken recently with long half-lives (amiodarone)
- Previous reactions to medications including hypersensitivity reactions (anaphylaxis) and adverse drug reactions (such as nausea)
- Medication adherence

Information from PharmaNet

- Up-to-date list and date of filled medications
- Previous adverse drug reactions when recorded

Information from the Patient Medical Records

- Diagnoses and past medical history
- List of medications prescribed for the patient (not necessarily filled)
- Trials of previous therapies
- Previous adverse drug reactions
- Diagnostics including laboratory tests

Information from others involved in the patient's care

- Case notes not otherwise included in the medical record
- Goals of drug therapy and history of effectiveness in meeting patient's goals
- Any other relevant insights into a patient's ongoing care and condition(s)

7.3 PATIENT EDUCATION

It's important for patients to understand and know what to expect from collaborative pharmacist prescribing. During the 2016 Pharmacist Prescribing Engagement, patients indicated it would be important for patients to have a clear understanding of how prescribing would work for patients. Education will play an important role in establishing the role Certified Pharmacist Prescribers can play on a patient's care team, and the important role collaboration plays in pharmacist prescribing.

The College will develop patient education plan and a communications strategy to build awareness and understanding of pharmacist prescribing in BC.

The patient education plan will focus on topics such as:

- How a Pharmacist Prescriber can help provide care
- How to identify a Certified Pharmacists Prescriber
- Patient informed consent
- Collaborative practice
- Sharing health information
- Medication history and patient assessment
- Ongoing medication management
- Documentation and communication
- Patient follow-up and progress reporting

7.4 INFORMED CONSENT

Pharmacists must have the patient or patient's representative informed consent before undertaking prescribing.
This involves ensuring the provided was provided with sufficient information about the proposed course of treatment, including any known serious or common side effects or adverse reactions, and voluntarily provided their informed consent.

The process for informed consent may vary depending on where the prescribing takes place. For example, informed consent may be part of the admissions process in Hospital or Residential care, while a Certified Pharmacist Prescriber may directly receive informed consent within a community pharmacy.

7.5 PRESCRIBING AND DISPENSING

Separating pharmacist prescribing from dispensing and business interests removes the concern for a potential business conflict of interest. This was a frequent point of concern brought up in the initial stakeholder consultation conducted by the College.

Within this framework, a Certified Pharmacist Prescriber that prescribes a medication for a patient must not dispense that medication.

Requiring a different pharmacist to dispense the drug also ensures that a separate pharmacist reviews the patient's profile and completes a clinical assessment of the prescription. This clinical assessment by a pharmacist is a part of the College's requirements for dispensing drugs.[93]

[93] *Health Professions Act,* Bylaws, Schedule F, Part, Part 2, and Part 3.

7.6 PROPOSED ELIGIBILITY REQUIREMENTS

The College's regulation of Certified Pharmacist Prescribers is designed to ensure pharmacist prescribers must demonstrate they are competent and qualified to prescribe in collaborative relationships. Only pharmacists who successfully complete the application process and are approved by the College will be granted prescribing authority.

The College's eligibility requirements are based on feedback received from pharmacists, other prescribers and patients in BC in addition to a review of the pharmacist prescribing requirements in other jurisdictions.[94]

The College heard through the 2016 Pharmacist Prescribing Engagement that applicants should be able to demonstrate they have the practical knowledge, clinical training and experience needed to be able to prescribe. While courses were suggested as an effective way to build up knowledge and skills, stakeholders also indicated that limiting training to an exam or test was insufficient to become a Certified Pharmacist Prescriber.[95]

Stakeholders also indicated that pharmacist prescribers should have established knowledge, skills and abilities in diagnostics (and differential diagnosis), prescribing responsibilities, physical assessment, and therapeutics.

Pharmacists interested in applying to become a Certified Pharmacist Prescriber will need to go through an education, training and evidence based qualification process. They will also need to demonstrate that they understand the responsibilities of prescribing. Pharmacists will also need know how to minimize potential conflicts of interest associated with prescribing and dispensing by the same pharmacist.

Pharmacist Educational Background

Pharmacists must have completed an undergraduate degree in pharmacy, and successfully completed the Jurisprudence Examination and Pharmacy Examining Board of Canada Exams.

Pharmacist degrees are typically Bachelor of Science in Pharmacy degrees BSC (Pharm) or a Doctor of Pharmacy Degree (PharmD).

Entry-to-practice-PharmD degrees are now beginning to be offered at many Canadian Universities including through the Faculty of Pharmaceutical Sciences at the University of British Columbia. Doctor of Pharmacy Degrees include an additional focus on prescribing and monitoring of drug therapy, and interprofessional team-based primary care. They also require almost twice the amount of experiential learning – caring for patients under the supervision of practicing professionals – than previous BSc Programs. Universities have also begun to offer

---

[94] In particular, the College reviewed the Alberta College of Pharmacists Additional Prescribing Authorization eligibility requirements (https://pharmacists.ab.ca/additional-prescribing-authorization).

[95] College of Pharmacists of BC. Certified Pharmacist Prescriber Engagement Report. November 2016. http://library.bcpharmacists.org/5_Programs/5-5_CPP/1046-Certified_Pharmacist_Prescriber_Engagement_Report.pdf

opportunities where students across health faculties train together to develop collaborative relationships that prepare them for collaborative practice.

This means that moving forward pharmacists will be graduating with additional education and training in prescribing and collaboration, making them even better prepared for pharmacist prescribing in collaborative relationships.

Pharmacy residencies[96] and other PharmD programs such as the UBC Graduate PharmD degree[97] and Flex PharmD degree[98] also provide already practicing pharmacists with the knowledge skills and abilities to prescribe.

Pharmacists must also pass a national knowledge-based and objective structured clinical evaluation (OSCE) through the Pharmacy Examining Board of Canada to be able to receive a pharmacy licence. The OSCE evaluates the candidate's ability to interact with and assess patients and their drug therapy needs, and to apply their knowledge to ensure appropriate drug therapy is prescribed and monitored. As part of this exam, pharmacists also have to demonstrate they can assess patients through observation, consultation, and analysis of information including lab values, medical history and medication history.

Experience

Pharmacists must have a minimum of 1 year in practice experience to apply to be a pharmacist prescriber with the College. They will also need to have had enough practice experience to provide examples of patient cases that demonstrate their competency to prescribe in collaborative relationships.

Good Standing

Only pharmacists in good standing may apply for the Certified Pharmacist Prescriber designation.

[96] Pharmacy Practice Residency, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/pharmacy-practice-residency

[97] Graduate PharmD degree, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/graduate-pharmd-degree

[98] Flex PharmD degree, Faculty of Pharmaceutical Sciences, University of British Columbia. https://pharmsci.ubc.ca/programs/flex-pharmd-degree

Eligibility Criteria

Pharmacists must meet the following criteria to be eligible to become a Certified Pharmacist Prescriber:

1) Have at least one year of full-time experience in direct patient care.
2) Have strong collaborative relationships with other regulated health professionals.
3) Have and maintain the necessary knowledge, skills, abilities and clinical judgment to enhance patient care.
4) Have the required supports in the practice environment to enable safe and effective management of drug therapy.

Self-Assessment

Pharmacists will need to complete a self-assessment to assess their own knowledge, skills and abilities and their readiness to prescribe in a collaborative environment.

Both the Alberta College of Pharmacists and the Pharmacy Examining Board of Canada use self-assessments to help applicants determine if they have the knowledge skills, and abilities to practice.[99] [100]

Evidence Based Competency Evaluation

The College will use an objective criterion-referenced assessment to evaluate the competency of applicants to prescribe in collaborative practice. Objective criterion-referenced assessments are conducted through the evaluation of evidence based on a set of established criteria to equally assess all applications.[101] Measuring all applications against the same set of criteria deters subjective interpretation, holds all applicants to the same standard, and helps ensure public safety.

The College will evaluate whether a pharmacist demonstrates competency to prescribe using six competency indicators.

[99] Alberta College of Pharmacists. Additional Prescribing Authorization Self Assessment Form. https://pharmacists.ab.ca/sites/default/files/APASelfAssessmentForm.pdf

[100] Pharmacy Examining Board of Canada. Document Evaluation. http://www.pebc.ca/index.php/ci_id/3116/la_id/1.htm

[101] Alberta College of Pharmacists. Additional Prescribing Authorization. Key Activities and Indicators. https://pharmacists.ab.ca/sites/default/files/APAKeyActivities.pdf

Competency Indicators for Pharmacist Prescribing in Collaborative Relationships

1. Form and maintain a professional relationship with a patient
2. Patient assessment
3. Develop care plan and follow-up
4. Collaboration
5. Documentation
6. Judgment

The evaluation is completed through the submission of competency information and patient care cases documenting the pharmacist's clinical involvement to demonstrate knowledge, skills and abilities under each one of the competency indicators.

Applicants will need to provide information about their experience, education, and training. This will also be an opportunity for pharmacists to highlight relevant practice experience, residencies or mentorships they have been involved in that contribute to their preparation for the designation of the Certified Pharmacist Prescriber. Pharmacists should also show how their pharmacy practice supports collaborative practice, or how they will be contributing to shaping their practice environment into one that supports collaborative relationships.

Patient Cases

Applicants will need to demonstrate they clearly understand how to provide patient care through pharmacist prescribing in collaborative relationships. They will need to describe the full patient care process together with supporting examples for each step.

Records of care provide the strongest evidence of the preparedness of an applicant to become a Certified Pharmacist Prescriber.

Applicants will need to submit three real patient cases (i.e. records of care). These cases must be within the last 2 years leading up to an application. The cases must show:

- Collaboration (including the elements required in a collaborative relationship)
- Assessment and synthesis
- Drug therapy care plan development and implementation
- Monitoring and follow-up
- Documentation and communication

As part of patient case submission, applicants would need to describe the patient care process for each case.

Patient Care Process

- Describe the collaborative relationship with other regulated health professional on the patient's care team with supporting examples.
- Describe how patient information is gathered with supporting examples. This should also include how patient information that is not readily available in a pharmacy is accessed, and how diagnostics would be acquired and ordered as needed.
- Describe the process of patient assessment, synthesis, development of care plans and prescribing decisions with supporting examples. This should also include how to determine whether to prescribe for the patient, or refer them back to another health professional on their care team.
- Describe monitoring and follow-up to ensure continuity of care with supporting examples.
- Describe the documentation of care provided with supporting examples.

Educational Program

Every pharmacist has knowledge, skills and abilities tailored to meet the needs of their practice. However, some key topics are of specific relevance to pharmacist prescribing.

The College will be looking for evidence of continuous learning that supports the applicant's evolving practice, benefits patients, and expands their knowledge, skills and abilities in ways that support pharmacist prescribing in collaborative relationships.

As part of the education program for Certified Pharmacist Prescribers, the College will recommend (but not require) a series of preparatory courses based on topics that support pharmacist prescribing in collaborative relationships. While some pharmacists will have education, training and experience in these areas, the preparatory course topics can assist other pharmacists to build up the knowledge and training needed to apply to become a Certified Pharmacist Prescriber.

Preparatory Courses for Certified Pharmacist Prescribers

- Collaboration (including inter/intra professional collaboration, and collaborative practice)
- Patient Interviewing and assessment (including physical assessment)
- Diagnostic interpretations (including laboratory results)
- Evidence-based clinical decision making
- Documentation
- Patient Care skills

Required Courses

The College will also develop and require a course program series on the responsibilities of pharmacist prescribing. The course program will focus on fundamental knowledge all Certified Pharmacist Prescribers require to effectively and safely prescribe in collaborative practice.

Responsibilities of Pharmacist Prescribing Course Program

- Prescribing responsibilities (including standards, limits and conditions)
- Patient informed consent
- Collaborative practice relationships
- Sharing and accessing relevant health information
- Medication history and patient assessment
- Medication management role in pharmacists prescribing
- Documentation and communication
- Patient Follow-up and progress reporting

7.7 PROPOSED RENEWAL REQUIREMENTS

Renewal requirements for a Certified Pharmacist Prescriber includes proof of an additional 15 units of continuing education and an annual self-declaration.

Certified Pharmacist Prescribers may want to consider courses identified in the educational program as having the greatest relevance to pharmacist prescribers as part of their ongoing professional development. However, prescribers may also want to focus on areas of expertise most relevant to their practice.

Each year, Certified Pharmacist Prescribers would declare they understand the responsibilities of pharmacist prescribing in BC and have the knowledge, skills, abilities and collaborative relationships to prescribe.

Renewal as a Certified Pharmacist Prescriber will be incorporated into the existing annual process for pharmacy professional registration renewals.

7.8 PROPOSED STANDARDS, LIMITS, AND CONDITIONS

The Certified Pharmacist Prescriber is legally responsible for the outcomes of their prescribing decisions and legally required to inform the patient's primary care provider of their actions to ensure continuity of care.

Standards

1. Pharmacists prescribe Schedule I drugs, vaccines, parenteral nutrition and blood products only within the scope of their education, training and competence
2. Pharmacists must have the patient's or patient representative's informed consent before undertaking prescribing.
3. Pharmacists must review the patient's record[102] (medical and medication)
4. Pharmacists must work collaboratively with the patient's primary healthcare provider.
5. Pharmacists must review the pharmacy patient's record[103] prior to prescribing.
6. Pharmacists must review the PharmaNet patient medication record when available prior to prescribing.
7. Pharmacists must conduct a medication history that includes:
    - developing and/or updating a best possible medication history[104]
    - using reliable sources of information to obtain and verify the patient's medication use (prescribed and non-prescribed)
8. Pharmacists must review or conduct a patient assessment that may include:
    - physical assessment
    - mental health assessment
    - laboratory values
    - diagnostic information
9. Pharmacists must complete prescriptions accurately and completely, that includes all information required for a prescription, in accordance with College bylaws.[105]
10. Pharmacists are solely accountable for their prescribing decisions.

---

[102] In accordance with the College of Physicians and Surgeons of British Columbia's Professional Standards and Guidelines for Medical Records https://www.cpsbc.ca/files/pdf/PSG-Medical-Records.pdf

[103] Patient record (11) *Health Professions Act*, Bylaws Community; Patient record (12) *Health Professions Act* Bylaws Hospital; and Resident Record (13) HPA Bylaws Residential Care.

[104] Best possible medication history is a snapshot of the patient's actual medication use, which may be different from what is contained in the patient's records.

[105] *Health Professions Act,* Bylaws, Schedule F, Part 1, Part 2, and Part 3.

11. Pharmacists must notify and provide relevant information to the patient's primary care provider and other health professionals, as appropriate.
12. Pharmacists must have a monitoring and follow-up plan in place to monitor the outcomes of the drug therapy.
13. Pharmacists must document in the patient's record:
    - informed consent
    - patient assessment
    - prescribing decision and the rationale
    - patient understood the instructions provided
    - monitoring and follow-up plan
    - patient's primary health care provider and other relevant health professionals, as appropriate were notified and provided with relevant information
14. Pharmacists must refer the patient to another prescriber as appropriate.
15. Pharmacists must only prescribe where there is a genuine clinical need for treatment, and should only prescribe medication to meet identified needs of patients and never for convenience, or because patients demand the medication.
16. Pharmacists engages in evidence-informed prescribing and considers best practice guidelines and other relevant guidelines and resources when prescribing for patients, including when recommending complementary or alternative health therapies. If an adverse drug reaction as defined by Health Canada is identified the pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record, and report the reaction to the Canada Vigilance Program regional office.
17. After prescribing, pharmacists must:
    - inform patients of the need for follow-up care to monitor whether any changes to the prescription are required
    - monitor patients for any adverse events, emerging risks, or complications
    - stop drug therapy, following appropriate protocol, if it is not effective, or the risks outweigh the benefits
18. Pharmacists need to collaborate by communicating respectfully, effectively and in a timely way about a patient with the patient's primary care provider, and other health care providers as appropriate.
19. Pharmacists need to engage a patient's most responsible practitioner in discussions aimed at determining mutual goals of therapy for a patient and mutual sharing of relevant patient information.
20. A pharmacist who transfers care to another pharmacist or other health professional within the same or different pharmacy, hospital, or other healthcare facility must ensure the accepting health care provider has the necessary information to assume care.

Limits

1. A Certified Pharmacist Prescriber is not authorized to prescribe controlled drug substances which are regulated federally by the *Controlled Drugs and Substances Act* and its regulations.
2. A Certified Pharmacist Prescriber must not prescribe a drug unless the intended use is:
    - an indication covered by Health Canada,
    - considered a best practice or accepted clinical practice in peer-reviewed clinical literature, or
    - part of an approved research protocol.
3. A Certified Pharmacist Prescriber that prescribes a medication for a patient must not dispense that medication.
4. A Certified Pharmacist Prescriber must not self-prescribe or prescribe for a family member or friend, unless there is an emergency and no other prescriber is available.

Conditions

1. A full pharmacist must apply to the College of Pharmacists of British Columbia to be a Certified Pharmacist Prescriber to prescribe Schedule I drugs.
2. A full pharmacist must not prescribe Schedule I drugs prior to receiving confirmation from the College of Pharmacists of BC of their authority as a Certified Pharmacist Prescriber to prescribe Schedule I drugs.
3. Certified Pharmacist Prescribers must prescribe within a collaborative practice relationship.

   A collaborative relationship involves developing a relationship with a regulated health professional who has the authority to prescribe to:

   - Facilitate communication
   - Determine mutual goals of therapy that are acceptable to the patient
   - Share relevant health information
   - Establish the expectations of each regulated health professional when working with a mutual patient

8. APPENDICES

1 Certified Pharmacist Prescriber Case Scenarios
2 Other Prescribers in BC – Prescribing Parameters
3 Pharmacists' Prescribing Authorities Nationally and Internationally
4 CPhA "Pharmacists' Expanded Scope of Practice in Canada, December 2016"
5 Training requirements for the current scope of pharmacist practice
6 Models of Collaborative Pharmacist Prescribing
7 Legislation and Regulation of Interprofessional Collaboration

APPENDIX 1: PHARMACIST PRESCRIBING CASE ILLUSTRATIONS

These cases are based on actual patients encountered in practice and illustrate patient-centred actions taken by pharmacists in collaboration with the patient and their healthcare team to optimize patient health and medication outcomes.

They are written in the standard form of health professionals communicating and collaborating with each other to ensure continuity of care.

Like all health professionals, pharmacists must collect and assess information about their patients' condition and/or concerns, synthesize this information to draw conclusions about the potential etiologies of problems, develop a care plan and perform interventions to resolve the problems and thereby improve their patients' health. The pharmacist communicates, collaborates and documents in the provision of patient-centred care. Many terms are used for these fundamental components of health care provision. In the cases below, the following are the terms used and their definitions:

"Collect patient information" – subjective and objective information about the patient is collected by the pharmacist to understand the relevant medical and medication history, and the clinical status of the patient. This information includes patient assessments performed by the pharmacist, including those based on interview, drug therapy assessment, physical assessment, and laboratory test interpretation.

"Assessment by pharmacists" – the information is assessed by the pharmacist to analyze the clinical effects of the drug therapy. Such assessments take many forms and are influenced and guided by the patient's presentation and the information available and the clinical acumen and professional judgment of the pharmacist.

"Synthesis" – a description of the conclusions reached by the pharmacist based on the Assessments performed. These conclusions may prompt actions in order to address and resolve the patient's issue(s).

"Care Plan" – an individualized patient-centred care plan is developed by the pharmacist in collaboration with the patient and their healthcare team.

"Actions" - distinct from the "Assessments" (which are also types of actions), these are the interventions the pharmacist performs in order to address the patients' problems and improve their health. Modifications to the care plan are made by the pharmacist in collaboration with the patient and their healthcare team.

"Patient Chart" – documentation by the pharmacist is made in the patient record (medical and medication).

Cases

Cases 1-7 are prescribing pharmacists' approach to assessment of drug therapy working in collaboration with the patient and their healthcare team.

Selected Medical Abbreviations used in the Cases

A+O: alert and oriented

A1C: hemoglobin A1C

ACR: albumin to creatinine ratio

AECOPD: acute exacerbation of COPD

AF: atrial fibrillation

ASCVD: atherosclerotic cardiovascular disease

BP: blood pressure

CAD: coronary artery disease

CC: chief complaint

CBC: complete blood count

CHADS2/ CHA2DS2-VASc: the two dominant atrial fibrillation stroke risk estimation clinical prediction rules

CKD: chronic kidney disease

COPD: chronic obstructive pulmonary disease

CVD: cardiovascular disease

eGFR: estimated glomerular filtration rate

EMR: electronic medical record

FBG: fasting blood glucose

FRS: Framingham risk score

GERD: gastroesophageal reflux disease

HCTZ: hydrochlorothiazide

HF: heart failure

HPI: history of present illness

HTN: hypertension

Hx: history

JVP: jugular venous pressure

LAA: left atrial appendage

LVEF / EF: left ventricular ejection fraction / ejection fraction

MedicationHx: medication history

MMSE: mini mental status exam

MPL: medical problem list

NFA: no fixed address

NKA: no known allergies

NOAC/DOAC: new oral anticoagulant / direct oral anticoagulant

NRT: nicotine replacement therapy

O/E: on examination

OAC: oral anticoagulant

PFT: pulmonary function test (spirometry)

POC: point-of-care

PMH: past medical history

PVD: peripheral vascular disease

QOL: quality of life

SOBOE: shortness of breath on exertion

SocialHx: social history

S&Sx: signs and symptoms

STEMI: ST-elevation myocardial infarction

T2DM: type 2 diabetes mellitus

Td booster: tetanus diphtheria booster

UBT: urea breath test

CASE 1: Diabetes and Cardiovascular Disease

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based primary care clinic helps manage a patient's drug therapy for diabetes and cardiovascular disease .

COLLECT PATIENT INFORMATION			
ID	65-year-old male presents to the primary care clinic today for their intake consultation with pharmacist (initial patient assessment prior to seeing physician). He has a meet-and-greet appointment scheduled with his new GP scheduled for 2 months from now.	**SOCIALHx**	• Lives alone • Retired • Occasional EtOH • Non-adherent to diabetic diet • No regular exercise
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• metformin 1000 mg PO bid x 15 yr • glyburide 10 mg PO bid x 10 yr • ramipril 2.5 mg PO daily x 1 month • acetaminophen 500-1000 mg PO daily PRN • sitagliptin 100 mg PO daily x 1 month (stopped himself 3 months ago due to high cost and no self-observed improvement to fasting glucose levels)

HPI	N/A	**O/E**	• Appears well, A+O
PMH	• T2DM (diagnosed 15 yr ago) • HTN (diagnosed 15 yr ago) • Ex-smoker (quit 15 y ago) CKD (diagnosed 3 yr ago)	**MPL**	• T2DM with inadequate glycemic control • HTN • High CV risk (primary prevention) • Diabetic nephropathy

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
- Laboratory values accessed via my e-health
- Glycemic control assessment
    - Asymptomatic
- A1c 9.6% (1 month ago), FBG (ac breakfast) 10-16 mmol/LCV risk assessment
    - Lipids: TC 5.5 mmol/L, HDL-C 1.0 mmol/L, LDL-C 3.8 mmol/L
    - BP 169/92 mmHg, HR 66 bpm and regular
    - Asymptomatic
    - No family Hx of premature CVD
    - Framingham Risk Score >20%
- CKD assessment
    - Asymptomatic
    - SCr 185 µmol/L, CrCl 50 mL/min, ACR 3 mg/mmol
- Ask patient re: most recent eye exam
- Perform diabetic foot exam
- Assess vaccination Hx (influenza, pneumococcal)
- Height 170 cm, weight 100 kg, BMI 34.6 kg/m^2
    - Assess based on patient interview willingness to take medication, potential for adherence, affordability of medication

SYNTHESIS

- Pre-contemplative re: lifestyle changes
- Glycemic control not at target
- BP not at target
- Inadequate CV risk reduction therapy

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
- Consult with the prescriber on duty
    - Inform prescriber about the upcoming meet-and-greet appointment scheduled with his new GP scheduled for 2 months from now
    - Recommend initiating changes today
    - Reassure prescriber about the follow-up telephone call in 2-4 weeks with the patient
    - Inform the prescriber that an update on the patient's progress will be provided until the new GP is involved with providing patient care
    - Address prescriber concerns if needed

ACTION

- Prescribe atorvastatin 10 mg PO daily and educate (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost)
- Increase ramipril to 5 mg PO daily and educate
- Secure special authority for linagliptin 5mg PO daily (covered by PharmaCare) and educate
- Prescribe 1 additional serving of fruit/vegetable per day and educate
- Document all above patient assessments, actions, rationale, monitoring plan in EMR

MONITORING PLAN

- Follow-up via phone in 2-4 weeks
- A1C, SCr and ACR in 2 months

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Timely initiation of therapy
- Increased efficiency (time, cost) of care by pharmacist performing initial consultation, which streamlines eventual physician assessment
- Pharmacist is working with other members of the patient's team

CASE 2: Optimizing Blood Pressure

A Certified Pharmacist Prescriber in a community pharmacy establishes a collaborative practice relationship with a patient's GP. The care plan developed allows the Certified Pharmacist Prescriber to help optimize the patient's blood pressure between visits to his GP every few months.

COLLECT PATIENT INFORMATION			
ID	40-year-old male presents at the pharmacy at 8pm on a Friday to pick up his refills for anti-hypertensives. Reports concern that home BP reading have been gradually increasing and wondering if current meds are working.	**SOCIALHx**	• Lives with his wife. Desk job with more work stress recently. • Occasional alcohol. • No regular exercise. Eats out 5-6 times a week. Admits that he has been gaining weight – up 10 lbs in the last 6 months.

CC	Home BP readings consistently > 140/90 recently	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA
			• Vaccinations: influenza, Td booster up to date
			• Medication:
			  ○ HCTZ 12.5mg po daily (on for the last 5 years)
			  ○ ramipril 5mg po daily (on for the last 4 year)
			  ○ acetaminophen 500mg 2 po prn (takes for occasional headaches – max 2 doses/day)

HPI	Gradually increasing numbers over the last 6	**O/E**	• Appears well. Here with home BP readings diary

	months. Sees GP annually for BP review/refills. BPs at the time of last GP visit 6 months ago were consistently < 140/90. Unable to see GP in the next couple of months. Not willing to go to walk in clinic or ED.		from the last 4 weeks: 140-155/88-95
PMH	• Ex-smoker: Quit ~5 years ago • HTN diagnosed 5 years ago	**MPL**	• Uncontrolled HTN

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
  - No medication adherence concerns or barriers
  - No OTC NSAID use
- Home BP monitoring routine is twice weekly
- Consider secondary causes of HTN
  - Sleep apnea ruled out by patient interview
  - Hyperaldosteronism unlikely based on serum K
  - Hyper/hypothyroidism improbable in 40 year old male, no S&Sx based on interview, and much more probable explanation for worsening BP control (inactivity, weight gain, stress, inattentive diet)"
  - HPI does not indicate secondary causes as likely, and alternative hypothesis for
- CKD assessment:
  - No concerns noted with last screening
- Lifestyle Management for HTN:
  - Diet: Eating red meat 3-4 times/week and struggles to eat fruits and veggies consistently. Some juice or pop 3-4 days/week as well. Salt: adding "a bit" and restaurant food is high
  - Exercise: "none" except for an occasional 20-30 minute walk on weekends
  - Stress management: No tools for managing this
- O/E: Labs provided per eHealth profile 6 months ago:
  - FBG: 5.8
  - LDL: 3.2 T Chol 5.0 HDL 1.2

worsening BP control is available

- Glycemic Control (via myehealthBC and patient interview)
  - Last FBG outside normal range
  - Family Hx of diabetes: mother and older brother
  - Recent increasing stress and weight increases risk for insulin resistance
  - No symptoms of hyperglycemia but reports more carb craving
- CV risk assessment:
  - No symptoms of concern
  - Lytes normal (notably, Na/K)
  - SCr 85
- BMI: 28
- FRS < 10%
- BP: 150/90 P 70

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
  - Initiate lifestyle changes immediately with the patient
- Determine collaborative relationship with patient's GP
  - Identify patient's GP
  - Confirm collaborative relationship with the GP
- Consult GP on Monday
- Inform GP about patient unable to see GP in the next couple of months. Not willing to go to walk in clinic or ED
- Recommend initiating additional drug therapy, amlodipine
- Provide evidence of adding additional BP therapies is superior to maximizing doses of existing BP drugs
- Reassure GP about the follow-up in 2 weeks with the patient
- Inform the GP that an update on the patient's progress will be provided (i.e. no change or describe change
- Address GP concerns if needed

SYNTHESIS

- BP not at target
- Increasing risk for prediabetes and uncontrolled HTN in view of increasing weight
- Struggling with lifestyle management of HTN
- Primary prevention for CV disease and current risk remains low

ACTION

- Prescribe amlodipine 2.5mg po daily and educate patient re: goals of therapy, potential adverse effects (adding additional BP therapies is superior to maximizing doses of existing BP drugs)
- Daily BP monitoring at variable times of the day, keep BP diary

- Confirm Lifestyle Action Plan, including:
    1) 1 additional fruit/vegetable serving/day
    2) no added salt
    3) week day walking: park 5 blocks away from work and walk.
- Generate documentation and convey to primary care provider
- Include information about the patient's inability to see primary care provider in the next couple of months

MONITORING PLAN

- Reassess patient in 2 weeks via phone or in person
- Update primary care provider with patient assessment (no change or describe change)

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- ED/Urgent care/walk-in clinic visit averted
- Timely initiation of therapy
- Patient received care immediately, no referrals, no waiting
- Primary care provider is informed about the patient's progress
- Pharmacist is working with other members of the patient's team

CASE 3: Polypharmacy

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based residential care facility establishes a collaborative practice relationship with a patient's primary care provider. Certified Pharmacist Prescriber helps optimize and address unnecessary drug therapy to reduce the risks associated with polypharmacy.

COLLECT PATIENT INFORMATION			
ID	92-year-old female is being assessed in a residential care facility for regularly-scheduled 6-month medication review	**SOCIALHx**	• Widow • Lives in residential care facility • Retired • 2 children and 4 grandchildren—all live nearby • No EtOH
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• alendronate 70 mg PO q week on Sundays x 2 yr • furosemide 40 mg PO daily x 3 months • KCl 8 mEq PO bid x 3 months • warfarin 5 mg PO daily • rabeprazole 20 mg PO daily x 3 months • metoprolol 25 mg PO bid • citalopram 20 mg PO daily • brinzolamide/timolol eye drops 1 drop ou daily • acetaminophen ER 650-1300 mg PO up to tid PRN pain
HPI	N/A	**O/E**	• Appears well, A+O

PMH	• Atrial Fibrillation (CHADS2 = 2) • Osteoarthritis (knee, hip) • Hypertension • Osteoporosis (diagnosed 2 yr ago) • Depression/anxiety • CKD • Glaucoma • Community acquired pneumonia requiring hospitalization (3 months ago)	**MPL**	(polypharmacy)

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
  - Furosemide and KCl were prescribed on discharge from hospital 3 months ago (admitting diagnosis: community-acquired pneumonia). Had never taken either medication in the past
  - Does not know why she takes rabeprazole. No Hx of peptic ulcer disease, GERD or GI bleeding
  - Has never taken calcium or vitamin D
- Emergency Department assessment and discharge summary reviewed from 3 months prior
  - Furosemide and KCl prescribed on admission for possible heart failure
- Functional assessment:
  - Ambulates with walker
- Heart failure assessment:
  - Denies SOBOE or at rest, orthopnea or PND
  - Able to ambulate around home normally
  - Denies peripheral edema
  - Recent echocardiogram: normal LV size and function, LVEF 55%, normal valves
- Assess vaccination Hx (influenza, pneumococcal)
- Height 158 cm, weight 54 kg, BMI 21.6 kg/m^2
- O/E: BP 135/80 mmHg, HR 50 bpm and irregularly irregular, no postural change in BP or HR, JVP <2 cm ASA, normal

- Rabeprazole was prescribed for stress ulcer prophylaxis while in hospital
- Laboratory values from last week accessed from facility chart
  - SCr 55 µmol/L, CrCl 49 mL/min, Na 138 mmol/L, K 4.0 mmol/L, INR 2.3

breath sounds bilaterally, no peripheral edema
- Denies palpitations, occasional presyncope

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient, caregiver and/or family
- Consult with the physician at the residential care facility
  - Inform physician about the cause of the unnecessary medications
  - Recommend initiating changes today
  - Reassure physician about the follow-up in 1 week with the patient and the healthcare team at the facility
  - Inform the physician that an update on the patient's progress will be provided
  - Address physician concerns if needed

SYNTHESIS

- Questionable indication for furosemide and KCl, initiated during ED visit, sx later attributed to CAP, not heart failure. No diagnosis of HF made despite echo.
- No identifiable valid indication for rabeprazole
- Resting bradycardia—may not require current dose of beta-blocker
- No calcium and vitamin D for osteoporosis

ACTION

- Decrease furosemide to 20 mg PO daily
- Decrease KCl to 8 mEq PO daily
- Decrease metoprolol to 12.5 mg PO bid
- Discontinue rabeprazole

- Educate for each of the above (rationale, administration/titration, goals of therapy, common adverse effects & their management, cost)
- Document in facility patient record and convey to primary care provider

- Prescribe calcium 500 mg PO elemental PO bid and vitamin D 1000 units PO daily

MONITORING PLAN

- Follow-up in 1 week with the patient and healthcare team in the facility
- Monitor for worsening signs or symptoms of heart failure
- Monitor for palpitations/assess resting HR, BP
- Monitor for any symptoms of GERD

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Reduce polypharmacy
- Potentially avoid adverse effects associated with unnecessary therapy (e.g., hypovolemia leading to fall, C. difficile infection secondary to chronic PPI)
- Optimize osteoporosis therapy to prevent vertebral/non-vertebral fracture and associated hospitalization +/- mortality

CASE 4: Medication Reconciliation on Admission

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based community hospital practice helps prevent the interruption of essential chronic drugs during a hospital stay.

COLLECT PATIENT INFORMATION			
ID	35-year-old female admitted overnight to general surgery unit at a community hospital for cholecystectomy for recurrent cholecystitis. She is assessed by the pharmacist in the morning.	**SOCIALHx**	• Single • Lives alone • Unemployed • No children or family support • Denies EtOH or illicit drugs • Smoker 1 ppd x 22 yr
CC	Right upper quadrant abdominal pain, nausea, abdominal tenderness	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• aripiprazole 15 mg PO daily in AM • divalproex 500 mg PO bid • sertraline 100 mg PO daily at HS
HPI	Patient was admitted for cholecystitis 6 months ago. She received supportive care and was discharged home. She did not have any recurrent symptoms until last night, and promptly presented to the Emergency Department. General surgery was consulted and laparoscopic cholecystectomy is planned for later today. The general surgery resident	**O/E**	• Appears in distress with abdominal pain and nausea • A+O x 3, able to converse appropriately

	completed the admission orders, but did not perform any medication reconciliation, no orders currently written re: prior-to-admission medications.		
PMH	• Schizophrenia (x 8 yr) • Depression/anxiety • Obesity	**MPL**	• Cholecystitis • Schizophrenia • Depression/anxiety • Nicotine dependence

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (BPMH) including PharmaNet
  - Patient receives q1 weekly blister packs
  - Contact community pharmacy to review medication administration times
    - Knowledgeable about her medications—she is very concerned about worsening symptoms if she does not receive her medications
  - Carries accurate home medication list
  - Reports very good adherence (only 1 missed dose in past 3 months)
  - All medications deemed to be appropriate to continue while in hospital and not contraindicated by surgery.

- Perform assessment of nicotine dependence
  - 22-pack yr Hx
  - Never tried to quit in the past
  - No interest in quitting long-term, but willing to accept nicotine replacement therapy (NRT) while in hospital
  - Has never used NRT or pharmacotherapy
  - Starting to experience symptoms of withdrawal (restlessness, agitation, tachycardia)

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
- Consult with the general surgery resident
    - Inform general surgery resident about:
        - the continuation of essential chronic medications during the patient's hospital stay to prevent adverse events
        - addition of nicotine replacement therapy to prevent nicotine withdrawal symptoms
    - Recommend initiating changes immediately
    - Reassure the general surgery resident about the daily follow-up with the patient
    - Inform the general surgery resident that an update on the patient's progress will be provided
    - Address the general surgery resident concerns if needed

SYNTHESIS

- High-risk for exacerbation of psychiatric medications due to lack of medication reconciliation—all members of the general surgery team are currently in the operating room (and unavailable)
- Indication for NRT to prevent/treat withdrawal symptoms

ACTION

- Prescribe medications as per home regimen including aripiprazole, divalproex and sertraline
- Order nicotine patch 21 mg applied daily
- Explain actions to patient
- Document in patient record

MONITORING PLAN

- Pharmacist to follow-up daily while in hospital
- Assess for psychiatric symptoms
- Assess for nicotine withdrawal symptoms

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Prevents adverse event due to lack of indicated psychiatric medications
- Prevent medication withdrawal symptoms (e.g., SSRI)
- Positive patient experience due to lack of interruption of chronic therapy, and minimization of discomfort form mandatory temporary smoking interruption
- Surgical team not interrupted

CASE 5: Medication Reconciliation

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based primary care clinic helps provide appropriate drug therapy is initiated to ensure a safe and effective transition in care during discharge from hospital.

COLLECT PATIENT INFORMATION			
ID	72-year-old male recently discharged to a shelter as he had no-fixed-address prior. Admitted 3 weeks ago due ischemic right arm and bilateral leg ischemia. Identified by primary care clinic pharmacist for med review due to discharge 3 days go from hospital. Patient not previously known to the clinic.	**SOCIALHx**	• etOH abuse • Smoker 1ppd • Was NFA now living in shelter • Receives pension

CC	He is out of meds, lost discharge prescription	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA
			• Patient did not have any meds with him
			• Med list per discharge summary:
			  ○ warfarin 7mg OD
			  ○ bisoprolol 5mg OD
			  ○ ASA 81mg OD
			  ○ furosemide 40mg OD
			  ○ ramipril 2.5mg OD
			  ○ spironolactone 12.5mg OD

HPI	None	**O/E**	• Reviewed labs from chart prior to discharge • WBC 6.9, Hgb 123, Hct 0.38, HCV 110, Plts 460, INR 2.2, Na 136, K 4.5, SrCr 104, eGFR 61 • Vague historian unable to describe what happened in hospital or where his discharge prescription went
PMH (from hospital d/c summary and CareConnect)	• CAD with STEMI in 2011 and bare metal stent x 1 • CHF with EF 27% • PVD • Left atrial appendage and left ventricular apex thrombus found while hospitalized	**MPL**	• CHF with reduced EF – not on treatment • Identified thrombus – not on anticoagulation • CAD – not on appropriate secondary prevention

ASSESSMENTS BY PHARMACIST	
• BPMH based on discharge note, PharmaNet and client. Nothing on PharmaNet • Assess vitals: BP 130/70, HR 66, weight 63.5kg • Patient currently not on any medications or OTCs • Lab values from CareConnect	• LV/LAA thrombus • Denies numbness or unusual weakness to arms/legs, visual changes, difficulty speaking or vertigo • Ascertain pts PharmaCare coverage status (Plan I, able/willing to pay deductible)

- Normal liver function test
- CHF assessment/CAD/Secondary prevention
- Denies orthopnea, SOBOE, sleeps with 2 pillows, can walk 2 blocks until leg pain makes him stop
- Denies pre/syncope
- Denies angina

- Ascertained that his shelter provides Medication Management and Outreach workers to help him store and administer his medications. Outreach workers can walk with him to the lab for INR and other labwork

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
- Consult with the prescriber on duty
    - Recommend restarting/initiating drug therapy today
    - Inform prescriber about the coordination of care between the primary care clinic and shelter
    - Reassure prescriber about the follow-up in 2 weeks with the patient at the shelter
    - Inform the prescriber that an update on the patient's progress will be provided
    - Address prescriber concerns if needed

SYNTHESIS

- CHF assessment: Bblocker, ACEi, diuretics should be restarted
- CAD/secondary prevention: ACEi, ASA should be restarted; Statin should be initiated
- LV/LAA thrombus risk of sequelae (embolic stroke, peripheral embolism) as not anticoagulated
- With the supports provided by his shelter, it may be feasible to prescribe these indicated therapies

ACTION

- Restart/initiate medications from hospital discharge Rx
    - ramipril 2.5mg OD
    - furosemide 40mg OD

- Additional education
    - Anticoagulation: importance of compliance, and risks of bleed and embolic risks

    - spironolactone 12.5mg OD
    - bisoprolol 5mg OD
    - ASA 81mg OD
    - warfarin 7mg daily.
- Prescribe atorvastatin 10 mg once daily.
- Plan to titrate ACEi, B-blocker to target doses (10mg, 10mg, respectively).
- Adjust furosemide to symptoms.
- Educate for all of the above re: rationale, administration/titration, goals of therapy, common adverse effects & their management, cost
    - CHF: fluid management, salt restrictions
    - Medication education regarding each med and monitoring parameters.
- Liaise with shelter to communicate therapeutic plan, schedule follow-up, coordinate outreach and medication management services.
- Document all above patient assessments, actions, rationale, monitoring plan in EMR

MONITORING PLAN

- Reassess patient in 2 weeks in person at shelter
- Bloodwork: SrCr/eGFR, lytes, INR at 7 days.
- Need to be re referred at 3 mos for possible echocardiogram to determine duration of warfarin

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Prevention of serious adverse effects /hospitalization from any of his conditions. He could have deteriorated quickly (CHF/fluids, embolic event etc)
- Timely access to care especially for marginalized patients
- Was able to work with his social supports to coordinate supportive services

CASE 6: Chronic Obstructive Pulmonary Disease (COPD)

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based primary care clinic helps review and adjust drug therapy for the patient's COPD.

COLLECT PATIENT INFORMATION			
ID	60-year-old male coming to see primary care clinic pharmacist for general medication review.	**SOCIALHx**	• Smoking – decreased to 13 cigs/day • Family Hx – father – emphysema, mother smokes, sister recently dx with non hodgkins lymphopa
CC	None	**MEDICATIONHx / ALLERGIES / IMMUNIZATIONS**	• NKA • warfarin titrated to INR 2-3 • OTCs including senna, CaCarbonate • Never had flu/pneumo vaccine
HPI	N/A	**O/E**	• No visible distress, well groomed, good eye contact • Height 178, weight 90.2kg, RR 16, oximetry resting SpO2 95%, HR 78 • Cough, productive of grey sputum

PMH	• Hx of recurrent unprovoked PEs/DVTs, prothrombin gene mutation– indefinite anticoagulation • COPD diagnosed 6 months ago via spirometry. No AECOPD since diagnosis. • GI – polypectomy • Remote history of suicidal ideation in the 80s	**MPL**	• History of COPD - untreated

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- Review Spirometry results (patient has spirometry report): FEV1/FVC ratio 0.55.
- History of symptoms: SOBOE, mild cough, worse at night, moderate grey sputum to clear during the night and AM
- Infrequent colds
- INR therapeutic – continue same dose
- Assess based on patient interview willingness to take medication, potential for adherence, affordability of medication

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
- Consult with the prescriber on duty
    - Recommend initiating changes today
    - Reassure prescriber about the follow-up in 1 month with the patient
    - Inform the prescriber that an update on the patient's progress will be provided

  Address prescriber concerns if needed

SYNTHESIS

- Patient would benefit from initiation of chronic COPD therapy
- Guideline-recommended therapy for his level of severity is LABA+ICS
- Willingness / ability to use MDIs, cost, coverage status make starting with ICS, LABA, or both debatable
- Smoking cessation is an important priority

ACTION

- Initiate salbutamol 2 puffs QID PRN and ipratropium 2 puffs QID
- Education about
  - rationale, goals of therapy
  - optimal MDI use
  - monitoring (may need LABA and/or ICS if regular bronchodilator use)
  - smoking cessation
  - vaccines
- Initiate patient self-management through COPD Action Plan
- Reassess smoking cessation plan
- Generate documentation and convey to primary care provider

MONITORING PLAN

- Reassess patient in 1 month via phone or in person
- Reinforce COPD education and warning signs on each visit
- Reassess smoking cessation plan on each visit
- Update primary care provider on patient progress

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- Timely initiation of treatment
  - Reduce risk of AECOPD
  - Improved quality of life
- Pharmacist is working with other members of the patient's team

CASE 7: AF Stroke Prevention

A Certified Pharmacist Prescriber with a collaborative practice relationship in a team-based primary care clinic helps reduce stroke risk for a patient by starting anticoagulation drug therapy.

COLLECT PATIENT INFORMATION			
ID	66-year-old female presents to your primary care clinic today, prompted by a cardiologist who recently diagnosed her with recent-onset atrial fibrillation. The cardiologist told her to talk to her primary care provider about starting anticoagulation.	**SOCIALHx**	Unremarkable
CC	Asymptomatic, no specific complaints. She presents the report from the cardiologist which documents atrial fibrillation and advises her primary care provider to "start anticoagulation".	**MEDICATIONHx/ ALLERGIES / IMMUNIZATIONS**	• amlodipine 10 mg daily x 3 years for HTN • bisoprolol 10mg daily x 2 weeks for rate control since ED visit. • NKA • Immunization status unknown
HPI	Last seen in your clinic 6 months ago for routine check-up. Developed palpitations and dizziness 1 week ago and went to ED. Assessed there by a cardiologist who prompted today's visit.	O/E	• HR 70, irregularly irregular • Otherwise unremarkable

PMH	• HTN x 3 years. • Hysterectomy 10 years ago for uterine fibroids	MPL	• plan to initiate AF stroke prevention therapy

ASSESSMENTS BY PHARMACIST

- Perform best-possible medication history (incl. PharmaNet) (BPMH)
- CHADS2/ CHA2DS2-VASc re: AF stroke risk. CHADS2=1 (3.6% annual stroke risk); CHA2DS2-VASc=3 (4.3% annual stroke risk). Candidate for OAC therapy.
- HAS-BLED score re: OAC major bleeding risk. Score ~0 (HTN, but controlled) (2-3% annual risk of major bleeding on any OAC).
- Assess based on patient interview willingness to take, potential for adherence, affordability

SYNTHESIS

- Patient remains in AF. Ventricular rate is controlled.
- Patient is willing to take SPAF therapy. Prefers OAC to aspirin. Wants to take a NOAC/DOAC, but is concerned about the cost, has no private coverage, understands PharmaCare won't cover unless warfarin unsuccessful.

