College of Pharmacists of British Columbia

Board Meeting
September 14, 2018
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Members Present:
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
Anar Dossa, District 6
Sorell Wellon, District 8
Tracey Hagkull, Government Appointee
Justin Thind, Government Appointee
Jeremy Walden, Government Appointee

Regrets:
Ryan Hoag, Government Appointee

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
Jon Chen, Communications Project Officer
Stephanie Kwok, Executive Assistant

Guests:
Sam Chu, UBC Pharmacy Undergraduate Society President

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1. **WELCOME & CALL TO ORDER**
   Chair Kwong called the meeting to order at 10:30am on September 14, 2018.

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2. CONSENT AGENDA

a) Items for further discussion

Item 2b.vii.a. PPP Housekeeping Amendments: PPP-58 Medical Management (Adapting a Prescription) was removed from the Consent Agenda and placed onto the regular Agenda for further discussion.

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:

Approve the Consent Agenda as amended.

CARRIED

3. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:

Approve the September 14, 2018 Draft Board Meeting Agenda as circulated.

CARRIED

4. COMMITTEE UPDATES

a) Governance Committee

Arden Barry, Chair of the Governance committee reported that the committee met twice since the last Board meeting. On July 18th, the committee reviewed and provided feedback on the Board Reference and Policies and discussed about committee structure and composition. On August 29th, the committee approved the revised Board Reference and Policies to be brought to the Board for approval at this Board meeting. The next Governance committee meeting will be scheduled for early November.

b) Hospital Pharmacy Advisory Committee

Arden Barry, Chair of the Hospital Pharmacy Advisory Committee reported that the committee has not met since the last Board meeting.

c) Inquiry Committee

Ming Chang, Chair of the Inquiry Committee reported that between May to July 2018, the committee met twice in-person and 13 times via teleconference. 71 files were reviewed and these numbers are comparable to previous years. The committee hosted an orientation meeting on June 27th to welcome newly appointed committee members.

d) Practice Review Committee

Tracey Hagkull, Chair of the Practice Review Committee provided an update under item 9 of the regular agenda.

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e) Audit and Finance Committee

Frank Lucarelli, Vice-Chair of the Audit and Finance Committee, reported that the committee has not met since the last Board meeting.

f) Quality Assurance Committee

Frank Lucarelli, Chair of the Quality Assurance Committee, reported that the committee has not met since the last Board meeting. Next meeting is scheduled for November. Since the last Board meeting, communication was sent out to registrants regarding the PDAP app. The committee has been auditing the CE credits received via the app. A further update will be provided at the November Board meeting.

g) Community Pharmacy Advisory Committee

Tara Oxford, Chair of the Community Pharmacy Advisory Committee reported that the committee has not met since the last Board meeting.

h) Jurisprudence Examination Subcommittee

Christopher Szeman, Chair of the Jurisprudence Examination Subcommittee reported that the committee met on June 26th to review and approve the results of the June 4th Jurisprudence examination. Questions and comments from candidates were reviewed and the committee also looked at the statistical data on how well the questions performed. The next Jurisprudence examination is scheduled for October 29th.

i) Discipline Committee

Jeremy Walden, Chair of the Discipline Committee, provided an update under item 5a of the regular agenda.

j) Legislation Review Committee

Jeremy Walden, Chair of the Legislation Review Committee, provided an update under item 5a of the regular agenda.

k) Registration Committee

Jeremy Walden, Chair of the Registration Committee, provided an update under item 5a of the regular agenda.

l) Application Committee

Sorell Wellon, Chair of the Application Committee, provided an update under item 10 of the regular agenda.

m) Ethics Advisory Committee

Sorell Wellon, Chair of the Ethics Advisory Committee, provided an update under item 11 of the regular agenda.

n) Residential Care Advisory Committee

Sorell Wellon, Residential Care Advisory Committee, provided an update under item 10 of the regular agenda.

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o) Drug Administration Committee

Doreen Leong, staff resource to the committee reported that the committee has not met since the last Board meeting. Operationally, Doreen Leong, staff resource to the committee has started drafting a discussion paper that will be presented to the committee end of October. The committee will be looking at removing restrictions off the standards, limits and conditions for injection authority and possibly bring some recommendations to be discussed at the November Board meeting.

5. LEGISLATION REVIEW COMMITTEE

Jeremy Walden, Chair of the Legislation Review Committee presented.

a) Committee Update

Registration Committee

Jeremy Walden, Chair of the Registration Committee, reported that the committee met once over the summer. The committee has received a higher than normal volume of registration cases to review. Next meeting scheduled for Thursday, September 20th.

Discipline Committee

Jeremy Walden, Chair of the Discipline Committee, reported that there are two ongoing files being reviewed by the committee.

Legislation Review Committee (Appendix 3)

Jeremy Walden, Chair of the Legislation Review Committee reported that the committee met on August 15th.

b) Electronic Record Keeping

It was moved and seconded that the Board:

(1) Approve the following resolution to amend the bylaws made under the Pharmacy Operations and Drug Scheduling Act and the Health Professions Act regarding electronic record keeping:

"RESOLVED THAT, in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act ("PODSA") and section 19(1) of the Health Professions Act ("HPA"), and subject to the requirements in section 21(4) of PODSA and section 19(3) of HPA, the Board of the College of Pharmacists of BC approves the proposed bylaws made under PODSA and HPA relating to electronic record keeping for filing with the Minister of Health, as circulated."

(2) Approve rescinding Professional Practice Policy-12 Prescription Hard Copy File Coding System, effective on the date that the bylaws come into force.

(3) Approve rescinding Professional Practice Policy-20 Prescription Refills, effective on the date that the bylaws come into force.

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(4) Approve consequential amendments to Professional Practice Policy-31 Emergency Prescription Refills, as circulated, effective on the date that the bylaws come into force.

(5) Approve consequential amendments to Professional Practice Policy-58 Medication Management (Adapting a Prescription), as circulated, effective on the date that the bylaws come into force.

CARRIED

6. BRITISH COLUMBIA'S APPROACH TO CANNABIS LEGALIZATION AND REGULATION (Appendix 4)

Mary Shaw, Executive Director, Cannabis Legalization and Regulation Secretariat provided an overview of the Cannabis Control and Licensing Act and the Cannabis Distribution Act and discussed about the provincial regulatory framework established in anticipation of the federal legalization of non-medical cannabis on October 17, 2018.

7. TRANSFORMATIVE LEADERSHIP TO ACHIEVE FIRST NATIONS HEALTH AND WELLNESS (Appendix 5)

Joe Gallagher, Chief Executive Officer, First Nations Health Authority presented on the history of discrimination of aboriginal people in British Columbia and discussed about how transforming relationships between First Nations communities and BC's various public health organizations is crucial to achieving First Nations Health & Wellness in BC.

8. ACTING ON OUR COMMITMENT TO IMPROVE CULTURAL SAFETY AND HUMILITY FOR FIRST NATIONS AND ABORIGINAL PEOPLES (Appendix 6)

Gillian Vrooman, Director of Communications & Engagement presented an update on the ongoing work done by the College's as part of its commitment to improve cultural safety and humility for First Nations and Aboriginal Peoples.

9. PRACTICE REVIEW COMMITTEE UPDATE (Appendix 7)

Tracey Hagkull, Chair of the Practice Review Committee and James Van, College's Community Pharmacy Compliance Officer provided an update on the Practice Review Program and presented results of the Registrant Feedback Survey.

10. APPLICATION COMMITTEE UPDATE

Residential Care Advisory Committee

Sorell Wellon, Chair of the Application Committee, reported that the committee has not met since the last Board meeting.

Application Committee (Appendix 8)

Sorell Wellon, Chair of the Application Committee, provided an update on the activities of the Application Committee since its first meeting on June 21, 2018.

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11. PATIENT RELATIONS STANDARD (Appendix 9)

Sorell Wellon, Chair of the Ethics Advisory Committee provided an update on the activities of the Ethics Advisory Committee.

It was moved and seconded that the Board:

Approve the Patient Relations Program Standard for inclusion under Schedule A of the HPA bylaws.

CARRIED

12. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

a) Item 2b.vii.a. PPP Housekeeping Amendments: PPP-58 Medical Management (Adapting a Prescription)

A question was raised regarding why there is still an exclusion of psychiatric medication in the adaptation program.

It was moved and seconded that the Board:

Approve housekeeping amendments to the Professional Practice Policy 58 – Medication Management (Adapting a Prescription)

CARRIED

ADJOURNMENT

Chair Kwong adjourned the meeting at 3:12pm on September 14, 2018.

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BOARD MEETING
September 14, 2018

2. 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. Compliance Certificate
    b. Risk Register September 2018
    c. Current Strategic Plan Update
    d. Action Items & Business Arising
iii. June 15, 2018 Draft Board Meeting Minutes **[DECISION]**
iv. Committee Updates
v. Audit and Finance Committee – Finance Report – July Financials
vi. Legislation Review Committee
    a. PODSA Modernization (Phase 2)
    b. PODSA Fee and Form Amendments **[DECISION]**
vii. PPP Housekeeping Amendments
    a. PPP-58: Medication Management (Adapting a Prescription) **[DECISION]**
    b. PPP-66: Opioid Agonist Treatment
    c. PPP-67: Injectable Opioid Agonist Treatment **[DECISION]**
viii. Ethics Advisory Committee – Amendment to the Terms of Reference **[DECISION]**
ix. Governance Committee – Approval of the College of Pharmacists of BC Board Reference and Policies **[DECISION]**
x. Approval of June 14, 2018 Committee of the Whole Meeting Minutes **[DECISION]**
xi. Approval of August 23, 2018 Board Meeting Minutes **[DECISION]**
xii. Strategic Plan Themes 2019/2020- 2022/2023 **[DECISION]**

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BOARD MEETING
September 14, 2018

2.b.i. Chair's Report

INFORMATION ONLY

Chair's Report of Activities

Since the previous Board Meeting report (June 2018) as chair, I have been involved in the following activities as Board Chair:

General Administration

- Communications for Board Strategic Planning Session (for planning)
- Attended regular meetings with Registrar, Deputy Registrar, Vice-Chair on general Board related items and on CPBC related items
- Reviewed agendas and minutes
- Correspondence sent for College Name Change
- Correspondence sent for Pharmacist Prescribing
- Election call-out messaging

Conference/Meetings/AGM on behalf of CPBC

- UBC Faculty of Pharmaceutical Sciences - Advance Pharmacy Education Session Discussion

Committee/Group Involvement
(*attended 1 meeting as ex-officio for understanding of committee)

- Audit and Finance Committee
- Governance Committee
- Inquiry Committee*
- Legislation Review Committee
- Practice Review Committee*
- Quality Assurance Committee*
- Registrar Evaluation Task Group and Process Rollout

Registrant/Public Engagement and Understanding

- Answered general questions from registrants and public (phone and in person) about roles of committee members, what are the roles of board members, what occurs in planning for public, linked individuals to departmental emails to answer questions

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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 29, 2018

Non-profit Tax Return – Mailed August 27, 2018

Non-profit Information Return – Filed August 27, 2018

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.

Bank signing authority documents – current as per policy.

Insurance – all insurance policies are up to date.

Business Licence – current.

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

BOARD REPORT (DRAFT)

Aug 27, 2018 by Mary O'Callaghan

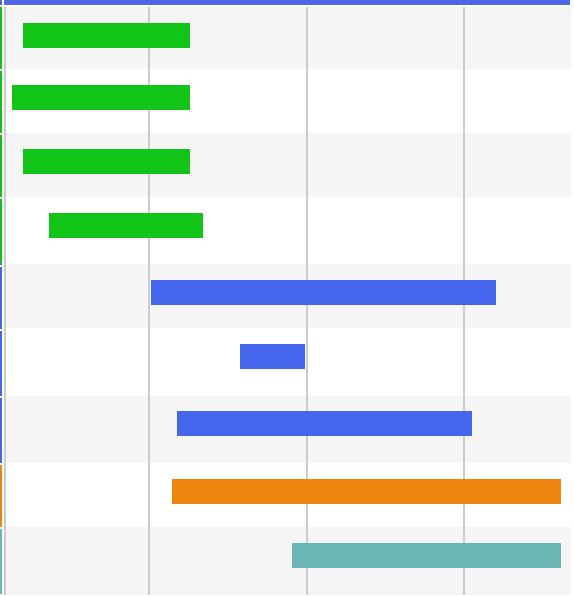
39
ACTION ITEMS

67%
ACTION ITEM COMPLETION

COLLEGE OF BC PHARMACISTS PLAN

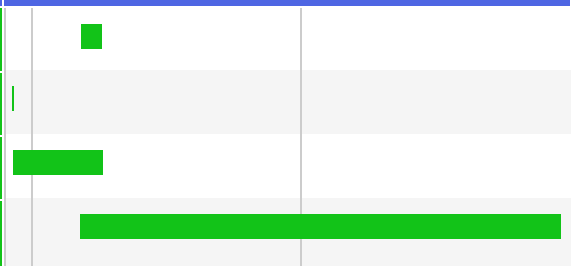
LEGISLATIVE STANDARDS & MODERNIZATION

Action Item	Owner	Current Completion
Implement PODSA ownership changes (Phase 1) by 1st Apr 2018	Director of Registration, Licensure & Pharmanet	100% -
→ Implement revised bylaw by 1st Apr 2018	Director of Policy and Legislation	100% -
→ Streamline business processes by 1st Apr 2018	Director of Registration, Licensure & Pharmanet	100% -
→ Complete communications and engagement activities by 30th Apr 2018	Director of Communications	100% -
Implement PODSA Modernization (Phase 2) by 31st Mar 2020	Director of Registration, Licensure & Pharmanet	5% -
→ Update and re-scope entire PODSA Phase 2 project by 31st Dec 2018	Director of Registration, Licensure & Pharmanet	95% 78% ahead
→ Implement revised bylaw (POSDA Phase2) by 31st Jan 2020	Director of Policy and Legislation	30% 4% ahead
→ Streamline business processes by 31st Aug 2020	Chief Operating Officer	0% 20% behind
→ Complete communications and engagement activities (PODSA 2) by 31st Aug 2020	Director of Communications	0% -



PROFESSIONAL EXCELLENCE

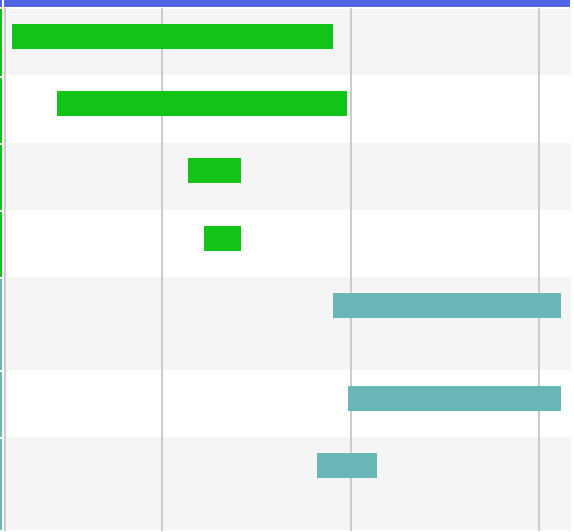
Action Item	Owner	Current Completion
Implement Hospital PRP by 1st Apr 2017	Director PR & QA	100% -
→ Develop Hospital PRP program by 26th Nov 2016	Director PR & QA	100% -
→ Launch Hospital PRP program by 3rd Apr 2017	Director PR & QA	100% -
Complete Implementation of Methadone Action Plan by 31st Dec 2018	Deputy Registrar	100% -



Provide recommendations to the board based on findings of MMT inspections and undercover operations. by 31st Dec 2018	Deputy Registrar	100% -
Complete legal elements by 31st Dec 2018	Director of Policy and Legislation	100% -
Manage inspections by 31st Dec 2018	Deputy Registrar	100% -

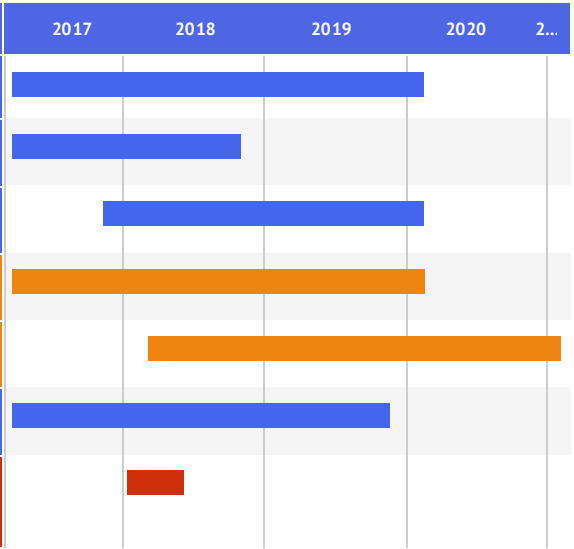
DRUG THERAPY ACCESS & MONITORING

Action Item	Owner	Current Completion
Recommend to the Minister of Health that pharmacists be granted the authority to prescribe by 30th Nov 2018	Director of Registration, Licensure & Pharmanet	100% -
Develop framework/proposal for pharmacist prescribing for submission to the Minister of Health by 31st Dec 2018	Director of Registration, Licensure & Pharmanet	100% -
Complete communication and engagement activities by 31st May 2018	Director of Communications	100% -
Submit Proposal for Pharmacist Prescribing to Minister of Health by 31st May 2018	Director of Registration, Licensure & Pharmanet	100% -
Seek greater access to patient lab values to enhance pharmacists' ability to provide quality, timely service to patients by 29th Feb 2020	Director of Registration, Licensure & Pharmanet	0% -
Complete communications and engagement activities by 29th Feb 2020	Director of Communications	0% -
Develop and submit framework/proposal document outlining a strategy for how to create access to Patient Lab Values by 28th Feb 2019	Director of Registration, Licensure & Pharmanet	0% -

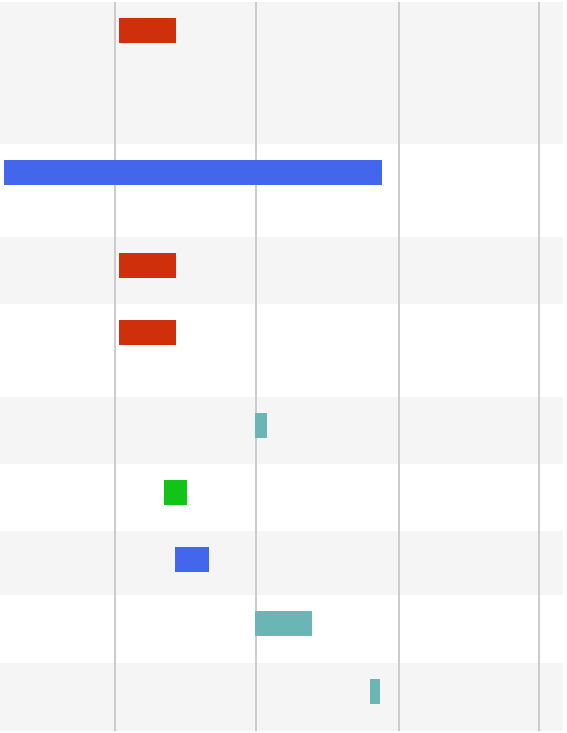


ORGANIZATIONAL EXCELLENCE

Action Item	Owner	Current Completion
Update IT infrastructure by 28th Feb 2020	Chief Operating Officer	51% 1% ahead
Implement IT updates required by PODSA Modernization (Phase 1) by 31st Oct 2018	Chief Operating Officer	90% 1% ahead
Implement IT Department organization, processes and procedures by 29th Feb 2020	Chief Operating Officer	80% 45% ahead
Implement Enterprise Content Management system by 29th Feb 2020	Chief Operating Officer	25% 25% behind
Enhance public safety through ensuring Practice Review Program systems needs are addressed by 28th Feb 2021	Chief Operating Officer	10% 6% behind
Enhance organizational best practices to obtain silver certification from Excellence Canada by 29th Nov 2019	Chief Operating Officer	80% 26% ahead
Develop human resources / wellness policies and procedures (plans or guidelines) required to attain Silver certification by 1st Jun 2018	Chief Operating Officer	98% 2% behind



Develop Governance and Leadership policies and success indicators required to attain Silver certification by 1st Jun 2018	Chief Operating Officer	90% 10% behind
Develop organizational policies and procedures (plans or guidelines) required to attain Silver certification by 29th Nov 2019	Chief Operating Officer	90% 36% ahead
Define customer segments and develop a customer experience plan, including key partners by 1st Jun 2018	Chief Operating Officer	95% 5% behind
Develop a methodology for regularly identifying and capturing key processes, including Project Management, Change Management and Procurement by 1st Jun 2018	Chief Operating Officer	80% 20% behind
Register with Excellence Canada for official verification by 31st Jan 2019	Chief Operating Officer	0% -
Review gap analysis and assign secondary action plan projects to teams by 30th Jun 2018	Chief Operating Officer	100% -
Complete secondary projects by 1st Sep 2018	Chief Operating Officer	85% 9% behind
Facilitate Excellence Canada verification team visits and focus groups by 31st May 2019	Chief Operating Officer	0% -
Receive Silver Certification from Excellence Canada by 29th Nov 2019	Chief Operating Officer	0% -



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BOARD MEETING
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2.b.ii. Registrar's Update
d) Action Items & Business Arising

INFORMATION ONLY

	MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UPDATE
1.	Motion: Pursue officially changing the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia. **Status: Received letter from Minister Dix on August 22, 2018, declining College request for name change.**	09-2016	COMPLETE
2.	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. **Status: Recommended implementation plan has been communicated to registrants. College staff will bring forward a proposed motion for the Board's consideration, to officially adopt the Standards, closer to the May 2021 effective date.**	04-2017	IN PROGRESS
3.	Motion: Direct the Registrar to develop bylaws and/or practice standards for Medication Reviews and require mandatory training for pharmacists who wish to conduct them. To be prioritized by the Legislation Review Committee for implementation. **Status: Research and analysis will begin in summer 2018, in accordance with the College's Legislation Operational Plan.**	06-2017	IN PROGRESS
4.	Motion: Direct the Registrar to develop requirements and training tools as it pertains to the role and responsibilities of the Pharmacy Manager. To be prioritized by the Legislation Review Committee for implementation. **Status: Community Pharmacy Managers Training brought to the June 2018 Board meeting. The Board approved a Professional Practice Policy with a September 2018 effective date.**	06-2017	COMPLETE

	MOTIONS/ACTION ITEMS	RELEVANT BOARD MEETING	STATUS UPDATE
5.	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. **Status: Research and analysis will begin in summer 2018; briefing note and decision to be brought to the November 2018 Board meeting.**	11-2017	IN PROGRESS
6.	Motion: 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. **Status: Letter sent to Minister of Health on August 3, 2018**	11-2017	COMPLETE
7.	Motion: (1) Direct the Registrar to explore the development of new requirements for the security of information in local pharmacy computer systems; (2) If new requirements are deemed necessary, direct the Registrar to propose that the Ministry of Health consider amending their PharmaNet Professional and Software Compliance Standards document to enhance the software security requirements of the local pharmacy computer systems." **Status: The Ministry of Health is currently working on the PharmaNet Professional and Software Conformance Standards and will communicate with the Deputy Registrar as the project progresses. CPBC E-record keeping bylaws will create a baseline for software requirements at community pharmacies.**	02-2018	IN PROGRESS

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2.b.iii. June 15, 2018 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the June 15, 2018 Draft Board Meeting Minutes as circulated.

Appendix	
1	http://library.bcpharmacists.org/2_About_Us/2-1_Board/Board_Meeting_Minutes-20180615.pdf

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BOARD MEETING
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2.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	Audit and Finance Committee Meeting Minutes
2	Discipline Committee Update
3	Governance Committee Meeting Minutes
4	Inquiry Committee Update
5	Practice Review Committee Meeting Minutes
6	Quality Assurance Committee Meeting Minutes

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BOARD MEETING
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2.b.v. Audit and Finance Committee – Finance Report – July Financials

INFORMATION ONLY

Purpose

To report on the highlights of the July 2018 financial reports.

Background

The July 2018 financial reports reflect **five 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 almost $1,701,000. Cash is in our Operating Bank account with excess transferred to a Premium Savings account. Investments totalled more than $5.7 million. Payables and accruals amount to the usual $692,000; so, are well-funded by the cash balance.

Revenue

Licensure revenues are slightly under budget; approximately 1% under budget in total. *Other revenues* (administrative fees, etc.) are significantly over budget but most of the overage is in flow-through funds; so, not significant to the operation. Grant revenue is over budget as the main contracted grant project is now progressing and we received a draw request early in the fiscal year. In total, revenues are over budget by almost $67,000.

Expenses

Total Year to Date actual expenditures are under budget by $76,580. See the variance analysis which follows for details.

Variance analysis by department:

Department	Budget	Actual	Comment
Board & Registrar's Office	301,448	346,628	Primarily due to timing of events.
Finance and Administration	1,578,706	1,551,139	
Grant distribution	90,000	117,895	Timing
Registration & Licensure	353,613	396,500	Primarily due to the flow-through funds (off-setting the revenue) and Application Committee meetings.
Quality Assurance	23,540	13,735	Timing
Practice Review	667,116	596,023	Timing and gapping in staffing
Complaints Resolution	689,068	705,164	A large legal invoice re a discipline case received after year-end. Auditors may select to treat as a prior period adjustment.
Policy and Legislation	198,965	185,728	
Public Engagement	197,981	153,644	Timing
Projects	114,000	98,670	Timing
Amortization	165,078	137,810	Timing of development projects
Total Expenses	4,379,515	4,302,935	

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

Statement of Financial Position

As at July 31, 2018

ASSETS	
Cash and Cash Equivalents	1,700,790
Investments	5,702,329
Receivables	77,024
Prepaid Expense and Deposits	165,967
Current Assets	7,646,110
Investments in College Place Joint Venture	1,576,956
Development Costs	428,427
Property & Equipment	572,256
Non-current Assets	2,577,639
Total Assets	**10,223,748**

LIABILITIES AND NET ASSETS	
Payables and Accruals	692,330
Capital Lease Obligations (Current)	9,295
Deferred Revenue	5,344,007
Deferred Contributions	80,711
Total Current Liabilities	6,126,342
Capital Lease Obligations (Non-current)	-
Total Liabilities	6,126,342
Total Net Assets	4,097,406
Total Liabilites and Net Assets	**10,223,748**

College of Pharmacists of BC

Statement of Revenue and Expenses

For the 5 months ended July 31, 2018

	Budget YTD 2018/19	Actual YTD 2018/19	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Licensure revenue	3,344,195	3,319,761	(24,434)	(1%)
Non-licensure revenue	274,762	366,007	91,245	33%
Transfer from Balance Sheet	460,590	460,590	-	0%
Total Revenue	**4,079,547**	**4,146,358**	**66,811**	2%
Total Expenses Before Amortization	4,214,436	4,165,125	49,312	1%
Amortization	165,078	137,810	27,269	17%
Total Expenses Including Amortization	**4,379,515**	**4,302,935**	**76,580**	2%
Net Surplus/(Deficit) of revenue over expenses	**(299,968)**	**(156,577)**	**143,391**	

College of Pharmacists of BC

Statement of Revenue

For the 5 months ended July 31, 2018

	Budget YTD 2018/19	Actual YTD 2018/19	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Licensure revenue				
Pharmacy fees	1,310,795	1,334,886	24,091	2%
Pharmacists fees	1,714,763	1,694,051	(20,712)	(1%)
Technician fees	318,636	290,824	(27,813)	(9%)
	3,344,195	3,319,761	(24,434)	(1%)
Non-licensure revenue				
Other revenue	47,578	121,613	74,034	156%
Grant Revenue	73,017	90,000	16,983	23%
Investment income	43,750	54,394	10,644	24%
College Place joint venture income	110,417	100,000	(10,417)	(9%)
	274,762	366,007	91,245	33%
Transfer from Balance Sheet	460,590	460,590	-	0%
Total Revenue	**4,079,547**	**4,146,358**	**66,811**	2%

College of Pharmacists of BC
Statement of Expenses
For the 5 months ended July 31, 2018

	Budget YTD 2018/19	Actual YTD 2018/19	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Expenses				
Board and Registrar's Office	301,448	346,628	(45,179)	(15%)
Finance and Administration	1,578,706	1,551,139	27,567	2%
Grant Distribution	90,000	117,895	(27,895)	(31%)
Registration, Licensure and Pharmanet	353,613	396,500	(42,887)	(12%)
Quality Assurance	23,540	13,735	9,804	42%
Practice Reviews	667,116	596,023	71,093	11%
Complaints Resolution	689,068	705,164	(16,096)	(2%)
Policy and Legislation	198,965	185,728	13,238	7%
Public Engagement	197,981	153,644	44,338	22%
Projects	114,000	98,670	15,330	13%
Total Expenses Before Amortization	4,214,436	4,165,125	49,312	1%
Amortization	165,078	137,810	27,269	17%
Total Expenses Including Amortization	**4,379,515**	**4,302,935**	**76,580**	2%

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.vi. Legislation Review Committee
a) PODSA Modernization (Phase 2)

INFORMATION ONLY

Purpose

To provide a status update on Phase 2 of the modernization of bylaws and policies made under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA"), referred to as "PODSA Phase 2".

Background

In accordance with its Strategic Plan, the College of Pharmacists of B.C. (the "College") is conducting a comprehensive review and reform of legislative requirements under PODSA, including bylaws and Professional Practice Policies (PPPs) made under PODSA.

PODSA Phase 1 involved amendments to the PODSA Bylaws relating to pharmacy ownership requirements. The legislative reforms in PODSA Phase 1 came into effect on April 1, 2018.

PODSA Phase 2 involves a review of legislation and PPPs to ensure the following:

- Bylaws are clearer and duplication in bylaws and policies is addressed.
- PPPs are standardized and transitioned to bylaw where needed.
- Bylaws and PPPs have consistent writing style and structure.

The following key bylaw topics to be addressed in PODSA Phase 2 have been identified from College staff and informed by registrant and stakeholder feedback:

PODSA Bylaws

High Priority Topics	Lower Priority Topics
Operation of a Community Pharmacy without a Full Pharmacist.	Developing provisions to allow for community telepharmacy reinstatement.
Responsibilities of Managers, Direct Owners, Directors, Officers and Shareholders.	Reviewing/addressing provisions that might be more appropriately placed in the *Health Professions Act* Bylaws
Storage of drugs and confidential health information, including offsite storage.	Reviewing the "Top 10" requirements that are not being complied with (based on Practice Review Program data) and determining if any bylaw amendments are needed.

High Priority Topics	Lower Priority Topics
House-keeping amendments, including ensuring consistency of writing style.	Reviewing PharmaNet requirements in light of the recent transition of administration of PharmaNet functions to the Ministry of Health.
Temporary pharmacy licences.	Reviewing requirements regarding registrants' duty to respond to the College.
Removal of forms from the bylaws.	

College staff, informed by registrant and stakeholder feedback, have also identified the following PPPs to be included in PODSA Phase 2, for the purposes of updating and transitioning to bylaw, as appropriate:

Professional Practice Policies

High Priority PPPs	Lower Priority PPPs
Depot Shipments of Prescriptions (PPP-24)	Temporary Pharmacy Closures (PPP-46)
Pharmacy Disaster Preparedness (PPP-25)	Operational Procedures for Complying with Benzodiazepines & Other Targeted Substances Regulation (PPP-47)
Repackaging Bulk Non-prescription Drugs (PPP-40)	Identifying Patients for PharmaNet Purposes (PPP-54)
Cold Chain Management of Biologicals (PPP-68)	Pharmacy Equipment (PPP-59)
	Narcotic Counts and Reconciliations (PPP-65)
	Inquiry and Discipline Publication Policy (PPP-72)
	Validate Identification of College Registration Status for New Pharmacy Hires (PPP-73)

Research and analysis on the various above-noted issues is currently underway. An internal Working Group comprised of staff from several College departments has been established. The Working Group is developing the College's preliminary proposals for amendments, which will form the basis for further consultations with external advisors and stakeholders later in the year.

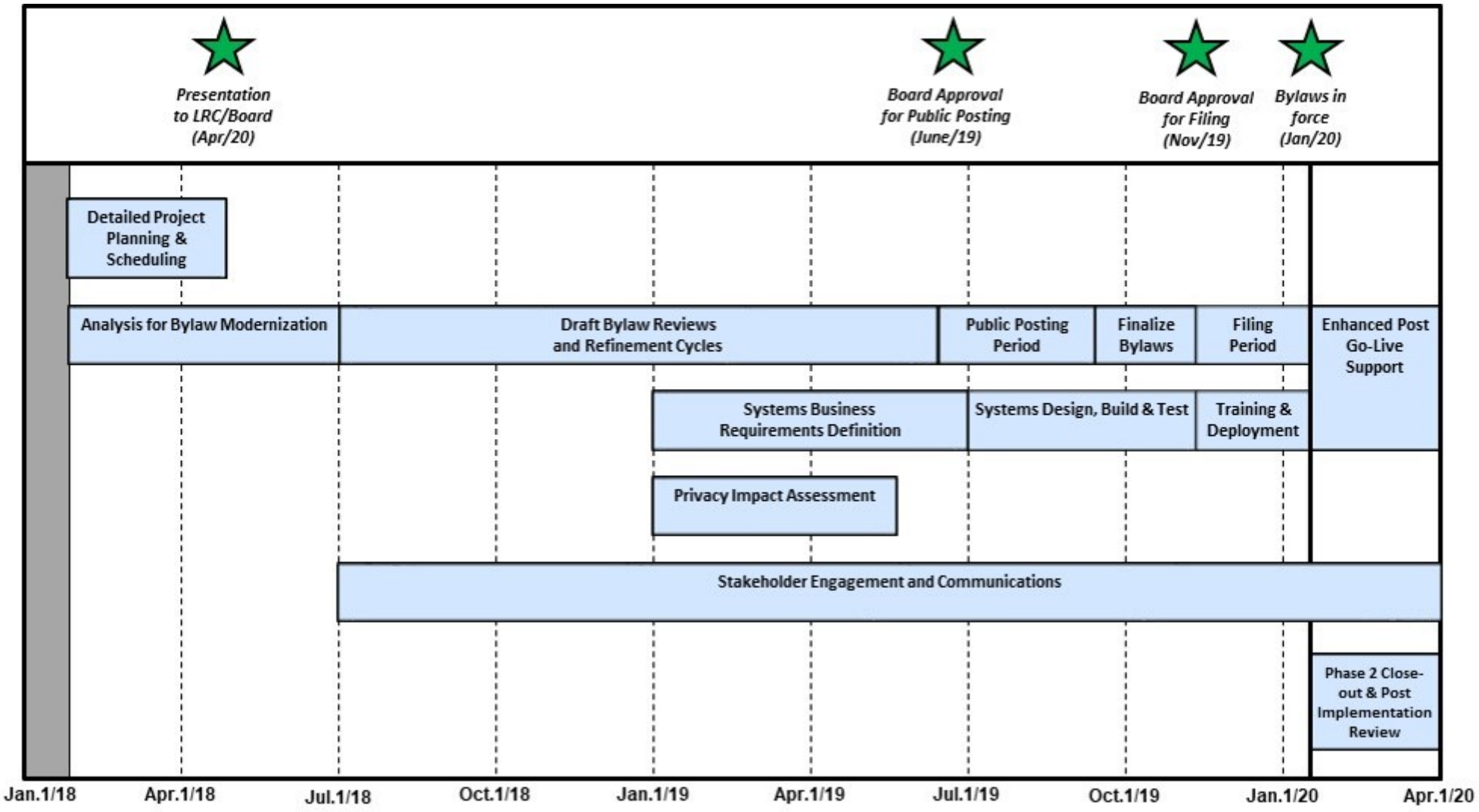
Next Steps

It is anticipated that draft bylaws will be presented to the Board for public posting by June 2019. Please refer to Appendix 1 for the detailed project timeline.

Appendix	
1	Project timeline

PODSA Phase 2

Project Timeline



College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.vi. Legislation Review Committee
b) PODSA Fee and Form Amendments

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution to file amended bylaws to actualize Pharmacy Operations and Drug Scheduling Act fee changes from the College's 2018/2019 budget:

RESOLVED THAT, in accordance with the authority established in section 21(1)(c.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 of the College of Pharmacists of British Columbia regarding pharmacy licensure fees, as set out in the schedule attached to this resolution.

Purpose

To approve amendments to the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws Schedule A – Fee Schedule in accordance with the College's 2018/2019 budget, as circulated (see Appendix 1).

Background

The Board may make bylaws as per section 21(1)(c.1) of PODSA to determine requirements for the fees that must be provided for the purposes of making an application to issue, renew or reinstate a pharmacy licence.

At their April 2018 meeting, the Board approved publicly posting an amended Fee Schedule and corresponding forms to actualize PODSA fee increases previously approved as part of the College's 2018/2019 budget. A *Health Professions Act* ("HPA") Fee Schedule and corresponding forms were also approved at that time; however, as these are not required by legislation to be publicly posted, the Board approved filing those HPA documents. See Appendix 2 for the April 2018 Board briefing note regarding the public posting of the PODSA Fee Schedule and forms.

After the April 2018 meeting, the proposed PODSA Fee Schedule and forms were publicly posted for a 90-day period, which ended in July 2018. No comments were received.

See Appendix 2 for the track change version of the proposed PODSA Fee Schedule to be considered for approval for filing with the Minister of Health. The Fee Schedule includes the proposed amendments that were publicly posted after the Board's April 2018 meeting, and previously approved changes from 2017. Please note that at their June 2017 Board meeting, the Board approved amendments to the PODSA Fee Schedule for public posting, as part of the PODSA Ownership Bylaw package. Those amendments involved the addition of new fee categories; however, no dollar value was attached to these fees. Those 2017 PODSA Fee Schedule amendments were publicly posted but not filed with the Minister, and have been added to this proposal.

Approval of HPA and PODSA Forms

Following recent legislative amendments and confirmation from legal counsel, it has been identified that Board approval is no longer required for PODSA or HPA forms:

- As part of the PODSA Ownership changes, amendments were made to both PODSA and the PODSA Bylaws to authorize the Registrar to approve forms.

- Following a recent review of the Registrar's authority with respect to HPA forms, it was confirmed with legal counsel that the Registrar can approve filing those forms with the Minister of Health. HPA forms do not require publicly posting, but are required to be filed with the Minister of Health.

Next Steps

Pending Board approval, the PODSA Fee Schedule will be submitted to the Minister of Health for a 60-day filing period. After that period, it will be posted on the College website.

Recommendation

The Legislation Review Committee recommends that the Board approve the PODSA Bylaws Schedule A – Fee Schedule for filing with the Minister of Health.

Appendix	
1	Schedule to the Resolution (fees)
2	April 2018 PODSA Fees and Forms Board Briefing Note
3	Amended Fee Schedule (track changes)

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 Schedule A- Fee Schedule.

College of Pharmacists of B.C.
FEE SCHEDULE
PODSA Bylaw "Schedule A"

PHARMACY

LICENSURE FEES

Community Pharmacy Licence	Annual licence fee.	$	2,299.00
Hospital Pharmacy Licence	Annual licence fee.	$	2,299.00
Pharmacy Education Site Licence	Annual licence fee.	$	550.00
Telepharmacy	Annual licence fee.	$	2,299.00
Hospital Pharmacy Satellite	Annual fee for each satellite site, to be charged to Hospital Pharmacy.	$	300.00
Application for New Pharmacy Licence (Community, Hospital and Telepharmacy)	Application valid for up to three years. Includes change of ownership.	$	550.00
Reinstatement of Pharmacy Licence	For re-instatement of a pharmacy licence that has been expired for 90 days or less.	$	0.00
Change of direct owner	Annual licence fee + application for new pharmacy	$	2,849.00
Change of indirect owner		$	0.00
Change of manager		$	0.00
Change in corporation name		$	0.00
Change in operating name of the pharmacy		$	0.00
Change in location of the pharmacy		$	0.00
Change in layout of the pharmacy		$	0.00
Criminal Record History (CRH)	*Fee charged by Sterling Talent Solutions (formerly known as BackCheck)	$	-

INSPECTION FEE

Follow-up site review(s)	Where 3 or more site reviews are required to address deficiencies. From visit 3 onwards, this fee applies for each additional visit.	$	1,000.00

NOTES:

1) Fees are non-refundable.

2) Fees are subject to GST.

3) Annual renewal notices of pharmacy licensure are sent at leas t sixty (60) days prior to the expiry date.

College of Pharmacists of British Columbia

BOARD MEETING
April 20, 2018

5. Legislation Review Committee
d) PODSA Fee and Form Amendments

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, and related forms for public posting, as circulated.

Purpose

To approve amendments to the *Pharmacy Operations and Drug Scheduling Act* (PODSA) Bylaws Schedule A – Fee Schedule and related forms in accordance with the College's 2018/2019 budget, as circulated (Appendix 1).

Background

The Board may make bylaws as per section 21(1)(d) of PODSA to determine requirements for the licensing and operation of a pharmacy – including fees and forms. Unlike the *Health Professions Act* (HPA), PODSA does not exempt particular bylaws (e.g. fee schedules) from the 90 day public posting period requirement. Additionally, in contrast to the HPA, PODSA does not authorize the Registrar to establish forms.

This package includes proposed bylaw amendments to actualize PODSA fee increases previously approved as part of the College's 2018/2019 budget. At their February 2018 meeting, the Board approved the 2018/2019 budget which included fee increases in order to meet the needs of the College. See Appendix 2 for the February 2018 Board briefing note outlining both discussion and details of the budget.

The related form changes (Appendix 3) recommended under PODSA are:

- Form 1A Application for New Pharmacy Licence (Community)
- Form 1C Application for New Pharmacy Licence (Hospital)
- Form 2 Application for New Telepharmacy Licence (Community)
- Form 2A Application for Pharmacy Licence Renewal (Community)
- Form 2C Application for Pharmacy Licence Renewal (Hospital)
- Form 3A Application for Pharmacy Licence Reinstatement (Community)
- Form 3C Application for Pharmacy Licence Reinstatement (Hospital)
- Form 8A Application for Change of Direct Owner
- Form 12 Application for Telepharmacy Licence Renewal (Community)

Next Steps

Once the 90 public posting period is completed, pending review of any feedback received, both the bylaws and forms will be brought to the Board at their September 2018 meeting for filing approval.

Recommendation

The Legislation Review Committee recommends that the Board approve the PODSA Bylaws Schedule A – Fee Schedule and related forms for public posting as circulated.

Appendix	
1	Amended Fee Schedule (track changes)
2	February 2018 Board Briefing Note – Budget 2018-19
3	Forms (track changes)

College of Pharmacists of B.C.
FEE SCHEDULE
PODSA Bylaw "Schedule A"

PHARMACY

LICENSURE FEES

Community Pharmacy Licence	Annual licensce fee.	~~$ 2,250.00~~	$2,299.00
Hospital Pharmacy Licence	Annual licensce fee.	~~$ 2,250.00~~	$2,299.00
Pharmacy Education Site Licence	Annual licensce fee.	$ 550.00	
Telepharmacy	Annual licensce fee.	~~$ 2,250.00~~	$2,299.00
Hospital Pharmacy Satellite	Annual fee for each satellite site, to be charged to Hospital Pharmacy.	$ 300.00	
Application for New Pharmacy Licen~~cesure~~ (Community, Hospital and Telepharmacy)	Application valid for up to three years. Includes change of ownership.	$ 550.00	
Reinstatement of Pharmacy Licence	For re-instatement of a pharmacy licence that has been expired for 90 days or less.	$ 0.00	
Change of direct owner	Annual licence fee + application for new pharmacy licence	~~$ 2,800.00~~	$2,849.00
Change of indirect owner		$ 0.00	
Change of manager		$ 0.00	
Change in corporation name		$ 0.00	
Change in operating name of the pharmacy		$ 0.00	
Change in location of the pharmacy		$ 0.00	
Change in layout of the pharmacy		$ 0.00	
Criminal Record History (CRH)	*Fee charged by Sterling Talent Solutions (formerly known as BackCheck)	$ -	

INSPECTION FEE

Follow-up site review(s)	Where 3 or more site reviews are required to address deficiencies. From visit 3 onwards, this fee applies for each additional visit.	$ 1,000.00

NOTES:

1) Fees are non-refundable.

2) Fees are subject to GST.

3) Annual renewal notices of pharmacy licensure are sent at least ~~thirty (30)~~ sixty (60) days prior to the expiry date.

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.vii. PPP Housekeeping Amendments
a) PPP-58: Medication Management (Adapting a Prescription)

DECISION REQUIRED

Recommended Board Motion:

Approve housekeeping amendments to the Professional Practice Policy 58 – Medication Management (Adapting a Prescription)

Purpose
To approve housekeeping amendments to Professional Practice Policy 58 – Medication Management (Adapting a Prescription) ("PPP-58").

Background
PPP-58 provides the framework to guide pharmacists in the safe and effective adaptation of existing prescriptions. The three primary activities considered under the notion of adapting a prescription include change, renew, and substitution.

Discussion
Recently, it came to the attention of College staff that the amendment chart included as part of PPP-58 is unclear. Specifically, the chart outlined requirements that were no longer in place, and so, registrants may not be fully aware of the provisions contained within PPP-58.

To better ensure compliance, the amendment chart has been amended to remove outdated provisions and notations that no changes were made at specific dates (see Appendix 1).

Next Steps
If approved by the Board, the above-noted amendments would take effect immediately. College staff would ensure that the amended version of PPP-58 is updated on the College website and that the changes are communicated to stakeholders.

Recommendation
The Legislation Review Committee recommends that the Board approve housekeeping amendments to PPP-58.

Appendix	
1	Amendments to PPP-58 (track changes and clean copy)

College of Pharmacists
of British Columbia

IMPORTANT INFORMATION

Amendment to
Orientation Guide – Medication Management (Adapting a Prescription)
(December 2008 – revised February 2011/April 2016/October 2016)

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Prescription (Fundamental 3)	You must have an original prescription (an authorization from a practitioner to dispense a specified drug for use by a designated individual) and it must be current, authentic, and otherwise appropriate for the patient.	Section 2.1.3; page 7.	**October 2016:** • Pharmacists may adapt an original prescription, including the first and subsequent refills of that prescription, in accordance with PPP-58. • The adaptation does not need to be the beginning of a new drug therapy. • Original prescriptions do not include transferred prescriptions, previously adapted prescriptions, or emergency refills.

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Liability Insurance	Minimum requirements for liability insurance: • Personal professional liability insurance (minimum $2 million)	Section 4.1; Page 19	**December 2008:** Minimum requirements for liability insurance are: • The policy provides a minimum of $2 million coverage, and • The policy provides occurrence-based coverage or claims-made coverage with an extended reporting period of at least three years, and • If not issued in the pharmacist's name, the group policy covers the pharmacist as an individual.
			~~**February 2011:**~~ ~~No change~~
			~~**April 2016:**~~ ~~**No change**~~
			~~**October 2016:**~~ ~~**No change**~~
Handwritten notation from prescriber "Do Not Renew / Adapt" (or similar)	"review . . . the acknowledgement of any hand-written notations on the prescription by the prescriber."	Section 2.1.2; Page 7	**December 2008:** • Pharmacists will honour hand-written (not pre-stamped) "Do Not Renew / Adapt" notification on prescriptions • If a prescriber electronically produces their prescriptions they must sign or initial beside the notation
			~~**February 2011:**~~ ~~No change~~
			~~**April 2016:**~~ ~~**No change**~~
			~~**October 2016:**~~ ~~**No change**~~

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Renewals – specific conditions &/or drugs	No limits and/or conditions stated	n/a	~~**December 2008:**~~ • ~~Renewals apply to stable, chronic conditions (same medication, with no change, for a minimum of six months)~~ • ~~For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams~~
			February 2011: • Renewals apply to stable, chronic conditions (same medication, with no change) *Note: 'no change' is defined as usually a minimum of six months* • For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams
			~~**April 2016:**~~ ~~**No change**~~
			~~**October 2016:**~~ ~~**No change**~~
Renewals – length of time	"for whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription"	Section 2.2.2; Page 15 and Section 2.1.3; Page 7	~~**December 2008:**~~ • ~~Maximum renewal up to 6 months from the date of the original prescription~~
			February 2011: • For whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription *Note: All prescriptions have an expiry of one year from the date the original prescription is written; oral contraceptives have a 2 year expiry date*
			~~**April 2016:**~~ ~~**No change**~~
			~~**October 2016:**~~ ~~**No change**~~

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Change: dose or regimen	No limits and/or conditions stated	Section 2.2.1; Page 14	**December 2008:** Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will not change the dose or regimen of prescriptions for: cancer, cardio-vascular disease, asthma, seizures or psychiatric conditions • Pharmacists can complete missing information on a prescriptions if there is historical evidence to support it
			~~**February 2011:**~~ ~~No change~~
			~~**April 2016:**~~ ~~**No change**~~
			~~**October 2016:**~~ ~~**No change**~~
Therapeutic Substitution	No limits and/or conditions stated	Section 2.2.3; Page 16	~~**December 2008:**~~ ~~Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists:~~ • ~~Will limit therapeutic substitution to: Histamine 2 receptor blockers (H2 blockers), Non-steroidal anti-inflammatory drugs (NSAIDs), Nitrates, Angiotension converting enzyme inhibitors (ACE inhibitors), Dihydropyridine calcium channel blockers (dihydropyridine CCBs) and Proton pump inhibitors (PPIs)~~
			~~**February 2011:**~~ ~~No change~~
			~~**October 2016:**~~ ~~**No change**~~

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
			April 2016: Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: Will limit therapeutic substitution to those categories under the Ministry of Health's Reference Drug Program, the updated list can be accessed here: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/general-coverage-policies#rdp
			~~**October 2016:**~~ ~~**No change**~~

College of Pharmacists
of British Columbia

IMPORTANT INFORMATION

Amendments to
Orientation Guide – Medication Management (Adapting a Prescription)
(December 2008 – revised February 2011/April 2016/October 2016)

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Prescription (Fundamental 3)	You must have an original prescription (an authorization from a practitioner to dispense a specified drug for use by a designated individual) and it must be current, authentic, and otherwise appropriate for the patient.	Section 2.1.3; page 7.	**October 2016:** • Pharmacists may adapt an original prescription, including the first and subsequent refills of that prescription, in accordance with PPP-58. • The adaptation does not need to be the beginning of a new drug therapy. • Original prescriptions do not include transferred prescriptions, previously adapted prescriptions, or emergency refills.
Liability Insurance	Minimum requirements for liability insurance: • Personal professional liability insurance (minimum $2 million)	Section 4.1; Page 19	**December 2008:** Minimum requirements for liability insurance are: • The policy provides a minimum of $2 million coverage, and • The policy provides occurrence-based coverage or claims-made coverage with an extended reporting period of at least three years, and If not issued in the pharmacist's name, the group policy covers the pharmacist as an individual.
Handwritten notation from prescriber "Do Not Renew / Adapt" (or similar)	"review . . . the acknowledgement of any hand-written notations on the prescription by the prescriber."	Section 2.1.2; Page 7	**December 2008:** • Pharmacists will honour hand-written (not pre-stamped) "Do Not Renew / Adapt" notification on prescriptions • If a prescriber electronically produces their prescriptions they must sign or initial beside the notation.

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Renewals – specific conditions &/or drugs	No limits and/or conditions stated	n/a	**February 2011:** • Renewals apply to stable, chronic conditions (same medication, with no change) *Note: 'no change' is defined as usually a minimum of six months* • For psychiatric medications renewals are reserved for pharmacists working in multidisciplinary teams
Renewals – length of time	"for whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription"	Section 2.2.2; Page 15 and Section 2.1.3; Page 7	**February 2011:** • For whatever period of time felt appropriate as long as it does not exceed the expiry of the prescription *Note: All prescriptions have an expiry of one year from the date the original prescription is written; oral contraceptives have a 2 year expiry date*
Change: dose or regimen	No limits and/or conditions stated	Section 2.2.1; Page 14	**December 2008:** Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: • Will not change the dose or regimen of prescriptions for: cancer, cardio-vascular disease, asthma, seizures or psychiatric conditions • Pharmacists can complete missing information on a prescriptions if there is historical evidence to support it

Topic	Current wording in Orientation Guide	Reference in Orientation Guide	Clarification / Update
Therapeutic Substitution	No limits and/or conditions stated	Section 2.2.3; Page 16	**April 2016:** Unless in practice settings such as hospital, long-term care facilities or multi-disciplinary environments where collaborative relationships or appropriate protocols are established, pharmacists: Will limit therapeutic substitution to those categories under the Ministry of Health's Reference Drug Program, the updated list can be accessed here: http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/general-coverage-policies#rdp

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.vii. PPP Housekeeping Amendments
b) PPP-66: Opioid Agonist Treatment
PPP-67: Injectable Opioid Agonist Treatment

DECISION REQUIRED

Recommended Board Motions:

(1) Approve housekeeping amendments to the following Professional Practice Policies (PPPs):

- *PPP-66 - Opioid Agonist Treatment*
- *PPP-67 – Injectable Opioid Agonist Treatment*

(2) Approve housekeeping amendments to the following Policy Guides:

- PPP-66-Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)
- PPP-66-Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)
- PPP-66-Policy Guide – Methadone Maintenance Treatment (2013)
- PPP-67-Policy Guide – Injectable Hydromorphone Maintenance Treatment (2018)

Purpose

To approve the following housekeeping amendments to the following policy documents:

- PPP-66 Opioid Agonist Treatment
- PPP-66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)
- PPP-66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)
- PPP-66 Policy Guide – Methadone Maintenance Treatment (2013)
- PPP-67 Injectable Opioid Agonist Treatment (2018)
- PPP-67 Policy Guide – Injectable Hydromorphone Maintenance Treatment (2018)

Background

At their April 2018 meeting, the Board approved amendments to PPP-66 and the three policy guides to include minor changes requested by stakeholders and registrants. As of June 2018, the Board approved PPP-67 and the policy guide for injectable hydromorphone maintenance treatment, which became effective on Sept 1, 2018.

Discussion

In May 2018, the federal *Narcotic Control Regulation* (NCR) was amended to remove the requirement for a practitioner to obtain an exemption under section 56 of the *Controlled Drugs and Substances Act* (Canada) in order to prescribe methadone. As a result, references to the exemption process need to be removed from PPP-66 Policy Guide – Methadone Maintenance Treatment (2013). In addition, other housekeeping amendments to the above-noted policy documents have been requested by the Ministry of Health (MoH) and identified via internal review. Lastly, very minor changes were identified (e.g., formatting, spelling corrections, etc.).

The tables below summarize the proposed changes requested by MoH (Table 1) and those identified via internal review (Table 2), noting the affected sections in each document[1]. The very minor changes identified (e.g., formatting, spelling corrections, etc.) have not been outlined below, but are noted in the appendices to this briefing note (See Appendix 1-6).

Table 1. Summary of Proposed Changes: Content Clarification and MoH Requested Updates

Proposed changes	Affected sections
Content clarification	
Principle 1.2.1 was amended to remove the 2nd and 3rd sentences detailing instructions on how to take SROM (i.e., swallow pellets whole). The same instructions were duplicated under Principle 4.1.4. Without full context provided under 4.1.4, the instruction can be confusing.	SROM: 1.2.1.
Principle 3.2.1 was amended to replace “using appropriate PIN” with “using the appropriate Drug Identification Number (DIN) or Product Identification Number” to note the difference between DIN and PIN.	MMT: 3.2.1. SROM: 3.2.1.
Guidelines under Principle 4.1.4 and 4.1.5 were amended to replace "Avoid swallowing…" with "The Patient should avoid swallowing…" to improve clarity.	BN: 4.1.4, and 4.1.5.
Content updates	
The word “new” was removed when referring to the BCCSU Guide and Kadian PIN since the document and information are no longer new.	BN: 1.2.3. SROM: 1.2.3, and 3.2.1.
"witness ingestion" was replaced with "scheduled release of medication" to include reporting missed take-home doses to prescriber.	MMT: 5.2.3. BN: 5.1.3. SROM: 5.1.3.
Principle 3.2.1 (processing methadone prescriptions) was amended to replace "maintenance" with "opioid use disorder" to align with terms used in the new 2018 CPSBC *Practice Standard – Prescribing Methadone*.	MMT: 3.2.1.

[1] For the purposes of Table 1 and Table 2: BN means PPP-66 Policy Guide - Buprenorphine/Naloxone (2018); MMT means PPP-66 Policy Guide - Methadone Maintenance Treatment (2013); PPP-66 means PPP-66 Opioid Agonist Treatment; and, SROM means PPP-66 Policy Guide - Slow Release Oral Morphine (2018).

Table 2. Summary of Proposed Changes: Content Updates Identified through Internal Review.

Proposed changes	Affected sections
References to the Federal Section 56 exemption were removed, as it is no longer required.	MMT: 5th paragraph in "Forward", 2.3.1, and 3.2.1.
Sections for 2014 methadone policy amendment effective dates, implementation timeline, and transition period requirements were removed as those were no longer relevant in 2018.	PPP-66: 2, 2.1, Implementation Timeline, and Transition Period.
The name of the CAMH document, *A Pharmacist's Guide to Treatment (2000),* was updated to the name of the current version: *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders (2015)*.	PPP-66: 2 (Required References).
To reflect the full range of SROM options, "approved, commercially available strengths" was replaced with "approved, commercially available strengths and formulations".	PPP-66: 3.3(c). SROM: 3.1.1.

Next Steps

If approved by the Board, the above-noted amendments would take effect immediately. The following next steps would then take place:

- Communicate amendments to policy documents.
- Update the College website with revised policy documents.
- Update the CPBC online MMT training video to indicate the removal of the prescriber Section 56 exemption.
- Migrate PPP-66 Policy Guide – Methadone Maintenance Treatment (2013) to the new Policy Guide format. (Note: This project will include reviewing PPP-71, and ensuring alignment with the newer OAT Policy Guides.)

Recommendation

The Legislation Review Committee recommends that the Board approve housekeeping amendments to:

- PPP-66 Opioid Agonist Treatment and accompanying policy guides (i.e., PPP-66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018), PPP-66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018) and PPP-66 Policy Guide – Methadone Maintenance Treatment (2013)); and,
- PPP-67 Injectable Opioid Agonist Treatment and accompanying policy guide (i.e., PPP-67 Policy Guide – Injectable Hydromorphone Maintenance Treatment (2018)).

Appendix	
1	Amendments to PPP-66 Opioid Agonist Treatment (track changes)
2	Amendments to PPP-66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018) (track changes)
3	Amendments to PPP-66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018) (track changes)
4	Amendments to PPP-66 Policy Guide – Methadone Maintenance Treatment (2013) (track changes)
5	Amendments to PPP-67 Injectable Opioid Agonist Treatment (track changes)
6	Amendments to PPP-67 Policy Guide – Injectable Hydromorphone Maintenance Treatment (2018) (track changes)

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

Effective January 1, 2018:

1. Buprenorphine/nNaloxone 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 pharmacists, 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/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU) *"A Guideline for the Clinical Management of Opioid Use Disorder"*, and
    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 pharmacists, 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 the BCCSU's *"A Guideline for the Clinical Management of Opioid Use Disorder"*,
    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), 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 pharmacists, 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 BCCSU~~'s "~~*A Guideline for the Clinical Management of Opioid Use Disorder*~~."~~
- The m~~M~~ost current ~~edition~~ version of ~~Methadone Maintenance: A Pharmacist's Guide to Treatment,~~ the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders (2015).*
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

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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 pharmacists, 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 the BCCSU~~'s "~~*A Guideline for the Clinical Management of Opioid Use Disorder*~~"~~, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 Sep 2013 / 17 Nov 2017 / 20 Apr 2018
Reaffirmed:

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 pharmacists, 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) *Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

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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.~~

Note: 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~~ most recent version ~~guideline to~~ of the British Columbia Centre on Substance Use (BCCSU) ~~website~~ *"A Guideline for the Clinical Management of Opioid Use Disorder"*. Recommend completion of online training through the University of British Columbia Faculty of Medicine, Continuing Professional Development's Provincial Opioid Addiction Treatment Support Program. ~~(https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program).~~

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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 and formulations. Capsule contents cannot be split.

Principle 3.1.2 **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.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 Drug Identification Number (DIN) or 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.

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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~~SROM 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 before the next scheduled release of medication~~witnessed ingestion~~. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication* ~~f~~Form (Appendix 2) can be used for this purpose.

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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 the ~~'Appendix 3: Induction and dosing guidelines for Slow Release Oral Morphine' of the~~ BCCSU's ~~"~~*A Guideline for*

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the Clinical Management of Opioid Use Disorder" - Appendix 3: Induction and Ddosing Gguidelines for Slow Release Oral Morphine.

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* fForm (Appendix 2) can be used for the documentation and communication.

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The *SROM Part-Fill Accountability Log* (Appendix 1) can be used for the Part-Fill Accountability Log.

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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.

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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			

DRAFT

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

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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 slow release oral morphine 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

Professional Practice Policy #66

Policy Guide

Buprenorphine/Naloxone Maintenance Treatment (2018)

Buprenorphine/Naloxone Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to bBuprenorphine/nNaloxone 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.

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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 bBuprenorphine/nNaloxone 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 bBuprenorphine/nNaloxone 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 bBuprenorphine/nNaloxone induction. Educate patients on the inclusion of naloxone in bBuprenorphine/nNaloxone 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 most recent version of to the British Columbia Centre on Substance Use (BCCSU) website "*A Guideline for the Clinical Management of Opioid Use Disorder*". Recommend completion of online training through the University of British Columbia Faculty of Medicine, Continuing Professional's *Provincial Opioid Addiction Treatment Support Program* (https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program).

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2.0 Receiving Buprenorphine/Naloxone Prescriptions

2.1 Controlled Prescription Program Forms - Overview

Principle 2.1.1 Buprenorphine/nNaloxone prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting bBuprenorphine/nNaloxone 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/n~~N~~aloxone for maintenance must be dispensed to patients as an approved, commercially available formulation.

Guideline: Buprenorphine/n~~N~~aloxone 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 b~~B~~uprenorphine/n~~N~~aloxone 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 b~~B~~uprenorphine/n~~N~~aloxone maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the b~~B~~uprenorphine/n~~N~~aloxone maintenance program. Co-ingestion of b~~B~~uprenorphine/n~~N~~aloxone 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 bBuprenorphine/nNaloxone 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 bBuprenorphine/nNaloxone 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 b~~B~~uprenorphine/n~~N~~aloxone 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 b~~B~~uprenorphine/n~~N~~aloxone 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. The patient should a~~A~~void swallowing, talking, eating, drinking, and smoking.

Principle 4.1.5 If a prescriber orders the bBuprenorphine/nNaloxone 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. The patient should aAvoid 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 ~~b~~Buprenorphine/~~n~~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 bBuprenorphine/nNaloxone 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 bBuprenorphine/nNaloxone 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 before the next ~~witnessed ingestion~~scheduled release of medication. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication* fForm (Appendix 2) can be used for this purpose.

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Principle 5.1.4 -If a patient misses 6 or more consecutive days, 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 the ~~'Appendix 2: Induction and dosing guidelines for Buprenorphine/Naloxone' of the~~ BCCSU~~'s~~ *'A Guideline for the Clinical Management of Opioid Use Disorder'* - Appendix 2: Induction and D~~d~~osing G~~g~~uidelines for Buprenorphine/Naloxone.

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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* f~~F~~orm (Appendix 2) can be used for the documentation and communication.

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The *Buprenorphine/Naloxone Part-Fill Accountability Log* (Appendix 1) can be used for the Part-Fill Accountability Log.

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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.

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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			

DRAFT

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity				Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Commented [CP1]: 'DRAFT' watermark to be removed

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
Safe and Effective Pharmacy Care

Professional Practice Policy #66

Policy Guide

Methadone Maintenance Treatment (2013)



Forward

Opioid dependence is a health concern with implications for the individual patient as well as the public. Methadone maintenance treatment is recognized internationally as among the most effective treatments for opioid dependency. Addiction treatment experts recommend that methadone treatment for opioid dependence be delivered with a maintenance-oriented, rather than abstinence-oriented, philosophy. This approach acknowledges opioid dependence as a chronic disease.

Many studies, conducted over several decades in different countries, have clearly demonstrated that the 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.

Methadone, a long-acting, orally effective opioid, is used as a substitute for heroin or other narcotics when treating opioid dependence. Methadone eliminates withdrawal from and reduces cravings for, opioids. Methadone does not produce euphoria, and it blocks the euphoric effects of other opioids. When used in the treatment of opioid dependence, a single oral dose of methadone is effective for at least 24 hours. Eventual withdrawal from methadone is not necessarily the goal of the program, although some individuals may work with their physician and pharmacist to decrease their dose and eventually stop using methadone.

Methadone prescribing is controlled by both federal and provincial legislation, as well as administrative procedures and guidelines.

~~Physicians are required to obtain a special exemption to prescribe methadone for opioid dependence. In BC, the College of Physicians and Surgeons of BC (CPSBC) administers the exemption process to enable specific physicians to prescribe methadone for maintenance treatment. To obtain an exemption to prescribe methadone, physicians must complete a one-day training program and mentor with another methadone-prescribing physician. Methadone maintenance treatment exemption is separate from the exemption to prescribe methadone for pain. Some physicians are exempted to prescribe methadone for both indications.~~

Registered pharmacists are permitted to purchase and dispense methadone without federal exemption. However, the College of Pharmacists of BC's (CPBC) *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* requires that the pharmacy manager and all staff pharmacists employed in a community pharmacy that provides services related to methadone maintenance treatment complete the CPBC's training program and any subsequent updates. You must log into eServices to complete the "Declaration of Completion and Understanding" prior to providing methadone maintenance treatment services.

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How to Use This Guide

Note:

This document is not intended to cover all possible practice scenarios.

This Policy Guide (the Guide) is a companion to *Professional Practice Policy (PPP-66) –Opioid Agonist Treatment* (Appendix 1) and supports the 'live' and 'online' training. The intention of the *Guide* is to provide pharmacists with further detail and clarity (including practical examples) to assist in the implementation of the policy into practice to ensure consistency in the safe and effective delivery of methadone maintenance treatment services.

As always the expectation is that pharmacists will practice in compliance with their legislative requirements, including the principles outlined in this *Guide*. It is understood however that pharmacy practice is not always 'black and white' and when navigating the 'grey' pharmacists must use sound professional judgment, ensuring that their decisions are made in the best interest of the patient and with appropriate collaboration, notification and most importantly, documentation.

The *Guide* is to be read in conjunction with completion of the mandatory training session. Information regarding the mandatory sessions can be found on the CPBC website at **www.bcpharmacists.org.**

Declaration

After completing the mandatory 'live' or 'online' training session, and subsequently reading this *Guide*, pharmacists must log into eServices to complete the '*Declaration of Completion and Understanding*'.

Acknowledgement

The development of this *Guide* involved a collaborative and consultative process with input and feedback gathered from a volunteer group of dedicated community pharmacists currently engaged, in varying capacities, in the delivery of methadone maintenance treatment services.

The group was comprised of both frontline pharmacists and pharmacy managers and represented a cross-section of practice types (independent to large chain retailers) and practice settings including pharmacies located in Vancouver's Downtown Eastside whose primary focus is on the provision of methadone maintenance treatment.

Feedback was also solicited from other stakeholder groups including; the Ministry of Health Services, the College of Physicians and Surgeons of BC, the BC Pharmacy Association, the City of Vancouver, patient advocacy groups Vancouver Area Network of Drug Users (VANDU), and the BC Association for People on Methadone (BCAPOM).

The College of Pharmacists of BC would like to sincerely thank each of these individuals and organizations for their invaluable feedback in the creation of this significant resource for pharmacists.

Feedback

Questions and comments about this *Guide* are welcome and can be sent to:

College of Pharmacists of British Columbia
200 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

Telephone: 604-733-2440 or 800-663-1940
Facsimile: 604-733-2493 or 800-377-8129
E-mail: practicesupport@bcpharmacists.org
Web site: www.bcpharmacists.org

Table of Contents

Methadone Maintenance Treatment Policy Guide

In accordance with *Professional Practice Policy (PPP-66) – Opioid Agonist Treatment* (Appendix 1), all pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC's (CPBC) Methadone Maintenance Treatment Policy Guide (2013) and all subsequent revisions. The responsibility of pharmacy technicians in the dispensing of MMT is consistent with their scope of practice outlined in the *Health Professions Act* (HPA) Bylaws Schedule F Part 1 section 4.

Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1

Patients must attend the pharmacy unless exceptional circumstances are provided for under *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment*. The pharmacy hours of service must be consistent with the supervised dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily witness ingestion (ie; 7 days per week) the pharmacy hours of service must accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for methadone maintenance treatment from 'daily witness' to a 'take-home' dose.

1.2 Privacy and Confidentiality – Premise

Principle 1.2.1

All pharmacies offering methadone maintenance treatment must be in compliance with all relevant legislation pertaining to the structure of the licensed premise with particular attention given to ensuring there is sufficient space to accommodate patients waiting for witnessed ingestion and/or take home methadone doses while simultaneously maintaining privacy for pharmacist-patient consultation.

Guideline: It may be appropriate to establish a staggered schedule for regular patients requiring witnessed ingestion to ensure that there is adequate space within the pharmacy to accommodate patients who are waiting and ensure privacy of pharmacist-patient consultation.

1.3 Security – Premise

Principle 1.3.1

All pharmacies offering methadone maintenance treatment must ensure that their pharmacy is in compliance with all relevant legislation pertaining to pharmacy security requirements including those outlined in *Professional Practice Policy (PPP-74) – Community Pharmacy Security.*

2.0

Receiving Methadone Prescriptions

2.1 Methadone Maintenance Controlled Prescription Forms – Overview

Principle 2.1.1

Methadone maintenance prescriptions can **only** be accepted when written using an original Methadone Maintenance Controlled Prescription form.

Guideline: When accepting a methadone maintenance prescription a pharmacist must ensure that the Methadone Maintenance Controlled Prescription form is completed by the prescriber as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3).

Principle 2.1.2

The pharmacist must ensure that the patient, as well as themselves, sign the form, in the space indicated on the bottom of the form.

Principle 2.1.3

Faxed Methadone Maintenance Controlled Prescription forms are not acceptable unless under extenuating circumstances where the prescriber has determined, following consultation with the pharmacist, that the urgency of the situation warrants it.

Note:

The Emergency Fax Controlled Prescription Program Form Documentation (Appendix 4) can be used for this purpose.

Guideline: In such cases the pharmacy, prior to dispensing the medication, must receive, in addition to a fax of the Methadone Maintenance Controlled Prescription form, written confirmation (fax acceptable) signed by the prescriber that briefly describes the emergency situation and guarantees the delivery of the original Methadone Maintenance Controlled Prescription form to the pharmacy the next business day or as soon as possible when the physician is not available.

The faxed Methadone Maintenance Controlled Prescription form and related documentation, as described in Appendix 4, must be attached to the original Methadone Maintenance Controlled Prescription form once received.

Principle 2.1.4

In an effort to maximize the effectiveness of the methadone maintenance treatment program, the pharmacist may find it beneficial to engage in a specific dialogue with the patient, either when they initiate treatment or at various times throughout treatment, that clearly outlines the expectations of both the patient and the pharmacist.

Guideline: The *Methadone Maintenance Treatment Expectation Form* (Appendix 5) can be used for this purpose.

Principle 2.1.5

In the rare circumstance (disruptive or threatening behavior or verbal or physical abuse) where a pharmacist finds that they must terminate the pharmacist-patient relationship, reasonable notice must be provided to the patient to ensure their continuity of care.

Guideline: It is important to remember that the decision to terminate a pharmacist-patient relationship is a serious one and must be made with due consideration and based on appropriate rationale. It is unethical for a pharmacist to terminate the pharmacist-patient relationship or refuse to treat a patient on morally irrelevant grounds. The pharmacist's decision should be documented and retained in the patient record.

2.2 Methadone Maintenance Controlled Prescription Forms – Alterations

Principle 2.2.1

Alterations to the Methadone Maintenance Controlled Prescription form are the exception to the rule and should not be normal practice as they increase the likelihood of errors and drug diversion and put the public at risk.

In the rare circumstance when an alteration is necessary to ensure the continuity of care pharmacists must always use due diligence to ensure authenticity and accuracy of the prescription.

Note:

The Pharmacist-Prescriber Communication Form (Appendix 6) can be used for this purpose.

Guideline:

Alterations completed at the prescriber's office:

Alterations are only permitted on the sections of the form that the prescriber completes provided that the prescriber has initialed the alteration.

Alterations are not permitted to the pre-printed sections of the form.

Alterations completed at the pharmacy:

Pharmacists do not have independent authority to make any alterations or changes to a Methadone Maintenance Controlled Prescription form. Any required or requested change(s) must be patient-specific and authorized by the patient's prescriber through direct consultation with the pharmacist. Any prescriber-authorized changes must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication whenever possible and attached and filed with the original prescription.

2.3 Out-of-Province Prescriptions

Principle 2.3.1

Pharmacists are permitted to dispense methadone prescriptions from prescribers in provinces other than BC.

Note:

It's important to realize that not all provinces are required to use Controlled Prescription Program Forms.

Guideline: If there are any doubts regarding the authenticity of the out-of-province prescription, the pharmacist must contact the out-of-province prescriber to confirm the legitimacy of the prescription ~~(including the prescriber's exemption to prescribe methadone)~~. When satisfied that the prescription is authentic, the pharmacist can dispense and process the prescription in the same manner as other prescriptions from out-of-province prescribers.

3.0

Processing (Dispensing) Methadone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1

Methadone for maintenance must be dispensed to patients in a concentration of 10 mg/ml.

Guideline: Only commercially available 10 mg/ml oral preparations are permitted for use.

Principle 3.1.2

Positive identification is required for all patients presenting a prescription for the first time, and reasonable steps to positively identify the patient must be taken prior to dispensing any subsequent prescriptions.

Guideline: The CPBC's *Professional Practice Policy (PPP-54) – Identifying Patients for PharmaNet Purposes* requires the pharmacist to view one piece of "primary identification" or two pieces of "secondary identification" as verification of a positive identification. If a patient cannot provide the required identification, the prescriber may be contacted to assist with verifying the patient's identity.

Principle 3.1.3

Pharmacists and pharmacy technicians must review the prescription to ensure that it is completed by the prescriber as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3) and that the directions for use appropriately meet the specific needs of the patient and can be accommodated by the pharmacy.

Guideline: Each prescription must be reviewed in detail in consultation with, and consideration given to the specific needs of, the patient. The following list is a sample only:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a weekend when the patient will not be able to see a physician for a new prescription.
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, divided dose, 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.
- Confirm that stamped or preprinted sticker directions do not conflict with written directions.

Any ambiguous or conflicting information identified must be clarified with the prescriber. Should an alteration or change to the prescription be required, it must be done in compliance with the Principles and Guidelines outlined in section 2.2.

3.2 Assessment of a Prescription

Principle 3.2.1

Pharmacists and pharmacy technicians must correctly identify the product as prescribed for 'pain' or '~~maintenance~~opioid use disorder' by using the appropriate Drug Identification Number (DIN) or Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

~~**Guideline:** If the prescriber is not authorized to prescribe methadone for the purpose indicated on the prescription PharmaNet will reject the prescription and send a message (*#174 – Transaction not processed – prescriber not authorized*) to the pharmacy. Should this occur the pharmacist should check that the correct CPSBC ID number (not the Medical Services Plan billing number) and the correct methadone DIN has been entered.~~

~~In rare instances, the most recent daily data load from the CPSBC may not include a newly authorized prescriber's information. To confirm a prescriber's status, contact the CPSBC BC Methadone Program at (604) 733-7758 x2628. The PharmaNet Helpdesk cannot change a physician's methadone status on PharmaNet, this change can only be made by the CPSBC.~~

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 methadone prescription.

This step is particularly critical for methadone prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system does not include methadone. Pharmacists providing methadone maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to methadone. General information in this regard can be found in Appendix 7.

Guideline: A PharmaNet patient record review must 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

Mood altering drugs, including benzodiazepines and narcotics, are not generally prescribed to patients on the methadone maintenance program. Should a patient present a prescription for a mood altering drug 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 methadone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the methadone maintenance program.

Guideline: The pharmacist should document the outcome of the consultation(s) with the prescriber(s) and attach it to the original prescription.

Principle 3.2.4

The 'sig field' on the prescription label must include the start and end dates of the original current prescription.

Principle 3.2.5

As required by HPA Bylaws Schedule F Part 1 the 'dispensing date' on the prescription label must accurately reflect the actual date dispensed on the PharmaNet system.

3.3 Preparing Methadone Prescriptions

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.

Guideline: 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.

Principle 3.3.2

Reconciliation procedures must be conducted in accordance with *Professional Practice Policy (PPP-65) – Narcotic Counts and Reconciliations*.

Guideline: As per *PPP-65,* the pharmacy manager must ensure that narcotic counts and reconciliations, which include methadone, are completed:

- At a minimum of every 3 months, and
- After a change of manager, and
- After a break-in or robbery.

Reconciliation means the quantity of methadone on hand must equal the quantity received minus the quantity dispensed over a specific period of time.

3.4 Loss or Theft and Disposal of Methadone

Principle 3.4.1

The Narcotic Control Regulations require that pharmacists report the loss or theft of controlled drugs and substances to the Office of Controlled Substances, Health Canada within 10 days of the discovery of the loss or theft.

In the event of a loss or theft the pharmacy should also notify the CPBC as soon as possible.

Guideline: The form for reporting loss or theft of narcotics can be found on the CPBC website **www.bcpharmcists.org** under *Resources.*

Principle 3.4.2

Methadone, like any other narcotic or controlled drug, can only be disposed of with authorization from Health Canada and after being rendered unusable.

Guideline: To receive authorization to dispose of methadone the pharmacist must submit a written *Authorization to Destroy for Expired Narcotic and Controlled Drugs* to the Office of Controlled Substances, Health Canada.

An acceptable method of rendering methadone unusable is to place the product in a leak-proof container or plastic bag and add kitty litter until the mixture is almost solid.

Once the required authorization is received from Health Canada the pharmacist must record the amount of product to be disposed of, having a second healthcare professional sign for the disposal, and place the now rendered unusable product in the pharmacy's medication return container.

3.5 Methadone in Tablet Form for Air Travel

Principle 3.5.1

Hand luggage restrictions governing the transportation of fluids in air travel may be problematic for patients and in certain circumstances may necessitate the prescription of methadone in tablet form. Only commercially available methadone in tablet form may be dispensed. Pharmacists need to be aware that the prescription of methadone in tablet form may result in increased risk for both patients and the public.

Note: dispensing of methadone powder by way of sachet, capsule, or other format is never acceptable due to the increased potential for diversion and misuse.

Guideline: Long-term methadone maintenance treatment clearly limits patients' ability to travel because of the need for regular follow-up as well as the restrictions associated with the dispensing of methadone. If patients receiving MMT wish to travel for a period of time that exceeds their regular carry period, the usual standard of care should not be compromised, particularly if the patient is not stable and still requires daily supervised ingestion.

Patients are significantly limited in their ability to transport methadone across international borders but it is possible to arrange for methadone dispensing in some jurisdictions. The CPSBC advises physicians to research each case to ensure decisions do not compromise patient safety. In some cases, patients may require documentation for the purpose of crossing international borders or to assist in accessing temporary care from a methadone program at their destination. The physician is responsible to provide the required travel documentation.

4.0

Releasing Methadone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1

A pharmacist must be present and witness the release of a methadone 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 methadone prescription the pharmacist must assess the competence of the patient (i.e. ensure that the patient is not currently intoxicated or otherwise mentally impaired) to ensure that it is safe to release the medication to them.

Guidelines: Pharmacists must 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 'normal' behaviour in order to be able to detect significant deviations from normal.

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 attach it to the original prescription.

Principle 4.1.3

Prior to releasing a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log (the sample *Methadone Part-Fill Accountability Log* (Appendix 9) can be used for this purpose).

Guidelines: Every part-fill dispensed must be accounted for. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

The pharmacist releasing and the patient receiving the part-fill of the prescription must sign for each witnessed ingestion dose and each take-home dose. **Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.**

The patient/prescription specific log (the sample *Methadone Part-Fill Accountability Log* (Appendix 9) can be used for this purpose) must be attached to the original Controlled Prescription Program form and once complete filed sequentially by the first prescription or transaction number assigned to the prescription.

Principle 4.1.4

As with all prescriptions, prior to releasing a methadone prescription, the pharmacist must counsel the patient on the risks (including common side effects) and benefits of taking their medication. As per HPA Bylaws Schedule F Part 1 section 12.

Guidelines: The most common adverse reactions with methadone include; sweating, constipation, sexual dysfunction, change in menstruation, drowsiness, sleep disturbances, muscle and bone aches, weight changes (usually gain), skin rash, gastrointestinal upset, headaches and edema. Patients will benefit from information about the non-drug approaches, nonprescription products and prescription items that can provide relief from these side effects.

Principle 4.1.5

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.

Guidelines: Given the concentrated solution of 10mg/ml, it may be helpful to provide a glass of water to the patient to enable rinsing out of the dispensing container to ensure full dose administration.

Immediately following observing the patient's ingestion of the medication the pharmacist should engage the patient in a short conversation to ensure that the entire dose has been swallowed.

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.

Note:

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.

Guidelines: Each dose must be dispensed in an individual, appropriately sized, child-resistant container.

Each container must be individually labeled.

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.

Patients should be reminded that methadone should be stored out of the reach of children, preferably in a locked cupboard or small lock box if stored in the refrigerator.

Principle 4.1.7

In extraordinary situations, when a patient cannot attend the pharmacy, the patient's representative may pick up and sign for their authorized take-home dose(s) if confirmed in writing by the prescriber.

Note:

Patient representative is defined in HPA Bylaws.

Guidelines: This authorization must be date specific, and the representative and circumstances must be clearly defined. The written and signed authorization from the prescriber (fax acceptable) must be attached to the original Methadone Maintenance Controlled Prescription form.

Principle 4.1.8

Delivery of methadone is **prohibited** under federal legislation except as provided for in extraordinary circumstances according to *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*

Guidelines: The pharmacist must read and understand *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*

Responding to Methadone Dosing Issues

5.1 Divided (Split) Doses

Principle 5.1.1 Only the prescriber, by stating this on the original Methadone Maintenance Controlled Prescription form, can authorize a divided (split) dose of a prescription. Unless otherwise specified by the prescriber, the first portion of the daily dose must be by witnessed ingestion.

Guideline: The decision to authorize a divided dose can only be made by the prescriber however, should a pharmacist believe that a patient would benefit from this they should discuss this option with the prescriber.

5.2 Missed Doses

Principle 5.2.1 Any methadone 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 methadone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.2.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.2.3 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~~ scheduled release of medication.

Guideline: The notification document must be retained and filed with the prescription consistent with filing retention requirements. The *Pharmacist-Prescriber Communication Form* (Appendix 6) can be used for this purpose.

5.3 Partial Consumption of Doses

Principle 5.3.1 If a patient refuses to consume their full dose, the pharmacist must not insist that they ingest the total amount. The unconsumed portion however cannot be given as a take-home dose.

Guideline: The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. *The Pharmacist-Prescriber Communication Form* (Appendix 6) can be used for this purpose.

All patient documentation including the *Methadone Part-Fill Accountability Log* (Appendix 9) and PharmaNet record must accurately reflect the actual dose consumed by the patient.

5.4 Vomited Doses

Principle 5.4.1

If a patient reports that they vomited their dose, a replacement dose cannot be provided without authorization from the patient's prescriber.

Guideline: The pharmacist must contact the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). Should the prescriber authorize a replacement dose, it must be confirmed in writing, signed by the prescriber, received by the pharmacy (fax is acceptable) prior to dispensing the medication and attached and filed with the original prescription.

5.5 Lost or Stolen Doses

Principle 5.5.1

If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided without authorization from the patient's prescriber.

Guideline: The pharmacist must contact the prescriber and discuss the situation with them. Should the prescriber determine that the situation warrants it they may authorize the acceptance of a new Methadone Maintenance Controlled Prescription form by fax (refer to Principle 2.1.3) or the prescriber may advise the pharmacy that they must wait until the patient presents a new original Methadone Maintenance Controlled Prescription form.

5.6 Tapering

Principle 5.6.1

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 6) can be used for the purpose of notifying the prescriber.

5.7 Emergency Dosing

Principle 5.7.1

Emergency dosing is not recommended. If however a pharmacist feels in their professional judgement that an emergency dose is required to ensure continuity of patient treatment the pharmacist may provide an emergency dose. The pharmacist must counsel the patient to obtain a new prescription as soon as possible. This practice is the exception to the rule and not the normal practice, refer to *Professional Practice Policy (PPP-31) – Emergency Prescription Refills*.

Guideline: Pharmacists need to document, as per *PPP-31*, the attempt to reach the prescriber with information about the situation. The prolonged half-life of methadone ensures that a patient maintains a single dose for at least 36 hours. Although the patient may feel uncomfortable an emergency dose may not be necessary. Emergency doses may hinder treatment success and health outcomes. It is a patient's responsibility to make sure they have a valid prescription.

6.0

Continuity of Care

6.1 Transfer of Pharmacy

Principle 6.1.1 When a patient chooses to move from one pharmacy to another to receive their methadone prescription it is the responsibility of the new pharmacy to contact the previous pharmacy and prescriber (if applicable) to discuss the exact transfer date and any other pertinent concerns. The previous pharmacy must cooperate fully with the request from the new pharmacy.

Guideline: Communication between the previous and new pharmacy is critical to ensure the patient's continuity of care and to avoid duplicate or missed methadone doses. A review of the patient's PharmaNet patient record can be of assistance in determining the previous pharmacy and prescriber.

6.2 Hospitalization or Incarceration

Principle 6.2.1 When a patient is discharged or released to the community from a hospital or correctional facility it is the responsibility of the community pharmacist receiving the patient to verify the date and amount of the last dose administered.

Guideline: Effective communication sharing among those who provide the patient's methadone maintenance treatment (hospital or correctional facility and pharmacy) is essential to ensure the patient's continuity of care and to avoid duplicate or missed methadone doses.

6.3 Compounding in Exceptional Circumstances

Principle 6.3.1 The only situation that would constitute consideration of exceptional circumstances is when a commercially available 10 mg/ml oral preparation is not available.

Principle 6.3.2 Methadone for maintenance must be at the strength of 10 mg/ml to ensure minimization of errors.

Principle 6.3.3 A compounding log must be established to record when methadone solutions are prepared, how much was prepared, and who prepared the product. The *Compounding Log* (Appendix 8) can be used for this purpose.

Guideline: The compounding log must incorporate the following elements:

- Preparation date,
- Methadone powder and/or liquid concentrate manufacturer's lot number and expiry date,
- Methadone powder and/or liquid concentrate quantity used and quantity prepared,
- Batch number and use-by date assigned by the pharmacy,
- Preparer's and pharmacist's identification.

A separate compounding log must be maintained for each strength of stock solution.

Principle 6.3.4

All concentrated solution containers must be clearly labeled with the drug name, strength, use-by date and appropriate warning labels.

Guideline: If different concentrations are prepared for pain management, they must be easily identifiable with clear labeling. A best practice would be to use different styles of storage container for each concentration or use food grade dyes to differentiate between the different concentrations prepared.

In order to help ensure liquid methadone preparations remain stable for up to 30 days from the date of pharmacy dispensing and to minimize the growth of bacteria, mold and fungus the *American Association for the Treatment of Opioid Dependence (2004)* recommends that pharmacists should:

- Use distilled water for the dilution of methadone products,
- Use new, clean, light-resistant containers for dispensing,
- Refrigerate take-home containers as soon as possible and keep refrigerated until used.

Principle 6.3.5

Methadone for maintenance solutions must be made with full-strength Tang™ or similar full-strength beverage crystals with daily doses (witnessed ingestion or take-home). Plain water is never an acceptable vehicle for dispensing to patients in the methadone maintenance treatment program.

Guideline: The beverage crystals are full-strength when made according to the manufacturer's directions found on the product's packaging.

Dispensing as a standard volume (e.g. all doses dispensed as a volume of 100 mL) is not acceptable.

References

Centre for Addiction and Mental Health. Methadone Maintenance: A Pharmacist's Guide to Treatment (2000)

Centre for Addiction and Mental Health. Methadone Maintenance Treatment: A Community Planning Guide (2009)

Centre for Addiction and Mental Health. Methadone Maintenance Treatment: Recommendations for Enhancing Pharmacy Services (2009)

Centre for Addictions Research of BC (CARBC): Methadone Maintenance Treatment in British Columbia, 1996 – 2008 Analysis and Recommendations (May 2010 Report)

Health Canada. Best Practices: Methadone Maintenance Treatment (2002)

Health Canada. Literature Review: Methadone Maintenance Treatment (2002)

Health Canada. Methadone Maintenance Treatment (2002)

Health Canada. The Use of Opioids in the Management of Opioid Dependence (1992)

British Columbia Centre on Substance Use. A Guideline for the Clinical Management of Opioid Use Disorder

Recommendations for the Use of Methadone for Pain. College of Physicians and Surgeons of BC (2010)

Stockley's Drug Interactions. Pharmaceutical Press (2010)

Align this section to match the updated PPP-66

CPBC Professional Practice Policy 66 – 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 pharmacists, 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 POLICY STATEMENT:

Effective February 1, 2018:

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 pharmacists, 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 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 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. methadone oral preparation product monographs

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 pharmacists, 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 BCCSU's "*A Guideline for the Clinical Management of Opioid Use Disorder*"
- 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 pharmacists, 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.

CPBC Professional Practice Policy 71 – Delivery of Methadone Maintenance Treatment

Policy Statement

Under extraordinary circumstances, if the patient has severe restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of Methadone Maintenance Treatment (MMT). This practice is the exception to the rule and not normal practice.

Neither the pharmacy manager nor the staff pharmacist may authorize the provision of home delivery for MMT in the absence of the prescriber's authorization on the prescription.

Delivery Standards:

1. **Prescribing Physician Authorization of Home Delivery**

   a. Should the prescribing physician determine that, due to the patient's immobility, delivery is required; the physician may authorize delivery by signing the declaration on the MMT CPP form.

      i. If the pharmacist or pharmacy technician has concerns regarding the authenticity of the prescriber's signature they must contact the prescriber for verification.

      ii. Physicians will not authorize delivery unless patient safety is assured and severe restrictions in mobility have been identified.

      iii. Distance between patient home and pharmacy does not qualify as a severe restriction in mobility.

2. **Home Delivery Schedule and Location**

   If delivery is authorized as noted in section 1 above, the pharmacist must be present to do the delivery and meet the following requirements:

   a. The pharmacist must determine whether home delivery is feasible within the services and resources the pharmacy provides. If the pharmacy does not provide delivery service – it may be appropriate to refer the patient to a pharmacy that can provide the delivery.

   b. If the pharmacy is able to provide home delivery the pharmacist must work with the patient to make appropriate arrangements for delivery. Arrangements must include:

      i. Address for delivery - MMT may only be delivered to a patient's home with a valid street address; delivery to a public location is not permitted.

      ii. Time for delivery

      iii. Procedure if patient not available at address to receive methadone delivery including communication of appropriate alternate arrangements for the

patient to obtain their prescription.

Note: it is not acceptable for the pharmacist to deliver the methadone to an alternate person or location or to leave the methadone unattended.

3. **Secure Transportation and Storage**

   a. The dispensing pharmacist is responsible for securely transporting and appropriately storing methadone.

   b. Methadone must be transported directly from the dispensing pharmacy to the patient's home address; methadone may not be stored outside of the pharmacy under any circumstances.

4. **Release of Methadone for Maintenance**

   The pharmacist must be present to:

   a. Confirm the identity of the patient.

   b. Assess the competence of the patient.

   c. Witness the release and ingestion of methadone to the patient, this responsibility cannot be delegated to a pharmacy technician or any other pharmacy support staff.

   d. Provide appropriate patient counseling.

   e. If carries are provided, the pharmacist must always witness first dose of the take-home prescription; all subsequent doses must be dispensed in child-resistant containers with explicit warning label(s).

5. **Documentation**

   The pharmacist must:

   a. At the time of release of a methadone prescription the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific part-fill accountability log. Neither party may 'pre-sign' for future doses.

   b. Document any and all home deliveries of MMT in the patient's record.

   c. Log the home delivery with the address where the delivery was made on the methadone part-fill accountability log.

   d. Document any appropriate follow-up plan in the patient's record.

   e. File the methadone part-fill accountability log with original methadone prescription form.

Background:

Legislation

Federal legislation does not support delivery of narcotics. The Controlled Drugs and Substances Act (CDSA) defines the transport or delivery of narcotics as trafficking, the Narcotic Control Regulations (NCR) limit the transport of narcotics to licensed dealers only.

Controlled Drugs and Substances Act

"Section 2 - Interpretation, Definitions[1]

"traffic" means, in respect of a substance included in any of Schedules I to IV,

(a) to sell, administer, give, transfer, ***transport***, send or ***deliver*** the substance"

Narcotic Control Regulations

"Section 2 - Interpretation, Definitions [2]

"licensed dealer" means the holder of a licence issued under section 9.2.

Dealers' Licenses and Licensed Dealers [3]

8. *(1) Subject to these Regulations, no person* ***except a licensed dealer*** *shall produce, make, assemble, import, export, sell, provide,* ***transport, send or deliver a narcotic.****"*

Pharmacists are required to adhere to the CDSA and its regulations as well as the *Health Professions Act*, *Pharmacy Operations and Drug Scheduling Act* and their *Bylaws*. The College of Pharmacists and the College of Physicians and Surgeons recognize that there are extraordinary circumstances where due to temporary or permanent severe restrictions in mobility patients would require delivery of their methadone for maintenance treatment to ensure best patient health outcomes and continuity of care.

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1 http://laws-lois.justice.gc.ca/eng/acts/C-38.8/page-1.html#h-2

2 http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-1.html#docCont

3 http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._1041/page-3.html#docCont

Appendix

3

Methadone for Maintenance Controlled Prescription Form Guidelines

Methadone prescriptions can only be accepted when written using an original Methadone Maintenance Controlled Prescription form. When accepting a Methadone Maintenance Controlled Prescription form a pharmacist must ensure that the form is completed by the prescriber as outlined in these guidelines.

Methadone Maintenance Controlled Prescription Form (Example; Figure 1):

These duplicate copy prescriptions are pre-printed with the following information; drug name and strength, prescriber's name, address (optional), College ID number and prescription folio number. These prescription forms are used only for prescribing methadone for maintenance.

Top Section of Form:

Note:

If no 'start day' is indicated in the 'Directions for Use' section of the form the 'prescribing date' becomes the 'start day'.

The prescriber must complete in full, the patient information including; personal health number (PHN), name, address and date of birth. The 'prescribing date' indicates the date that the prescriber saw the patient. The 'Drug Name and Strength' section is preprinted and the prescriber must complete the 'Quantity' section by stating the total quantity of the prescription in numeric and alpha forms.