COLLABORATIVE CARE PLAN

- Develop a care plan that is evidence-based and cost-effective in collaboration with the patient
- Consult with the prescriber on duty
    - Inform prescriber about the individualized care plan based on the clinic protocol for anticoagulation starts
    - Recommend initiating warfarin 10mg daily and titrate to INR 2-3
    - Reassure prescriber about the follow-up calls with the patient to adjust warfarin doses and the involvement of the patient's community pharmacist
    - Inform the prescriber that an update on the patient's progress will be provided
    - Address prescriber concerns if needed

ACTION

- Educate patient re: AF, stroke risk, therapeutic options, implications of OAC therapy vs. aspirin vs. no therapy. Bleeding risks, INR testing, cost, diet/etOH, drug interactions, # of daily doses.
- Guide patient through choice of therapy based on preferences using a decision aid (e.g., sparctool.com, afib.ca)
- Based on this, prescribe warfarin 10mg daily. Use dosing nomogram, schedule INR testing, followup phone calls to titrate to INR 2-3.
- Do warfarin teaching and provide written and online counselling resources
- Discuss self-monitoring and self-adjusting via POC testing at a pharmacy or at home, and advise that we can assess this once stabilized on warfarin
- Generate documentation and convey to community pharmacist and cardiologist

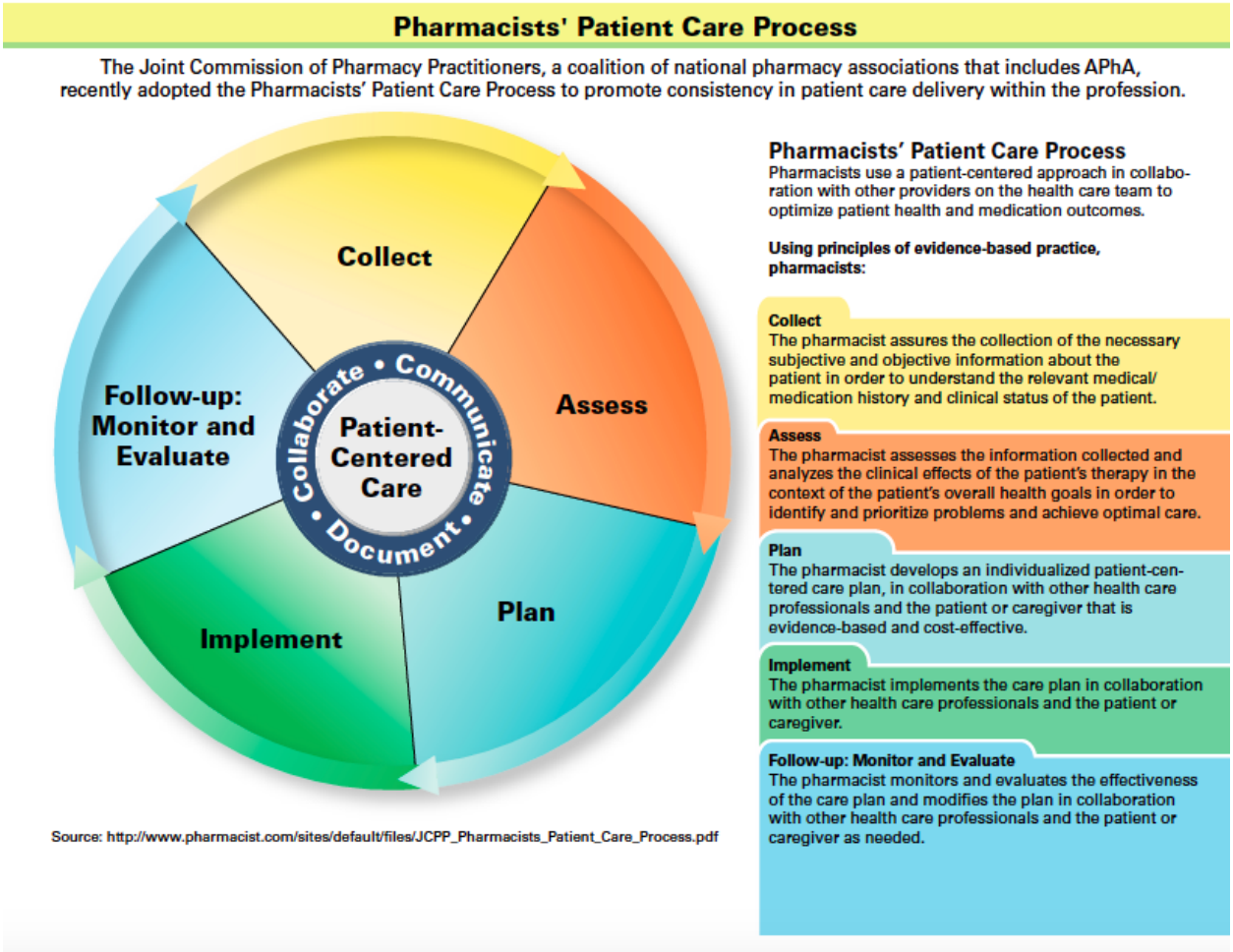
MONITORING PLAN

- Reassess patient every 2-4 days initially until the INR is at target
- Reassess patient weekly once INR at target
    - Gradually increase up to every 4 weeks if the INR remains stable and within the therapeutic range
- Support patient with dose adjustments
- Reinforce AF and warfarin education
- Update primary care provider on patient progress

BENEFITS OF PATIENT SEEING CERTIFIED PHARMACIST PRESCRIBER

- More efficient management of drug therapy than by GP
- Pharmacist in clinic more accessible than physician
- Pharmacist is working with other members of the patient's team

APPENDIX 2: PHARMACISTS' PATIENT CARE PROCESS



Pharmacists Working in Collaboration With Physicians and Other Health Care Professionals, Pharmacy Health Information Technology Collaborative: http://www.pharmacyhit.org/pdfs/workshop-documents/WG1-Post-2015-01.pdf

APPENDIX 3: OTHER PRESCRIBERS IN BC – PRESCRIBING PARAMETERS

	Naturopaths	Midwives	Nurse Practitioners	Optometrists
Training	Prescribing Certification requirements: Registrants must successfully complete the Prescribing Upgrade Course offered by the Boucher Institute of Naturopathic Medicine (BINM) including an online course and oral exam.	4-year undergraduate degree. Clinical experience requires 40 births attended as a primary midwife.	Master's degree program. No additional training; however, created new competencies and updated OSCE's. Three streams of practice are used to register NPs: family, adult and pediatric	No training requirements if they graduated after 2000. *Optometrists certified in Ocular Therapeutics to treat and manage ocular disease as per Bylaws Schedule:* Successfully completed a 20-hour therapeutic pharmaceutical agent updating course given at any time after January 1, 2004 and has also successfully completed one of the following: (a) a 100-hour course in ocular therapeutics; (b) the Treatment and Management of Ocular Disease section of the National Board of Examiners in Optometry; or (c) the ocular therapeutics section of the national qualifying examination.
Schedule of Drugs	Schedule I, II and III.	Schedule I, IA, II and III.	Schedule I, IA (controlled prescriptions), II.	Schedule I, II and III.
List of Drugs	List of excluded drugs (e.g., antibiotics with narrow therapeutic index and antipsychotics.	Inclusive list of drugs.	List of drugs: Schedule I, IA, II. NP prescribes in area registered to practice (family, adult, pediatric)	Limited list of drugs: Glaucoma agents, topical treatment of eye disease.
Standards	Usual and customary standards for prescribing	Standards provide indications, routes of administration and upper dosage limits where appropriate.	Usual and customary standards for prescribing.	Standards for the treatment of eye disease Standards for anti-glaucoma medication prescribing Co-manage with ophthalmologist for glaucoma. Inform patients they have a choice to be managed by an optometrist or ophthalmologist for glaucoma. Must refer to an ophthalmologist if condition does not improve or worsens.

Appendix 3: Other prescribers in BC (continued)

	Naturopaths	Midwives	Nurse Practitioners	Optometrists
Limits	Cannot prescribe drugs for a number of categories.	Limited to pregnancy, lactation and labour.	Limits and conditions by drug category. A drug category with the notation "No Exceptions" means that NPs may prescribe all drugs in that category. A drug category with the letters C (continuation prescribing only) and/or O (cannot prescribe) mean there are restrictions on NP prescribing.	No glaucoma drugs for patients age < 30.
Conditions	Can request special authority medications	Conditions around prescribing some drugs in collaboration with a medical practitioner, e.g., controlled drugs for labour.	Restrictions on prescribing – see above.	Cannot prescribe if glaucoma is advanced.
Narcotics	Under the federal *Controlled Drug Substances Act and Regulations*, no authority to prescribe narcotics and controlled drugs, including benzodiazepines.	Yes	Yes	No

APPENDIX 4: PHARMACISTS' PRESCRIBING AUTHORITY - NATIONALLY AND INTERNATIONALLY

Pharmacists Initiating Prescriptions in Canadian Provinces

Province	Can Initiate Prescription Drug Therapy	Can Order and Interpret Laboratory Tests
BC	x	X
AB	✓	✓
SK	✓	Pending legislation, regulation, or policy for implementation
MB	✓	✓ (authority limited to ordering lab tests)
ON	For smoking/tobacco cessation	x
QC	For smoking/tobacco cessation For minor ailments	✓
NB	✓	Pending legislation, regulation, or policy for implementation
PEI	For smoking/tobacco cessation For minor ailments	Pending legislation, regulation, or policy for implementation
NS	✓	✓
NL	For smoking/tobacco cessation For minor ailments	X

Pharmacists' Scope of Practice in Canada, Canadian Pharmacists Association, December 2016.
https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/ScopeofPracticeinCanada_DEC2016.pdf

Pharmacists Initiating Prescriptions Internationally

Country	Can Initiate Prescription Drug Therapy	Can Order and Interpret Laboratory Tests
NZ	✓	✓
UK	✓	✓
USA	✓	✓ >75% of the States and federal government (armed forces and Veterans Affairs)

APPENDIX 5: PHARMACISTS' EXPANDED SCOPE OF PRACTICE IN CANADA, DECEMBER 2016

Pharmacists' Scope of Practice in Canada

Scope of Practice [1]		Province/Territory												
		BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NWT	YT	NU
Prescriptive Authority (Schedule 1 Drugs) [1]	Independently, for any Schedule 1 drug	X	✓ [5]	X	X	X	X	X	X	X	X	X	X	X
	In a collaborative practice setting/agreement	X	✓ [5]	✓ [5]	✓ [5]	X	X	✓	✓	X	X	X	X	X
Initiate [2]	For minor ailments/conditions	X	✓	✓	✓ [5]	X	✓	✓	✓	✓ [5]	✓	X	X	X
	For smoking/tobacco cessation	X	✓	P	✓ [5]	✓	✓	✓	✓	✓ [5]	✓	X	X	X
	In an emergency	X	✓	✓	✓	X	X	✓	✓	✓	X	X	X	X
Adapt [3]/ Manage	Independently, for any Schedule 1 drug [4]	X	✓ [5]	X	X	X	X	X	X	X	X	X	X	X
	Independently, in a collaborative practice [4]	X	✓ [5]	✓ [5]	✓ [5]	X	X	✓	✓	X	X	X	X	X
	Make therapeutic substitution	✓	✓	✓	X	X	X	✓	✓	✓	✓	X	X	X
	Change drug dosage, formulation, regimen, etc.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X
	Renew/extend prescription for continuity of care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Injection Authority (SC or IM) [1,5]	Any drug or vaccine	X	✓	✓	✓	X [7]	X [7]	✓	X	✓	✓	X	X	X
	Vaccines [6]	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	X	X
	Travel vaccines [6]	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	X	X
	Influenza vaccine	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	X	X
Labs	Order and interpret lab tests	X	✓	P [8]	✓ [9]	X	✓	P	P [8]	P	X	X	X	X
Techs	Regulated pharmacy technicians	✓	✓	✓	✓ [10]	✓	X	✓	✓	✓	✓	X	X	X

1. Scope of activities, regulations, training requirements and/or limitations differ between jurisdictions. Please refer to the pharmacy regulatory authorities for details.
2. Initiate new prescription drug therapy, not including drugs covered under the *Controlled Drugs and Substances Act*.
3. Alter another prescriber's original/existing/current prescription for drug therapy.
4. Pharmacists independently manage Schedule 1 drug therapy under their own authority, unrestricted by existing/initial prescription(s), drug type, condition, etc.
5. Applies only to pharmacists with additional training, certification and/or authorisation through their regulatory authority.
6. Authority to inject may not be inclusive of all vaccines in this category. Please refer to the jurisdictional regulations.
7. For education/demonstration purposes only.
8. Ordering by community pharmacists pending health system regulations for pharmacist requisitions to labs.
9. Authority is limited to ordering lab tests.
10. Pharmacy technician registration available through the regulatory authority (no official licensing).

✓ Implemented in jurisdiction
P Pending legislation, regulation or policy for implementation
X Not implemented

CANADIAN PHARMACISTS ASSOCIATION / ASSOCIATION DES PHARMACIENS DU CANADA

Pharmacists' Scope of Practice in Canada, Canadian Pharmacists Association, December 2016.
https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/ScopeofPracticeinCanada_DEC2016.pdf

APPENDIX 6: TRAINING REQUIREMENTS FOR THE CURRENT SCOPE OF PHARMACIST PRACTICE

Scope of Pharmacist Practice	Training Requirements
Adaptations of Prescriptions	Read and understand the Orientation Guide and Amendment to the Orientation Guide Must adhere to the 7 fundamentals for adapting a prescription as outlined in Professional Practice Policy-58: Medication Management (Adapting a Prescription) including notification of other health professionals
Administration of Injections	Successfully complete a CCCEP-accredited drug administration training program approved by the College of Pharmacists of BC as listed in Schedule C of the *Health Professions Act* Bylaws Possess valid certification in first aid and CPR from a recognized provider
Independently prescribe Schedule IV drugs for emergency contraception (4 norgestrol)	No additional training required
Independently prescribe emergency refills	No additional training (see Professional Practice Policy-31: Emergency Prescription Refills) Apply the fundamentals of: • individual competence • appropriate patient information • appropriateness of providing an emergency refill • informed patient consent • document rationale and follow-up plan in PharmaNet and patient pharmacy record
Prescribe Schedule II and III drugs	No additional training

APPENDIX 7: MODELS OF COLLABORATIVE PHARMACIST PRESCRIBING

Collaborative Model	Description	Training Requirements	Prescribing Standards of Practice
Collaborative team-based care for in-patients Hospital-based care	Pharmacist prescribing is a natural extension of the role of the hospital pharmacist Canadian hospital pharmacist prescribing increased from 46% in 2005/06 to 61% in 2007/08, mainly through protocols	No additional training required	No
Collaborative team-based care for out-patients Ambulatory clinics	Pharmacist prescribing is a natural extension of the role of the ambulatory clinic pharmacist	No additional training required	No
Primary care team-based clinics	Pharmacist prescribing is a natural extension of the role of the primary care clinic pharmacist	No additional training required	No
Saskatchewan Collaborative Practice Agreement	Saskatchewan pharmacist prescribing through collaborative practice agreements	No additional training required	No
UK Dependent Prescribing	Supplementary Prescribing through protocols and formularies	Additional training required	No (Prescribing Guidelines only)
USA Collaborative Drug Therapy Management Agreements	Dependent prescribing through agreements	Specific training requirements per agreement	No
New Zealand Post Graduate Pharmacist Prescribers	Dependent prescribing arrangements with authorized prescribers through standing orders or protocols	Additional training required	Yes

College of Pharmacists
of British Columbia

FRAMEWORK FOR PHARMACIST PRESCRIBING IN BC

ENGAGEMENT REPORT

November 2017

CONTENTS

INTRODUCTION

The College of Pharmacists of BC is in the final stages of developing a Framework for Pharmacist Prescribing in BC which aims to help protect patient safety and improve patient outcomes.

The Framework for Pharmacist Prescribing in BC is focused on preventing patient harm by reducing preventable drug-related problems and providing safer transitions in care through increased involvement of pharmacists, as medication experts in the delivery of patient-centred collaborative care. Improving medication management and reducing preventable drug-related hospitalizations protects public safety and will improve patient outcomes.

Pharmacist prescribing is proposed to take place through interdisciplinary team-based care where physicians and nurse practitioners would continue to be responsible for the diagnosis, and access to health records and diagnostics, including lab tests, would be facilitated. Certified Pharmacist Prescribers would also be restricted from dispensing medications they prescribed for a patient. The Framework also focuses closely on the benefit to patient care and identifies specific opportunities to prevent patient harm and improve patient outcomes.

After widely seeking input on an initial draft framework for pharmacist prescribing in 2016, the College used the input from patients, pharmacists and other prescribers to develop the new Framework for Pharmacist Prescribing in BC which focuses more closely on collaborative practice.

The second engagement on pharmacist prescribing was conducted through June to October 2017 and sought feedback on the new Framework for Pharmacist Prescribing in BC.

This report consolidates all the feedback received through the second engagement under four key themes:

- Confidence in Pharmacist Prescribing
- Collaboration
- Improving Patient Care
- Support for Pharmacist Prescribing

The results of the second engagement build on the feedback previously received to provide meaningful input from pharmacists, patients, and other health care professionals on how pharmacists prescribing could work in BC to help protect patient safety and improve patient outcomes. This engagement report is intended to help inform the finalization of the Framework for Pharmacist Prescribing in BC and assist the College Board in making a decision on how the College should move forward with this framework.

The College would like to thank everyone who contributed feedback during this engagement.

BACKGROUND

Development of a proposal for pharmacist prescribing dates back to 2010 when the College Board first decided to move forward with a feasibility study. An initial draft framework was developed in 2015 and used to help facilitate stakeholder engagement in 2016.

During the initial engagement on pharmacist prescribing, the College held over 16 different workshops discussions and meetings and heard from over 25 different stakeholder groups. The College also received over 11,400 comments through its online survey.

The greatest convergence across stakeholder groups surrounded the opportunity pharmacist prescribing could have in providing greater access to care, especially for minor ailments, emergency situations, continuity of care and for patients without a primary care provider. Feedback from pharmacists and other prescribers also highlighted that pharmacist prescribing might work best in interdisciplinary team-based settings where access to more patient information and lab test results, and having a physician or nurse practitioner available to provide a diagnosis, provided respondents with greater confidence in pharmacist prescribing.

See the 2016 Engagement Report for more details on the feedback provided on pharmacist prescribing through the initial engagement.

After reviewing the results of the engagement, the College Board made the decision to amend the initial draft framework by narrowing the scope of pharmacist prescribing to within collaborative practice.

CAVEATS AND LIMITATIONS

The interpretation of the results in this Engagement Report – like many other stakeholder engagements – is subject to limitations and caveats ranging from methodological and survey design challenges, to response bias and response mirroring. These limitations are reasons why the results and analysis could differ from the exact conditions "on the ground".

However, these limitations do not mean that the feedback is without merit or insight. The results from this stakeholder engagement were rich with insight into the Framework for Pharmacist Prescribing in BC.

Where possible, the analysis completed attempted to account for and mitigate these issues.

SUMMARY

Overall, most stakeholder groups had confidence in pharmacist prescribing in BC. Feedback indicated strong support for implementing pharmacist prescribing to help care for patients from pharmacists, pharmacy technicians, pharmacy students and members of the public. Physicians illustrated strong resistance, while others (such as nurses and nurse practitioners) indicated support for pharmacist prescribing. This pattern was apparent across the four key themes of confidence in pharmacists prescribing, collaboration, improving patient care, and support for pharmacist prescribing.

Feedback was significantly more supportive for pharmacist prescribing compared to earlier feedback in 2016 on the initial draft framework. While previously members of the public were divided over their confidence and interest in pharmacist prescribing, the public responded positively across the areas of confidence in pharmacists prescribing, collaboration and communication, improving patient care, and support for pharmacist prescribing. This is a significant and important change towards the new Framework for Pharmacist Prescribing and its focus on collaborative practice relationships.

While most physicians continued to disagree with pharmacist prescribing, the level of disagreement was less compared to earlier feedback in 2016 on the initial draft framework. There was also strong division between responses from physicians and others in the same category (such as nurses and nurse practitioners). Other health care professionals (excluding physicians) demonstrated support for pharmacist prescribing across their responses. There were also points on which general practitioners demonstrated less disagreement than physician specialists, such as being open to collaborating with a pharmacist prescriber.

The greatest convergence across stakeholder groups surrounded the opportunities for greater collaboration in caring for patients as well as the ability to help protect patient safety and improve patient outcomes. In particular respondents noted that pharmacist prescribing would be beneficial for chronic disease management as well as minor ailments and prescription renewals and increased monitoring and management of drug therapy.

ENGAGEMENT PROCESS

The College followed the International Association for Public Participation (IAP2) best practices in planning and executing the second pharmacist prescribing engagement. The engagement process was communicated to stakeholders, including identifying how the feedback received would be used and how the results of the engagement would be shared – this is part of an effective and transparent engagement strategy and follows IAP2 Core Values.

This engagement was at the level of consult on the spectrum of engagement (based on IAP2 Participation Spectrum). This means the College has promised to listen to and acknowledge ideas and concerns, and provide feedback on how input affects the decision.

A dedicated pharmacist prescribing web page (bcpharmacists.org/prescribing) was published on the College`s website which provided an overview of the proposed Framework, the purpose of the engagement and an outline of the process, as well as results from previous engagements and invitations to participate in the consultation. This engagement report will also be made available through the page.

2016 ENGAGEMENT ON PHARMACIST PRESCRIBING

The initial consultation period ran from February 2016 to August 2016, soliciting feedback on the initial draft framework developed in 2015. This consultation period was comprised of 16 different workshops and stakeholder meetings with over 25 different groups and organizations as well as an online survey which received more than 11,400 comments from over 1,500 respondents.

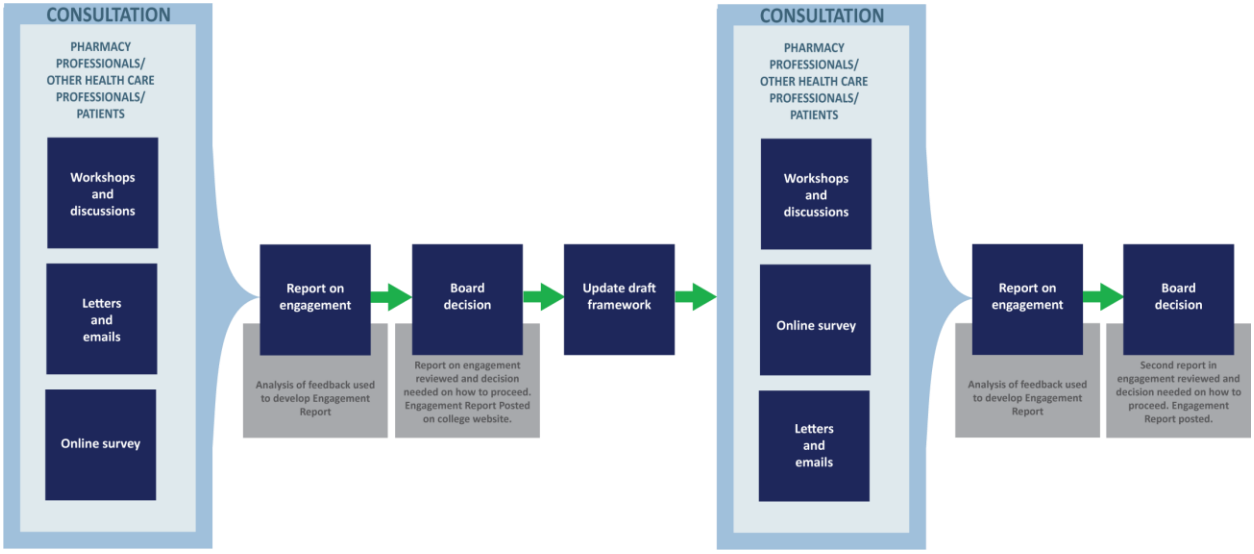
Analysis and reporting of the results of this initial engagement occurred from September and October 2016, culminating in an Engagement Report that was presented to the College Board at the November 2016 Board Meeting.

The College Board reviewed and discussed the results of the initial pharmacist prescribing engagement at the November 2016 College Board Meeting.

2017 ENGAGEMENT ON PHARMACIST PRESCRIBING

The second engagement on pharmacist prescribing ran from June to October 2017 and consisted of an online survey as well as live engagement sessions.

The online consultation ran from September 21 through to October 8, 2017 and sought feedback from registered pharmacy professionals, patients and other health professionals.



WHO WE HEARD FROM

The College reached out to patients, pharmacy professionals, pharmacy students and other health professionals as part of the engagement on pharmacist prescribing. Like the initial engagement in 2016, the College continued to receive significant participation during the second engagement on pharmacist prescribing.

We would like to thank everyone who provided feedback during the consultation period, as well as those who helped build awareness of the opportunity to provide input.

ENGAGEMENT OVERVIEW

- 1,122 completed responses through an online survey
- 3 live engagement sessions
- 152 social comments and 471 reactions
- 10 letters

The College's Online Engagement Survey ran from September 21 to October 8, 2017, inviting pharmacy professionals, patients and other health professionals to provide feedback on pharmacist prescribing in BC. Over 1,120 completed the online survey providing over 10,364 comments to a range of questions on pharmacist prescribing.

The College also hosted live engagements sessions with patients and pharmacy professionals.

Over 30 people joined into the pharmacist prescribing patient session on September 21, 2017, and an additional 255 viewers watched our live-broadcast of the session through the College's Periscope channel.

Other sessions included meeting with the College's Advisory Committees, Canadian Society of Hospital Pharmacists BC Branch and Health Authority Pharmacy Directors. The College also heard from the BC Pharmacy Association, Doctors of BC, Specialists of BC, University of British

Columbia's Pharmacists Clinic, University of British Columbia's Faculty of Pharmaceutical Sciences, Providence Health Care, the BC Cancer Agency and the Fraser Health Authority.

During the course of the online consultation period there were more than 3,700 visits to the Pharmacist Prescribing Engagement Page on the College`s website.

SOCIAL ENGAGEMENT

The College also used its social media channels (Twitter, Facebook, Instagram) to share information about the Framework for Pharmacist Prescribing, encourage participation in the online survey and invite people to an in-person patient engagement session.

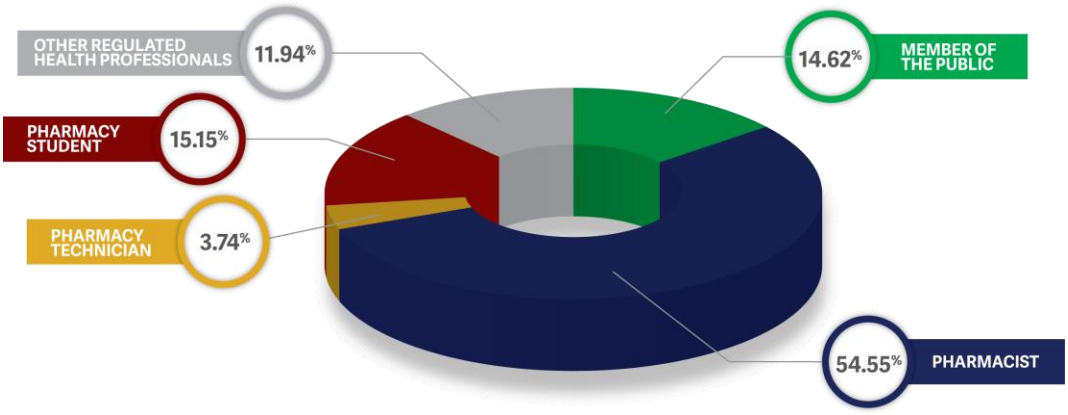
The College reached an estimated 58,000 through Facebook and received over 470 reactions (with more than 90% positive reactions including likes and loves) and over 150 comments. The College also reached over 5,800 on Instagram and over 2,800 on twitter.

ONLINE SURVEY DEMOGRAPHICS

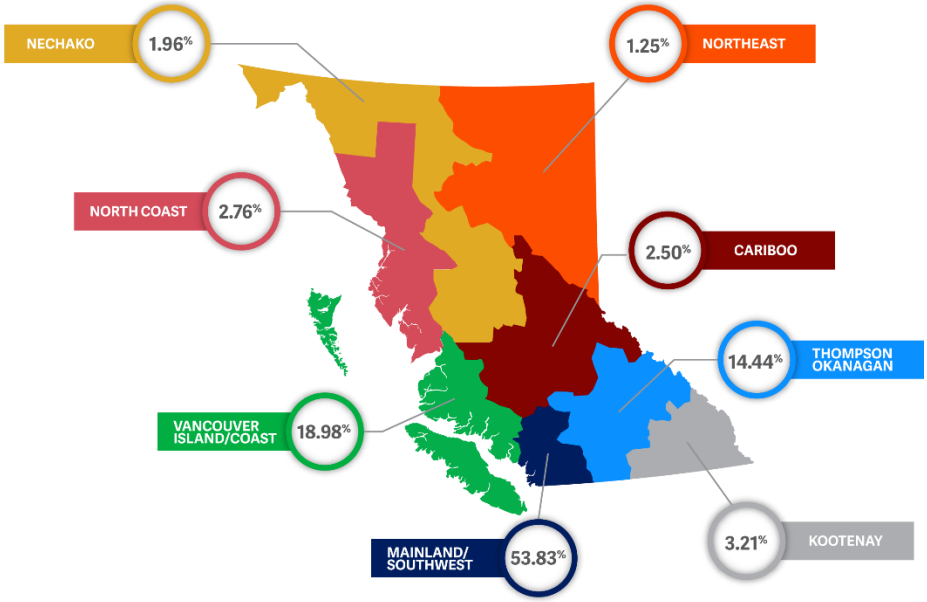
The College asked participants for information including region, community size and gender, in addition to health profession details to help provide meaningful data through the survey and review the diversity in respondents.

The College asked survey respondents to identify if they were a pharmacist, pharmacy technician, pharmacy student, member of the public or other healthcare professional.

While most responses came from registered pharmacists (54%), the College received many responses from both members of the public (14%) and other health professionals (11%). Pharmacy students also made significant contributions to the survey (15%).

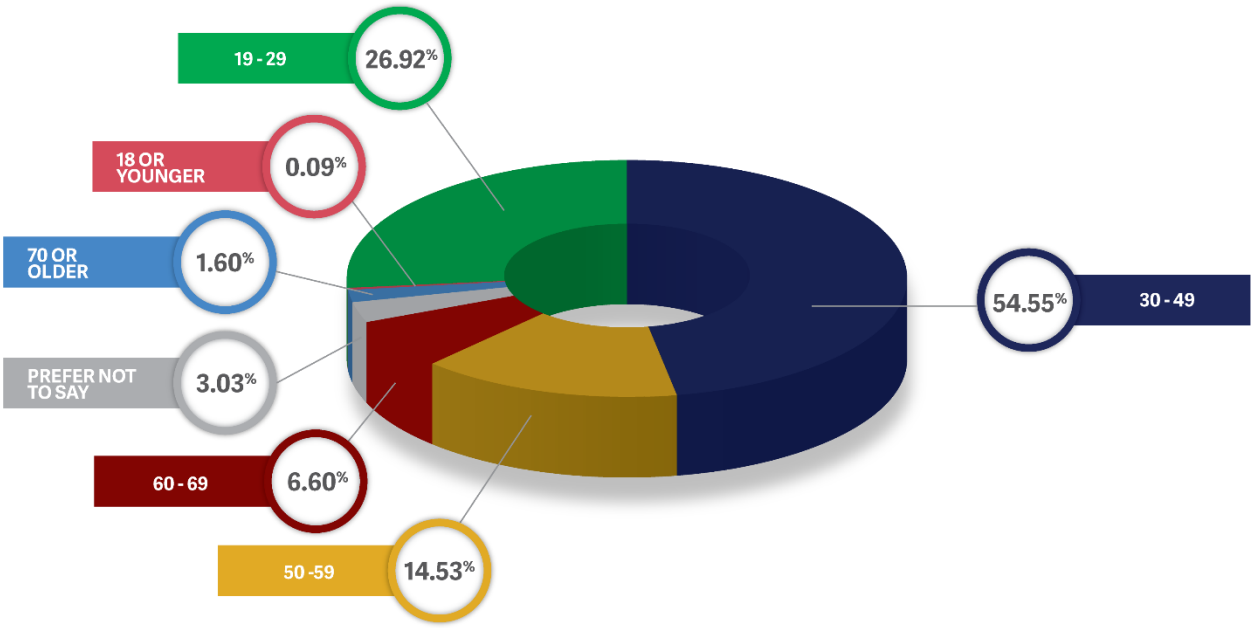


The College received the most responses from the regional areas of Mainland /Southwest (58%), Vancouver Island/Coast (18%) and Thompson Okanogan. Given that over 60% of BC's population lives in Mainland/Southwest followed by Vancouver Island/Coast and Thompson Okanagan (based on 2016 Census results for the same regions), the responses by region appear proportional to their population.

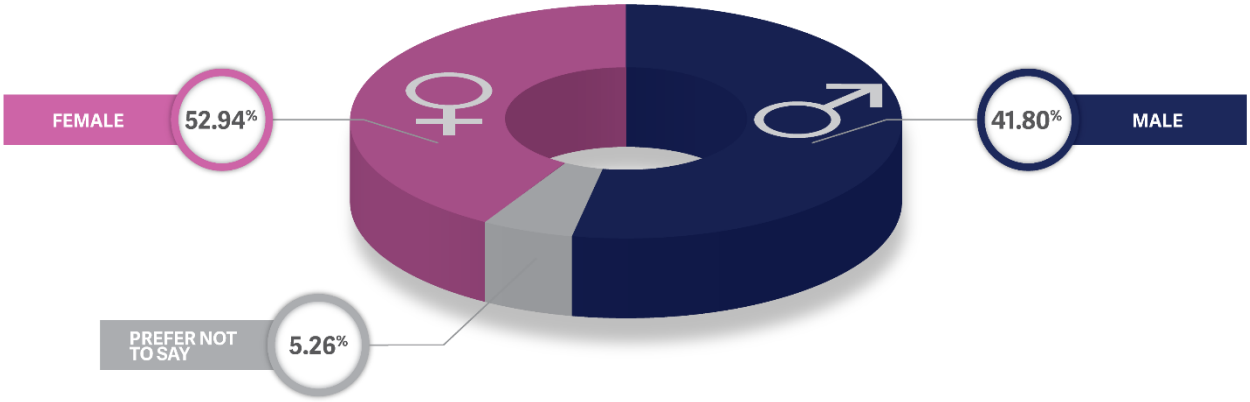


While the majority of respondents (78%) lived in large communities of over 25,000 people, responses were also received from very small (less than 3,999), small (4,000-9,999), and medium (10,000-24,999) sized communities.

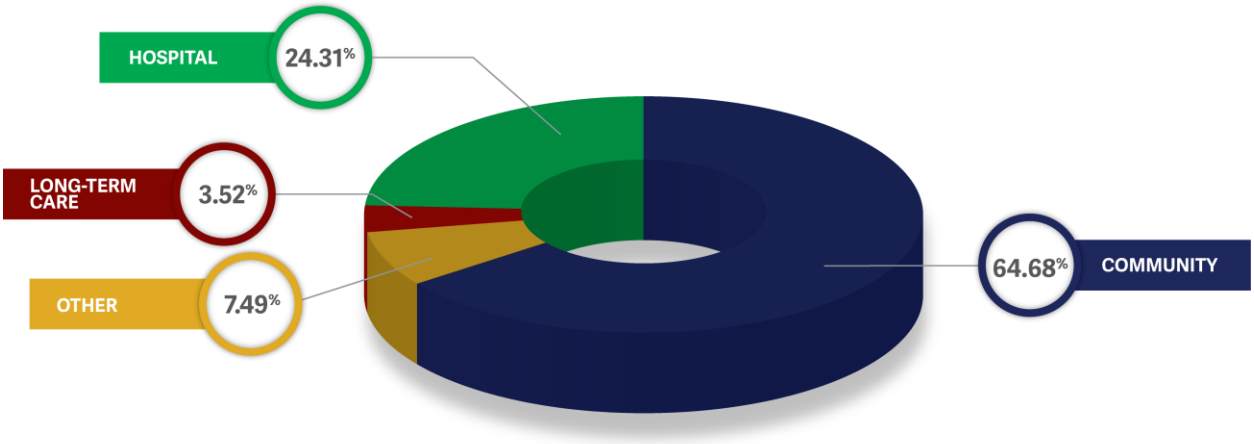
The majority of respondents identified as being between the age of 30-49 (54%), 19-29 (26%) and 50-59 (14%).



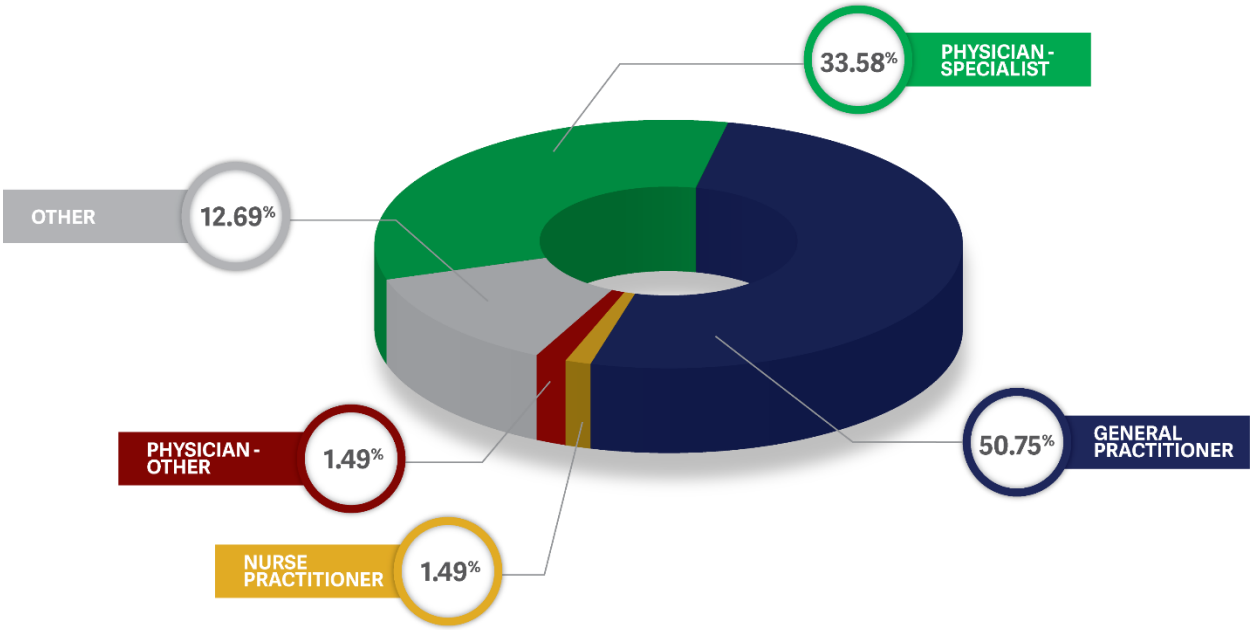
Responses were relatively balanced between those who identified as either male or female, with slightly more respondents identifying as female (52%).



Pharmacy Professionals were asked to identify their practice settings. The majority indicated they practiced in community settings (64%), while 24% indicated they worked in Hospital. In addition to long-term care, other practice settings included multidisciplinary, primary care, and ambulatory clinics, cancer centres, military clinics, outpatient centres, academic, institutions, consultancies/self-employed and government.



We also asked other health care professionals to identify their role. The majority of other health care professionals indicated they were a general practitioner (50%) followed by physician-specialist. Other responses included registered nurse, nursing student, physician student and registered massage therapist.



CONFIDENCE IN PHARMACIST PRESCRIBING

The College sought feedback from respondents related to confidence in pharmacist prescribing through a series of related questions. This covered gauging the level of confidence patients would have in receiving care from a pharmacist prescriber, confidence other healthcare providers would have in working with a pharmacist prescriber as well as pharmacy professionals level of confidence with providing care for patients through pharmacist prescribing. It also included seeking feedback on the planned educational program and assessment process to become a Certified Pharmacist Prescriber as well as the approach to managing potential and perceived conflicts of interest with pharmacist prescribing.

Overall, the majority of respondents demonstrated they had confidence in pharmacist prescribing. Levels of confidence were highest amongst pharmacy students, pharmacists and pharmacy technicians with agreement towards confidence ranging between 68% and 94% to related questions. However, many still expressed concerns around the approach to addressing conflict of interest. Members of the public expressed confidence with responses ranging between 68% -72% in agreement to related questions.

Other healthcare professionals indicated they do not have confidence in pharmacist prescribing with responses ranging between 60% - 70% in disagreement to related questions. However, responses from different types of health care professionals varied with physicians expressing more disagreement and others (such as nurses and nurse practitioners) expressing more agreement. Establishing a collaborative practice relationship between another health professional with prescribing authority (such as a physician or nurse practitioner) and a Certified Pharmacist Prescriber was the area where respondents' answers most closely aligned.

The feedback received shows a significant increase in confidence for the public compared to earlier feedback in 2016 on the initial draft framework. Even within responses from other health professionals, results show an increase in confidence with less negative responses received related to confidence in the new Framework for Pharmacist Prescribing.

CONFIDENCE IN PRESCRIBING WITHIN A COLLABORATIVE PRACTICE RELATIONSHIP

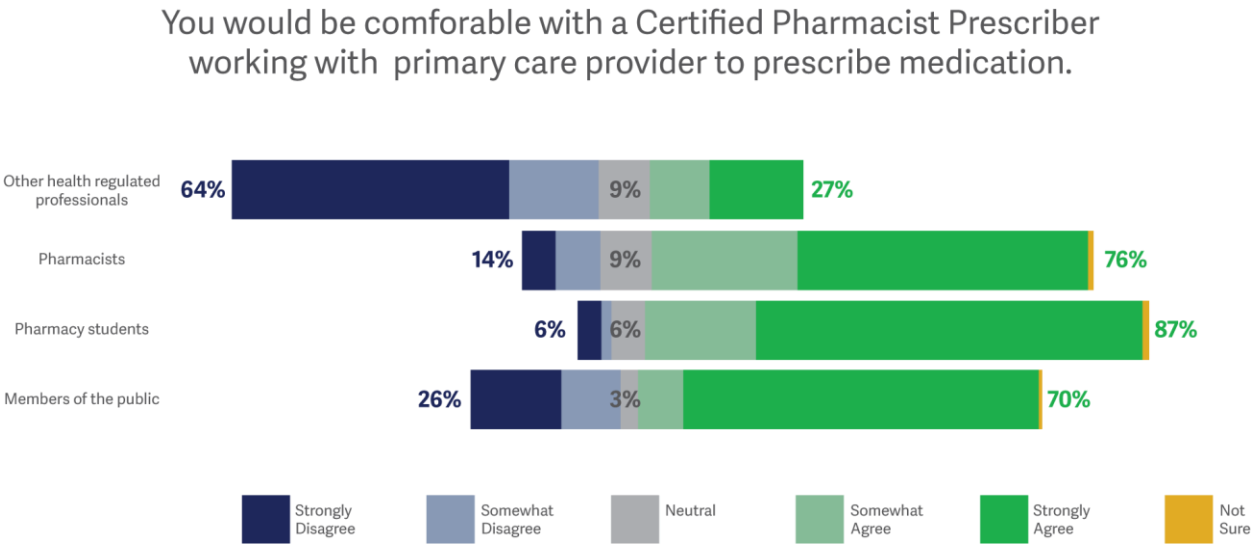
The new Framework for Pharmacist Prescribing introduced collaborative practice relationships as the approach for interprofessional collaboration through pharmacist prescribing.

Collaborative practice relationships involve developing a relationship with a regulated health professional who has the authority to prescribe, to:

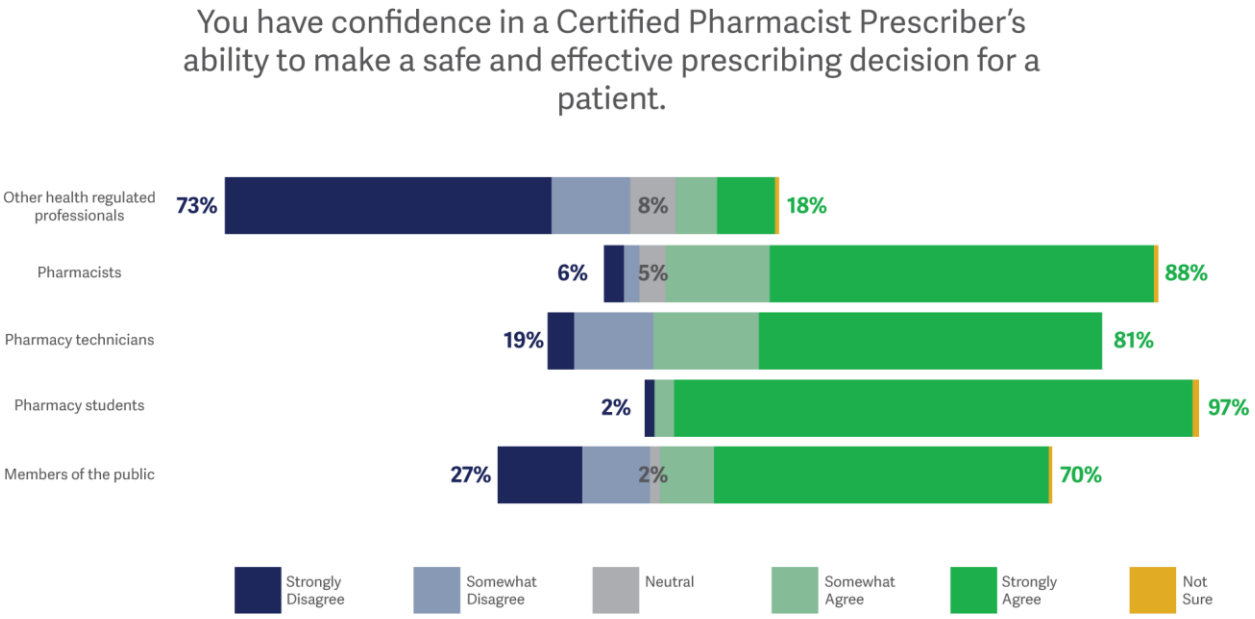
- Facilitate communication
- Determine mutual goals of therapy that are acceptable to the patient
- Share relevant health information
- Establish the expectations of each regulated health professional when working with a mutual patient

The College sought feedback on whether the new requirements for a collaborative practice relationship between a Certified Pharmacists Prescriber and other regulated health professionals gave respondents confidence in pharmacist prescribing.

The majority of members of the public (72%), pharmacists (83%), pharmacy technicians (81%), and pharmacy students (90%) either agreed or strongly agreed that they had confidence in this requirement. Most other health professionals (64%) either disagreed or strongly disagreed with collaborative practice relationships, while 27% agreed or strongly agreed with the requirement.



Most respondents, with the exception of other health care professionals, also indicated they would be comfortable with a Certified Pharmacist Prescriber working with a primary care provider to prescribe medication.

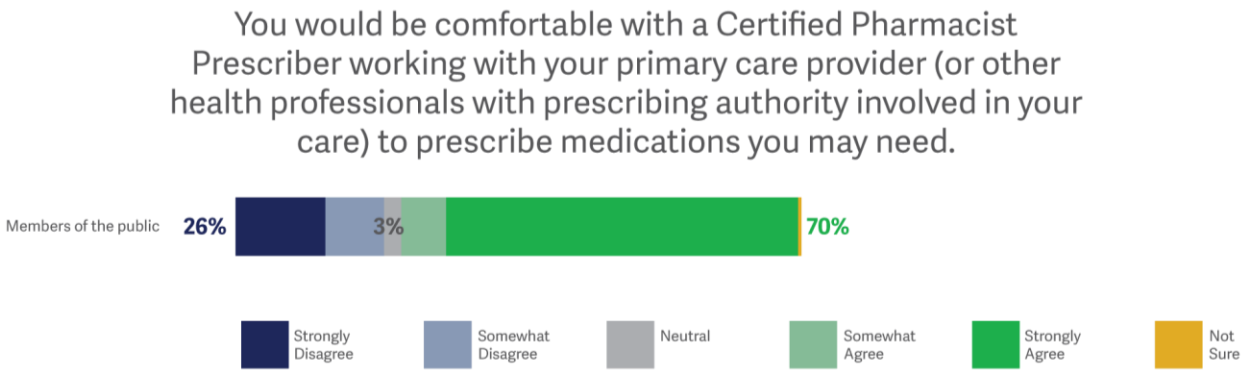


The majority of members of the public (70%), pharmacists (88%), pharmacy technicians (81%), and pharmacy students (97%) also had confidence in a Certified Pharmacist Prescribers' ability to make a safe and effective prescribing decision.

Slightly more other healthcare professionals disagreed (73%) that a Certified Pharmacist Prescribers would be able to make a safe and effective prescribing decision compared to their responses related to the requirement for a collaborative practice relationship (64% disagreed) and level of comfort having a pharmacist prescriber work with a primary care provider (64% disagreed).

PUBLIC CONFIDENCE IN PHARMACIST PRESCRIBING WITHIN COLLABORATIVE PRACTICE RELATIONSHIPS

The majority of public respondents (72%) indicated that they had confidence in collaborative practice relationships for pharmacist prescribing with 70% also agreeing that they were comfortable with a Certified Pharmacist Prescriber working with their primary care provider or others on their care team to prescribe medications they may need.



This shows a significant increase in confidence compared to earlier feedback in 2016 on the initial draft framework where only 45% indicated they were comfortable with pharmacist prescribing and only 43% agreed that they felt confident in a pharmacist's ability to make the best prescribing decision for a patient.

In contrast, when asking for feedback on the new Framework for Pharmacist Prescribing, 70% of public respondents indicated they had confidence in a Certified Pharmacist Prescriber's ability to make a safe and effective prescribing decision. Members of the public highlighted the confidence they have in a pharmacist's medication expertise and appreciated their accessibility.

However, some patients still had concerns about pharmacist prescribing. Some felt that while greater collaboration would be beneficial, the pharmacist's involvement should remain a recommendation rather than a prescribing decision. Others indicated that the benefits from pharmacist prescribing might be limited in rural and remote communities where collaboration with other health care professionals (including a separate pharmacist to dispense medications) may be limited. Some also indicated that they felt the assessments involved in prescribing should only be completed by a physician.

"I feel that a Certified Pharmacist Prescriber would be more current in their knowledgeable about the medications and their best use for me." – Patient

"I trust pharmacists in their knowledge of medications and their interactions and contra indications in relation to the diagnosis of the patients." - Patient

"Yes. If the pharmacist prescriber is working in concert with a doctor then I'd have confidence in that. I've been more comfortable in the past with a pharmacists opinion when I've been prescribed something by a walk-in clinic doctor who gave me a prescription with what seemed like very little information and no history." – Patient

"If the pharmacist if truly working with the doctor, why can't the doctor decide on the prescription? The pharmacist can advise-- that is their role." – Patient

"Ideal for chronic ongoing conditions where a renewal requires a trip to a physician when it's just a review of blood level and another rx." – Patient

"Anything is better than what I have now. There is NO availability of a family doctor anywhere in Victoria - I even checked clinics in Duncan. That means NO ability to make an appointment. It means allocating a whole day to get a refill for a prescription I've had for many years, and doing the same again in less than 3 months time. It's an undue burden. The last time I saw the walk-in clinic doctor we BOTH agreed that this is not something I should have to do, that I should NOT have to personally see a doctor to get my prescription. I couldn't agree more." – Patient

"I think healthcare providers NEED to collaborate on patient care. Long gone are the days of seeing one professional for the be-all-end-all. Humans are complex. Complexity requires different minds and multiple perspectives to complement each other on deciding what is best for the patient." – Patient

"I believe it is should not even be necessary to have a collaborative practice. Pharmacists should be able to prescribe independently. They are the medication EXPERTS. My doctors have made more mistakes than my pharmacists and my pharmacists have made drug recommendations and suggestions to my therapy that have saved my life. Doctors are very capable but the reality is that they often don't have time and see me in less than 5 minutes." – Patient

"I don't believe that the collaborative practice setting should necessarily be the only setting in which pharmacists can prescribe. It has been shown in other jurisdictions that pharmacists can safely and effectively prescribe on their own. Major benefits to pharmacist prescribing come in rural and remote communities where the possibility of collaborative care may be limited." – Patient

"This type of collaboration simply won't happen. Medication will be prescribed without a proper exam or even experience in determining what is wrong with me." – Patient

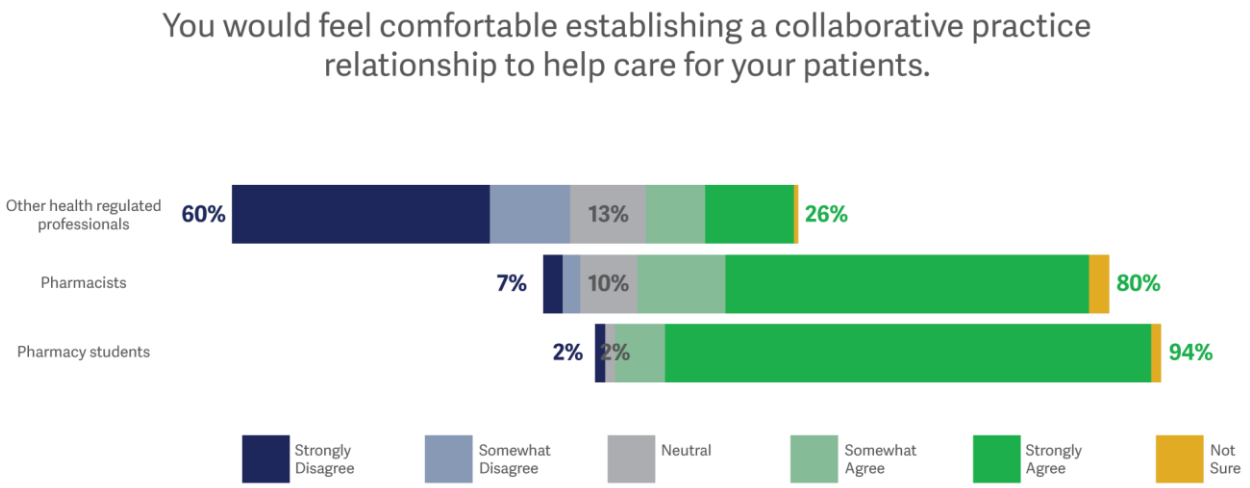
"Pharmacists are experts on drugs and drug interactions, which is very important for the safe prescribing of drugs. I don't think doctors should be able to prescribe without pharmacists - and they can't, they write a prescription that a pharmacist has to fill. Likewise, I don't think pharmacists should be able to prescribe without doctors and nurse practitioners - they aren't trained in the physical exam and history key features as extensively as prescribers, they can't make safe autonomous decisions." – Patient

"Yes much more confidence than a physician even. Considering a naturopath and nurse can write me prescriptions and a pharmacist can't is hard for me to understand. In England, pharmacists can prescribe and they have shown to make less errors than physicians." – Patient

"In a nursing home setting or hospital, i think it would work well....community pharmacists should be able to prescribe for minor ailments and look at how Saskatchewan does it." – Patient

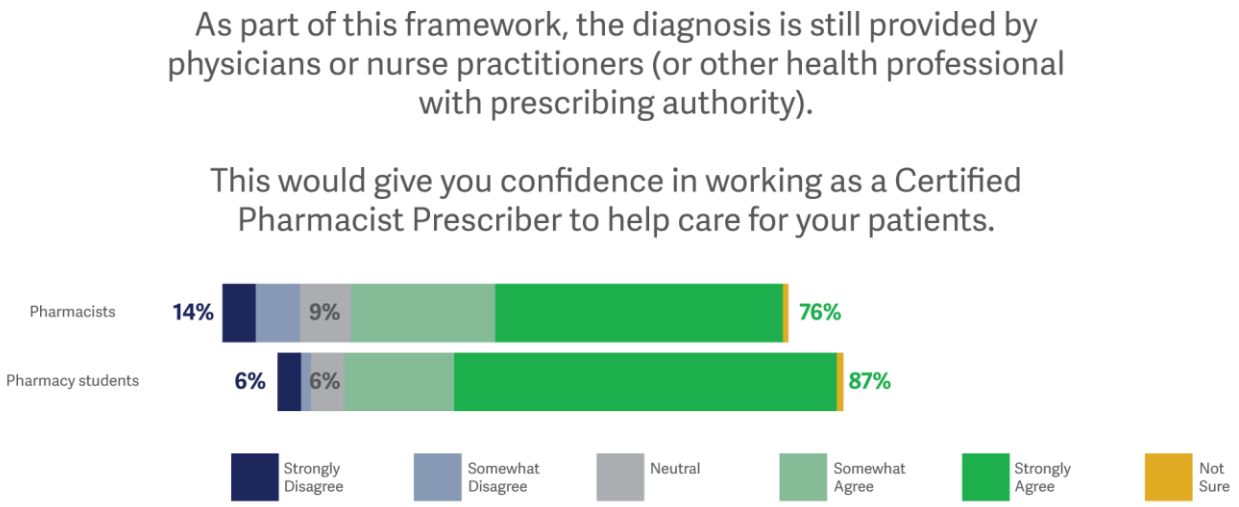
HEALTH PROFESSIONAL CONFIDENCE IN PHARMACIST PRESCRIBING WITHIN COLLABORATIVE PRACTICE RELATIONSHIPS

The majority of pharmacists and pharmacy students indicated they had confidence in pharmacist prescribing within collaborative practice relationships, while more than half of other health care professional respondents did not have confidence. However, different types of other health care professionals – physician specialists, general practitioners and others (such as nurse practitioners and nurses) – showed different levels of confidence .



The majority of pharmacy technicians also indicated they would be comfortable recommending patients see a Certified Pharmacist Prescriber for care.

Pharmacists (80%) and pharmacy students (94%) indicated they would feel comfortable establishing a collaborative practice relationship as required within the Framework for Pharmacist Prescribing. They also expressed confidence in a Certified Pharmacist Prescriber's ability to make a safe and effective prescribing decision and having a diagnosis come from another health professional with prescribing authority (such as a physician or nurse practitioner).



Pharmacists still expressed some reservations surrounding establishing this relationship including workforce pressures, limiting opportunities for collaboration, challenges in establishing a relationship, and willingness of other health professionals to participate in the relationship.

"It is not only a feeling of comfort but a necessity to have such collaboration." – Pharmacist

PHARMACIST RESPONDENT

PHARMACIST RESPONDENT

"A collaborative practice is already what is the norm in my practice. In the hospital, pharmacists work very closely with physicians and plans are discussed together. Establishing a collaborative practice as a certified pharmacist prescriber is a natural next step and does not actually change the model of established team-based patient care." – Pharmacist

"No time for collaboration as we have to check rxs for appropriatness, safety, interactions, injections, adaptations, emergency supplies and the list goes on and on and on.... we are working in mess right now..." – Pharmacist

PHARMACIST RESPONDENT

"However, the relationship is built through trust and experience. We need to start somewhere and give it a chance. The starting/establishing can be challenging because it may be the first collaborative relationship ever." – Pharmacist

"I have already established a collaborative practice relationship with my team, and the ability to prescribe would help everyone. It eats up a lot of time tracking down doctors to get orders for things like OTC pain relievers, med rec medications, etc. that could be better spent providing patient care." – Pharmacists

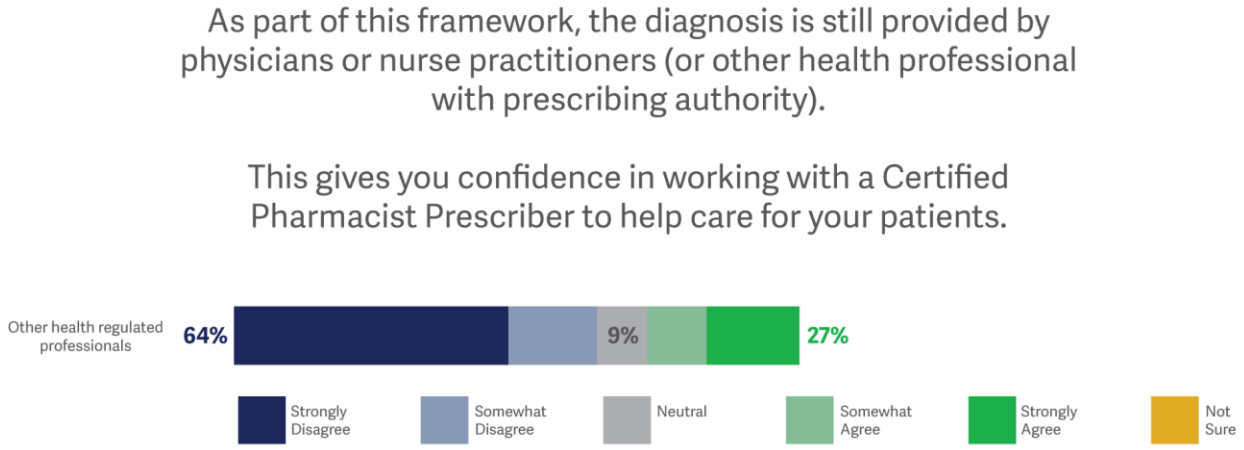
"Some doctors are very traditional in their thought - they feel their word is all and do not respect collaborative practice. These situations would not allow for collaborative practice and therefore their patients would not have access to pharmacist prescribing." – Pharmacists

"Many other health professionals in BC with less medication-related training than pharmacists already have prescribing authorities; pharmacists are often involved in training these prescribers (e.g. Naturopathic Physicians)." – Canadian Society of Hospital Pharmacists, BC Branch

"What is concerning in the recent draft framework is the notion that pharmacists, in order to prescribe at all, require oversight from physicians or nurse practitioners, who would diagnose and provide access to lab test results." – BC Pharmacy Association

The majority of other health care professionals did not feel comfortable in establishing a collaborative practice relationship to support pharmacist prescribing or in working with a Certified Pharmacist Prescriber when the diagnosis was provided by a physician or nurse practitioner (or other health professional with prescribing authority).

However, they were slightly less opposed to establishing a collaborative practice relationship with a Certified Pharmacist Prescriber compared to other measures of confidence in pharmacist prescribing – only 60% indicated they disagreed or strongly disagreed compared to 73% disagreement with a confidence in a Certified Pharmacist Prescribers ability to make a safe and effective prescribing decision.



Physician specialists had the least confidence with 91% indicating they disagreed or strongly disagreed that a Certified Pharmacist Prescriber would make a safe and effective prescribing decision, 77% indicating that the diagnosis being provided by another health professional authorized to prescribe would not give them confidence working with a Certified Pharmacist Prescriber, and 73% indicating they would not be comfortable establishing a collaborative practice relationship to support pharmacist prescribing.

General Practitioners had slightly more confidence with 77% disagreeing that a Certified Pharmacist Prescriber would make a safe and effective prescribing decision, 69 % indicating that the plan for the diagnosis to be provided by another health professional authorized to prescribe would not give them confidence, and 64% indicating they would not be comfortable establishing a collaborative practice relationship to support pharmacist prescribing.

In particular, physicians cited concerns about a pharmacist's clinical background being sufficient to support pharmacists prescribing in addition to the ability to conduct physical assessments. Some also suggested that working with a Certified Pharmacist Prescriber may take up too much of their time. Physicians also highlighted the importance of drawing on a complete medical history which they were unsure if a pharmacist would have access too as well as the growing complexity of diagnosis and patient care. However, within the Framework for Pharmacist Prescribing there are specific requirements to ensure pharmacists would be familiar with a patient's medical history and discuss the patient's needs and health goals with their primary care provider prior to prescribing.

"Pharmacists are not trained clinicians. I cannot trust they have the broad clinical background to be able to safely prescribe medication." – General Practitioner

"Guideline based care may be taken beyond the interest of the patient if the pharmacist isn't also part of the larger decision making process. For example, de-prescribing in our frail elderly population is well-described in the literature as a benefit, however it is tough to determine the timing without broader context of patient-centered care." – General Practitioner

"Before prescribing, I perform a full history and physical examination. I am not sure if a pharmacist can do this." – General Practitioner

"Too much time commitment for physicians." – Physician Specialist

"Excepting physicians being trained in pharmacy, or pharmacists being trained in medicine, we think it would be unwise and unsafe for doctors to practice as pharmacists or pharmacists to practice as doctors." – Specialists of BC

"Diagnosis is becoming more complex as are patient considerations for rx. without knowing complete past medical history and current confounding medical issues I highly doubt effective and safe prescribing in many cases. In simple, healthy, minor issues (eg. tinea) it could be fine. otherwise I see it as high risk and another way for fragmented care." – General Practitioner

"A complex understanding of the patients entire medical history, social situation as well as clinical hands-on training should be required." – General Practitioner

"The definition of "collaborative practice relationships" is broad and could be interpreted to include practices where there is only a nominal level of inter-professional collaboration. At the operational level, there remain many challenges to effective collaboration between pharmacists and physicians and the broad description of collaborative practice relationships, as outlined in CPP Framework 2017, may not adequately capture such nuances." – Doctors of BC

In contrast, other health care professionals (excluding physicians) such as nurse practitioners and nurses expressed confidence in these areas. 84% indicated they have confidence that a Certified Pharmacist Prescriber would make a safe and effective prescribing decision and in working with a Certified Pharmacist prescriber when the diagnosis is provided by another health professional authorized to prescribe. 84% also indicated they would be comfortable establishing a collaborative practice relationship with a Certified Pharmacist Prescriber. Some also indicated that a Certified Pharmacist Prescriber should be able to assess and diagnose the patient in some cases.

"The wait to see a physician is very long. If they still have to diagnosis a condition it defeats the purpose of having a pharmacist to prescribe. Whole point of having pharmacists prescribe is to decrease wait times and increase access to drug therapy fast." – Nurse

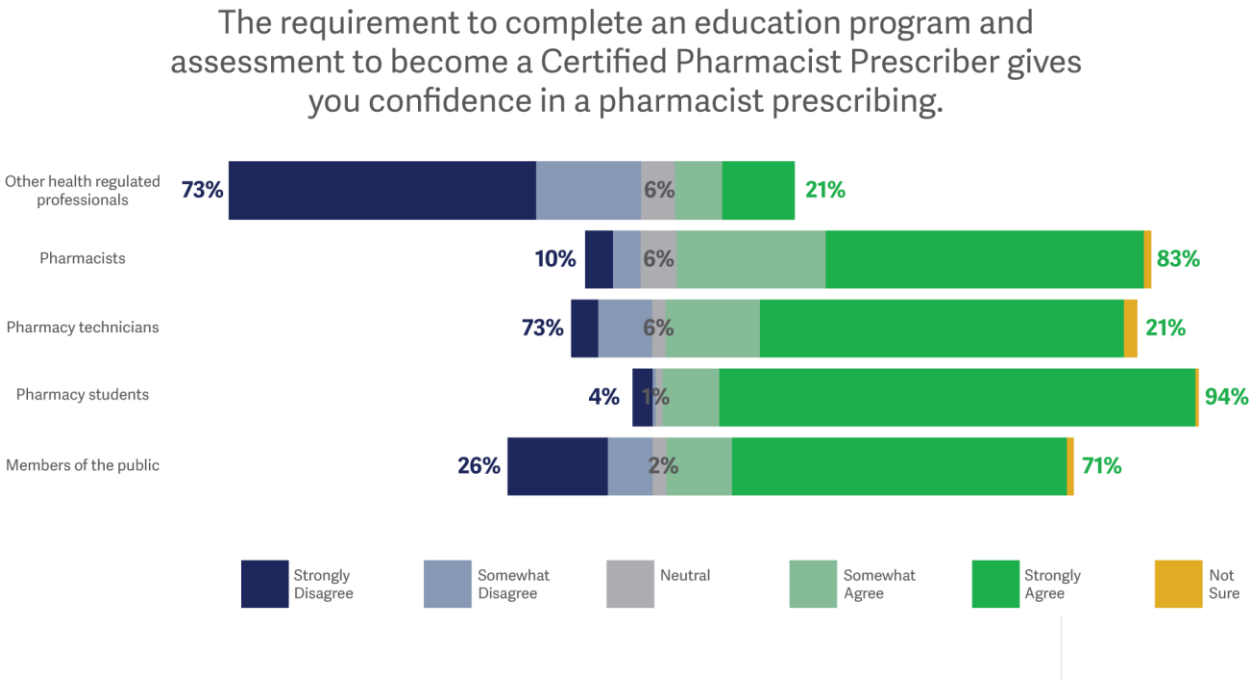
"Patients see their pharmacists more regularly than the doctor. They have a better established relationship with them." – Nurse

"Currently work in a team-based primary health care clinic. Would allow us to make much more efficient and effective use of our team members if we had a pharmacist prescribing in line with diagnosis provided by another member of the team and in line with our goals of care." – Nurse

"Have the pharmacist involved in the patients care/reviewing medications order by provider/clarifying and adjusting orders to meet the patients needs." – Nurse

CONFIDENCE WITH ELIGABILITY REQUIREMENTS

Overall the majority of respondents (68%) felt that the education program and assessment to become a Certified Pharmacist Prescriber gave them confidence in a pharmacist prescribing. Agreement was strongest from pharmacy students followed by pharmacists, pharmacy technicians and members of the public. The majority of other health professionals either disagreed or strongly diagreed with this.



Many patients felt that the additional education program and assessment, together with a system for checks and balances to ensure patient safety would be important to become a Certified Pharmacist Prescriber. Some patients also expressed that no amount of additional training other than a medical degree, would give them confidence in a pharmacist prescribing, while others felt no additional training was needed.

PUBLIC RESPONDENT

"There should definitely be some checks and balances in place to ensure pharmacists are not prescribing things out-of-hand. I think some kind of audit system or method of following-up on pharmacists' prescribing behaviours would also be appropriate in part to completing an educational program/assessment." – Patient

"Provided that the program and assessment was rigorous enough to demonstrate competence." – Patient

"Although knowledge of medications is strong, this is not a substitute to an M.D." – Patient

"It is unnecessary. Pharmacists spend so many years specializing in medication." – Patient

"An education program and assessment would be of utmost importance before a Pharmacist has prescribing ability." – Patient

"A rigid training program is absolutely required for them to prescribe medications" – Patient

Other healthcare professionals primarily indicated that no additional training program would be sufficient to allow pharmacists to prescribe. They also emphasized the importance of clinical experience as well as the ability to complete assessments and diagnosis. Others noted that the depth, duration and scope of the education program would be key in preparing pharmacists to prescribe. Some suggested that the eligibility requirements and certification process does give them confidence in pharmacist prescribing. A small number also indicated they felt pharmacists already have the education and experience required to safely prescribe.

"Training will have to be appropriate to the area of prescribing permitted Medical training for physicians have to do with overall assessment before prescription - and that is one among many treatment modalities. So pharmacists will either have to come from a defined framework to make the training compatible." – General Practitioner

"Prescribing requires knowledge of other conditions, follow up requirements, indications for further testing, continued testing, screening, timings of reassessment - not just knowledge of the medication." – Physician Specialist

"Will they also be taught the techniques of physical assessment?" – Nurse Practitioner

"Pharmacists should be able to prescribe as long as they have an active license. They shouldn't have to do extra schooling for this." – Nurse

"An education program is not enough time nor experience to develop clinical skills to prescribe." – Physician Specialist

"Before prescribing a treatment one must have a diagnosis, consider all the options and their possible outcomes (good and bad) and then make a judgement, based on experience. Prescribing a medication is only one option in treatment. Some diagnoses are better treated with operative management, some with physical therapy, some with psychological support and some with social support. Others need observation to assess the natural history. I do not believe that pharmacists have the core training and on-going experience to practice at this level." – Physician Specialist

"As a family physician, prescription renewals is a time for me to review the chart and see what routine screening needs to be competed. (Eg FIT, mammograms, paps etc) If it is regarding a new medication, will the pharmacist be trained in auscultation and palpation of abdomens?" – General Practitioner

"Duration of program and breadth of scope are important considerations." – General Practitioner

"Pharmacists are trained in history taking, but would also need training in physical exam and diagnostic investigations. They should be trained to use this information to come up with a differential diagnosis and treatment plan. They would also need confidential exam rooms with appropriate equipment to conduct their exams. This type of training requires several years. You cannot assume high blood pressure is essential hypertension or that heartburn is GERD, there are other diagnosis to consider and these require the above system (history, exam, investigations, differential diagnosis, plan)." – General Practitioner

"We also support the rigorous credentialing/certification process that will ensure the pharmacist maintains a high standard of practice. With these high standards of certification in place other providers can be confident that the pharmacist is competent in this scope of practice and communication and documentation will go above that required of any other current prescriber which will enhance care and close gaps that currently exist. The fact that there will be a robust credentialing process required by the College ensures that only pharmacists who have demonstrated the skills and abilities will be able to prescribe." – Fraser Health Authority

Many pharmacists highlighted that the combination of an education program and assessment may be beneficial in giving members of the public and Certified Pharmacists Prescribers confidence in prescribing. Some felt pharmacists already had the knowledge skills and abilities to prescribe and the additional training would be unnecessary. Assessment, diagnostics and therapeutics were mentioned as important topics to cover in the education program in addition to the responsibilities of prescribing.

"The purposeful changes in how the Faculty trains pharmacy students and supports practice innovation have been made so pharmacists can take on more drug therapy responsibilities for patients, thereby enabling other members of the health care team to align their skills and expertise for optimal patient and societal benefit." – *Faculty of Pharmaceutical Sciences, University of British Columbia*

Formal education program is more reliable than assessment or portfolio. Combination is preferred." – *Pharmacist*

"This is important for public safety and my confidence to diagnose and prescribe safely" – *Pharmacist*

"The education program would need to be rigorous, comprehensive and of a standard comparable to that required of medical doctors." – *Pharmacist*

"Pharmacy schools don't always emphasize assessment. I believe assessment training will be an important part the certification process." – *Pharmacist*

It would be wise to learn nuances of prescribing, legalities and liabilities of prescribing before taking up that responsibility. – *Pharmacist*

"Don't necessarily agree that there should be any additional requirements. Pharmacists are medication experts and we are trained to do this and manage medications - just never given the opportunity due to regulatory constraints." – *Pharmacist*

"Many practicing pharmacists, especially those in hospital, already have the skills to prescribe confidently and going through certification will not necessarily train those who do not have the experience with real patients and years of experience interacting and learning from other disciplines". – Pharmacist

"Making sure the pharmacist is competent enough knowledge-wise is crucial to make sure the public will get the best care." – Pharmacist

"I strongly agree there should be a process and assessment in place. I would propose that this process is widely accessible perhaps via online training." – Pharmacist

"I think this depends on what types of medications we are to prescribe and if we are also diagnosing and prescribing. If we are only initiating drug therapy for long term chronic illnesses, I feel we are already educated on these matters. I also feel we are fairly educated on antimicrobial therapy. However, more education is never a bad thing. I just feel some of the longer term practicing pharmacists may not appreciate that? Perhaps we can include challenge exams as they have for assistants to get regulated?" – Pharmacist

"An education programs and assessments must be mandatory to become a Certified Pharmacist Prescriber. Not only does it give me confidence in the Certification process but it gives the public confidence in my prescribing. These programs must be specific and achievable but challenging also. The assessments must be skillfully designed to determine prescribing competence in order to fully protect public safety." – Pharmacist

"Not all pharmacists are equally educated; thus, having a separate assessment can ensure that pharmacist prescribers are all qualified and capable of prescribing the right medications to the right patients." – Pharmacist

"It is the only way to guarantee I am ready for prescribing, and for the public to know I certainly am qual*ified for it." – Pharmacist*

*"The process must have a therapeutics section. I would recommend 40 hours of training then care plans written a*nd assessed." *– Pharmacist*

"It all depends on how comprehensive the education program is. I am a PharmD. I believe the education level needs to be equivalent to that of a PharmD degree is required to ensure pharmacist prescribing is appropriate." – Pharmacist

Pharmacy students highlighted the additional preparation to prescribe included in the training provided through UBC's PharmD and Entry to Practice PharmD Program verses earlier Bachelor of Science in Pharmacy programs. However, while some pharmacy students felt the additional educational program was unnecessary for PharmD students, others felt that the educational program and assessment was still needed to ensure Certified Pharmacist Prescribers understand the required processes and responsibilities when prescribing.

"Mandating an education program and assessment would allow for increased competency in this area of practice." – Pharmacy Student

"I agree after completing the Entry-to-Practice Doctor of Pharmacy degree, I will have the confidence to be a certified pharmacist prescriber. I disagree that there needs to be an additional required education program and assessment in order to be a certified prescriber, for those graduation with the E2P PharmD program. I feel we will be fully prepared upon graduation to make prescribing decisions. However, should a current practicing pharmacist or recent graduate, not feel confident in prescribing then an additional education program and assessment should be made available for them." – Pharmacy Student

"I also think that this certification process should be different depending on if the pharmacist has a BSc or a PharmD". – Pharmacy Student

"Pharmacists should be required to complete an education program and assessment in order to understand the appropriate process when prescribing medications to patients. We must ensure that pharmacists understand which medications they will be able to prescribe to the public." – Pharmacy Student

"Certification will ensure a standardized level and quality of patient care in relation to pharmacist prescribing." – Pharmacy Student

"To understand the mechanism of drugs, we first have to fully understand the cause of the underlying disease/illness. The current PharmD program is built to help students understand and recognize different disease states in addition to drug therapies." – Pharmacy Student

PATIENT EDUCATION PLAN

The Framework for Pharmacist Prescribing includes the plan to develop patient education plan to support patients in learning about how pharmacist prescribing in collaborative practice would work. The College asked respondents what would be important to include for patients about pharmacist prescribing.

Patients highlighted the importance of building understanding of how a Certified Pharmacist Prescriber can provide patient care, including what is within and outside of their scope. They also emphasized that patients need to understand the collaborative practice relationship, including how the Certified Pharmacist Prescriber and primary care provider will work together to care for a patient with an understanding of when it is appropriate to seek care from a pharmacist prescriber or the patient's primary care provider. Outlining how patient health information will be shared is also noted. Patients also wanted to learn more about a Certified Pharmacist Prescribers training.

"There will have to be a very good patient engagement/communication strategy as the patient is really the holder of information. So, along with acute and community care providers, the patient needs to be very aware of the value the Pharmacist plays in their medication journey." – Patient

"How to get the most out of my pharmacist help. List of things of what pharmacists and doctors can do." – Patient

"It would be important for them to explain how their prescriptions are not driven by advertising, gifts (like dinners, parties and travel) from drug reps and not driven by revenue and profits." – Patient

"What are the limitations. Is it just for medications or also prescribing soft/hard braces, orthotics, other physical aides, medical marijuana. Also, explain why they are only prescribing a medication for 2 weeks or 1 month and not for 3 months (ie. if you want to see if there are side effects, etc). Also, maybe if it will mean more standing around the pharmacy instead of sitting around the doctor's waiting room." – Patient

"How pharmacist education will be improved in ensuring their full capabilities in prescribing and making them fully qualified in doing so." – Patient

"Just increase common knowledge that pharmacists can prescribe, and for patients to understand any limitations or restrictions, eg instances where a pharmacist can choose NOT to prescribe if it's outside of their expertise." – Patient

"Giving some examples of practical scenarios in which a pharmacist may prescribe a medication would give people a better idea of what pharmacists can safely treat. Obviously people shouldn't be expecting the pharmacist to heal broken bones or heart attacks, but if they have an idea of conditions that can be treated, they may be more willing to use the system effectively." – Patient

"Rules and regulations synopsis (what Certified Pharmacist Prescribers can and can't do). Also a framework for expectations of each professional, like what a patient would expect from their physician, pharmacist, specialist, Certified Pharmacist Prescriber... also a guideline for how these professionals should be working together. Sometimes, professionals fight and this could spell bad news for patients." – Patient

"I think it would be very important to illustrate the exact scope and breadth of the typical pharmacists' expertise. I mean, the reason that there is even a debate on this is that people don't see pharmacists as being as qualified as doctors to prescribe medication. And this is a fair assessment. I think the real issue here is that the public simply doesn't realize the counselling ability required to become a pharmacist." – Patient

"Clarifying the level of expertise and training that pharmacists have in drug therapy and how that makes them a huge asset to the health care team." – Patient

"Patients should clearly understand the role of the certified Pharmacist Prescriber and know that the pharmacist will not replace the physician for the patient's health care." – Patient

Health care professionals also highlighted the importance of highlighting what is within and outside of a Certified Pharmacist Prescriber's scope of practice. They emphasized that it was important for patients to understand that pharmacist prescribing will be part of a collaborative approach in providing care and that a Certified Pharmacist Prescriber is not a replacement for a primary care provider.

"Framework and scope of expertise Who to access for what and when Conflict of interest issues for pharmacist and physicians Each professional is responsible for their actions or prescription separately Importance of communication from patient regarding what they are taking and why, regardless of who has prescribed the medications." – General Practitioner

"What they can prescribed and what scenarios they can approach a pharmacist for evaluation and treatment." – Pharmacist

"Training & emphasize that pharmacists are part of a collaborative team, not functioning independently." – Pharmacist

"What they can and cannot do, when to go to primary provider etc." – Nurse Practitioner

"1) Awareness that a pharmacist can now prescribe for certain conditions. 2) That their family doctors are also involved into achieving the same goal of therapy as set before. 3) They cannot see you for everything but only for certain specific conditions and should be dealt with same respect as doctors." – Pharmacist

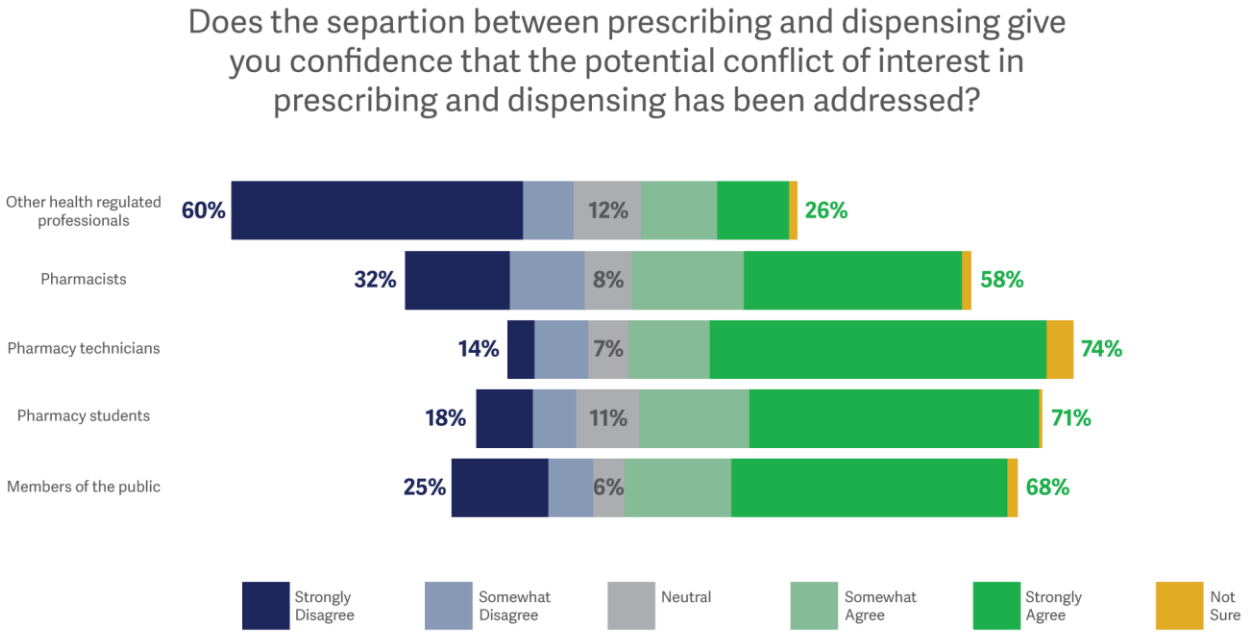
"Types of medications (ie narcotics) that would not be able to be prescribed by pharmacist." – Nurse

"What your pharmacist can and CAN'T do, what resources we have access to, and how we do it and an approximate time it will take (so they can plan for their visit) and how they should prepare for their visit." – Pharmacist

ADDRESSING CONFLICT OF INTEREST

Overall, while there were still some concerns about the potential for a conflict of interest with pharmacist prescribing, the majority (59%) felt that the separation between prescribing and dispensing addressed the conflict of interest. Pharmacists, pharmacy technicians, pharmacy students and members of the public primarily felt conflict of interest had been addressed, while the majority (60%) of other health care professionals still indicated they did not have confidence it had been addressed through the Framework.

The level of confidence on conflict of interest being addressed has significantly increased compared to earlier feedback in 2016 on the initial draft framework where dispensing and prescribing were not required to be separated. In the feedback on the initial draft framework, only 44% indicated they had confidence that the conflict of interest had been addressed. The greatest change is seen through the feedback from other health care providers with an increase from 5% to 26% agreement and from members of the public with an increase from 46% to 68% agreement.



Many members of the public highlighted that this separation between prescribing and dispensing would be inconvenient if there was not another pharmacist to dispense the prescription nearby, while others highlighted this separation would give them greater confidence in pharmacist prescribing. Some felt that the requirements should be further restricted to

prevent the same pharmacy from benefiting from the prescription prescribed by a Certified Pharmacist Prescribers. Others also felt that these measures were unnecessary and believed their professional obligations were sufficient.

"This is a good idea and would help me feel confident that there wasn't a benefit to a pharmacist for prescribing one drug over another."
– Patient

"As long as I don't have to drive to a completely different pharmacy. This may pose a difficulty in small towns. It would be great in small/rural/remote towns as there is often a super long wait to see the doctor, but if a person is able to go to a Certified Pharmacist Prescriber at the one pharmacy in town, what if they have to drive to another pharmacy to have it dispensed?"
– Patient

The pharmacists should be at different locations or be part of different companies. This would give me more confidence that conflict of interest is appropriately managed. (Colleagues can still talk to each other at the same place.) – Patient

"This is not necessary. Optometrists sell you glasses, dentists suggest braces and then make money off of those braces; there are conflicts of interests everywhere in healthcare. I don't think it is okay to not trust pharmacists' integrity, especially when they can be so helpful if allowed to expand their scope." – Patient

"Yes but this is silly if we trust a healthcare professional then we should give them full trust Naturopathic doctors sell vitamins out of their office Isn't that the same conflict Also it would benefit a pharmacist now to sell me every otc medication possible when I have a cold but they don't do that." – Patient

"The issue lies with the corporate structure of pharmacy where numbers are the top priority. This complicates things immensely because as the patient, would it not be the most convenient for them to fill the prescription at the same pharmacy? It is a tough situation when considering all angles. I hope that there can be a resolution where patient health is put first and payment for services comes second." – Patient

"I do not think there is a conflict of interest in prescribing and dispensing." – Patient

"As professionals they should not have a conflict of interest. It is their license and livelihood on the line. There should be more pressure from the college on companies to not impose quota's to pharmacy's. It is a business, but it's patients health care too." – Patient

"The pharmacist should take an oath that when they become a Certified Pharmacist Prescriber they should not be influenced by the pharmaceutical company with their financial kickback." – Patient

The majority (60%) of other health care professionals did not feel that the potential for a conflict of interest was addressed by separating pharmacist prescribing and dispensing. Physician specialists had the greatest level of disagreement with 71% either strongly or somewhat disagreeing that the conflict of interest had been addressed, while General Practitioners were 52% in disagreement. However, some physicians (21%) did indicate that the measures in the Framework have addressed the conflict of interest, or indicated they do not think the conflict of interest is significant.

Other health care professionals (excluding physicians), including nurse practitioners and nurses, primarily strongly or somewhat agreed (52%) that the conflict of interest was addressed. Many other health care professionals (including physicians) noted that the process of separating pharmacist prescribing and dispensing may be less convenient for patients, especially in small communities where an alternate pharmacist or pharmacy may not be easily accessible.

"Do they work in the same pharmacy? There can be a general incentive to increase the business to the pharmacy." – General Practitioner

"SMALL COMMUNITIES MAY ONLY HAVE 1 PHARMACIST"
– Registered Nurse

"Prescribers who have the ability to also dispense could simply refer to one another. Unless the prescriber gave up ALL dispensing activities, there is still a conflict of interest."
– General Practitioner

"If it were another pharmacy that dispensed the medication, I would be satisfied the COI was addressed." – Physician Specialist

"Not sure how this conflict between prescribing and dispensing can truly be resolved. there is always an inherent conflict." – Physician Specialist

"This is reassuring to me. I would hope that the separation would be between pharmacies as well, thus preventing conflict of interest." – Physician Specialist

"I actually don't see the need for this if there is proper collaboration and defined "rules" for the management of prescriptions by the pharmacist. Surgeons don't prescribe operations for other surgeons to carry out. If the concern is financial then there should be some regulation that prevents that. I don't see a professional issue otherwise. The issue is the decision to use a specific drug not the dispensing of that drug. The same is already true for physicians." – Physician Specialist

"The CPP Framework 2017 attempts to address conflict of interest concerns by prohibiting a [Certified Pharmacist Prescriber] from prescribing and dispensing the same medication to a patient. Despite this safeguard, a [Certified Pharmacist Prescriber] may still be influenced by the dispensing interests of colleagues or employers." – Doctors of BC

Pharmacists were the most divided on the plans for addressing conflict of interest with only 58% expressing confidence in the approach. Many pharmacists highlighted that the requirement to have a separate pharmacist dispense the medications will be inconvenient for patients and pharmacists. This was a particular concern for smaller communities where another pharmacist may not be available in the same community. Some respondents suggested that Certified Pharmacist Prescribers in small or remote communities should be able to request an exception to this requirement to prevent delays in providing treatment to patients.

Others suggested that the requirements should be strengthened to not allow a pharmacist at the same store from dispensing a prescription. Some also suggested that the College's Code of Ethics should be sufficient to address the conflict of interest. Others suggested that this restriction should only apply to community pharmacies. Some suggested that alternative funding models for pharmacist prescribing and dispensing could help address the potential conflict of interest.