Under extraordinary circumstances, if the patient has severe restrictions in mobility and if the prescribing physician has provided written authorization on the prescription by signing the declaration, pharmacists may provide home delivery of Methadone Maintenance Treatment (MMT). This practice is the exception to the rule and not normal practice. Refer to *Professional Practice Policy (PPP-71) – Delivery of Methadone Maintenance Treatment.*

Middle Section of Form:

The prescriber must complete the 'Directions for Use' section as follows:

- State the daily dose:
    - the daily dose multiplied by the number of days must equal the total quantity indicated on the prescription, if there is a discrepancy the pharmacist should seek clarification from the prescriber

Note:

"DWI except when pharmacy closed" is not an acceptable prescription instruction.

- Indicate the 'start day' and 'last day':
    - if no 'start day' is indicated, the 'prescribing date' becomes the 'start day'
    - should the 'start day' overlap with, or leave gaps from, an existing prescription the pharmacist should seek clarification from the prescribe
- Indicate any special instructions:
    - may be used to provide special instructions to the pharmacist for example split doses, or special situations for carries.

- Indicate either DWI or CARRIES, if carries are indicated the prescriber must indicate both in numeric and alpha the required number of days per week of witnessed ingestion:
    - if neither of these options are circled the pharmacist is to assume that all doses are DWI
    - if CARRIES has been circled but the specific witnessed ingestion days (ex; Monday and Thursday) have not been noted by the prescriber the pharmacist can determine the days in consultation with the patient. However, the first dose of the prescription and the dose before any carries must be witnessed ingestion. Additionally, the witnessed ingestion doses must be spread evenly throughout the week
    - if CARRIES has been circled but the number of days per week of witnessed ingestion has been left blank the pharmacist must seek clarification from the prescriber
- Authorize the prescription by signing their name in the 'prescriber's signature' box

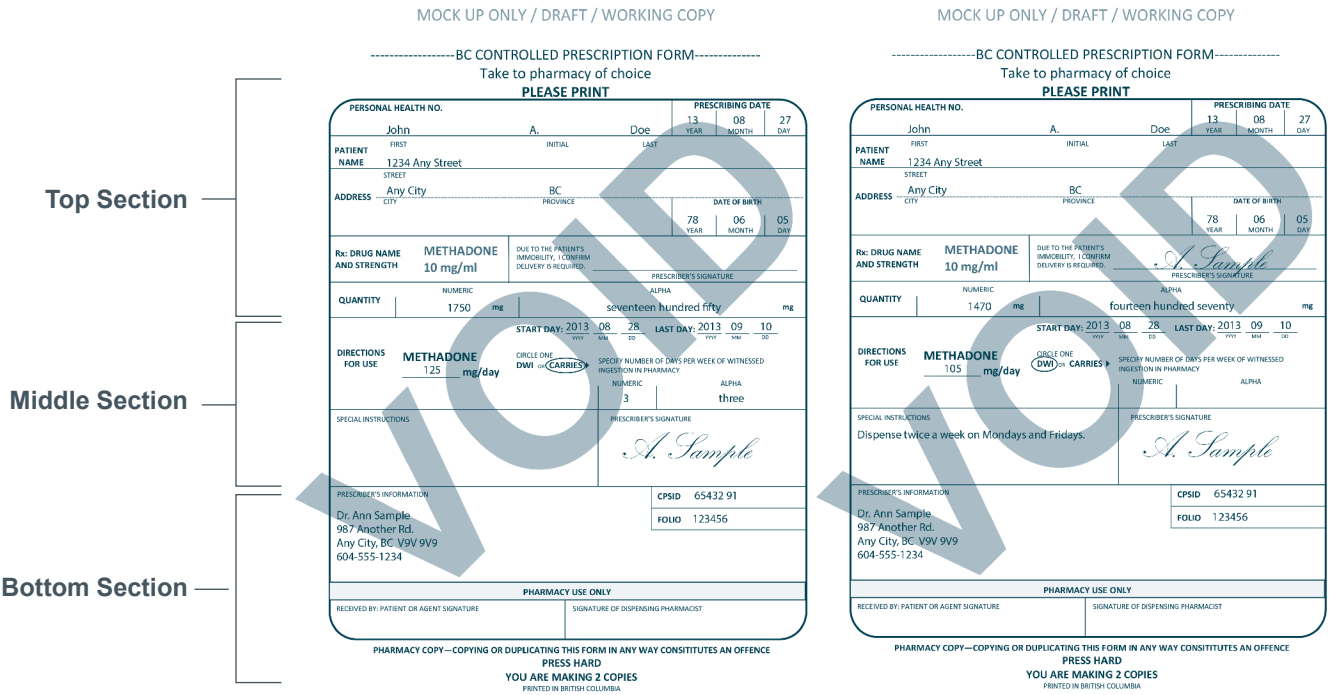
Bottom Section of Form:

Note:

A patient's representative signature is only acceptable with prior written authorization from the prescriber.

As a minimum the prescriber's name, College ID number and prescription folio number will be pre-printed on the form. If the prescribers address is not pre-printed it must be completed by the pharmacist prior to dispensing the prescription. Both the patient and the pharmacist must sign the prescription in the appropriate box.

Figure 1: Methadone Maintenance Controlled Prescription Form



Emergency Fax Methadone Maintenance Controlled Prescription Form Documentation

This form is for the use only in the event of an emergency that requires a faxed Methadone Maintenance Controlled Prescription form which has been initiated following direct consultation between the patient's pharmacist and prescriber.

It is understood that the pharmacist must obtain written documentation from the prescriber prior to dispensing any medication and as such is requesting that the prescriber complete this form and fax back to the pharmacy along with a fax of the Methadone Maintenance Controlled Prescription form as soon as possible.

Prescriber: _____ Patient Name: _____

Pharmacy: _____ Fax Number: _____

Pharmacist: _____ Date: _____

As the prescriber, I request that the above-named pharmacy accept a faxed transmission of the Methadone Maintenance Controlled Prescription form for the above-named patient. I understand that the Methadone Maintenance Controlled Prescription form must be faxed to and received by the pharmacy prior to the pharmacy dispensing methadone. I guarantee that the original Methadone Maintenance Controlled Prescription form will be sent to the pharmacy by the next business day.

Brief description of the emergency situation:

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Methadone Maintenance Treatment Expectation Form

As your pharmacists, we believe in the principles of the methadone maintenance treatment program, and the valuable role it can play in improving people's lives and their health. We are committed to being an active member of your healthcare team and understand that the success of the program is dependent on ongoing collaboration and communication between yourself, ourselves and your prescriber.

To help you succeed in the program it is important that we both clearly understand the commitment and expectations of each other.

As your pharmacists, you can expect that we will:

- Treat you professionally and respectfully at all times.
- Make ourselves available to discuss any questions or concerns that you may have regarding the program.
- Provide methadone to you exactly as your prescriber has prescribed it and will ensure that they are made aware of any of the following:
    - Missed dose(s) for any reason (ie; failure to pick up, vomited, lost or stolen)
    - Less than full dose consumed (ie; tolerance, self-initiated tapering)
    - Presenting at the pharmacy while intoxicated
    - Prescribing of contraindicated medications (ie; mood-altering drugs)
- Not dispense your methadone (unless directed by your prescriber) to anyone other than you.
- Respect your choice (unless directed by your prescriber) of the pharmacy you wish to have dispense your medication.

As our patient, we can expect that you will:

- Treat all pharmacy staff and other patients respectfully at all times.
- Do your utmost to adhere to the methadone maintenance treatment program as prescribed to you.
- Discuss any concerns you may have regarding your methadone maintenance treatment with us or your prescriber prior to making any adjustments to treatment independently.
- Ensure that any take-home doses of methadone are stored safely and securely.
- Respect the pharmacy's greater community by refraining from loitering or littering.

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 methadone dose _____ (dates).

☐ This patient did not take their full daily dose _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.

For Prescriber's Signature and Return of Form to Pharmacy

☐ We require clarity regarding the 'prescribing date' and/or 'start day' for the attached Methadone Maintenance Controlled Prescription form. Please indicate the actual 'prescribing date' (actual date the prescription was written) and dispensing 'start date' or range.

Prescribing Date: _____

Dispensing Start Date or Range: _____

☐ We require clarification and/or a change to the 'Directions for Use' section of the attached Methadone Maintenance Controlled Prescription form.

Description of authorized changes: _____

_____

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Drug Interactions – General Information

Methadone is extensively metabolized by cytochrome CYP3A4 in liver microsomes. Most drug interactions with methadone are associated with drugs that either induce or inhibit these enzymes.

The sequence of administration of the drugs is the key to evaluating the significance of the interaction. When a patient is stabilized on a drug that affects liver metabolism and methadone is introduced, the interaction may not be observed unless the first drug is discontinued. It is only if a patient is stabilized on methadone and an interacting drug is initiated or discontinued that an interaction may occur.

Drugs that may lower plasma levels (ie; increase the metabolism) of methadone include rifampin, barbiturates, phenytoin and carbamazepine. Drugs that may increase plasma levels (ie; decrease the metabolism) of methadone include ciprofloxacin and fluvoxamine.

Medications that might precipitate a withdrawal syndrome for patients on methadone must be avoided. These are mainly opioid antagonists such as pentazocine, butorphanol, nalbuphine, and naltrexone.

Pharmacists should not rely on PharmaNet to warn of a drug interactions for methadone. The use of PharmaNet is not intended as a substitute for professional judgment. Information on PharmaNet is not exhaustive and cannot be relied upon as complete. The absence of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective in any given patient. Health care professionals should confirm information obtained from PharmaNet, and ensure no additional relevant information exists, before making patient care decisions.

Appendix

8

Compounding Log

10 mg/ml Stock Solution

Preparation Date	Manufac-turer's Lot Number (Powder)	Manufac-turer's Expiry Date (Powder)	Quantity Used (Powder)	Quantity Prepared (Solution)	Use-By Date (Solution)	Batch Number (Assigned by pharmacy)	Preparer's ID (Initials)	Pharmacist's ID (Initials)

Appendix
9

Methadone Part-Fill Accountability Log

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Address if Applicable	Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Patient Name: _____

Date Dispensed	Prescription or Transaction Number	Quantity			Delivery Address if Applicable	Pharmacist's Initials	Patient's Signature
		Witnessed	Take Home	Total			

Methadone Information For Patients

What is methadone?

Methadone is a long-acting narcotic medication. Since the mid-1960s methadone has been used as an effective and legal substitute for heroin and other opiates. Methadone maintenance programs help opiate-dependent individuals stabilize their lives and reduce the harm associated with drug use.

How is methadone taken?

Methadone is prepared in a liquid. Doses are usually taken once a day as the effects of a single dose last for about one day. Your physician will write a prescription specifying your dose and how often you need to come to the pharmacy. Initially methadone is prescribed as a daily witnessed dose. As your treatment progresses you may be eligible for take-home doses.

How does methadone work?

Methadone is part of a long-term maintenance program for opiate or heroin dependent people. Drug cravings are reduced without producing a “high.” The goal is to find the dose that will prevent physical withdrawal. The right dose will decrease your drug cravings, and help you to reduce or eliminate heroin use.

How long do I have to stay on methadone?

You should stay on methadone for as long as you experience benefits. Everyone responds differently and methadone can safely be taken for years. If you decide you want to stop taking methadone, you should discuss this with your physician.

Does methadone have side effects?

Methadone is usually tolerated well once the dose is stabilized. Most people experience few, if any, side effects. Please let your pharmacist or physician know if any of these symptoms are bothering you:

- Sweating – This can be due to the methadone itself, or a dose that is too high or too low.
- Constipation – Increasing exercise, fluids and fiber in your diet may decrease this problem.
- Sexual difficulties – This can be either a reduction or an increase in desire.
- Sleepiness or drowsiness – This may be caused by too much methadone. If this occurs consult your doctor to have your dose adjusted. Do not drive a car or participate in activities that require you to be alert when you are drowsy.
- Weight change – An increase in body weight may be due to better health and an improved appetite.

Can methadone interact with other drugs?

Yes. Alcohol and drugs, including prescription, nonprescription, herbal and street drugs, may interfere with the action of methadone in your body. Discuss all medications you are taking with your pharmacist or physician.

Is methadone dangerous?

Methadone is safe to use when it is prescribed and monitored by a physician. It can be very dangerous if used inappropriately. Methadone should never be taken by anybody except the person for whom it is prescribed as overdose and death can occur if the person is not dependent on opiates. Children are especially at risk for overdose and death if they swallow methadone accidentally.

What is my responsibility?

Your responsibility is to drink your methadone dose every day. If you have carries, you must make sure that they are stored safely to prevent possible ingestion by anyone else. If you store your carries in the fridge ensure that they are not accessible. Methadone can be very dangerous if used inappropriately so you must not give or sell your dose to anyone.

Will methadone cure me?

The methadone maintenance program can help you to make positive lifestyle changes. The goal of treatment is to stabilize your body physically and to provide an environment that supports you.

Recommended Reading

Methadone Maintenance Treatment

Provides a general overview of methadone maintenance treatment programs and describes the impact of opioid dependence, methadone pharmacology and benefits. This 16-page document is available at:

http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/methadone-treatment-traitement/index_e.html

Literature Review – Methadone Maintenance Treatment

Examines the forty years of accumulated research knowledge and treatment literature about methadone maintenance and reviews the evidence of effectiveness, including cost-effectiveness, the factors that define successful programs, and the program policies associated with the highest success rates. This 86-page document is available at:

http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/methadone/index_e.html

Best Practices – Methadone Maintenance Treatment

Provides information on evidence-based best practices in methadone maintenance treatment. It also includes “Insight from the Field” which summarizes comments from experts in the area of methadone maintenance treatment. This 94-page document is available at:

http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/methadone-bp-mp/index_e.html

Methadone for Pain Guidelines

http://www.cpso.on.ca/uploadedFiles/policies/guidelines/methadone/Methadone_or_PainGUIDE.pdf

Contact Information

Alberta Health Services Opioid Dependency Program

W: www.albertahealthservices.ca
T: 780-422-1302
F: 780-427-0777

All patients planning to transfer to Alberta should contact the Opioid Dependency Program.

Alcohol & Drug Information and Referral Service

T: 604-660-9382 (24/7)

British Columbia Pharmacy Association

W: www.bcpharmacy.ca
T: 604-261-2092 or 800-663-2840
F: 604-261-2097
E: info@bcpharmacy.ca

British Columbia Centre on Substance Use (BCCSU)

W: www.bccsu.ca
T: 604-806-9142
F: 604-806-9044
E: bccsu@cfenet.ubc.ca

Med Effect Canada (report adverse drug reactions)

Canada Vigilance Regional Office
W: www.healthcanada.gc.ca/medeffect
T: 866-234-2345
F: 866-678-6789
E: CanadaVigilance_BC@hc-sc.gc.ca

College of Pharmacists of British Columbia

W: www.bcpharmacists.org
T: 604-733-2440 or 800-663-1940
F: 604-733-2493 or
E: practicesupport@bcpharmacists.org

College of Physicians and Surgeons of British Columbia

W: www.cpsbc.ca
T: 604-733-7758 or 800-461-3008
~~BC Methadone Program ext 2628~~
F: 604-733-1267
~~E: drmcnestry@CPSBC.CA~~

Office of Controlled Substances

T: 613-946-5139 or 866-358-0453 (methadone)
T: 613-954-1541 (thefts or losses)
T: 613-952-2177 (general)
F: 613-957-0110 (thefts or losses)
E: OCS-BSC@hc-sc.gc.ca

Health Protection Branch

Drug diversion of narcotics and controlled drugs

T: 604-666-3350

Non-Insured Health Benefits Program

ESI Canada

W: www.provider.esicanada.ca
W: www.healthcanada.gc.ca/nihb
T: 888-511-4666 (provider claims processing centre)

PharmaCare Help Desk (includes PharmaNet)

www.healthservices.gov.bc.ca/pharme/newsletter/index.html (newsletter)

For Pharmacists

T: 604-682-7120 Lower Mainland
T: 800-554-0250 Elsewhere

For the Public

T: 604-683-7151 Lower Mainland
T: 800-663-7100 Elsewhere

COLLEGE OF PHARMACISTS
OF BRITISH COLUMBIA

Safe and Effective Pharmacy Care

College of Pharmacists of BC
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POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 67**
POLICY FOCUS: **Injectable Opioid Agonist Treatment**

This policy provides guidance to registrants employed in a community pharmacy which provides injectable opioid agonist maintenance treatment.

1. INJECTABLE HYDROMORPHONE POLICY STATEMENTS:

Effective September 1, 2018:

1. Injectable hydromorphone maintenance treatment must only be dispensed as an approved, commercially available single-use vial formulation.
2. The College of Pharmacists of British Columbia (CPBC) *Injectable Hydromorphone Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacist supervision of injectable hydromorphone opioid maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Injectable Hydromorphone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) have implemented all necessary practice requirements identified in the CPBC *Injectable Hydromorphone Maintenance Treatment Policy Guide (2018)*,
    c) be familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder*", and
    d) be familiar with the information included in the product monographs of approved, commercially available formulations.

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First approved: 15 June 2018
Revised:
Reaffirmed:

PPP-67

College of Pharmacists
of British Columbia

Professional Practice Policy #67

Policy Guide

Injectable Hydromorphone Maintenance Treatment (2018)

Injectable Hydromorphone Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacist supervision of injectable hydromorphone maintenance treatment must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC~~'s~~ (CPBC) *Injectable Hydromorphone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

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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 supervised injection (i.e., 7 days per week, multiple doses per day) the pharmacy hours of service need to accommodate this dosing requirement. Patients may need to have access to injectable hydromorphone up to three times per day with a minimum of three hours between doses.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Only full pharmacists who successfully fulfill the following requirements may be considered "iOAT trained pharmacists":
- Authorized by the CPBC under the Certification of Practicing Pharmacists for Drug Administration (injection and intranasal route);
- Trained to administer emergency use naloxone as per Principle 1.2.4;
- Holds current certification in cardiopulmonary resuscitation and first aid;
- Is familiar with the information included in the most recent version of British Columbia Centre on Substance Use (BCCSU) "*Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder*";
- Completed online training through the University of British Columbia Faculty of Medicine, Continuing Professional Development's Provincial Opioid Addiction Treatment Support Program;
- Trained in the use of all equipment required under Principle 1.3.3;
- Knows and applies the principles and guidelines outlined in the CPBC "*Injectable Hydromorphone Maintenance Treatment Policy Guide (2018)*" and all subsequent revisions; and,
- Records self-declaration of knowledge and training completion in eServices prior to dispensing injectable hydromorphone.

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Guideline: Refer to *HPA Bylaws*, Schedule F, Part 4 – Certified Practice – Drug Administration by Injection and Intranasal Standards, Limits and Conditions for more information.

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Principle 1.2.2 With respect to pharmacist supervised injectable hydromorphone maintenance treatment, only iOAT trained pharmacists can: accept a prescription for injectable hydromorphone; release a dose of injectable hydromorphone to a patient; conduct a pre- or post-injection patient assessment; or, supervise patients self-administering injectable hydromorphone. These functions cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 1.2.3 Patients must be advised to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, cravings, and/or non-medical opioid use.

Principle 1.2.4 All registrants must be trained to administer emergency use naloxone and hold current certification in cardiopulmonary resuscitation and first aid.

Guideline: It is recommended that all pharmacy staff be trained to administer emergency use naloxone, cardiopulmonary resuscitation and first aid.

Naloxone education and training resources are available through the BC Centre for Disease Control's Towards the Heart Program.

Principle 1.2.5 Registrants must always practice within the scope of their education, training and competence. Where needed, they must obtain appropriate education and training as necessary.

Guideline: Refer to *HPA Bylaws*, Schedule A - Code of Ethics.

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1.3 Facility and Equipment

Principle 1.3.1 The pharmacy must have a separate injection room within which the drug is to be self-administered by the patient that is clean, safe, comfortable and appropriately private and furnished for the patient. This room must be equipped with the following at a minimum: stainless steel table, chair, secure container for sharps that is not easily removable, sink, soap, hand sanitizer, antiseptic cleaning wipes and paper-towel in a dispenser.

Principle 1.3.2 The injection room must have the following clean and sterile injection supplies for patient use, including but not limited to: needles for patient self-injection (intravenous, intramuscular and subcutaneous), tourniquets, alcohol swabs, bandages and cotton swabs.

Principle 1.3.3 The injection room must have the following equipment for assessment and overdose management: adequate naloxone and related supplies (e.g., needles, etc.), breathalyzer, pulse oximeter, blood pressure monitor, oxygen, and bag valve mask.

Principle 1.3.4 The injection room surfaces and equipment must be cleaned with appropriate disinfectant at the beginning and end of each day, and between each patient use to prevent the spread of infection.

2.0 Receiving Injectable Hydromorphone Prescriptions

2.1 Controlled Prescription Program Forms – Overview

Principle 2.1.1 Injectable hydromorphone for maintenance prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting prescriptions for injectable hydromorphone maintenance treatment, the iOAT trained pharmacist must ensure that the Controlled Prescription Program fForm is completed by the prescriber as outlined in the Controlled Prescription Program.

Note: A pharmacist does not have the independent authority to adapt a prescription for injectable hydromorphone maintenance treatment.

3.0 Processing Injectable Hydromorphone Prescriptions

3.1 Assessment of a Prescription

Principle 3.1.1 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 injectable hydromorphone 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.

Guideline: Concurrent use of injectable hydromorphone with other depressants such as benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

Note: Patients on injectable hydromorphone maintenance treatment are routinely co-prescribed other oral opioid agonist drugs. Consulting with prescribers ensures that they are aware that the patient is currently receiving injectable hydromorphone maintenance treatment.

3.2 PharmaNet Records

Principle 3.2.1 The prescribed injectable hydromorphone dose (in both mg and mL) and dose frequency must be entered in the 'sig' field for each patient on PharmaNet. Any injectable hydromorphone dose that has been processed but is not self-administered by the patient on the prescribed day is considered cancelled and must be reflected accurately 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 self-administered injectable hydromorphone doses as other health professionals rely on this information in making treatment decisions.

Example: Patient presents a valid prescription for injectable hydromorphone for supervised injection, stating 125 mg three times daily. Using commercially prepared single use vials of 50mg/mL hydromorphone, each dose corresponds to 2.5mL. Each vial is 1mL. Therefore, 3 X 1mL vials are needed to prepare each dose.

In this example, the sig field should contain something similar to: "'125mg (2.5mL) three times daily supervised injection'".

The patient is injecting a total of 7.5mL per day. However, three vials are needed to prepare each dose. So, the total amount dispensed would be 9mL.

At the end of the day, it is expected that the total quantity posted on PharmaNet accurately reflects what was dispensed. If this patient attended and received two doses but missed one, the total amount on PharmaNet at the end of the day should be 6mL.

When viewing patient profiles on PharmaNet, care must be taken to distinguish between dose prescribed and quantity dispensed, as there may be discrepancies between the two due to vial size and wastage from dose preparation.

4.0 Releasing Injectable Hydromorphone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 An iOAT trained pharmacist must release the injectable hydromorphone dose to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

4.2 Pre-Injection Assessment

Principle 4.2.1 Prior to releasing an injectable hydromorphone dose, an iOAT trained pharmacist must complete a pre-injection assessment of the patient to assess for signs of intoxication, including severe agitation, dyskinesia, sedation, slurred speech, or smelling of alcohol. The iOAT trained pharmacist who conducts this assessment must document this by signing a patient/prescription specific log. If the patient is intoxicated, the dose must be postponed or withheld and this must be documented and included with the original prescription. The prescriber must be notified.

Guideline: The sample *Pre-Injection Assessment Checklist* (Appendix 1) can be used for the pre-injection assessment. The sample *Injectable Hydromorphone Part-Fill Accountability Log* (Appendix 2) can be used for the patient/prescription specific log.

If the initial assessment results in suspicion of recent use of psychoactive substances, the iOAT trained pharmacist should discuss with the patient if they have consumed illegal or non-medical drugs (including any non-prescribed pharmaceutical drug) or alcohol. Where observation warrants further assessment for alcohol intoxication (e.g., slurred speech, unsteady gait, or smelling of alcohol), the iOAT trained pharmacist may administer breathalyzer testing to check that the patient's blood alcohol level does not exceed 0.05%.

Note: The BCCSU *"Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder"* requires a minimum of three hours between doses.

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4.3 Dose Preparation

Principle 4.3.1 If after the pre-injection assessment, the iOAT trained pharmacist deems the patient fit, the injectable hydromorphone dose may be prepared.

Principle 4.3.2 Best practices and established standards for preparing and handling injections must be followed.

Principle 4.3.3 Injectable hydromorphone for maintenance must be dispensed to patients as an approved, commercially available single-use vial formulation.

Principle 4.3.4 Single-use vial formulation allows only one needle puncture per vial. Any unused injectable hydromorphone remaining in the vial must be rendered unusable at the time of dose preparation according to Principle 4.3.6. This principle must be followed unless the preparation is done according to Principle 4.3.5.

Principle 4.3.5 Vials can be used for a maximum of two needle punctures when preparing syringes for the same patient (e.g., patient specific dose), only if the most recent version of NAPRA ~~"~~*Model Standards for Pharmacy Compounding of Non-hazardous Sterile Preparations*~~"~~ is followed. Any unused injectable hydromorphone remaining in the vial must be rendered unusable by the end of beyond-use date (BUD) according to Principle 4.3.6.

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Note: NAPRA "Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations" requires that preparation be done in a primary engineering control (PEC) (e.g., laminar airflow workbench or compounding aseptic isolator) that maintains ISO Class 5 air quality. Once the single-use vial is punctured in the PEC, the BUD of the drug remaining in the vial is ***6 hours***.

~~**Note:**~~ In addition to equipment, facility and BUD requirements noted above, it is important to note that there are numerous requirements outlined in the NAPRA "Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations" (i.e., labelling, personnel, policy and procedure requirements, etc.) which must be met to prepare the dose under Principle 4.3.5 to ensure patient safety. Otherwise, Principle 4.3.4 must be followed.

Principle 4.3.6 Prior to being rendered unusable as per Principles 4.3.4 or 4.3.5, any unused drug in vials from dose preparation must be documented in the patient/prescription specific log. A pharmacist and one other health professional must sign off on this drug destruction. This documentation must be kept in accordance with CPBC filing retention requirements. Empty vials must be disposed of in a secure container for sharps.

Guideline: The goal is to alter or denature the drug to such an extent that consumption has been rendered impossible or improbable. It should be readily apparent that the resulting product has been safely rendered unusable.

The sample *Injectable Hydromorphone Part-Fill Accountability Log* (Appendix 2) can be used for the patient/prescription specific log.

4.4 Prior to Releasing the Dose

Principle 4.4.1 Prior to releasing the injectable hydromorphone dose, the iOAT trained pharmacist must confirm the patient's identity against the original prescription and verify that the correct quantity of the dose has been prepared in the syringe.

Principle 4.4.2 The patient and iOAT trained 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. Every part-fill dispensed must be reviewable as a complete history on one document.

Guideline: The sample *Injectable Hydromorphone Part-Fill Accountability Log* (Appendix 2) can be used for this purpose. Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

4.5 Supervised Injection

Principle 4.5.1 An iOAT trained pharmacist must supervise the patient self-administering the prepared dose of injectable hydromorphone, to address patient safety and potential drug diversion issues. An iOAT trained pharmacist must be physically present in the injection room and directly monitor the patient for the full duration of the self-administered injection. The patient must never be left unattended in the injection room.

Guideline: Patients may inject intravenously, intramuscularly, or subcutaneously. For safety reasons, it is recommended that intravenous injection only be allowed in the upper extremities (hands or arms, no jugular use is permitted), while intramuscular injections can be allowed in the deltoid, thighs, and gluteal muscles.

Under no circumstances may a registrant administer the dose of injectable hydromorphone to a patient.

Assisting a patient to self-administer an injection (for example, by steadying a patient's hand) may place a health professional at high risk of a needle-stick injury. Part of the ongoing assessment of the patient is ensuring their continued ability to safely self-administer an injection, and notifying the prescriber if the patient can no longer do so.

Principle 4.5.2 If for any reason the patient does not self-administer a full dose, the remaining drug in the syringe must be rendered unusable. A pharmacist and one other health professional must sign off on this drug destruction. This documentation must be kept in accordance with CPBC filing retention requirements. The iOAT trained pharmacist must estimate the amount of drug injected and note this on the patient/prescription specific log. The prescriber must also be notified.

Guideline: The goal is to alter or denature the drug to such an extent that consumption has been rendered impossible or improbable. It should be readily apparent that the resulting product has been safely rendered unusable.

The sample *Injectable Hydromorphone Part-Fill Accountability Log* (Appendix 2) can be used to document the amount of drug injected in the patient/prescription specific log.

Principle 4.5.3 An iOAT trained pharmacist must only supervise one patient self-administering a dose of hydromorphone at a time (i.e., a 1:1 pharmacist to patient) ratio. The 1:1 ratio is needed to better ensure effective overdose response and emergency management.

Guideline: Staffing needs of the pharmacy should be considered when providing injectable hydromorphone treatment. While an iOAT trained pharmacist is required to monitor patients self-administering the dose of hydromorphone, appropriate supervision of the pharmacy premise is also needed, in compliance with legislative requirements.

Principle 4.5.4 Any empty used syringes and needles must be immediately disposed of in a secure container for sharps in the injection room.

4.6 Post-Injection Assessment

Principle 4.6.1 Post-injection, the patient must stay in the pharmacy for a minimum of 15 minutes, and within view of an iOAT trained pharmacist. Any refusal must be documented and the prescriber must be notified. After 15 minutes has elapsed, the iOAT trained pharmacist must conduct a post-injection assessment, observing any signs of intoxication including dyskinesia, sedation, slurred speech, agitation, or decreased respiration rate. If adverse events are observed, the pharmacist must notify the prescriber. The iOAT trained pharmacist who conducts this assessment must document this by signing a patient/prescription specific log.

Guideline: The sample *Post-Injection Assessment Checklist* (Appendix 3) can be used for the post-injection assessment. The sample *Injectable Hydromorphone Part-Fill Accountability Log* (Appendix 2) can be used for the patient/prescription specific log.

While awaiting the post-injection period to elapse, the patient must remain within the view of an iOAT trained pharmacist. This may be in the separate

injection room, a reception area or elsewhere within 25 feet from the perimeter of the dispensary.

If the patient seems to be intoxicated, a pulse oximeter and/or a vital sign assessment should be completed and documented. If at any time during the post-injection assessment the iOAT trained pharmacist determines that the patient requires medical attention, they should immediately call 911.

Principle 4.6.2 If after the post-injection assessment, the iOAT trained pharmacist deems the patient fit to leave the premises, then the patient may do so.

5.0 Security and Reconciliation

Principle 5.1.1 At the end of each day the secure container(s) for sharps must be kept in a locked area, such as a locked cage or cabinet that only registrants have access to.

Principle 5.1.2 At the end of each day, a count and reconciliation for injectable hydromorphone must be conducted and signed off on by a pharmacist and one other regulated health professional. This documentation must be kept in accordance with CPBC filing retention requirements.

Principle 5.1.3 The pharmacy must have a security camera in the injection room.

Guideline: Patients must be informed of the security camera, see *Professional Practice Policy 74 – Community Pharmacy Security* for more guidance.

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6.0 Responding to Dosing Issues

6.1 Missed Doses

Principle 6.1.1 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 6.1.2 The prescriber must be notified of any missed doses before the next supervised injection. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

Guideline: The *Pharmacist-Prescriber Communication* fForm (Appendix 4) can be used for this purpose.

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Principle 6.1.3 If a patient misses 9 consecutive sessions or 3 days (whichever is first), the prescription must be cancelled, and the prescriber notified of the cancellation. A new prescription is required for the next dose.

Appendix 1

Pre-Injection Assessment Checklist

Patient Name:	Assessment Date and Time:

Yes	No	Unknown	
☐	☐	☐	Severely anxious or agitated
☐	☐	☐	Dyskinetic
☐	☐	☐	Overly sedated
☐	☐	☐	Slurred speech
☐	☐	☐	Smells of alcohol

Baseline respiration rate: _____ breaths/minute

Pasero Opioid-induced Sedation Scale (POSS) level: _____

Breathalyzer required: ☐ Yes ☐ No

If yes, breathalyzer reading: _____

Notes:

Appendix 2

Injectable Hydromorphone Part-Fill Accountability Log

Patient Name:_____

Prescription Number:_____

Date	Time	Transaction Number	Prescribed Dose (mg and mL)	Total Volume Used to Prepare Dose (mL)	Wastage after Dose Preparation (mL)	Drug Destruction (Health Professional's Signatures)	Pre-Injection Assessment (Pharmacist's Initials)	Patient's Signature	Supervision (Pharmacist's Initials)	Post-Injection Assessment (Pharmacist's Initials)	Notes

Appendix 3

Post-Injection Assessment Checklist

Name:	Assessment Date and Time:

Yes	No	Unknown	
☐	☐	☐	Severely anxious or agitated
☐	☐	☐	Dyskinetic
☐	☐	☐	Overly sedated
☐	☐	☐	Slurred speech
☐	☐	☐	Smells of alcohol
☐	☐	☐	Decreased respiration rate

Respiration rate: _____

Pasero Opioid-induced Sedation Scale (POSS) level: _____

Notes:

Appendix 4

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 injectable hydromorphone dose(s) _____ (dates).

❑ This patient did not take their full AM dose(s) today _____ (date) and consumed only ____ mg/mL of the ____ mg/mL prescribed dose.

❑ This patient did not take their full PM dose(s) today _____ (date) and consumed only ____ mg/mL of the ____ mg/mL prescribed dose.

Additional Information/Other

You May Attach Controlled Prescription Form.

Notes:

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.viii. Ethics Advisory Committee – Amendment to the Terms of Reference

DECISION REQUIRED

Recommended Board Motion:

Approve the amended Terms of Reference (TOR) for the Ethics Advisory Committee.

Purpose

To seek Board approval of minor amendments to the 'Responsibilities' section of the Ethics Advisory Committee TOR.

Background

In October 2017, the Ethics Advisory Committee (the Committee) decided to amend its TOR to clarify its responsibilities in relation to the Patient Relations Program. Subsequently, amendments to the TOR were drafted over the course of three Committee meetings held in early 2018, and approved by the Committee at their May 2018 meeting.

The main amendments are to add two new responsibilities of the Committee. These duties involve the provision of guidance and advice with respect to registrant-patient relations, for the purpose of:

- Addressing questions and dilemmas; and,
- Preventing professional misconduct.

In addition, minor formatting and phrasing changes were made to improve the clarity and consistency of the document.

Next Steps

Upon Board approval, changes would be effective immediately and the revised TOR will be posted on the "Committees" section of the College's website.

Recommendation

To approve the 2018-05-09 version of the Ethics Advisory TOR (see Appendix 1).

Appendix	
1	Proposed Revised Ethics Advisory TOR (track changes)

ETHICS ADVISORY COMMITTEE

Background

The Board has established the Ethics Advisory Committee.

Authority

Health Professions Act (HPA) s. 19(1)(t); HPA Bylaws s. 19.

Mandate

To provide recommendations to the Board or the Registrar on matters relating to the Code of Ethics, Conflict of Interest Standards and any other related policies or guidelines.

Responsibilities

- ~~To meet from time to time to p~~ Provide advice and guidance regarding:
  - ~~e~~Ethical questions and dilemmas that have been directed to the committee from the Board, Board committees or College staff ~~the Registrar~~,
  - ~~.~~Registrant-Patient relations questions and dilemmas that have been directed to the committee from the Board, Board committees or College staff,
  - Registrant-patient relations to prevent professional misconduct that have been directed to the committee from the Board, Board committees or College Staff
- Review and recommend updates to the Code of Ethics and Conflict of Interest Standards as necessary.
- Consult on education program proposals relating to ethics issues.

Reporting relationship

The committee as a whole must submit a report of its activities through the chair 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).
- A credentialed ethicist (ie; doctorate in philosophy with a specialization in medical or bioethics or a doctorate in philosophy with experience in medical ethics, such as a chair or committee member of an ethics review Board).
- One public member

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.

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- 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 chair. 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 committee member is entitled to one vote on all matters coming before the committee.

Meeting procedures

Schedule:	As required to fulfill its mandate and responsibilities.
Format:	In person, by teleconference or by videoconferencing.
Agenda:	Developed by College staff in consultation with the committee chair with input from committee members.
Attendees:	Only Ethics Advisory Committee members and College staff are entitled to attend committee meetings, with the exception of invited guests.
Quorum:	A majority of the committee.
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 honoraria 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
September 14, 2018

2.b.ix. Governance Committee – Approval of the College of Pharmacist of BC Board Reference and Policies

DECISION REQUIRED

Recommended Board Motion:

Approve the College of Pharmacists of BC Board Reference and Policies document.

Purpose

To seek Board approval of the College Board's Reference and Policies document.

Background

The College Board's Reference and Policies document was first approved on September 24, 2010. The Governance Committee has recently worked with an external consultant to refresh the document, resulting in minor changes to condense information and remove redundancies. No substantive changes have been made.

Next Steps

Upon Board approval, changes would be effective immediately and the document will be formatted. The revised Board Reference and Policies document will be made available on the Board Portal of the College's SharePoint site.

Recommendation

To approve the recent version of the CPBC Board Reference and Policies document (see Appendix 1).

Appendix	
1	College of Pharmacists of BC Board Governance and Policies (track changes)

College of Pharmacists
of British Columbia

College of Pharmacists of BC Board Reference and Policies

Table of Contents

Part 1 – An Introduction to the College of Pharmacists of British Columbia Governance

Mandate

The College of Pharmacists of BC (CPBC) is the regulatory body for pharmacy in BC and is responsible for the registration of pharmacists and pharmacy technicians and the licensing of pharmacies throughout the province. The College receives its authority from the government of BC through the *Health Professions Act (HPA)* and the *Pharmacy Operation and Drug Scheduling Act (PODSA)*.

Duties and Objects of the College

Duties and objects of the College are set out in the *HPA – Part 2 section 16 (1) and (2):*

16(1) It is the duty of a College at all times

(a) to serve and protect the public, and

(b) to exercise its powers and discharge its responsibilities under all enactments in the public interest

(2) A College has the following objects:

(a) to superintend the practice of the profession;

(b) to govern its registrants according to this Act, the regulations and the bylaws of the College;

(c) to establish the conditions or requirements for registration of a person as a member of the College;

(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;

(e) to establish and maintain a continuing competency program to promote high practice standards amongst registrants;

(f) to establish, for a College designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;

(g) to establish, monitor and enforce standards of professional ethics amongst registrants;

(h) to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances;

(i) to inform individuals of their rights under this Act and the Freedom of Information and Protection of Privacy Act;

(i.1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair;

(j) to administer the affairs of the College and perform its duties and exercise its powers under this Act or other enactments;

(k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following:

(i) collaborative relations with other Colleges established under this Act, regional health Boards designated under the Health Authorities Act and other entities in the Provincial health system, post-secondary education institutions and the government;

(ii) inter-professional collaborative practice between its registrants and person practicing another health profession;

(iii) the ability of its registrants to respond and adapt to changes in practice environments, advances in technology and other emerging issues.

Additional objects of the College are set out in *HPA – Part 2.2 section 25.9*

25.9 In addition to the objects set out in section 16 (2), the College has the following objects:

(a) subject to the Food and Drugs Act (Canada), to establish the terms and conditions of sale for drugs and devices;

(b) to ensure that the public is protected from the unauthorized or inappropriate sale of drugs and devices;

(c) to superintend the operation of pharmacies;

(d) to establish, maintain and promote standards for pharmacies, including for the ownership and operation of pharmacies.

Mandated Responsibilities of the Board

HPA section 18 sets out the following Responsibilities of a Board:

18(1) A Board must govern, control and administer the affairs of its College in accordance with this Act, the regulations and the bylaws.

(2) A Board must submit an annual report respecting its College, in the form and containing the information required by regulation of the Minister, to the Minister not later than 120 days after the end of the fiscal year for the College.

(3) A Board must ensure that a website that is accessible to the public free of charge is established and maintained by or on behalf of its College, subject to the regulations of the Minister.

Legal and Regulatory Responsibilities of the Board

It is the responsibility of all Board members to abide by the relevant legislation and regulations governing the College as stated in the *Health Professions Act (HPA)* and the *Pharmacy Operations and Drug Scheduling Act (PODSA)*. Additionally, *HPA section 19* authorizes the Board of the College to make bylaws and *section 19 (t)* mandates that the College establish specific committees including: Registration, Inquiry, Discipline, Quality Assurance, Application and Patient Relations committees. The most current copy of these documents is available on the College website at www.bcpharmacists.org.

Amendment procedures for the *HPA*, *PODSA* or subsequent bylaws can be lengthy. An *Act* amendment requires the approval of the provincial legislature and it may take several years to have the proposed amendment go before the legislature and Board recommended bylaw changes require the approval of the Minister of Health Services.

Oath of Office

As per *HPA Section 17.11* before taking office, Board members must take and sign an Oath of Office prescribed by the Minister*. The Oath of Office is:*

I do swear that:

I will abide by the Health Professions Act and I will faithfully discharge the duties of the position, according to the best of my ability;
I will act in accordance with the law and the public trust placed in me;
I will act in the interests of the College as a whole;
I will uphold the objects of the College and ensure that I am guided by the public interest in the performance of my duties;
I have a duty to act honestly;
I will declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest;
I will ensure that other memberships, directorships, voluntary or paid positions or affiliations remain distinct from work undertaken in the course of performing my duty as a board member.

Governance Structure

The Board of the College is the elected and appointed group responsible for leading and guiding the College. The Board is comprised of seven elected pharmacist Board members and one elected pharmacy technician Board member from each of the 8 electoral districts (Appendix B) and four government appointed Board members.

The College governance framework is empowered and informed by:

- The Health Professions Act (HPA)
- The Pharmacy Operations and Drug Scheduling Act (PODSA)
- HPA bylaws
- Governing model
- Board policies
- Chair and Vice-Chair
- Board committees
- Registrar

Guiding Principles of the Board

The structure and integrity of the Board's governing model is rooted in a set of coherent guiding principles. These fifteen principles guide the Board in defining its role, its relationship with the Registrar and staff, and how it will conduct itself as a governing body. For the full list of principles, please see the terms of reference in 2.1.

Committees and Task Groups

Because the Board acts as a whole and does not delegate its power and authority to individual Board members or committees, the Board primarily functions as a whole. However, there is an important role for a limited number of Board committees and task groups to do the initial research and analysis and present their findings and recommendations to the Board.

There are three types of College committees and/or task groups: Board initiated committees and task groups; Operational staff committees and task groups; and Committees required by legislation (Registration, Inquiry, Discipline, Quality Assurance, Application and Patient Relations). Operational staff committees and task groups are the purview of the Registrar and his/her staff.

Board-Initiated Committees and Task Groups

These committees and task groups are created to assist the Board in getting its work accomplished. This could mean gathering information on issues of concern to the Board, developing recommendations for consideration, and carrying out a project of importance to the Board.

The Key Characteristics of College Board-Initiated Committees and Task Groups are:

- They are created by the Board.
- The Board determines their mandate and terms of reference.

- At least one sitting member of a committee or task group is a Board member.
- On-going direction and supervision is provided by the Board (usually by the Chair of the Board).
- They report directly to the Board.

Board Meetings

Regular Meetings

Regular meetings are generally held on a bi-monthly basis for the discussion of general business. College registrants and members of the public may attend these meetings as observers. The minutes of the meetings are recorded and made available on the College's website.

The schedule of Board meetings is usually as follows:
- September
- November
- January/February
- April
- June

The Board usually does not meet during the summer months.

Board Information Requirements

The information needs of the Board can be classified into three categories.

1. ***Decision information:*** This is the information the Board receives to assist it in making decisions. As much as is possible, this information should be factual and nonjudgmental. Although staff might have an interest in responding to one need over the others, this bias is not contained in the information presented to the Board, unless directly requested by the Board.

2. ***Monitoring information:*** This is the information used to gauge whether Board decisions have been satisfied. This information is essentially evidence that demonstrates degree of achievement of a specific outcome or goal or compliance with one or more Board policies.

3. ***Incidental information:*** This is the general information that is valuable or important to Board members, but which is not necessary for them to conduct Board business. Such things might be program initiatives, restructuring of various departments, etc.

It is important to the effective and successful operation of the Board that the Registrar delivers high quality, focused information in the decision and monitoring categories.

Terms of Reference and Policies

In discharging its responsibilities under the *Act*, the Board is frequently called upon to make decisions on many diverse issues.

The way in which a Board defines roles, responsibilities and accountability relationships is through terms of reference. Terms of reference are deemed effective on a majority vote of the Board.

The way in which a Board communicates its decisions, positions and intentions to staff and to others regarding all areas of its responsibilities is through policies. Policy statements are deemed effective on a majority vote of the Board.

The Board may set policy in four key areas:

1. ***Board Governance***. This category includes policies that address the Board's purpose and their role in governing.

2. ***Board Operations***. This category sets out policies to guide the operations of the Board in carrying out its role and functions.

3. ***Standards of Organizational Conduct***. This category describes any conditions and constraints on the Registrar and staff (the actions and conditions that guide their work in operating the College).

4. ***Professional Practice***. This category includes policies that affect pharmacists, pharmacy technicians or pharmacies.

Relationship of the Board and the Registrar

Governance of the College will be most effective when the Board and the Registrar understand each other's roles, responsibilities and authorities, and work collaboratively. However, the Registrar is accountable to the Board, but is not accountable for Board performance.

Although the Board's purpose and mandate is to govern and the Registrar's is to manage the day-to-day operations of the College, the key elements that are the focus of their work are the same. These are:

- Protecting the public.
- Providing leadership and direction.
- Monitoring and oversight.
- Establishing conditions and constraints for all actions and decisions.
- Ensuring the financial health and sustainability of the College.
- Building relationships with stakeholders.

The Board's approach to its work is that its overriding purpose is to guide, direct and oversee the performance of the College. Consequently, it has the power, authority and control to ensure that the College, through the Registrar and their staff, fulfills its legislated mandate and achieves the Board's stated Mission, Vision and Strategic Goals.

The Registrar's approach is to ensure effective contribution to the key elements and to develop and implement strategies and means (programs, services, standards, management, administrative and operational structures) for successfully fulfilling the College's legislated mandate and achieving the Board's stated Mission, Vision and Strategic Goals. The Board gives the Registrar the necessary power and authority to carry out these duties and responsibilities, but the ultimate power rests with the Board.

A primary purpose of both the Board and the Registrar is to provide leadership. The talent, knowledge and skill that each brings to the table needs to be optimized in providing leadership and direction to the College. This is best achieved when each of the parties invite and value the contribution of the other.

For the relationship to be effective and successful, both the Board and Registrar must understand and respect the boundaries of their respective powers and authority. The process for developing the Mission, Vision and Strategic Goals has input from and the active participation of the Board and the Registrar. Although they work as partners, particularly in the area of providing leadership and direction, it is the Board that has the ultimate power and authority to decide the Mission, Vision and Strategic Goals for the College.

Relationship of the Chair and the Registrar

The Chair of the Board is responsible for fostering a constructive and harmonious relationship

between the Board and the Registrar, and acts as the main point of contact and communication between the Board and the Registrar on decisions of the Board between board meetings. The Chair of the Board has no decision-making authority unless delegated this authority by the Board.

The Chair of the Board will typically meet – either by phone or in person – weekly to check in on the current state of the College's affairs and provide guidance (within Board approved policies) to the Registrar on issues raised by the Registrar. The Vice Chair and Deputy Registrar may also be invited to participate in these meetings. If, through these conversations, significant issues arise that require the attention of the full Board, the Chair of the Board is responsible for ensuring that a board meeting is called (if urgent) or that the issue is placed on the agenda of the next regularly scheduled board meeting.

For a full description of the Chair of the Board's role, please see the Chair of the Board terms of reference.

Relationship of Board and Staff

As the Registrar is the Board's only employee, Board members will refrain from giving direction to other College employees. This statement does not mean that staff and the Board do not communicate or interact. It does mean that the method and frequency of interaction is different. Staff attend Board meetings at the discretion of the Registrar. In some cases, senior staff may be observers at Board meetings. In other cases, specific staff may be present when they are providing information or performing specific functions requested by the Registrar.

Part 2 – Terms of Reference

2.1 Terms of Reference for the Board

The Board of the College of Pharmacists of British Columbia is responsible for managing and supervising the activities and affairs of the College, and as such, is the highest decision-making authority within the College. This responsibility of the Board consists primarily of the duty to govern and oversee the Registrar, who has responsibility to manage the business and affairs of the College.

The role of the Board is to govern the College to ensure fulfillment of the mandate set out in the *Health Professions Act (HPA)* and the *Pharmacy Operations and Drug Scheduling Act (PODSA).*

The Board is guided in its work by a set of Governing Principles *(page 11)*. In addition to its Governing Principles, the Board may set policy to govern the operations of the Board and the College.

In fulfilling its role, the Board will be guided by the following principles:

- Board members are encouraged to think and act in ways that seek to achieve outcomes or results that are in the best interests of the public it is committed to serve.
- The Board commits to stating the desired outcomes that it expects the College to achieve and to specifying the standards of organizational conduct that must be satisfied by staff in achieving them.
- The Board's authority rests in it acting collectively.
- The Board acts as a whole in determining policy and direction.
- Members of the Board maintain solidarity with other board members in support of a decision made at a Board meeting.
- Board authority is generally not delegated to the Chair or to committees (except in very specific or exceptional circumstances) unless mandated to do so by legislation. All Board committees report to the full Board.
- The role of the Chair is to manage the work of the Board and to chair Board meetings. The Chair can act on behalf of the Board where authorized to do so by the whole Board.
- The Board has only one employee and that is the Registrar.
- The Registrar reports to the whole Board, not to any individual Board members or committee.
- The Board delegates to the Registrar the necessary power and authority normally allocated to a chief executive officer to enable the effective execution of the operation of the College.
- All Board authority delegated to staff is delegated through the Registrar.
- The Registrar is accountable to the whole Board for the achievement of the outcomes stated in the Vision and Strategic Plan and for complying with the standards of organizational conduct set by the Board (unless otherwise indicated by legislation, regulation or the bylaws of the College).

- Recognizing that there will be circumstances where it will be necessary for the Registrar to interpret Board policy, the Board empowers him or her to do so as long as it is consistent with any reasonable interpretation of Board policy, and is communicated to the Board in a timely manner.
- Direction to and supervision of the Registrar's performance is a function of the whole Board.
- Monitoring and evaluating the performance of the Registrar is based on achievement of goals and outcomes in the Strategic Plan, compliance with Board established standards of organizational conduct, and other criteria set out in the employment contract with the Registrar.

The Board will:

- Set and ensure fidelity to mission and mandate, and approve organizational strategy, plans, and budgets.
- Establish governance policies, and review and update them regularly.
- Ensure management policies and systems are in place for compliance, including, but not limited to finance and human resources.
- Gain and maintain reasonable assurance that the College meets all financial reporting and disclosure obligations imposed on the College by applicable laws and regulations.
- Adopt and ensure adherence to a written Code of Conduct and Conflict of Interest Policy.
- Establish and hold the Registrar accountable to measures of organizational performance.
- Hire, evaluate, set objectives and set compensation for the Registrar.
- Ensure appropriate management of major risks (including financial, as well as risks to the College's assets, reputation, and intellectual property) to the College.
- Preserve and support the College's core values.
- Create and maintain policies for orientation and continuing education development of the Board
- Ensure sound relationships are maintained with its key stakeholders.
- Position the College as a highly effective, reputable, credible College and leader in its field.

2.2 Terms of Reference for Board Members

Board members play a vital role in ensuring the success and effectiveness of the College. Although the role is one in which Board members are asked to provide leadership and guidance to the College, there are also obligations that each Board member undertakes as soon as he/she formally assume the title "Board member."

As a member of the Board, Board members are held liable and accountable for all decisions and actions in support of this self-regulated entity. As a result, the responsibilities and duties of a Board member are subject to public scrutiny. These responsibilities can be divided into two categories:

- Contribution to Board effectiveness.
- Legal and regulatory responsibilities *(refer to page 10).*

Contribution to the Board's Effectiveness

The responsibilities in this area are concerned with the personal approach, commitment and style of involvement of a Board member. The College gains the most from a Board when its members are committed to working and sharing together in its best interests.

The following are obligations and guidelines for maximizing the contribution you make to Board effectiveness.

Every Board member has a fiduciary duty to the College, and must, in discharging his or her duties:

- act honestly and in good faith with a view to the best interests of the College and to act in accordance with the College's policies; and
- exercise the care, diligence, and skill that a reasonably prudent person would exercise in comparable circumstances.

It fulfilling these obligations it is the responsibility of each Board member to:

- Participate actively in the business of the Board and make a positive contribution to providing visionary leadership and direction;
- Fully participate with other Board members in overseeing the management of the affairs and business of the College;
- Act honestly, in good faith and in the best interests of the public;
- Exercise the care, diligence and skill of a reasonably prudent person under comparable circumstances;

- Ensure compliance with relevant acts, bylaws, regulations and policies;
- Stay informed on matters relevant to governing the College;
- Participate actively and constructively in the discussions of the Board;
- Follow Board approved rules and policies in governing and conducting Board business;
- Contribute to building and maintaining a healthy, effective and cohesive Board;
- Represent the interests of the public and not the interests of special groups or individuals. Board members may raise issues brought forward by registrants, members of the public and special interest groups. However, once the issue is brought to the Board table all Board members must examine the issue from the perspective of public safety;
- Maintain solidarity with other Board members in support of a decision made at a Board meeting.
- Come completely prepared and informed regarding all materials compiled and sent to you in order to fully participate in the discussion regarding the agenda.
- Help to advise and direct the Registrar in the management and operations of the College through Board policy;
- Attend all Board meetings. If it is apparent that you are likely to miss several Board meetings and are unable to fulfill your obligations, you may wish to discuss your continued involvement as a Board member with the Chair;
- Inform yourself of the proceedings, decisions, and proposed actions decided upon at missed Board meetings;
- Encouraged to participate fully in debates at the Board table and expressing views which may lead to a more fulsome discussion.
- Board members who are in disagreement with other Board members or the Registrar on Board or College issues or business should use the Board meeting as the venue to express their disagreement or dissatisfaction. The integrity, credibility, public image and ability of the Board to function effectively are enhanced if disagreements or dissatisfaction are confined to Board meetings.

2.3 Terms of Reference for the Chair of the Board

The Board assumes responsibility for the governance and stewardship of the College and as a consequence has accountability for the performance of the College. Critical to meeting this accountability are the relationships between the Board, Board members and the Registrar.

The Chair is appointed by the Board and provides leadership in guiding the Board and coordinating its activities in the best interests of the College. In performing this role, the Chair manages the affairs of the Board and works closely with the Registrar.

- Chair Working with the Registrar
    - Fosters a constructive and harmonious relationship between the Board and the Registrar.
    - Acts as the main point of contact and communication between the Board and the Registrar between meetings of the Board on decisions of the Board.
    - Leads the Board in monitoring and evaluating the Registrar's performance.

- Chair Relationship with the Board
    - Ensures the Board has effective oversight of the College's business and affairs and is alert to its obligations to the College under the law.
    - Leads the Board in reviewing and monitoring the strategic business plan, policy and directions of the College and the achievement of its objectives.
    - Fosters cohesion of direction and purpose at a policy and strategic level.
    - Builds consensus, encourages participation, and develops teamwork within the Board.
    - Communicates with the Board to keep it up to date on all major developments, including timely discussion of potential developments.
    - Ensures that the Board has sufficient knowledge to permit it to make major decisions when required.
    - Approves the board agenda, briefing packages and related events for Board meetings with the Registrar and the Corporate Secretary.
    - Is an ex-officio member on all Board-established committees.
    - Establishes annually, in advance and in consultation with the Registrar, the Board Calendar and coordinates fulfillment of the requirements set by Board policies.
    - Chairs Board meetings.
    - Ensures Board meetings are conducted in an efficient, effective and focused manner.
    - Ensures, with the assistance of the Registrar and the Governance Committee, that there is an orientation program for new Board members and an ongoing development program for existing Board members aimed at increasing the Board members' familiarity with the College and its context.

2.4 Terms of Reference for the Vice Chair

The Board assumes responsibility for the governance and stewardship of the College and as a consequence has accountability for the performance of the College. Critical to meeting this accountability are the relationships between the Board and the Registrar.

In the absence of the Chair, the Vice Chair provides leadership in guiding the Board and coordinating its activities in the best interests of the College.

- In the absence of the Chair, the Vice Chair will:
    - Preside over meetings of the Board.
    - Act as the main point of contact between the Registrar and the Board.
    - If and as required, fulfill the other responsibilities of the Chair, consistent with the College's regulations, bylaws, policies and terms of reference.

Part 3 – Board Governance Policies

3.1 Purpose and Role

The purpose and role of the Board is to govern the College to efficiently and effectively fulfill its legislated mandate; achieve its mission and vision; and, be accountable to the general public for competent, conscientious and effective performance as defined in the legislation applicable to the College.

1) In governing, the Board will:
   a) Be mindful of its obligation to serve and protect the public.
   b) Be visionary and progressive.
   c) Support strategic leadership.
   d) Ensure a clear distinction of Board and Staff roles and responsibilities.
   e) Achieve collective decision-making through healthy and respectful discussion and hearing all points of view.
   f) Recognize that it has one employee, namely, the Registrar.
   g) Recognize its responsibility to evaluate the Registrar's performance on an annual basis.

2) To fulfill its purpose and role, the Board will provide leadership to the College in carrying out the following key areas of governing responsibility:

   a) Protect the Public

   b) Guidance and Direction

   c) Standards of Organizational Conduct

   d) Organizational Oversight

   e) Ensure Financial Health and Sustainability

   f) Relationships with Stakeholders

3) Board members are expected to uphold their sworn Oath of Office.

3.2 Protect the Public

The Board will act to ensure that the decisions and actions of the College are to protect the public and do not jeopardize or put the College at risk.

Accordingly, the Board will:

1. Ensure that risk management policies and practices are in place
2. Review all Board decisions and policies regularly to ensure they satisfy the criteria for protecting the public.
3. Be proactive in identifying issues and matters that could jeopardize the Board and staff's ability to protect the public and the College.
4. Regularly engage in environmental scanning practices to identify and ensure that it is aware of strengths, weaknesses, opportunities, threats and changes to the environment in which the College operates that could affect its operating practices.

3.3 Guidance and Direction

As the body elected to lead and guide the College, the Board will develop and set the Vision and Strategic Goals to be achieved in fulfillment of its Mandate, Mission and responsibilities.

Accordingly, the Board will:

1. In partnership with the Registrar and designated staff, develop the Vision and Strategic Goals for the College.
2. Develop a Strategic Plan that articulates its Vision and Strategic Goals. This plan will act as the Board's directive to the Registrar regarding priorities.
3. Develop the Values for the College which guide the Board and directs the Registrar and College staff in interactions with each other and all stakeholder groups.
4. Annually review the Strategic Plan and confirm continuation or make necessary adjustments to accommodate conditions impacting the College and the public.
5. In collaboration with the Registrar, for the purpose of fulfilling their commitment to achieving the Mission and Vision of the College, keep current with information and knowledge affecting the practice of pharmacy in BC, identify and address issues and matters that could or will have a material impact or consequence on pharmacy practice.

3.4 Standards of Organizational Conduct

A major focus of the Board's work is on leading and guiding the College by determining the desired results or outcomes to be achieved. The Board also has an obligation to establish the conditions and limitations that will guide the Registrar.

Accordingly, the Board will:

1. Establish Standards of Organizational Conduct policies in any area they deem essential to guide the staff in achieving Board stated goals. (see part 5 of this manual)
2. Ensure the Standards of Organizational Conduct policies form part of the performance evaluation of the Registrar; are regularly monitored for compliance; and, are reviewed annually by the Board or an assigned task group.
3. Ensure that Board policies on Standards of Organizational Conduct reflect a common interpretation by the Board and the Registrar. The agreed upon interpretation should meet the "reasonable person" criteria and the intent of the policy.

3.5 Organizational Oversight

As one of the key elements of governing is ensuring the achievement of its Vision and Strategic Goals and compliance with its policies, the Board will regularly and systematically monitor and oversee organizational performance. As the Registrar is responsible for the management and operation of the College, the Registrar's performance is considered to be the same as the College's performance.

Accordingly, the Board will

1. At its discretion, use one or all of the following three methods to monitor performance of the College:

    a. **Executive Report:** Disclosure of compliance information to the Board from the Registrar.
    b. **External Audit:** Discovery of compliance information by an external auditor, inspector or consultant who is selected by and reports directly to the Board. Such reports must assess executive performance only against the specific policy or policies of concern to the Board, not those of the external party unless the Board has previously indicated that party's opinion to be the standard.
    c. **Direct Inspection:** Discovery of compliance information by a Board member, a committee or the Board as a whole. This is a Board inspection of documents, activities or circumstances directed by the Board, which allows a "prudent person" test of policy compliance.

2. Bring any concerns arising from any monitoring activity to the attention of the Registrar in a timely manner.

3.6 Financial Health and Sustainability

The Board will act to ensure that the financial health and viability of the College is not jeopardized.

Accordingly, the Board will:

1. Direct the Registrar to develop and submit to it, annually, a multiyear financial plan (2 – 5 years) that identifies key areas of expenditure growth, inflationary costs, revenue sources and potential or planned fee changes.
2. Direct the Registrar to present an annual plan for the College's contingency and reserve funds.
3. Review or establish Standards of Organizational Conduct policies that address budget planning, financial management and risk management.
4. Annually review the financial plan to determine changes in assumptions, environmental conditions, and integrity of the plan.
5. Direct the Registrar to present a progressive actual year-to-date budget and variance report at each Board meeting.
6. Establish an Audit & Finance Committee to support the Board in fulfilling its financial health and sustainability oversight obligations.

3.7 Relationship with Stakeholders

In recognizing that governing requires having knowledge of the interests, concerns, needs and expectations of stakeholders, the Board will act to ensure that it is informed on matters relevant to its stakeholders.

Accordingly, the Board will:

1. Annually establish, review and evaluate the Board with regards to stakeholder relationships.

2. Provide opportunities throughout the year for interested parties to make presentations on matters of interest and concern to the Board.

3. Ensure that the College has a comprehensive communications strategy and maintains a website containing current information.

4. Post the schedule of its public meetings on the College's website.

5. Post minutes of its public Board meetings on the College's website.

6. Produce an annual report that is made available electronically on the College's website.

Part 4 - Board Operations

4.1 Code of Conduct

Board members will conduct themselves respectfully, ethically, and professionally in their personal and professional interactions, consistent with the oath that all Board members have sworn or affirmed.

In fulfilling their responsibilities as a Board member of the College, they will:

1. Exercise the duties of care, diligence and skill and the duty of loyalty to the College and the public interest.
2. Respect the confidentiality of Board discussions and deliberations.
3. Abide by all Board policies governing Board member behaviour, practices, decisions and actions.
4. Respect and abide by the Board's values, governing principles and conflict of interest guidelines.
5. Honour their obligations to attend all Board meetings and where this is not possible notify the Chair in advance.
6. Come to the Board meetings having read the materials relevant to the Board meeting agenda.
7. Abide by the Board's Meeting rules and by the method or process agreed to for conducting Board meetings.
8. Assist the Board with its work by serving as a member on one or more Board committees or task groups during the course of the Board year.
9. Maintain solidarity with other Board members in support of a decision made by the Board.
10. Participate and contribute to building and maintaining a strong, healthy, productive and effective functioning Board.
11. Respect and honour the governing principle that a Board member's individual interaction with the Registrar or staff carries no authority or formal influence.
12. Refrain from exercising individual authority over the College except as explicitly set forth in Board policies.
13. Not represent or appear to represent the Board to external organizations, unless specifically authorized to do so. Individual Board members will re-direct enquires from members of the public and media to the Registrar, and copy the Board Chair, so that proper action can be taken.

4.2 Conflict of Interest

Board members will avoid and refrain from involvement in situations of conflict of interest. Board members represent the interests of the public and not the registrants who elected them or those who appointed them. Board members shall have no conflict of interest with regards to representation as a Board member or at Board meetings.

Conflict of interest is a breach of an obligation to the College that has the effect or intention of advancing one's own interest or the interest of others in a way detrimental to the interests or potentially harmful to the integrity or fundamental Mission of the College. Conflicts of interest and the appearance of conflicts of interest must be avoided. Board members and staff are responsible for seeking guidance from the appropriate source before embarking on activities, which might be questionable.

Accordingly:

1. A Board member is in a conflict when there exists a personal interest that could influence their decisions and impair their ability to act in the College's best interests.
2. Board members must not use their positions to obtain for themselves, family members or close associates employment within the College.
3. Should the College consider a Board member for employment they must temporarily withdraw from Board deliberation, voting and access to applicable Board information.
4. Acceptance of gifts, entertainment, travel and services for personal use from people or organizations who conduct business with the College could impede the objectivity of the Board and create a conflicting obligation. It is necessary, therefore, for full disclosure to occur and for approval to be granted, prior to the receipt of a personal benefit.
    a. Gifts, entertainment, travel or services require evaluation of the source, value, purpose and frequency of offering in assessing the case.
    b. A Board member may attend, as a guest, a hosted lunch or dinner meeting that involves the discussion of items of mutual interest.
    c. Personal gifts may not be accepted by Board members from people or companies seeking business or intervention with any College policy or process.
    d. Gifts for the College office may be accepted, depending on the purpose of the gift. Commemoration of a significant anniversary or event would be acceptable, but material appreciation for positive response to an appeal relating to policies and procedures would not be acceptable.
5. Board members who have a material interest in a company with whom the College may decide to transact business, have a responsibility to disclose their involvement whenever they have influence over a decision to engage the services of the company.
6. Board members approached, in their capacity as College representatives, to serve as

members of a Board of a for-profit, charitable, or advocacy organization must obtain the approval of the Board.

7. The Board review of a request to serve as a member of a Board of another organization will take into account the interests of the College, as well as the benefits that may accrue to the individual and to the outside organization.

8. College representatives to outside organizations must be approved and recorded as such by the Board.

9. Unless approval is given, a Board member or staff member serving on the Board of an outside organization does so in their individual capacity.

10. If Board members have material interests in companies seeking College business they must disclose their interests and withdraw from the College decision making process that is applicable to those companies.

11. Board members should not solicit remunerated consultative contracts through their positions with the College. Requests from College members for such services should be referred to other experts in the field, other than in exceptional cases.

Process for Addressing Conflicts of Interest

1. On appointment, a Board member will act in a manner that will prevent real, potential or perceived conflicts from arising in their private, professional and institutional interests; declare any real, potential or perceived conflict of interest and sign a conflict of interest declaration; and annually update the declaration and sign it.
2. In the event that a Board member is in a conflict of interest or believes they might be in a conflict of interest they will immediately disclose, in writing, any real, potential or perceived conflicts of interest to the Chair of the Board, or to the Vice-Chair if they are the Chair.
3. At the beginning of each board meeting any real, potential or perceived conflicts of interests with regard to the business of that meeting will be disclosed by any Board member who believes they may be in a conflict, or perceived to be in a conflict. The declaration will be recorded in the minutes.
4. Should a board member have a concern regarding non-disclosure of a real, potential or perceived conflict of interest of another board member, he / she shall bring this concern to the attention of the Chair (or Vice Chair, as appropriate)
5. When a conflict of interest has been declared the affected board member(s) will abstain from participation in any discussion on the matter, not attempt to personally influence the outcome, refrain from voting on the matter, and leave the meeting room for the duration of any such discussion or vote. The time the affected Board member(s) left and returned to the meeting room will be recorded in the minutes.

4.3 Confidentiality

There are aspects of the Board's work requires confidentiality. It is important and necessary that Board members recognize this responsibility and ensure that their actions do not violate Board confidentiality.

Accordingly:

1. Confidential and sensitive information about the affairs of the College provided during in-camera meetings within the knowledge of Board members are not to be disclosed to others.
2. Board members are required to comply with provincial and federal legislation and regulations regarding privacy and freedom of information.
3. Board confidentiality and integrity is strongly affected by individual Board member actions. Board members must respect the confidentiality of in-camera Board discussions and refrain from discussing or sharing information on these matters with non-Board members.

4.4 Board-Established Committees and Task Groups

Other than committees required by legislation, the Board may establish committees and task groups to help carry out its responsibilities.

Accordingly:

1. Board committees and task groups are established by the Board to help the Board fulfill its role and carry out its responsibilities. To preserve Board authority, Board committees and task groups will be used only as required to support the Board's work.
    a. A Board committee is a standing committee of the Board. A Board committee will typically be composed of Board members, with an ongoing, defined role in supporting the work of the Board. A Board Committee may also be composed primarily or entirely of outside experts tasked with providing advice directly to the Board on policy or other issues requiring specialized expertise.
    b. A task group is a time-limited, task-specific committee of the Board established to undertake specific tasks or deliverables within a predetermined timeframe. Once the tasks are completed the task group is dissolved. A task group may include both Board members and/or non-Board members based on the needs of the Board.
2. The full Board holds the ultimate responsibility for governing the organization. Board committees and task groups, unless otherwise specified by the Board, do not have any independent authority to act on behalf of the Board.
3. The Board will establish terms of reference for committees and task groups that will usually include the following:
    a. the mandate or purpose of the committee or task group;
    b. the term for the committee or task group;
    c. appointment of members to the committee or task group;
    d. appointment of the Chair of the committee or task group;
    e. skills and expertise required of members of the committee or task group;
    f. term and term limits for members of the committee or task group;
    g. quorum requirements of the committee or task group; and
    h. any other terms as determined by the Board.
4. The Chair of the Board will be an ex-officio member of all Board committees and task groups unless otherwise specified in terms of reference, and he/she may participate on committees or groups at his/her discretion.
5. The Registrar will be notified of all committee and task group meetings and invited to attend in a non-voting capacity, but his/her attendance is not counted for the purpose of committee or task group quorum requirements.
6. If committees or task groups are established they:
    a. Do not speak or act for the Board except when formally given such authority for specific and time-limited purposes. Such authority will be stated through terms of reference or Board minutes.

b. Are to assist the Board in doing its job by recommending, analyzing, deciding and/or acting as directed by the Board.
c. Cannot exercise authority over staff and operations and must work within the organization's mission and policy framework.
d. Will receive their terms of reference, specific tasks, staffing, reporting process, time lines, etc. from the Board as the committee or task group is established.
e. Will use a committee or task group work plan, which will specify goals for the committee or task group, strategies to meet the goals and timelines for completion of the goals.
f. May only establish sub-Committees if approved by the Board.

7. Committee and task group reports that are presented to the Board on matters requiring decisions or actions will generally contain a recommended course of action, with supporting rationale, unless otherwise requested by the Board.

8. Deviations from the approved budget for a committee or task group are to be reported immediately to the Board by the Registrar.

9. Timelines for completion of tasks and submission of reports are to be consistent with the Board's directions or mandate.

10. Once those committees or task groups that have completed their tasks or assignments and where there is no longer a need for their continuation or existence, they will be disbanded automatically.

4.5 Board Work Plan & Meeting Agendas

To govern effectively, the Board must recognize that the work it will do throughout the year is based on fulfilling its governing responsibilities. This means that it will not devote time and energy to the methods and means that will be employed by the Registrar to achieve the Board's stated Vision and Strategic Goals.

Accordingly:

1. At the beginning of each new Board year the Board will, in a special session or as part of its first regular Board meeting, identify the goals, tasks and issues it intends to address, and incorporate these into a 'Board work-plan' and calendar for the coming year.
2. Items on the Board's 'work-plan' will form part of each Board meeting agenda.
3. The agenda will consist of those items that pertain to the Board's areas of governing responsibilities and to matters raised by the Registrar that require Board policy or direction. The agenda will meet all requirements set out in the Health Professions Act.
4. The Board authorizes the Chair to develop, in consultation with the Registrar, the 'draft agenda' for each Board meeting.
5. Board members are encouraged to submit to the Chair agenda items that meet the criteria for Board agendas.
6. It will be the practice of the Board not to accept last minute items for additions to the agenda unless, in the combined view of the Chair and the Registrar, they require the immediate attention of the Board.
7. The Board determines the final version of the agenda, and the approval of the agenda is the first item of business at the Board meeting.
8. The Board will, at each meeting, acknowledge the traditional lands of the First Nation on which the meeting is taking place.
9. Agenda items for Board meetings must be circulated to members before the meetings, according to the established procedures.
10. If the agenda item is not completed in its allotted time, the Board will vote whether to continue discussing the topic or table the item until the next meeting.
11. The Board's meeting format should adhere to the most recent edition of Robert's Rules of Order. Consensus agreement is the goal whenever possible.

4.6 Meeting Observers

Once the dates of the Board meetings are determined, they are published on the College's website.

Accordingly:

1. The Board will maintain positive relationships with the public through open access to the Board.
2. The Regular Meetings of the Board are public meetings and may be made available through internet streaming or live video.
3. Individuals or groups may request to make a presentation at a Regular Meeting of the Board.
4. The Board Chair has the prerogative to permit an observer at the Regular Meeting to make a contribution to a topic being discussed.

4.7 Succession Planning

To ensure that the College is able to fulfill its mandate of protecting the public it is the responsibility of the Board to oversee, at all times, that the College is managed by a professionally qualified and competent Registrar.

Accordingly, the Board will:

1. Ensure senior management succession planning policies and processes are in place, including a review of an annual review on such plans and policies by the Registrar.

2. The Registrar will prepare a successor in the event of unexpected incapacity in addition to ongoing management development plans.

4.8 Board Assessment & Evaluation

It is the obligation and responsibility of the Board to govern effectively, to ensure fulfillment of the College's legal mandate and to work together in building a healthy and effective Board team.

Accordingly, the Board will:

1. Assess the effectiveness of its meetings and use the data from the assessment to make changes that will improve meetings of the Board.
2. At least once during any given Board year, conduct a full assessment or evaluation of Board functioning regarding its governing responsibilities, relationship with the Registrar, its committees and task groups, its decision-making processes and practices, and its ability to work effectively as ateam.
3. Address areas of concern, focus on team building, encourage participation and mutual understanding on a continual basis.

4.9 Registrar Performance Evaluation

It is the responsibility of the Board to conduct an annual evaluation of the performance of the Registrar. This will be done in a respectful, fair and professional manner employing a process, timelines and data collection and analysis tools agreeable to the Board and the Registrar.

Accordingly, the Board will:

1. Delineate the performance outcomes, expectations regarding attitude and behaviour, and any compliance requirements that will be used to evaluate the Registrar's performance in the employment contract.
2. Have the Chair establish a 'Registrar' performance evaluation task group that will be responsible for conducting and managing the evaluation process on behalf of the Board. At a minimum this task group will have the Chair, Vice-Chair and a public appointee as its members.
3. Identify and agree with the Registrar on the process and timelines that will be employed for the performance evaluation.
4. Articulate how formative and summative data, that acknowledges progress, achievement and provides direction to further the Registrar's role and development, will be provided to the Registrar as feedback.
5. Receive the Task Group's Performance Evaluation Report after it has been hand delivered by the task group to the Registrar.
6. Commit to meeting with the Registrar directly after it has received and accepted the Performance Evaluation Report from its task group to discuss the report and any recommendations determined by the Board.
7. Ensure that the information regarding the performance evaluation of the Registrar is kept confidential.

Board Operations

4.10 The Board/Registrar Relationship

It is in the best interest of the Board and the College that the Board develops a positive, respectful and harmonious working relationship with the Registrar. To that end, both parties need to function as partners in providing leadership, guidance and direction to managing the business of the College.

Accordingly, the Board will:

1. Delegate to the Registrar the necessary power and authority, including spending authorizations, to effectively manage and operate the College.

2. Enter into a legal employment contract with a new Registrar that addresses such matters as responsibilities, accountabilities, deliverables, compensation, benefits, conditions for terminating the agreement, and the process and timeframe for the annual performance evaluation of the Registrar.

3. Appoint a Board Selection Committee to conduct a search for a new Registrar when required. The Committee will be responsible for establishing the committee's Terms of Reference, to be approved by the Board, which determine the parameters and process for the completion of a successful search.

4.11 Reimbursement of Expenses to Board and Committee Members

1. **Expenses**
   a. For reimbursement of reasonable, budgeted expenses incurred while on College business, all receipts must be affixed to a completed expense claim form. Expenses will be reimbursed as incurred consistent with the College's expense claim guidelines. Expense claim forms (with attached receipts) must be submitted within 60 days of when the expense is incurred.

2. **Travel**
   a. **Air:** Air travel is to be booked through the College-specified travel agent, whenever possible, as per the criteria established for the College of Pharmacists' account. The appropriate College staff will supply the College-specified travel agent's contact information.

   b. **Personal automobile:** Mileage will be reimbursed using the Canada Revenue Agency Automobile Allowance Rate.

      http://www.cra-arc.gc.ca/tx/bsnss/tpcs/pyrll/bnfts/tmbl/llwnc/rts-eng.html

   c. The total mileage claim is to be limited to the cost of the lowest fare for economy class air transportation to the same destination (where applicable). Lower Mainland residents may claim for travel between their homes and the meeting site.

   d. **Other:** Parking, cabs, airport buses or shuttles (Please submit original receipts showing taxes paid – other than for parking meters.)

3. **Accommodation**
   a. Hotel accommodations are to be arranged by the appropriate College staff.
   b. The College maintains a master hotel account at certain hotels. The room rate for a standard single occupancy room and applicable taxes for the day(s) spent on College business or meetings will be automatically billed to the master account. Individuals must arrange to pay all other expenses incurred during their stay (such as mini-bar charges, laundry, in room movies and personal telephone calls); these expenses are not reimbursed by the College of Pharmacists of BC.
   c. Board or committee members are eligible to expense hotel accommodation on the night before or between Board or committee meetings. Individuals are expected to exercise prudence when deeming it necessary to stay in hotel accommodation.
   d. Board or committee members who stay in non-commercial lodging (i.e. with friends or family) may spend up to $30.00 per night in lieu of commercial lodging on a gift (e.g. meal or gift certificate) for the hosts. Receipts are required and must be attached to the expense claim form with a notation explaining the claim.

4. Meals – General

a. Actual costs, or a per diem allowance where permitted, may be claimed for meals on College of Pharmacists' business. The business purpose should be indicated on the expense claim.

b. There is no reimbursement if the traveler has the opportunity to eat breakfast or lunch before leaving home or eat dinner at home at the end of the day.

c. The names of individuals, or the group, in attendance must be indicated on the claim.

d. Original restaurant receipts are required for reimbursement of actual expenses. The amount of the gratuity may be noted on the receipt for reimbursement.

5. Per Diem Meal Allowance

a. A fixed allowance covering meals and incidentals (e.g. gratuities for housekeeping services, bellhops, etc.) may be claimed without receipts, in lieu of specific expense reimbursement when travelling to conferences or other similar situations. If travelling for more than one meal period, the maximum daily reimbursement will be calculated based on the total for all applicable meals, rather than by individual meal. If travelling for one meal period, the traveler will only be reimbursed up to the amount for that particular meal.

b. Maximum amounts include all taxes and gratuities.

c. In the course of meetings, group breakfasts, lunches, or dinners may be arranged. All participants are encouraged to join in these group functions. There is no reimbursement for meals purchased independently at alternative venues in these situations.

d. There is no reimbursement if the traveler has the opportunity to eat breakfast or lunch before leaving home or eat dinner at home at the end of the day.

e. The College uses the meal allowance rate set by the Government of British Columbia, which is updated periodically. Please contact staff for the most recent per diem rates.

6. Honoraria

a. Honoraria will be paid on an hourly basis at $50.00 per hour, $200.00 for one half-day, or

b. $400.00 for a full 8-hour day for scheduled Board or Committee meetings whether in-person or by teleconference or web-conference. The maximum honoraria of $400.00 will include any travel time on that day.

c. Board or Committee members will be paid the hourly rate for their meeting preparation time. Note: Acceptable billable hours for a particular meeting will be determined by the Committee consensus at that meeting. Board preparation time is to be a maximum of 8 hours per meeting.

d. Honoraria will not be paid for the following:

- Travel time (except for Board members who travel further than 50 km or one hour from the meeting site.)
- Attending conferences, training sessions, etc.

e. Note: Honoraria payments are subject to statutory deductions (Federal and provincial taxes and Canada Pension Plan contributions).

7. Other Costs (for Board members only)

a. A reimbursement of $20 per Board meeting will be given for miscellaneous supplies or incidentals (up to a maximum of $100 per year.) Receipts are required when available.

8. Submitting Expense Claims

a. Complete the expense claim form (found on the portal) and attach the receipts.

b. Forward the claim form and receipts (by mail or email with scanned attachments) to the appropriate staff member for approval within 60 days from when the expenses were incurred.

c. Reimbursements are made via electric funds transfer.

Part 5 – Standards of Organizational Conduct

First Approved: **September 24, 2010**
Revised:
Reaffirmed: **April 19, 2013**

Monitoring Frequency: **Annually or as required**
Monitoring Method:
Responsibility of: **The Board of CPBC**

5.1 Financial Planning and Budgeting

Financial planning and budgeting for any fiscal year will be based on Board stated goals, maintenance of the on-going operations of the College, and avoidance of financial risk.

Accordingly, the Registrar will:

1. Use credible planning assumptions.
2. Ensure that the budget is based on the College's strategic and operational plans.
3. Develop a balanced budget aligning annual expenditures with projected annual revenues.
4. Construct and submit a budget that shows a separation of capital and operating items.
5. Provide sufficient funds for the Board's annual operating costs.
6. Ensure sufficient cash balance to settle payroll and debts in a timely manner.
7. Invest surplus funds in in accordance with the Investment Policy and Provincial legislation.
8. Submit a draft budget to the Board prior to the beginning of each new budget year that will allow sufficient time for review, comments and changes (if required) prior to final approval.
9. See Reserves Policy (5.3) for further information.

5.2 Financial Management

The Registrar will ensure the College operates with internal controls and a financial management system that protects the organization from risk and meets or exceeds the standards set by the auditors.

1. Regarding the receipt and expenditure of funds, the Registrar will:

    a. Receive, process and disburse funds under controls sufficient to meet Generally Accepted Accounting Principles.

    b. Not expend more funds than have been received in the fiscal year to date unless the amount can be repaid by certain and otherwise unencumbered funds within 30 days of the end of the fiscal year.

    c. Not allow legal, statutory and other operational financial requirements to become delinquent.

    d. Not indebt the College in an amount that cannot be repaid within any conditions that the Board may set from time to time.

    e. Exercise adequate internal controls over receipts and disbursements to avoid unauthorized payments or material dissipation of assets.

    f. Not allow actual allocations to vary materially from those in the Board approved budget.

2. The Board designates the Registrar, Deputy Registrar, Chief Operating Officer, Board Chair and Board Vice-Chair as signatories for cheques, purchase orders and agreements:

    a. up to and including an amount of $5,000.00 require the signature of one of the following: Registrar, Deputy Registrar or the Chief Operating Officer.

    b. over the amount of $5,000.00 and up to and including the amount of $200,000.00 require the signature of two of the following: Registrar, Deputy Registrar or the Chief Operating Officer.

    c. over the amount of $200,000.00 require the signature of two of the following: Registrar, Deputy Registrar or the Chief Operating Officer plus the Chair or Vice-Chair of the Board.

3. The Registrar will establish a Signing Authority Policy, consistent with this Policy. The Signing Authority Policy will be reviewed and approved by the Board annually.

4. The Registrar will establish a Procurement Policy, consistent with this Policy.

5.3 Reserves Policy

The purpose of the reserves is to help to ensure the long-term financial stability of the College and position it to respond to varying economic conditions and changes affecting the College's financial position and the ability of the College to continuously carry out its Mission.

1. **Scope / Limits**
    a. This policy applies to all reserve funds of the College. In accordance with Canadian accounting standards for private sector not-for-profit organizations, externally restricted funds held by the College are classified as deferred revenue and, consequently, not considered a reserve fund for the purposes of this policy.

2. **Policy**
    a. The College shall hold the following reserve funds
    b. Capital Asset and Building Reserve
    c. Joint Venture Reserve
    d. Automation Reserve
    e. Legal Reserve
    f. Grants Reserve
    g. Operating Reserve

3. The reserve funds will not be shown in the budget, but will be held in separate general ledger balance sheet accounts with equivalent funds invested in either College bank accounts and / or College investment accounts. These funds will be separately reported in the annual financial statements.

4. The annual and multi-year budgets shall include a statement of the current balances in the reserves. The budget will include a line for anticipated net transfers between the reserve funds and the operating account, if applicable.

5. **Fund Balances -** The goal of the Board is to maintain the reserves for the following purposes and the target balances as follows:

    a. Capital Asset Reserve (Target balance is $250,000):
    The Capital Asset Reserve is maintained to assist in funding any unanticipated leasehold improvements, furniture purchases and other capital acquisitions, other than automation purchases.

    b. Joint Venture Reserve (Target balance is $500,000):
    The Joint Venture Reserve is maintained to assist in funding any special levies required to maintain the upkeep of the building jointly owned by the College of Pharmacists and the College of Dental Surgeons. These would be outside of the planned joint venture reserve fund schedule.

    c. Automation Reserve (Target balance is $500,000):
    The Automation Reserve is maintained to provide for the substantial maintenance,

upgrading or replacement of IT equipment, software purchases, audiovisual equipment and telecommunications equipment over and above regular maintenance, upgrades or replacements provided for in the annual operating budget.

d. Legal Reserve (Target balance is $500,000):
The Legal Reserve enables the College to sustain operations in the event of legal costs arising from an unanticipated increase in the number of Inquiry or Discipline cases (or other significant events requiring extensive legal assistance).

e. Grants Reserve (Target balance is $250,000):
The Grants Reserve is maintained to provide the opportunity to fund proposals for research projects or training opportunities that support the College's Strategic Plan.

f. Operating Reserve (Target balance is $1,000,000):
The Operating Reserve is maintained to achieve the following objectives:

i. To enable the College to sustain operations through delays in payments of committed funding, unanticipated operating expenditures or increases in service delivery costs that cannot be financed through changes in the regular budget lines and to permit acceptance of reimbursable contracts and grants without jeopardizing ongoing operations.
ii. To create an internal line of credit to manage cash flow and maintain financial flexibility.

6. Total Reserves = $3,000,000.

7. Fund Expenditures

a. Expenditures from the reserves and transfers between reserves and operations may only be made at the discretion of the Board and only for the purposes outlined below:

8. Capital Asset Reserve:

a. The Capital Asset Reserve funds may be used for expenditures related to leasehold improvements, furniture purchases, the purchase of other capital assets (other than automation purchases), a facility needs analysis, expanding the existing property or the College's share of ownership of the property and / or acquiring a new property.

9. Joint Venture Reserve:

a. The Joint Venture Reserve may be used to pay for the College's portion of a special levy related to a large capital expenditure for the upkeep of the Joint Venture building.

10. Automation Reserve:

a. Capital purchases and large maintenance projects related to IT equipment, audiovisual equipment, telecommunications equipment, as well as software licencing and purchases will first be met through the annual operating budget. In the event of unanticipated large projects, the Board may approve withdrawing

funds from the Replacement Reserve to enable these projects to proceed in a timely manner.

11. Legal Reserve:

a. The Legal Reserve may be used to pay for legal costs arising from an unanticipated increase in the number of Inquiry or Discipline cases (or other significant events requiring extensive legal assistance).

12. Grants Reserve:

a. The Grants Reserve is maintained to provide the opportunity to fund proposals for research projects or training opportunities. Upon receipt of proposals requesting support, the Board may approve the grant being funded from this reserve.

13. Operating Reserve:

a. The Operating Reserve is maintained to achieve the following objectives:
    i. To enable the College to sustain operations through delays in payments of committed funding, unanticipated operating expenditures or increases in service delivery costs that cannot be financed through changes in the regular budget lines and to permit acceptance of reimbursable contracts and grants without jeopardizing ongoing operations.
    ii. To create an internal line of credit to manage cash flow and maintain financial flexibility.
b. The Board may approve withdrawing funds from the Operating Reserve for #1 – to cover proposals for unanticipated operating expenditures, etc.
c. For #2 – in the case of a cash flow shortfall of three months or less, the Chief Operating Officer shall use Reserve funds before using the commercial line of credit. A draw-down from the fund that will not or cannot be replaced with operating funds within three months, must be approved by the Board.

14. Replenishing the Reserves

a. If any of the Reserves is and has been less than 75% of the targeted reserve level for two consecutive years, the Board of Board members, in the absence of any extraordinary circumstances, will adopt an operational budget that includes a projected surplus sufficient to rebuild the Reserve(s) to the targeted reserve level over the following two years. Board approval will be required to authorize transfers from unrestricted net assets to one of these reserves.

5.4 Investment Policy

All cash and investments are to be used for the general operational expenses of the College of Pharmacists of British Columbia (henceforth referred to as the "College") unless specifically identified for other purposes. Surplus funds are to be invested to meet these operational expenses. These funds must be invested conservatively and should not be subject to speculative situations.

1. Investment Objectives

a. The primary investment objective is to protect the capital from loss.
b. The secondary objective is to obtain the highest rate of return while preserving capital.
c. The third objective is to insure the portfolio contains sufficient liquidity to provide the College with the flexibility to meet its anticipated and potentially changing cash requirements.

2. Investment Restrictions

a. All fixed income investments with a maturity of one year or less must have a Dominion Bond Rating (or equivalent) of at least R1 Low.
b. The total amount of R1 Low fixed income investments at any one time shall not exceed 30% of the total investment portfolio.
c. All fixed income investments with a maturity of greater than one year must have a Dominion Bond Rating (or equivalent) of A Low or higher (e.g. bonds and strip coupons).
d. The investment portfolio must, where practicable, produce sufficient cash to meet the College's expected cash demands without relying upon the sale of securities having one year or more until maturity.
e. At all times, not more than 50% of the portfolio may be invested with any one issuer unless it is the Government of Canada, a Provincial Government, or an entity with a Federal or Provincial guarantee. Investments vehicles meeting the definition of "bank deposits" may also be excepted from this concentration provision provided they are deposit based investments issued by a Schedule I Canadian bank.
f. If the portfolio is less than $500,000 then 100% of the portfolio may be invested with one issuer.
g. GIC exposure to any one issuer must be limited to the CDIC (Canada Deposit Insurance Corporation) limit of $100,000 unless the issuer is a "Big 6" Schedule I Canadian bank; a credit union backed by an unlimited provincial guarantee; or a large scale international issuer that may, from time to time, be identified as having sufficient resources to warrant exceeding the $100,000 per issuer CDIC limit.

3. Investment Guidelines

a. The Investment Guidelines must at all times be in agreement with the Investment Objectives and the Investment Restrictions.

b. For the purposes of the Investment Restriction criteria, GICs can be treated as
    i. money market vehicles for maturities of one year or less and as bonds for maturities greater than one year.
c. For surplus funds anticipated to be in excess of current and projected operational needs, the maximum remaining term to maturity should not exceed five years.
d. An exception for Guideline C is for funds which are set aside for a specific purpose whose payment date exceeds these terms.
e. An investment should be sold and replaced when its credit rating drops below minimum levels.
f. All investments should be held in segregated accounts.

5.5 Risk Management

Protection of the College's assets is critical to its current and long-term operational viability. As the Registrar has operational control of the assets it is essential that risk management practices be implemented to ensure the assets are protected.

Accordingly, the Registrar will:

1. Purchase insurance and implement controls to protect College assets against theft and casualty losses and prevent access to funds by unauthorized personnel.

2. Take measures to maintain and protect the College premises and its contents.

3. Implement policies and practices that will prevent exposing the College, its Board and staff to claims of liability, as well as ensure that the Board and staff are adequately insured against liability claims. Also, review the policy annually to maintain sufficient coverage.

4. Arrange to have the office premises and contents appraised every 5 years, and insured on a replacement cost basis with the coverage being reviewed annually and retendered every 5 years.

5. Only commit the College to those expenditures that comply with Board directives and policies.

6. When investing or holding the College's operating capital, ensure their liquidity and safety, guided by the future needs of the College and include easily accessible cash reserves equal to the cost of operating the College for six months.

7. Follow Board policies or guidelines to acquire, encumber or dispose of real property.

8. Not reduce the College's current assets without Board knowledge and approval.

9. Observe and enforce the working conditions and standards set out in the Employment Standards Act of the Province of British Columbia.

10. Ensure a business continuity plan is in place, and that all information systems are backed up daily in case of fire, theft or an Act of God in order to prevent business loss and disruption.

11. Ensure a risk management policy is in place.

12. Maintain and report regularly on the College's risk register.

5.6 Employee Relations

A healthy and safe working environment and fair, respectful, dignified and non-discriminatory working conditions are ensured for all employees and volunteers.

1. Regarding the treatment of employees and volunteers: Accordingly, the Registrar will:

    a. Honour the spirit and intent of the College's collective agreement(s).
    b. Not knowingly practice, condone or tolerate harassment of any kind within the College and working environments under the jurisdiction or direct influence of the College.
    c. Be proactive in protecting the staff from unsafe and unhealthy conditions in the workplace.
    d. Provide a fair and equitable complaints and grievance process that is free from retribution.
    e. Have written personnel policies, consistent with any applicable legal requirements, that clearly address the College's expectations of employees and volunteers and their obligations.
    f. Promote diversity in the workplace. This includes (but is not limited to) diversity regarding ethnic origin, culture, religion, gender, sexual orientation, age, skill sets and experience.
    g. Ensure that all employees and volunteers are well informed of their rights and the College policies that affect them.

2. Other than their requested attendance at Board meetings or their participation on committees involving Board members, non-unionized staff will only have access to the Board as a 'last resort' on matters regarding their treatment by the Registrar or allegations of illegal activities or actions by the Registrar. On all other matters, staff must deal directly with the Registrar.

3. The Board will ensure that any employee engaged in 'whistle blowing' activity or raising matters with the Registrar will not suffer retribution or discrimination as a result of bringing these matters forward. If the person is not satisfied with the response from the Registrar, he or she can then approach the Board Chair.

Standards of Organizational Conduct

5.7 Employee Compensation and Benefits

With respect to employment, compensation and benefits to employees, consultants, contract workers and volunteers, the Registrar must protect the College against financial risk or negative public image.

Accordingly, the Registrar will:

1. Not promise or imply to current or potential employees permanent or guaranteed employment.
2. Make sure that every employee has received and agreed to a letter of employment or a letter of services or a letter of requirements prior to commencement of services.
3. Establish current compensation and benefits which:

    a. Comply with the Board's policies on compensation.
    b. Do not create long-term obligations that the Board believes cannot be met from its normal revenue sources.

4. Not establish deferred or long-term compensation and benefits which:

    a. Cause unfunded liabilities to occur or in any way committing the College to benefits that incur unpredictable future costs.
    b. Deviate from Board approved levels of benefits.

Standards of Organizational Conduct

5.8 Contractor Services

With respect to contracting services, the Registrar must protect the fiscal integrity and public image of the Board.