"Agree with this, however, provisions must be made so this requirement can work in a rural setting where there may be only 1 pharmacist on duty in the small town at the time. Something must be in place to allow care to occur." – Pharmacist

"In a small pharmacy with only one or two pharmacists this does provide limitations. Although I do feel it is an important separation. I do think that patients should be able to have the choice to take it to another pharmacy if they want to. That being said code of ethics should also be a driving force for a pharmacist being able to both prescribe and dispense. (Especially in some situations such as a travel clinic setting)." – Pharmacist

"This an extremely fair and reasonable stipulation and helps negate any conflict of interest. However, this may not be an option in rural areas or in areas where there would only be a single pharmacist on duty at any one time. Or there may be only a single pharmacist in a particular region. In this instance, a patient would be unfairly disadvantaged or inconvenienced. One such method to guard against such an event would be to limit the remuneration received in situations where the prescribing pharmacist and dispensing pharmacist is the same (similar to a dispensing physician). Having some form of cap in place would help reduce potential conflicts of interest and at the same time still meet the needs of patients in the region." – Pharmacist

"I believe patients will want to fill their prescription right after having their consultation with the pharmacist prescriber. As the majority of pharmacies only have one pharmacist on duty at a time, we would have to send our patients to another pharmacy to fill the prescription. In most cases, patients will not want to make the trip to another pharmacy, and as they already have an established pharmacists patient relationship with our pharmacy, they should not have to. But then the problem of conflict of interest will remain, and the patient will not get their double check by another pharmacist." – Pharmacist

"Dentists prescribe their own procedure, vets do this as well. Physicians dispense samples. Not really sure what the difference is between these professionals and pharmacists." – Pharmacist

"A known critical success factor for implementation of pharmacist prescribing in other jurisdictions is the absence of perceived or actual COI related to dispensing what has been prescribed. This should be extended to address pharmacist prescribers in the same dispensing environment. I'd prefer that this not be allowed." – Pharmacist

"I would only be confident if there was absolutely no possibility of a financial relationship between the prescribing and dispensing pharmacists. They should not be allowed to work for the same company or any company or organization that has any common ownership." – Pharmacist

"This is a highly impractical idea. Code of ethics, as dictated and enforced by the [College of Pharmacists] would take care of conflict of interest concerns. Duplicating work of having two pharmacists review for safety and clinical appropriateness makes little sense." – Pharmacist

"The pharmacy profession has a strong business component unlike other healthcare professions. We do see many pharmacists indulge in promoting OTC meds and hardly endeavor to de-prescribe unnecessary medications. Thus there is a great potential for conflict of interest." – Pharmacist

"Pharmacists in health authorities do not receive any incentive for any prescribing or dispensing. They do not get money for drugs that are sold. I see no conflict of interest at all." – Pharmacist

"This is a tough one. Ideally, the prescribing pharmacist should not benefit financially from the dispensing of the medications, but there needs to be some mechanism in place for compensation for the prescribing service. Having the patient take prescriptions to a different store in a community setting is not very practical. There won't be such problems in hospitals, but prescribing pharmacist will still be more at risk of conflicts of interest in their relationship with drug companies." – Pharmacist

"I think this gives others confidence and therefore it should be included. In reality I think the concern about COI in this setting is exaggerated. Pharmacists must follow a code of ethics like all other HCPs. This is not much different than an orthopedic surgeon recommending surgery and then doing the surgery. Pharmacists who do not follow their code of ethics should face disciplinary action." – Pharmacist

"Keeping the two separate helps with additional inputs and to minimize any potential conflict of interest. This does create barriers in Pharmacies that operate with only 1 Pharmacist at a time." – Pharmacist

"Yes, I do agree with this with the exception of very small communities with pharmacies that may only have one pharmacist on at a time." – Pharmacist

The majority of pharmacy technicians (74%) and pharmacy students (71%) felt the potential conflict of interest had been addressed. However, some still highlighted concerns such as workforce or corporate pressures or highlighted that the restriction may be difficult for communities where only one pharmacist is available.

"While this might mitigate the issue of conflict of interest, I believe that this might hinder the public from accepting this idea due to increased inconvenience." – Pharmacy Student

"Some community pharmacies don't have the luxury of two pharmacists. How is that helping with patient care?" – Pharmacy Technicians

"The potential conflict of interest in prescribing and dispensing has been fully and adequately addressed. Since doctors are able to prescribe and dispense medication for the same patient without an implication of conflict of interest, it should follow logically that pharmacists who separate the roles of prescribing and dispensing will avoid conflict of interest as well." – Pharmacy Student

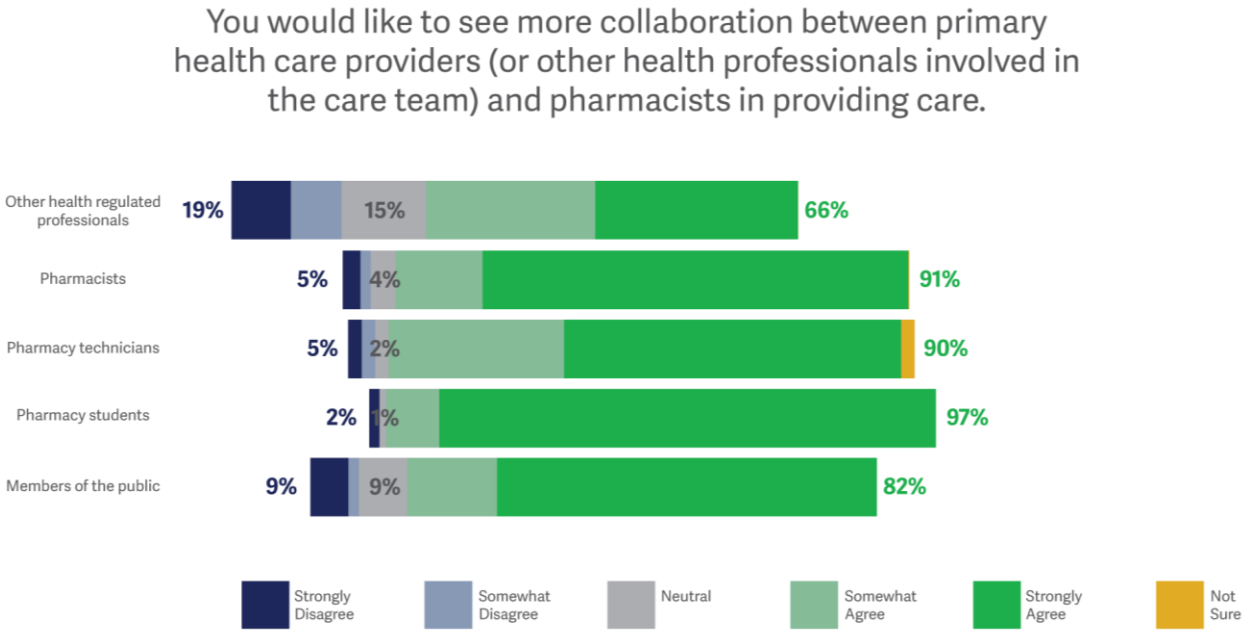
"I honestly don't think they should have to be different, as we are all held to a very high ethical standard. However, I do see the wisdom in doing so, at least from the standpoint of building the trust of patients and fellow HCPs." – Pharmacy Technicians

"Depends on management in the retail setting if they are pressuring the pharmacists to get money for more Rx prescribed. I feel that Retail pharmacies should be paid by the government on the number of pt's served and not on quantity of Rx filled." – Pharmacy Technicians

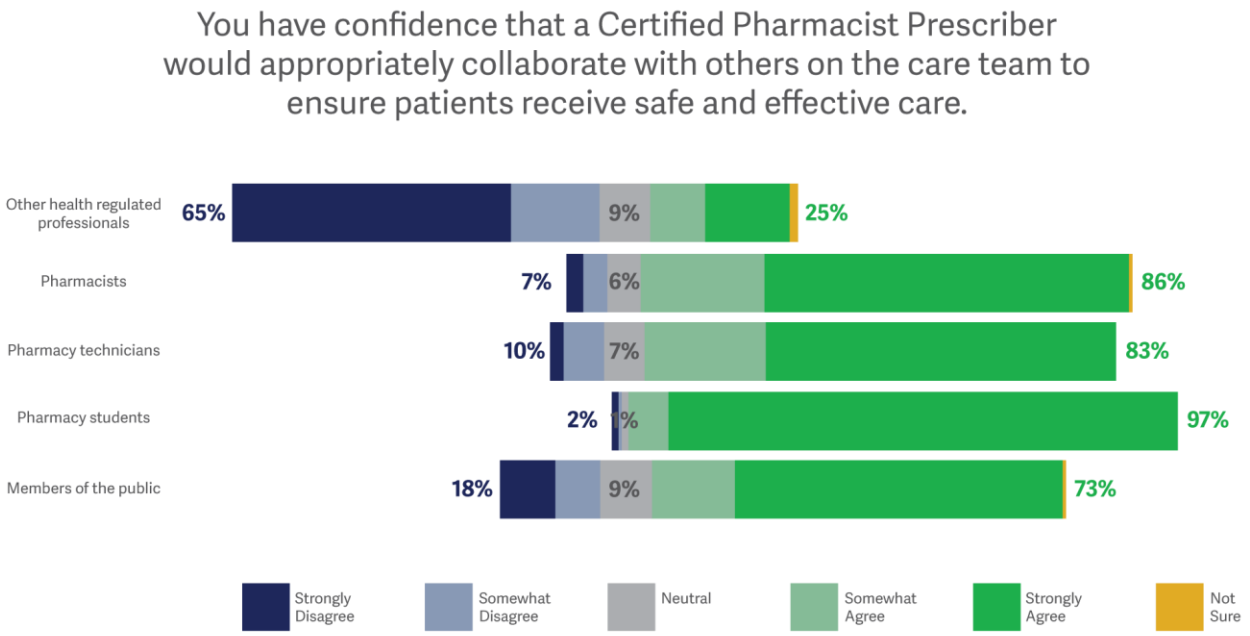
COLLABORATION

The College sought feedback from stakeholders on the collaboration and communication that would be necessary to support pharmacist prescribing in collaborative practice relationships. Public respondents shared their thoughts on the importance of this kind of collaboration and how they would expect pharmacist prescribers to communicate and collaborate with other practitioners. We also heard from pharmacists and other healthcare providers on the planned requirements for access to information and documentation as well as their thoughts on collaborative practice relationships for pharmacists prescribing.

Collaboration was one of the areas of the Framework of Pharmacist Prescribing where there was the greater convergence of agreement between different respondent groups. The majority (85%) of respondents indicated they would like to see more collaboration between primary health care providers (or other health professionals) and pharmacists in providing care. Only slightly less (73%) agreed they had confidence that a Certified Pharmacist Prescriber would appropriately collaborate with others on the care team to ensure safe and effective care.



Pharmacy students had strongest agreement towards the role of collaboration in providing care and the greatest confidence in its effectiveness followed by pharmacists, pharmacy technicians and members of the public.

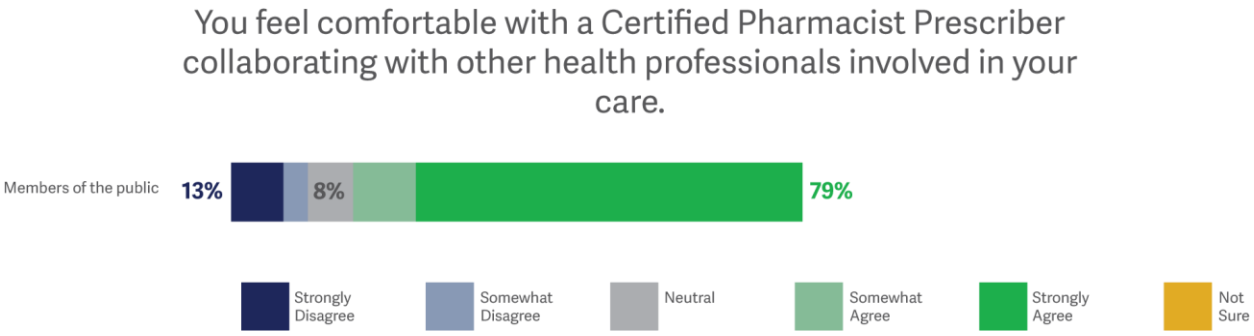


The majority of other health care professionals also agreed that they would like to see more collaboration with pharmacists in providing care, but had less confidence that a Certified Pharmacist Prescriber would appropriately collaborate. However, responses from different types of health care professionals were divided. Physician specialists expressed the most disagreement, general practitioners expressed slightly less disagreement, and other health professional respondents (such as nurses and nurse practitioners) clearly indicated they want to see more collaboration and also showed they had confidence that a Certified Pharmacist Prescriber will collaborate appropriately.

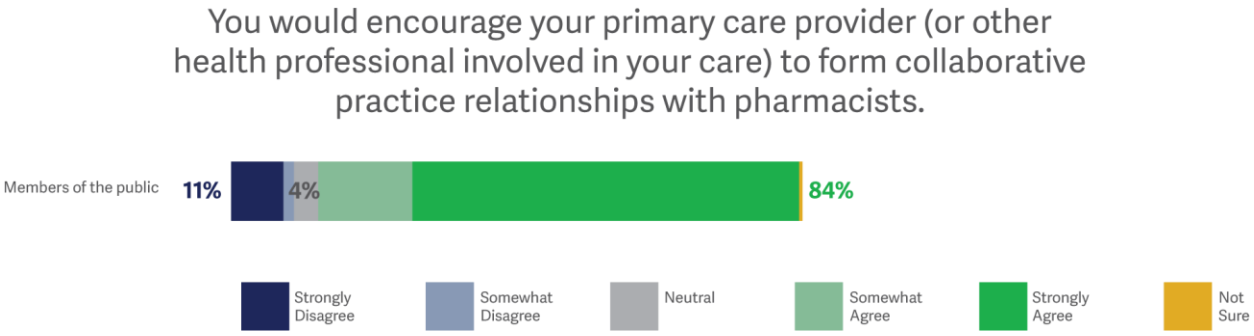
PATIENTS

Members of the public demonstrated that they want to see more collaboration between health care professionals in providing patient care and have confidence in the collaborative practice relationship involved in pharmacist prescribing. Over 80% agreed they would like to see more collaboration between primary health care providers (or other health professionals) and pharmacists.

Overall, public respondents clearly indicated that they felt comfortable with a Certified Pharmacist Prescriber collaborating with other health care professionals involved in their care – 79% agreed or strongly agreed that they would feel comfortable with this. However, some members of the public still had reservations or concerns, such as duplication and redundancy, conflict of interest, lack of existing collaboration, and access to information barriers. Others suggested that it would depend on the individual pharmacist.



Over 70% of patients also expressed confidence that a Certified Pharmacist Prescriber would appropriately collaborate with others on the care team to ensure patient safety. Previously, only 49% of public respondents agreed that a Certified Pharmacist Prescriber would consult appropriately.



The majority of public respondents also indicated they would encourage pharmacist to pursue becoming a Certified Pharmacist Prescriber (74%). Over 80% also agreed that they would encourage their primary care provider (or other health professional involved in their care) to form a collaborative practice relationship with a pharmacist prescriber. This is a significant increase compared to earlier feedback in 2016 where only 61% of public respondents agreed that they would encourage their primary care provider to work more collaboratively with a Certified Pharmacist Prescriber to improve their care.

"I think if there was an issue too large for my pharmacist to handle, he would refer me where appropriate or communicate with other health care professionals to help solve the issue in a timely fashion." – Patient

"It's just creating multi-disciplinary teams in the community, which already exist at general hospitals and other tertiary care facilities. I think each patient deserves multiple opinions and consensus on their treatment." – Patient

"This would allow me to trust that the level of care needed for me is appropriate as it has been discussed between two health professionals." – Patient

"I would feel more comfortable the more health professionals I have involved in my care." – Patient

"Not if this involves an overlap of responsibilities." – Patient

"It depends on the pharmacist. I think safeguards need to be in place." – Patient

"I believe that this would give me the best possible health care possible as I can have multiple people collaborating to focus on my well being." – Patient

"It would be the responsibility of the doctor to include the pharmacist in the patient's care team." – Patient

"This is respectful and good to see. There should really be no "hierarchy" in health care. It's a health care team. Every team member is working for the good of this particular patient. So every team is unique, because each team has a different patient and family/caregiver, team members." – Patient

"Don't really see it happening with existing health care professionals so why would this be any better." – Patient

"I don't have a gp, so I'd like to see walk-in clinics form relationships with pharmacist prescribers to provide this. this would likely help with the long lines for walk-in clinics." – Patient

"In a large centre I don't think I could expect my GP to develop a relationship with my pharmacist because my pharmacist is frequently not the same person even though I'm getting my prescription filled at the same pharmacy." – Patient

"The government needs to pay them for their time. My doctor has little kids and a student loan. I'm already worried they'll leave like the last one." – Patient

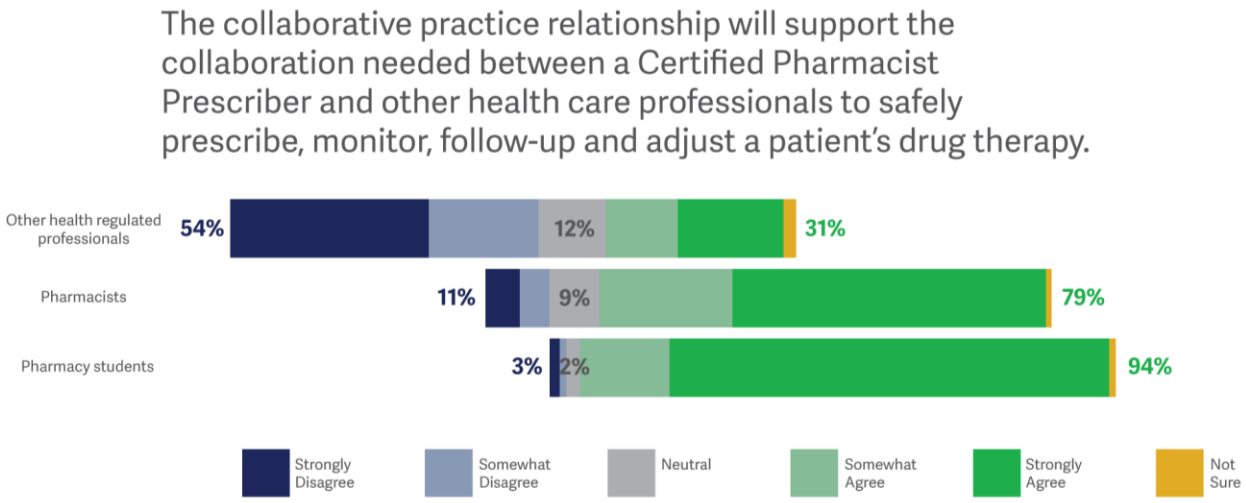
"I've received care from doctors, physiotherapist and pharmacists. Collaborations definitely help improving my health outcome." – Patient

HEALTH PROFESSIONALS

Pharmacists, pharmacy technicians and pharmacy students all strongly expressed that they would like to see more collaboration between primary care providers (or others on the patient's care team) and pharmacists. 91% of pharmacists, 90% of pharmacy technicians and 97% of pharmacy students all indicated more collaboration was needed between pharmacists and primary care providers. The majority of pharmacists (86%), pharmacy technicians (83%) and pharmacy students (97%) also had confidence that a Certified Pharmacist Prescriber would appropriately collaborate with others on the care team to ensure patients receive safe and effective care.

The majority of other health care professionals also indicated that they would like to see more collaboration between primary care providers (or others on the patient's care team) and pharmacists. However, they did not necessarily feel that the proposed Framework for Pharmacist Prescribing was the best approach for achieving more collaboration.

Responses between different types other health professionals varied especially between physicians and others (such as nurses and nurse practitioners). Only 55% of physician specialists expressed that they want to see more collaboration with pharmacists in providing care, while slightly more general practitioners (64%) agreed with wanting to see more collaboration. Over 94% of others (such as nurses and nurse practitioners) indicated they did want to see more collaboration with pharmacists.



Just over 30% of other health care professionals agreed that the collaborative practice relationship described in the Framework for Pharmacist Prescribing will support the collaboration needed between a Certified Pharmacist Prescriber and other health care professionals, while 54% disagreed. Slightly less (28%) agreed that working collaboratively with a Certified Pharmacists Prescriber would help them care for their patients.

Most physician specialists (80%) indicated they did not have confidence a Certified Pharmacist Prescriber would collaborate appropriately and 69% of general practitioners also indicated this, while 84% of other health professional respondents agreed that a Certified Pharmacist Prescriber would collaborate appropriately with others on the care team to provide safe and effective care.

Some physicians suggested that they would welcome collaboration with PharmD graduates, or with pharmacists they have established a long term relationship with in caring for patients. Others suggested that the degree of physical closeness of the Certified Pharmacist Prescriber would give them greater comfort in collaboration, such as within interdisciplinary teams, a physician or clinic office, or pharmacies with a close relationship with a nearby clinic or physician's office. Some physicians also suggested that pharmacist prescribing could play a role in the emerging Patient Medical Home model of care. Some also felt that they do not have the time required to collaborate more with pharmacists and others suggested they should be compensated for the additional work involved in collaboration.

OTHER HEALTH PROFESSIONAL RESPONDENT

"I would hope so, and my confidence would be strengthened were the proposed changes envisioned as being part of the emerging Patient Medical Home model of primary care practice in B.C. and not a separate pharmacy-run structure in any way running 'parallel' to regular models of care." – General Practitioner

"To the best of their ability, yes, I believe they would try to be safe. But, you don't know what you don't know. So, in other words, there could be major physical exam findings/history that isn't found as they didn't know to ask. A course isn't going to teach this." – General Practitioner

OTHER HEALTH PROFESSIONAL RESPONDENT

OTHER HEALTH PROFESSIONAL RESPONDENT

"It would allow an informed member of the interdisciplinary team to rake on responsibility for aspects of patient care, in their area of specialty." – Nurse

"I would like to have a PharmD as part of team based care in my practice. This person would know and understand the patient with the patient consent and communicate directly with me. This model was trialled in my office and is well received." – General Practitioner

"I think there is already a lot of collaboration. In my specialty I don't write too many prescriptions but I have had many useful conversations with my pharmacist colleagues over the years." – Physician Specialist

"Doctors of BC believes that pharmacists and physicians are well positioned to work together to collectively improve patient care and safety. Physicians strongly support opportunities to work with pharmacists, as part of a multidisciplinary team, to improve quality of care. Doctors of BC welcomes opportunities to work with the College of Pharmacists to support the integration of pharmacists into multidisciplinary health care teams. For example, Doctors of BC supports the work of the General Practice Services Committee and Divisions of Family Practice to integrate clinical pharmacists into Patient Medical Homes. In these practices, physicians and pharmacists work together to optimize drug treatments for patients with complex medical conditions." – Doctors of BC

"In long-term relationships that have clear delineation of responsibilities and elimination of conflict of interest with good evidence-based care." – General Practitioner

"What pharmacists are doing now is good: giving polypharmacy advice (and also being reimbursed for the medication reviews), being paid for glucometer education with patient, etc are areas in which I do not see a problem. But greater scope in prescribing is not appropriate. – Physician Specialist

"Worried about potential loopholes for private pharmacies. Would feel much better if Pharmacist prescribers were required to be a health authority employees working in the context of team." – Nurse

"I already have a good relationship with some of the pharmacists in my neighbourhood. It is helpful having a pharmacist directly next door. We each walk back and forth to ask each other questions. This is very helpful." – General Practitioner

"I think if the government would restructure health care to provide more support in the primary care setting it would be helpful to have a pharmacist work in a clinic alongside physicians and NPs similar to PharmD's that work in the hospital setting.

Physicians also provided feedback on how they might establish or work within a collaborative practice relationship with a Certified Pharmacist Prescriber as well as what that relationship might look like. Physicians highlighted interdisciplinary teams and collaborative practice settings the most as examples where they felt pharmacist prescribing may be appropriate. They also suggested that they might use the collaborative practice relationship with a pharmacist prescriber for more complex patients, cases of polypharmacy and ongoing management of chronic conditions. There was less confidence in establishing a collaborative practice relationship in community practice other than when a close working relationship and mutual trust and recognition of expertise had been established on an individual basis. Some physicians also continued to emphasized that pharmacist prescribing could work within the emerging Patient Medical Home model of care. Others suggested that pharmacist prescribing might work well if pharmacist prescribers were funded through the provincial government or health authorities rather than through corporate pharmacies.

"I would like to see them working in our offices, so patients see pharmacist and physician together, or one and then the other. I would like to see more of a team approach." – General Practitioner

"Working together for a period of time on a team making decisions together and learning how each other makes decisions on the same patients in the service area of focus (ie hospital vs residential care, vs community care). A form of mediation or team assesment on a regular basis in the first year before an ongoing relationship is established. Communication is always best on a team basis or directly between professionals and never via the patient in order to avoid schism in care." – General Practitioner

"I could see this succeeding within the emerging structure of the "Patient Medical Home", the community practice scenario envisioned by the Ministry of Health and Doctors of BC to wrap care around patients themselves, in THEIR context, and in THEIR community. Most patients surveyed identified the most logical physical place for that to happen, to be in their family physician's or group's offices. A co-located pharmacist in this context could be at arm's reach from their own pharmacy practice, could be paid to provide such clinical services, and even be delegated with followup of prescription interactions, new prescription monitoring, and the like, even out of the patient's home, if the patient were in any way debilitated or home-bound." – General Practitioner

"This would be effective in a primary health care team, as in the government funded multi-disciplinary clinics. I worry that it might be a challenge in fee for service models of primary care." – General Practitioner

"I would like a PharmD in my office with no connection to a private pharmacy." – General Practitioner

"Through multidisciplinary care teams set up by the health authority. Need time to see patients together and discusses cases to develop trusting relationship regarding independent prescribing." – Physician Specialist

"Clinical pharmacists are very helpful in a hospital setting, could expand their role in nursing homes. Both settings have information systems designed for this type of collaboration across the health care team. I worry about challenges in community primary care practice." – General Practitioner

"Need to be integrated as a team member, not just someone sending faxes to doctors." – Physician Specialist

"Have a pharmacist working in/visiting the office and seeing patients. Buy who would pay the overhead for this?" – General Practitioner

"Changes would need to be made to physician compensation to make time to establish collaboration and coordination of care. – Physician Specialist

"The patient medical home, with interdisciplinary care, is the perfect model for this type of interaction." – General Practitioner

"I would use a pharmacist prescriber to manage my INR warfarin patients. That is all." – General Practitioner

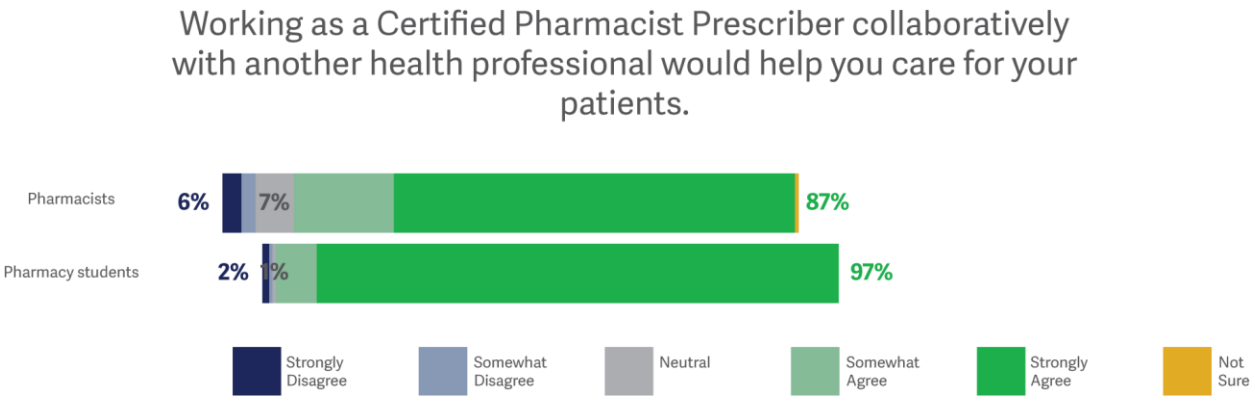
"They can help me formulate plans for my more complex patients… e.g. Similar to care conferences that we do for the elderly." – General Practitioner

"A collaborative practice relationship often develops naturally with time as you work with pharmacists that know our patients." – General Practitioner

"Assist with the most complex, polypharmacy patient. Offer alternatives to existing regimen that would streamline meds, reduce conflict, and save money. Counsel pt about safety of meds - esp opiates, benzos, etc." – General Practitioner

"There would be discussions between the primary healthcare provider and the pharmacist to maximize the benefit of the knowledge base of each participant." – General Practitioner

Just under 80% of pharmacists and over 90% of pharmacy students agreed that the collaborative practice relationship described in the Framework for Pharmacist Prescribing will support the collaboration needed for pharmacist prescribing. Pharmacists and pharmacy students also strongly agreed that working as a Certified Pharmacists Prescriber collaboratively with another health professional would help them care for their patients. Some pharmacists emphasized they already had effective collaborative relationships established that could support pharmacist prescribing, while others said physicians are not as open to collaboration as they need to be. Some also suggested that the requirement for a collaborative practice relationship was too narrow and might limit some of the opportunities for pharmacist prescribing to benefit patients. Others expressed concern that physicians already seem too busy to collaborate. Effective communication – both through documentation and in developing relationships that involve detailed discussions about a patient care – was highlighted as an important part of the collaboration needed for pharmacist prescribing. Pharmacy technicians also highlighted how they could help support more collaboration.



PHARMACIST RESPONDENT

"The more communication there is, the better understanding the pharmacist will have of the patient and their needs and the better care they can provide." – Pharmacist

"Pharmacotherapy decision making is inherently complex and we have to stop pretending that it isn't. Greater collaboration allows for all factors to be considered and brought forward to the patient for truly informed care planning." – Pharmacist

PHARMACIST RESPONDENT

PHARMACIST RESPONDENT

"Some healthcare providers are, unfortunately, not up to date with current treatments and will occasionally prescribe medications that are no longer indicated for effective treatment. Pharmacists already have conversations with these healthcare providers on a regular basis when forced to fax prescriptions back and forth with suggestions. Having a more open conversations or being able to prescribe would alleviate the number of call-back or fax-back prescriptions that other healthcare providers must deal with." – Pharmacist

"Primary care providers see retail pharmacists as an irritant in that there is endless faxes for refills. We need to find a way to get away from this type of relationship into one where we can provide value to the primary care provider and therefore support the patient." – Pharmacist

"Communication is key in patient-centered care. Constant and frequent communication also reduces the number of errors and increases efficiency and accuracy of care for the patient." – Pharmacy Student

"The model of practice with pharmacists as part of primary health care teams already exists in other Canadian jurisdictions and has been developed at the UBC Pharmacists Clinic for implementation in British Columbia." – Pharmacists Clinic, University of British Columbia

"I've actually had experience working in a collaborative agreement with other health care professionals including Doctors and Nurse Practitioners. I found that all health care professionals involved experienced an increased level of professional satisfaction." – Pharmacist

"As patients are at the centre of our care, we need to ensure that services provided by each member of the patient's healthcare team is complementary to one another." – Pharmacy Student

"This will bridge the gap between healthcare professionals and hopefully move towards a progressive healthcare system. – Pharmacist

"The College implies in its draft framework that pharmacists would be best to be physically co-located with physicians (in either hospitals or at a doctor's office) to improve patient care. There are examples in British Columbia in which pharmacists have proven they do not need to co-locate in a physician's office or work alongside nurses and doctors at a hospital to create a collaborative team environment and provide excellent patient care." – BC Pharmacy Association

"I feel we have a fantastic working relationship with all primary care providers in our community, Vernon, BC. One area I could see room for change is in the sharing of lab work and any applicable charting information." – Pharmacist

"It is often very difficult to get a hold of a physician in the first place. Sometimes it takes days to hear a response from a dr when it comes to rx refills or just for a simple clarification." – Pharmacist

"I think in clinical settings, pharmacists are already collaborating really well with other HCPs. However, in the community setting, this may still be lacking. I've noticed that physicians aren't always open to taking recommendations from pharmacists and sometimes pharmacists are reluctant to make recommendations too in fear of putting a strain on the physician-pharmacist relationship." – Pharmacy Student

"In fact, it will also be good to see collaboration between pharmacists in addition to other healthcare providers. This becomes feasible only the competitive business aspect is removed from the pharmacy practice." – Pharmacist

"Primary healthcare providers and pharmacists already collaborate to ensure patient safety and effectiveness of their drug therapy. However, it would be more beneficial if primary health care providers and pharmacists could share their information easier. The world is so technologically advanced, yet our healthcare system is relatively far behind. Like we have PharmaNet that can be accessed by any pharmacy in BC, a central EMR in BC would greatly improve patient outcomes and also save healthcare costs (especially by saving time, and reducing negative outcomes that result in hospitalization and use of healthcare money)." – Pharmacy Student

"Having a mindset in which the patient is prioritized first, and working together to achieve universal health goals for the patient." – Pharmacy Student

"Having access to the patient's information/records so that we can both be fully caught up with the patient's conditions and prescriptions. Also, short phone calls to discuss any confusion in the patient's records or ask for advice with something outside of the scope of either health professional. If time permits, (like if I am in the same office/building as the other health professional), meeting in person would probably be better than phone calls, but it depends on the busyness of both professionals. It would be easier to develop this relationship in a more clinical setting, but with sufficient communication, collaboration would be possible." – Pharmacy Student

"It would improve the work flow greatly! They are best at knowing proper dosing, what is covered under pharmacare, interactions, new medications, better collaboration with pharmacy technicians. Save more time for Dr's to see more PT's... and be more thorough, and less time answering questions from pharmacy." – Pharmacy Technician

"It would increase work flow as it would remove obstacles of refills for chronic illnesses, and help patients adjust their warfarin, or other bloodwork requiring medications, faster and easier for both patient and pharmacy team." – Pharmacy Technician

"Techs can handle all the technical and dispensing duties. Leave it to the pharmacists, the drug experts, to prescribe." – Pharmacy Technician

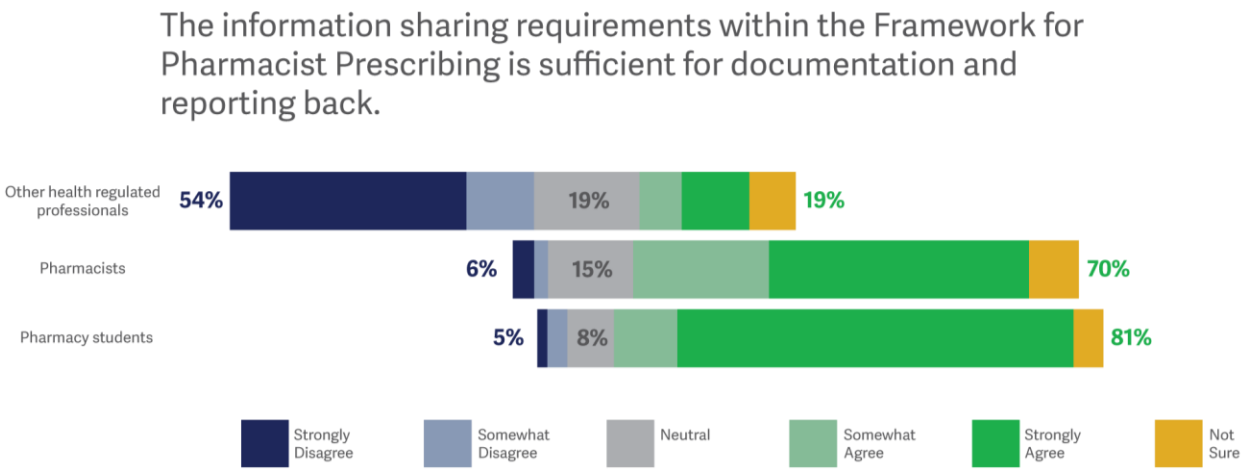
ACCESS TO INFORMATION AND DOCUMENTATION

Based feedback received in 2016 on the initial framework, the College set out more detailed requirements related to access to health information, documentation and communication in the new Framework for Pharmacist Prescribing in BC. The College sought feedback on these new requirements.

COMMUNICATION AND DOCUMENTATION

While caring for a patient through a collaborative relationship, a Certified Pharmacist Prescriber will be required to document the patient assessment, prescribing decision and rationale, monitoring and follow-up plan. They will also need to report back this information to the patient care team, including the patient's primary health care provider and other relevant health professionals (as appropriate). The methods for communication and sharing this information would also need to be established initially as part of developing the collaborative relationship.

The majority of pharmacists (70%) and pharmacy students (81%) felt the information sharing requirements were sufficient. While 54% of other health professionals disagreed, just under 40% either agreed with the requirements or were neutral.



Some pharmacists expressed concerns that the documentation requirements could take up too much time, while others felt that the requirements were appropriate and reflected how they currently collaborate with other health professionals. Pharmacists also emphasized the importance of ensuring others on the care team also reviewed information provided and shared adequate information with the pharmacist prescriber. They also identified the importance of

building a strong working relationship with the other health professionals involved in a patient's care where discussions about the patient's needs and health goals and results of ongoing monitoring are expected to be discussed.

"Too much documentation and follow-up patient's are not feasible in a busy pharmacy with understaff and overloaded work." – Pharmacist

"This is the level of collaboration that one would expect to find with adapted prescriptions or medication reviews that require pharmacist consultation." – Pharmacist

"I remember a time when a pharmacist would call to speak to a physician and the pharmacist would be connected directly to that physician. Now pharmacist can only fax. The importance of this conversational and relationship building practice needs to be revisited and potentially encouraged by both the pharmacist and physician colleges." – Pharmacist

"This seems to encompass all that is needed, but the time it would take to write up and send all this information is concerning." – Pharmacist

"Collaboratively using PharmaNet, Patient Medical Records and other communicated information will ensure both the pharmacist and physician are on the same page in terms of diagnosis, prescribing and the over-all treatment plan. I think as well, meetings for collaborative exchanges on patient treatments may also be necessary depending on the situation, patient condition/disease and progression, and the course of medication treatment." – Pharmacy Student

"I think this is sufficient as long as there is a system in place so there is an acknowledgement from the health care provider that the communication is being read." – Pharmacist

"There must be a thorough understanding of who all the care providers are and that the entire team is involved and communicated with. For example, some patients see a physician, a diabetes educator, a home health nurse, a cardiologist, a physiotherapist, and may be in a treatment program. I have found circumstances where a provider may not be aware of another provider and they accidentally worked at odds with each other. I think the communication detailed in the above statement must have a time component." – Pharmacist

"It actually seems like overkill. No other prescribers are required to do so much documentation and reporting." – Pharmacist

"Pharmacists are absolutely capable of sufficient and excellent documentation. They document in practice already, such as when communicating with physicians regarding a patient's medication (SOAP notes), or adapting a prescription. Furthermore, pharmacy students write 4 page care plans on their rotations and throughout their schooling, in which they learn extensively how to write such documentation." – Pharmacy Student

"Yes, but again a collaborative relationship is not a binary unidirectional one. Other prescribers should be required to do this with a Certified Pharmacist Prescriber as well. It doesn't work if only the pharmacist is required to "report back this information". Other relevant health professionals should have to report back this information to pharmacists as well to maintain continuity of care for the patient." – Pharmacist

Other health professionals expressed concern about the amount of extra work that could be involved with the communication and documentation requirements, while others expressed concerns about possibly delays in communication. Others emphasized that communication needs to be bidirectional between other members of the care team and the Certified Pharmacist Prescriber.

"Often there is a delay in communication. If there is a change in a patients medication that is made without consultation to the patient's physicians this could be detrimental to the patient's health. If pharmacists are to collaborate in prescribing it should be done in consultation with the patients attending physicians." – General Practitioner

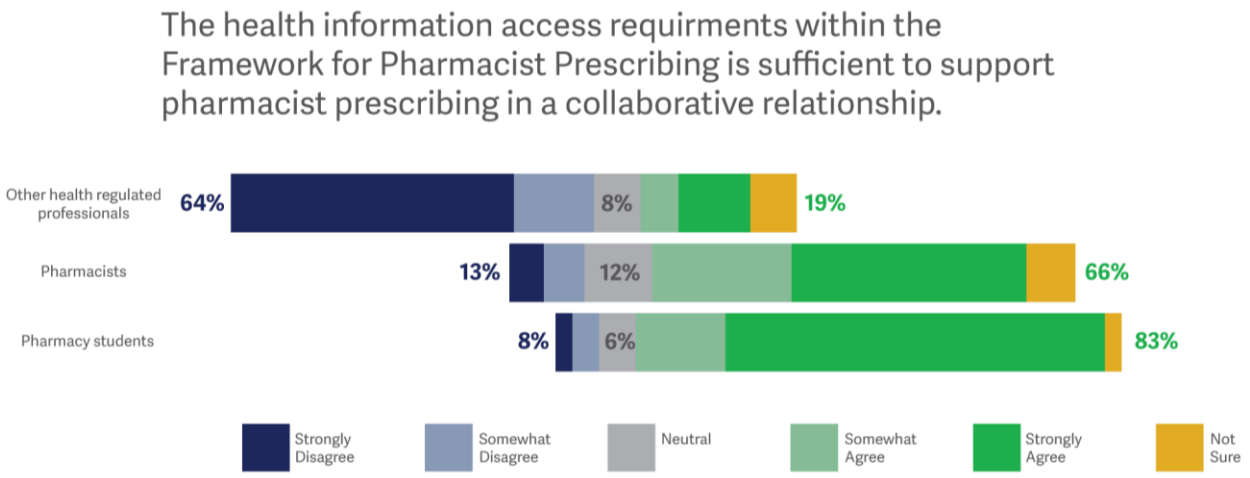
"Well as long as the communication is bidirectional and not one way - this could create more problems for the MD having to undue changes in treatment plans." – Physician Specialist

"This is going to be awful for primary care physicians who then have to spend time reading this info. When are we supposed to do this? It will take away from our time to actually see patients, and no family physician will be happy about this, given that the paperwork is already endless and there is no pay for it." – General Practitioner

"If physicians are not compensated for this collaboration time there isn't inventive to have the pharmacist fill any prescribing roll." – Physician Specialist

Under the Framework for Pharmacist Prescribing, Certified Pharmacist Prescribers will be required to have access to relevant health information including information from the patient (including a medication history), PharmaNet, Patient Medical Records, and information from those involved in the patient's care.

Both other health professionals and pharmacists had slightly less confidence in these requirements compared to the information sharing requirements. Both groups highlighted tools such as electronic medical records, and broader use of PharmaNet, that could help meet these requirements. In some cases, typically within interdisciplinary team-based settings, access to the necessary information was already available, while in others, additional work would be needed within the practice setting and processes to facilitate the appropriate information access.



Pharmacists primarily heighted the importance of being able to access and order lab tests and the ability to have easier and consistent access to patient health information to help inform medication management for patients. Pharmacists highlighted that this would help them better care for patients regardless of whether they were a Certified Pharmacist Prescriber.

PHARMACIST RESPONDENT

"Also pharmacist should have access to patients laboratory results because it is key factor in deciding dose, frequency, direction of medication as well as pharmacist will able to catch drug therapy problems on basis of patients current lab values and can contact other health care professionals to make changes in therapy according to current status of lab values."
– Pharmacist

"This should be enough if the Patient Medical Records includes access to their lab values as that is a key component in ensuring optimal care. There are many clinical conditions that require monitoring of lab values to assess optimal therapy (dyslipidemia, diabetes etc.)."
– Pharmacist

PHARMACIST RESPONDENT

"I'm not sure how pharmacists would be able to see patient's records if hospital providers already struggle with continuity of care." – Pharmacist

"I need full access to all lab reports, including full history. For example, renal function is important in many conditions and therapeutic choices. It is also essential to know the trend in renal function (up, down or steady). In many cases, this requires a discussion with the collaborating physician to help determine the best course of action for the patient. Looking at HbA1c for diabetes, it is important to know CBC results as low levels of red blood cells of Hgb could result in an inaccurate HbA1c result. There are many, many more examples I could give." – Pharmacist

"Both parties should have the same information available to them to be truly collaborative. Each individual should be able to review information so there is not an error in communication potentially being relayed from one person to another. There is a greater chance of error". – Pharmacist

"Although pharmacists are still faced with the logistical barriers of ordering lab tests, are community pharmacists allowed to request copies of lab results ordered by another prescriber? We may need to build flexibility into the framework to allow opportunities for change and improvement." – Pharmacist

*"Pharmacists should NOT have to request such information from other health care professionals. This EXCLUDES the pharmacist from the patient's "circle of care". Pharmacists should be given the authority to access relevant patient information (e.g. INR, lytes, etc.) without having to contact other health care professionals. *EVEN if pharmacists are not granted prescribing authority, access to relevant medical history is ESSENTIAL to patient medication management. – Pharmacist*

"Ideally, this would be electronic and made available in a shared "folder" of patient records between the healthcare team members." – Pharmacist

"Currently pharmacists practice somewhat in a void with respect to diagnosis and lab/medication dose history. Access to blood pressure, blood lipid & blood sugar history, are examples of labs that would facilitate prescribing decisions." – Pharmacist

"Electronic methods need to be established. Fax is antiquated and time consuming and often ignored." – Pharmacist

"Rather than the College looking at pharmacist prescribing rights, I feel they should be focusing on equal access to healthcare information. I believe it is a major patient safety issue that currently BC community pharmacists cannot access laboratory or EMR data. How can a pharmacist possibly evaluate the full safety considerations of a prescribed medication without this information." – Pharmacist

Other health professionals expressed concerns that pharmacist would not be able to access the diagnostics and other personal health information. Some suggested, that without a provincial electronic health record available, it would be too time consuming for physicians to help provide pharmacist prescribers with the access they need. Some also highlighted that electronic medical records may not always have all the necessary information.