Accordingly, the Registrar will:

1. Employ a tendering process for suppliers, consultant services, service contracts and equipment/facility leases or purchases by obtaining three quotes, or through a competitive process, wherever practical. Any tendering process must be transparent, fair and comply with the College's conflict of interest guidelines.
2. Ensure goods and services are acquired in a manner that results in supply arrangements at the most effective net cost, in the correct quantities, of the appropriate quality and from the most responsive and responsible source.
3. Promote accountability in its use of funds for the acquisition of goods and services.
4. With respect to leases, not enter into individual lease agreements that financially commit the College to terms greater than five years, to total lease payments greater than $250,000.00 and to annual lease payments greater than $50,000.00 for each lease agreement, unless approved by the Board.
5. Ensure all agreements entered into by the Registrar are in writing and signed by both parties
6. Make sure that every consultant and contract worker has received and agreed to a letter of employment or a letter of services or a letter of requirements prior to commencement of services.
7. Not enter into any long-term contractual obligations that exceed the College's ability to ensure that it will have the financial resources to fulfill the terms of the contract unless approved by the Board.
8. Not continue with a contractual agreement if the contractor fails to satisfy the terms and obligations of the contract.
9. Withhold payment or appropriate funds until the agreed upon contracted services have been completed satisfactorily.
10. Ensure a Procurement Policy and a Signing Authority Policy are in place.

5.9 Protection of Registrant Information

Protection of registrant information is essential to ensuring the privacy of those persons registered to practice pharmacy in British Columbia.

Accordingly, the Registrar will:

1. Ensure that the College is in compliance with the privacy sections of the Health Professions Act (HPA) and all other Privacy and Protection legislation, provincial and federal.
2. Ensure a Privacy Policy is in place.

Standards of Organizational Conduct

5.10 Charitable/Grant Donations and Sponsorship

From time to time the College will be approached by external organizations for charitable donations or event sponsorship.

Accordingly, the Registrar will:

1. Ensure that all monies of the College donated to charitable organizations or to sponsor events or conferences or for grant purposes such as UBC are based on previously approved requests by the Board and are included in the current year's operating budget. Such requests will align with the College's mission, vision and values and align with the College's strategic plan and communications strategy.

Standards of Organizational Conduct

5.11 Collaborative Agreements

The Registrar or Deputy Registrar may approve collaborative agreement protocols provided the protocol includes the following:

1. A statement delegating medication therapy management authority from a specific physician to the pharmacist.
2. A description of who will obtain the authority (e.g. the named pharmacist or pharmacists under the supervision of the named pharmacist).
3. A time period for the protocol (not to exceed two years).
4. Patient eligibility criteria.
5. Specified delegated activities (i.e. disease, drugs, categories).
6. A description of the type of pharmacist medication therapy management authority being delegated (e.g. continuation, modification, initiation).
7. A plan, guideline or algorithm for medication therapy management decisions.
8. Procedures for documenting the decision and actions taken.
9. A plan for periodic reporting/review of decisions with collaborating prescriber.
10. Copies of all forms used, including the patient consent form.
11. A procedure for resubmission to the College when substantive therapeutic changes occur.
12. That each staff approved protocol will be included on the next Board agenda as a consent item.

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First Approved: **September 24, 2010**
Revised:
Reaffirmed: **April 19, 2013**

Monitoring Frequency: **Annually or as required**
Monitoring Method:
Responsibility of: **The Board of CPBC**

4. Professional Practice Policies

(This category includes policies that affect pharmacists, pharmacy technicians and pharmacies).

PPP-3 Pharmacy References PPP-5 Pharmacy Security
PPP-12 Prescription Hard Copy File Coding System
PPP-15 Narcotic Controlled Drug Signing Authorizations
PPP-20 Prescription Refills
PPP-24 Depot Shipments of Prescriptions
PPP-25 Pharmacy Disaster Preparedness
PPP-26 Pharmacists Distribution of Alternative and Complementary Health Products
PPP-27 Registration Requirements for Pharm.D. Program Students PPP-29 Triazolam Dispensing Guidelines (rescinded)
PPP-31 Emergency Prescription Refills PPP-32 Dispensing Multidose Vials
PPP-35 Pharmacists' Refusal to Provide a Product or Service for Moral or Religious Reasons
PPP-39 Responsibility of the Pharmacist When Asked to Provide a Drug That May Harm the Patient (rescinded)
PPP-40 Repackaging Bulk Nonprescription Drugs PPP-43 Automated Pharmacy Dispensing System PPP-46 Temporary Pharmacy Closures
PPP-47 Operational Procedures for Complying with Benzodiazepines and Other Targeted Substances Regulations
PPP-50 Centralized Prescription Processing
PPP-54 Identifying Patients for PharmaNet Purposes PPP-55 Telepharmacy
PPP-56 Standards for Pharmacy Technician Verification of Non-Sterile Products in Hospital Pharmacy Practice
PPP-57 Standards for Pharmacy Technician Verification of Sterile Products in Hospital Pharmacy Practice
PPP-58 Medication Management (Adapting a Prescription) PPP-59 Pharmacy Equipment
PPP-60 Professional Liability Insurance
PPP-61 Hospital Pharmacy Published Standards
PPP-63 Hospital Pharmacist Role with Respect to Drug Distribution Systems, Drug Administration Devices, Products and Services

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.x. June 14, 2018, 2018 Draft Committee of the Whole Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the June 14, 2018 Draft Committee of the Whole Minutes as circulated.

Appendix	
1	June 14, 2018 Draft Committee of the Whole Minutes (and appendices)

College of Pharmacists of British Columbia

Committee of the Whole
June 14, 2018
9:00 AM – 3:00 PM
Held at the College of Pharmacists of British Columbia
200-1765 West 8th Avenue, Vancouver, BC

MINUTES

Present:
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
Anar Dossa, District 6
Sorell Wellon, District 8
Tracey Hagkull, Government Appointee
Justin Thind, Government Appointee
Jeremy Walden, Government Appointee

Regrets:
Ryan Hoag, Government Appointee

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

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1. OPIOID WARNING STICKERS AND PATIENT INFORMATION (APPENDIX 1)

Christine Paramonczyk, Director of Policy & Legislation presented on the upcoming Health Canada requirement of a warning sticker and a patient information handout to be provided with prescription opioids sold at pharmacies.

The Committee discussed the following:

- The College's current priorities;
- L'Ordre des Pharmaciens du Québec's position and public statements with regards to this requirement;
- Consideration of the needs of patients;
- ensuring Pharmacists are able to exercise their professional judgement
- Consideration of other drugs.

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The Board discussed different approaches to communicate the Health Canada requirements with registrants. The Board suggested that the College inform registrants about the requirements, and continue to monitor the situation.

2. STRATEGIC PLANNING COMMITTEE WORKING GROUPS BY CHAIR KWONG AND CHIEF OPERATING OFFICER O'CALLAGHAN (APPENDIX 2)

Chair Kwong and COO O'Callaghan, provided a refresher to the Strategic Planning session at the Committee of the Whole meeting on April 19, 2018 and provided a handout which included the focus of today's session. **(APPENDIX 3)**

3. PLENARY SESSION

WORKING GROUP 1: PRACTICE TRENDS
Members: Anar Dossa, Frank Lucarelli, Ryan Hoag (Absent)
Staff Resource: Doreen Leong, David Pavan

Refined Theme Scope (4 key points)

1) Interprovincial Pharmacy Services
- Scope redefined as interprovincial pharmacy services, previously intra-provincial pharmacy services and interjurisdictional pharmacy services
- What is happening in other provinces?
- What are their trends and their response to these trends?

2) Centralization of Pharmacy
- Distribution of product and clinical services
- Centralized clinical services can impact a huge number of patients

3) Point of Care Testing
- Health Tab

4) New and Emerging Models of Pharmacy Service Delivery
- How do patients want to get their services delivered?
- Ways of getting access to services
- Vending machines
- Drones

Consultation Scope:
- Environmental Scans (What are they doing? What legislation they have?
- Looking at other PRAs (National and International)
- Washington State Pharmacy Board
- Patients and Prescribers
- Pharmacists, Pharmacy Technicians and Pharmacy Owners
- Other Health Authorities – may operate under different interests
- Government and Advocacy Groups
- Site visits

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Questions to Pose:

1) **Public**
   - How do patients want to receive their pharmacy services? (I.e. product and clinical services?
   - Create a list and rate in a 1-10 order
   - How does out of province patients like to receive their pharmacy services?

2) **Retailer:**
   - What business models are retailers currently using and what are you projecting?
   - Compare cross-province

3) **Stakeholder:**
   - What services models are other PRAs currently using?
   - What Interprovincial pharmacy service models currently exist?
   - What are other provincial jurisdictions doing (i.e. point of care testing ad outcomes measuring)?

Other Plenary Discussion and Things to Consider:

- Empowering the patient
- Trust between patient and health care system
- Pharmacist as the primary care provider
- How does the theme relate to patient and providing better health through excellence in pharmacy?
- What's in scope or out of scope?
- How does the College have the ability to impact?

Discussion Points Removed from previous meeting:

- What are trends in Rx reimbursement?
- What will government cover re imbursement?
- Integration of roles was referred to optimized roles of registrants group
- Opioids and cannabis for medical use: is this a practice trend? Work is underway on Opioids and Medical prescribing of Marijuana may already be in place by the time the next strategic plan is in place

<u>WORKING GROUP 2: PROFESSIONALISM IN PHARMACY</u>

Members: Ming Chang, Justin Thind
Staff Resource: Mary O'Callaghan, Bob Nakagawa

How would you define your theme?

- Enhancing stature, credibility and reputation of the pharmacy professional

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What background might be needed to understand the theme?

- Survey key stakeholders as per question list

Why is the theme important?

- Patients view pharmacists as trusted expert.

What's in scope, or out of scope?

- Right Touch legislation?
- Nothing really out of scope

Consultation Scope:

- Patients / the public – no changes from April list
- Physicians (& Nurse Practitioners, etc.) – no changes from April list
- Business owners
- Registrants

Questions to Pose:

- Pharmacists and the public – see questions developed in April
- **Business owners:**
  - What are the barriers to professionalism for pharmacy professionals?
- **Pharmacy Technicians:**
  - Do you feel that you are being treated as a professional by pharmacists?
  - Do you have autonomy in doing your work?
  - Perhaps ask PTechs to find more questions

Other Plenary Discussion and Things to Consider:

- Patient care/ Public Safety – needs to be broader – as not necessarily a patient
- Broadening understanding of what our role and responsibilities are
- Identify any barriers in our current regulatory framework and legislations that prevent us going to where we want/need
- Public vs Patient
- Promote the "aspirational" in our bylaws.
- Counselling on refills – the goal is to empower the patient to look at their health / lifestyle changes / etc.
- Look at relationship building, overall health, etc.
- Health objectives versus the "Product".
- Education about the role.
- Build bridges with other healthcare professions.
- Website videos about professionalism / professional interactions?
- University classes – discuss professionalism
- Conference presentations – at other healthcare professions' conferences
- Include Cultural Humility?

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WORKING GROUP 3: BEST PHARMACY PRACTICE

Members: Arden Barry, Christopher Szeman, Jeremy Walden, Sorell Wellon
Staff Resource: Gillian Vrooman

Theme Refinement Topics:

- Promote Best Pharmacy Practice for the delivery of pharmacy case in B.C.
- Excellence in pharmacy (from our vision)
- "Raising the bar"
- Aspirational
- Raising the standards of practice
- Vision for 2023
- Clinical care
- Evidence based practice
    - Broad requirements for making evidence based recommendations?
- Using scope to meet patient care needs
- Maximizing registrants full potential to meet patient needs
- Title to play with: Promote best practices to enable registrants to meet the needs of patients
- Invasion the pharmacy care…
- Highlight issue with payment
- Imagine excellence in pharmacy where pharmacy professionals are able to raise the bar in patient care
- BC as a leader
- Raising the bar in patient care through excellence in pharmacy / promoting
- Envision where…
- Promoting best practices for the delivery of pharmacy care in BC
- Elevating pharmacy care in BC through
- What are your ideas on how to implement "raising the bar"

Why is the theme important?

- Provides opportunities for pharmacists to provide more clinical services which results in better patient outcomes
- Results in better patient outcomes
- Pharmacists are being
- Focus on the patient - Patient centered care
- Making sure patients get the best out of their medications
- Ptechs, best practice, ensure accuracy and excellence in dispensing, allows
- Provide real life example of how Ptechs can support have a more clinical role, pharmacists more involved in counselling patients talk.
- Inspirational leaders ted talk, change happens when the patients ask for it, paint the picture of the future.
- Imagine X scenario of pharmacy in best practice
- Imagine a scenario where Ptechs are injecting

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Environmental Scan:

- How are assistants used / restricted elsewhere?
- How are other provinces or international areas using techs?
- How are other regulators being aspirational or getting involved with best practices?

Consultation Scope:

- Pharmacy technicians
- Pharmacists
- Pharmacy Assistants
    - PTSBC and pharmacy managers may be best leads for these
- Pharmacy Owners
    - All directors / owners College has on file as of Oct 2018
    - We have all pharmacists directors and are starting to collect all non-registrant indirect owners through pharmacy renewals under the new pharmacy ownership requirements
- Members of the public
- Patient groups (College has list of contacts)
- First Nations
    - FNHA
    - FN Health Council
- Pharmacy Education groups
    - UBC Pharmacy
    - Faculty
    - Students
- Other continuing Ed programs
- Pharmacists clinic
    - UBC other (other medical programs that may collaborate with pharmacy)
    - Pharmacy Tech schools
- Sorell, we have some listed, but do you have specific orgs you recommend we connect with, we don't get much traction typically.
- Other healthcare professionals (who prescribe)
    - Physicians
- GP
- Specialists
    - Nurses and Nurse Practitioners
    - Dentists (since they can prescribe?)
    - Vets (since vets and pharmacists sometimes collaborate and may need to more with further compounding requirements from Health Canada coming soon)
- Other (non-health) professionals?
    - This may be too out of scope for the online engagement, we'd need to be clear about what kind of questions we want to ask, but may work as part of an environmental scan

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Question to Pose:

- What is your vision of "best practice" or "excellence" in pharmacy practice?
- What do we need to know more about on this topic from stakeholders?
- What should "best practice" or "excellence" in pharmacy practice look like in 2023?
- How can pharmacists be empowered to meet the future needs of patients?
- How can pharmacy technicians be empowered to meet the future needs of patients?
- What barriers exist to pharmacists practicing to their full scope of practice?
- What barriers exist to pharmacy technicians practicing to their full scope of practice?
- How can the College “raise the bar” to ensure best practice and patient safety?
- How can the College best promote evidence-based practice and patient-centered care?

Risks:

- Will this work seem to advocacy focused?
- Will best practice requirements be ignored by registrants?

WORKING GROUP 4: HPA MODERNIZATION

Members: Tracey Hagkull, Mona Kwong, Tara Oxford
Staff Resource: Ashifa Keshavji, Christine Paramonczyk

How would you define your theme?

The HPA is an “umbrella’ statue that provides a common regulatory framework for health professions in BC.

The regulatory colleges have been delegated the authority under provincial legislation to govern the practice of their registrants in the public interest. Their mandate at all times is to serve and protect the public.

Our job is to protect the public health by licensing and regulating pharmacists and pharmacy technicians and the pharmacies where they practice. We are responsible for making sure every pharmacist and pharmacy technician in BC is fully qualified and able to provide the public with safe and ethical pharmacy care. The College receives its authority from and is responsible for administering provincial pharmacy legislation.

(The primary function of the colleges is to ensure their registrants are qualified, competent and following clearly defined standards of practice and ethics.)

Since the standards directly impact the care that a patient receives, it is critical that updates must reflect current day practice to enhance/keep at forthright the public and patient safety.

As practice changes or evolves, the standards of practice need to reflect current day practice (reviewed and updated to reflect current practice; rapidly, evolving health system to provide best care)

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Theme Refinement Topics:

- In order to protect the public interest, the CPBC bylaws under the HPA define the expectations of the practice of pharmacy by pharmacists and pharmacy technicians
- PODSA (requirements of the site) and Bylaws to HPA governs the practice.
- The HPA governs the practice of all the regulated health professions in BC.
- The bylaws are divided into 3 main areas: community, hospital, and RC which define practice specific requirements

OUT OF SCOPE:

- Business interest and related matters are not within the College jurisdiction
- Board administration
- Prescribing
- Federal requirements and rules

OUR SCOPE: HPA Modernization will be focusing on the Standards of Practice (Community, Hospital and Residential Care)

Consultation Scope:

- Stakeholders
- Government?
- Patient groups – Patient Voices Network, BC Quality Council; CLBC, CCALA, HA Directors, HA – ambulatory pharmacy
- All groups noted in the backgrounder: CPBC staff: PRP, Investigations, Policy team; BCPHA, Neighborhood Pharmacy Association, CSHP, Pharmacy Technicians Society of BC, CRNBC, CPSBC

Questions to Pose:

1. What are you hoping to learn through the input you receive?
   - Are they current and appropriate and required and are there gaps or missing information. What is misinterpreted? What is misunderstood?
2. What are you looking for ideas on?
   - What is too much? Too little?
   - Relevancy to practice, current, clear?
   - Sticky topics?
   - Anything that blocks ability to practice? What is prohibitive to optimize patient care?
   - Hybrid model/practice – emerging models
   - Primary Care – practitioners not attached to a hospital, community or RC
   - HA – ambulatory care; satellites (patient consent, emerge fill, ID verification, privacy – Freedom of Information and Privacy)
3. What do you need to know more about on your theme? NIL
4. Suggest 3 to 5 of the most important areas you need input on.
   - Suggest ideas for questions

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Questions must keep in mind the community, hospital and residential care

- Impact on rules, indirectly, how does it impact you – Why does a pharmacist have to counsel?
- How does HPA impact on physicians and nurses and their relationship with pharmacists?
- Community Care and Assistance Living Act – group homes, Plan B – whoever guides this in the Ministry; Foster care

Other Plenary Discussion and Things to Consider:

- Healthy choice the easy choice
- So why do we define site?
- Professionalism → who? Registrant, patient, mD?
- Practice trends – how do you define pharmacy services?? Always tried to product
- Do we have role in prevention? Lost?

5. GROUP DISCUSSION

Key point 1:

- Is the word patient care limiting?
- People can go to a pharmacy to ask questions but necessarily a patient
- Maybe a better word would be public care?

Key point 2:

- Counselling – Pharmacists should engage with their patients and empower them beyond prescription medication
- Empowerment - Giving them tools of knowledge to be successful
- Not just giving them instructions on how to take their medication but empowering the patients to make life changes
- Building a relationship with your patient – something your patient might not think is important but you pick up as significant
- Optimizing role – fostering this kind of environment
- This is where Health care needs to go

Key point 3:

- Idea of Trust and building credibility
- Professionalism is trust
- Best practice and standards –meeting the standards and achieving best practice
- Work on engagement and relationship building with health care providers
- Trend – Trusting pharmacists to step in and be that person be that better healthcare provider

Key point 4:

- How do we shift health care to a more outcome based?
- Challenges – some medications sometimes take 30-40 years to work
- Pharmacists can't not get paid, outcomes might not be there

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Opioid Warning Stickers and Patient Information

Christine Paramonczyk

Director, Policy & Legislation

College of Pharmacists of British Columbia

Background

- Recently, Health Canada made regulatory amendments as part of the federal government's response to the opioid crisis.
- The Food and Drug Regulations were amended to require a warning sticker and a patient information handout to be provided with prescription opioids at pharmacies in Canada.
- Pharmacists and practitioners will be responsible for obtaining or producing the stickers and handouts, and absorbing the costs.
- The amendments will be effective in November 2018.

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Warning Sticker

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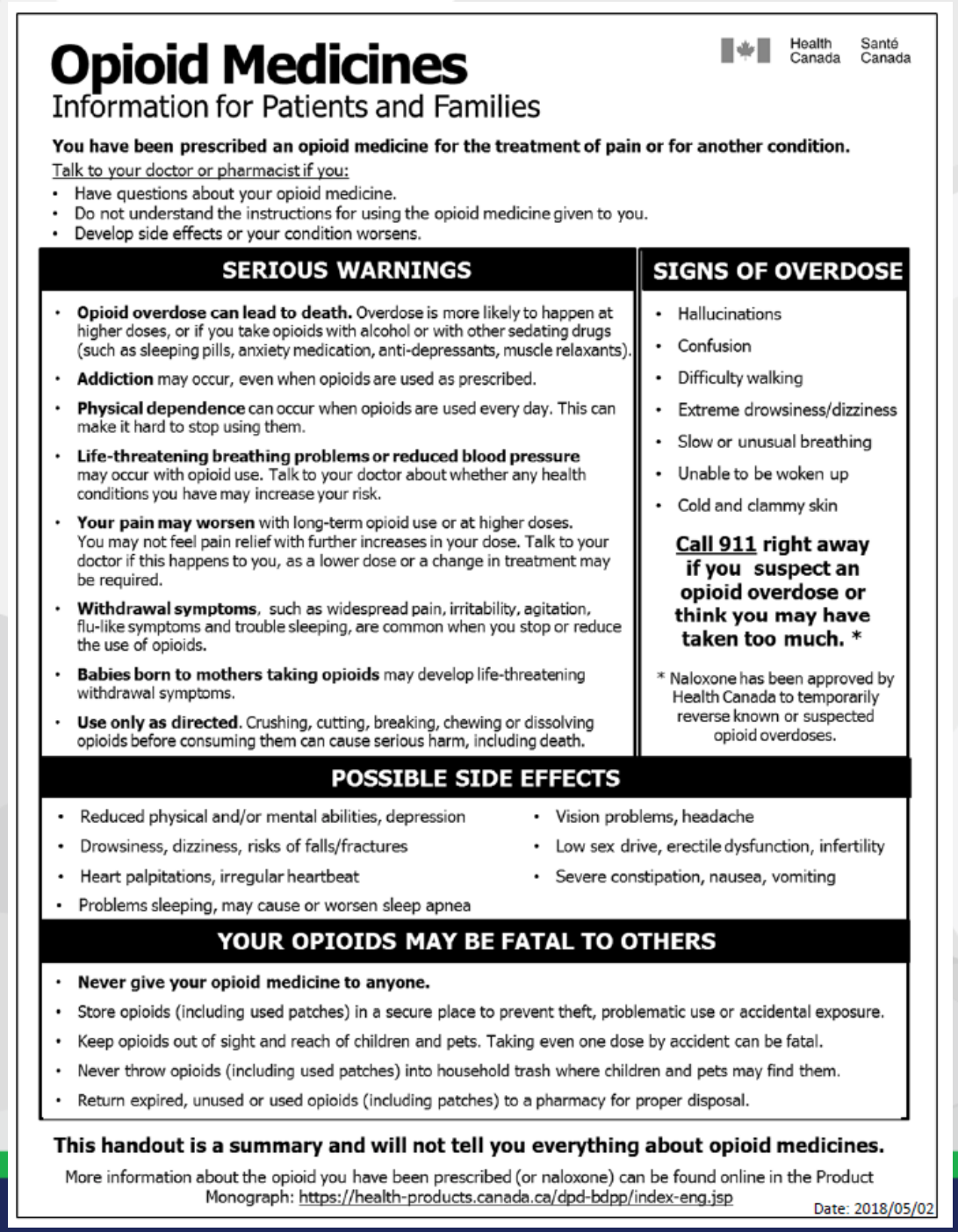
Patient Information Handout



Opioid Medicines

Information for Patients and Families

Health Canada / Santé Canada

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

Talk to your doctor or pharmacist if you:

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

SERIOUS WARNINGS

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

SIGNS OF OVERDOSE

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

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

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

POSSIBLE SIDE EFFECTS

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

YOUR OPIOIDS MAY BE FATAL TO OTHERS

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

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

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

Date: 2018/05/02

College of Pharmacists of British Columbia

NAPRA Concerns with Federal Approach

Issue	Description
Could Deter Appropriate Use of Opioids	• Does not allow pharmacists to exercise professional judgement in how they present information to patients. • The warning label and patient information handout could be inappropriate in some cases, and deter the appropriate use of opioids.
Significant Consequences for Non-Compliance	• Pharmacists may face severe consequences for non-compliance, including significant fines and imprisonment.
Outside of Federal Jurisdiction	• The practice of pharmacy is regulated at the provincial/territorial level. • How pharmacists advise patients and the information provided to patients is outside of the jurisdiction of the federal government. • Note: The federal government's position is that their approach flows from their authority regarding the labelling of prescription drugs.

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NAPRA Concerns with Federal Approach, continued

Issue	Description
Security Concerns	• Warning labels put a “bullseye” on opioids, making them a target for theft and potentially putting those patients at risk.
Lack of Evidence	• There is a lack of evidence supporting the use of warning labels and patient information handouts for pharmaceuticals on patient behavior.
Lack of Clarity on Costs	• There is a lack the clarity on costs and potential underestimation of the cost of the requirements.

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Ordre des pharmaciens du Québec

- On May 2, 2018, issued a news release raising the following concerns about the federal warning sticker and patient information handout provisions:
  - The new requirements are ill-suited to effectively addressing the opioid crisis.
  - Enhancing the authority of pharmacists to adjust a patient's opioid prescription, could help reduce the harms associated with the opioid crisis.
  - *"By making full use of pharmacists' competencies and allowing them to use their judgment rather than requiring them to treat each patient using a cookie-cutter approach, the government would be helping to reduce the harm associated with this public health crisis."*
- It is not known if other pharmacy regulatory authorities in Canada will be issuing similar news releases.

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Potential College Response to Federal Approach

Option	Pros	Cons
Advise Registrants and <u>Not</u> Officially Endorse	• NAPRA's response may be sufficient. • Avoids the College potentially receiving negative reaction from government. • Registrants and public will be provided with learning opportunities.	• The College does not raise concerns potentially impacting public safety (e.g., if patients are deterred from the appropriate use of opioids).
Issue a Statement Highlighting Concerns	• CPBC could address concerns regarding public protection and inform federal measures. • Registrants and public will be provided with learning opportunities. • Supports NAPRA's position and another PRA.	• May receive negative reaction from government. • May appear unsupportive of measures to address the opioid crisis. • May be considered advocacy.
Advise Registrants and Officially Endorse	• Registrants and public will be provided with learning opportunities. • Would not receive negative reaction from government.	• Would counter NAPRA feedback and Québec news release. • Would not address public safety concerns.

College of Pharmacists of British Columbia Strategic Plan 2019/20 – 2022/23

THEME WORKING GROUPS

JUNE 14, 2018

Strategic Planning Agenda

9:30 to 11:30	Strategic Planning Working Groups
Lunch	
12:30 to 1:30	Plenary to discuss the Working Groups' Plans
	Report Back: 10 minutes each group
1:10 to 2:00	General Discussion

Milestone	2018		2019
Brainstorm Retreat: Draft Themes and Theme Committees	Feb	✓	
April Board Meeting: Confirm Theme Committee Membership	Apr	✓	
Theme Committees: Develop Consultation Focus	Apr to Aug		
September Board Meeting: Ratify Consultation Focus	Sep		
CPBC Staff: Eight-week Consultation on Themes	Oct & Nov		
Theme Committees :Review Consultation and Develop Findings to Share at Retreat			Jan to Mar
Board Retreat: Develop Draft Strategic Plan			Apr
Board Meeting: Present Draft Strategic Plan			Jun
CPBC Staff: Budgeting Strategic Plan			Jul & Aug
Board Meeting: Approve Strategic Plan			Sep


2018
2019
FE MR AL MA JN JL AU SE OC NO DE JA FE MR AL MA JN JL AU SE
Brainstorm Retreat
Draft Themes and
Theme Committees
April Board Meeting
Confirm Theme Committee
Membership
Theme Committees
Develop Consultation Focus
Board Meeting
Ratify Consultation Focus
CPBC Staff
Eight-week Consultation on
Themes
Theme Committees
Review Consultation and
Develop Findings to Share at
Retreat
Board Retreat
Develop Draft Strategic Plan
Board Meeting
Present Draft Strategic Plan
CPBC Staff
Budgeting Strategic Plan
Board Meeting
Approve Strategic Plan

Four Themes

1. Practice Trends
2. Professionalism in Pharmacy
3. Best Pharmacy Practice
4. HPA Modernization

Working Groups

Practice Trends	Professionalism in Pharmacy	Best Pharmacy Practice	HPA Modernization
Board Lead: Frank Board: Ryan, Anar Staff: Doreen, David	Board Lead: Ming Board: Justin Staff: Bob, Mary	Board Lead: Chris Board: Arden, Sorrell, Jeremy Staff: Gillian	Board Lead: Tara Board: Mona, Tracey Staff: Ashifa, Christine

Working Groups: Possible Scope of Themes

Practice Trends	Professionalism in Pharmacy	Best Pharmacy Practice	HPA Modernization
• Inter jurisdictional pharmacy services • Intra-provincial pharmacy services • Centralized fill services • Point of care testing • New and emerging models of service delivery • Deprescribing	• Changing - drug selling to complete health approach • Enhance Patient Pharmacist relationship • Demonstrate oneself as professional • Revisit requirements practice • Identify name, role... • Confidential setting • Promote education to public • Patient safety > business metrics • Review legislation • Opportunity / skills to promote prof. communication	• Role of non-registrants, evidence-based care: • Antimicrobial stewardship • Pharmacogenomics • Academic detailing • Health promotion • Labs, diagnostic tests	• Review current standards of practice and update if necessary • Define clinical and technical aspects for each

Working Groups: Consultation Scope

Practice Trends	Professionalism in Pharmacy	Best Pharmacy Practice	HPA Modernization
• Other pharmacy regulators • Patients, prescribers • Pharmacists, owners, directors • Pharmacy technicians • Government • Advocacy groups	• Registrants • Patients • Physicians	• Pharmacists • Technicians • Pharmacies • Non-registrants	• Advisory committees • Registrants • Ministry of Health • Associations • Nurses / MDs

Activities Today

Next Steps:

- Review last meeting's scope and drafted questions. (see handout)
- Finalize focus for your theme.
- Recommend consultation questions.
- Recommend groups for engagement.
- Environmental scans required? What topic? Who should do it?
  - When should it be done?

Reminder

Remember that the Strategic Planning portal is available:

- Resources from previous meetings
- General strategic planning resources
- Area to gather notes, etc. for your team

College of Pharmacists
of British Columbia

Preparing Strategic Plan Themes for Engagement

June 14, 2018

Finalize the focus for your theme

- How would you describe your theme? Would members of the public understand it? Try to make it clear and succinct.
- What background might be needed to understand the theme?
- Why is the theme important?
    - How does it relate to patient safety and providing better health through excellence in pharmacy?
- What's in scope, or out of scope?
    - What does the College have the ability to impact?
    - What might the College not be able to impact?

Recommend consultation questions (things to consider)

- What are you hoping to learn through the input you receive?
- What are you looking for ideas on?
- What do you need to know more about on your theme?
- Suggest 3-5 of the most important areas you need input on.
    - Suggest ideas for questions.
        - Can they apply to registrants, members of the public and other health stakeholders?
        - How might you ask the question to different stakeholders? (For example, pharmacists/ techs/ hospital community / member of the public, other health stakeholders etc.)
        - Can input be expressed quantitatively (such as an agreement scale) and/or qualitatively (comments / text based) .

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.xi. August 23, 2018 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the August 23, 2018 Draft Board Meeting Minutes as circulated.

Appendix	
1	August 23, 2018 Draft Board Meeting Minutes (and appendices)

College of Pharmacists of British Columbia

Board Meeting
August 23, 2018
Held via Teleconference

MINUTES

Members Present:
Mona Kwong, Chair, District 1
Arden Barry, Vice-Chair, District 7
Tara Oxford, District 3
Christopher Szeman, District 4
Frank Lucarelli, District 5
Anar Dossa, District 6
Sorell Wellon, District 8
Tracey Hagkull, Government Appointee
Justin Thind, Government Appointee
Jeremy Walden, Government Appointee

Regrets:
Ming Chang, District 2
Ryan Hoag, Government Appointee

Staff:
Bob Nakagawa, Registrar
David Pavan, Deputy Registrar
Christine Paramonczyk, Director of Policy and Legislation
Angela Woo, Policy & Legislation Analyst
Stephanie Kwok, Executive Assistant

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1. **WELCOME & CALL TO ORDER**
   Chair Kwong called the meeting to order at 4:00pm on August 23, 2018.

2. **MEDICAL ASSISTANCE IN DYING – STANDARDS, LIMITS, AND CONDITIONS (Appendix 1)**
   David Pavan, Deputy Registrar presented.

   It was moved and seconded that the Board:

   Approve the following resolution to amend the Health Professions Act (HPA) Bylaws relating to the standards of practice for dispensing drugs for the purposes of medical assistance in dying:

   "RESOLVED THAT, in accordance with the authority established in section 19(1)(k) 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 of the College of Pharmacists of British Columbia

College of Pharmacists of British Columbia

amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution, and file such bylaws with the Minister of Health."

CARRIED

ADJOURNMENT

Chair Kwong adjourned the meeting at 4:10pm on August 23, 2018.

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College of Pharmacists of British Columbia

BOARD MEETING
August 23, 2018

Medical Assistance in Dying – Standards, Limits, and Conditions

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution to amend the *Health Professions Act* (HPA) Bylaws relating to the standards of practice for dispensing drugs for the purposes of medical assistance in dying:

"RESOLVED THAT, in accordance with the authority established in section 19(1)(k) 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 of the College of Pharmacists of British Columbia amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution, and file such bylaws with the Minister of Health."

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Purpose

To approve amendments to the HPA Bylaws regarding dispensing drugs for the purposes of medical assistance in dying ("MAiD") for filing with the B.C. Minister of Health.

Background

HPA Bylaws – Schedule F – Part 5 contains standards, limits and conditions for dispensing drugs for the purposes of MAiD ("MAiD Standards"). Pharmacists who dispense drugs for MAiD must comply with the College's bylaws as well as the British Columbia Pharmacy Protocols for MAiD dated December 5, 2016 (the "Protocol") developed by the Provincial Medical Assistance in Dying Working Group's Sub-Committee on Pharmacy[1].

The new federal *Regulations for the Monitoring of Medical Assistance in Dying* (the "Regulations") made under the *Criminal Code* (Canada) will come into force on November 1, 2018.[2] Under the new Regulations, pharmacists who dispense drugs in connection with MAiD must report the information set out under Schedule 7 of the Regulations, including basic details about the patient, pharmacist, prescription and dispensing, within 30 days of dispensing. The

[1] This group is comprised of the Health Authorities of B.C, the College of Pharmacists of B.C., the College of Physicians and Surgeons of B.C., the College of Registered Nurses of B.C., the B.C. Pharmacy Association, the Canadian Society of Hospital Pharmacies (B.C. Branch), and the B.C. Ministry of Health.

[2] *Regulations for the Monitoring of Medical Assistance in Dying:* http://www.gazette.gc.ca/rp-pr/p2/2018/2018-08-08/html/sor-dors166-eng.html

information is to be provided to the Deputy Minister of Health of B.C., who has been designated to collect the information on behalf of the federal government.

The B.C. Ministry of Health (the "B.C. Ministry") wishes to collect more information than what is being required federally, and within a shorter timeline. Additional information to be requested by the B.C. Ministry includes confirmation of the dispensing of drugs signed by the practitioner and the pharmacist, and the pharmacists' reconciliation of unused drugs returned to the pharmacy. The B.C. Ministry will not have its own legislation governing MAiD reporting. As a result, the College is proposing to amend its practice standards for MAiD to incorporate those additional requirements.

Under the proposed bylaws, pharmacists who dispense drugs in connection with MAiD will be required to submit to the B.C. Ministry a form containing both the federally and provincially required information within 6 days after the scheduled date and time of drug administration. Information that is currently required to be documented by pharmacists on the MAiD prescription, pursuant to the current Standard 5, would be included on the new form. The form is being developed by the B.C. Ministry, but has not yet been finalized. Please refer to the draft form attached as Appendix 3.

The proposed bylaws have been reviewed by the B.C. Ministry, the College of Physicians and Surgeons of B.C., and the College of Registered Nurses of B.C. No issues have been identified.

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Recommendation

College staff recommend that the Board approve the amended MAiD Standards, as attached in Appendix 1 and Appendix 2, for filing with the Minster of Health.

Next Steps

Pursuant to s. 19(6.2) of the HPA, bylaws establishing standards, limits and conditions for the practice of the designated health profession by registrants are not required to be publicly posted on the College's website. If the Board approves the amended MAiD Standards for filing with the Minister of Health, as recommended, the amended MAiD Standards will be filed with the Minister of Health on September 3, 2018, and will become effective 60 days after filing, on November 1, 2018.

Appendix	
1	HPA Bylaws – Schedule F – Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying – Standards, Limits and Conditions (proposed amendments in track changes)
2	HPA Bylaws – Schedule F – Part 5 – Dispensing Drugs for the Purposes of Medical Assistance in Dying – Standards, Limits and Conditions - Schedule of Amendments
3	Draft form to be submitted to B.C. Ministry of Health

HPA BYLAWS SCHEDULE F
Part 5 – DISPENSING DRUGS FOR THE PURPOSES OF MEDICAL ASSISTANCE IN DYING
STANDARDS, LIMITS AND CONDITIONS

STANDARDS

1. The full pharmacist must work in a collaborative team based approach with the medical practitioner or nurse practitioner throughout the process.

2. The full pharmacist must discuss and confirm with the prescribing medical practitioner or nurse practitioner:
   (a) The patient's drug therapy;
   (b) The patient's eligibility and consent for medical assistance in dying;
   (c) The protocol selected;
   (d) The scheduled time and date for the administration of medical assistance in dying;
   (e) The time required to order and prepare the drugs;
   (f) Completion of the medication administration record; and
   (g) The procedures for returning unused drugs to the pharmacy.

3. The full pharmacist must ensure that the drugs dispensed for the purposes of medical assistance in dying are **labeled** as required by the current Standards of Practice and that the drugs are labeled in order of the administration as per the protocol selected.

4. The full pharmacist must **dispense** the drugs:
   (a) In a sealed tamper proof kit;
   (b) With a medication administration record listing all of the drugs included in the kit that also identifies the order of their administration; and
   (c) With the written agreed upon procedures in (2) (g).

~~5. The full pharmacist must **document** on the prescription:~~
   ~~(a) The date and time the drugs were dispensed;~~
   ~~(b) The name and signature of the medical practitioner or nurse practitioner to whom the drugs were dispensed; and~~
   ~~(c) If the medical practitioner or nurse practitioner to whom the drugs were dispensed is not known to the pharmacist, that the pharmacist confirmed the prescribing medical practitioner's or nurse practitioner's identity by means of photo identification.~~

~~6.~~5. The full pharmacist must contact the prescribing medical practitioner or nurse practitioner after the scheduled date and time of drug administration to collaborate relating to the return, within 72 hours of the patient's death, of any unused and partially used medications to the pharmacist for disposal. Upon receipt of the returned medications and the medication administration record from the prescribing medical practitioner or nurse practitioner, the full pharmacist must review the medication administration record for reconciliation of returned medications.

6. The full pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must provide the B.C. Ministry of Health with the information referred to in Schedule 7 of the *Regulations for the Monitoring of Medical Assistance in Dying* made under the *Criminal Code* (Canada), as well as the additional information required for provincial oversight, monitoring and reporting purposes. The information shall be documented on the provincial form designated for this purpose and submitted to the B.C. Ministry of Health within 6 business days after the day on which the substance is scheduled to be administered to the patient. The information to be documented by the full pharmacist includes but is not limited to the following:
   (a) The date and time the drugs were dispensed;
   (b) The name and signature of the medical practitioner or nurse practitioner to whom the drugs were dispensed; and

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5195-HPA_Bylaws_MAID v2018.1 (Aug 2018 revisions v.3) Effective 2018-04-17 (Posted 2018-04-17)

(c) If the medical practitioner or nurse practitioner to whom the drugs were dispensed is not known to the pharmacist, that the pharmacist confirmed the prescribing medical practitioner's or nurse practitioner's identity by means of photo identification.

6.1. The full pharmacist must comply with any request for information or provision of records sought by the B.C. Ministry of Health for the purpose of oversight and monitoring of medical assistance in dying.

7. The following Standards of Practice do not apply to medical assistance in dying:
   (a) Sections 6(5) (c) and (e), 6(6), 10 (1) and (2), 11(4)(f) and (g), and 12 of the Health Professions Act Bylaws, Schedule F, Part 1;
   (b) Sections 13(5) and (8) of the Health Professions Bylaws, Schedule F, Part 2; and
   (c) Sections 8 and 9 of the Health Professions Act Bylaws, Schedule F, Part 3.

8. Where there is an inconsistency between this Part and any other Part of Schedule F, the provisions of this Part prevail.

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HPA BYLAWS SCHEDULE F
Part 5 – DISPENSING DRUGS FOR THE PURPOSES OF MEDICAL ASSISTANCE IN DYING
STANDARDS, LIMITS AND CONDITIONS

LIMITS

1. Only a full pharmacist may dispense drugs for the purposes of medical assistance in dying.

2. A full pharmacist may delegate to a pharmacy technician any aspect of the preparation of drugs for the purposes of medical assistance in dying that is within a pharmacy technician's scope of practice.

3. A full pharmacist must only dispense the drugs for medical assistance in dying directly to the prescribing medical practitioner or nurse practitioner.

4. A full pharmacist must not dispense a drug to a prescribing medical practitioner or nurse practitioner for medical assistance in dying unless the prescription is in writing and includes confirmation that it is for medical assistance in dying.

5. A full pharmacist must not participate in dispensing drugs intended to provide medical assistance in dying:
   (a) To themselves or a family member;
   (b) To someone who has made the pharmacist a beneficiary under the person's will or to someone whom the pharmacist has reason to believe has made them a beneficiary under the person's will; or
   (c) In circumstances where the pharmacist will receive financial or other material benefit from the person's death, other than the standard compensation for their services relating to the dispensing of drugs.

6. A full pharmacist must not perform any activity that may imply he or she is leading the medical assistance in dying process, and may not:
   (a) Assess whether a person satisfies the criteria for medical assistance in dying set out in section 241.2 of the Criminal Code; or
   (b) Adapt a prescription for medical assistance in dying.

CONDITIONS

1. The full pharmacist has the requisite competency, knowledge and skills to prepare and/or dispense the prescription for medical assistance in dying.

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SCHEDULE OF AMENDMENTS

Schedule F – Part 5 of the bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended to revise the standards, limits and conditions for the dispensing of drugs for the purposes of medical assistance in dying, as follows:

1. Section 5 of the Standards is repealed.

2. Section 6 of the Standards is renumbered section 5.

3. The following new section is added after section 5 of the Standards.

    6. The full pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must provide the B.C. Ministry of Health with the information referred to in Schedule 7 of the *Regulations for the Monitoring of Medical Assistance in Dying* made under the *Criminal Code* (Canada), as well as the additional information required for provincial oversight, monitoring and reporting purposes. The information shall be documented on the provincial form designated for this purpose and submitted to the B.C. Ministry of Health within 6 business days after the day on which the substance is scheduled to be administered to the patient. The information to be documented by the full pharmacist includes but is not limited to the following:
        (a) The date and time the drugs were dispensed;
        (b) The name and signature of the medical practitioner or nurse practitioner to whom the drugs were dispensed; and
        (c) If the medical practitioner or nurse practitioner to whom the drugs were dispensed is not known to the pharmacist, that the pharmacist confirmed the prescribing medical practitioner's or nurse practitioner's identity by means of photo identification.

4. The following new section is added after section 6 of the Standards.

    6.1. The full pharmacist must comply with any request for information or provision of records sought by the B.C. Ministry of Health for the purpose of oversight and monitoring of medical assistance in dying.

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BRITISH COLUMBIA | Ministry of Health

1641

Medical Assistance in Dying

DISPENSING PHARMACIST - PRESCRIPTION MANAGEMENT

A full pharmacist who dispenses a substance in connection with the provision of MAiD **must** fax a copy of this form to the BC Ministry of Health at ---------- within six business days of the day on which the substance is scheduled to be administered to the patient.

Upon completion of Medical Assistance in Dying (MAiD):

1) Prescriber will provide copy of completed MAR to Pharmacist for reconciling the return of unused and partially used medications in "Prescription Accountability" section of this form;
2) Pharmacist to provide copy of completed Prescription and this form to Prescriber for retention in patient's health record.

PATIENT INFORMATION

Last Name	First Name	Second Name(s)

Personal Health Number (PHN) ☐ N/A	Province or Territory that issued the health insurance number	Birthdate (YYYY / MM / DD)

PRESCRIPTION PLANNING

Prescription Release		Return of Unused Medications	
Planned Release Date (YYYY / MM / DD)	Planned Release Time (00:00 am/pm)	Planned Return Date (YYYY / MM / DD)	Planned Return Time (00:00 am/pm)

Plan for Concluding Medical Assistance in Dying Process

Procedures have been established for the return of any unused and partially used medication(s) within three business days to the Pharmacy for secure and timely disposal. Any Pharmacist within the dispensing pharmacy can receive back unused and partially used medications from the Prescriber.	☐ Completed

PRESCRIPTION ACCOUNTABILITY

Medication Adminstrative Record

The Prescriber has been instructed on how to complete the Medication Administration Record for medical assistance in dying medications.	☐ Completed
Confirmation of photo ID of Prescriber, if applicable	☐ Completed

Dispensing Sign-Off: Pharmacist

Last Name	First Name	CPBC License Number	Phone Number

Work Mailing Address	Work Email Address

Where was the substance dispensed? ☐ Hospital Pharmacy ☐ Community Pharmacy ☐ Other (specify)	Date (YYYY / MM / DD)	Time

Provide supplementary information to clarify your response (if applicable). Add additional page if needed.	Dispensing Pharmacist Signature

Received By: Prescriber

Last Name	First Name	CPSID # / CRNBC Prescriber #	Date (YYYY / MM / DD)	Time

	Prescriber Signature

Return of All Unused and Partially Used Medications to Pharmacist for Disposal

The Prescriber will return all unused and partially used medications to the pharmacy within three business days of the patient's death. The Pharmacist will reconcile and document the return of unused and partially used medication(s) below.

Medication Name(s)	Form	Strength	Quantity

Returning Prescriber Last Name	Returning Prescriber First Name	CPSID # / CRNBC Prescriber #	Date and Time Returned	Prescriber Signature

Receiving Pharmacist Last Name	Receiving Pharmacist First Name	CPBC #	Date and Time Returned	Pharmacist Signature

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DRAFT 2
Aug 22, 2018

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

2.b.xii. Strategic Plan Themes 2019/2020 – 2022/2023

DECISION REQUIRED

Recommended Board Motion:

Direct the Registrar to proceed with engagement on the Strategic Plan Themes developed by the Strategic Plan Working Group.

Purpose

To obtain approval for the next phase of planning for the 2020/2021 to 2023/2024 Strategic Plan.

Background

The Strategic Plan Working Group developed four main themes for the 2020/2021 to 2023/2024 Strategic Plan. Over the last few months each theme group has defined stakeholders to consult and information to be gathered.

Discussion

College staff will review the materials prepared by each theme group and will prepare an Engagement Plan which will take place over the next two to three months. The resulting report will be used at the Board Strategic Plan retreat to inform the development of the draft strategic plan.

Recommendation

Direct the Registrar to proceed with engagement on the Strategic Plan Themes developed by the Strategic Plan Working Group.

Appendix	
1	June 14, 2018 Theme Working Groups Report

College of Pharmacists of British Columbia

Strategic Plan 2020 – 2023
Working Groups Report – Revised (Rev2)
June 14, 2018

Karen Graham

July 5, 2018
July 9, 2018
July 10, 2019

Contents

Participants

Board

Mona Kwong, Chair, District 1 – Metropolitan Vancouver
Arden Barry, Vice-Chair, District 7 – Community Hospitals
Ming Chang, District 2 – Fraser Valley
Tara Oxford, District 3 – Vancouver Island/Coastal
Christopher Szeman, District 4 – Kootenay/Okanagan
Frank Lucarelli, District 5 – Northern British Columbia
Anar Dossa, District 6 - Urban Hospitals
Sorell Wellon, District 8 – Pharmacy Technicians
Jeremy Walden, Government Appointee
Justin Thind, Government Appointee
Tracey Hagkull, Government Appointee

Regrets
Ryan Hoag, Government Appointee

Staff

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

Introduction

At CPBC's February 2018 Strategic Planning Brainstorm Retreat, participants identified four themes for further elaboration. More detail is found in the report from that session: *Strategic Plan 2020 – 2023 Foundation Document.* A brief *Foundation Report Summary of Next Steps* is appended (Appendix A).