"Pharmanet does not have patient's disease condition such as chronic kidney failure or congestive heart failure, lab reports etc." – Physician Specialist

"The last thing we need in our current patient information system is yet another layer of documentation that is not within the patient's primary chart!" – General Practitioner

"Unless the pharmacist and physician share the same health record/ chart access this is insufficient." – Physician Specialist

"Pharmacists will need to implement an electronic medical record system similar to GPs office, if they want to take on this activity. All of the notes should be logged, and transmitted to GPs/NPs and relevant specialists. Records must be maintained as per standards set forth by the College of physicians for patient medical records. All these logistics must be carefully laid out ahead of time." – General Practitioner

"This would best be done in a Provincial EHR - which we don't have. This will, therefor require interoperability of electronic systems." – General Practitioner

"How will pharmacists obtain access to patient medical records? This is an added cost to primary care physicians if their office staff are asked to retrieve the patient records, ask the physician if ok to share. . . patients may need to sign forms to state they give consent to sharing of this information. This is an added burden to physicians and creates an added cost to physicians personally, as they are paying for the time for the office staff to perform these tasks." – Physician Specialist

"Will the pharmacist understand all of the implications of the medical information? How ill the collection, formatting and reporting of a patient's medical information support the pharmacist? I don't think this has been considered in the development of the current EHR's in BC." – Physician Specialist

"Meditech or other EMRs (electronic medical record), imaging results, and consultation reports." – Nurse

"Most patient medical records are not available easily online. Management notes from GPs office for example. The pharmacists will be missing a huge part of what's going on with the patient. Looking at pharmanet and lab values is not enough information." – Physician Specialist

"How will the pharmacist access and interpret relevant imaging (eg chest x-ray, if no report available yet, CT scan), how will the pharmacist perform diagnostic tests required to follow up unusual symptoms or signs (e.g. vitals signs and interpretation; order lab work; perform physical examinations)." – Physician Specialist

Some patients also highlighted that they would like to have their personal health information more accessible to themselves as well as to pharmacists as an extension of their care team. However, some expressed that they were not comfortable with their medical information being shared with a pharmacist.

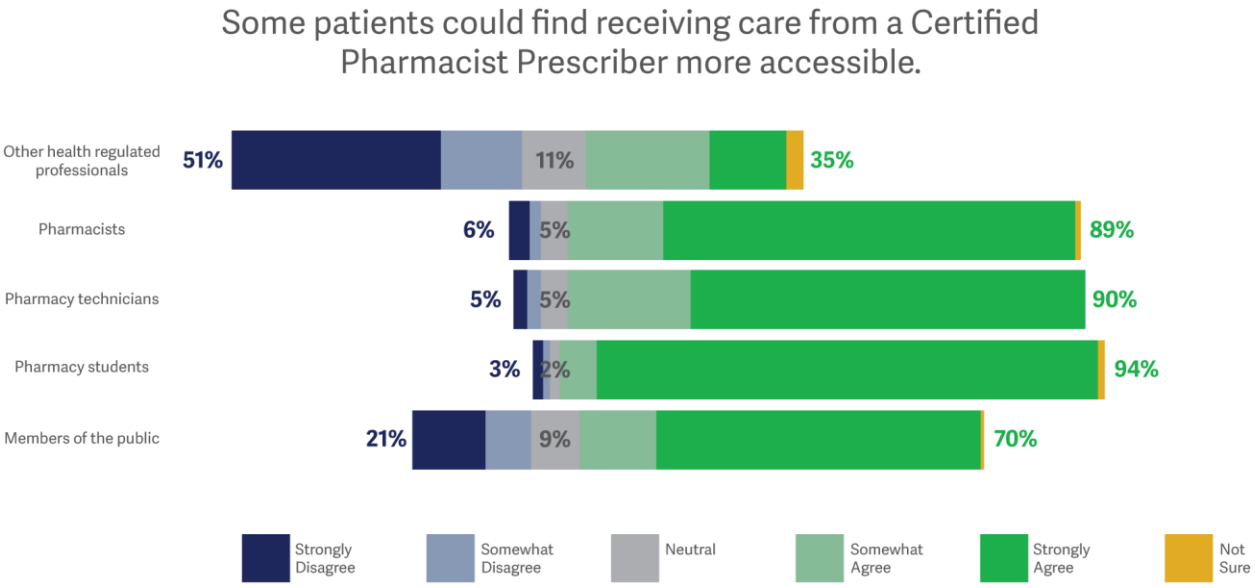
"I would feel most comfortable if my care providers and pharmacist shared an information system in real-time. I would also like access to that system." – Patient

"What about my personal information? I am not comfortable with a pharmacist having access to all of my medical information." – Patient

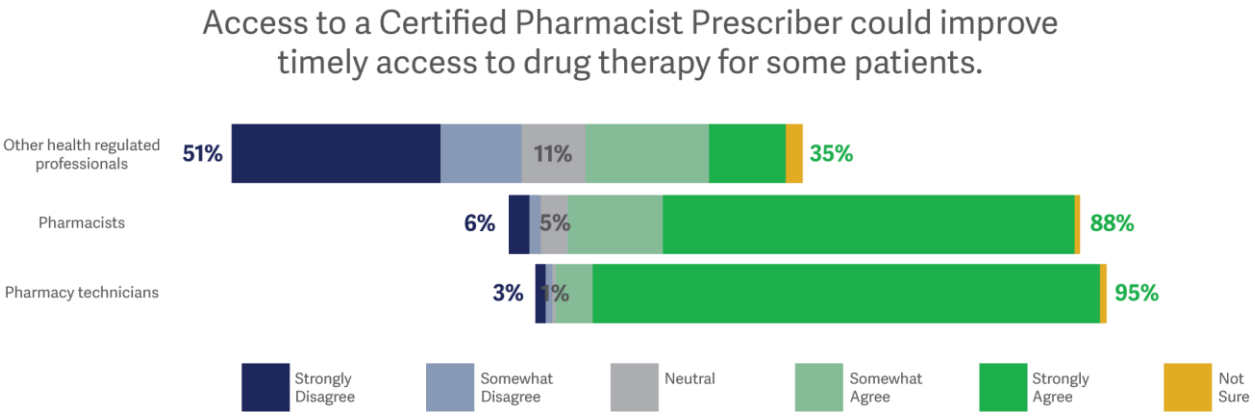
PATIENT SAFETY & IMPROVING OUTCOMES

The College sought feedback on how pharmacist prescribing could help protect patient safety and improve health outcomes. This included hearing from respondents on accessibility and timeliness of care, quality of care, and medication management. The College also heard from respondents on what they thought patients might use pharmacist prescribing for.

Overall, the majority of respondents indicated that pharmacist prescribing could help protect patient safety and improve patient outcomes. While other health care professionals still expressed some disagreement surrounding the benefit to patient safety, this was also an area where there was the greater convergence of agreement between different respondent groups. Feedback also showed a significant increase in agreement surrounding the benefit to patient safety compared to earlier feedback in 2016 on the initial draft framework.



Pharmacy students (94%), pharmacy technicians (90%), pharmacists (89%) and neutral members of the public all agreed that some patients could find receiving care from a pharmacist prescriber more accessible. Just over half of other health care professionals did not agree that patients could find pharmacist prescribers more accessible, while 46% either agreed or felt neutral towards the benefit to patients. Physician specialists disagreed the most (42%), however 55% were either neutral or agreed. Both general practitioners and others (nurses and nurse practitioners) agreed that patients could find pharmacist prescribing more accessible.



Pharmacists and pharmacy technicians also strongly agreed that access to a Certified Pharmacist Prescriber could improve timely access to drug therapy for some patients. Other health care professionals were more divided with just over half disagreeing and 35% in agreement.

Some respondents highlighted that the requirements surrounding forming a collaborative practice relationship, and the requirement for separate pharmacist to prescribe and dispense a medication may limit the opportunity for pharmacist prescribers to improve accessibility in some smaller communities.

This is a significant increase compared to earlier feedback on the initial draft framework where only 73% of other prescribing respondents disagreed that access to care would be improved and only 53% of patients indicated they agreed.

"I believe that by restricting pharmacist prescribing to the collaborative care setting would limit accessibility since it would still require the involvement of a physician and/or other health care professionals." – Patient

PUBLIC RESPONDENT

OTHER HEALTH PROFESSIONAL RESPONDENT

"Although ease of access would be improved, as I have stated, pharmacists often have a limited appreciation of the full picture of what's going on with patients. I don't think this is a great practice model." – Physician Specialist

"This is especially important for elderly patients who may not be as mobile as younger patients. This constant having to go to the physician, wait for an hour just to get a prescription renewed… needs to stop. Some physicians already work around this by providing allowing patients to pay a nominal annual fee to have the prescription renewed by phone/ fax rather than having to drag the patient in for a "consultation"." – Patient

"I worry that patients might see this as an easy option, such as we see with virtual docs located in pharmacies. If patients deal only with a pharmacist, they may miss details until later in the course of illness before presenting to physicians. That said, this may be no different from walk in visits or virtual physician visits." – General Practitioner

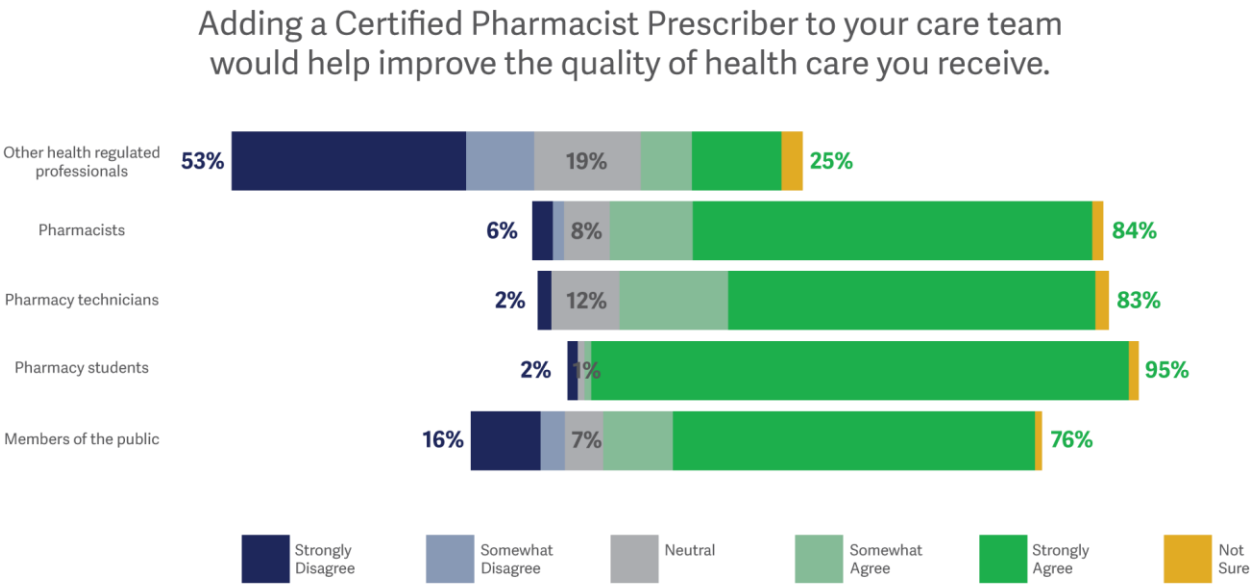
"Just because it's accessible doesn't mean it's safe or appropriate." – Physician Specialist

"Absolutely, especially when 25% of people in BC do not have a family physician, wait times for medical walk in clinics can be hours, and many medical walk-in clinics will not deal with chronic care situations and conditions. Everyone knows where they can access a pharmacist rather quickly and there is a high likelihood that everyone who requires chronic medications knows their pharmacists name and visits the pharmacy regularly for these medications. This would strongly suggest that access to a pharmacist prescriber could improve timely access to drug therapy. This is already the case for therapies that are currently available as schedule ii and iii." – Pharmacist

"It is absolutely ridiculous that we have to send our patients back to emergency when they come in with a prescription that isn't complete or has an issue. For example and antibiotic with a significant drug interaction or an allergy to antibiotic prescribed. With a diagnosis and access to lab values pharmacist should be able to change the antibiotic without putting strain on the emergency system if the prescribed isn't able to be reached. Also it can take a week or more to see primary health provider. For minor ailments or other simple issues pharmacists can triage and ensure all health avenues are getting used appropriately."

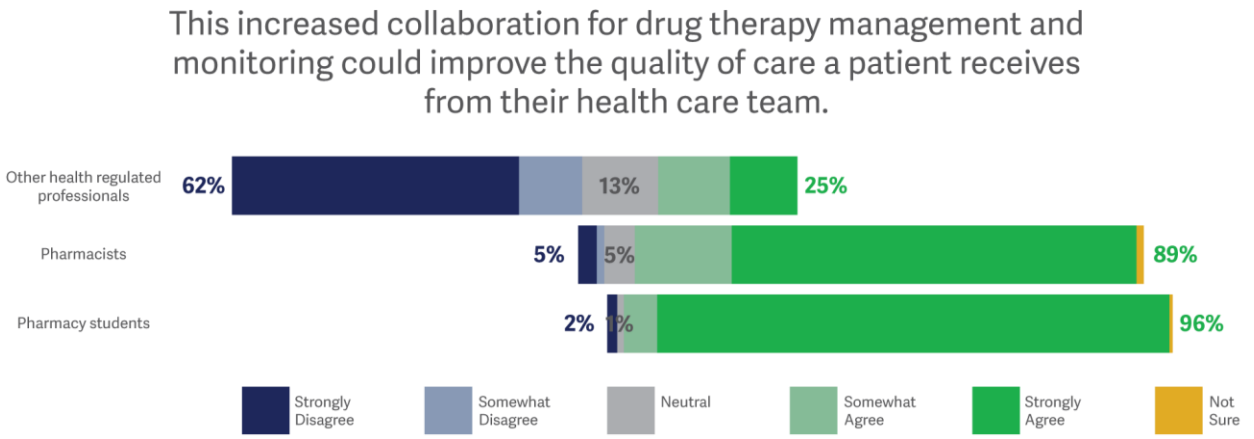
"As patients would now have to see multiple prescribers as well as a second pharmacist, I don't believe access to a Certified Pharmacist Prescriber would improve timely access to drug therapy in most cases. As well, other patients would have to wait longer for their prescriptions to be dispensed as the Certified Pharmacist Prescriber would need to dedicate more time to reading the information provided by the primary care provider, determining what treatment to prescribe and documenting and sending all relevant information to the primary care provider." – Pharmacist

"As long as the pharmacists are prescribing in a safe manner, I think this is the biggest benefit that a Certified Pharmacist Prescriber could offer, especially now that so many people are having trouble finding a family doctor on Vancouver Island." – Patient

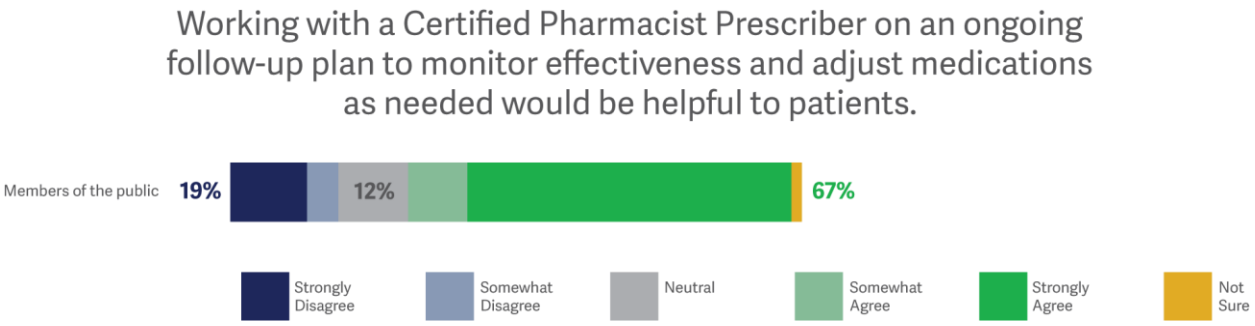


There was strong agreement from pharmacy students, pharmacists, pharmacy technicians, and members of the public that adding a Certified Pharmacist Prescriber to the patient care team would help improve the quality of health care patients receive. While over half of the other health care professionals did not agree, over 40% either agreed or felt neutral.

Within the Framework for Pharmacist Prescribing, a Certified Pharmacist Prescriber would create a monitoring and follow-up plan for patients – a pharmacist prescriber follows-up with patients they provide care for, and patients may also check in with the pharmacist prescriber. The Certified Pharmacist Prescriber would also notify and provide relevant information to the patient's primary care provider and other health professionals, as appropriate.



Pharmacists (89%) and pharmacy students (96%) strongly indicated that they felt the increased collaboration for drug therapy management and monitoring could improve the quality of care the patient receives from their health care team. Physicians disagreed with this. Members of the public also indicated that working with a Certified Pharmacist Prescriber on an ongoing drug therapy monitoring and follow-up plan would be helpful.



PHARMACIST RESPONDENT

Pharmacists are specialists in drug therapy, and very often make recommendations and alert of monitoring that is necessary to optimize drug therapy and patient response. This is already part of usual care, but having prescribing authority allows the pharmacist to respond to signals in the monitoring that should lead to adjustments in pharmacotherapy. – Pharmacist

"Monitoring dosage/side effects of meds is critical to keeping patients safe at home (along with interactions of their home/herbal meds) and keeping patients out of our hospitals - this is a BIG value!" – Patient

PUBLIC RESPONDENT

STUDENT RESPONDENT

"It seems like pharmacists and their role in health care aren't take advantage of fully. While being the medication experts, without the authority of prescribing, they aren't allowed to change potentially harmful drug therapies if the original prescriber doesn't agree. Utilizing pharmacists and their expertise in medication management could reduce a lot of the drug therapy problems seen today." – Pharmacy Student

"This is a major benefit of pharmacist prescribing. The ability (i.e. the time availability) to work with patients to maximize the effectiveness of their drug therapy is a major benefit of having pharmacists as part of the care team." – Patient

PUBLIC RESPONDENT

OTHER HEALTH PROFESSIONAL RESPONDENT

"A defined Pharmacist Prescriber would have a personal/professional relationship with a patient which would provide support above that from an anonymous pharmacist dispenser." – Physician Specialist

"Collaborative relationships will increase efficiency, improve communication, help determine mutual goals of therapy among healthcare providers, and help the patient achieve their own goals of therapy." – Pharmacy Student

"If you can't appropriately monitor the patients, you will just create more work for the physicians." – Physician Specialist

"There is often a lack of continuation in care that leaves patients feeling like they're falling through the cracks of the healthcare system and irritated at the discontinuity. I have personally seen instances where physicians have made incorrect prescriptions, and have been completely unreachable by pharmacists to correct that error. In the end, the patient becomes frustrated with the pharmacist because they want their medication, but the pharmacist cannot do anything because the physician isn't replying. More collaboration between primary health care providers and pharmacists would ultimately prevent situations like this from happening and enhance patient care." – Pharmacy Student

"This is already done by some pharmacists when doing comprehensive medication reviews, and so would come as a natural progression in patient care." – Pharmacist

"It also depends on how busy the pharmacy actually is. Potentially, there would have to be appointments made just like a physicians office as well. If there is no incentive for having a prescribing pharmacist in the building it may not improve the quality of care due to the time commitment involved in providing the best quality of care." – Pharmacist

"There are several services, programs and agencies within PHSA where prescribing authority for the pharmacist within collaborative team is an opportunity to support better patient care, given the composition and availability of care teams at various sites around the province."
– Lower Mainland Pharmacy Services, Provincial Health Services Authority

"[I would use pharmacist prescribing] for regulating and coordination in managing medication regime for chronic disease management." – Patient

"I work in an anticoagulation clinic, patients are referred to our clinic following diagnosis. I currently present the options for treatment, discuss with the family MD and make final recommendations. I cannot write the prescription that the patient, primary care provider and I have decided on. I refer the patient to their family doctor to obtain a prescription resulting in inefficient use of the patient and MDs time. I also perform discharge medication reconciliation in the hospital. Pharmacists are the best HC provider to complete this task." – Pharmacist

Patients, pharmacists, pharmacy students and other health professionals suggested that pharmacist prescribing could be used for:

- Titrating medication to determine the best dosage
- Minor ailments and contraception
- Renewals
- Hypo and hyperthyroidism management
- Warfarin therapy management
- Chronic disease management
- Increased monitoring and management of drug therapy

"Medication reconciliation. Medication titration. Reducing the stress of the health care system as a whole." – Nurse

"Uptitration of previously instituted therapies – Physician Specialist

"Minor medication adjustments or standard renewals." – Physician Specialist

"Physicians a lot of times don't have the required knowledge about a lot of medication side effects. Pharmacist should be given full prescribing authority to minimize risks of adverse reactions." – Patient

"Titrating drugs to the optimal dose. Choosing or switching to the drug which is based on patient preferences as well as safety and efficacy. Treating a minor ailment and other self-limiting conditions. Facilitate the optimal therapeutic regimen, drug and dose, for someone who is newly diagnosed with a condition." – Pharmacist

"Emergency refills. INR management would be reasonable as well." – Physician Specialist

My husband is on multiple medications. We don't understand the interactions or the efficacy of each medication because they are ordered by different specialists. I would prefer someone who had expertise in medication to advise me. – Patient

"Routine medication. Identifying antibiotics that have worked well for me vs ones that have not. Identifying the best medications among those covered by my extended plan or taking into account cost." – Patient

"One thing I have mentioned was having expensive medications switched to medications that are covered under my insurance is something I would like to see my pharmacist be able to do. I also think for less serious conditions, such as allergies or heartburn, I would trust the pharmacist to be able to prescribe something to help. Although it doesn't apply to me specifically, I think pharmacists should also be able to prescribe for birth control." – Patient

"I have four autoimmune diseases and am on a variety of medications and take supplementary vitamins. I would use them to renew prescriptions and ensure my medications are effective, as well as to monitor my vitamins. If possible, I would also use them to monitor my blood work." – Patient

"I can envisage working more closely with a pharmacist prescriber to tailor drug therapy more effectively, and to monitor more closely the effectiveness of treatment and the appearance of side effects." – Patient

"Basic cold and flu symptoms. It takes hours waiting in the doctors clinic. Many times the doctor does not even take walk ins so I need to go to a general physician walk in clinic who does not have my medically history. This makes my medical history separate in two different places. Having a pharmacist collaborate with a physician will be more accessible for me and my needs. I am a student who often time falls sick after midterms, and a pharmacist being able to accommodate me at my busy times is just what I need." – Patient

Medications to treat persistent symptoms that do not require another trip to the doctor but do require changes in medication regime. And, medications to treat side effects of treatment prescribed by a doctor. – Patient

As someone with longstanding prescriptions (including oral contraceptives) it is extremely difficult to have to routinely see a doctor for refills when my family does not have a Family Doctor, nor does our community have a walk in clinic. – Patient

"I would use this for many things. One being able to refill medications without needing to go back to the doctor, which can be very inaccessible. There are little to no available family doctors and getting in to a walk in can prove quite difficult. This would open up many doors for people, especially those that work unconventional hours, as pharmacies have different hours than doctors offices and usually have a larger availability." – Patient

"I have hypothyroid, my gp doesn't do renewals without a face to face appt, if they had my blood work they RPh could give that time back to a gp for a more acute patient. I also get a q 3 weeks b12 shot and would love to be able to get that injection without a regular trip to the doctor." – Patient

"Decreased visit to emergency for filling of prescription. Many people in our small community can't find a family physician in spite of there being over 16 physicians working in this community and we see many clients having to access emergency room time to refill prescriptions or get health care for minor issues." – Nurse

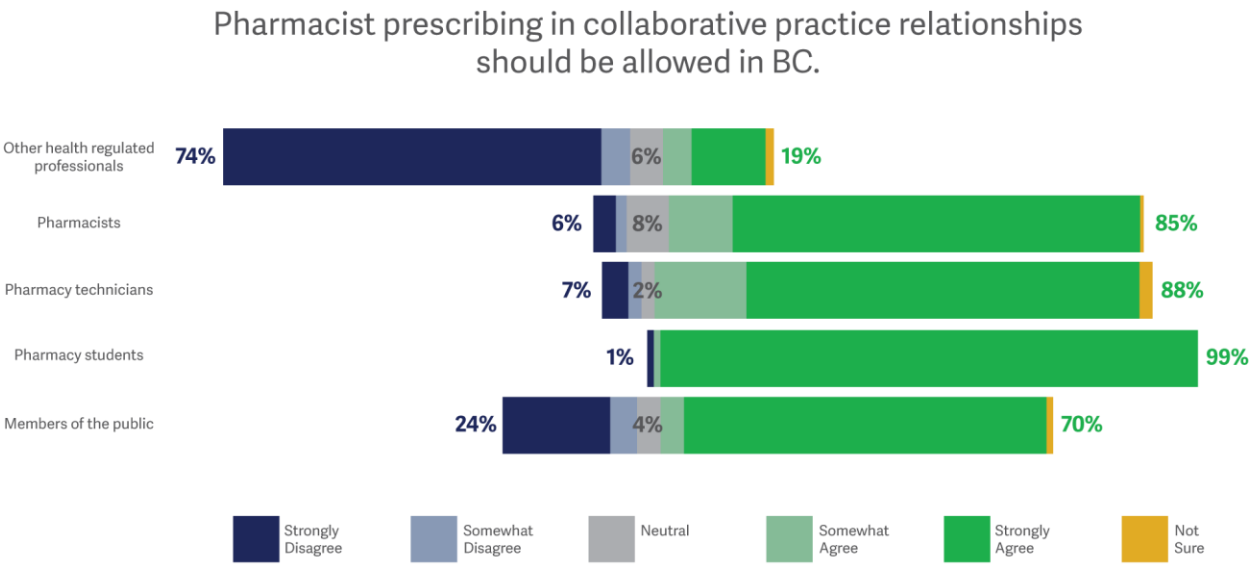
SUPPORT FOR PHARMACIST PRESCRIBING

The College heard from pharmacists, pharmacy technicians, other health care professionals and members of the public on whether they supported moving forward with a proposal for pharmacist prescribing.

Overall, feedback indicated strong support for pharmacist prescribing in BC from patients, pharmacists, and pharmacy technicians, and pharmacy students while responses from other healthcare providers illustrated strong resistance. There was a significant shift towards support for pharmacist prescribing from both patients and other healthcare providers compared to earlier feedback in 2016 on the initial draft framework, while support from pharmacists, pharmacy technicians and pharmacy students remained strong.

The social sentiment through comments and dialogue through the engagement on Facebook also showed majority support for pharmacist prescribing.

All stakeholder groups still had many questions about how pharmacists prescribing could work in BC.



SOCIAL SENTIMENT

The College welcomed comments and dialogue about the Framework for Pharmacist Prescribing in BC through two related Facebook posts. The posts received a total of nearly 150 comments and responses across the three posts. Comments were categorized based on the relative sentiment they appeared to express regarding the framework for pharmacist prescribing in BC.

RESPONSE SENTIMENT BREAKDOWN

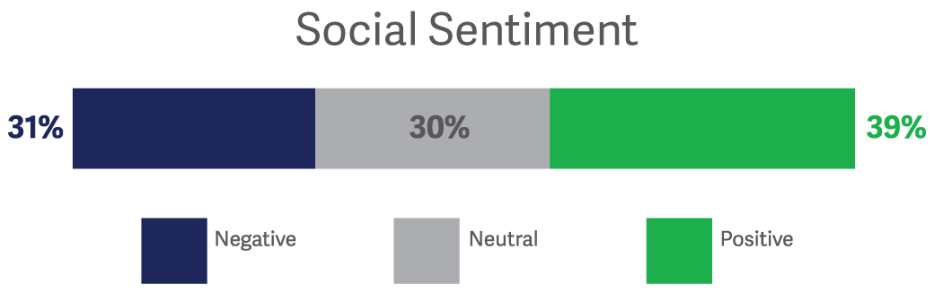
Positive comments expressed clear support for the initiative, whether as lone statements or as responses to the comments of other individuals.

Negative comments expressed clear opposition to the initiative, whether as lone statements or as responses to the comments of other individuals

Neutral comments did not provide a clear position on the initiative.

SENTIMENT ANALYSIS

Overall the majority (39%) of Facebook comments received were positive. Over 90% of the 470 reactions (likes and loves etc.) to the Facebook posts were also positive.



Note: comments that provided no reference to pharmacist prescribing or pharmacy practice in BC, or response to a comment made by another individual were excluded from the count.

PUBLIC SUPPORT FOR PHARMACIST PRESCRIBING IN BC

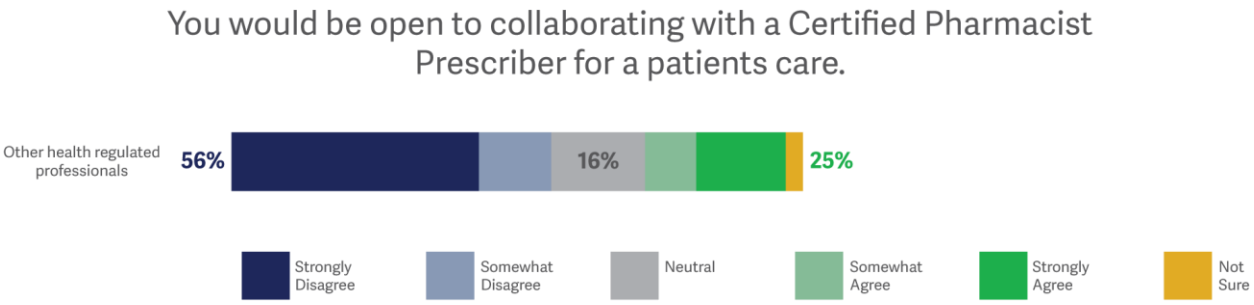
Many patients expressed support for pharmacist prescribing. Over 70% agreed that pharmacist prescribing should be allowed in BC. This is a significant increase compared to earlier expressions of support in 2016 on the initial draft framework where only 47% agreed.

Similarly, patients also indicated they would use pharmacist prescribing services if they became available.

OTHER HEALTH CARE PROFESSIONALS SUPPORT FOR PHARMACIST PRESCRIBING

While most other healthcare providers (74%) did not agree that pharmacist prescribing in collaborative practice relationships should be allowed in BC, there was less disagreement compared to earlier feedback in 2016 on the initial draft framework where only 94% disagreed that pharmacist prescribing should be allowed.

Physician specialists expressed slightly more disagreement (91%) than general practitioners, while others (such as nurses and nurse practitioners) expressed strong support (84%) for allowing pharmacist prescribing in BC.



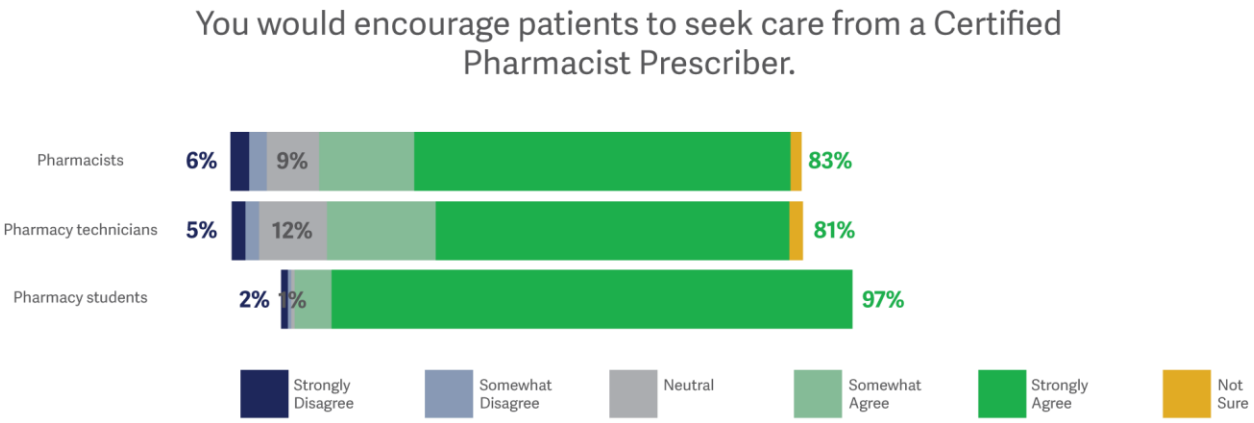
A greater number of other health care professionals indicated they would be open to collaborating with a Certified Pharmacist Prescriber. 41% indicated they were open to collaborating or were neutral while only 56% disagreed. Physician specialists expressed the most disagreement (77%), while only 54% general practitioners disagreed and 84% others (such as nurses and nurse practitioners) agreed.

PHARMACY PROFESSIONALS SUPPORT FOR PHARMACIST PRESCRIBING

Pharmacists, pharmacy technicians and pharmacy students all strongly supported allowing pharmacist prescribing in collaborative practice relationships in BC.

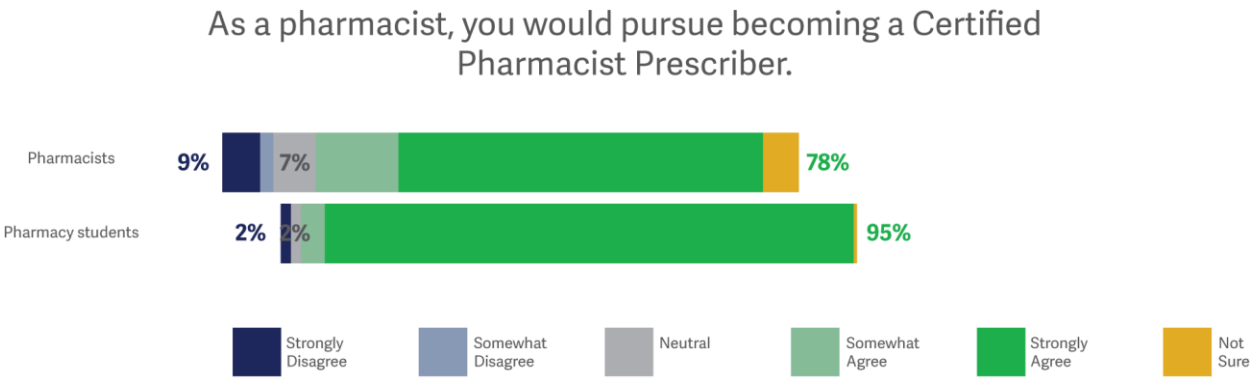
Pharmacy students showed the strongest support with 99% agreeing that pharmacist prescribing should be allowed in BC. 85% of Pharmacists agreed while 88% of pharmacy technicians also indicated they supported pharmacist prescribing.

This is slightly less agreement from pharmacists compared to earlier feedback in 2016 on the initial draft framework where 90% indicated support for moving forward with pharmacist prescribing in BC. This is likely a result of the move towards narrowing the scope of the Framework to within collaborative practice relationships which some pharmacists felt was too restrictive. Concerns about workforce pressures shared through the feedback may also have contributed to slightly less support.

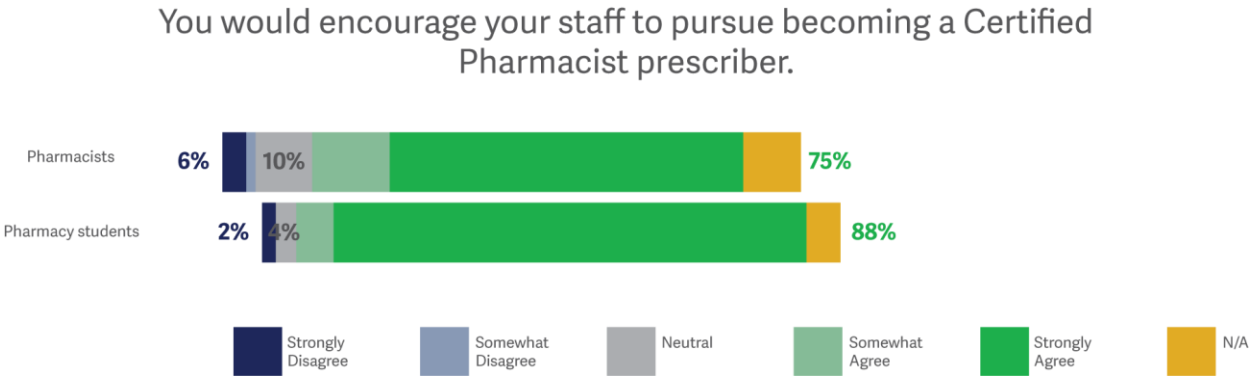


Pharmacists (83%), pharmacy technicians (81%) and pharmacy students (97%) all indicated they would encourage patients to seek care from a Certified Pharmacist Prescriber.

The majority of pharmacists (78%) indicated they would pursue becoming a Certified Pharmacist Prescriber if the authority was granted in BC. 95% of pharmacy students also indicated they would purse the additional certification.



Pharmacists who manage staff (such as pharmacy managers and owners) also indicated they would encourage their staff to pursue becoming a Certified Pharmacist Prescriber.



APPENDIX 8: LEGISLATION AND REGULATION OF INTERPROFESSIONAL COLLABORATION

Jurisdiction	Legislative and Regulatory Framework	Government Policy Supporting IPC	Key Legislative and Regulatory Mechanisms Supporting Enhanced IPC
BC	• *Health Professions Act* between 2001-2011 (both common acts and restrictions)	• Health Professions Council 2001 • Primary Health Care Charter 2007 • Divisions of Family Practice	• Scope of Practice Statements • Reserved Actions
Ontario	• *Health Professions Act* 1991 (both common acts and restrictions)	• Family Health Teams • Community Health Centres • Health Force Ontario (develop new provider roles) • Blueprint for Advancing IPC (team-based approach) • Ministerial Referral to the Health Professions Regulatory Advisory Council (make recommendations for shared controlled acts)	• Health System Improvement Act 2007 (Colleges promote IPC, and develop standards/programs to support IPC)
Alberta	• *Health Professions Act* 1999 (only common acts) • Government Organization Act 2000 (lists restricted activities)	• Health Policy Framework 2006 (team based care; new compensation models) • Health Workforce Action Plan 2007-16 (new and expanded provider roles to increase patient access to needed health services • Primary Care Networks	• Non-restrictive Scopes of Practice • Restricted Activities • Delegation • Common complaints and Discipline • Provincial Ombudsman

Adapted from http://www.hprac.org/en/projects/resources/hprac-collaboration.JurisdictionReviewENFINAL.feb1208.pdf

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

November 2, 2017
Bob Nakagawa
Registrar
College of Pharmacists of British Columbia
200-1765 West 8th Avenue
Vancouver, BC
V6J 5C6

Dear Mr. Nakagawa:

RE: Support for Certified Pharmacist Prescribing in British Columbia

The BC Cancer Agency Provincial Pharmacy Professional Practice Council is the Pharmacy Leadership team and we are writing to express our support for allowing Pharmacists who are certified in prescribing and who work in collaborative health care settings to prescribe medications in British Columbia.

Pharmacists play an integral role in our health authority as medication experts and are involved in direct patient care and administrative duties, including the development of treatment guidelines to standardize and promote best practices in drug use to improve patient care. Our pharmacists are involved in all aspects of a patient's medication therapy, assessing treatments and recommending the most appropriate and safest regimen for each individual.

One of the roles for Pharmacists at the BC Cancer Agency is to provide care in our ambulatory oncology clinics. Allowing Certified Pharmacist prescribing would improve patient care further by streamlining care in the ambulatory oncology clinics to ensure that patients have the medications that they need in an efficient and safe process.

Thank you for taking the time to consider how Certified Pharmacist prescribers could profoundly improve the care of our patients in the province.

Sincerely yours,

Lynne Nakashima, BSc (Pharm), PharmD
Chair, Provincial Pharmacy Professional Practice Council

On behalf of the BC Cancer Agency Provincial Pharmacy Professional Practice Council:
Jennifer Cowie, Pharmacy Professional Practice Leader, Abbotsford Centre
Randy Goncalves, Pharmacy Professional Practice Leader, Centre for the Southern Interior
Kimberly Kuik, Pharmacy Professional Practice Leader, Vancouver Island Centre
Sylvie Labelle-Stimac, Pharmacy Professional Practice Leader, Fraser Valley Centre
Crystal Maric, Pharmacy Professional Practice Leader, Vancouver Centre
Alison Pow, Pharmacy Professional Practice Leader, Centre for the North

600-750 West Broadway
Vancouver, BC
V5Z 1H1

Phone: 604.707.5923
Toll Free: 1.800.663.3333
Fax: 604.708.2026

British Columbia Pharmacy Association
Suite 1530 - 1200 West 73rd Avenue
Vancouver, BC V6P 6G5
Tel: 604 261-2092 Fax: 604 261-2097
info@bcpharmacy.ca www.bcpharmacy.ca

November 2, 2017

Mr. Bob Nakagawa
Registrar
College of Pharmacists of British Columbia
200 – 1765 W. 8th Avenue
Vancouver, BC V6J 5C6

Dear Bob:

The BC Pharmacy Association thanks the College of Pharmacists of BC for the opportunity to provide comments on the Framework for Pharmacist Prescribing in British Columbia that was revised in September 2017.

The Association represents more than 3,200 pharmacists and more than 900 community pharmacies across British Columbia and works hard to advance and support the professional role and economic viability of our members.

The BCPhA supports allowing pharmacists to initiate prescriptions. In fact, pharmacist expansion of scope reflects the aspiration of B.C. pharmacists, and one of the Association's key goals is: "Pharmacists are able to practice the profession of pharmacy at the highest levels and to its fullest extent."

We appreciate the College's consideration of our feedback on the 2016 draft framework, most noticeably our request for engagement with prescribers. However, the BCPhA remains concerned about the approach the College has now taken in its newly revised draft framework, specifically narrowing pharmacist prescribing to only within collaborative practice and continued restriction of pharmacist prescribers from dispensing the medications for a patient.

1. Narrowing the scope of pharmacist prescribing to within collaborative practice.

As mentioned in our 2016 submission on the first draft framework for the certified pharmacist prescriber initiative, the BCPhA supports pharmacist prescribing. We have advocated for pharmacist prescribing for minor ailments and dispensing the appropriate medications in rural areas. Pharmacists have the authority to treat minor ailments in many provinces in Canada and elsewhere,[i] but not in British Columbia.

A minor ailment is commonly defined as a self-limiting medical condition that will resolve itself on its own and can be reasonably self-diagnosed and managed without medical intervention. It is also generally accepted that lab tests are not needed to diagnose the condition; that treating the condition as a minor ailment will not mask underlying more serious health conditions; that medical and medication histories can reliably differentiate more serious conditions; and that only minimal or short-term follow-up with the patient is necessary. Minor ailments include common conditions like headaches, back pain, insect bites, diaper rash, cold sores, acne, athlete's foot, heartburn or indigestion and nasal congestion.[ii]

What is concerning in the recent draft framework is the notion that pharmacists, in order to prescribe at all, require oversight from physicians or nurse practitioners, who would diagnose and provide access to lab test results. It's no surprise that prescribers' feedback indicates they feel pharmacists should have more supervision from them. The College of Family Physicians of Canada expressed concerns about allowing other health-care professionals to prescribe and recommended a collaborative care model,[iii] and the Canadian Medical Association (CMA) has said more forcefully in

response to Alberta's legislation to allow pharmacists to prescribe, "that pharmacists not be given independent prescribing authority."[iv]

The BCPhA believes this revised framework while trying to assuage concerns from physicians, has gone too far in its limiting of scope for pharmacists. Rather than working toward gaining incremental steps forward for the profession, it has relegated pharmacists into a helper-like position. We recommend the College take a more stepped approach with first asking for pharmacist prescribing for minor ailments. This would help address the long-standing challenges of access to care in rural areas.

The Ministry of Health's 2015 cross-sector policy discussion paper identified the unique challenges B.C. faces in providing appropriate access to health care in rural areas of the province. These ranged from "geographic remoteness, long distances, low population densities, less availability of other providers and inclement weather conditions".[v] People living in remote and rural areas have a lower life expectancy[vi] and face difficulties accessing health services. It is a challenge to attract and retain health care providers in rural areas.[vii]

We take issue with the College's assertation that it is "much more difficult"[viii] for community pharmacists to relay information to family physicians. The College implies in its draft framework that pharmacists would be best to be physically co-located with physicians (in either hospitals or at a doctor's office) to improve patient care. There are examples in British Columbia in which pharmacists have proven they do not need to co-locate in a physician's office or work alongside nurses and doctors at a hospital to create a collaborative team environment and provide excellent patient care.

Nowhere in this revised draft framework does the College address the other key factor in the success of pharmacist prescribing: ensuring payment of the services.

In other Canadian provinces where pharmacists have prescribing authority, but no one willing to pay for it, there is little evidence to demonstrate the value of this for the system or patients. If these services are not paid for, it's unlikely that there would be uptake by a patient, who would pay out of pocket for this expense. Additionally, it would seem there would be no incentive to see a prescribing pharmacist co-located at a family practice and pay a fee when a patient could see a physician, whose services are paid for.

It appears this revised framework addresses hospital pharmacists, who are already co-located in hospitals with prescribers, but leaves little in addressing the important role that more than 3,900 community pharmacists play in delivering patient care in B.C., especially in rural and remote communities, where community pharmacists are often the first point of care and key to continuity of care.

Considering that in rural communities, where there may not even be a family doctor, this plan becomes an even bigger issue for access to care for patients.

2. Restricting certified pharmacist prescribers from dispensing medications they prescribed for a patient.

The BCPhA remains concerned that the College's proposal still excludes pharmacists, and ultimately pharmacist owners, from prescribing and dispensing these medications to a patient because of "a potential business conflict of interest".[ix] At no point have we seen any evidence to show there is an issue.

As we have stated in our past submissions, not allowing pharmacists to prescribe and dispense medications for a patient will impact access to care for patients in rural and remote communities already facing issues of access to care.