Also appended (Appendix B) is the Strategic Planning Timeline, that outlines the steps from project inception to approval of CPBC's 2020-2023 strategic plan.

Theme working groups include:

1. Practice Trends
2. Professionalism in Pharmacy
3. Best Pharmacy Practice (Previously Optimized Roles of Registrants)
4. HPA Modernization.

Working groups convened their first working session on April 19, 2018. A summary of their deliberations is found in *Revised Report Theme Working Groups April 19, 2018.*

At this June planning session, the four working groups built on their work from the April 19, 2018 to further develop their themes. Focus questions included:

1. *Finalise the theme's focus*
   - How would you describe your theme? Would members of the public understand it? Try to make it clear and succinct.
   - What background might be needed to understand the theme?
   - Why is the theme important?
   - How does it relate to patient safety and providing better health through excellence in pharmacy?
   - What's in scope, or out of scope?
     - What does the College have the ability to impact?
     - What might the College not be able to impact

2. *Recommend consultation questions (things to consider)*

   - What are you hoping to learn through the input you receive?
   - What are you looking for ideas on?
   - What do you need to know more about on your theme?
   - Suggest 3-5 of the most important areas you need input on:
     - Suggest ideas for questions.
       - Can they apply to registrants, members of the public and other health stakeholders?
       - How might you ask the question to different stakeholders? (For example, pharmacists, technicians, hospital community, member of the public, other health stakeholders etc.)
       - Can input be expressed quantitatively (such as an agreement scale) and/or qualitatively (comments/ text based)

Theme Working Group Reports – June 14, 2018

Following are the reports from each theme working group.

1. Practice Trends

Members: Anar Dossa, Frank Lucarelli, Ryan Hoag (Absent)
Staff Resource: Doreen Leong, David Pavan

Finalized Theme Focus

Why is the theme important?

- Patient safety: identify gaps between central fill and Community Pharmacy

How does it relate to patient safety and providing better health through excellence in pharmacy?

- Are they both following the Community Pharmacy Standards of Practice (SOP)

Refined Theme Scope
Following four are all in-scope:

1. Interprovincial pharmacy services (Direct CPBC Impact)

    - Scope redefined as interprovincial pharmacy services, previously interjurisdictional pharmacy services and interjurisdictional pharmacy services
    - What is happening in other provinces? States?
    - What are their trends and their response to these trends?

2. Centralized Pharmacy Services (Direct CPBC Impact)

    - Include distribution, clinical and technical services
    - Centralized clinical services can impact a huge number of patients
    - Environmental scan of other PRAs:
        - What are they doing, what legislation do they have?
        - Site visits

3. Point of Care Testing (Indirect CPBC impact)

    - HealthTAB

4. New and emerging models of pharmacy service delivery (Direct CPBC Impact)

- How do patients want to get their services delivered?
- Ways of getting access to services
- Vending machines, drones etc.

Consultation Scope

- Environmental scans (What are they doing? What legislation do they have?)
- Other PRAs – national and international
    - Washington State Pharmacy Board
- Patients
- Prescribers – relationship with pharmacist
- Pharmacists/owners/directors
- Pharmacy technicians
- Government
- Advocacy groups
- Health Authorities
- Site Visits

Questions to Pose

Public:

- How do patients want to receive their pharmacy services: product and clinical services?
    - List of options and have them rate/rank the options 1-10
- How do out of province patients like to receive their pharmacy services

PRAs:

- What service models do other PRAs have – national and international?
- What interprovincial pharmacy service models currently exist?
- What are other provincial jurisdictions doing re Point of Care testing and measuring outcomes?

Retailers:

- What business models are you currently using and what are you projecting?
- Compare across provinces

Discussion Points Removed from Previous Meeting:

- What are trends in Rx reimbursement?
- What will government cover via reimbursement?
- Integration of roles was referred to optimized roles of registrants group
- Opioids and cannabis for medical use:
    - is this a practice trend?
    - Work is underway on Opioids and Medical prescribing of Marijuana may already be in place by the time the next strategic plan is in place

Plenary Discussion Highlights

- Empowering the patient
- Pharmacists as the primary care provider
- Trust between patient and health care system

2. Professionalism in Pharmacy

Members: Ming Chang, Justin Thind
Staff Resource: Mary O'Callaghan, Bob Nakagawa

Finalized Theme Focus

- How would you describe your theme?
    - Enhancing stature, credibility and reputation of the pharmacy professional
- What background might be needed to understand the theme?
    - Survey key stakeholders as per question list
- Why is the theme important?
    - Patients view pharmacists as trusted expert.
- What's in scope, or out of scope?
    - Right Touch legislation?
    - Nothing really out of scope

Consultation Scope:

- Patients / the public – no changes from April list
- Physicians (& Nurse Practitioners, etc.) – no changes from April list
- Business owners
- Registrants

Questions to Pose

Patients / the public – no changes from April list:

1. Is the interaction between you and your pharmacist is held in a confidential and private setting?
2. Do you feel the pharmacist spends enough time with you and your health/meds? Available for OTCs?
3. Do you feel the interaction is professional?
4. Do you view the Pharmacist as a professional?
5. How do you choose your pharmacy?
6. How to maintain a professional image of pharmacy – in marketing?

Physicians (& Nurse Practitioners, etc.) – no changes from April list

1. Do you consider pharmacists to be peers? Drug therapy experts? Professionals?
2. How do you rate your interaction with pharmacists? Rate value of most recent interaction
3. List pharmacist roles and responsibilities: Did you know? Do you feel they are being done?
4. Do you contact Pharmacist for drug information? For other reasons?
5. Preference for/mode/method of communication? Any challenges?

Business owners:

1. What are the barriers to professionalism for pharmacy professionals?

Pharmacy Technicians:

1. Do you feel that you are being treated as a professional by pharmacists?
2. Do you have autonomy in doing your work?
3. …. perhaps ask Pharmacy Technicians to find more questions….

Plenary discussion highlights

- Patient care needs to be broader to include people seeking care in pharmacy who are not necessarily patients; consider public safety.
- Broadening understanding of our role and responsibilities.
- Identify any barriers in our current regulatory framework and legislation that prevent us going to where we want/need
- Promote the "aspirational" in our bylaws.
- Counselling on refills: the goal is to empower the patient to look at their health / lifestyle changes / etc.
- Look at relationship building, overall health, etc.
- Consider health objectives versus the "Product".
- Education about the role.
- Build bridges with other healthcare professions.
- Website videos about professionalism / professional interactions?
- University classes – discuss professionalism.
- Conference presentations at other healthcare professions' conferences.
- Include Cultural Humility?

3. Best Pharmacy Practice (Formerly Optimized Roles of Registrants)

Members: Arden Barry, Christopher Szeman, Jeremy Walden, Sorell Wellon
Staff Resource: Gillian Vrooman

Finalized Theme Focus

Tentative Theme Title: Promote best practices for the delivery of pharmacy care in BC

Why is it important?

- Provides opportunities for pharmacists to provide more clinical services which results in better patient outcomes
- Results in better patient outcomes
- Making sure patients get the best out of their medications
- Pharmacy technicians, best practice, ensure accuracy and excellence in dispensing, allows
- Provide real life example of how Pharmacy technicians can support have a more clinical role, pharmacists more involved in counselling patients talk.
- Inspirational leaders TED talk, change happens when the patients ask for it, paint the picture of the future.
- Imagine X scenario of pharmacy in best practice
- Imagine a scenario where Pharmacy technicians are injecting

Description of theme should be developed based on these concepts:

- Aspirational
- Future of pharmacy
- Best Pharmacy Practice
- BC as a leader in pharmacy practice / patient care
- Elevating pharmacy care in BC
- Excellence in pharmacy (from our Vision)
- "Raising the bar"
    - raising the standards of practice
    - raising the bar in patient care through excellence in pharmacy
- Clinical care best practices
- Evidence-based practice; broad requirements for making evidence-based recommendations?
- Using scope to better meet patient care needs
- Maximizing registrants' full potential
- Enable registrants to meet the needs of patients
- Focus on the patient; patient centered care
- Imagine excellence in pharmacy where pharmacy professionals are able to raise the bar in patient care
- BC as a leader
- Raising the bar in patient care through excellence in pharmacy
- Promoting best practices for the delivery of pharmacy care in BC
- Elevating pharmacy care in BC: What are your ideas on how to implement "raising the bar"

Considerations

- How do we address payment / affordability concerns?
    - Out of our scope as a regulator, but impact what care could be possible

- Ensure best practices for both pharmacists (clinical) and pharmacy technicians (technical)
- Reflect different models of team-based care

Questions to Pose

Question concepts
In addition to questions considered in earlier sessions, consider, imagine X scenarios where we ask people to consider what the future of pharmacy practice should look like to meet the needs of patients.

- Provide examples of how techs can perform technical / dispensing roles and support pharmacists having a more clinical role
- Pharmacists more involved in counselling patients…
- Change happens when the patients ask for it, paint the picture of what the future could look like
- Look to inspirational leaders & TED talks for ideas

Question Ideas
What do we need to know more about on this topic from stakeholders?

- What is your vision of "best practice" or "excellence" in pharmacy practice?
- What should "best practice" or "excellence" in pharmacy practice look like in 2023?
- How can pharmacists be empowered to meet the future needs of patients?
- How can pharmacy technicians be empowered to meet the future needs of patients?
- What barriers exist to pharmacists practising to their full scope of practice?
- What barriers exist to pharmacy technicians practising to their full scope of practice?
- How can the College “raise the bar” to ensure best practice and patient safety?
- How can the College best promote evidence-based practice and patient-centered care?

Environmental Scan

- How are assistants used / restricted elsewhere?
- How are other provinces or international areas using Pharmacy Technicians?
- How are other regulators being aspirational or getting involved with best practices?

Stakeholders / Engagement Audience

- Pharmacy technicians
- Pharmacists
- Pharmacy Assistants
    - PTSBC and pharmacy managers may be best leads for these
- Pharmacy Owners
    - All directors / owners: College has on file as of October 2018
        - We have all pharmacist directors and are starting to collect all non-registrant indirect owners through pharmacy renewals under the new pharmacy ownership requirements
- Members of the public
- Patient groups (College has list of contacts)
- First Nations
    - FNHA
    - FN Health Council
- Pharmacy Education groups

    - UBC Pharmacy
        - Faculty
        - Students
        - Other Continuing Ed programs
        - Pharmacists Clinic
    - UBC other (other medical programs that may collaborate with pharmacy)
    - Pharmacy Technician schools
        - Obtain recommendations for specific organization from Sorell Wellon – to enhance traction
- Other healthcare professionals (who prescribe)
    - Physicians
        - General Practitioners
        - Specialists
    - Nurses and Nurse Practitioners
    - Dentists (since they can prescribe)
    - Veterinarians (since Veterinarians and Pharmacists sometimes collaborate and may need to collaborate more with anticipated further compounding requirements from Health Canada)
- Other (non-health) professionals?
    - This may be too out of scope for the online engagement, we'd need to be clear about what kind of questions we want to ask, but may work as part of an environmental scan

Risks

- Will this work seem to advocacy focused?
- Will best practice requirements be ignored by registrants?

4. Health Professions Act Modernization

Members: Tracey Hagkull, Mona Kwong, Tara Oxford
Staff Resource: Ashifa Keshavji, Christine Paramonczyk

Finalized Theme Focus

The HPA is an 'umbrella' statute that provides a common regulatory framework for health professions in BC.

The regulatory colleges have been delegated the authority under provincial legislation to govern the practice of their registrants in the public interest. Their mandate at all times is to serve and protect the public.

Our job is to protect the public by licensing and regulating pharmacists and pharmacy technicians and the pharmacies where they practice. We are responsible for making sure every pharmacist and pharmacy technician in BC is fully qualified and able to provide the public with safe and ethical pharmacy care. The College receives its authority from and is responsible for administering provincial pharmacy legislation.

(The primary function of the colleges with respect to the HPA is to ensure their registrants are qualified, competent and following clearly defined standards of practice and ethics).

Since the standards directly impact the care that a patient receives, it is critical that updates must reflect current day practice to enhance/keep at forthright the public and patient safety.

As practice changes or evolves, the standards of practice need to reflect current day practice (reviewed and updated to reflect current practice; rapidly evolving health system to provide best care)

Finalized theme focus

- The HPA governs the practice of regulated health professionals in BC.
- The CPBC Bylaws under the HPA define the expectations of the practice of pharmacy by pharmacists and pharmacy technicians with the aim of protecting the public interest.
- In general, the Bylaws under PODSA govern the requirements of the pharmacy site; whereas, the Bylaws under HPA govern the practice of pharmacy.
- The Standards of Practice under the College's HPA Bylaws are primarily divided into three main areas: community pharmacy, hospital pharmacy, and residential care facilities and homes, which define practice specific requirements in those settings.

Out of Scope

- Business interests and related matters (e.g. billing, etc.) are not within the College jurisdiction
- Board administration
- Pharmacist prescribing
- Federal requirements and rules

Our Scope:
HPA Modernization will be focussing on the main Standards of Practice (Community, Hospital and Residential Care)

Questions to Pose

1. What are you hoping to learn through the input you receive?
    - Are they current and appropriate and required and are there gaps or missing information? What is mis-interpreted? What is misunderstood?
2. What are you looking for ideas on?
    - What is too much? Too little?
    - Relevancy to practice, current, clear?
    - "Sticky" topics?
    - Anything that blocks ability to practice? What is prohibitive to patient care?
    - Hybrid model/practice – emerging models
    - Primary Care – practitioners not attached to a hospital, community or RC
    - HA – ambulatory care; satellites (patient consent, emergency fill, ID verification, privacy – Freedom of Information and Privacy)

3. Questions must keep in mind the community, hospital and residential care

    1. Impact of rules, indirectly, how does it impact you - e.g., why does a pharmacist have to counsel?
    2. How do the HPA Bylaws impact physicians and nurses and their relationship with pharmacists?
    3. Community Care and Assisted Living Act – group homes, Plan B – whoever guides this in the Ministry, Foster care

Stakeholders:

- Government?
- Patient groups – Patient Voices Network, BC Quality Council; CLBC, CCALA, HA Directors, HA – ambulatory pharmacy
- All groups noted in the backgrounder: CPBC staff: PRP, Investigations, Policy team; BCPHA, Neighbourhood Pharmacy Association, CSHP, Pharmacy Technicians Society of BC, CRNBC, CPSBC

Plenary Discussion

Following are the key points made in the plenary discussion, for consideration in CPBC's strategic planning in general.

Patient Care versus Public Care

- Is the term *patient care* limiting?
- People can go to a pharmacy to ask questions but not necessarily be patients
- Maybe a better term would be *public care*?

Empowering Patients

- Counselling – Pharmacists should engage with their patients and empower them beyond prescription medication
- Empowerment - Giving them tools of knowledge to be successful
- Not just giving them instructions on how to take their medication but empowering the patients to make life changes
- Building a relationship with your patient – something your patient might not think is important, but you pick up as significant
- Optimizing role – fostering this kind of environment
- This is where health care needs to go

Trust and Credibility

- Idea of trust and building credibility
- Professionalism is trust
- Best practice and standards –meeting the standards and achieving best practice
- Work on engagement and relationship building with health care providers
- Trend – Trusting pharmacists to step in and be that person, be that better healthcare provider

Shift to Outcomes-based Care

- How do we shift health care to a more outcome based?
- Challenges – some medications sometimes take 30-40 years to work
- Pharmacists can't not get paid, outcomes might not be there

Other things to consider

- Healthy choice versus the easy choice.
- Why do we define site?
- Professionalism with whom: Registrant, Patient, MD?
- Practice trends – how do we define pharmacy services? Always tied to product.
- Do we have a role in prevention?

Appendix A: Foundation Report Summary for Board Next Steps (v3.1)

A well-founded strategic plan is critical to the success of any organization, allowing it to make intentional progress on its own agenda. CPBC's February 17, 2018 Brainstorm Retreat provided a springboard for its 2020-23 strategic plan. Participants came to consensus on several high-level themes for further development and consultation and Working Groups were established to lead next steps for each theme.

Developed to guide board members in leading next steps, the following is an overview of the four strategic themes including working groups, scope, preliminary work plan, approach and next steps envisioned at the retreat.

More detail is found in the Feb 23, 2018 *CPBC Strategic Plan 2020 – 2023 - Foundation Document.*

	1. Practice Trends	2. Professionalism in Pharmacy	3. Optimized Roles of Registrants	4. HPA Modernization
Working Group	Board Lead: Frank Board: Ryan, Staff: Doreen, David	Board Lead: Ming Board: Justin Staff: Bob, Mary	Board Lead: Chris Board: Arden, Sorrell, Jeremy, Anar Staff: Gillian	Board Lead: Tara Board: Mona, Tracey Staff: Ashifa, Christine
Possible Scope of Theme	Interjurisdictional practice Central fill technology Point of care testing Integration of roles New and emerging models of service delivery	Business versus profession E.g. quotas, incentives, Privilege of being a professional is earned Professionalism extends 24/7	Best clinical practice Evidence based care Best choice of drug for individual patients, including their informed consent Links to CPBC Vision: *Better Health through Pharmacy Excellence* Links to *Practice Trends Theme* Technician practice to full scope to enable pharmacist to practice to full scope Assistants' roles: may revisit previous work on this Uptake, use of full scopes; dependent on business and workflow	Links to all other themes Standalone because large piece of work Foundational – not just a support for contemporary or current practice Impact of PODSA and HPA together
Possible Scope of Engagement	Site Visits: McKesson, Safeway. Save-on Foods, London Drugs	Pharmacist, Technicians Academics Owners/head offices BCPhA CSHP BC Branch Pharmacy Technicians association of BC Patient groups: Seniors, First Nations	Pharmacists, Technicians, Hospital/Community Associations Other Health Care Professionals Other Board members Staff	Engage advisory committees including community, hospital, residential care Consider joint advisory committee

	1. Practice Trends	2. Professionalism in Pharmacy	3. Optimized Roles of Registrants	4. HPA Modernization
Work Plan	Monthly Teleconference possibly on Wednesdays Doreen/David – Staff Support	Teleconferences PRN – biweekly – monthly SharePoint portal	Teleconferences as needed Shared on line space to build /share material	In person Meetings: at/around Board Meetings Teleconferences in between Board Meetings April Board Meeting: initial discussion June Board Meeting: Go through collated information and initial themes Upload information to SharePoint September Board Meeting present to the Board: what, who, how - *consulting*
Possible Approach	Environment Scan on emerging service delivery Focus groups/advisory committees Site Visits: McKesson, Safeway. Save-on Foods, London Drugs	April NS conference – members to attend conference Also, relevant work by Saskatchewan College of Pharmacy Professionals Review notes from previous discussions	Solidify theme Determine questions to ask Determine who to ask Identify research/resources	Historical and new information Linking data – enforcement, PRP
Next Steps	Agree to meeting schedule Staff resources to plan approach	First meeting 1st or 2nd week in March – when Ming is back Define and determine scope/draft TOR Conference Attendance – Nova Scotia and Saskatchewan	Expand working group to enhance capacity: include breadth of experience, practice sites invite guests: Board Members, staff, other	In person at April Board Meeting: initial discussion Internal staff to collate information initially

Two broad concerns were flagged:
(a) Composition of Group Three to be expanded to include adequate numbers and mix of backgrounds and practice experience; and
(b) Working Groups' efforts must be carefully aligned with overall Board direction.

Possible general next steps for working groups included:

Activities	Membership	Board Reporting
Define theme scope Develop Terms of Reference Develop key questions and target groups to submit for an eight-week online engagement in October and November After eight-week engagement, feedback to be shared with working groups for review	Working Groups can open to other people to supplement discussions e.g. guests: Board, staff Consider committee overload	Carve time at Board meetings to review progress Chair and Vice Chair to provide updates to Board Build in one-page updates at Board meetings

Appendix B: Strategic Planning Timelines

Milestone	2018		2019
Brainstorm Retreat: Draft Themes and Theme Committees	Feb	✓	
April Board Meeting: Confirm Theme Committee Membership	Apr	✓	
Theme Committees: Develop Consultation Focus	Apr to Aug		
September Board Meeting: Ratify Consultation Focus	Sep		
CPBC Staff: Eight-week Consultation on Themes	Oct & Nov		
Theme Committees :Review Consultation and Develop Findings to Share at Retreat			Jan to Mar
Board Retreat: Develop Draft Strategic Plan			Apr
Board Meeting: Present Draft Strategic Plan			Jun
CPBC Staff: Budgeting Strategic Plan			Jul & Aug
Board Meeting: Approve Strategic Plan			Sep

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

3. Confirmation of Agenda

DECISION REQUIRED

Recommended Board Motion:

Approve the September 14, 2018 Draft Board Meeting Agenda as circulated, or amended.

Appendix	
1	September 14, 2018 Draft Board Meeting Agenda

College of Pharmacists of British Columbia

Board Meeting
Friday, September 14, 2018
CPBC Office, 200-1765 West 8th Avenue, Vancouver

AGENDA

10:30am - 10:35am	5	**1.**	Welcome & Call to Order *Land Acknowledgement*	Chair Kwong
		2.	Consent Agenda a) Items for Further Discussion b) Approval of Consent Items **[DECISION]**	Chair Kwong
		3.	Confirmation of Agenda **[DECISION]**	Chair Kwong
10:35am - 10:50am	15	**4.**	Committee Updates: a) Governance Committee b) Hospital Pharmacy Advisory Committee c) Inquiry Committee d) Practice Review Committee (update to be provided in item 9) e) Audit and Finance Committee f) Quality Assurance Committee g) Community Pharmacy Advisory Committee h) Jurisprudence Examination Subcomittee i) Discipline Committee j) Legislation Review Committee (update to be provided in item 5) k) Registration Committeee l) Application Committee (updated to be provided in item 10) m) Ethics Advisory Committee n) Residential Care Advisory Committee o) Drug Administration Committee	Committee Chairs: Arden Barry Arden Barry Ming Chang Tracey Hagkull Frank Lucarelli Frank Lucarelli Tara Oxford Christopher Szeman Jeremy Walden Jeremy Walden Jeremy Walden Sorell Wellon Sorell Wellon Sorell Wellon Doreen Leong
10:50am - 11:15am	25	**5.**	Legislation Review Committee: a) Committee Update b) Electronic Record Keeping **[DECISION]**	Jeremy Walden
11:15am - 12:15pm	60	**6.**	British Columbia's Approach to Cannabis Legalization and Regulation	Mary Shaw
12:15pm - 1:00pm	45		***LUNCH***	
1:00pm - 2:00pm	60	**7.**	Transformative Leadership to Achieve First Nations Health and Wellness	Joe Gallagher
2:00pm - 2:15pm	15	**8.**	Acting on our Commitment to Improve Cultural Safety and Humility for First Nations and Aboriginal Peoples	Gillian Vrooman
2:15pm - 3:00pm	45	**9.**	Practice Review Committee Update	Tracey Hagkull James Van
3:00pm - 3:15pm	15	**10.**	Application Committee Update	Sorell Wellon
3:15pm - 3:30pm	15	**11.**	Patient Relations Program Standard **[DECISION]**	Sorell Wellon
3:30pm - 3:35pm	5	**12.**	Items Brought Forward from Consent Agenda	Chair Kwong
			CLOSING COMMENTS AND ADJOURNMENT	

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

5. Legislation Review Committee
a) 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
September 14, 2018

5. Legislation Review Committee
b) Electronic Record Keeping

DECISION REQUIRED

Recommended Board Motions:

(1) Approve the following resolution to amend the bylaws made under the *Pharmacy Operations and Drug Scheduling Act* and the *Health Professions Act* regarding electronic record keeping:

"RESOLVED THAT, in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act ("PODSA") and section 19(1) of the Health Professions Act ("HPA"), and subject to filing with the Minister as required by section 21(4) of PODSA and section 19(3) of HPA, the Board of the College of Pharmacists of BC approves the proposed bylaws made under PODSA and HPA relating to electronic record keeping for filing with the Minister of Health, as set out in the schedules attached to this resolution."

(2) Approve rescinding Professional Practice Policy-12 Prescription Hard Copy File Coding System, effective on the date that the bylaws come into force.

(3) Approve rescinding Professional Practice Policy-20 Prescription Refills, effective on the date that the bylaws come into force.

(4) Approve consequential amendments to Professional Practice Policy-31 Emergency Prescription Refills, as circulated, effective on the date that the bylaws come into force.

(5) Approve consequential amendments to Professional Practice Policy-58 Medication Management (Adapting a Prescription), as circulated, effective on the date that the bylaws come into force.

Purpose

To approve the following for filing with the Minister of Health (the "Minister"):

- Amendments to the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws relating to electronic record keeping requirements for registrants and licensees.

- Amendments to the *Health Professions Act* ("HPA") Bylaws relating to electronic record keeping requirements for registrants.

In addition, to approve the following (which require Board approval only):

- Rescinding Professional Practice Policy - 12 Prescription Hard Copy File Coding System ("PPP-12")
- Rescinding Professional Practice Policy-20 Prescription Refills ("PPP-20")
- Consequential amendments to Professional Practice Policy-31 Emergency Prescription Refills ("PPP-31")
- Consequential amendments to Professional Practice Policy-58 Medication Management (Adapting a Prescription) ("PPP-58")

Background

The College of Pharmacists of British Columbia (the "College") is proposing to create a new records management framework under which licensees and registrants will be permitted to retain either or both electronic and hard copies of the records required to be retained under the College's bylaws and other applicable legislation (e.g. prescriptions, patient records, etc.). This will require amendments to the PODSA Bylaws and the HPA Bylaws. In addition, if and when the new bylaws come into effect, PPP-12 and PPP-20 would be rescinded and consequential amendments to PPP-31 and PPP-58 would come into effect.

The HPA and PODSA Bylaws are essentially silent on the format in which records are to be maintained, except for limited references to "hard copy", "handwritten" and "written copy" that imply that hard copy records are to be maintained under certain specific circumstances. PPP-12 explicitly requires hard copy record keeping; however, this requirement is limited to prescriptions and prescription files only. To date, the College has interpreted its legislation as requiring hard copy records, particularly for prescriptions.

The College has received a number of requests from registrants to formally allow electronic record keeping. In practice, we understand that many pharmacies are already keeping electronic records and also maintaining hard copy files to comply with our requirements.

Informed by research and consultations with internal and external advisors and stakeholders, draft amendments to the PODSA Bylaws and HPA Bylaws regarding electronic record keeping were developed. At their February 2018 meeting, the Board approved the public posting of these proposed bylaws for a 90-day period. (See Appendix 1 for the February 2018 Board meeting note on electronic record keeping.)

The key proposed amendments involve removing existing restrictions on electronic record keeping and adding standards for electronic record keeping, such as minimum technology requirements. Pharmacies will be permitted to continue keeping only hard copy records, only electronic records or a combination of both. However, it should be noted that if a pharmacy keeps any form of electronic record that contains personal health information, it must have a system that complies with minimum technology requirements. Furthermore, a registrant who

creates and stores electronic records must do so using a system that complies with minimum technology requirements.

Discussion

Public Posting of Proposed Electronic Record Keeping Bylaws

The draft electronic record keeping bylaws were publicly posted for a 90 day period on the College's website, and distributed to the Minister and all of the regulatory colleges under the HPA. The public posting period ended on May 18, 2018. A total of eight responses were received from the following parties:

- B.C. Pharmacy Association
- Dennis Brox (WinRX)
- Canada Health Infoway
- Nikhil Gandhi
- Catherine McCann (Medicine Shoppe Pharmacy #169)
- PharmaCare Audit
- Save-On-Foods
- Shoppers Drug Mart

(Please refer to Appendix 2 for all comments received during the public posting period.)

It is proposed that minor amendments be made to six provisions as a result of the comments received.

Some of the main concerns raised in the comments include the following:

- The definitions of "electronic signature" and "electronic initials" are unclear. Commenters questioned the rationale for requiring pharmacists to apply signatures by hand when prescribing.
- The requirement that records must be "readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval" is not sufficiently prescriptive.
- Requiring colour scanning of prescriptions stored electronically will result in increased costs due to upgrades to scanning equipment and increased digital storage requirements, and will disrupt work flow. Commenters questioned the rationale for requiring colour scanning.
- The computer systems requirements are not sufficiently prescriptive. The College should adopt NAPRA's Pharmacy Practice Management Systems guidelines.
- Retention of hard copies of Controlled Prescription Program prescriptions is unnecessary since the scanned copy should be sufficient.

(Please refer to Appendix 3 for an amalgamation of public posting comments and the College's responses to the comments.)

Recommended Minor Amendments

Staff recommend the following minor amendments to the proposed electronic record keeping bylaws:

Amendments to PODSA Bylaws	Note
Revise language in paragraph (b) of the definition of "electronic signature" for clarity.	Reflects concerns raised by multiple commenters.
Revise language in the requirement to scan prescriptions in colour (s. 23.1(5)) for clarity.	Reflects concerns raised by multiple commenters.
Revise language in the systems requirements (s. 23.3(2)(b) and (e)) for clarity and consistency.	Reflects suggestion from BCPhA.
Revise language in the back up requirements (s. 23.3(b) and (c)) for clarity and consistency.	Reflects suggestion from BCPhA.

Amendments to HPA Bylaws	Note
Revise paragraph (b) of the definition of "electronic initial" for clarity.	Reflects concerns raised by multiple commenters.
Revise the requirement to scan prescriptions in colour (s. 65.1(5)) for clarity.	Reflects concerns raised by multiple commenters.

(Please refer to Appendices 4 and 5 for an updated revised versions of the proposed PODSA Bylaws and HPA Bylaws, respectively.)

Ministry of Health staff are aware of all proposed minor amendments, and have no concerns about them.

No comments were provided on the proposed amendments to HPA Bylaws – Schedule F – Part 1 – Community Pharmacy Standards of Practice or to HPA Bylaws – Schedule F – Part 2 – Hospital Pharmacy Standards of Practice. (Please refer to Appendices 6 and 7 for those proposed bylaws.)

Rescinding PPP-12

PPP-12 requires that prescription hard copies must be retained in accordance certain prescribed requirements. It is proposed that PPP-12 be rescinded if and when the proposed bylaws come into force. The proposed bylaws would permit all records required by the College, other than prescriptions for drugs included in the Controlled Prescription Program ("CPP") given the uniqueness and heightened risk of forgeries of CPP prescriptions, to be stored electronically, provided that certain requirements, such as minimum technology requirements, are met. Registrants would be required to retain the original prescription forms for prescriptions governed by the CPP. Pharmacies would be permitted to continue maintaining hard copies of other records if they prefer to do so.

The College believes that pharmacies should be allowed to adopt a record keeping system of their choice, provided that it meets the general requirements in s. 23.1 and the technology

requirements in s. 23.3 of the PODSA Bylaws. Therefore, unlike PPP-12, the proposed bylaws do not prescribe the system for organizing records, the format of records, or the method of storage. As a result, the College expects that there would be variations in the way that pharmacies organize and file records. Pharmacies would be required to have a written procedure in place that sets out how registrants would file and maintain records. This would assist registrants in understanding their record keeping obligations. It would also assist College staff in understanding the record keeping practices of each pharmacy, which will be useful when conducting inspections and investigations.

(Please refer to Appendix 8 for PPP-12)

Rescinding PPP-20

The current provisions in s. 6(9) of the HPA bylaws – Schedule F – Part 1 – Community Pharmacy Standards of Practice allow registrants to use the original prescription number for refill authorizations, which is not the typical or recommended practice. Registrants would be required to create a new prescription number for each refill authorization. Although this provision is peripherally related to electronic record keeping, the College has proposed this change in order to align this provision with best practices.

In conjunction with that amendment, PPP-20, which is duplicative of the above-noted provision and does not reflect best practices, would be rescinded if and when the bylaw amendments come into force.

(Please refer to Appendix 9 for PPP-20)

Consequential Amendments to PPP-31 and PPP-55

Consequential amendments are proposed to PPP-31 and PPP-55 to remove references that will no longer be applicable after the amended bylaws come into effect.

(Please refer to Appendix 10 for the proposed consequential amendments to PPP-31 and to Appendix 11 for the proposed consequential amendments to PPP-55.)

Recommendations

College staff recommend that the Board approve the following:

- Proposed bylaws for filing with the Minister (by approving the schedule to the resolution in Appendix 12)
- Rescinding PPP-12
- Rescinding PPP-20
- Consequential amendments to PPP-31
- Consequential amendments to PPP-55

Next Steps

If approved by the Board, the proposed bylaws would be filed with the Minister as required under s. 21(4) of PODSA and s. 19(3) of the HPA. The amended bylaws will come into effect 60 days after the filing date, in mid-November 2018, assuming that they are not disallowed by the Minister. In addition, on the date that the bylaws come into effect, PPP-12 and PPP-20 would be rescinded and the consequential amendments to PPP-31 and PPP-55 would come into effect.

The amended bylaws include a 6-month transition period. As such, registrants would not need to fully comply with the new requirements until 6-months after the effective date, which is likely to be in mid-May 2019.

The College would inform its registrants of the changes via communications tools, such as ReadLinks articles and Frequently Asked Questions articles on the College's website.

Appendix	
1	February 2018 Board meeting note on electronic record keeping
2	Comments received during the public posting period
3	Amalgamation of public posting comments and responses to comments
4	PODSA Bylaws (proposed amendments in track changes)
5	HPA Bylaws (proposed amendments in track changes)
6	HPA Bylaws – Part F – Schedule 1 – Community Pharmacy Standards of Practice (proposed amendments in track changes)
7	HPA Bylaws – Part F Schedule 2 – Hospital Pharmacy Standards of Practice (proposed amendments in track changes)
8	PPP-12 Prescription Hard Copy File Coding System (proposed to be rescinded)
9	PPP-20 Prescription Refills (proposed to be rescinded)
10	PPP-31 Emergency Prescription Refills (proposed amendments in track changes)
11	PPP-58 Medication Management (Adapting a Prescription) (proposed amendments in track changes)
12	Schedules to the Resolution

College of Pharmacists of British Columbia

BOARD MEETING
February 16, 2018

12. Legislation Review Committee
d) Electronic Record Keeping

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution:

"RESOLVED THAT, in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act and section 19(1) of the Health Professions Act, and subject to the requirements in section 21(8) of the Pharmacy Operations and Drug Scheduling Act and section 19(6.2) of the Health Professions Act, the Board of the College of Pharmacists of BC approves the proposed draft bylaws of the College of Pharmacists of British Columbia relating to electronic record keeping for public posting, as circulated."

Purpose

To consider approval of the following:

- Amendments to the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws relating to electronic record keeping requirements for registrants and licensees.
- Amendments to the *Health Professions Act* ("HPA") Bylaws relating to electronic record keeping requirements for registrants.

Background

The College of Pharmacists of British Columbia (the "College") is proposing to create a new records management framework under which licensees and registrants will be permitted to retain both electronic and hard copies of the records required to be retained under the College's bylaws and other applicable legislation (e.g. prescriptions, patient records, etc.). This will require amendments to the PODSA Bylaws and the HPA Bylaws. In addition, if and when the new bylaws come into effect, Professional Practice Policy 12 ("PPP-12") and Professional Practice Policy 20 ("PPP-20") would be repealed and amendments to Professional Practice Policy 31 ("PPP-31") and Professional Practice Policy 58 ("PPP-58") would come into effect.

The HPA and PODSA Bylaws are essentially silent on the format in which records are to be maintained, except for limited references to "hard copy", "handwritten" and "written copy" that imply that hard copy records are to be maintained under certain specific circumstances. PPP-12 explicitly requires hard copy record keeping; however, this requirement is limited to

prescriptions and prescription files only. To date, the College has interpreted its legislation as requiring hard copy records, particularly for prescriptions.

The College has received a number of requests from registrants to formally allow electronic record keeping. In practice, we understand that many pharmacies are already keeping electronic records and also maintaining hard copy files to comply with our requirements.

At the September 15, 2017 meeting of the Board of Directors of the College (the "Board"), Board members were presented with an "information only" briefing note entitled "Records Management – Electronic Record Keeping". At the time, the College had conducted research and an analysis of its current records management regime. It was noted that B.C. is the only province in Canada that requires pharmacies to keep hard copies of prescriptions and that does not have technology requirements for pharmacies that keep electronic records.

Since September, the College has developed draft bylaw amendments in consultation with internal and external advisors and stakeholders.

Discussion

Project Goals

The goal of this project is to develop a record keeping framework in which:

- Record keeping can be completed efficiently and in a manner that promotes patient safety and the accountability of registrants;
- Records are filed systematically;
- Records are easily retrievable;
- Registrants' interactions with records are auditable (i.e. who did what and when); and
- Patient records and other personal and confidential information are stored securely, with appropriate back ups.

Consultations

The College has consulted with both internal and external advisors and stakeholders, including the following:

- The College's internal working group, comprised of staff from the policy and legislation, complaints and investigations, and practice reviews and quality assurance departments;
- The College's information technology manager;
- The College's Community Pharmacy Advisory Committee, Hospital Pharmacy Advisory Committee, and Residential Care Advisory Committee;
- B.C. Pharmacy Association;
- Staff from two similar-sized pharmacy regulatory authorities in Canada;
- Ministry of Health – Professional Regulation and Oversight and PharmaNet/PharmaCare departments;
- A records management consultant; and
- A pharmacy software provider.

In general, the response to the College's proposals has been positive. The College has addressed some of the comments raised in consultations by revising the language of the proposed bylaw amendments.

The College understands that some pharmacies may be required to upgrade their software system in order to comply with the new minimum technology requirements. According to data provided to the College by licensees, 161 out of approximately 1,400 pharmacies are using a software system that may require upgrades in order to comply with the proposed minimum technology requirements. More current versions of that software may be largely compatible with the proposed requirements; however, data is not available regarding which version of the software each of the 161 pharmacies are using. In order to ease the transition, pharmacies would be given six months from the date that the amendments come into force to transition to a compliant software system.

Proposed Amendments

The key proposed amendments involve removing existing restrictions on electronic record keeping and adding standards for electronic record keeping, such as minimum technology requirements.

Electronic Storage of Prescriptions – Repeal of PPP-12

PPP-12 requires that prescription hard copies must be retained in accordance certain prescribed requirements. It is proposed that PPP-12 be rescinded if and when the proposed bylaws come into force. The proposed bylaws would permit all records required by the College, other than prescriptions for drugs included in the Controlled Prescription Program ("CPP") given the uniqueness and heightened risk of forgeries of CPP prescriptions, to be stored electronically, provided that certain requirements, such as minimum technology requirements, are met. Registrants would be required to retain the original prescription forms for prescriptions governed by the CPP. Pharmacies would be permitted to continue maintaining hard copies of other records if they prefer to do so.

General Record Keeping Requirements – PODSA Bylaws ss. 3(2)(k) and 8.1(1) and HPA Bylaws s. 65.1

Other than PPP-12, which only applies to prescriptions and is proposed to be repealed, the current bylaws do not specify the manner in which records are to be kept. A new general record keeping requirement would be added to ensure that records are readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval. In addition, the pharmacy manager would be required to ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction. These requirements apply to both hard copy and electronic records.

The auditability requirement is essential to promoting patient safety and the accountability of registrants. Electronic records will be required to be maintained on a system that is capable of tracing all amendments to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration. Minimum technology requirements for pharmacies maintaining electronic records are discussed below.

Written Record Keeping Policy – PODSA Bylaws s. 8.2

The College believes that pharmacies should be allowed to adopt a record keeping system of their choice, provided that it meets the general requirements in s. 8.1 and the technology requirements in s. 8.3 of the PODSA Bylaws. Therefore, the proposed bylaws do not prescribe the system for organizing records, the format of records, or the method of storage. As a result,

the College expects that there would be variations in the way that pharmacies organize and file records. Pharmacies would be required to have a written procedure in place that sets out how registrants would file and maintain records. This would assist registrants in understanding their record keeping obligations. It would also assist College staff in understanding the record keeping practices of each pharmacy, which will be useful when conducting inspections and investigations.

Minimum Technology Requirements – PODSA Bylaws ss. 8.3(1) and (2)
Pharmacies that maintain electronic records would be subject to minimum technology requirements. Since all pharmacies keep some form of electronic records, in reality these requirements would apply to all pharmacies. The requirements do not speak to the specific technology that must be used. The language is intended to be sufficiently broad to accommodate changing technology.

The College believes that most pharmacies have software systems that comply with the proposed requirements. As discussed above, some pharmacies may need to upgrade their software system in order to comply. In order to ease the transition, pharmacies would be given six months from the date that the amendments come into force to transition to a compliant software system.

Back Up Requirements – PODSA Bylaws s. 8.3(3)
Records would be required to be backed up at least once daily and stored securely, in a location resistant to environmental perils, and in accordance with the requirements of s. 8.1(1) of the PODSA Bylaws.

Electronic Signatures and Initials – Definitions in PODSA Bylaws and HPA Bylaws
The addition of the definitions of "signature" and "electronic signature" in the PODSA Bylaws, and the definitions of "signature", "initials" and "electronic initials" in the HPA Bylaws, explicitly permits registrants to sign documents using an electronic signature or initials. The definitions do not speak to the specific technology that must be used. The language is intended to be sufficiently broad to accommodate changing technology.

Manner of Disposal of Records – HPA Bylaws s. 75
Requirements for destruction and disposal of records would be updated to remove references to out-of-date technology and to allow registrants to use their judgment to select the appropriate method of destruction so long as records are destroyed in a manner that cannot be reconstructed. This provision would apply to both hard copy and electronic records.

Incidental Changes
Incidental changes have been proposed throughout the PODSA Bylaws and the HPA Bylaws in order to facilitate electronic record keeping. For example, a definition of "record" is proposed to be added to the PODSA Bylaws that clarifies that records include both hard copy and electronic records. This definition is consistent with the definition already contained in the HPA Bylaws. As another example, the word "handwritten" is proposed to be removed from s. 9(4)(d) of the HPA Bylaws – Schedule F – Part 2 – Hospital Pharmacy Standards of Practice.

Amendments to Other Policies – PPP-31 and PPP-58
In addition to the proposed repeal of PPP-12 and PPP-20 (discussed below), it is proposed that consequential amendments be made to PPP-31 - Emergency Prescription Refills and PPP-58 - Medication Management (Adapting a Prescription) if and when the proposed bylaws come into force. The details of those amendments will be presented to the Board for approval when the proposed bylaws are presented to the Board for filing with the Minister of Health.

Additional Amendments
Amendments to Patient Records to Correct Errors or Omissions Must Be Auditable – HPA Bylaws ss. 69 and 70
In order to promote patient safety and accountability of registrants, when a patient record is amended to correct an error or omission, the following would be required to be identifiable: the original entry, the identity of the registrant who made the amendment, the date of the amendment and the reasons for the amendment. This requirement would apply to amendments to both electronic and hard copy records.

Refill Authorizations – HPA Bylaws – Schedule F – Part 1 - Community Pharmacy Standards of Practice - s. 6(9)
The current provisions allow registrants to use the original prescription number for refill authorizations, which is not the typical or recommended practice. Registrants would be required to create a new prescription number for each refill authorization. Although this provision is peripherally related to electronic record keeping, the College has proposed this change in order to align this provision with best practices.

It is also proposed that PPP-20, which is duplicative of the above-noted provision and does not reflect best practices, would be rescinded if and when the bylaw amendments come into force.

Recommendation

That the Board approve the proposed bylaws for public posting, as presented.

Next Steps

If the Board approves the proposed bylaws for public posting, the bylaws would then be publicly posted on the College's website for 90 days. During this 90 period the public and other health regulatory colleges may provide comments on the proposed bylaws, and those comments would be reviewed and considered by College staff. If no substantive revisions are made to the draft bylaws, then at the September 2018 Board meeting, the College would propose that the draft bylaws be filed with the Ministry of Health. The College would also propose that PPP-12 and PPP-20 be rescinded, and that PPP-31 and PPP-58 be amended, on the date that the new bylaws come into force.

If the bylaw amendments are approved for filing at the September 2018 Board meeting, the amended bylaws would come into force in November 2018. The College would inform its registrants of the changes via communications tools, such as ReadLinks articles and Frequently Asked Questions articles on the College's website.

Pharmacies that need to upgrade their software systems to comply with new minimum technology requirements would be given a six month transition period from the date that the proposed bylaws come into force. If the revised bylaws come into force in November 2018, as forecasted, the deadline for transition would be May 2019.

Appendix	
1	PODSA Bylaws (proposed amendments in track changes)
2	HPA Bylaws (proposed amendments in track changes)
3	HPA Bylaws – Part F – Schedule 1 – Community Pharmacy Standards of Practice (proposed amendments in track changes)
4	HPA Bylaws – Part F Schedule 2 – Hospital Pharmacy Standards of Practice (proposed amendments in track changes)

May 16, 2018

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:

Meghan Thorneloe
A/Director of Regulatory Initiatives, Professional Regulation and Oversight
Clinical Integration, Regulation and Education 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: 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 bylaws under the *Health Professions Act*[1] ("HPA") and under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA").[2]

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. It is axiomatic that members of the public deserve safe and ethical care delivered by professionals who understand and adhere to their professional obligations. Appropriate records management is essential to supporting the safe provision of care. That is why we are so pleased to see the College propose modernized rules for record-keeping that will enable registrants to utilize electronic systems to manage patient records.

We understand that the amendments are meant to be enabling rather than prescriptive and as such will apply to all types of records regardless of whether they are paper or electronic. We appreciate that the bylaws are technologically neutral. Given the rapid pace of technological change, and the range of solutions available, it makes sense to take a principled approach. We note that the amendments also introduce a new requirement to have written records management procedures and policies, and that

[1] SBC 200
[2] SBC 2003, C. 77. All references are to the Act as amended by Bill 6.

in order to align the obligations of registrants with the obligations of licensed pharmacies, the proposed amendments to the HPA bylaw will require registrants who create and store electronic records to use systems that meet the requirements under the PODSA bylaw.

Members with electronic systems that don't currently meet these standards will have only six months after the bylaw comes into force to bring their system into compliance. We understand that the College intends to develop written guidance documents to assist registrants in ensuring compliance. We encourage the College to prepare and distribute that guidance as early as possible in order to ensure registrants have sufficient time to bring themselves and their organizations into compliance.

We have a few specific comments:

Draft PODSA Bylaw Amendments

Section 8.3(2) For purposes of subsection (1), the equipment, software and systems must…

The proposed amendments include new security obligations and note that the current draft contains some inconsistencies that create challenges in understanding the standard of care to be met. We suggest that the language used be amended to make it more consistent.

For example, the draft section 3(2)(j.1) provides that a manager must *"ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction."* The requirement in the draft s. 8.3(2) provides that the "*equipment, software and systems must: (2)(b) provide for sufficient security to prevent unauthorized access, use, disclosure, modification and destruction of electronic records."* The draft section 8.3(3)(b) would require a pharmacy manager to ensure that electronically backed up records are stored "*securely in a manner that avoids theft and unauthorized access, use…"* and draft s. 8.3(3)c) "*in a manner that complies with section 8.1.(1) requirements."*

We respectfully suggest that the different language used ("*secure from unauthorized access…"* vs. "*provide for sufficient security to prevent…*" vs. "*securely in a manner that avoids theft…*"*)* creates a level of confusion which could easily by avoided by some minor re-drafting.

In addition, we suggest that s. 8.3(2)(e) be amended to align it with the draft amendments to ss. 69 and 70 of the HPA Bylaw.

Accordingly, we suggest the following amendments:

section. 8.3(2) … "*equipment, software and systems must:*

> *(2)(b) ~~provide for sufficient security to prevent~~ keep the records secure from unauthorized access, use, disclosure, modification and destruction of electronic records."*
>
> *(e) be capable of tracing ~~modifications~~ alterations to records by identifying the original entry, the identity of the individual who made the alteration, ~~and~~ the date of the alteration and the reasons for the alteration;*

Section 8.3(3) A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily and that such electronically preserved and backed up records are stored

Section 8.3(3)(c) requires that backups be stored in a manner that complies with s. 8.1(1) requirements, which requires the system to main the records in a manner that "allows for easy retrieval". Generally, to restore a record from a backup requires a substantial amount of work and backups can't be used until the records are restored, and then the records would meet the standard of the original. Therefore, it isn't technically appropriate to require the same standard of easy retrievability for backups as for the main files and suggest that this section should be amended.

section 8.3(3) a pharmacy manager must ensure….backed up records are stored

> (b) "*~~securely in a manner that avoids theft and unauthorized access, use, modification, destruction and disclosure;~~ so that they are secure from unauthorized access, use, disclosure, modification and destruction; and*
>
> (c) "*in a manner that, would enable the backed-up records, once restored, to be compliant ~~complies~~ with section 8.1.(1) requirements.*

We appreciate the opportunity to make comments on the proposed bylaw.

Yours Sincerely,

Geraldine Vance
CEO
cc: Bob Nakagawa

Canada Health Infoway wishes to thank the College of Pharmacists of British Columbia and the British Columbia Ministry of Health enabling interested parties to review the Electronic Record Bylaw amendments. We are taking this opportunity to propose some minor changes to the amendments for the purpose of clarity. Suggested amendments have been bolded in red.

Section, Subsection or Appendix	**Page #**	**Comment (provide current and new text when applicable)**	**Rationale**
PODSA Bylaws definitions 1. "electronic signature" means (b)	3	(b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must also be unique and applied with a human hand; Paragraph (a) and must also be unique**. If the prescription is not transmitted electronically the signature must be applied with a human hand;**	The original wording of part (b) precludes pharmacists from ordering prescriptions electronically. There are current and developing practices that would not be allowed to evolve to their natural endpoint. i.e. Pharmacist practices in non- traditional settings where pharmacists may prescribe.
PODSA Bylaws – 8.1(4)	11	With respect to prescriptions for drugs included in the controlled prescription Program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically. **For purposes of clarity when a prescription for medication included in the controlled prescription program is transmitted electronically, a form printed from the pharmacy's Pharmacy Management System will be considered the original prescription form.**	This wording reflects practices in other jurisdictions and allows for the potential to transmit drugs in the controlled prescription program electronically. The secure electronic transmission of targeted medications has been shown to decrease diversion and reduce amount of medication prescribed.
PODSA Bylaws – 8.1(5)	11	Prescriptions stored electronically must be visible in colour. **Prescriptions stored electronically must be readable and complete. They may high-lighted, stored in colour or another acceptable format.**	The goal is for the files to be readable, requiring colour does not guarantee the legibility of the records.
HPA Bylaws – definitions 1. "electronic initial" means (b)	6	b) with respect to a prescription initialed by a full pharmacist, the electronic initial must meet the requirements of paragraph (a) and must also be unique and applied with a human hand; Paragraph (a) and must also be unique**. IF the prescription is not transmitted electronically the signature must be applied with a human hand;**	Similar thought process to proposed amendment to "electronic signature" bylaw.

Section, Subsection or Appendix	Page #	Comment (provide current and new text when applicable)	Rationale
HPA Bylaws 65.1 (4)	44	With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically **For purposes of clarity when a prescription for medication included in the controlled prescription program is transmitted electronically, a form printed from the pharmacy's Pharmacy Management System will be considered the original prescription form.**	This wording reflects practices in other jurisdictions and allows for the potential to transmit drugs in the controlled prescription program electronically. The secure electronic transmission of targeted medications has been shown to decrease diversion and reduce amount of medication prescribed.
HPA Bylaws 65.1.(50	44	Prescriptions stored electronically must be visible in colour **Prescriptions stored electronically must be readable and complete. They may high-lighted, stored in colour or another acceptable format.**	The goal is for the files to be readable, requiring colour does not guarantee the legibility of the records.

Christine Paramonczyk

From: Catherine McCann <catherine@cvmccann.com>
Sent: Tuesday, May 15, 2018 12:15 PM
To: CPBC Legislation
Cc: Tara Oxford
Subject: Bylaws for Comment: Electronic Record Keeping

Follow Up Flag: Follow up
Flag Status: Flagged

Thank you for the opportunity to comment on the proposed Electronic Record Keeping changes to the bylaws of the College. These changes are long over due and will facilitate the processing and storage of prescriptions and related documents. Given that the Canadian Revenue Agency uses entirely electronic documentation, it makes no sense that our College requires the maintenance of hard copy documentation.

I have four comments:

1. **Human Hand Signature**: In several amendments, there are references to "applied by human hand." Would this include electronic signature pads on prescription and medication review software, for example? Is it necessary to have this wording? There are many security features on prescription dispensing software that could replace this requirement. Given the difficulty in changing bylaws, and rapid changes in technology (bio scanning, for example), this requirement will quickly become outdated and frustrating for pharmacy personnel.

2. **Scanning in Colour:** This requirement is excessive. Most fast document scanners and software programs scan in black and white. We have been scanning all prescriptions and related documentation for over two years. We scan in black and white and have never had an occasion to need to refer to the original prescription to see the "colour version".

3.**Controlled Prescription Program:** I can't understand why there continues to be a requirement to retain the original hard prescription copy of the Controlled Prescription Program in these proposed changes to the Bylaws. The information on the form is what is important not the hard copy itself. In a previous role, I used to manage the Triplicate Prescription Program in Alberta. Given the requirements to check on Pharmanet for all prescriptions, prescriptions that are being filled in multiple locations or fraudulently are much easier to identify. This program needs to be reviewed and modernized. While it worked in an environment where there was not the connectivity we now have, it should not be necessary now to maintain hard copies.

4.**Drug Invoices and Other Patient Related Documents**: While it may be in the proposed changes, I did not find mention of electronic storage of drug invoices. Is this included in these amendments? We currently maintain both a hard copy and electronic copy of invoices. The cost of storing the hard copies is even more than storing prescriptions. We also scan documents such as vaccine consents and medication review documents. We keep hard copies but would rather only maintain the scanned documents.

Thank you for your consideration of my comments,

Catherine McCann, BScPharm, MBA
Owner/Pharmacy Manager
~~~~~~~~~~~~~~~~~~~~~~~~~
Medicine Shoppe Pharmacy #169
www.medicineshoppecomox.ca
~~~~~~~~~~~~~~~~~~~~~~~~~

250-339-5050

Your health. Our priority.

Christine Paramonczyk

From: dennis@arirx.ca
Sent: Tuesday, May 8, 2018 5:12 PM
To: Angela Woo
Cc: support@arirx.ca
Subject: Electronic records bylaw

Follow Up Flag: Follow up
Flag Status: Flagged

Angela Woo <Angela.Woo@bcpharmacists.org>

Mar 6

to me, Christine

Dear Dennis,

I'm working with Christine Paramonczyk on the electronic record keeping project. She has forwarded your email to me.

Colour copies of prescriptions – Under new s. 8.1(5) of the PODSA Bylaws, registrants are required to scan and store colour copies of prescriptions. The rationale is that it's easier to detect prescription tampering and forgeries by examining a coloured scan. If the original script is only in black and white, then the scan would of course also be in black and white, which is fine. However, if the prescriber signed with a blue pen, for example, we want to be able to see that in the scan. Therefore, the system needs to be capable of producing coloured scanned copies.

ANSWER: Scanning in color adds about 50% to space requirements and given most scripts received these days are produced on a printer, ink color is not the issue for verification it used to be. This requirement may err on the side of being over regulatory going forward.

Electronic signatures – We have based this definition on the Electronic Transactions Act, but included an exception for signatures by pharmacists when prescribing. The exception is consistent with the position of the College of Physicians and Surgeons and our College that signatures by prescribers on prescriptions must be "wet" signatures". In other words, the signature must be unique and applied with a human hand, be it pen to paper, or electronic pen to pad. Signatures made other than for the purposes of prescribing do not need to be "wet signatures". For example, an electronic signature by a pharmacist indicating that he has performed a final check can be made using a barcode or password, as long as it is "secure and is only reproducible and used by that person".

ANSWER: I had some trouble tracking down the Physician College answer to this as no one knows what a digital signature is except Dr. Galt Wilson and he is winding down his involvement in the College. However, we did manage to get to him and the College policy is to follow provincial law (which allows digital signatures) except where they shape their policy to conform with the College of Pharmacist requirement. I quote his position below:

"Specifically, prescriptions must meet the standards expected by the College of Pharmacists of BC.Â Given that a prescription is a written request of a registrant of the College of Pharmacists, it must facilitate dispensing in a fashion that allows pharmacists to meet the standards of their profession.Â One of those is reasonable diligence to verify the authenticity of the communication.Â Accordingly, the current expectation of physicians is set out in this communique from the College of Pharmacists to its registrants:Â http://www.bcpharmacists.org/readlinks/call-accepting-electronic-prescription
, which is essentially the same message we delivered to our registrants in the College Connector in 2014:Â https://www.cpsbc.ca/files/pdf/CC-2014-V02-02.pdf , page 7."

That is, their position is that a wet signature be used by physicians only because the College of Pharmacists deems it is more verifiable. Digital signatures allow for more
verification and security only when documents are electronically transmitted, not the case with prescriptions originating in doctors' offices, however where documents are exchanged electronically (by fax) between practitioners, the bylaws should allow digital signatures consistent with the MOH's own digitial certificate program.

Thanks,

Dennis

Dennis Brox
President, Applied Robotics Inc.
Cell: 778 891-4300

Christine Paramonczyk

From: Nikhil Gandhi <nikhil.gandhi@mail.utoronto.ca>
Sent: Wednesday, May 16, 2018 1:10 AM
To: CPBC Legislation
Subject: Re: Reminder: Bylaws for Comment - Electronic Record Keeping

Follow Up Flag: Follow up
Flag Status: Flagged

Hello,

One feedback: why is it necessary for records to be in full colour? This would significantly increase storage requirements and I can't think of why it would be useful.

On May 2, 2018, at 6:31 PM, College of Pharmacists of BC <info@bcpharmacists.org> wrote:

College of Pharmacists
of British Columbia

Bylaws for Comment - Electronic Record Keeping

The College is asking for your feedback on electronic record keeping. Provide your comments by May 18, 2018.

A new records management framework is being proposed–under which pharmacies and registrants will be permitted to retain both electronic and hard copies of the records under the College's bylaws and other applicable legislation–enables the College to achieve the following goals:

- Record keeping can be completed efficiently and in a manner that promotes patient safety and the accountability of registrants;
- Records are filed systematically;
- Records are easily retrievable;
- Registrants' interactions with records are auditable (i.e. who did what and when); and
- Patient records and other personal and confidential information are stored securely, with appropriate back-ups.

The key proposed amendments involve removing existing restrictions on electronic record keeping, and establishing minimum technology requirements.

As part of the new records management framework, in February 2018, the College Board approved proposed amendments to the College's Bylaws under both the *Pharmacy Operations and Drug Scheduling Act* and the *Health Professions Act*.

See Bylaws for Comment: Electronic Record Keeping for a detailed outline of the key proposed amendments.

We welcome comments from registrants and the public on the proposed amendments.

Comments on the draft bylaws should be submitted to the College or to the Ministry of Health no later than **May 18, 2018**.

Learn more and share your comments

College of Pharmacists of BC | 200 - 1765 West 8th Avenue, Vancouver, British Columbia V6J 5C6 Canada

Unsubscribe nikhil.gandhi@alum.utoronto.ca

Update Profile | About our service provider

Sent by info@bcpharmacists.org

Christine Paramonczyk

From: [redacted]
Sent: Monday, May 14, 2018 9:41 AM
To: Christine Paramonczyk
Cc: [redacted]
Subject: 1114300 Electronic Record Keeping Feedback

Follow Up Flag: Follow up
Flag Status: Flagged

1114300

Christine Paramonczyk
Christine.Paramonczyk@bcpharmacists.org

Dear Christine Paramonczyk:

Electronic Record Keeping Feedback

PharmaCare Audit Submission to College Proposed Bylaw Changes

Many of the questions/comments listed below also apply to proposed changes to the HPA, where there is overlap between the PODSA and the HPA.

PharmaCare Audit recognizes that some of the questions/comments listed below are not suitable for inclusion into bylaws, but the standards should be addressed with business rules and technical rules.

PharmaCare Audit recommends that rules (acts, regulations, bylaws, business rules, technical rules etc.) not be subjective because they are then open to interpretation which makes enforcement difficult. When a dispute arises around a bylaw or rule that is subjective, a judge will tend to side with the party that did not create the rules. By setting clear standards, it should reduce the likelihood of disputes which benefits all stakeholders. PharmaCare Audit supports electronic record keeping as long as our questions and comments are resolved and clear standards are developed so that the implementation of electronic record keeping results in a significant improvement compared to hard copy record keeping.

The following should be reviewed along with the proposed PODSA bylaws.

PODSA Bylaws

Definitions

"electronic signature"

Section (a) is unclear. What does "…that is in, attached to…" mean? This wording is similar, but not exactly the same as HPA Bylaws, Definitions, p6. It appears it is a typo and an extra comma was inserted and should read "…that is in or attached to…".

Section (b) – "must also be unique and applied with a human hand". Based on this wording, our interpretation is that a stored e-signature cannot be used.

Records

8.1(1)

"…shall be readable…". This is subjective wording and therefore a dots per inch standard should be established but we agree it is also necessary that the prescription is readable. Also, the image must not contain any distortions (e.g. streaking due to unclean scanning surface, distorted images due to paper jams while scanning etc.) as a result of the scanning process and must be a true representation of the original hard copy document.

"…shall be readable, complete, filed systematically…". Systematically is a subjective term and therefore records filed systematically must be in a way that the information can be obtained from the Healthideas database (e.g. records filed by Original Prescription Number, but not by the date it was logged).

"…auditable and allows for easy retrieval." Does auditable relate specifically to the College of Pharmacists of BC or does this also include Ministry of Health inspectors and other inspectors (federal, Blue Cross, etc)? Easy retrieval is subjective; what exactly does this mean? Immediate retrieval would be better. PharmaCare Audit requires the ability to obtain a copy, electronic or physical, while onsite, as fast as possible.

8.1(5) This wording does not work because many prescriptions that a pharmacy receives will not be in colour; for example, faxed prescriptions, or prescriptions written by a doctor on a white pad with black pen. Instead, the wording should be something like "The software used to scan documentation must be set to scan in colour and the ability to change this setting must be disabled by the software vendor."

8.2(1)(c) "is readily accessible to and understood by pharmacy staff." This should also include inspectors and should read "is readily accessible to and understood by pharmacy staff and shall be provided to inspectors upon request". What happens if the pharmacy does not have a policy? What are the standards going to be?

8.3(1) "…that regulates the practice of pharmacy." Should this read "...that regulates the practice of pharmacy and the billing practices of pharmacy"? If "billing practices of pharmacy" is not included, it might be possible for a lawyer to argue that this section does not apply to the PSA.

8.3(2)(b) Pharmacist/pharmacy owners are unlikely to be IT security experts. Therefore, an initial security standard should be established and then as technology changes, the standard can be updated.

8.3(2)(c)(d)(e) For each update, the original image must be available.

8.3(2)(f) The wording should be updated to the following: "be capable of searching, sorting, retrieving, and exporting prescription records chronologically, and by DIN/PIN, drug name, drug strength, patient, prescriber, prescription number, transaction number, and for a range of service dates." How do inspectors get access to the records? What happens if the pharmacy only has one terminal, or does not have extra terminals for inspectors to access?

8.3(3) What storage methods are acceptable? Is cloud storage OK? Is there a requirement for the server to be in Canada only? Can a hard drive be used for backup? Does it need to be encrypted?

8.3(3)(a) What does this mean exactly? Does this mean that records must be stored on the cloud or in a separate physical location?

8.3(3)(b) What is the actual standard required?

General Questions/Comments
PharmaCare Audit's main concern is that the proposed bylaw changes don't list standards and contain subjective language and so our main question is: are there any plans to develop technical and business rules for electronic record keeping, similar to what PharmaNet has?

Will there be compliance testing for each software vendor to make sure everything works as it is supposed to?

Will it be possible to easily download records? Will the software be capable of searching, sorting, retrieving, and exporting prescription records chronologically, and by DIN/PIN, drug name, drug strength, patient, prescriber, original prescription number, transaction number, and for a range of service dates? Will it be possible to search or filter for groups of records and download copies of them? If so, what assurance will there be that when the records are downloaded, they are free of viruses/malware?

Will it be possible to print records?

What file format(s) must electronic records be stored in?

What is the minimum image quality requirement (dots per inch)?

What storage methods are acceptable? Is cloud storage OK? Is there a requirement for the server to be in Canada only? Can a hard drive be used for backup? Does it need to be encrypted?

What happens to records, particularly electronic, when a pharmacy closes?

Assuming that the electronic prescription records are linked to the pharmacy software, what happens to the records when a pharmacy switches software? Is it still possible to retrieve the records from the old software system?

At what point does the pharmacy have to scan the prescription? Immediately upon presentation? By the end of the day? Once per week? Only before it is disposed of?

How do witnessed ingestion logs for methadone get scanned? Presumably the prescription would be scanned upon presentation but it could be weeks before the log is complete. Can the log be scanned once it is complete and connected to the prescription as it would be if it was a paper copy?

Consider the following scenario: the prescription is scanned in but later the pharmacist realizes that information was missing on the prescription and so the pharmacist faxes it back to the doctor to obtain the necessary information. The doctor faxes back the prescription and the pharmacist would scan the document again but can it be connected to the original scanned prescription so there is a clear trail as to what occurred? What happens in this scenario if instead of fax, the pharmacist phoned the doctor and made notes on the patient's profile in their local pharmacy software? How would this link to the original scan? Would the pharmacist be required to print the notes, scan them, and link it to the original scan?

Will there be a requirement to scan in documents specific to the Ministry of Health, such as Frequent Dispensing Authorization forms, Medication Review Services forms, and Smoking Cessation forms?

Will there a requirement for pharmacies to report to the College the manner in which they store records (electronic vs hard copy)?

HPA - Manner of Disposal of Records – education may be needed in order to ensure that when records are eligible for destruction, they are destroyed properly. For example, if a pharmacy used a printer with scanning

functionality to scan the records into their computer system, the printer may have memory of the scanned images; if the pharmacy was unaware of this and left the hard drive in the printer, it may inadvertently expose the prescription records to an unauthorized party. Similar care should be taken with both paper and electronic records.

Scenario 1
Four auditors from PharmaCare Audit fly to Kelowna to audit a pharmacy. As per standard procedure, no notice of the audit is provided. The auditors will be looking for prescription records to support 1,400 claims. Unknown to the auditors, the pharmacy has one computer terminal and the pharmacy only keeps electronic prescription records. How do the auditors access the prescription records if they are stored electronically when there is only one computer terminal and it is in use all day by the pharmacy? Even if an auditor is able to gain access to the terminal in between prescriptions being filled, what do the other three auditors do?

Scenario 2
PharmaCare Audit arrives at a pharmacy for an audit and discovers that the pharmacy only keeps electronic prescription records but due to a computer failure a year's worth of records were lost and the backup was also lost. This would result in all the claims being non-compliant with the *Pharmaceutical Services Act* and would likely wind up in court. The chance of this scenario occurring could be reduced if there were standards in place.

Sincerely,

[redacted]
PharmaCare Audit
Audit and Investigations Branch
Ministry of Health
Fx: 250-952-2913
PO Box 9666 STN PROV GOVT
Victoria BC V8W 9P6
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Christine Paramonczyk

From: Sammy_Lee@saveonfoods.com
Sent: Friday, May 18, 2018 4:13 PM
To: CPBC Legislation; PROREGADMIN@gov.bc.ca
Subject: Bylaws for Comment: Electronic Record Keeping

Follow Up Flag: Follow up
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Hello,

Thank you for the opportunity to provide feedback on the proposed changes on electronic record keeping. Please see my comments below.

- Definitions – "electronic signature" (b) – requirement for the signature to be "unique and applied with human hand" would means the signature would need to be physical signed and digitally captured. There are technologies that allow for a secured digital stamp in lieu of an actual digitized human signature that should be allowed.
- Records – 8.1.2 – does the term "valid" refer to prescriptions that currently still have valid refills remaining or any prescription that needs to be retained as per 8(1)?
- Records – 8.1.5 – the requirement to store the images in colour would significantly add to the file size (due to increased resolution required for a colour scan) and longer scan time (compared to scanning in black in white). We need to be mindful of adding further to the amount of time needed to fill prescriptions. Scanning in colour should be optional. What is the reason for this requirement? Colour is not required to differentiate between different handwritten notes on the rx.
- Records – 8.3.2(f) – the requirement to be able to search and sort by drug name, drug strength, patient, prescriber, rx number and transaction number is a significant work effort. Currently pharmacies would tag an rx image to an rx number in a patient profile. To be able to search for an image with only using the physician name for example would require multiple tags to the actual rx image file and require software changes for which we would need more transition time and effort to evaluate the feasibility.
- Records – 8.3.4 -Six-month's time frame after the new Records Management Framework comes into force is not sufficient for chain pharmacies to make the necessary changes to support this, even though scanning and storing prescriptions is more common now. New pharmacy software version upgrades, hardware changes, and implementation processes take more time. The transition period should be at least a year.

Thanks,

Sammy Lee, B.Sc.(Pharm), R.Ph., MBA, CPA, CMA
Regional Manager, Pharmacy Operations

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Feedback Submission– College of Pharmacists of BC Bylaws for Comment: Electronic Record Keeping

Comments submitted by:	
Name	Karen Sullivan
Profession or Organization	Shoppers Drug Mart/Loblaw Companies Limited
Date	May 17, 2018

Section, Subsection or Appendix	**Page #**	**Proposed text in draft bylaws**	**Recommended revision and rationale**
Health Professions Act Bylaws - Definitions	6	**"electronic initial"** means (a) information in electronic form that a person has created or adopted in order to initial a record, other than with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, that is in or attached to or associated with a record, is secure; and is only reproducible and used by that person; and (b) with respect to a prescription initialed by a full pharmacist, the electronic initial must meet the requirements of paragraph (a) and must also be unique and applied with a human hand;	**"electronic initial" means information in electronic form that a person has created or adopted in order to initial a record, that is in or attached to or associated with a record, is secure; and is only reproducible and used by that person;** Recommend deleting (b) as this is already covered in the NAPRA Pharmacy Practice Management Systems Requirements in Requirements 18 & 15. Rationale: • It is unclear what "unique and applied with a human hand" applies to. On its surface, this would seem to be very prescriptive in nature, rather than enabling, and preclude a variety of widely accepted and recognized electronic/digital initial/signature mechanisms, including biometric data (ie., retinal scan) and verifiable digital signatures. • Additionally, the requirement to be "applied with a human hand" is potentially discriminatory to handicapped individuals who may not have the use of their hands and would require alternate mechanisms to apply an electronic initial to a document (ie., quadriplegic, amputee, ALS, etc.)

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
			• The requirement to be “unique” is already articulated in the statement “is only reproducible and used by that person”, as this makes it unique to the individual user, as such the additional use of “unique” is redundant • Unclear why the requirements for a pharmacist prescriber in British Columbia would be different than the requirements in the NAPRA PPMS requirements or those for an electronic initial/signature on a prescription written by other types of prescribers and the standard currently used for recognized e-prescribing platforms in Canada • The requirements as outlined in the BC Electronic Transactions Act, which reads as follows: **"electronic signature"** means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record. It does not require that an electronic signature be “applied with a human hand”. • Health Canada recognizes electronic signature requirements as outlined in the Personal Information Protection and Electronic Documents Act , Part 2: Electronic Documents, which states: “secure electronic signature” means *“an electronic signature that results from the application of a technology or process whereby it can be proved that*: *a) the electronic signature resulting from the use by a person of the technology or process is unique to the person;* *b) the use of the technology or process by a person to incorporate, attach or associate the person’s electronic signature to an electronic document is under the sole control of the person;* *c) the technology or process can be used to identify the person using the technology or process; and*

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
			d) the electronic signature can be linked with an electronic document in such a way that it can be used to determine whether the electronic document has been changed since the electronic signature was incorporated in, attached to or associated with the electronic document." • PIPEDA does not require that a secure electronic signature be "applied with a human hand"
PODSA Bylaws-Definitions	3	**"electronic signature"** means (a) information in electronic form that a person has created or adopted in order to sign a record, other than with respect to a prescription signed by a full pharmacist for the purpose of prescribing, that is in, attached to or associated with a record, is secure and is only reproducible and used by that person; and, (b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must also be unique and applied with a human hand;	**"electronic signature" means information in electronic form that a person has created or adopted in order to sign a record, that is in or attached to or associated with a record, is secure; and is only reproducible and used by that person;** Recommend deleting (b) as this is already covered in the NAPRA Pharmacy Practice Management Systems Requirements in Requirements 18 & 15. Rationale: • It is unclear what "unique and applied with a human hand" applies to. On its surface, this would seem to be very prescriptive in nature, rather than enabling, and preclude a variety of widely accepted and recognized electronic/digital initial/signature mechanisms, including biometric data (ie., retinal scan) and verifiable digital signatures. • Additionally, the requirement to be "applied with a human hand" is potentially discriminatory to handicapped individuals who may not have the use of their hands and would require alternate mechanisms to apply an electronic initial to a document (ie., quadriplegic, amputee, ALS, etc.) • The requirement to be "unique" is already articulated in the statement "is only reproducible and used by that person", as this makes it unique to the individual user, as such the additional use of "unique" is redundant

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
			• Unclear why the requirements for a pharmacist prescriber in British Columbia would be different than the requirements in the NAPRA PPMS requirements or those for an electronic initial/signature on a prescription written by other types of prescribers and the standard currently used for recognized e-prescribing platforms in Canada • The requirements as outlined in the BC Electronic Transactions Act, which reads as follows: **"electronic signature"** means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record. It does not require that an electronic signature be "applied with a human hand". • Health Canada recognizes electronic signature requirements as outlined in the Personal Information Protection and Electronic Documents Act , Part 2: Electronic Documents, which states: "secure electronic signature" means *"an electronic signature that results from the application of a technology or process whereby it can be proved that*: *a) the electronic signature resulting from the use by a person of the technology or process is unique to the person;* *b) the use of the technology or process by a person to incorporate, attach or associate the person's electronic signature to an electronic document is under the sole control of the person;* *c) the technology or process can be used to identify the person using the technology or process; and* *d) the electronic signature can be linked with an electronic document in such a way that it can be used to determine whether the electronic document has been changed since the electronic signature was incorporated in, attached to or associated with the electronic document."*

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
			• PIPEDA does not require that a secure electronic signature be "applied with a human hand"
PODSA Bylaws – Records 8(2)	11	(2) Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices and documentation as described in subsection (1) until the completion of any audit or investigation for which the registrant has received notice.	**May want to consider not including this in the bylaws, but rather, provide a guidance document that outlines considerations based on the Limitations Act.** There is no limitation listed in this caveat with respect to when the Registrant receives the notice of an audit. For example, if an organization provides notice of an audit or investigation 4 years after the date of the last fill of the prescription, the records may have already been destroyed as per subsection 1.
PODSA Bylaws – Records 8.1(4)	11	(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.	**Consider deleting this section in its entirety.** • Unclear as to why a scanned copy of other narcotic prescriptions would be acceptable and this would not be. • Once electronic prescriptions are enabled (which is likely to be sooner rather than later and CPP prescriptions would likely be the first ones to be considered for electronic prescribing), this will be problematic and restrictive, rather than enabling.
PODSA Bylaws-Records 8.1(5)	11	(5) Prescriptions stored electronically must be visible in colour.	**(5)Prescriptions stored electronically must be of high resolution** Most prescriptions are monochromatic, so there is little value in a colour scan. In terms of readability of a scanned item, resolution is more important that colour, as such, it is recommended to revise the requirement to high resolution.
PODSA Bylaws-Records 8.3(1-4)	12-13	8.3 (1) A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of records that	**8.3 (1) A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of records that are required to be kept under bylaws of the**

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
		are required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy. (2) For purposes of subsection (1), the equipment, software and systems must: (a) be capable of storing the electronic records for the periods required by applicable law; (b) provide for sufficient security to prevent unauthorized access, use, disclosure, modification and destruction of electronic records; (c) for audit purposes, be capable of uniquely identifying each time an electronic record is accessed and modified; (d) be capable of restricting the functions that may be used by an authorized person; (e) be capable of tracing modifications to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration; (f) be capable of searching and sorting electronic prescription records chronologically, and by drug name, drug strength, patient, prescriber, prescription number and transaction number; (g) ensure that electronic records can be stored, backed up and recovered in accordance with subsection (3); and, (h) provide for a deliberate and auditable procedure to be carried out by the pharmacy manager or by an authorized person prior to the destruction of any electronic record that includes information identifying the pharmacy manager or authorized person who destroyed the record and the date, time and reason for its destruction. (3) A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily	**college or other legislation that regulates the practice of pharmacy.** **(2) For purposes of subsection (1), the equipment, software and systems must be compliant with the National Association of Pharmacy Regulatory Authorities requirements for Pharmacy Practice Management Systems.** **(3) Notwithstanding subsections (1) and (2), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1) and (2).** Rationale: The specific items listed as requirements in the proposed subsections 2 and 3 are already required in the NAPRA PPMS requirements and these are the nationally recognized standards that broadly apply to all information management systems used by pharmacy professionals and PPMS vendors adhere to. As such, it is redundant and unnecessary for the PODSA Bylaws to refer to each of these items individually. Referencing the NAPRA requirements ensures that there is consistency with national requirements and permits greater agility in terms of changes that may be required to software systems and breadth to the requirements that are aligned with other national regulatory requirements. (ie., the NAPRA PPMS requirements includes 38 requirements in two documents: *Pharmacy Practice Management Systems (PPMS)* and *Pharmacy Practice Management Systems Supplemental Requirements on Traceability and Bulk Preparation Labelling*.) Specifically, the draft requirements in 8.3(2) and (3) map to the NAPRA PPMS requirements as follows: (2) (a) - Requirement 27 (b) – Requirements 3-6, 22-29 and 33

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
		and that such electronically preserved and backed up records are stored: (a) in a location resistant to environment perils including but not limited to fires and floods; (b) securely in a manner that avoids theft and unauthorized access, use, modification, destruction and disclosure; and, (c) in a manner that complies with section 8.1(1) requirements. (4) Notwithstanding subsections (1), (2) and (3), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1), (2) and (3).	(c) –Requirement 2 (d) –Requirement 3 (e) -Requirements 21 and 30 (f) -Requirement 20 (g) –Requirement 31 (h) -Requirement 30 (3) (a) –Requirement 31 (b) –Requirement 31 (c) –Requirement 31
Health Professions Act Bylaws – record Keeping 65.1(4)	43	(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.	**Consider deleting this section in its entirety.** • Unclear as to why a scanned copy of other narcotic prescriptions would be acceptable and this would not be. • Once electronic prescriptions are enabled (which is likely to be sooner rather than later and CPP prescriptions would likely be the first ones to be considered for electronic prescribing), this will be problematic and restrictive, rather than enabling.
HPA Bylaws – Community Pharmacy Standards of Practice - prescription 6(2)(g)	4	**6. Prescription** (1) A registrant must ensure that a prescription is authentic. (2) Upon receipt from the practitioner, a prescription must include the following information: (g) the name and signature of the practitioner for written prescriptions;	**(g) the name and signature of the practitioner for written and electronic prescriptions** Add electronic prescriptions

Section, Subsection or Appendix	Page #	Proposed text in draft bylaws	Recommended revision and rationale
HPA Bylaws – Community Pharmacy Standards of Practice - prescription 6(4)(g)	5	**6. Prescription** (4) At the time of dispensing, a prescription must include the following additional information: (g) written confirmation of the registrant who	**(g) documented confirmation of the registrant who** This enables the use of an electronic audit trail as opposed to requiring written initials on a prescription hard copy
HPA Bylaws – Community Pharmacy Standards of Practice - prescription 6(7)	5	(7) A registrant must make a written record of a verbal authorization, and include his or her signature or initial.	**(7) A registrant must document a record of a verbal authorization, and include his or her signature or initial.** This enables the use of electronic documentation of the record (in a paperless system) as opposed to requiring a written prescription hard copy

Electronic Recordkeeping Bylaws (PODSA Bylaws) - Public Posting Feedback Received as of May 18, 2018

Colour Coding Legend:
GREEN – No comments received therefore no changes
YELLOW – Changes made as a result of comments received
RED – Comments were received but no changes made

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
s. 1 "electronic signature" means (a) information in electronic form that a person has created or adopted in order to sign a record, other than with respect to a prescription signed by a full pharmacist for the purpose of prescribing, that is in, attached to or associated with a record, is secure and is only reproducible and used by that person; and, (b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must also be unique and applied with a human hand;	**Dennis Brox (WinRX):** • CPSBC's position is that a wet signature be used by physicians only because the College of Pharmacists deems it is more verifiable. • Digital signatures allow for more verification and security only when documents are electronically transmitted, not the case with prescriptions originating in doctors' offices, however where documents are exchanged electronically (by fax) between practitioners, the bylaws should allow digital signatures consistent with the MOH's own digital certificate program. **PharmaCare Audit:** • Section (a) is unclear. What does "…that is in, attached to…" mean? This wording is similar, but not exactly the same as HPA Bylaws, Definitions, p6. It appears it is a typo and an extra comma was inserted and should read "…that is in or attached to…". • Section (b) – "must also be unique and applied with a human hand". Based on this wording, our interpretation is that a stored e-signature cannot be used. **Catherine McCann (Medicine Shoppe Pharmacy #169):** • Human Hand Signature: In several amendments, there are references to "applied by human hand." Would this include electronic signature pads on prescription and medication review software, for example? Is it necessary to have this wording? There are many security features on prescription dispensing software that could replace this requirement. Given the difficulty in changing bylaws, and rapid changes in technology (bio scanning, for example), this requirement will quickly become outdated and frustrating for pharmacy personnel.	Revise paragraph (b) by removing the term 'human hand' and replacing it with terminology that more accurately explains the intent of the provision. Paragraph (b) will read as follows: "(b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must be a unique mark personally applied by that pharmacist". Rationale: *Paragraph (a)* • Paragraph (a) applies to all signatures other a signature by a pharmacist on a prescription, which is governed by paragraph (b). • No change was made to paragraph (a). This definition was modeled on the definition in the Electronic Transactions Act (BC), and adapted for the purposes of PODSA. Electronic Transactions Act (BC) definition: "electronic signature" means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record.

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	Canada Health Infoway: • Paragraph (a) and must also be unique. If the prescription is not transmitted electronically, the signature must be applied with a human hand. • The original wording of part (b) precludes pharmacists from ordering prescriptions electronically. There are current and developing practices that would not be allowed to evolve to their natural endpoint. i.e. Pharmacist practices in non- traditional settings where pharmacists may prescribe. **Shoppers Drug Mart/Loblaws:** Recommend deleting (b) as this is already covered in the NAPRA Pharmacy Practice Management Systems Requirements in Requirements 18 & 15. Rationale: • It is unclear what "unique and applied with a human hand" applies to. On its surface, this would seem to be very prescriptive in nature, rather than enabling, and preclude a variety of widely accepted and recognized electronic/digital initial/signature mechanisms, including biometric data (ie., retinal scan) and verifiable digital signatures. • Additionally, the requirement to be "applied with a human hand" is potentially discriminatory to handicapped individuals who may not have the use of their hands and would require alternate mechanisms to apply an electronic initial to a document (ie., quadriplegic, amputee, ALS, etc.) • The requirement to be "unique" is already articulated in the statement "is only reproducible and used by that person", as this makes it unique to the individual user, as such the additional use of "unique" is redundant • Unclear why the requirements for a pharmacist prescriber in British Columbia would be different than the requirements in the NAPRA PPMS requirements or those for an electronic initial/signature on a prescription written by other types of prescribers and the standard currently used for recognized e-prescribing platforms in Canada • The requirements as outlined in the BC Electronic Transactions Act, which reads as follows: "electronic signature" means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record. It does not require that an electronic signature be "applied with a human hand". • Health Canada recognizes electronic signature requirements as outlined in the Personal Information Protection and Electronic Documents Act , Part 2: Electronic Documents, which states: "secure electronic signature" means "an electronic signature that results from the application of a technology or process whereby it can be proved that:	*Paragraph (b)* • Paragraph (b) applies only to pharmacist prescribers when signing prescriptions. Pharmacists currently have narrow prescribing authority so this paragraph has limited application. The comments received indicated that the language in paragraph (b) should be clarified. • The requirement was based on guidance from the College of Physicians and Surgeons of B.C. on signatures by physicians on prescriptions: "the signature must be unique and applied with a human hand—be it pen to paper, or electronic pen to pad". https://www.cpsbc.ca/for-physicians/college-connector/2014-V02-02/05 • This is consistent with guidance from CPBC: http://www.bcpharmacists.org/faq/are-e-signatures-acceptable-form-prescriber-authorization • Paragraph (b) does not change the existing practice of requiring "wet signature" on prescriptions – it reflects the current accepted practice. *Electronic transmission of prescriptions* • Currently, prescriptions cannot be transmitted electronically (other than by fax); if the College allows this in the future, the bylaws would likely need to be changed at that time to accommodate that practice.

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	a) the electronic signature resulting from the use by a person of the technology or process is unique to the person; b) the use of the technology or process by a person to incorporate, attach or associate the person's electronic signature to an electronic document is under the sole control of the person; c) the technology or process can be used to identify the person using the technology or process; and d) the electronic signature can be linked with an electronic document in such a way that it can be used to determine whether the electronic document has been changed since the electronic signature was incorporated in, attached to or associated with the electronic document." • PIPEDA does not require that a secure electronic signature be "applied with a human hand" **Save-On-Foods:** • Paragraph (b) – requirement for the signature to be "unique and applied with human hand" would mean the signature would need to be physical signed and digitally captured. There are technologies that allow for a secured digital stamp in lieu of an actual digitized human signature that should be allowed.	
s. 1 "record" has the same meaning as the definition of record in Schedule 1 of the Freedom of Information and Protection of Privacy Act;	No comments received.	n/a
s. 1"signature" on a record means either a handwritten signature in ink or an electronic signature;	No comments received.	n/a
3(2) A manager must do all of the following: (j.1) ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction;	No comments received.	n/a
s. 23(2) and (3) – [Note: No substantive change made. The order of (2) and (3) was reversed to improve the flow of the section.]	**Shoppers Drug Mart/Loblaws:** • s. 23(2) May want to consider not including this in the bylaws, but rather, provide a guidance document that outlines considerations based on the Limitations Act.	No change made. Rationale: s. 23(2) is not a new provision. It only appears as a change because the provision was relocated. Any substantive revisions to this section is beyond the scope of this project as it does not relate specifically to electronic record keeping. However, the College will make a note

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		of this comment for future potential PODSA revisions.
23.1 (1) All records required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval.	**PharmaCare Audit:** • "…shall be readable…". This is subjective wording and therefore a dots per inch standard should be established but we agree it is also necessary that the prescription is readable. Also, the image must not contain any distortions (e.g. streaking due to unclean scanning surface, distorted images due to paper jams while scanning etc.) as a result of the scanning process and must be a true representation of the original hard copy document. • "…shall be readable, complete, filed systematically…". Systematically is a subjective term and therefore records filed systematically must be in a way that the information can be obtained from the Healthideas database (e.g. records filed by Original Prescription Number, but not by the date it was logged). • "…auditable and allows for easy retrieval." Does auditable relate specifically to the College of Pharmacists of BC or does this also include Ministry of Health inspectors and other inspectors (federal, Blue Cross, etc)? Easy retrieval is subjective; what exactly does this mean? Immediate retrieval would be better. PharmaCare Audit requires the ability to obtain a copy, electronic or physical, while onsite, as fast as possible.	No change made. Rationale: *Principle-based approach* • The College is taking a principle-based approach to these bylaws. Since technology is regularly changing, the College has not prescribed specific technical requirements, as the bylaws would become quickly outdated. Because the bylaws are less prescriptive, registrants will be required to use their professional judgment to determine to what is "readable", "filed systematically", "easily retrievable", etc. The College believes that these terms are sufficiently clear and that registrants will interpret them in a reasonable manner. The language is similar to the language used by the Ontario College of Pharmacists. • The College recognizes that there will be variations in the way that pharmacies achieve compliance with these requirements. Section 23.2(1) will require that pharmacies have a policy describing their record keeping system that can be inspected. *Auditable and retrievable* • The College's bylaws focus on achieving the College's objectives under PODSA and the HPA. The bylaws do not grant authority to any inspectors outside of the College to perform audits or any other tasks, as this is outside of the College's jurisdiction. If those inspectors wish to retrieve records in a timely manner for audit purposes, they

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		should ensure that they are entitled to do so under their own governing legislation. • Regarding the comments on retrievability, s. 23.1(2) requires that a valid prescription must be retrievable immediately. The term "valid" is clarified in s. 23.1(3). It would not be reasonable to require that all records be retrievable immediately as some records may be stored offsite.
23.1 (2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately. (3) For purposes of subsection (2): (a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and (b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.	**Save-On-Foods:** • Does the term "valid" refer to prescriptions that currently still have valid refills remaining or any prescription that needs to be retained as per 23(1)?	No change made. Rationale: The term "valid" is clarified in s. 23.1(3): • Prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date. • Prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.
23.1(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.	**Catherine McCann (Medicine Shoppe Pharmacy #169):** • I can't understand why there continues to be a requirement to retain the original hard prescription copy of the Controlled Prescription Program in these proposed changes to the Bylaws. The information on the form is what is important not the hard copy itself. In a previous role, I used to manage the Triplicate Prescription Program in Alberta. Given the requirements to check on Pharmanet for all prescriptions, prescriptions that are being filled in multiple locations or fraudulently are much easier to identify. This program needs to be reviewed and modernized. While it worked in an environment where there was not the connectivity we now have, it should not be necessary now to maintain hard copies. **Canada Health Infoway:** • Suggested addition: *For purposes of clarity when a prescription for medication included in the controlled prescription program is transmitted electronically, a form printed from the pharmacy's Pharmacy Management System will be considered the original prescription form.* • This wording reflects practices in other jurisdictions and allows for the potential to transmit drugs in the controlled prescription program electronically. The secure electronic	No change made. Rationale: • Drugs that are part of the Controlled Prescription Program (CPP) have been identified as those at a higher risk for diversion and misuse. • Maintaining hard copies of CPP prescriptions is useful for verifying the authenticity of a prescription and identifying prescription forgery and tampering. • CPP prescriptions currently are not permitted to be transmitted electronically. These bylaws can be revisited if this is enabled in the future. • The College will forward the comments on this section to the CPP Advisory Committee.

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	transmission of targeted medications has been shown to decrease diversion and reduce amount of medication prescribed. **Shoppers Drug Mart/Loblaws:** • Consider deleting this section in its entirety. • Unclear as to why a scanned copy of other narcotic prescriptions would be acceptable and this would not be. • Once electronic prescriptions are enabled (which is likely to be sooner rather than later and CPP prescriptions would likely be the first ones to be considered for electronic prescribing), this will be problematic and restrictive, rather than enabling.	The CPP Advisory Committee's role is to periodically review and recommend revisions to CPP requirements. The Committee is comprised of representatives from 6 regulatory colleges, including the College, CPSBC, CRNBC, and CDSBC, and the Ministry of Health, who work collaboratively to advise on program changes.
23.1(5) Prescriptions stored electronically must be visible in colour.	**Dennis Brox (WinRX):** • Scanning in color adds about 50% to space requirements and given most scripts received these days are produced on a printer, ink color is not the issue for verification it used to be. • May be over-regulation **PharmaCare Audit:** • This wording does not work because many prescriptions that a pharmacy receives will not be in colour; for example, faxed prescriptions, or prescriptions written by a doctor on a white pad with black pen. Instead, the wording should be something like "The software used to scan documentation must be set to scan in colour and the ability to change this setting must be disabled by the software vendor." **Catherine McCann (Medicine Shoppe Pharmacy #169):** • This requirement is excessive. Most fast document scanners and software programs scan in black and white. We have been scanning all prescriptions and related documentation for over two years. We scan in black and white and have never had an occasion to need to refer to the original prescription to see the "colour version". **Health Canada Infoway:** • Prescriptions stored electronically must be readable and complete. They may high-lighted, stored in colour or another acceptable format. • The goal is for the files to be readable, requiring colour does not guarantee the legibility of the records. **Nikhil Gandhi:**	Revise section 23.1(5) for clarification. Colour scanning will continue to be a requirement. The intention is for the electronic copy of the prescription to reflect the colour composition of the original document. Section 23.1(5) will read as follows: "Prescriptions stored electronically must accurately reflect the original prescription, including the original colour composition of that prescription." Rationale: • Colour scanning has been proposed for verifying the authenticity of a prescription and identifying prescription forgery and tampering. • Pharmacies will have the option to continue retaining prescription hard copies. Pharmacies that choose to retain prescription hard copies will not be required to keep an electronic copy of the prescription, and as a result this provision would not apply. • The purpose of colour scanning is not to increase legibility, but to assist pharmacy staff, College inspectors, investigators, and

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	• Why is it necessary for records to be in full colour? This would significantly increase storage requirements and I can't think of why it would be useful. **Shoppers Drug Mart/Loblaws:** • Suggested wording: *Prescriptions stored electronically must be of high resolution* • Most prescriptions are monochromatic, so there is little value in a colour scan. In terms of readability of a scanned item, resolution is more important that colour, as such, it is recommended to revise the requirement to high resolution. **Save-On-Foods:** • The requirement to store the images in colour would significantly add to the file size (due to increased resolution required for a colour scan) and longer scan time (compared to scanning in black in white). We need to be mindful of adding further to the amount of time needed to fill prescriptions. Scanning in colour should be optional. Colour is not required to differentiate between different handwritten notes on the rx.	others in verifying the authenticity of a prescription. • The additional storage costs due to colour scanning is expected to be minimal, and will likely be less than the cost of storing hard copies. • This requirement was recommended by PharmaCare Audit.
23.2(1) A pharmacy manager must ensure that a policy is in place that: (a) describes the pharmacy's records filing system, the records format and the method and system for storing records, (b) is compliant with the sections 23.1, 23.2 and 23.3 requirements; and (c) is readily accessible to and understood by pharmacy staff. (2) With respect to electronic records, the policy must include a description of the process for the preservation, storage and backing up of records that is compliant with section 23.3 requirements.	**PharmaCare Audit:** • 23.2(1)(c) - This should also include inspectors and should read "*is readily accessible to and understood by pharmacy staff and shall be provided to inspectors upon request*". What happens if the pharmacy does not have a policy? What are the standards going to be?	No change made. Rationale: In s. 18(2)(d) of the PODSA Bylaws, there is already a duty for pharmacy managers to co-operate with inspectors acting under s. 17 of PODSA or sections 28 or 29 of the HPA. Therefore, it would be redundant to state in this provision that any information must be provided to inspectors.
23.3(1) A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of	**PharmaCare Audit:** • 23.3(1) "…that regulates the practice of pharmacy." Should this read "...*that regulates the practice of pharmacy and the billing practices of pharmacy*"? If "billing practices of pharmacy"	No change made. Rationale: The College does not regulate the billing practices of pharmacies.