There are currently 89 community pharmacies that serve 66 rural-designated communities in BC. Of those 66 communities, 60 per cent have only one pharmacy in town. In these areas, it is not unusual for the only pharmacist on duty to be the owner of the pharmacy, especially since many are independently owned.

A 2015 survey of pharmacists in rural BC, respondents said that more than 80 per cent of their patients would have to travel between one to two hours to access health care. In rural areas 85 per cent of community pharmacies are

independent operators. So, the ban on pharmacist owner prescribers would seem to favour corporate ownership and pharmacies that can have multiple pharmacists on staff at all times and would negatively affect patient care in rural and remote communities.

There is little evidence to support the belief that pharmacist prescribers cannot manage this ethical challenge, while other prescribers, like physicians, dentists, naturopaths, optometrists, who also run health-care businesses can. Based on discussions with other provinces that allow for pharmacist prescribing there have been no reports of such unethical practices by pharmacists.

We know there are always challenges that face all professionals who work for payment. In a health-care environment, it is always the pledge to put a patient's best interests first that drives professional judgement. If regulators of other professionals and in other jurisdictions have not put this requirement in place, we do not understand why the College is proceeding with this approach. The BCPhA asks the College to consider the impact this action will have on the reputation of pharmacists as a self-regulating profession.

If the profession of pharmacists itself does not believe it can adhere to ethical codes of conduct, then putting this requirement in place would be a vote of no confidence in the professionalism of its registrants. We continue to urge the College remove this restriction of pharmacist prescriber not being able to dispense and to monitor the issue of over time. We recommend looking at other ways of how to deal with this ethical challenge, such as strengthening the Conflict of Interest Standards.

B.C. has been a leader in continuing to advance the scope of practice for pharmacists. We believe there are ways to achieve pharmacist prescribing, which will have better health outcomes at optimal costs for patients through the expansion of prescribing for minor ailments.

Sincerely,

Geraldine Vance
Chief Executive Officer, BC Pharmacy Association

---

[i] Pharmacists' Expanded Scope of Practice. December 2016. http://www.pharmacists.ca/pharmacy-in-canada/scope-of-practice-canada/

[ii] BC Pharmacy Association submission to the Select Standing Committee on Health. July 2016.

[iii] College of Family Physicians of Canada. (2010, January). Prescribing Rights for Health Professionals [Position Statement].

[iv] Kondro, W. (2007). Canada's doctors assail pharmacist prescribing. Canadian Medical Association Journal, 177(6), 558-558. doi:10.1503/cmaj.071212

[v] British Columbia, Ministry of Health. (2015). *Rural health services in BC a policy framework to provide a system of quality care: Cross sector policy discussion paper*. Victoria, B.C.: Ministry of Health.

[vi] Romanow, R. J. (2002). Building on values: The future of health care in Canada (Commission on the Future of Health Care in Canada.). Saskatoon, Sask.: Commission on the Future of Health Care in Canada.

[vii] Ibid.

[viii] Certified Pharmacist Prescriber: Framework for Pharmacist Prescribing in British Columbia. (2017, September).

[ix] Ibid.

Canadian Society of Hospital Pharmacists | Société canadienne des pharmaciens d'hôpitaux
British Columbia Branch
200-1765 West 8th Avenue,
Vancouver, BC V6H 1V8

Position Statement on Pharmacist Prescribing

Certified Pharmacist Prescriber Task Force on behalf of CSHP BC Branch

Revised October 16, 2017

Situation:

- Care of patients in hospital and ambulatory care clinics is often compromised due to suboptimal medication use, inefficiencies in work flow, and rushed transitions in care (such as during admission and discharge)
- Hospital and ambulatory care pharmacists have the training and expertise to competently prescribe medications, which would improve the quality and efficiency of care provided to patients
- The College of Pharmacists of BC recently approved a motion to support a pharmacist prescribing initiative in collaborative practice settings

Background:

- Hospital pharmacists practice in a variety of settings, including inpatient units and ambulatory/primary care clinics
- Many hospital pharmacists have advanced training and additional qualifications to assess and optimize medication therapies beyond the entry-to-practice Baccalaureate Pharmacy degree, including a 1-year accredited hospital pharmacy practice residency and a 2-year post-graduate Doctorate of Pharmacy degree
- Hospital pharmacists work collaboratively with physicians and nurse practitioners in managing patients and have access to medical records, including laboratory and diagnostic results
- Hospital pharmacists currently have the authority to make changes to existing prescriptions, but cannot initiate new prescriptions even though they work in the medical team and are familiar with patient care plans
- Hospital pharmacists provide detailed recommendations to their medical teams regarding initiating, modifying and discontinuing medication regimens – they often write these orders but are not permitted to sign them
- A recent survey conducted by the College of Pharmacists of BC demonstrated that pharmacists are supportive of the expanded scope of prescribing
- Hospital pharmacists are funded by health authorities and do not have any real or perceived conflicts of interest related to dispensing of medications
- Numerous publications in peer-reviewed medical journals have demonstrated that pharmacists with full prescribing privileges improve patient outcomes, while being cost-effective to the healthcare system

Assessment:

- Hospital and ambulatory care pharmacists are ideally positioned to take on additional prescribing responsibilities to meet the medication-related needs of patients
- Many other health professionals in BC with less medication-related training than pharmacists already have prescribing authorities; pharmacists are often involved in training these prescribers (e.g. Naturopathic Physicians)
- Pharmacist prescribing aligns with the BC Ministry of Health's priorities and would result in improved patient care, including:
    - Reduced number of medication errors and improved patient safety
    - Improved patient outcomes
    - Reduced number of healthcare professionals involved during transitions of care by freeing up time of physicians and nurse practitioners
    - Enhanced opportunities for optimizing and de-prescribing (e.g. opioid drugs) medications
    - Improved patient education to ensure effective medication use
    - Improved patient experience across the healthcare system
    - Improved communication between hospital and community clinicians (including family physicians and community pharmacists)
    - Improved healthcare capacity and sustainability
- No additional funding is required for pharmacist prescribing, as hospital pharmacists are salaried by health authorities

Recommendation:

- CSHP BC Branch strongly supports the Certified Pharmacist Prescriber framework for collaborative settings, as proposed by the College of Pharmacists of BC
- CSHP BC Branch will advocate for pharmacist prescribing and obtain endorsements from hospital administrators, physicians, nurses, allied health, and patient groups to support pharmacist prescribing

October 11, 2017

Mr. Bob Nakagawa
Registrar
College of Pharmacists of British Columbia

Ms. Gillian Vrooman
Director, Communications and Engagement
College of Pharmacists of British Columbia

VIA Electronic Submission

Dear Mr. Bob Nakagawa & Ms. Gillian Vrooman:

Re: Framework for Pharmacist Prescribing in BC

In September 2017, the College of Pharmacists of British Columbia (the "College of Pharmacists") released a draft *Certified Pharmacist Prescriber – Framework for Pharmacist Prescribing in British Columbia* (the "CPP Framework 2017") for public consultation. The CPP Framework 2017 is a follow up on a College of Pharmacists proposal in 2016, which proposed granting qualified Certified Pharmacist Prescribers (CPPs) the authority to prescribe Schedule 1 drugs. The CPP Framework 2017 limits CPP prescribing to within "collaborative practice relationships" between pharmacists and health professionals, including physicians.

In 2016, Doctors of BC expressed significant concerns to the College of Pharmacists about its pharmacist prescribing proposal. Specifically, we highlighted issues such as conflict of interest and inadequate clinical training, and outlined our views on how pharmacist prescribing may hinder inter-professional collaboration, fragment care, and increase cost to the health care system. To view our 2016 submission to the College of Pharmacists, please see here. While the CPP Framework 2017 attempts to address some of these issues by restricting pharmacist prescribing to collaborative settings, Doctors of BC remains concerned about the potential implications of pharmacist prescribing within the current health care environment.

Doctors of BC believes that pharmacists and physicians are well positioned to work together to collectively improve patient care and safety. Physicians strongly support opportunities to work with pharmacists, as part of a multidisciplinary team, to improve quality of care. Doctors of BC welcomes opportunities to work with the College of Pharmacists to support the integration of pharmacists into multidisciplinary health care teams. For example, Doctors of BC supports the work of the General Practice Services Committee and Divisions of Family Practice to integrate clinical pharmacists into Patient Medical Homes. In these practices, physicians and pharmacists work together to optimize drug treatments for patients with complex medical conditions.

In addition to the issues raised in 2016, Doctors of BC has specific concerns about the CPP Framework 2017. First, the CPP Framework 2017 suggests that pharmacist prescribers can address the "redundant and time-consuming process where pharmacists make recommendations to other health care professionals who are asked to approve them." In our view, an inter-professional practice characterized by redundancy and unreasonable delay is not a properly functioning collaborative environment – the very type of practice setting that the CPP Framework 2017 intends to require for pharmacist prescribing.

T 604 736 5551
TF 1 800 665 2262
115—1665 West Broadway
Vancouver BC V6J 5A4
doctorsofbc.ca

Second, the definition of “collaborative practice relationships” is broad and could be interpreted to include practices where there is only a nominal level of inter-professional collaboration. At the operational level, there remain many challenges to effective collaboration between pharmacists and physicians and the broad description of collaborative practice relationships, as outlined in CPP Framework 2017, may not adequately capture such nuances.

Third, although particular health care practices are making progress in improving collaborative relationships between pharmacists and physicians, in most cases (and particularly in primary care), there remain significant barriers to timely communication and relevant information sharing between health care professionals. In situations where there is limited collaboration between pharmacists and physicians, adding certified pharmacist prescribers to the health care team may undermine inter-professional relationships. Whereas the current system requires pharmacists to discuss drug modifications with physicians, a CPP would be able to initiate or change drug treatment without further consultation with the patient’s physician. For the health care team, this overlapping scope may lead to disagreements between pharmacist and physician prescribers. For the patient, this can lead to contradictory drug treatment plans and the further fragmenting of patient care. For the healthcare system, this could lead to duplication and increased cost.

Finally, the CPP Framework 2017 attempts to address conflict of interest concerns by prohibiting a CPP from prescribing and dispensing the same medication to a patient. Despite this safeguard, a CPP may still be influenced by the dispensing interests of colleagues or employers.

Doctors of BC is unable to support the CPP Framework 2017 at this time. We believe that a proposal for pharmacist prescribing is premature given the work currently underway to foster multidisciplinary team-based care in BC. Time should be given to evaluate the benefits of such projects before consideration be given to expanding scopes of practice for members of the health care team.

We note that the limited timeframe given for this current phase of consultation is insufficient for obtaining physician feedback and we ask that the current consultation period be extended to allow more fulsome participation by physicians and other key stakeholders. Moving forward, we encourage the College of Pharmacists to explore ways in which pharmacists and physicians can work together, within existing scopes of practice, to collectively address BC’s health care challenges.

Sincerely,

Trina Larsen Soles, MD
President, Doctors of BC

fraserhealth

Better health.
Best in health care.

November 2, 2017

Bob Nakagawa
Registrar
College of Pharmacists of BC
1765 West 8th Avenue
Vancouver, BC V6J 5C6

Dear Bob,

Re: Certified Pharmacist Prescribing in Health Authorities

As the V.P. Regional Hospitals and Programs, the V.P. Patient Experience and the V.P. Medicine for Fraser Health we are in support of moving ahead with changes to the scope of practice for Pharmacists that support prescribing practices. We are aware that this is not a new concept and has been in the works for many years. We are also aware that other provinces have introduced Pharmacist Prescribing, notably Alberta and have had this in place for many years.

The need for pharmacist prescribing is evident in the number of medication order clarifications, changes to orders and communication between providers and pharmacists that occur daily. Pharmacists work both upfront and behind the scenes to effect proper medication order writing and prevent adverse drug events. This could be achieved in a more efficient and effective manner if pharmacists could prescribe. In ambulatory care settings where pharmacists are embedded in the clinic practice they do prescribe under certain delegated authorities. This practice is occurring in many care settings within the health authorities now but without a regulatory practice framework.

We also support the rigorous credentialing/certification process that will ensure the pharmacist maintains a high standard of practice. With these high standards of certification in place other providers can be confident that the pharmacist is competent in this scope of practice and communication and documentation will go above that required of any other current prescriber which will enhance care and close gaps that currently exist. The fact that there will be a robust credentialing process required by the College ensures that only pharmacists who have demonstrated the skills and abilities will be able to prescribe.

We appreciate the work of the College and moving this important change forward.

Sincerely,

Laurie Leith
Vice President,
Regional Hospitals and Programs

Linda Dempster
Vice President, Patient Experience

Dr. Roy Morton
Vice President, Medicine

Provincial Health Services Authority
Province-wide solutions. Better health.

November 7, 2017

e-mail to: Bob.Nakagawa@bcpharmacists.org

Bob Nakagawa
Registrar
College of Pharmacists of BC

Dear Mr. Nakagawa:

Re: Certified Pharmacist Prescribing in Health Authorities

As the Provincial Health Services Authority (PHSA) Executive Lead to Lower Mainland Pharmacy Services, I support the College of Pharmacists of BC initiative to advocate for legislative change to allow for Certified Pharmacist Prescribers in BC when working as part of a collaborative team in health authority settings.

There are several services, programs and agencies within PHSA where prescribing authority for the pharmacist within collaborative team is an opportunity to support better patient care, given the composition and availability of care teams at various sites around the province.

Given pharmacists role and scope currently within PHSA teams in supporting and advising appropriate medication prescribing, dose adjustments and monitoring to physicians and nurse practitioners, allowing pharmacists independent prescribing authority as part of the collaborative team is a logical next step in many settings, particularly in completing the medication transition process.

Maximizing and optimizing safe and appropriate scope for the health professions is a principle of professional practice in PHSA. Changing the legislation that enables pharmacist prescribing in a health authority setting as a member of a collaborative team could provide PHSA with more flexibility as we look at models of care across the variety of services and settings in PHSA, as well as the composition of the care team across settings. Supporting the College of Pharmacists to advocate for legislative change and provide the necessary oversight on practice would allow PHSA access to this role as a member of the collaborative team in defined settings.

Sincerely,

Susan Wannamaker
President, BC Children's & Women's Health
Vice President, PHSA

cc. S. Hamilton, Chief Nursing & Liaison Officer, PHSA

Specialists of BC

Response regarding pharmacists prescribing June 27, 2016

Thank you for the opportunity to provide input on the BC College of Pharmacists Draft Framework. The Specialists of BC represent the interests of the almost 5300 medical, diagnostic and surgical specialists within the province.

We are surprised that a pharmacist college policy in development for many months is now distributed for feedback with a deadline of four weeks. There are very significant issues to consider. We strongly recommend that you extend your deadline and encourage all interested and affected parties to submit further information. Such an extension is particularly important given that the request came mid-June, at the start of the summer season when many stakeholders in BC take time off.

In that context, and in preliminary consultation with our specialty leads, we identify the following issues that represent immediate concerns; there may be others:

1. Competency/training
2. Conflict of interest for pharmacists who are employed by, are partners in or own pharmacies
3. Scope of practice
4. Fragmentation of care
5. Delays in appropriate care
6. Patient safety
7. Potential for missed or incorrect diagnoses
8. Duplication of services
9. Cost increases
10. Liability/duty of care

We respect the training and skill set of pharmacists which have allowed us to work together to achieve the highest quality patient care possible, but it is difficult for us to understand how the current pharmacy training curriculum could provide for the safe independent assessment and management of patients. Medical students spend years studying history taking, physical examination, ordering and interpretation of laboratory and imaging tests. By completion of their undergraduate education and postgraduate residency training they have assessed thousands of patients. We are not aware of any such comparable training in the pharmacy curriculum.

We do note that the Bachelor of Pharmacy degree has been discontinued, and Entry-to-Practice Doctor of Pharmacy degree introduced. This new training relies on having

completed two years of undergraduate course work, perhaps not dissimilar to some of the standard undergraduate requirements that medical students complete in three to four years of undergraduate training before entering medicine.

The 2016/2017 UBC Calendar lists available pharmacy courses per the appendix below. We do not see course work in History Taking, Physical Examination, Pathology, or Radiology. Nor do we note clinical clerkships dealing with Family Practice, Medicine, Surgery, Pediatrics, Obstetrics, etc. After completion of this so-called Doctor of Pharmacy undergraduate degree, we do not see any practical requirements such as the two-year family practice, or the four to six years of additional on-the-job training of medical, surgical, diagnostics residencies required to be considered full-fledged doctors of medicine.

In contrast, the preparation in Pharmacy and Pharmacology appears very thorough and complete. This portion of training looks to be considerably more indepth than what medical students obtain. It is no wonder that physicians value the input of our pharmacy colleagues in their pharmaceutical areas of expertise. We cannot imagine any physician feeling capable of stepping into the role of a pharmacist, given the relative dearth of pharmacy training they receive.

As the College of Pharmacists considers the future roles of its graduates, should any of them have a desire to practice medicine, that is independently assess patients, order tests, examine them, and prescribe treatments, we would encourage those pharmacy graduates to consider applying to medical school. In fact, there have been many pharmacists who have chosen this route and have become fine medical doctors. Similarly, should any of our physicians desire to begin a career as a pharmacist, we would encourage them to enroll in the Entry-to-Practice Doctor of Pharmacy program, and we are sure that they would make fine pharmacists.

Excepting physicians being trained in pharmacy, or pharmacists being trained in medicine, we think it would be unwise and unsafe for doctors to practice as pharmacists or pharmacists to practice as doctors.

Yours sincerely,

John Falconer MD, FRCPC
President

Appendix – Pharmacy Course Listing UBC Calendar 2016/17:

Faculty of Pharmaceutical Sciences
PHAR: Pharmaceutical Sciences
PHRM 100 (18) Foundations of Pharmacy Scientific concepts and pharmacy practice principles. Role of the pharmacist, patient assessment skills, professional identity, communication skills, and an understanding of legal and ethical responsibilities. *This course is not eligible for Credit/D/Fail grading.*
PHRM 111 (15) Medication Management I Modules and integration activities focusing on: an introduction to infectious diseases; musculoskeletal disorders; dermatology; eyes, ears, nose, and throat disorders; fluid and electrolytes, and hematology. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 100; *Corequisite:* PHRM 131.
PHRM 131 (2) Study Design and Interpretation I Principles of clinical study design, focusing on biostatistical foundations, randomized controlled trials, and systematic review of randomized controlled trials. *This course is not eligible for Credit/D/Fail grading. Corequisite:* PHRM 111.
PHRM 141 (2) Seminar: Pharmacists in Practice I Current and future roles for pharmacists and controversies in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 161 (2) Technology in Healthcare Knowledge and skills related to the role and applications of technology in health care. *This course is not eligible for Credit/D/Fail grading.*
PHRM 170 (1) Community Service Learning I Service learning activities with external community partner sites and members. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 171 (2) Introductory Pharmacy Practice Experience - Outpatient I Prescription processing, drug distribution systems, and select patient care activities in real world outpatient environments. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.* **PHAR 201 (3) Pharmacist, Patient and Society** The Canadian health care system, the pharmacist-patient relationship, and contemporary trends and standards in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.* [3-0-0]
PHRM 211 (15) Medication Management II Modules and integration activities focusing on respirology and cardiovascular disorders. *Corequisite:* PHRM 231.
PHRM 212 (15) Medication Management III Modules and integration activities focusing on nephrology, endocrinology, and neurology. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 211; *Corequisite:* PHRM 231.
PHRM 221 (3) Nutrition for Pharmacists Foundations of nutrition, nutrition for healthy individuals through the lifespan, and selected clinical applications of nutrition in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 231 (2) Study Design and Interpretation II Principles of clinical study design, focusing on epidemiologic studies (cohort, case-control), pharmacoeconomic analyses, non-inferiority designs, clinical prediction rules, and guidelines. *This course is not eligible for Credit/D/Fail grading.*
Corequisite: All of PHRM 211, PHRM 212.
PHRM 241 (2) Seminar: Pharmacists in Practice II Current and future roles for pharmacists and controversies in pharmacy practice, focusing on the roles and training opportunities for pharmacists in specialty areas of outpatient and inpatient practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 251 (1) Institutional Practice Skills Preparation for experiential learning in the hospital setting. Focuses on enhancing familiarity with the care environment and developing skills suited for students to apply to patient care during institutional experiential rotations. *This course is not eligible for Credit/D/Fail grading.*
PHRM 270 (1) Community Service Learning II Service learning activities with external community partner sites and members. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 271 (2) Introductory Pharmacy Practice Experience - Outpatient II Prescription processing, drug distribution systems, and select patient care activities in real world outpatient environments. Focus on direct patient care activities. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 272 (1) Introductory Pharmacy Practice Experience - Inpatient Prescription processing, drug distribution systems, and select patient care activities in real world inpatient environments. Focus on direct patient care activities. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 311 (12) Medication Management IV Modules and integration activities focusing on psychiatry; gastroenterology; and obstetrics, gynecology, sexual health, and genito-urinary disorders. *This course is not eligible for Credit/D/Fail grading.*
PHRM 312 (12) Medication Management V Modules and integration activities focusing on special infectious diseases; toxicology; and oncology and palliative care. *This course is not eligible for Credit/D/Fail grading.*

Prerequisite: PHRM 311.
PHRM 341 (2) Seminar: Pharmacists in Practice III Current and potential roles for pharmacists, and contemporary issues in pharmacy practice. Focus on the role of pharmacists as patient educators, researchers and collaborators in interprofessional teams. *This course is not eligible for Credit/D/Fail grading.*
PHRM 351 (3) Practice Management and Leadership Application of management and leadership principles and skills to pharmacy operations. *This course is not eligible for Credit/D/Fail grading.*
PHRM 371 (4) Introductory Pharmacy Practice Experience - Outpatient III Direct patient care activities in an outpatient setting. Building on existing pharmaceutical knowledge and problem solving ability. Increased involvement in diverse patient care situations. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 441 (1) Seminar: Advanced Topics in Pharmacy Practice Roles and skills for pharmacists as preceptors, teachers and mentors; emerging issues in pharmacy practice. *This course is not eligible for Credit/D/Fail grading.*
PHRM 450 (2) Pharm.D. Seminar Seminar course about current and potential roles for pharmacists. Students will also deliver an individual and a group seminar. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 451 (4) Critical Appraisal of Pharmacotherapy Literature Principles of clinical study design, focusing on randomized controlled trials, systematic reviews, epidemiologic studies (cohort, case-control), pharmacoeconomic analyses, clinical prediction rules, and guidelines. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 452 (4) Patient Assessment Skills Principles and practices of patient assessment, applied to the monitoring of drug efficacy and toxicity. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 453 (3) Applied Pharmacokinetics and Pharmacogenomics Pharmacokinetic monitoring of drug therapy in common clinical situations with foundations for application to other drugs. Pharmacogenomics and personalized medicine principles and applications to practice. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 454 (2) Practice Management Values, concepts, issues and responsibilities of individuals exercising leadership and management roles in pharmacy practice and health care settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 461 (2) Pharmacotherapeutics 1 Therapeutic foundations. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 462 (2) Pharmacotherapeutics 2 Respirology, dermatology, and ears, eyes, nose, and throat. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 463 (2) Pharmacotherapeutics 3 Cardiovascular disorders. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 464 (2) Pharmacotherapeutics 4 Infectious diseases. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 465 (2) Pharmacotherapeutics 5 Neurology and psychiatry. Pass/Fail. *This course is not eligible for Credit/D/Fail grading. Prerequisite:* PHRM 461.
PHRM 466 (2) Pharmacotherapeutics 6 Gastroenterology and musculoskeletal disorders. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 467 (2) Pharmacotherapeutics 7 GU, OBS/GYN, endocrine, and renal. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 468 (2) Pharmacotherapeutics 8 Oncology, hematology, and toxicology. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 469 (2) Pharmacotherapeutics 9 Acute/critical care, neurology, cardiac, GI, infectious diseases, and respiratory. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: PHRM 461.
PHRM 471 (16) Outpatient Advanced Pharmacy Practice Experience Application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in outpatient settings. Patient care will be provided for a wide range of therapeutic areas. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 472 (10) Inpatient Advanced Pharmacy Practice Experience Application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in inpatient settings. Patient care will be provided for a wide range of therapeutic areas. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*

PHRM 473 (5) Selected Advanced Pharmacy Practice Experience Required 4-week experiential clerkship in an area chosen by the student. Diverse options available in such domains as patient care (various settings), research, health policy, education, and others. The available placement options will vary from year to year depending on site/preceptor availability. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 481 (2) Healthcare Quality Improvement Builds on the foundation of patient care and management learning with knowledge about healthcare system improvement. Focuses on principles of quality measurement and quality improvement in health. *This course is not eligible for Credit/D/Fail grading.*
PHRM 491 (6) Experiential Rotation I Community Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of community settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 492 (6) Experiential Rotation II Inpatient Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of inpatient settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 493 (6) Experiential Rotation III Advanced Practice Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in specialized (advanced practice) settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 494 (6) Experiential Rotation IV Ambulatory/Primary Care Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in a variety of ambulatory or primary care settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 495 (6) Experiential Rotation V Community or Inpatient Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in community or inpatient settings. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 496 (8) Experiential Rotation VI Elective Advanced Pharmacy Practice Experience with application of integrated problem-solving skills to resolve increasingly complex drug-therapy problems in community, inpatient, primary care, ambulatory care, or specialized (advanced practice) settings. This elective rotation requires Program Director approval. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
PHRM 499 (1) Comprehensive Examination Assessment of skills in the clinical problem-solving process. Pass/Fail. *This course is not eligible for Credit/D/Fail grading.*
Prerequisite: Successful completion of all other coursework

Specialists of BC

October 31, 2017

Christine Paramonczyk
Director of Policy and Legislation,
College of Pharmacists of BC
200-1765 West 8th Avenue
Vancouver BC V6J 5C6

Dear Ms Paramonczyk:

On June 27, 2016, we provided input on the BC College of Pharmacists Draft Framework as part of a call for such feedback from stakeholders. The timeline was short for such a significant undertaking but we hoped the College would take our response seriously. Unfortunately, the challenges of pharmacists prescribing have not been resolved adequately, and the opportunity we were given to comment again was provided on an even more straitened timeline of less than two weeks (September 28 to October 8, 2017).

The Specialists of BC represent the interests of the almost 5300 medical, diagnostic and surgical specialists within the province. In that context, we reiterate our concerns about the following issues, which have not changed in the ensuing 16 months:

1. Competency/training
2. Conflict of interest for pharmacists who are employed by, are partners in or own pharmacies
3. Scope of practice
4. Fragmentation of care
5. Delays in appropriate care
6. Patient safety
7. Potential for missed or incorrect diagnoses
8. Duplication of services
9. Cost increases
10. Liability/duty of care

As we stated in June of 2016, excepting physicians being trained in pharmacy, or pharmacists being trained in medicine, we think it would be unwise and unsafe for doctors to practice as pharmacists or pharmacists to practice as doctors. Please refer to our letter of June 26, 2016 (copy attached) for supporting documentation.

Yours sincerely,

John Falconer MD, FRCPC
President

cc: Council of Specialists, Doctors of BC

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Pharmaceutical Sciences

Vancouver Campus
2405 Wesbrook Mall
Vancouver, BC Canada V6T 1Z3

Phone 604 827 2673
Fax 604 822 3035
www.pharmacy.ubc.ca

November 7, 2017

Honorable Adrian Dix
Minister of Health and Minister Responsible for the Francophone Affairs Program
Room 337 Parliament Buildings
Victoria, BC V8V 1X4

Dear Minister Dix:

RE: Support for the Certified Pharmacist Prescriber Initiative

The Faculty of Pharmaceutical Sciences at the University of British Columbia (the Faculty) is responsible for training and graduating the pharmacist workforce and also leading pharmacist practice change in the province. We, the leadership team of the Faculty, are writing to express our support for the proposal put forth by the College of Pharmacists of British Columbia to expand the scope of practice for registered pharmacists who work in collaborative health care settings to include prescribing authority.

The Faculty's entry to practice degree for pharmacists is now the Doctor of Pharmacy (PharmD). This professional doctorate program is designed to prepare our graduates for work in collaborative health care teams as the drug therapy expert. Our graduates are trained to know and interpret the drug therapy evidence, establish and implement care plans, make therapeutic decisions, translate therapeutic decisions into good prescribing practice, and take responsibility for patient progress to optimize patient drug therapy outcomes. The Faculty also offers the Flexible PharmD program to enhance the skills of licensed, practicing pharmacists, including therapeutic decision-making, as they take on more clinical roles in collaborative health care settings.

Within the Faculty, the Office of the Associate Dean, Practice Innovation, is responsible for developing and supporting new models of collaborate team based care in BC and integration of the pharmacist into these teams. This portfolio includes the UBC Pharmacists Clinic, the professorship in sustainable health care and the professorship in patient adherence. In addition we continue to work with stakeholders throughout the province in expanding the role pharmacists play as members of collaborative health care teams throughout the continuum of care, including establishing a new model for primary health care delivery.

The purposeful changes in how the Faculty trains pharmacy students and supports practice innovation have been made so pharmacists can take on more drug therapy responsibilities for patients, thereby

enabling other members of the health care team to align their skills and expertise for optimal patient and societal benefit.

We fully support initiatives that leverage the pharmacist skill set within collaborative health care teams, and this includes giving British Columbia pharmacists authority to translate therapeutic decisions and patient care plans into action with prescribing authority.

Sincerely,

Michael Coughtrie BSc(Hons) PhD FCAHS
Professor and Dean

Sandra Jarvis-Selinger PhD
Professor and Associate Dean, Academic

Paul O'Shea BSc PhD
Professor and Associate Dean, Research

Peter Zed BSc(Pharm), ACRP, PharmD, FCSHP
Professor and Associate Dean, Practice Innovation

Thomas Chang PhD
Professor and Associate Dean, Graduate and Postdoctoral Studies

THE UNIVERSITY OF BRITISH COLUMBIA
Pharmacists Clinic
Faculty of Pharmaceutical Sciences

Vancouver Campus
2nd Floor, 2405 Wesbrook Mall
Vancouver, BC Canada V6T 1Z3

Phone 604 827 2584
Fax 604 827 2579
pharmacists.clinic@ubc.ca
pharmsci.ubc.ca/pharmacists-clinic

October 31, 2017

Honorable Adrian Dix
Minister of Health and Minister Responsible for the Francophone Affairs Program
Room 337 Parliament Buildings, Victoria, BC V8V 1X4

Dear Minister Dix:

RE: Support for the Certified Pharmacist Prescriber Initiative

I am writing to express my support for the proposal put forth by the College of Pharmacists of British Columbia to expand the scope of practice for registered pharmacists who work in collaborative health care settings to include prescribing authority.

Here at the UBC Pharmacists Clinic, our pharmacists take responsibility for patient drug therapy outcomes as part of a patient's health care team. Our pharmacists are experienced in translating evidence into practice for specific patient situations, and our physician colleagues increasingly rely on us to make the drug therapy decisions for our mutual patients.

With information from the care team and patient, our pharmacists establish the drug therapy care plans and monitor patient response to therapy. They determine which drug therapies to be started, stopped or changed, and how treatment plan changes can be safely implemented. Care is documented and shared amongst the collaborative team.

The model of practice with pharmacists as part of primary health care teams already exists in other Canadian jurisdictions and has been developed at the UBC Pharmacists Clinic for implementation in British Columbia. Giving pharmacists in collaborative health care settings the authority to prescribe would increase timely patient access to treatment from pharmacists, increase the alignment of prescribing with guidelines and Pharmacare policies, and enable traditional prescribers to leverage their time and scope of practice for optimal patient care.

Thank you for supporting the expanding role for pharmacist prescribing authority in collaborative health care settings in British Columbia.

Sincerely,

Barbara Gobis, BSc(Pharm), ACPR, MScPhm, RPh, PCC
Director, Pharmacists Clinic

Providence HEALTH CARE
How you want to be treated.

Mail 1081 Burrard Street
Vancouver, BC Canada V6Z 1Y6

Office 1190 Hornby Street
Vancouver, BC Canada V6Z 2K5

Tel 604 806 9090
www.providencehealthcare.org

November 03, 2017

Mr. Bob Nakagawa
Registrar
College of Pharmacists of BC
200 - 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Sent via e-mail to: Bob.Nakagawa@bcpharmacists.org

Dear Bob:

RE: Certified Pharmacist Prescribing in Health Authorities

As members of the Senior Leadership Team at Providence Healthcare, we fully support changing the legislation to allow pharmacist prescribing when working as part of a collaborative team in health authority settings. Patient care has become increasingly complex and involves many transitions along the health care journey. Medications are critical in these transitions and if not dealt with appropriately, result in adverse medication events. Our clinical pharmacists are critical in identifying and addressing these gaps in medication transitions.

Clinical pharmacists enter the workforce in our health authorities with years of extensive training in medication management. They are recognized as the medication experts on our health care teams both in acute and ambulatory care settings. Currently, pharmacists routinely provide advice and recommendations for medication prescribing, dose adjustments and monitoring to physicians and nurse practitioners. Research has shown that pharmacist recommendations when acted upon, result in more appropriate prescribing, increased patient safety, improved outcomes, and reduced healthcare costs. Unfortunately these recommendations are frequently not acted upon due to communication gaps and rushed transitions in care, particularly at admission and discharge from hospital. Having prescribing authority is essential to complete the medication transition process. We agree that full prescribing privileges should be limited to those pharmacists who have demonstrated appropriate background knowledge and expertise through a regulated credentialing process beyond their current licensing requirements.

As we move forward with medication reconciliation on discharge, the pharmacist is the best professional to reconcile the patient's medications, communicate to the primary care provider and liaise with the community pharmacy. In order to fulfill this obligation, pharmacists must have the ability to prescribe in order for community pharmacies to accept

...continued

the prescription and connect to the health authority pharmacist for follow up. This would allow for medication transitions in care to be seamless. There is no conflict of interest for health authority pharmacists as they are salaried and have no potential financial gain from this scope of practice.

Health Authority Medical Advisory Committees have already endorsed policies allowing pharmacists to prescribe therapeutic substitutions, put restrictions on drugs, change and monitor therapy, provide antimicrobial stewardship and other clinical activities. The final requirement to fully support appropriate medication management is independent prescribing.

BC has fallen behind many other provinces that have legislation supporting pharmacist prescribing and therefore has forgone an opportunity to utilize a vast, untapped resource of highly specialized expertise. Based on experiences in other provinces, particularly Alberta, this small change in provincial legislation could result in significant improvements to health outcomes and patient's experience with our healthcare system. This could address spiraling healthcare costs and patient harm resulting from too frequent medication related adverse events and inappropriate prescribing.

We strongly support the proposed change in legislation and are confident that such a change will improve patient care across the many health authority settings throughout BC. We are asking for your support to make this critical change.

Sincerely,

Leanne Heppell
Chief Operating Officer Acute Care &
Chief of Professional Practice and Nursing

Dr. Ronald G. Carere, MD
Vice President, Medical Affairs

College of Pharmacists of British Columbia

11. Framework for Pharmacist Prescribing in BC

Alex Dar Santos & Derek Desrosiers

BC Pharmacy Association

Sahil Ahuja & Michelle Ly

UBC Pharmacy Students Advancing Practice

Dr. Greg Egan

Canadian Society of Hospital Pharmacists BC Branch

Gillian Vrooman

Director of Communications & Engagement

UBC Student Pharmacists Advancing Practice

CPBC Board Meeting

November 17, 2017

Who do we represent?

What is our stance?

Student Pharmacists are preparing for and support:

- Patient-centred care
- Team-based collaborative care
- Pharmacist prescribing

Student Pharmacists support the Certified Pharmacist Prescriber Draft Framework which advances practice

Our curriculum is aligned with the BC MoH Patient-Centered Care Framework

The British Columbia Patient-Centered Care Framework

Introduction

Providing patient-centered care is the first of eight priorities for the B.C. health system as articulated the Ministry of Health's strategic plan, *Setting Priorities for the B.C. Health System* (February 2014). Under the strategic plan, the province will strive to deliver health care as a service built around the individual, not the provider and administration. This is not an overnight change, but a promise of a sustained focus that will drive policy, service design, training, service delivery, and service accountability systems.

SUMMARY: AFPC EDUCATIONAL OUTCOMES 2017 – ROLES and KEY COMPETENCIES

ROLE	DEFINITION	KEY COMPETENCIES – Pharmacy Graduates are able to:
CARE PROVIDER (CP)	As **Care Providers,** pharmacy graduates provide patient-centred pharmacy care by using their knowledge, skills and professional judgement to facilitate management of a patient's medication and overall health needs across the care continuum. Care Provider is the core of the discipline of pharmacy.	**CP1:** Practise within the pharmacist scope of practice and expertise. **CP2:** Provide patient-centred care. **CP3:** Actively contribute, as an individual and as a member of a team providing care, to the continuous improvement of health care quality and patient safety.

Curriculum

- Longer clinical experiential clerkships
- Evidence-based learning
- Critical appraisal
- Physical assessment

→ Competence to provide patient-centered care

We know how to work with other students (medicine, nurse practitioners, and nurses) to identify and resolve drug therapy problems.

CPBC Strategic Goal #2:

Work with other regulated healthcare professionals to identify interdisciplinary opportunities for collaboration and improvement in health care services

UBC Team-Based Care Program: Interprofessional Med Rec

In conjunction with Faculty of Medicine and School of Nursing, with support from CPBC

- Over 1385 interprofessional healthcare students & practicing pharmacists participated in this event

Fig. 1. Responses by affiliation to the statement: ***"I developed my collaboration skills with other professionals around medication-related issues."***

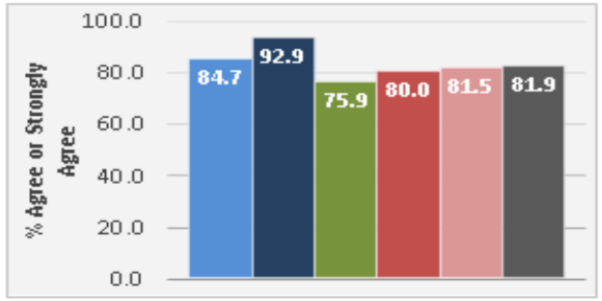
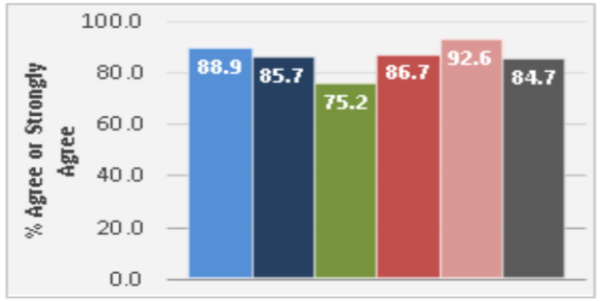


Fig. 2. Responses by affiliation to the statement: ***"Overall, this was a valuable learning opportunity."***



We support evidence based cost-effective pharmacist prescribing

Study	Intervention	Outcomes
RxEach	Cardiovascular Risk Reduction	Significant reduction in risk for cardiovascular events
RxAction	Hypertension management	Clinically important reduction in blood pressure
RxAct	Dyslipidemia management	> 3-fold patients reaching target LDL-C levels
RxIng + Economic Analysis	Insulin initiated in uncontrolled T2DM	Incremental cost savings and delays in development of diabetes-related complications

Cost-effective analysis in healthcare

For us, the EXPANDED scope is the EXPECTED scope

CURRENT PRACTICE:

We see pharmacists make recommendations and HOPE the physician accepts the recommendation.

ADVANCED PRACTICE:

We are being prepared to make recommendations and decisions and TAKE FULL RESPONSIBILITY for our clinical decision.

Thank you for listening to our perspective!

Certified Pharmacist Prescriber
CSHP-BC Branch

Dr. Greg Egan, PharmD, ACPR, BCGP
Clinical Pharmacy Specialist in Geriatric Medicine
Vancouver General Hospital

(Presenting on behalf of CSHP-BC Branch)

Friday, November 17th, 2017

cshp scph

British Columbia Branch

Outline

1. Who?

2. What?

3. Why?

cshp scph

British Columbia Branch

Who?

Canadian Society of Hospital Pharmacy (CSHP)

- National organization of pharmacists in health-authority practice settings
  - Advocacy, education, promotion of best practices
  - Collaborative practice

cshp scph

British Columbia Branch

What?
Pharmacist Prescribing

- Pharmacist in collaborative practice
  - Member of health care team
  - Prescribing by pharmacists
    - Additional training & qualifications
    - Prescribe within scope of expertise
    - Responsible for monitoring plan & follow-up

cshp scph

British Columbia Branch

Why?
Pharmacist Prescribing

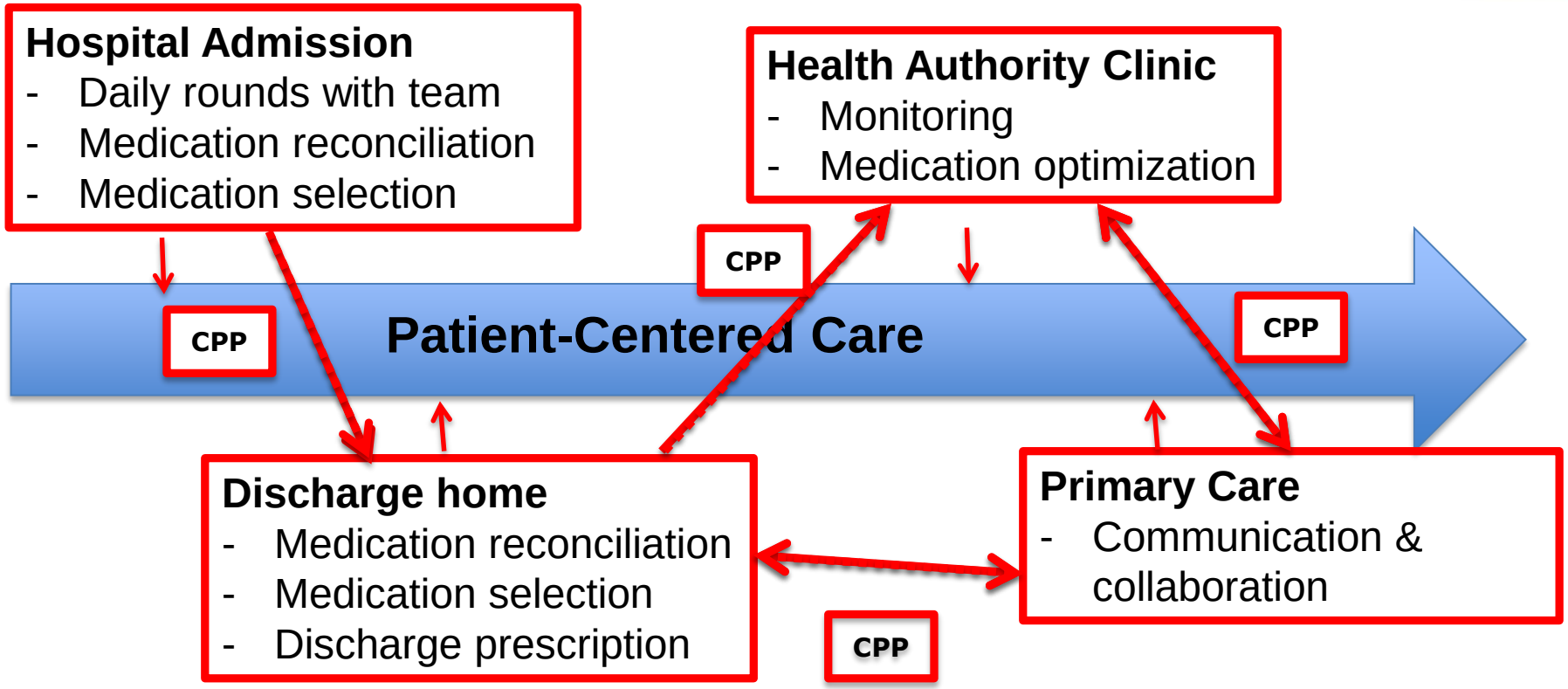
- RxIng, RxAction & RxAct
  - Three randomized controlled trials in Alberta
  - Prescribing performed by pharmacists vs. standard of care
  - 446 patients with hypertension, diabetes or high cholesterol
  - More patients met guideline targets with prescribing by pharmacists
- Cost-benefit analysis for hypertension
  - Prescribing by pharmacists was both more effective and less costly than standard of care

cshp scph

British Columbia Branch

BMJ Open 2013:3:e003154
Circ 2015;132:93-100
Can J Pharm 2016;149:283-292
Can Pharm J 2017;150:184-197

Why?
The Patient Experience



cshp scph

British Columbia Branch

Conclusion

- Who?
  - CSHP-BC
- What?
  - Prescribing by pharmacists
- Why?
  - To improve patient safety & outcomes

=

Better Patient Care

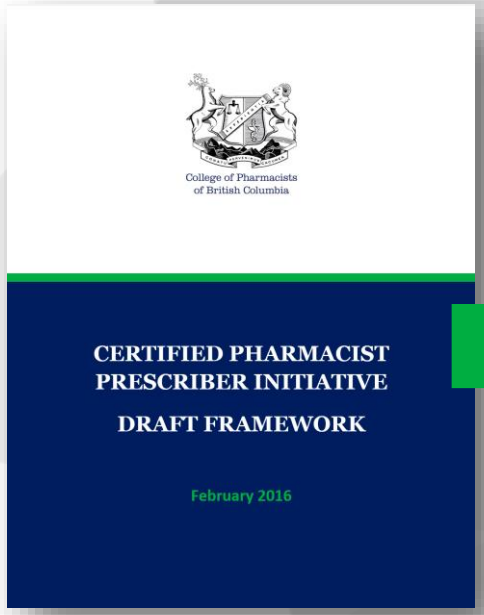
College of Pharmacists of British Columbia

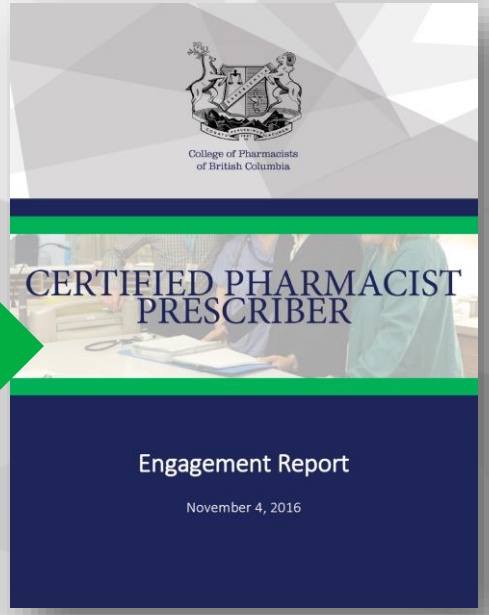
CERTIFIED PHARMACIST PRESCRIBER

Framework for Pharmacist Prescribing in BC
Engagement Report

College of Pharmacists of British Columbia

Developing the Framework for Pharmacist Prescribing in BC





College of Pharmacists of British Columbia

Framework for Pharmacist Prescribing in BC

College of Pharmacists of British Columbia

Greater Focus on Preventing Patient Harm

- Greater emphasis on the role of the pharmacist in preventing patient harm and improving patient outcomes
- Additional examples of improved patient outcomes by pharmacist prescribers:
  - Improved blood glucose (RxING Study)
  - Improved blood pressure (RxACTION Study)
  - Improved lipid levels (RxACT Study)
  - Reduced risk for major cardiovascular events (RxEACH Study)
  - Formal medicine reconciliation within the emergency department reduces the medication error rates for emergency admissions (UK)
  - Medication reconciliation in Canada: Raising the Bar Progress to date and the course ahead

College of Pharmacists of British Columbia

Collaborative Practice Relationship

Two or more regulated health professionals who develop a collaborative relationship to:

- Establish the expectations of each regulated health professional when working with a mutual patient
- Determine mutual goals of therapy that are acceptable to the patient
- Facilitate communication
- Share relevant health information

College of Pharmacists of British Columbia

Access to Relevant Health Information

Information from the patient – current medications, medications take recently, previous reactions, adherence.

Information from PharmaNet – medication history including dates of filled and adverse reactions.

Information from patient medical records – medications prescribed (not necessarily filled), previous adverse reactions, diagnostics including laboratory tests history including dates of filled and adverse reactions.

Information from others involved in care – case notes, goals of drug therapy, history of effectiveness in meeting patient's goals, any other relevant insights into patient's ongoing care and condition(s).

College of Pharmacists of British Columbia

Addressing Conflict of Interest

Limits

3. A Certified Pharmacist Prescriber that prescribes a medication for a patient must not dispense that medication.

Ensuring that important check at dispensing continues to occur

College of Pharmacists of British Columbia

Eligibility Requirements

- Meeting eligibility criteria
- Self assessment
- Evidence based competency evaluation
  - Demonstrate understanding of patient care process
  - Submission of three patient cases within the last 2 years Describe how patient information is gathered with supporting examples.
- Educational program
  - Preparatory Courses for Certified Pharmacist Prescribers (optional)
  - Pharmacist Prescribing Course Program (required)
- Annual self-declaration and additional 15 units of continuing education

College of Pharmacists of British Columbia

Pharmacist Prescribing Engagement

College of Pharmacists of British Columbia

Process

College of Pharmacists of British Columbia

Engagement Process

CONSULTATION

PHARMACY PROFESSIONALS/ OTHER HEALTH CARE PROFESSIONALS/ PATIENTS

- Workshops and discussions
- Letters and emails
- Online survey

Report on engagement

Analysis of feedback used to develop Engagement Report

Board decision

Report on engagement reviewed and decision needed on how to proceed. Engagement Report Posted on college website.

Update draft framework

CONSULTATION

PHARMACY PROFESSIONALS/ OTHER HEALTH CARE PROFESSIONALS/ PATIENTS

- Workshops and discussions
- Online survey
- Letters and emails

Report on engagement

Analysis of feedback used to develop Engagement Report

Board decision

Second report in engagement reviewed and decision needed on how to proceed. Engagement Report posted.

2016

College of Pharmacists of British Columbia

2017 Engagement Overview

- 1,122 completed responses (and over 10,000 comments) through an online survey
- 3 live engagement sessions
- 152 social comments and 471 reactions
- 10 letters

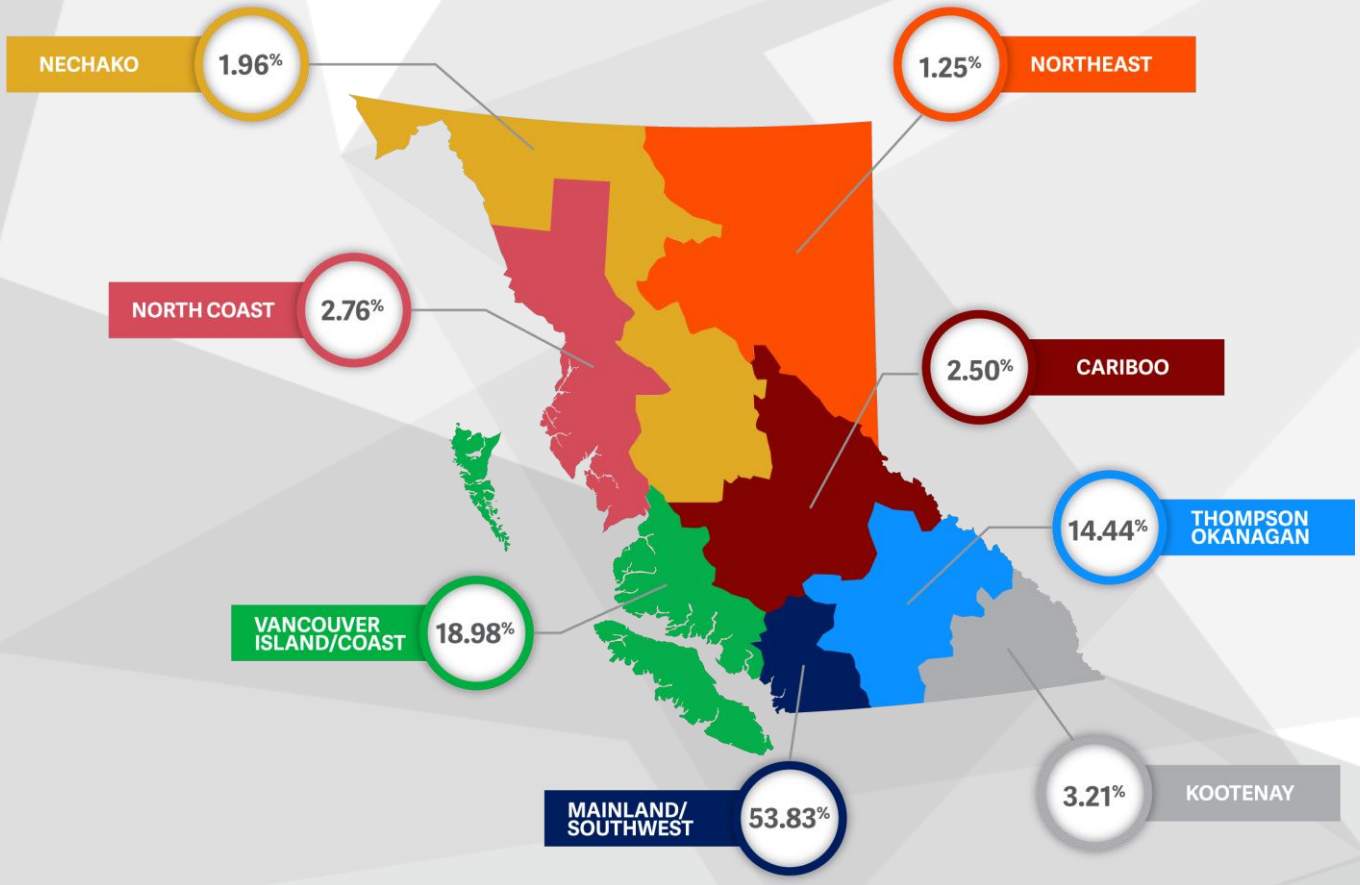
Plus a compilation of endorsement letters for pharmacist prescribing from senior hospital administrators from Health Authorities across British Columbia and *180 letters of support collected by CSHP-BC from physicians, nurses, allied health, and patients who work closely with pharmacists in everyday practice.*

College of Pharmacists of British Columbia

Who did we engage with?

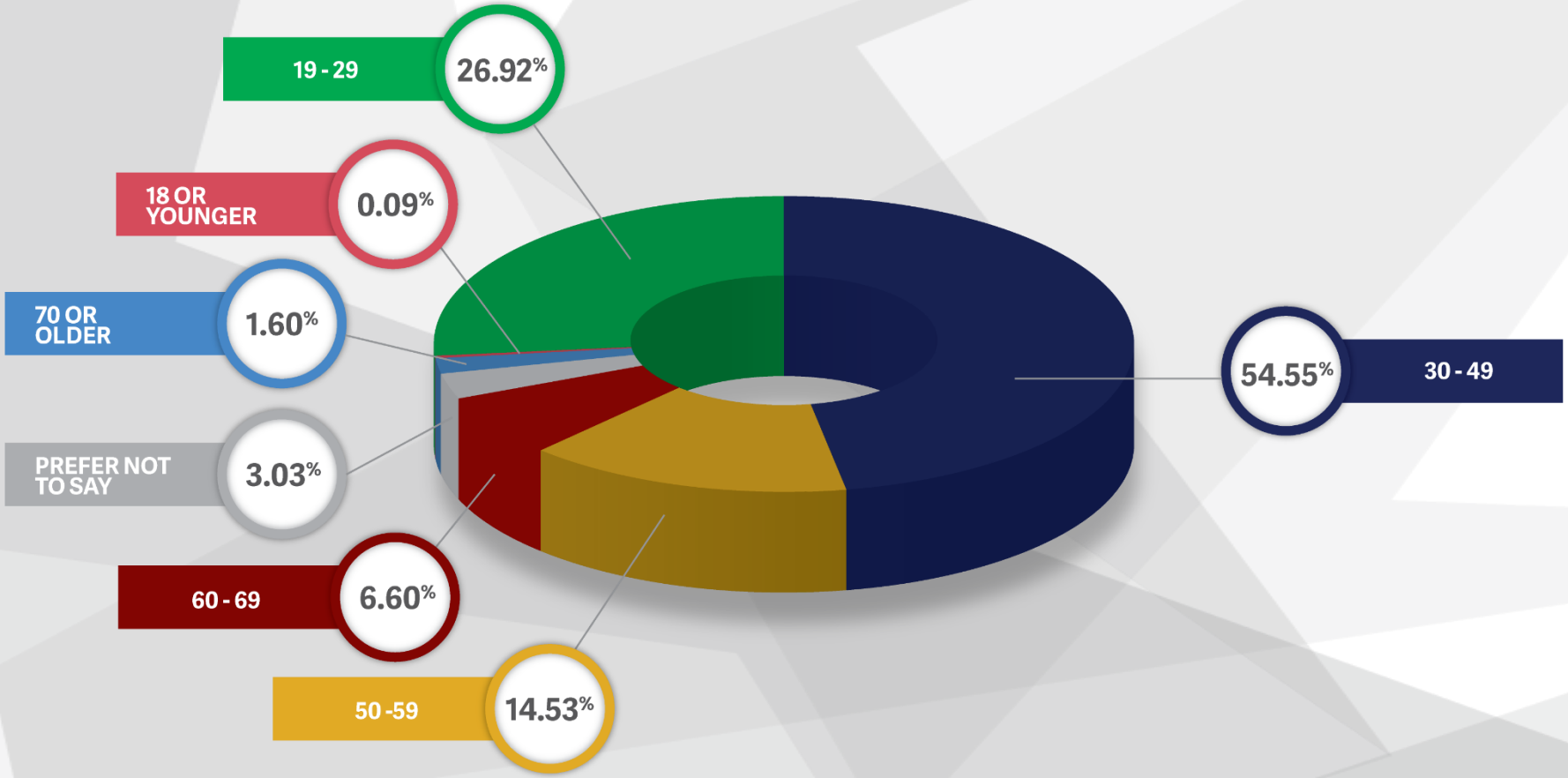
College of Pharmacists of British Columbia

We heard from all over BC...



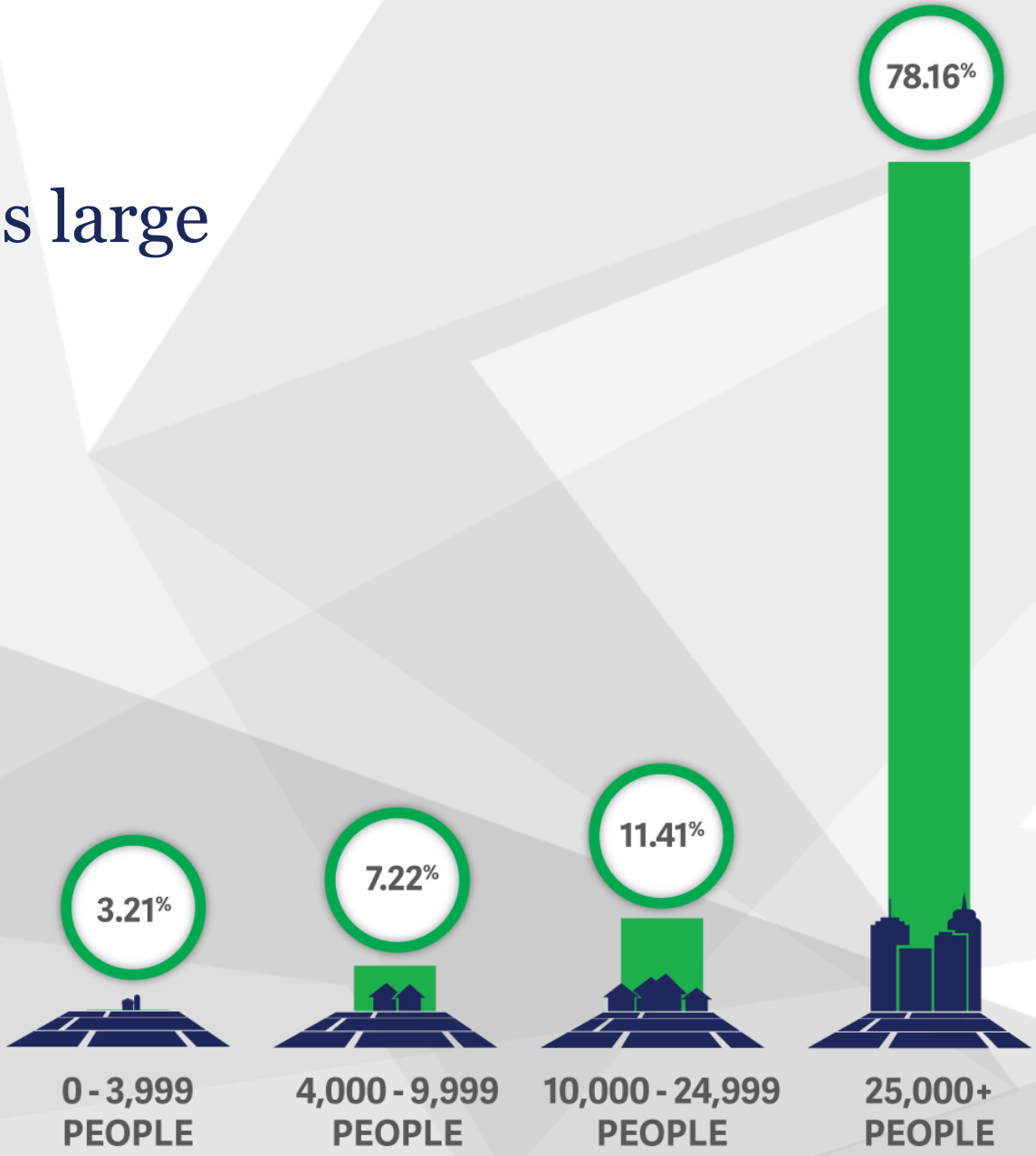
College of Pharmacists of British Columbia

From various different age groups...



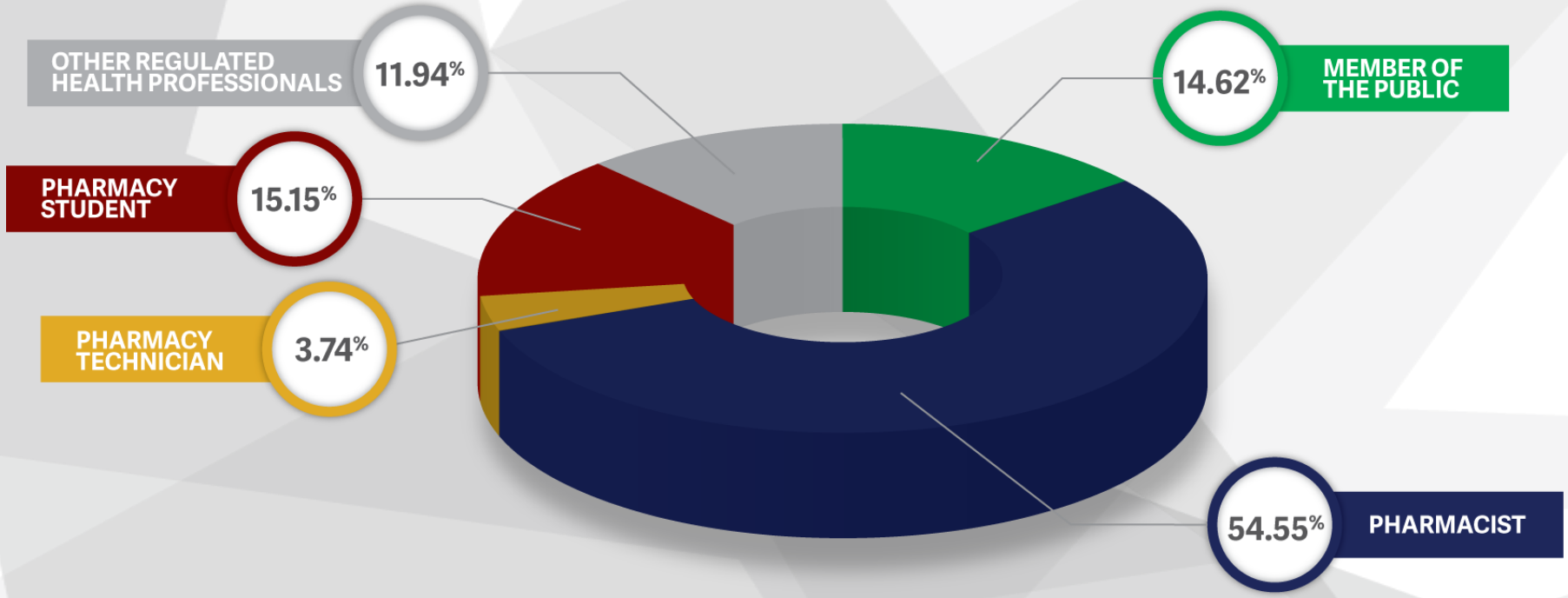
College of Pharmacists of British Columbia

Communities large and small...



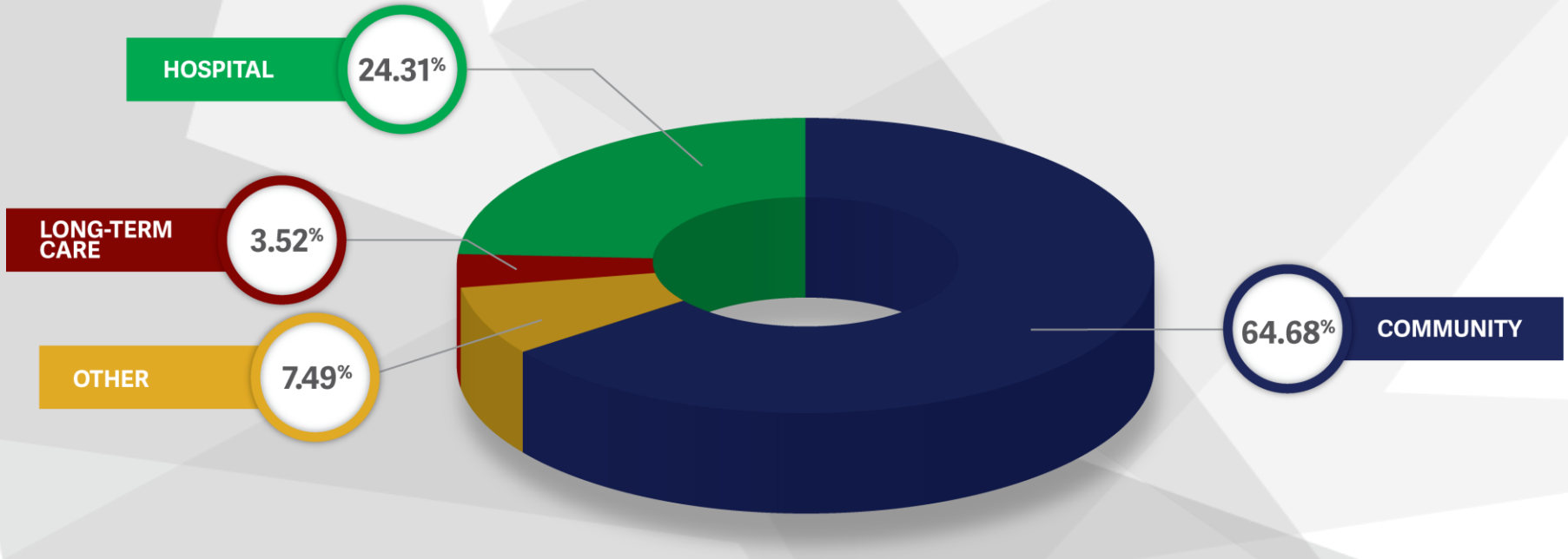
College of Pharmacists of British Columbia

Different stakeholder groups…



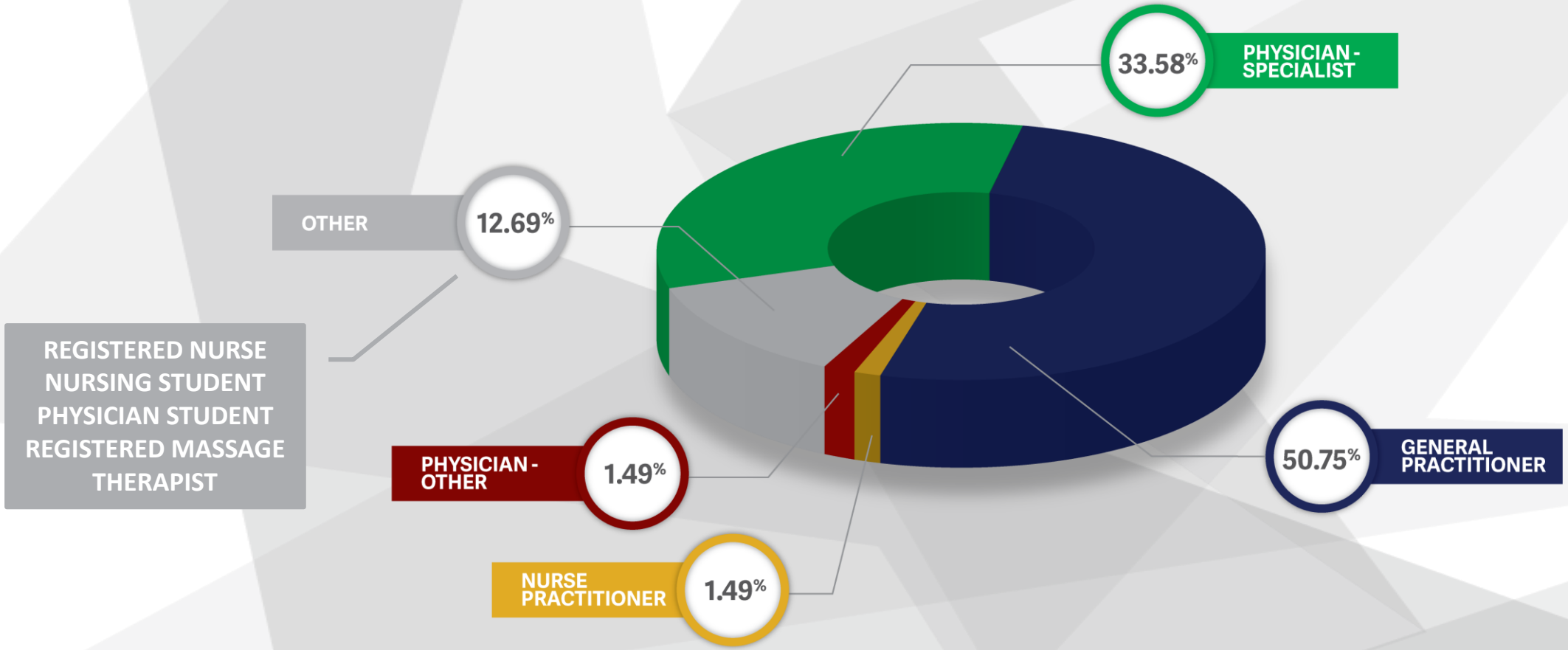
College of Pharmacists of British Columbia

Pharmacy professionals working in different practice settings…



College of Pharmacists of British Columbia

And other health professionals



College of Pharmacists of British Columbia

We also reached and heard from stakeholders through social media…

Facebook

- 58,000 reached through Facebook
- 470 reactions to pharmacist prescribing posts
- over 150 comments on pharmacist prescribing posts

Twitter

- 2,800 reached

Instagram

- 5,800 reached

College of Pharmacists of British Columbia

Letters and emails…

- BC Cancer Agency
- BC Pharmacy Association
- Canadian Society of Hospital Pharmacists – BC Branch
    - *endorsement letters from Health Authorities across British Columbia* and *180 letters of support from physicians, nurses, allied health, and patients*
- Canadian Association of Pharmacy Students and Interns
- Doctors of BC
- Provincial Health Services Authority, Lower Mainland Pharmacy Services
- UBC, Faculty of Pharmaceutical Sciences
- UBC Pharmacists Clinic
- Specialists of BC

College of Pharmacists of British Columbia

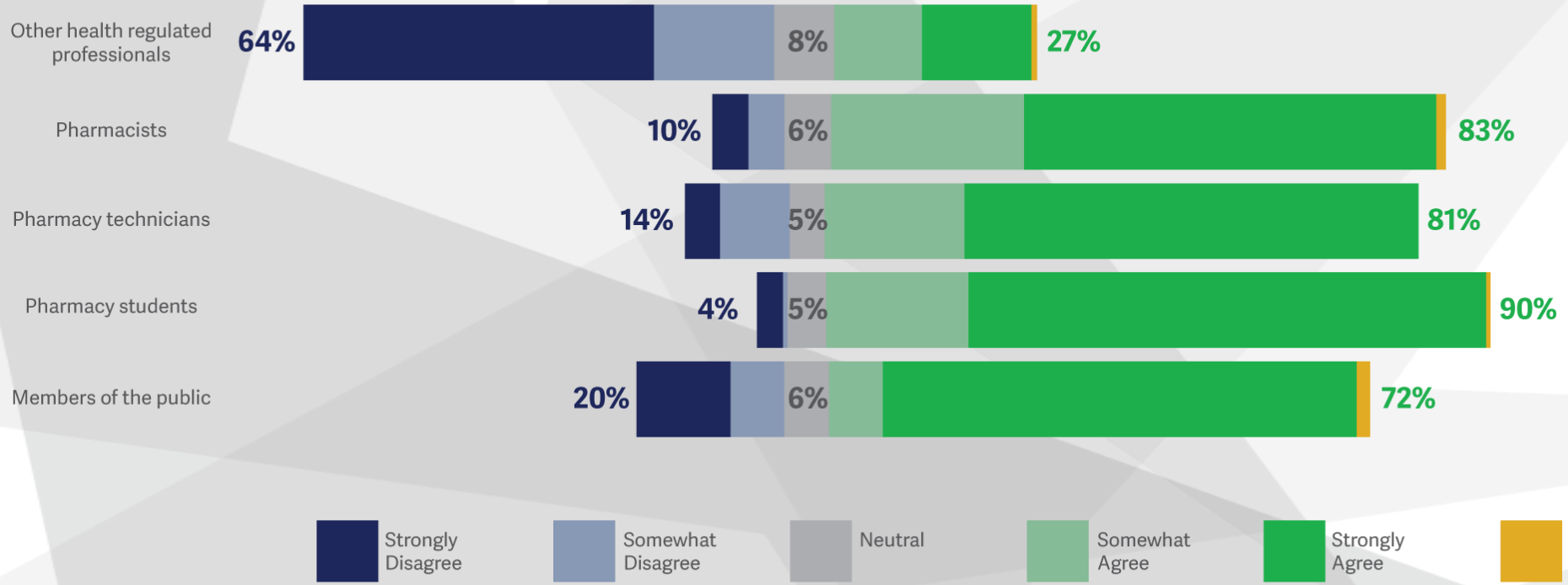
What did we hear?

College of Pharmacists of British Columbia

Confidence in Pharmacist Prescribing

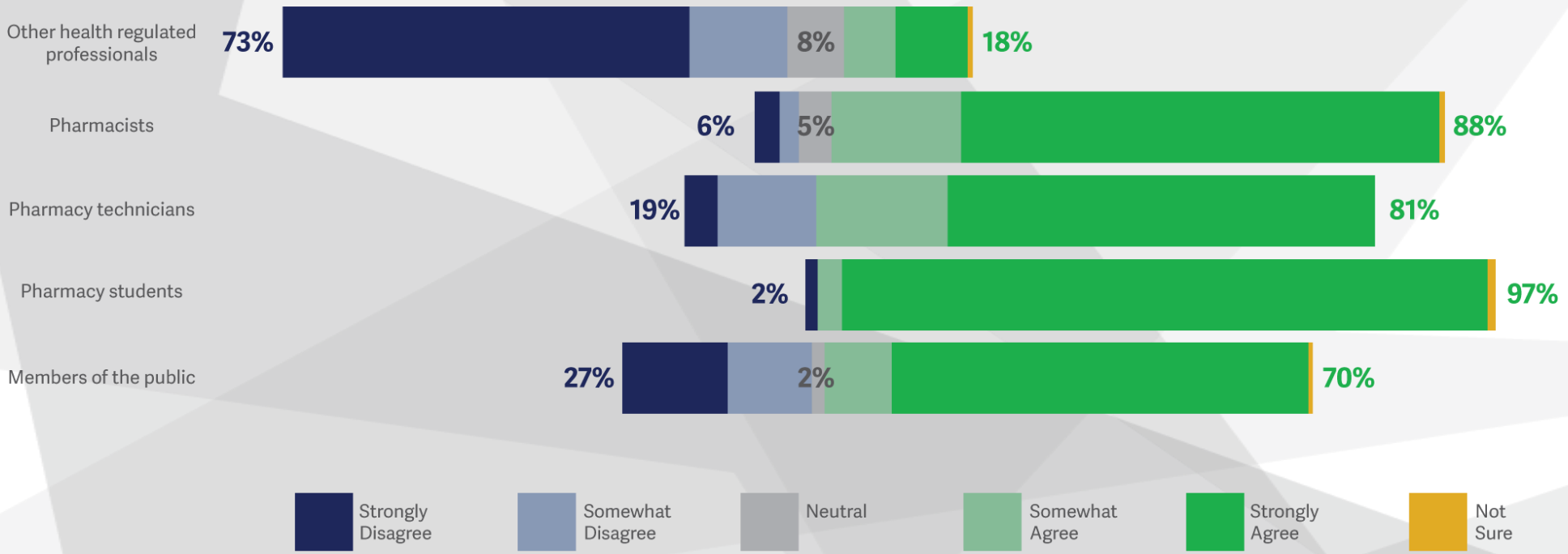
College of Pharmacists of British Columbia

The requirement for a collaborative practice relationship between a Certified Pharmacist Prescriber and other regulated health professionals gives you confidence in pharmacist prescribing.



College of Pharmacists of British Columbia

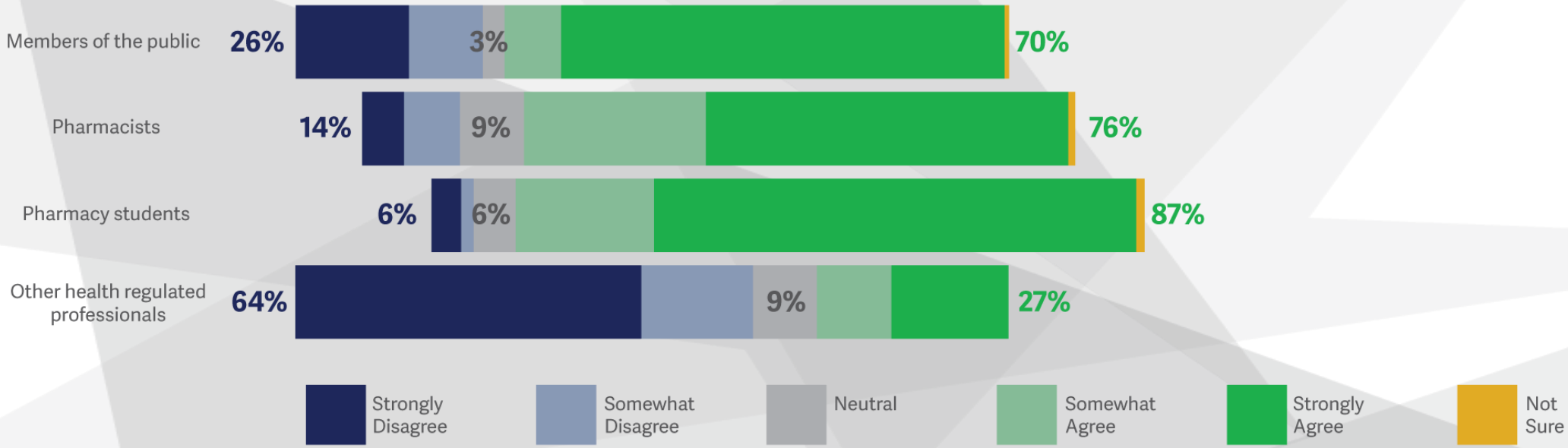
You have confidence in a Certified Pharmacist Prescriber's ability to make a safe and effective prescribing decision for a patient.



College of Pharmacists of British Columbia

As part of this framework, the diagnosis is still provided by physicians or nurse practitioners (or other health professional with prescribing authority).

This would give you confidence a Certified Pharmacist Prescriber helping to care for patients.



College of Pharmacists of British Columbia

PUBLIC RESPONDENT

"I feel that a Certified Pharmacist Prescriber would be more current in their knowledgeable about the medications and their best use for me." – Patient

"If the pharmacist if truly working with the doctor, why can't the doctor decide on the prescription? The pharmacist can advise-that is their role." – Patient

PUBLIC RESPONDENT

PUBLIC RESPONDENT

"I think healthcare providers NEED to collaborate on patient care. Long gone are the days of seeing one professional for the be-all-end-all. Humans are complex. Complexity requires different minds and multiple perspectives to complement each other on deciding what is best for the patient." – Patient

College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

"A collaborative practice is already what is the norm in my practice. In the hospital, pharmacists work very closely with physicians and plans are discussed together. Establishing a collaborative practice as a certified pharmacist prescriber is a natural next step and does not actually change the model of established team-based patient care."

"No time for collaboration as we have to check rxs for appropriateness, safety, interactions, injections, adaptations, emergency supplies and the list goes on and on and on.... we are working in mess right now..."

PHARMACIST RESPONDENT

PHARMACIST RESPONDENT

"However, the relationship is built through trust and experience. We need to start somewhere and give it a chance. The starting/establishing can be challenging because it may be the first collaborative relationship ever."

College of Pharmacists of British Columbia

OTHER HEALTH PROFESSIONAL RESPONDENT

"Pharmacists are not trained clinicians. I cannot trust they have the broad clinical background to be able to safely prescribe medication."
– General Practitioner

"Diagnosis is becoming more complex as are patient considerations for rx. without knowing complete past medical history and current confounding medical issues I highly doubt effective and safe prescribing in many cases. In simple, healthy, minor issues (eg. tinea) it could be fine. otherwise I see it as high risk and another way for fragmented care."

– General Practitioner

OTHER HEALTH PROFESSIONAL RESPONDENT

OTHER HEALTH PROFESSIONAL RESPONDENT

"Too much time commitment for physicians." – Physician Specialist

College of Pharmacists of British Columbia

OTHER HEALTH PROFESSIONAL RESPONDENT

"Currently work in a team-based primary health care clinic. Would allow us to make much more efficient and effective use of our team members if we had a pharmacist prescribing in line with diagnosis provided by another member of the team and in line with our goals of care." – Nurse

"Have the pharmacist involved in the patients care/reviewing medications order by provider/clarifying and adjusting orders to meet the patients needs." – Nurse

OTHER HEALTH PROFESSIONAL RESPONDENT

College of Pharmacists of British Columbia

OTHER HEALTH PROFESSIONAL RESPONDENT

"The wait to see a physician is very long. If they still have to diagnosis a condition it defeats the purpose of having a pharmacist to prescribe. Whole point of having pharmacists prescribe is to decrease wait times and increase access to drug therapy fast." – Nurse

"What is concerning in the recent draft framework is the notion that pharmacists, in order to prescribe at all, require oversight from physicians or nurse practitioners, who would diagnose and provide access to lab test results." – BC Pharmacy Association

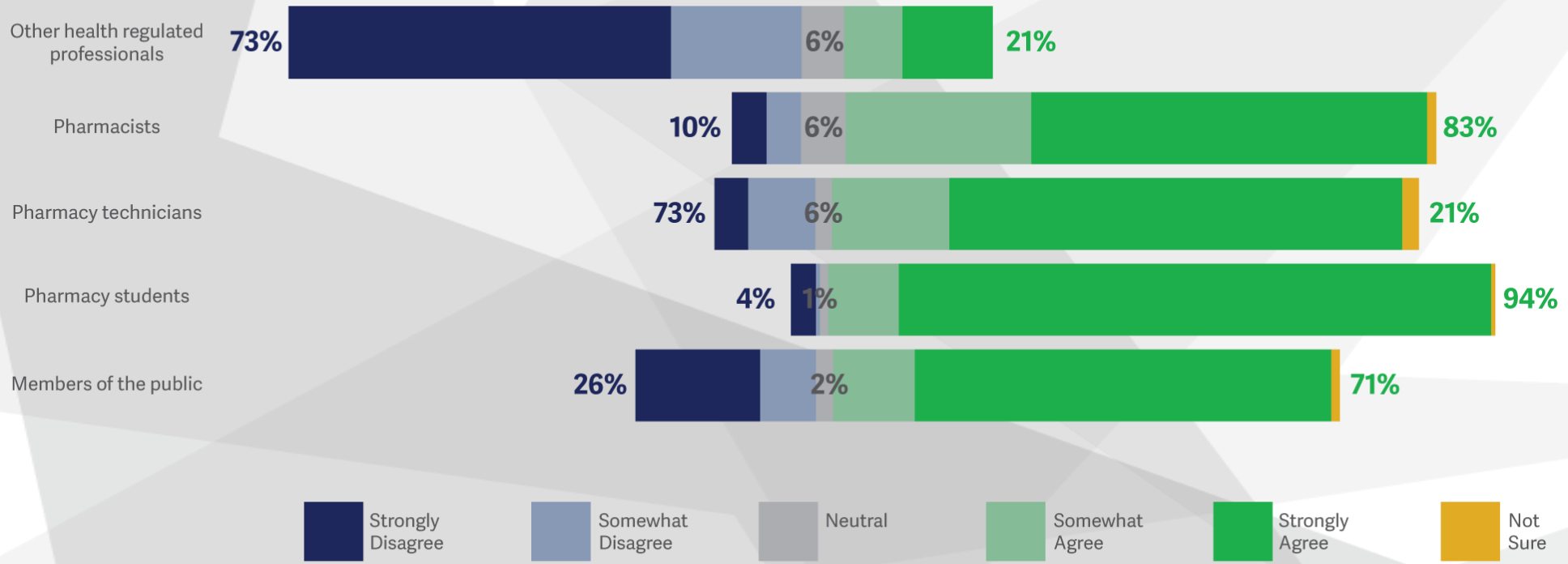
PHARMACIST RESPONDENT

College of Pharmacists of British Columbia

Eligibility requirements…

College of Pharmacists of British Columbia

The requirement to complete an education program and assessment to become a Certified Pharmacist Prescriber gives you confidence in a pharmacist prescribing.

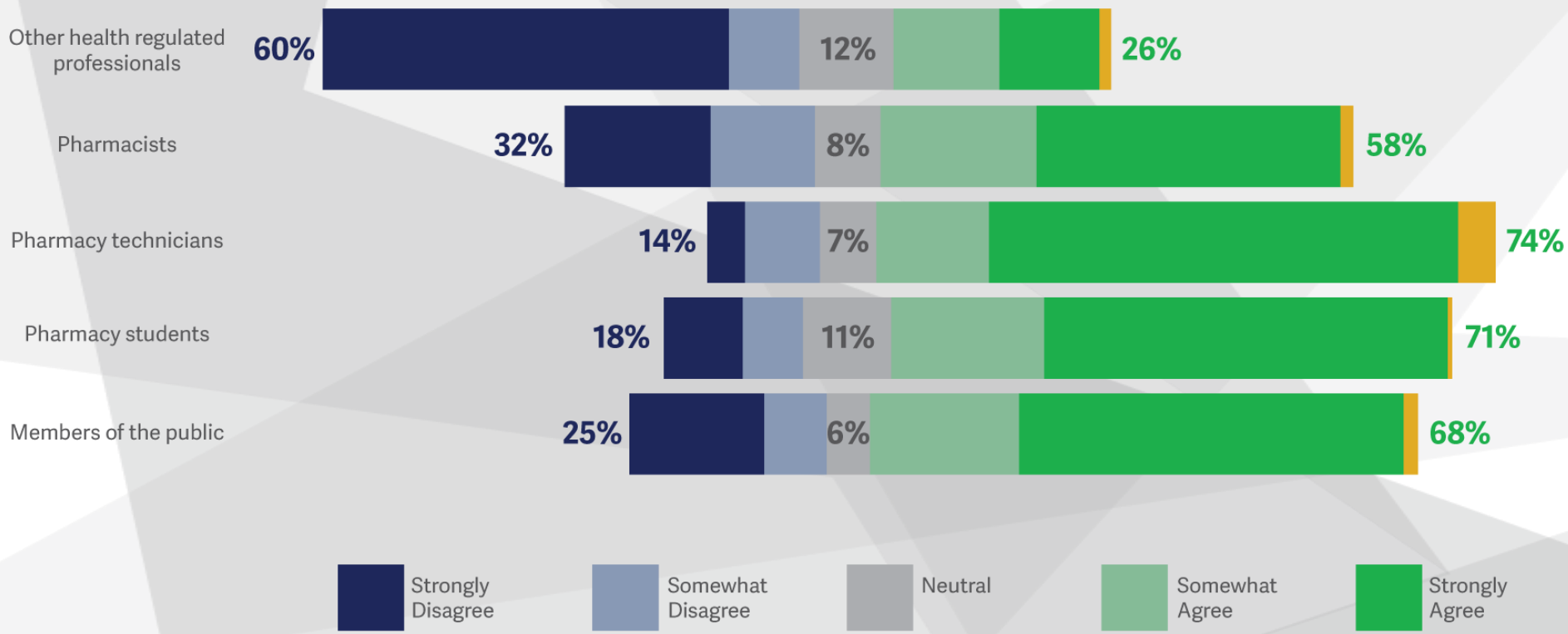


College of Pharmacists of British Columbia

Addressing conflicts of interest…

College of Pharmacists of British Columbia

Does the separation between prescribing and dispensing give you confidence that the potential conflict of interest in prescribing and dispensing has been addressed?



College of Pharmacists of British Columbia

PUBLIC RESPONDENT

"This is a good idea and would help me feel confident that there wasn't a benefit to a pharmacist for prescribing one drug over another."

PUBLIC RESPONDENT

"As long as I don't have to drive to a completely different pharmacy. This may pose a difficulty in small towns… what if they have to drive to another pharmacy to have it dispensed?" – Patient

PUBLIC RESPONDENT

"Yes but this is silly if we trust a healthcare professional then we should give them full trust Naturopathic doctors sell vitamins out of their office Isn't that the same conflict Also it would benefit a pharmacist now to sell me every otc medication possible when I have a cold but they don't do that." – Patient

PUBLIC RESPONDENT

"The pharmacists should be at different locations or be part of different companies. This would give me more confidence that conflict of interest is appropriately managed." – Patient

College of Pharmacists of British Columbia

OTHER HEALTH PROFESSIONAL RESPONDENT

"Do they work in the same pharmacy? There can be a general incentive to increase the business to the pharmacy." – General Practitioner

OTHER HEALTH PROFESSIONAL RESPONDENT

"If it were another pharmacy that dispensed the medication, I would be satisfied the COI was addressed." – Physician Specialist

OTHER HEALTH PROFESSIONAL RESPONDENT

"This is reassuring to me. I would hope that the separation would be between pharmacies as well, thus preventing conflict of interest." – Physician Specialist

OTHER HEALTH PROFESSIONAL RESPONDENT

"I actually don't see the need for this if there is proper collaboration and defined "rules" for the management of prescriptions by the pharmacist. Surgeons don't prescribe operations for other surgeons to carry out. If the concern is financial then there should be some regulation that prevents that. I don't see a professional issue otherwise." – Physician Specialist

College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

"In a small pharmacy with only one or two pharmacists this does provide limitations. Although I do feel it is an important separation. I do think that patients should be able to have the choice to take it to another pharmacy if they want to. That being said code of ethics should also be a driving force for a pharmacist being able to both prescribe and dispense."

– Pharmacist

PHARMACIST RESPONDENT

"This an extremely fair and reasonable stipulation and helps negate any conflict of interest. However, this may not be an option in rural areas or in areas where there would only be a single pharmacist on duty at any one time. Or there may be only a single pharmacist in a particular region. – Pharmacist

PHARMACIST RESPONDENT

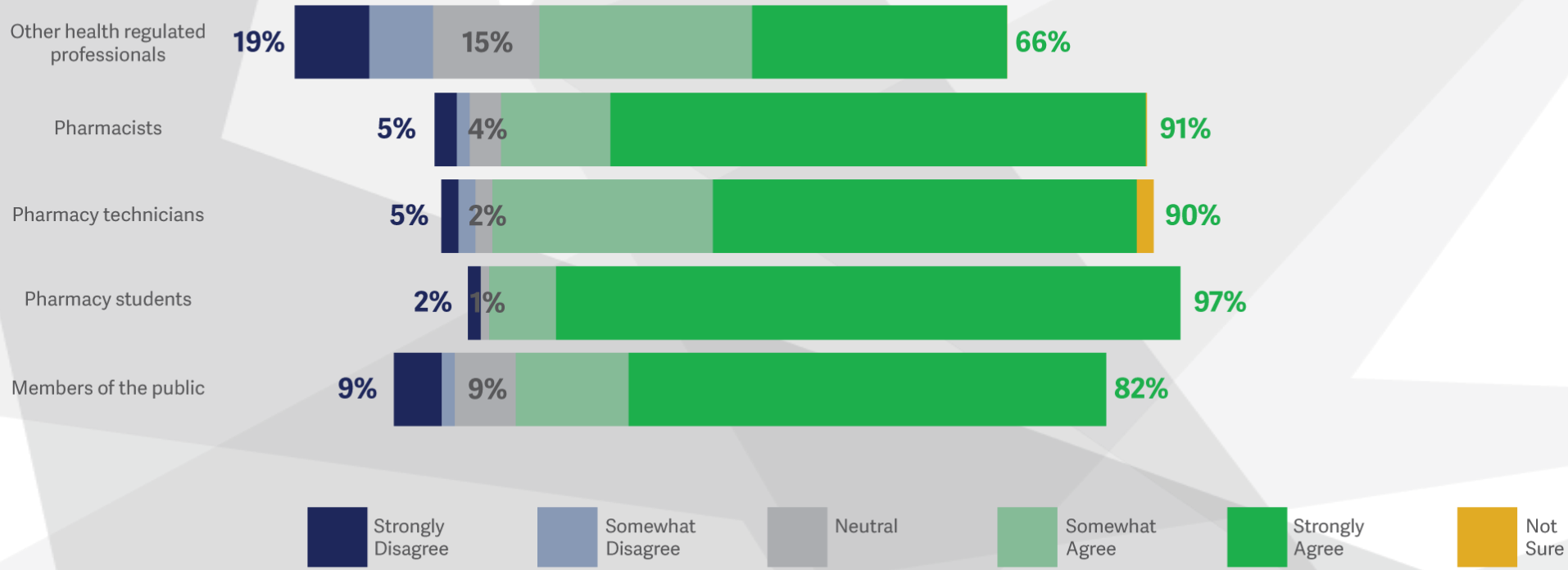
"A known critical success factor for implementation of pharmacist prescribing in other jurisdictions is the absence of perceived or actual COI related to dispensing what has been prescribed. This should be extended to address pharmacist prescribers in the same dispensing environment. I'd prefer that this not be allowed." – Pharmacist

College of Pharmacists of British Columbia

Collaboration

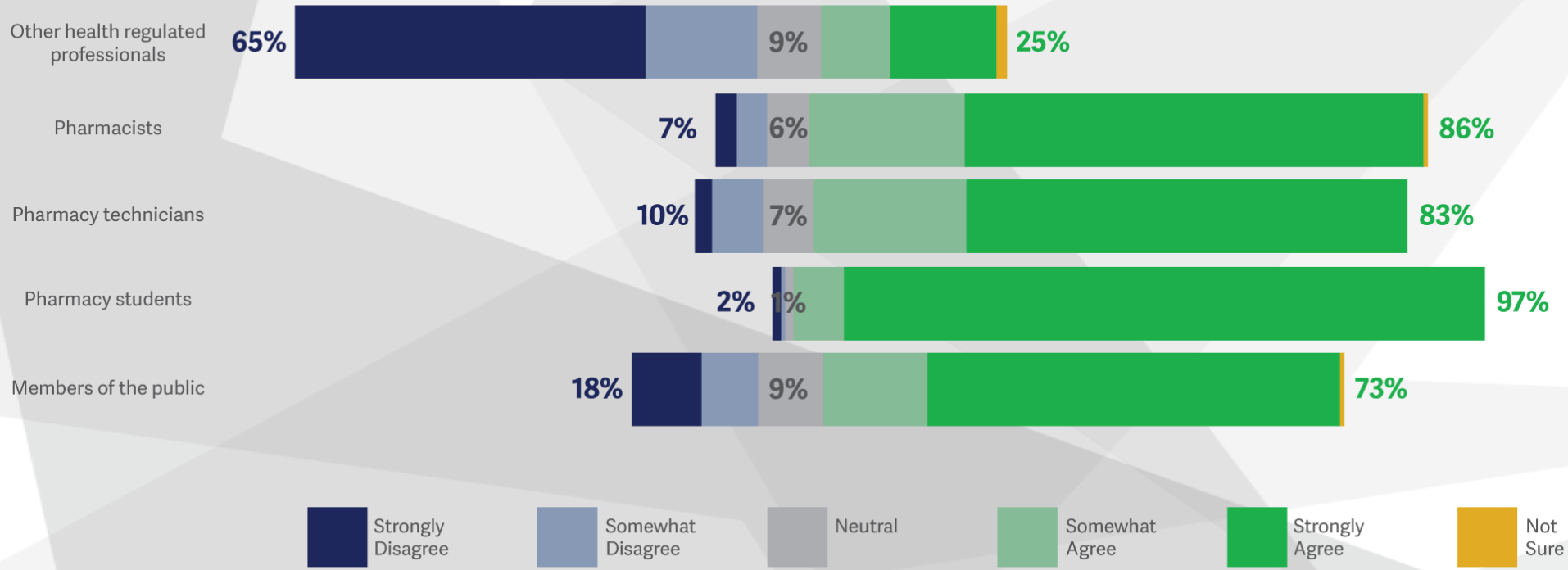
College of Pharmacists of British Columbia

You would like to see more collaboration between primary health care providers (or other health professionals involved in the care team) and pharmacists in providing care.



College of Pharmacists of British Columbia

You have confidence that a Certified Pharmacist Prescriber would appropriately collaborate with others on the care team to ensure patients receive safe and effective care.



College of Pharmacists of British Columbia

PUBLIC RESPONDENT

"I think if there was an issue too large for my pharmacist to handle, he would refer me where appropriate or communicate with other health care professionals to help solve the issue in a timely fashion." – Patient

PUBLIC RESPONDENT

"Don't really see it happening with existing health care professionals so why would this be any better." – Patient

PUBLIC RESPONDENT

"This would allow me to trust that the level of care needed for me is appropriate as it has been discussed between two health professionals." – Patient

PUBLIC RESPONDENT

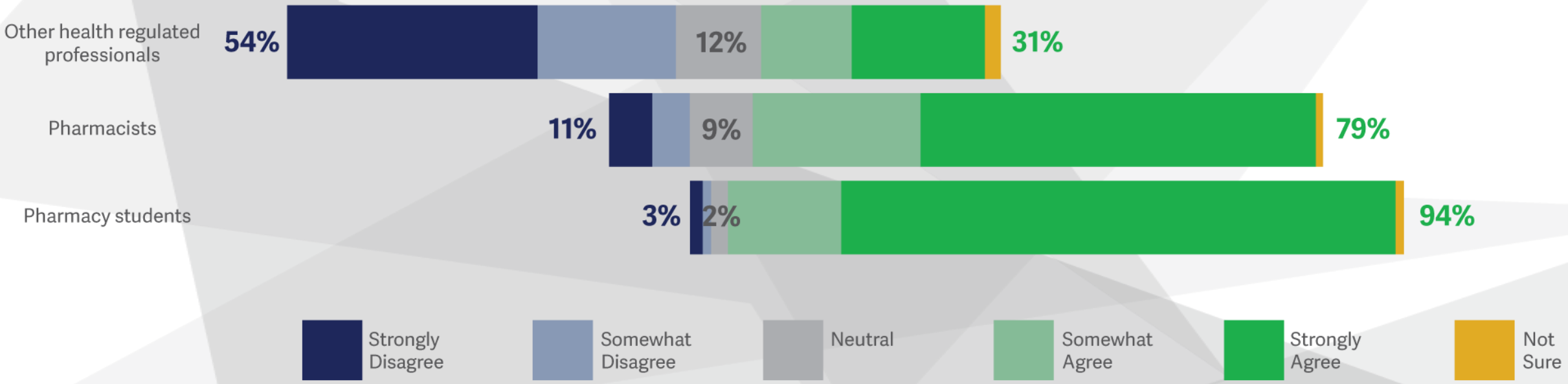
"In a large centre I don't think I could expect my GP to develop a relationship with my pharmacist because my pharmacist is frequently not the same person even though I'm getting my prescription filled at the same pharmacy." – Patient

College of Pharmacists of British Columbia

Collaborative practice relationship…

College of Pharmacists of British Columbia

The collaborative practice relationship will support the collaboration needed between a Certified Pharmacist Prescriber and other health care professionals to safely prescribe, monitor, follow-up and adjust a patient's drug therapy.



College of Pharmacists of British Columbia

OTHER HEALTH PROFESSIONAL RESPONDENT

"My confidence would be strengthened were the proposed changes envisioned as being part of the emerging Patient Medical Home model of primary care practice in B.C. and not a separate pharmacy-run structure in any way running 'parallel' to regular models of care."
– General Practitioner

OTHER HEALTH PROFESSIONAL RESPONDENT

"It would allow an informed member of the interdisciplinary team to rake on responsibility for aspects of patient care, in their area of specialty."
– Nurse

OTHER HEALTH PROFESSIONAL RESPONDENT

"I would like to have a PharmD as part of team based care in my practice. This person would know and understand the patient with the patient consent and communicate directly with me. This model was trialled in my office and is well received." – General Practitioner

College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

"The more communication there is, the better understanding the pharmacist will have of the patient and their needs and the better care they can provide."
– Pharmacist

PHARMACIST RESPONDENT

"This an extremely fair and reasonable stipulation and helps negate any conflict of interest. However, this may not be an option in rural areas or in areas where there would only be a single pharmacist on duty at any one time. Or there may be only a single pharmacist in a particular region. – Pharmacist

STUDENT RESPONDENT

"Having a mindset in which the patient is prioritized first, and working together to achieve universal health goals for the patient." – Pharmacy Student

PHARMACIST RESPONDENT

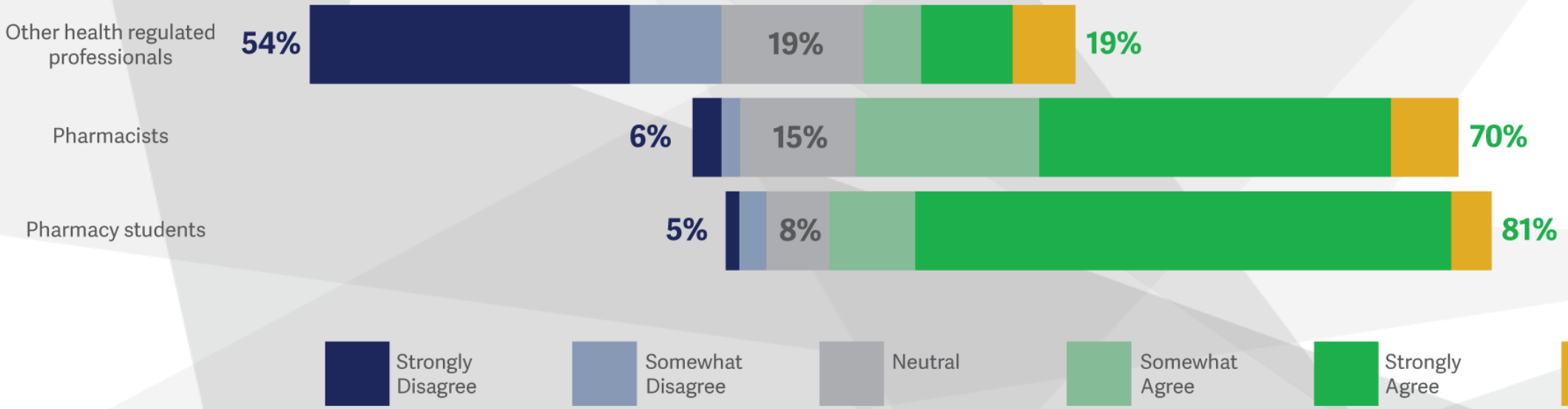
"Pharmacotherapy decision making is inherently complex and we have to stop pretending that it isn't. Greater collaboration allows for all factors to be considered and brought forward to the patient for truly informed care planning." – Pharmacist

College of Pharmacists of British Columbia

Access to information and documentation…

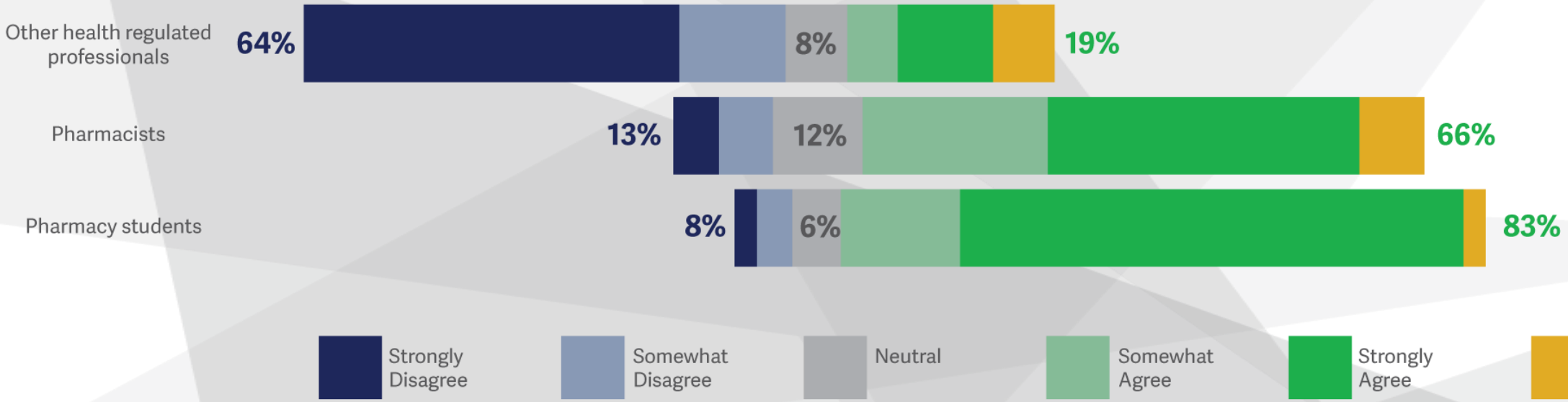
College of Pharmacists of British Columbia

The information sharing requirements within the Framework for Pharmacist Prescribing is sufficient for documentation and reporting back.



College of Pharmacists of British Columbia

The health information access requirments within the Framework for Pharmacist Prescribing is sufficient to support pharmacist prescribing in a collaborative relationship.



College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

"Currently pharmacists practice somewhat in a void with respect to diagnosis and lab/medication dose history. Access to blood pressure, blood lipid & blood sugar history, are examples of labs that would facilitate prescribing decisions."
– Pharmacist

PHARMACIST RESPONDENT

*"Pharmacists should NOT have to request such information from other health care professionals. This EXCLUDES the pharmacist from the patient's "circle of care". Pharmacists should be given the authority to access relevant patient information (e.g. INR, lytes, etc.) without having to contact other health care professionals. *EVEN if pharmacists are not granted prescribing authority, access to relevant medical history is ESSENTIAL to patient medication management." – Pharmacist*

PHARMACIST RESPONDENT

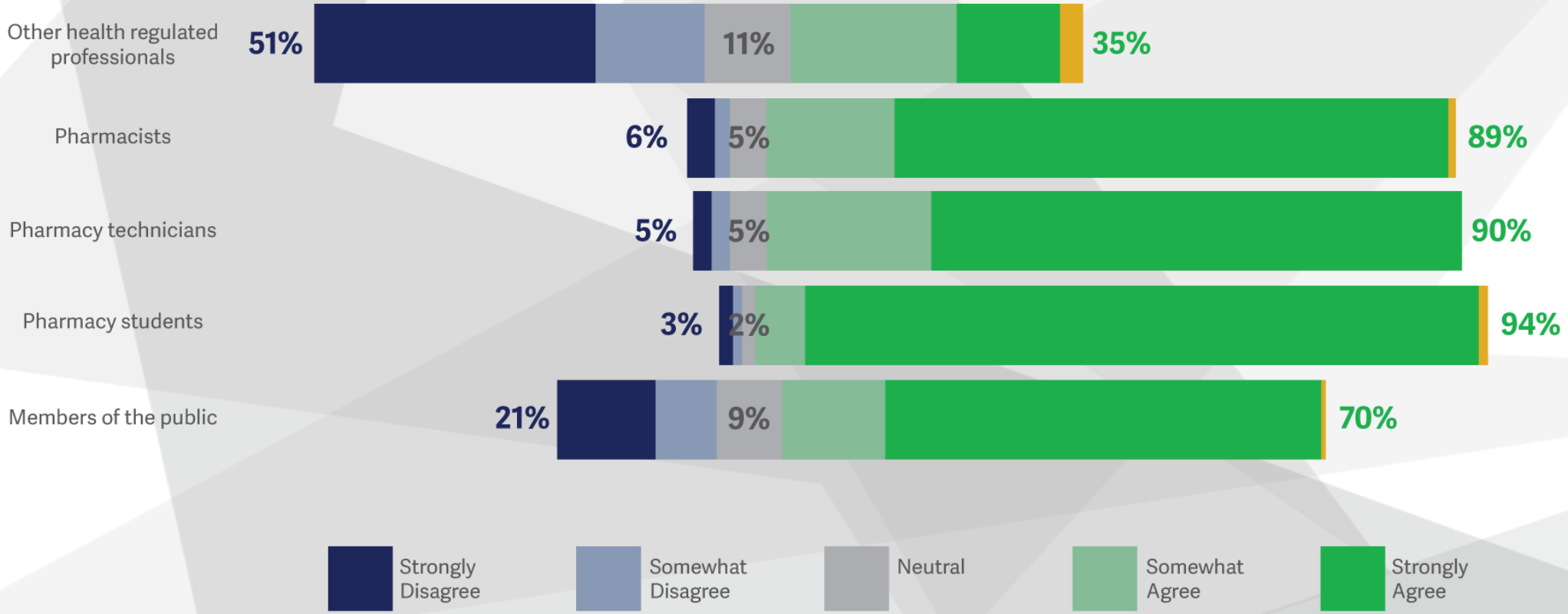
"Both parties should have the same information available to them to be truly collaborative. Each individual should be able to review information so there is not an error in communication potentially being relayed from one person to another. There is a greater chance of error". – Pharmacist

College of Pharmacists of British Columbia

Improving Patient Care

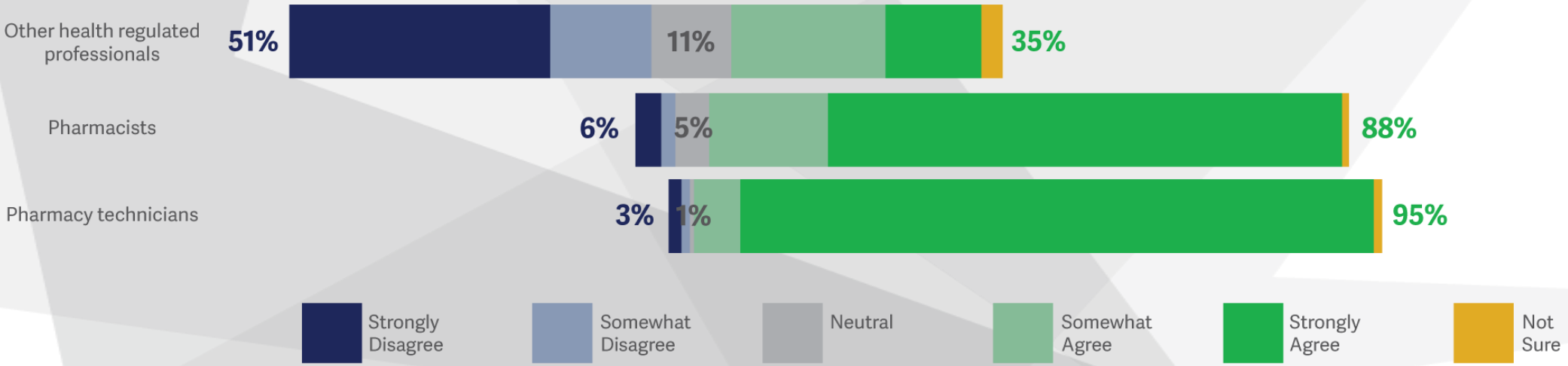
College of Pharmacists of British Columbia

Some patients could find receiving care from a Certified Pharmacist Prescriber more accessible.



College of Pharmacists of British Columbia

Access to a Certified Pharmacist Prescriber could improve timely access to drug therapy for some patients.



College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

"It is absolutely ridiculous that we have to send our patients back to emergency when they come in with a prescription that isn't complete or has an issue. For example and antibiotic with a significant drug interaction or an allergy to antibiotic prescribed. With a diagnosis and access to lab values pharmacist should be able to change the antibiotic without putting strain on the emergency system if the prescribed isn't able to be reached. Also it can take a week or more to see primary health provider. – Pharmacist

OTHER HEALTH PROFESSIONAL RESPONDENT

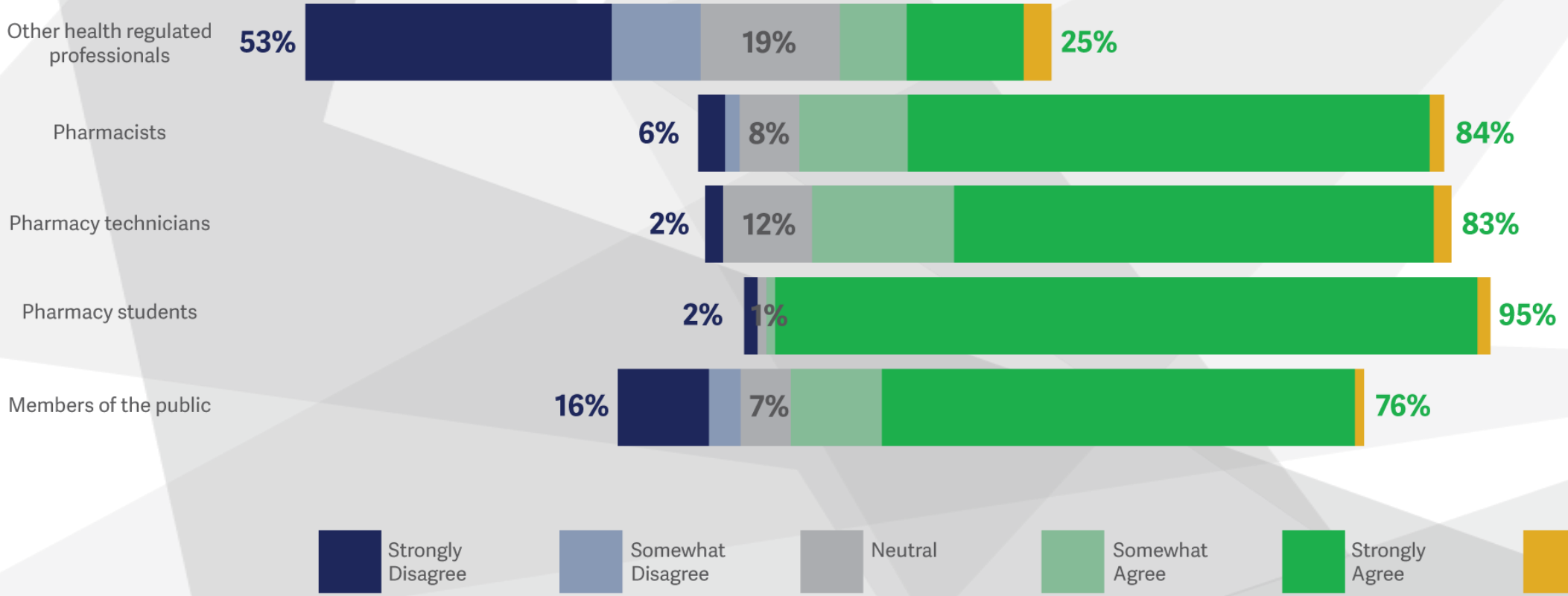
"Although ease of access would be improved, as I have stated, pharmacists often have a limited appreciation of the full picture of what's going on with patients. I don't think this is a great practice model." – Physician Specialist

PUBLIC RESPONDENT

"I believe that by restricting pharmacist prescribing to the collaborative care setting would limit accessibility since it would still require the involvement of a physician and/or other health care professionals." – Patient

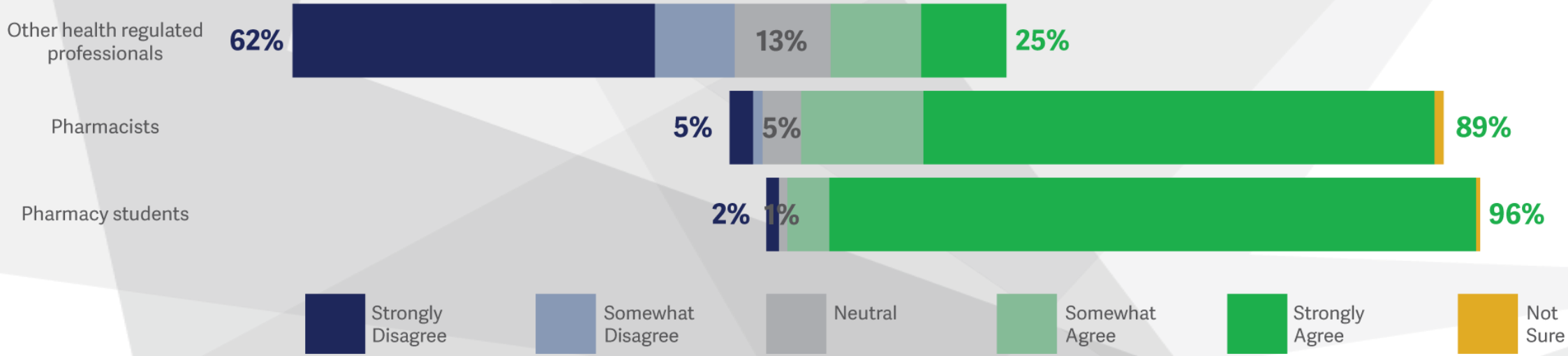
College of Pharmacists of British Columbia

Adding a Certified Pharmacist Prescriber to your care team would help improve the quality of health care you receive.



College of Pharmacists of British Columbia

This increased collaboration for drug therapy management and monitoring could improve the quality of care a patient receives from their health care team.



College of Pharmacists of British Columbia

PHARMACIST RESPONDENT

Pharmacists are specialists in drug therapy, and very often make recommendations and alert of monitoring that is necessary to optimize drug therapy and patient response. This is already part of usual care, but having prescribing authority allows the pharmacist to respond to signals in the monitoring that should lead to adjustments in pharmacotherapy. – Pharmacist

PUBLIC RESPONDENT

"Monitoring dosage/side effects of meds is critical to keeping patients safe at home (along with interactions of their home/herbal meds) and keeping patients out of our hospitals - this is a BIG value!" – Patient

STUDENT RESPONDENT

"Collaborative relationships will increase efficiency, improve communication, help determine mutual goals of therapy among healthcare providers, and help the patient achieve their own goals of therapy."– Pharmacy Student

OTHER HEALTH PROFESSIONAL RESPONDENT

"A defined Pharmacist Prescriber would have a personal/professional relationship with a patient which would provide support above that from an anonymous pharmacist dispenser." – Physician Specialist

College of Pharmacists of British Columbia

Respondents suggested that pharmacist prescribing could be used for:

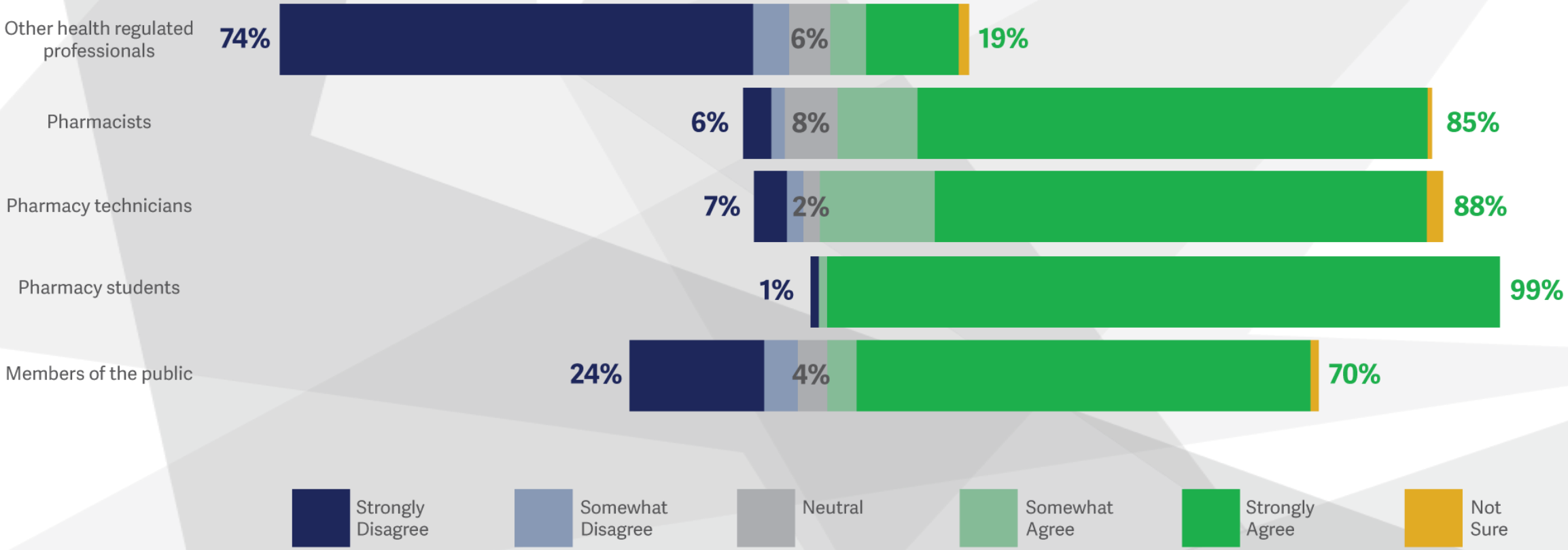
- Titrating medication to determine the best dosage
- Minor ailments and contraception
- Renewals
- Hypo and hyperthyroidism management
- Warfarin therapy management
- Chronic disease management
- Increased monitoring and management of drug therapy

College of Pharmacists of British Columbia

Support for Pharmacists Prescribing in BC

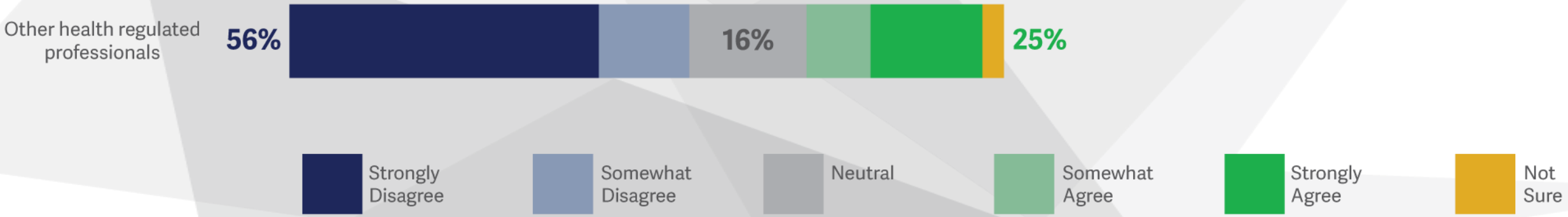
College of Pharmacists of British Columbia

Pharmacist prescribing in collaborative practice relationships should be allowed in BC.



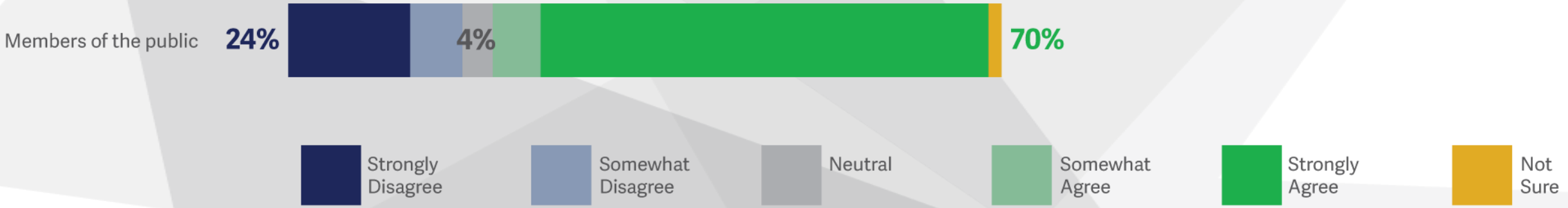
College of Pharmacists of British Columbia

You would be open to collaborating with a Certified Pharmacist Prescriber for a patients care.



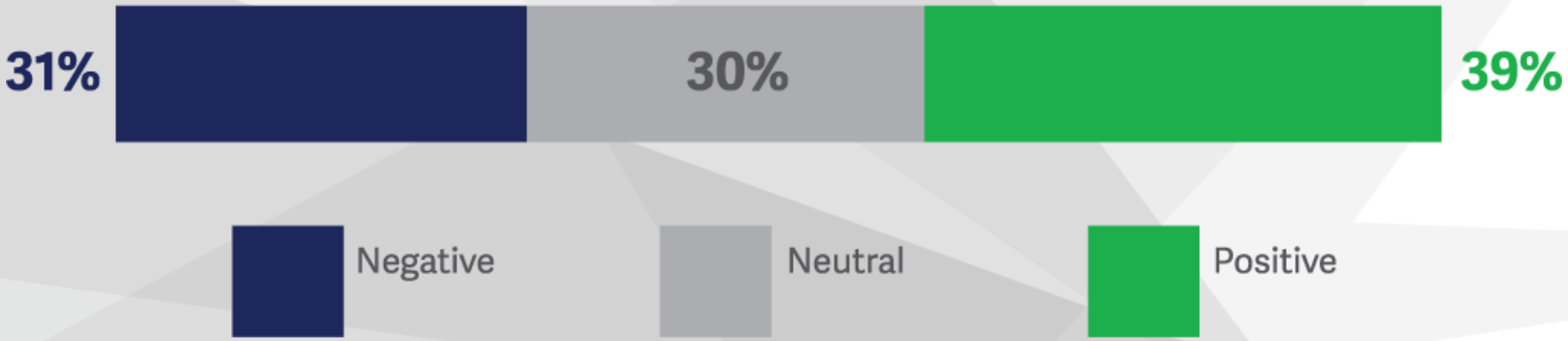
College of Pharmacists of British Columbia

You would use pharmacist prescribing services if they became available in BC.



College of Pharmacists of British Columbia

Social Sentiment

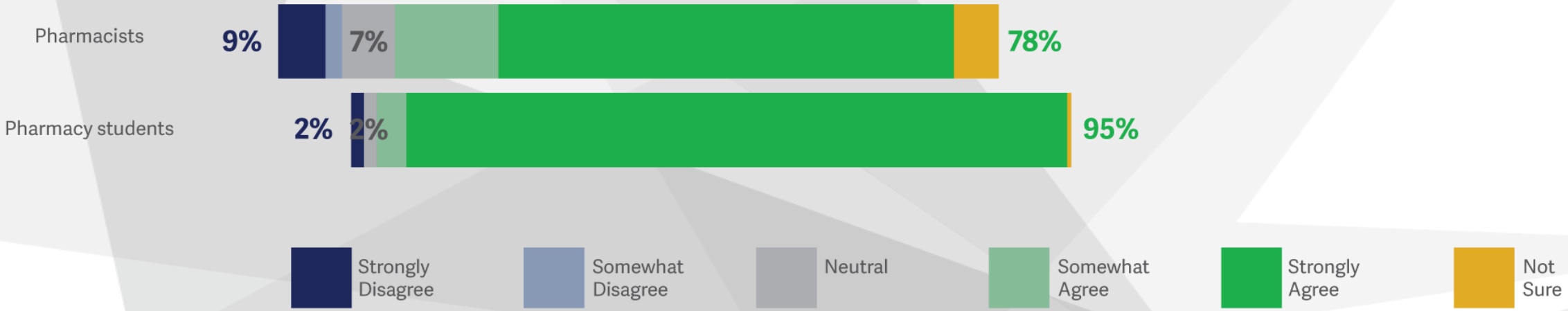


College of Pharmacists of British Columbia

Will pharmacists pursue this certification… ?

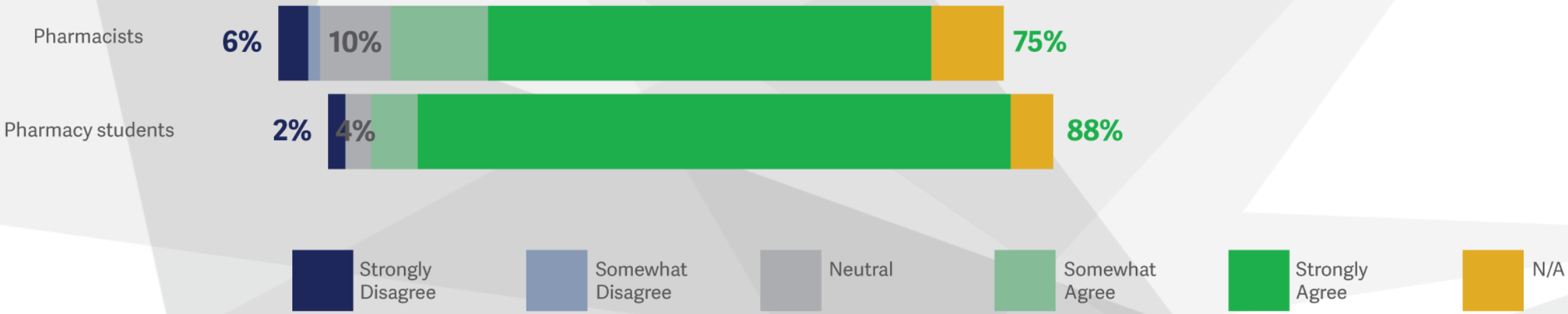
College of Pharmacists of British Columbia

As a pharmacist, you would pursue becoming a Certified Pharmacist Prescriber.



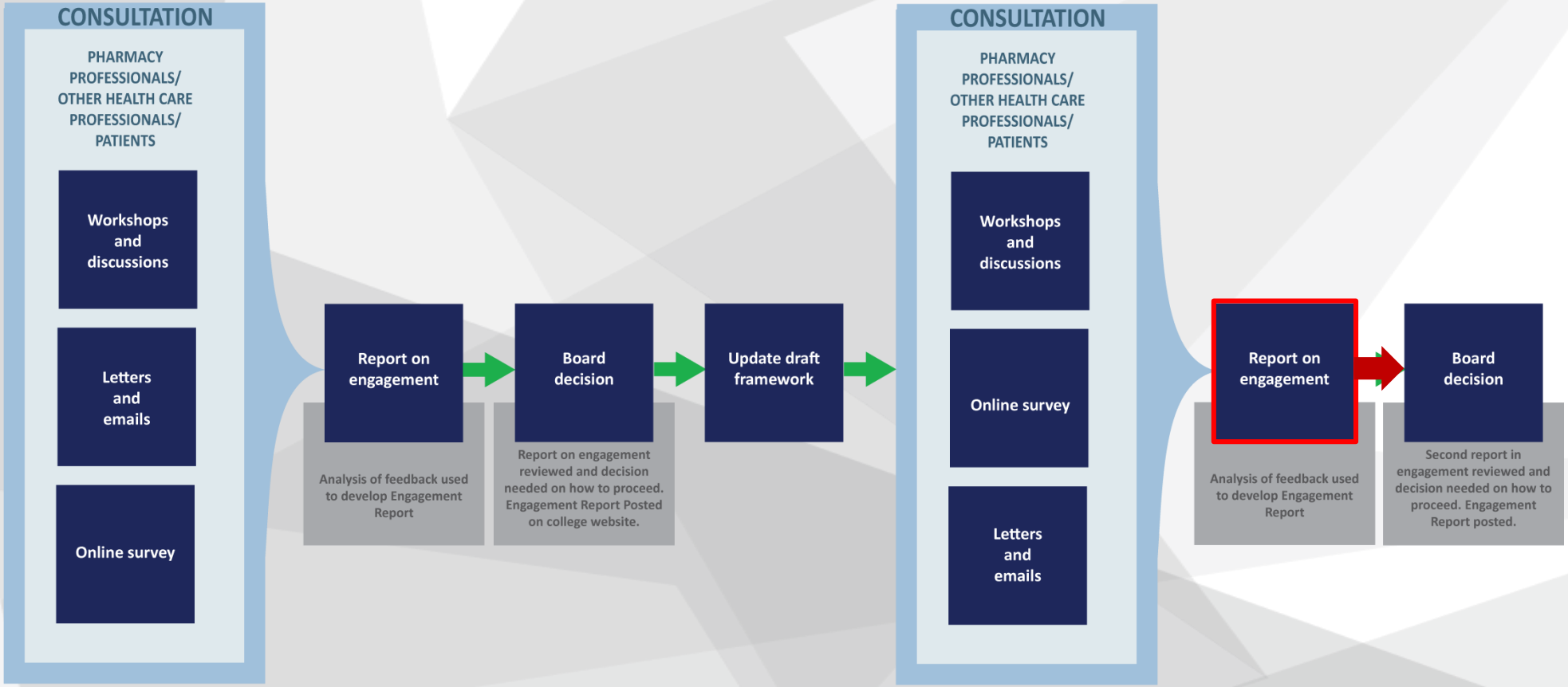
College of Pharmacists of British Columbia

You would encourage your staff to pursue becoming a Certified Pharmacist prescriber.



College of Pharmacists of British Columbia

Next Steps



College of Pharmacists of British Columbia

Questions

College of Pharmacists of British Columbia

BOARD MEETING
November 17, 2017

12. PODSA Ownership Project - Privacy and Security Update

INFORMATION ONLY

Purpose

To provide an update regarding the work being undertaken on the PODSA Ownership Project regarding privacy and security.

Background / Executive Summary

The College recognizes the importance of establishing and maintaining fulsome privacy and security requirements.

To date, the privacy and security activities being completed by the College in relation to the PODSA Ownership Project include:

- Implementing the key recommendations from a thorough organization wide IT security review that was completed by Opus in 2016
- A Privacy Impact Assessment has been developed with a legal/privacy expert and will soon be reviewed with College executive for approval
- A process review is being undertaking to determine any additional privacy risk mitigation strategies
- A consultation with the Office of the Information and Privacy Commission is being planned for a proactive review and an opportunity to learn other best practices

Given the sensitive nature of some of the information that the College is legislatively required to collect and use (e.g. Criminal Record Histories), there will need to be a continued focus on privacy and security over time. Some of the ongoing steps will include:

- Continuing to monitor and implement emergent best practices as and when appropriate
- Continuing to review and refine internal staff process and processes involving the soon to be formed Application Committee
- Continuing to review Bylaws and Forms to ensure ongoing alignment with the legislative framework within which the College is collecting, using and disclosing information
- Continuing to review retention and disposal timelines

Appendix	
1	N/A – A presentation on this topic will also be provided on November 17, 2017

College of Pharmacists of British Columbia

12. PODSA Ownership Project Privacy and Security Update

Doreen Leong

Director of Registration and Licensure

College of Pharmacists of British Columbia

Agenda

1. Security Update
2. Privacy Update
3. Ongoing Steps

College of Pharmacists of British Columbia

Security Update

- An organization wide IT security review was completed by Opus in 2016
- CPBC has implemented key recommendations, including those related to the iMIS application, and will continue to monitor and implement emergent best practices as and when appropriate

College of Pharmacists of British Columbia

Privacy Update

- A Privacy Impact Assessment (PIA) has been developed with a legal/privacy expert and will soon be reviewed with College executive
- A process review is being undertaking to determine any additional privacy risk mitigation strategies
- A consultation with the Office of the Information and Privacy Commissioner is being planned for a proactive review

College of Pharmacists of British Columbia

Ongoing Steps

- Continue to:
  - Monitor and implement emergent best practices
  - Review and refine internal staff processes and processes with the Application Committee
  - Review Bylaws and Forms to ensure ongoing alignment with the legislative framework regarding the collection, use of and disclosure of information
  - Review retention and disposal timelines