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
records that are required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy.	is not included, it might be possible for a lawyer to argue that this section does not apply to the PSA.	
23.3(2) For purposes of subsection (1), the equipment, software and systems must: (a) be capable of storing the electronic records for the periods required by applicable law; (b) provide for sufficient security to prevent unauthorized access, use, disclosure, modification and destruction of electronic records; (c) for audit purposes, be capable of uniquely identifying each time an electronic record is accessed and modified; (d) be capable of restricting the functions that may be used by an authorized person; (e) be capable of tracing modifications to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration; (f) be capable of searching and sorting electronic prescription records chronologically, and by drug name, drug strength, patient, prescriber, prescription number and transaction number; (g) ensure that electronic records can be stored, backed up and recovered in accordance with subsection (3); and, (h) provide for a deliberate and auditable procedure to be carried out by the pharmacy manager or by an authorized person prior to the destruction of any electronic record that includes information identifying	**PharmaCare Audit:** • 23.3(2)(b) - Pharmacist/pharmacy owners are unlikely to be IT security experts. Therefore, an initial security standard should be established and then as technology changes, the standard can be updated. • 23.3(2)(c)(d)(e) - For each update, the original image must be available. • 23.3(2)(f) The wording should be updated to the following: "be capable of searching, sorting, retrieving, and exporting prescription records chronologically, and by DIN/PIN, drug name, drug strength, patient, prescriber, prescription number, transaction number, and for a range of service dates." How do inspectors get access to the records? What happens if the pharmacy only has one terminal, or does not have extra terminals for inspectors to access? **BCPhA:** • Suggested wording changes to correct inconsistences in language in ss. 18(2)(j.1), 23.3(2)(b), and 23.3(3)(b): *23.3(2)(b) ~~provide for sufficient security to prevent~~ keep the records secure from unauthorized access, use, disclosure, modification and destruction of electronic records."* *(e) be capable of tracing ~~modifications~~ alterations to records by identifying the original entry, the identity of the individual who made the alteration~~, and~~ the date of the alteration and the reasons for the alteration;* **Shoppers Drug Mart/Loblaws:** • Suggested wording: *23.3(2) For purposes of subsection (1), the equipment, software and systems must be compliant with the National Association of Pharmacy Regulatory Authorities requirements for Pharmacy Practice Management Systems.* *(3) Notwithstanding subsections (1) and (2), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1) and (2).* Rationale: • The specific items listed as requirements in the proposed subsections 2 and 3 are already required in the NAPRA PPMS requirements and these are the nationally recognized standards that broadly apply to all information management systems used by pharmacy professionals and PPMS vendors adhere to.	Adopt BCPhA's suggested wording for clarity and consistency, with some modifications. Section 23.3(2(b) and (e) will read as follows: "(b) keep the records secure from unauthorized access, use, disclosure, modification and destruction;… (e) be capable of tracing modifications to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration;…" Rationale: *PharmaCare Audit Comments* *s. 23.3(2)(b):* • The College is taking a principle-based approach to these bylaws. Since technology is regularly changing, the College has not prescribed specific technical requirements as the Bylaws would become quickly outdated. *s. 23.3(2)(c), (d), and (e):* • s. 23.3(e) already requires that the original entry must be retained s. 23.3(2)(f): • No additional search fields were added to s. 23.3(2)(f) as the College believes that the existing fields are sufficient for retrieving the necessary information. • The College is currently reviewing its operational methodology for conducting pharmacy reviews and inspections, in light of these proposed bylaw changes. It is not within the purview of the College to

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
the pharmacy manager or authorized person who destroyed the record and the date, time and reason for its destruction.	• As such, it is redundant and unnecessary for the PODSA Bylaws to refer to each of these items individually. Referencing the NAPRA requirements ensures that there is consistency with national requirements and permits greater agility in terms of changes that may be required to software systems and breadth to the requirements that are aligned with other national regulatory requirements. (ie., the NAPRA PPMS requirements includes 38 requirements in two documents: Pharmacy Practice Management Systems (PPMS) and Pharmacy Practice Management Systems Supplemental Requirements on Traceability and Bulk Preparation Labelling.) • Specifically, the draft requirements in 23.3(2) and (3) map to the NAPRA PPMS requirements as follows: (2) (a) - Requirement 27 (b) – Requirements 3-6, 22-29 and 33 (c) –Requirement 2 (d) –Requirement 3 (e) -Requirements 21 and 30 (f) -Requirement 20 (g) –Requirement 31 (h) -Requirement 30 (3) (a) –Requirement 31 (b) –Requirement 31 (c) –Requirement 31 **Save-On-Foods:** • 23.3(2)(f) – The requirement to be able to search and sort by drug name, drug strength, patient, prescriber, rx number and transaction number is a significant work effort. Currently pharmacies would tag an rx image to an rx number in a patient profile. To be able to search for an image with only using the physician name for example would require multiple tags to the actual rx image file and require software changes for which we would need more transition time and effort to evaluate the feasibility.	comment on the methodology of external inspectors. *BCPhA Comments* • BCPhA's suggested wording adds clarity and consistency. • BCPhA's suggestion to add "reasons for alteration" to s. 23.3(2)(e) was not adopted because not all systems require tracking of reasons for alterations. It would not be reasonable to adopt a provision that is unlikely to be achievable. • The amendments to s. 69(2) of the HPA will require registrants to include reasons for alterations when they make changes to correct errors or omissions, but will not dictate how the reasons will be documented and stored. The registrant will have the discretion to determine that. *Shoppers Drug Mart Comments* • The College did not adopt NAPRA's PPMS requirements in full, but the amended bylaws include many of the same themes and essential elements. • While the College's bylaws are fairly consistent with NAPRA's PPMS, not all of the PPMS requirements are being mandated by the College (e.g. PPMS Requirement 12 – Lab Tests, Requirement 13 – Patient Identification on e-Prescriptions, Requirement 14 – Prescriber Identification, Requirement 15 – Prescriber E-Prescription Authenticity, Requirement 16 – Authoritative Version of E-Prescription, Requirement 22 – Safety and Quality, Requirement 32 – PPMS

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		Privacy Impact Assessment, and Requirement 33 – PPMS Security Threats and Risks). *Save-On-Foods Comments* • The College believes that most, if not all, of the systems currently being used by pharmacies will be able to comply with the search and sort requirements in s. 23.3(2)(f).
23.3(3) A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily and that such electronically preserved and backed up records are stored: (a) in a location resistant to environment perils including but not limited to fires and floods; (b) securely in a manner that avoids theft and unauthorized access, use, modification, destruction and disclosure; and, (c) in a manner that complies with section 23.1(1) requirements.	**Pharmacare Audit:** • 23.3(3) What storage methods are acceptable? Is cloud storage OK? Is there a requirement for the server to be in Canada only? Can a hard drive be used for backup? Does it need to be encrypted? • 23.3(3)(a) What does this mean exactly? Does this mean that records must be stored on the cloud or in a separate physical location? • 23.3(3)(b) What is the actual standard required? **BCPhA:** • Suggested wording changes to correct inconsistences in language in ss. 18(2)(j.1), 23.3(2)(b), and 23.3(3)(b): 23.3(3)(b) "~~*securely in a manner that avoids theft and unauthorized access, use, modification, destruction and disclosure;*~~ *so that they are secure from unauthorized access, use, disclosure, modification and destruction; and* (c) "*in a manner that, would enable the backed-up records, once restored, to be compliant* ~~*complies*~~ *with section 23.1.(1) requirements.*	Adopt BCPhA's suggested wording for clarity and consistency. Section 23.3(b) and (c) will read as follows: "(b) so that they are secure from unauthorized access, use, modification, destruction and disclosure; and, (c) in a manner that would enable the backed up records, once restored, to be compliant with section 23.1(1) requirements." Rationale: *PharmaCare Audit Comments* • The College is taking a principle-based approach to these bylaws. Since technology is regularly changing, the College has not prescribed specific technical requirements, as the Bylaws would become quickly outdated. • The College's bylaws do not contain geographical restrictions on storage of records. However, pharmacies are advised to determine whether they are subject to privacy laws that require storage of their records within Canada. The College is aiming to develop communications to explore this issue further.

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		BCPhA recommendations • The College has adopted BCPhA's suggested wording as it adds clarity and consistency.
23.3(4) Notwithstanding subsections (1), (2) and (3), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1), (2) and (3).	**Save-On-Foods:** • Six-month's time frame after the new Records Management Framework comes into force is not sufficient for chain pharmacies to make the necessary changes to support this, even though scanning and storing prescriptions is more common now. New pharmacy software version upgrades, hardware changes, and implementation processes take more time. The transition period should be at least a year.	No changes made. Rationale: The majority of comments received did not include concerns with the 6 month transition period. The transition period ends 6 months after the bylaws come into force, and the deadline for transition is currently estimated to be in May 2019.
General comments: Not related to a specific provision.	**Catherine McCann (Medicine Shoppe Pharmacy #169):** • While it may be in the proposed changes, I did not find mention of electronic storage of drug invoices. Is this included in these amendments? We currently maintain both a hard copy and electronic copy of invoices. The cost of storing the hard copies is even more than storing prescriptions. We also scan documents such as vaccine consents and medication review documents. We keep hard copies but would rather only maintain the scanned documents.	No changes made. Rationale: Drug invoices can be stored electronically, but do not need to be stored on a system that complies with s. 23.3. Drug invoices are not referenced specifically in s. 23.3(1) because the systems currently available were not designed to track changes made on drug invoices. Therefore, subjecting drug invoices to the same tracking requirements applicable to prescriptions is likely to be too onerous. Vaccine consents and medication reviews are part of patient record and would be considered "personal health information" under s. 23.3(1). If pharmacies choose to keep electronic copies of those records, they must comply with the requirements in s. 23.3. Pharmacies also need to comply with any Ministry of Health requirements for keeping those records.
General comments: Not related to a specific provision.	**PharmaCare Audit:**	No changes to the bylaws are necessary as a result of these questions from PharmaCare Audit. Some of the questions are addressed in

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	• PharmaCare Audit's main concern is that the proposed bylaw changes don't list standards and contain subjective language and so our main question is: are there any plans to develop technical and business rules for electronic record keeping, similar to what PharmaNet has? • Will there be compliance testing for each software vendor to make sure everything works as it is supposed to? • Will it be possible to easily download records? Will the software be capable of searching, sorting, retrieving, and exporting prescription records chronologically, and by DIN/PIN, drug name, drug strength, patient, prescriber, original prescription number, transaction number, and for a range of service dates? Will it be possible to search or filter for groups of records and download copies of them? If so, what assurance will there be that when the records are downloaded, they are free of viruses/malware? • Will it be possible to print records? • What file format(s) must electronic records be stored in? • What is the minimum image quality requirement (dots per inch)? • What storage methods are acceptable? Is cloud storage OK? Is there a requirement for the server to be in Canada only? Can a hard drive be used for backup? Does it need to be encrypted? • What happens to records, particularly electronic, when a pharmacy closes? • Assuming that the electronic prescription records are linked to the pharmacy software, what happens to the records when a pharmacy switches software? Is it still possible to retrieve the records from the old software system? • At what point does the pharmacy have to scan the prescription? Immediately upon presentation? By the end of the day? Once per week? Only before it is disposed of? • How do witnessed ingestion logs for methadone get scanned? Presumably the prescription would be scanned upon presentation but it could be weeks before the log is complete. Can the log be scanned once it is complete and connected to the prescription as it would be if it was a paper copy? • Consider the following scenario: the prescription is scanned in but later the pharmacist realizes that information was missing on the prescription and so the pharmacist faxes it back to the doctor to obtain the necessary information. The doctor faxes back the prescription and the pharmacist would scan the document again but can it be connected to the original scanned prescription so there is a clear trail as to what occurred? What happens in this scenario if instead of fax, the pharmacist phoned the doctor and made notes on the patient's profile in their local pharmacy software? How would this link to the original scan? Would the pharmacist be required to print the notes, scan them, and link it to the original scan?	the College's responses to the above-noted comments on specific proposed provisions. The College will provide further clarification in a guidance document. Below are the College's responses to some of the questions: • The College is taking a principle-based approach to these bylaws. Since technology is regularly changing, the College has not prescribed specific technical requirements, as the Bylaws would become quickly outdated. • Regarding the various scenarios presented by PharmaCare Audit, it is important to note that the College is not prescribing or endorsing any one record keeping system. It will be the responsibility of the pharmacy manager/registrant to ensure that the system used will comply with record keeping requirements, including the requirement that the record be complete. • The College believes that most, if not all, pharmacies currently have systems that are able to print records. The College does not believe it is necessary to explicitly require printing capabilities. • When a pharmacy closes, its records must be handled in accordance with the procedures in the existing provisions of the PODSA Bylaws (s. 18(2)(t)) • If a pharmacy switches software, it must ensure that it continues to comply with the College's record keeping bylaws. • Pharmacies will not be required to report to the College the manner in which they store records. However, pharmacies will be

Proposed Requirements: PODSA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	• Will there be a requirement to scan in documents specific to the Ministry of Health, such as Frequent Dispensing Authorization forms, Medication Review Services forms, and Smoking Cessation forms? • Will there a requirement for pharmacies to report to the College the manner in which they store records (electronic vs hard copy)? • HPA - Manner of Disposal of Records – education may be needed in order to ensure that when records are eligible for destruction, they are destroyed properly. For example, if a pharmacy used a printer with scanning functionality to scan the records into their computer system, the printer may have memory of the scanned images; if the pharmacy was unaware of this and left the hard drive in the printer, it may inadvertently expose the prescription records to an unauthorized party. Similar care should be taken with both paper and electronic records. Scenario 1 Four auditors from PharmaCare Audit fly to Kelowna to audit a pharmacy. As per standard procedure, no notice of the audit is provided. The auditors will be looking for prescription records to support 1,400 claims. Unknown to the auditors, the pharmacy has one computer terminal and the pharmacy only keeps electronic prescription records. How do the auditors access the prescription records if they are stored electronically when there is only one computer terminal and it is in use all day by the pharmacy? Even if an auditor is able to gain access to the terminal in between prescriptions being filled, what do the other three auditors do? Scenario 2 PharmaCare Audit arrives at a pharmacy for an audit and discovers that the pharmacy only keeps electronic prescription records but due to a computer failure a year's worth of records were lost and the backup was also lost. This would result in all the claims being non-compliant with the Pharmaceutical Services Act and would likely wind up in court. The chance of this scenario occurring could be reduced if there were standards in place.	required to provide the College with a copy of the record keeping policy described in s. 23.2(1) upon request. • Destruction of records is addressed in s. 75 of the HPA Bylaws.

Electronic Recordkeeping Bylaws (HPA Bylaws) - Public Posting Feedback Received as of May 18, 2018

Colour Coding Legend:
GREEN – No comments received therefore no changes
YELLOW – Changes made as a result of comments received
RED – Comments were received but no changes made

Table 1: HPA Bylaws

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
s. 1 "controlled prescription program" has the same meaning as in section 1 of the Pharmacy Operations and Drug Scheduling Act Bylaws;	No comments received.	n/a
s. 1 "electronic initial" means (a) information in electronic form that a person has created or adopted in order to initial a record, other than with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, that is in or attached to or associated with a record, is secure; and is only reproducible and used by that person; and (b) with respect to a prescription initialed by a full pharmacist, the electronic initial must meet the requirements of paragraph (a) and must also be unique and applied with a human hand;	**Canada Health Infoway:** • Paragraph (a) and must also be unique. If the prescription is not transmitted electronically the signature must be applied with a human hand. **Shoppers Drug Mart/Loblaws:** • Recommend deleting (b) as this is already covered in the NAPRA Pharmacy Practice Management Systems Requirements in Requirements 18 & 15. Rationale: • It is unclear what "unique and applied with a human hand" applies to. On its surface, this would seem to be very prescriptive in nature, rather than enabling, and preclude a variety of widely accepted and recognized electronic/digital initial/signature mechanisms, including biometric data (ie., retinal scan) and verifiable digital signatures. • Additionally, the requirement to be "applied with a human hand" is potentially discriminatory to handicapped individuals who may not have the use of their hands and would require alternate mechanisms to apply an electronic initial to a document (ie., quadriplegic, amputee, ALS, etc.)	Revise paragraph (b) by removing the term 'human hand' and replacing it with terminology that more accurately explains the intent of the provision. Paragraph (b) will read as follows: "(b) with respect to a prescription initialed by a full pharmacist, the electronic initial must meet the requirements of paragraph (a) and must be a unique mark personally applied by that pharmacist;" Rationale: *Paragraph (a)* Paragraph (a) applies to all signatures other a signature by a pharmacist on a prescription, which is governed by paragraph (b). No change was made to paragraph (a). This definition was modeled on the definition in the Electronic Transactions Act (BC), and adapted for the purposes of

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
	• The requirement to be “unique” is already articulated in the statement “is only reproducible and used by that person”, as this makes it unique to the individual user, as such the additional use of “unique” is redundant • Unclear why the requirements for a pharmacist prescriber in British Columbia would be different than the requirements in the NAPRA PPMS requirements or those for an electronic initial/signature on a prescription written by other types of prescribers and the standard currently used for recognized e-prescribing platforms in Canada • The requirements as outlined in the BC Electronic Transactions Act, which reads as follows: "electronic signature" means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record. It does not require that an electronic signature be “applied with a human hand”. • Health Canada recognizes electronic signature requirements as outlined in the Personal Information Protection and Electronic Documents Act , Part 2: Electronic Documents, which states: “secure electronic signature” means “an electronic signature that results from the application of a technology or process whereby it can be proved that: a) the electronic signature resulting from the use by a person of the technology or process is unique to the person; b) the use of the technology or process by a person to incorporate, attach or associate the person’s electronic signature to an electronic document is under the sole control of the person; c) the technology or process can be used to identify the person using the technology or process; and d) the electronic signature can be linked with an electronic document in such a way that it can be used to determine whether the electronic document has been changed since the electronic signature was incorporated in, attached to or associated with the electronic document.” • PIPEDA does not require that a secure electronic signature be “applied with a human hand”.	PODSA. Electronic Transactions Act (BC) definition: "electronic signature" means information in electronic form that a person has created or adopted in order to sign a record and that is in, attached to or associated with the record. *Paragraph (b)* Paragraph (b) applies only to pharmacist prescribers when signing prescriptions. Pharmacists currently have narrow prescribing authority so this paragraph has limited application. The comments received indicated that the language in paragraph (b) should be clarified. The requirement was based on guidance from the College of Physicians and Surgeons of B.C. on signatures by physicians on prescriptions: “the signature must be unique and applied with a human hand—be it pen to paper, or electronic pen to pad”. https://www.cpsbc.ca/for-physicians/college-connector/2014-V02-02/05 This is consistent with guidance from CPBC: http://www.bcpharmacists.org/faq/are-e-signatures-acceptable-form-prescriber-authorization Paragraph (b) does not change the existing practice of requiring “wet signature” on prescriptions – it reflects the current accepted practice. *Electronic transmission of prescriptions* Currently, prescriptions cannot be transmitted electronically (other than by fax); if the College allows this in the future, the bylaws would likely need to be changed at that time to accommodate that practice.
s. 1 “initial” on a record means either an original handwritten initial or an electronic initial;	No comments received.	n/a

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
s. 1 "record" has the same meaning as in section 1 of the Pharmacy Operations and Drug Scheduling Act Bylaws;	No comments received.	n/a
s. 1 "signature" has the same meaning as in section 1 of the Pharmacy Operations and Drug Scheduling Act Bylaws;	No comments received.	n/a
s. 65.1(1) All records required to be kept under the bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete and filed systematically by a registrant in a manner that is secure, auditable and allows for easy retrieval.	No comments received. However, please refer to the comments on s. 23.1(1) of the PODSA Bylaws, which sets out the same requirements: **PharmaCare Audit:** • "…shall be readable…". This is subjective wording and therefore a dots per inch standard should be established but we agree it is also necessary that the prescription is readable. Also, the image must not contain any distortions (e.g. streaking due to unclean scanning surface, distorted images due to paper jams while scanning etc.) as a result of the scanning process and must be a true representation of the original hard copy document. • "…shall be readable, complete, filed systematically…". Systematically is a subjective term and therefore records filed systematically must be in a way that the information can be obtained from the Healthideas database (e.g. records filed by Original Prescription Number, but not by the date it was logged). • "…auditable and allows for easy retrieval." Does auditable relate specifically to the College of Pharmacists of BC or does this also include Ministry of Health inspectors and other inspectors (federal, Blue Cross, etc)? Easy retrieval is subjective; what exactly does this mean? Immediate retrieval would be better. PharmaCare Audit requires the ability to obtain a copy, electronic or physical, while onsite, as fast as possible.	No change made. Rationale: *Principle-based approach* • The College is taking a principle-based approach to these bylaws. Since technology is regularly changing, the College has not prescribed specific technical requirements as the bylaws would become quickly outdated. Because the bylaws are less prescriptive, registrants will be required to use their professional judgment to determine to what is "readable", "filed systematically", "easily retrievable", etc. The College believes that these terms are sufficiently clear and that registrants will interpret them in a reasonable manner. The language is similar to the language used by the Ontario College of Pharmacists. • The College recognizes that there will be variations in the way that pharmacies achieve compliance with these requirements. Section 23.2(1) will require that pharmacies have a policy describing their record keeping system that can be inspected. *Auditable and retrievable* • The College's bylaws focus on achieving the College's objectives under PODSA and the HPA. The bylaws do not grant authority to any inspectors outside of the College to perform audits or any other tasks, as this is outside of the College's jurisdiction. If those inspectors wish to retrieve

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		records in a timely manner for audit purposes, they should ensure that they are entitled to do so under their own governing legislation. • Regarding the comments on retrievability, s. 23.1(2) requires that a valid prescription must be retrievable immediately. The term "valid" is clarified in s. 23.1(3). It would not be reasonable to require that all records be retrievable immediately as some records may be stored offsite.
s. 65.1(2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately. (3) For purposes of subsection (2): (a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and (b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.	No comments received. However, please refer to the following comments on s. 23.1(2) of the PODSA Bylaws, which sets out the same requirements: Save-On-Foods: • Does the term "valid" refer to prescriptions that currently still have valid refills remaining or any prescription that needs to be retained as per 23(1)?	No change made. Rationale: The term "valid" is clarified in s. 23.1(3) of the PODSA Bylaws and s. 65.1(3) of the HPA Bylaws: • Prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date. • Prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.
s. 65.1(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.	**Canada Health Infoway:** • For purposes of clarity when a prescription for medication included in the controlled prescription program is transmitted electronically, a form printed from the pharmacy's Pharmacy Management System will be considered the original prescription form. • This wording reflects practices in other jurisdictions and allows for the potential to transmit drugs in the controlled prescription program electronically. The secure electronic transmission of targeted medications has been shown to decrease diversion and reduce amount of medication prescribed. **Shoppers Drug Mart/Loblaws:** • Consider deleting this section in its entirety. • Unclear as to why a scanned copy of other narcotic prescriptions would be acceptable and this would not be. • Once electronic prescriptions are enabled (which is likely to be sooner rather than later and CPP prescriptions would likely be the first ones to be considered for electronic prescribing), this will be problematic and restrictive, rather than enabling.	No change made. Rationale: • Drugs that are part of the Controlled Prescription Program (CPP) have been identified as those at a higher risk for diversion and misuse. • Maintaining hard copies of CPP prescriptions is useful for verifying the authenticity of a prescription and identifying prescription forgery and tampering. • CPP prescriptions currently are not permitted to be transmitted electronically. These bylaws can be revisited if this is enabled in the future. • The College will forward the comments on this section to the CPP Advisory Committee. The CPP Advisory Committee's role is to periodically review and recommend revisions to CPP requirements. The Committee is comprised of representatives

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
		from 6 regulatory colleges, including the College, CPSBC, CRNBC, and CDSBC, and the Ministry of Health, who work collaboratively to advise on program changes.
s. 65.1(5) Prescriptions stored electronically must be visible in colour.	**Canada Health Infoway:** • Prescriptions stored electronically must be readable and complete. They may high-lighted, stored in colour or another acceptable format. • The goal is for the files to be readable, requiring colour does not guarantee the legibility of the records. See comments on s. 23.1(5) of the PODSA Bylaws.	Revise section 65.1(5) for clarification. Colour scanning will continue to be a requirement. The intention is for the electronic copy of the prescription to reflect the colour composition of the original document. Section 65.1(5) will read as follows: "Prescriptions stored electronically must accurately reflect the original prescription, including the colour composition of that prescription." Rationale: • Colour scanning is needed for verifying the authenticity of a prescription and identifying prescription forgery and tampering. • Pharmacies will have the option to continue retaining prescription hard copies. Pharmacies that choose to retain prescription hard copies will not be required to keep an electronic copy of the prescription, and as a result this provision would not apply. • The purpose of colour scanning is not to increase legibility, but to assist pharmacy staff, College inspectors, investigators, and others in verifying the authenticity of a prescription. • The additional storage costs due to colour scanning is expected to be minimal, and will likely be less than the cost of storing hard copies. • This requirement was recommended by PharmaCare Audit.
s. 65.1(6) A registrant who creates and stores electronic records must do so using the equipment, software and systems prescribed by subsections 23.3(1) and 23.3(2)	No comments received.	n/a

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
of the Pharmacy Operations and Drug Scheduling Act Bylaws.		
s. 69(2) In addition to correcting personal information in a record in accordance with section 70, a registrant who discovers an error or omission in such a record must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record, the date of the amendment and the reasons for the amendment.	No comments received.	n/a
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): (a) 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.; or, (b) the registrant agrees that there is an error or omission in the record, the registrant must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record, the date of the amendment, and the reasons for the amendment.	No comments received.	n/a
s. 75 A registrant must ensure that records are disposed of or destroyed only by (a) transferring the record to another registrant, or	No comments received.	n/a

Proposed Requirements: HPA Bylaws	Comments Received	Policy Decisions from Review of Feedback
(b) destroying the records in a manner that ensures that they cannot be reconstructed.		

Table 2: HPA Bylaws - Schedule F – Part 1 – Community Pharmacy Standards of Practice

Proposed Requirements: HPA Bylaws – Schedule F – Part 1 – Community Pharmacy Standards of Practice	Comments Received	Policy Decisions from Review of Feedback
s. 6(9)For refill authorizations, a registrant may (a) accept a refill authorization for Schedule I drugs from a practitioner's agent if confident the agent consulted the practitioner and accurately conveyed the practitioner's direction, and (b) must (i) cancel any unused refill authorizations remaining on any previous prescription if a patient presents a new prescription for a previously dispensed drug, (ii) advise the other pharmacy of the new prescription if unused refills are at another pharmacy, and (iii) create a new prescription number.	No comments received.	n/a
s. 11(2) For purposes of subsection (1), the patient record must include…	No comments received.	n/a

Table 3: HPA Bylaws - Schedule F – Part 2 – Hospital Pharmacy Standards of Practice

Proposed Requirements: HPA Bylaws – Schedule F – Part 2 – Hospital Pharmacy Standards of Practice	**Comments Received**	**Policy Decisions from Review of Feedback**
s. 9(4) A separate production record must be kept for each compounded bulk product and must include (d) the identification of each registrant and pharmacy assistant involved in each step of the compounding process,	No comments received.	n/a
s. 16(2) For the purposes of subsection (1), the documentation must include but is not limited to (h) the full pharmacist's signature.	No comments received.	n/a

Pharmacy Operations and Drug Scheduling Act - BYLAWS

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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 *Act*;

"electronic signature" means

(a) information in electronic form that a person has created or adopted in order to sign a record, other than with respect to a prescription signed by a full pharmacist

for the purpose of prescribing, that is in, attached to or associated with a record, is secure and is only reproducible and used by that person; and,

(b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must ~~also~~ be a unique ~~and~~ mark personally applied by that pharmacist ~~with a human hand~~;

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

"health authority" includes

(a) a regional health board designated under the *Health Authorities Act*,
(b) the Provincial Health Services Authority,
(c) First Nations Health Authority, and
(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;

"record" has the same meaning as the definition of record in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*;

"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*;

"signature" on a record means either a handwritten signature in ink or an electronic signature;

"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

(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, demonstrating compliance with the physical requirements in the bylaws and applicable policies;

(d) Form 10;

(e) photographs or video demonstrating compliance with the physical requirements in the bylaws and applicable policies; 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 14 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 14.

(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 *Ac*t.

(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 14.

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 application in Form 2;

(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 telepharmacy, confirming compliance with Schedule “C”;

(d) Form 11;

(e) photographs or video confirming compliance with Schedules “C” and “E”; and

(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. A direct owner may apply to renew a telepharmacy licence 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) 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. 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.

Unlawful Operation

15. (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 II - All Pharmacies

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

16. (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 14 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 14 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

17. (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.

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

18. (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;

(j.1) ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction;

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

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

(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,

(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.

(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;

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

(x) require 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;

(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*;

(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 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.

(5) Subsection (2)(aa) does not prevent a manager, 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.

(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) 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

19. (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

20. (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

21. 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

22. 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

23. (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) Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices and documentation as described in subsection (1) until the completion of any audit or investigation for which the registrant has received notice.

(32) Registrants, support persons, managers, direct owners, 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.~~

23.1. (1) All records required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval.

(2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately.

(3) For purposes of subsection (2):

(a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and

(b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.

(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.

(5) Prescriptions stored electronically must ~~be visible in colour~~ accurately reflect the original prescription, including the original colour composition of that prescription.

23.2. (1) A pharmacy manager must ensure that a policy is in place that:

(a) describes the pharmacy's records filing system, the records format and the method and system for storing records,

(b) is compliant with the sections 23.1, 23.2 and 23.3 requirements; and

(c) is readily accessible to and understood by pharmacy staff.

(2) With respect to electronic records, the policy must include a description of the process for the preservation, storage and backing up of records that is compliant with section 23.3 requirements.

23.3. (1) A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of records that are required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy.

(2) For purposes of subsection (1), the equipment, software and systems must:

(a) be capable of storing the electronic records for the periods required by applicable law;

(b) keep the records secure from ~~provide for sufficient security to prevent~~ unauthorized access, use, disclosure, modification and destruction ~~of electronic records~~;

(c) for audit purposes, be capable of uniquely identifying each time an electronic record is accessed and modified;

(d) be capable of restricting the functions that may be used by an authorized person;

(e) be capable of tracing ~~modifications~~ alterations to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration;

(f) be capable of searching and sorting electronic prescription records chronologically, and by drug name, drug strength, patient, prescriber, prescription number and transaction number;

(g) ensure that electronic records can be stored, backed up and recovered in accordance with subsection (3); and,

(h) provide for a deliberate and auditable procedure to be carried out by the pharmacy manager or by an authorized person prior to the destruction of any electronic record that includes information identifying the pharmacy manager or authorized person who destroyed the record and the date, time and reason for its destruction.

(3) A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily and that such electronically preserved and backed up records are stored:

(a) in a location resistant to environment perils including but not limited to fires and floods;

(b) ~~securely in a manner that avoids theft and~~ so that they are secure from unauthorized access, use, modification, destruction and disclosure; and,

(c) in a manner that would enable the backed up records, once restored, to be compliant ~~complies~~ with section 23.1(1) requirements.

(4) Notwithstanding subsections (1), (2) and (3), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1), (2) and (3).

PART III – Community Pharmacies

Community Pharmacy's Manager – Quality Management

24. (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

25. (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,

(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

26. (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 26(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 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.

(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

27. (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

28. (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 IV – Hospital Pharmacies

Hospital Pharmacy's Manager – Quality Management

29. (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

30. (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 V – Telepharmacy

Telepharmacy Licence

31. (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 VI – PharmaNet

Application of Part

32. This Part applies to every pharmacy that connects to PharmaNet.

Definitions

33. 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

34. 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

35. (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

36. 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

37. 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.

Health Professions Act – BYLAWS

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8. Application for Non-Practising Registration
9. Certificate of Registration
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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);

"controlled prescription program" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act* Bylaws*;*

"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;

"electronic initial" means

(a) information in electronic form that a person has created or adopted in order to initial a record, other than with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, that is in, ~~or~~ attached to or associated with a record, is secure~~;~~ and is only reproducible and used by that person; and

(b) with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, the electronic initial must meet the requirements of paragraph (a) and must ~~also~~ be a unique mark ~~and~~ personally applied ~~with a human hand~~ by that pharmacist;

"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*;

“initial” on a record means either an original handwritten initial or an electronic initial;

“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"~~ has the same meaning as ~~defined~~ in ~~Schedule~~section 1 of the ~~*Freedom of Information*~~*Pharmacy Operations* and ~~*Protection of Privacy*~~*Drug Scheduling Act*~~;~~ Bylaws;

"Regulation" means the Pharmacists Regulation, B.C. Reg. 417/2008;

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

"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 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) 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 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 consecutive terms.

(3) Subsections (1) and (2) 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

(4) basis, if the person also meets the requirements established in subsection (1)(b) to (h).

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.

Record Keeping

65.1 (1) All records required to be kept under the bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete and filed systematically by a registrant in a manner that is secure, auditable and allows for easy retrieval.

(2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately.

(3) For purposes of subsection (2):

(a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and

(b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.

(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.

(5) Prescriptions stored electronically must ~~be visible in colour~~ accurately reflect the original prescription, including the colour composition of that prescription.

(6) A registrant who creates and stores electronic records must do so using the equipment, software and systems prescribed by subsections 238.3(1) and 238.3(2) of the *Pharmacy Operations and Drug Scheduling Act* Bylaws.

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. (1) The registrant must make every reasonable effort to ensure that personal information collected about patients is current and is legibly, accurately and completely recorded.

(2) In addition to correcting personal information in a record in accordance with section 70, a registrant who discovers an error or omission in such a record must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record, the date of the amendment and the reasons for the amendment.

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)~~),~~):

(a) 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~~.~~; or,

(b) the registrant agrees that there is an error or omission in the record, the registrant must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record,

the date of the amendment, and the reasons for the amendment.

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 or destroyed only by

(a) transferring the record to another registrant, or

~~(b) effectively~~ (b) 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~~the records in a manner that ensures that ~~the information~~they 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".

Health Professions Act – **BYLAWS**

SCHEDULE F

PART 1 - Community Pharmacy Standards of Practice

Table of Contents

Application

1. This Part applies to all registrants providing pharmacy services in a community pharmacy.

Definitions

2. In this Part:

"community pharmacy" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"drug therapy problem" means a potential or actual adverse consequence of drug therapy that interferes with achieving the goals of the drug therapy;

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the prescription information and the information on the manufacturer's label with respect to:

(i) drug,

(ii) dosage form,

(iii) strength,

(iv) quantity, and

(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug has not expired and will not expire within the duration of use; and

(d) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

"**incentive**" means money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods or rewards;

"patient representative" means a person who is authorized to act on a patient's behalf;

"personal health number" means a unique numerical lifetime identifier used in the specific identification of an individual patient who has any interaction with the BC health system;

"prescription copy" means a copy of a prescription given to a patient by a registrant for information purposes only;

"prescription transfer" means the transfer via direct communication from a registrant to another registrant of all remaining refill authorizations for a particular prescription to a requesting community pharmacy;

"refill" means verbal or written approval from a practitioner authorizing a registrant to dispense additional quantities of drug(s) pursuant to a prescription;

"renewal" means authorization by a full pharmacist to dispense additional quantities of drug(s) pursuant to a previously dispensed prescription, in accordance with section 25.92 of the *Act*;

"*Residential Care Facilities and Homes Standards of Practice*" means the standards, limits and conditions for practice established in Part 3 of this Schedule.

Patient Choice

3. Registrants, owners and directors must not enter into agreements with patients, patient's representatives, practitioners, corporations, partnerships, or any other person or entity, that limit a patient's choice of pharmacy, except as required or permitted under the bylaws.

Community Pharmacy Technicians

4. (1) Pharmacy technicians in a community pharmacy may prepare, process and compound prescriptions, including

(a) receiving and transcribing verbal prescriptions from practitioners,

(b) ensuring that a prescription is complete and authentic,

(c) transferring prescriptions to and receiving prescriptions from other pharmacies,

(d) ensuring the accuracy of a prepared prescription,

(e) performing the final check of a prepared prescription, and

(f) ensuring the accuracy of drug and personal health information in the PharmaNet patient record.

(2) Despite subsection (1), a pharmacy technician in a community pharmacy may dispense a drug but must not

(a) perform the task of ensuring the pharmaceutical and therapeutic suitability of a drug for its intended use, or

(b) do anything described in

(i) sections 6(5), 6(10), 10(2), 11(3), 11(4), 12, 13(2), 13(3) or 13(4) of this Part, or

(ii) Part 4 of this Schedule

(c) dispense a drug pursuant to HPA Bylaws Schedule F, Part 5

(3) A pharmacy technician must identify his or her registrant class in any interaction with a patient or a practitioner.

Pharmacy Assistants

5. A registrant may delegate technical functions relating to the operation of the community pharmacy to a pharmacy assistant if the registrant directly supervises the pharmacy assistant and implements procedures, checks and controls to ensure the accurate and safe delivery of community pharmacy services.

Prescription

6. (1) A registrant must ensure that a prescription is authentic.

(2) Upon receipt from the practitioner, a prescription must include the following information:

(a) the date the prescription was written;

(b) the name of the patient;

(c) the name of the drug or ingredients and strength if applicable;

(d) the quantity of the drug;

(e) the dosage instructions including the frequency, interval or maximum daily dose;

(f) refill authorization if applicable, including number of refills and interval between refills;

(g) the name and signature of the practitioner for written prescriptions;

(3) For the purpose of subsection (4), “prescription” includes a new prescription, a refill, a renewal or a balance owing.

(4) 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;

(g) written confirmation of the registrant who

(i) verified the patient identification

(ii) verified the patient allergy information,

(iii) reviewed the personal health information stored in the PharmaNet database in accordance with section 11.4;

(iv) performed the consultation,

(v) performed the final check including when dispensing a balance owing, and

(vi) identified and addressed a drug therapy problem, if any.

(5) A full pharmacist must

(a) review prescriptions for completeness and appropriateness with respect to the drug, dosage, route and frequency of administration,

(b) review patient personal health information for drug therapy problems, therapeutic duplications and any other potential problems,

(c) consult with patients concerning the patient's drug history and other personal health information,

(d) consult with practitioners with respect to a patient's drug therapy unless s.25.92(2) of the *Act* applies, and

(e) take appropriate action respecting a drug therapy problem.

(6) A registrant may receive verbal prescription authorizations directly from a practitioner or from a practitioner's recorded voice message.

(7) A registrant must make a written record of a verbal authorization, and include his or her signature or initial.

(8) A registrant must not dispense a prescription issued for more than one patient.

(9) For refill authorizations, a registrant

~~(a)~~ may

~~(i)~~(a) accept a refill authorization for Schedule I drugs from a practitioner's agent if confident the agent consulted the

practitioner and accurately conveyed the practitioner's direction, and

~~(ii) retain the current prescription number for a quantity change if the software system is capable of retaining a record of the quantity dispensed on each previous occasion, and~~

~~(iii) document the refill authorization on the original prescription if~~

~~(A) a computerized transaction log is maintained, or~~

~~(B) a new prescription number is assigned, and~~

(a) must

(i) cancel any unused refill authorizations remaining on any previous prescription if a patient presents a new prescription for a previously dispensed drug,

(ii) advise the other pharmacy of the new prescription if unused refills are at another pharmacy, and

(iii) create a new prescription number ~~if a renewal authorization involves a different drug identification number, practitioner or directions for use.~~.

(10) If a full pharmacist authorizes a prescription renewal, he or she must

(a) create a written record,

(b) assign a new prescription number, and

(c) use his or her college identification number in the practitioner field on PharmaNet.

Transmission by Facsimile

7. (1) Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if

(a) the prescription is sent only to a pharmacy of the patient's choice,

(b) the facsimile equipment is located within a secure area to protect the confidentiality of the prescription information, and

(c) in addition to the requirements of section 6(2), the prescription includes

(i) the practitioner's telephone number, facsimile number and unique identifier if applicable,

(ii) the time and date of transmission, and

(iii) the name and fax number of the pharmacy intended to receive the transmission.

(2) Prescription refill authorization requests may be transmitted by facsimile from a pharmacy to a practitioner, if the pharmacy submits refill requests on a form that includes space for

(a) the information set out in section 6(2),

(b) the name, address and 10 digit telephone number of the pharmacy, and

(c) the practitioner's name, date and time of transmission from the practitioner to the pharmacy.

(3) A registrant must not dispense a prescription authorization received by facsimile transmission for a drug referred to on the Controlled Prescription Drug List.

(4) Prescription transfers may be completed by facsimile transmission if

(a) the transferring registrant includes his or her name and the address of the pharmacy with the information required in section 8(4), and

(b) the name of the registrant receiving the transfer is known and recorded on the document to be faxed.

Prescription Copy and Transfer

8. (1) If requested to do so, a registrant must provide a copy of the prescription to the patient or the patient's representative, or to another registrant.

(2) A prescription copy must contain

(a) the name and address of the patient,

(b) the name of the practitioner,

(c) the name, strength, quantity and directions for use of the drug,

(d) the dates of the first and last dispensing of the prescription,

(e) the name and address of the community pharmacy,

(f) the number of authorized refills remaining,

(g) the signature of the registrant supplying it, and

(h) an indication that it is a copy.

(3) Upon request, a registrant must transfer to a pharmacy licenced in Canada a prescription for a drug if

(a) the drug does not contain a controlled drug substance, and

(b) the transfer occurs between a registrant and another registrant or an equivalent of a registrant in another Canadian jurisdiction.

(4) A registrant who transfers a prescription to another registrant under subsection (3) must

(a) enter on the patient record

(i) the date of the transfer,

(ii) the registrant's identification,

(iii) identification of the community pharmacy to which the prescription was transferred, and

(iv) identification of the person to whom the prescription was transferred, and

(b) transfer all prescription information listed in subsection (2) (a) to (f).

(5) A registrant must make prescriptions available for review and copying by authorized inspectors of Health Canada.

Prescription Label

9. (1) All drugs dispensed pursuant to a prescription or a full pharmacist-initiated adaptation must be labeled.

(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.

(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.

(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.

(5) For a compounded preparation, the label must include all active ingredients.

(6) If a drug container is too small to accommodate a full label in accordance with subsection (2),

(a) a trimmed prescription label must be attached to the small container,

(b) the label must include

(i) the prescription number,

(ii) the dispensing date,

(iii) the full name of the patient, and

(iv) the name of the drug, and

(c) the complete prescription label must be attached to a larger container and the patient must be advised to keep the small container inside the large container.

(7) All required label information must be in English, but may contain directions for use in the patient's language following the English directions.

Preparation of Prescription Product

9.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to:

(i) drug,
(ii) dosage form,

(iii) strength,
(iv) quantity,
(v) drug identification number;

(b) the prescription product label matches the prescription information with respect to the matters set out in section 6(2)(a) to (g);

(c) the drug is not expired and will not expire within the duration of use; and

(d) his or her identity is documented in writing.

(2) A pharmacy manager must ensure that the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed.

Dispensing

10. (1) A registrant may adjust the quantity of drug to be dispensed if

(a) a patient requests a smaller amount,

(b) a manufacturer's unit-of-use standard of package size does not match the prescribed quantity,

(c) the quantity prescribed exceeds the amount covered by the patient's drug plan, or

(d) a trial prescription quantity is authorized by the patient.

(2) A full pharmacist may adjust the quantity of drug to be dispensed, if

(a) he or she consults with a practitioner and documents the result of the consultation, and

(b) if

(i) a poor compliance history is evident on the patient record,

(ii) drug misuse is suspected, or

(iii) the safety of the patient is in question due to the potential for overdose.

(3) If a registrant doubts the authenticity of a prescription, the registrant may refuse to dispense the drug.

(4) All drugs must be dispensed in a container that is certified as child-resistant unless

(a) the practitioner, the patient or the patient's representative directs otherwise,

(b) in the registrant's judgment, it is not advisable to use a child-resistant container,

(c) a child-resistant package is not suitable because of the physical form of the drug or the manufacturer's packaging is designed to improve patient compliance, or

(d) child-resistant packaging is unavailable, or

(e) the drugs are prescribed for medical assistance in dying.

(5) A registrant must not dispense a prescription more than one year from the prescribing date, except for oral contraceptives which may be dispensed for up to two years.

(6) Before dispensing a prescription product, a registrant must perform a final check and record his or her identity in writing.

(7) A pharmacy manager must ensure the record in paragraph (6) is readily available and retained for at least three years after the last date on which that prescription product was last dispensed.

Patient Record

11. (1) A patient record must be established and maintained for each patient for whom a Schedule I drug is dispensed.

(2) ~~The~~For purposes of subsection (1), the patient record must include

(a) the patient's full name,

(b) the patient's personal health number,

(c) the patient's address,

(d) the patient's telephone number if available,

(e) the patient's date of birth,

(f) the patient's gender,

(g) the patient's clinical condition, allergies, adverse drug reactions and intolerances if available including the source and date the information was collected,

(h) the date the drug is dispensed,

(i) the prescription number,

(j) the generic name, strength and dosage form of the drug,

(k) the drug identification number,

(l) the quantity of drug dispensed,

(m) the intended duration of therapy, specified in days,

(n) the date and reason for discontinuation of therapy,

(o) the directions to the patient,

(p) the identification of the prescribing practitioner,

(q) special instructions from the practitioner to the registrant, if appropriate,

(r) past and present prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,

(s) the identification of any drug therapy problem and the description of any action taken,

(t) the description of compliance with the prescribed drug regimen, and

(u) Schedule II and III drug use if appropriate.

(3) If a full pharmacist obtains a drug history from a patient, he or she must request and if appropriate record the following information on the patient record:

(a) medical conditions and physical limitations,

(b) past and current prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy,

(c) compliance with the prescribed drug regimen,

(d) Schedule II and III drug use.

(4) A full pharmacist must review the patient's personal health information stored on the PharmaNet database before dispensing a drug and take appropriate action if necessary with respect to any concern regarding the appropriateness of the drug or any drug therapy problem.

Pharmacist/Patient Consultation

12. (1) Subject to subsection (2), a full pharmacist must consult with the patient or patient's representative at the time of dispensing a new or

refill prescription in person or, where not practical to do so, by telephone.

(2) Where a patient declines the consultation, the full pharmacist must document that the consultation was offered and declined.

(3) The full pharmacist must conduct the consultation in a manner that respects the patient's right to privacy.

(4) The pharmacist/patient consultation for a new prescription must include:

(a) confirmation of the identity of the patient,

(b) name and strength of drug,

(c) purpose of the drug,

(d) directions for use of the drug including the frequency, duration and route of therapy,

(e) potential drug therapy problems, including any avoidance measures, and action recommended if they occur,

(f) storage requirements,

(g) prescription refill information,

(h) information regarding

(i) how to monitor the response to therapy,

(ii) expected therapeutic outcomes,

(iii) action to be taken in the event of a missed dose, and

(iv) when to seek medical attention.

(i) issues the pharmacist considers relevant to the specific drug or patient.

(5) The pharmacist/patient consultation for a refill prescription must include:

(a) confirmation of the identity of the patient,

(b) name and strength of drug,

(c) purpose of the drug,

(d) directions for use of the drug including frequency and duration,

(e) whether the patient has experienced a drug therapy problem.

(6) If a drug therapy problem is identified during patient consultation for a new or refill prescription, the full pharmacist must take appropriate action to resolve the problem.

(7) If an adverse drug reaction as defined by Health Canada is identified, the full pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record and report the reaction to the appropriate department of Health Canada.

Schedule II and III Drugs

13. (1) A registrant must not attribute a new prescription or refill for a Schedule II or Schedule III drug to a practitioner without the authorization of the practitioner.

(2) A pharmacist must offer to consult with the patient or the patient's representative regarding the selection and use of a Schedule II drug at the time of purchase.

(3) The pharmacist/patient consultation for a Schedule II drug must include potential drug therapy problems, including any avoidance measures, and action recommended if they occur.

(4) A pharmacist must be available for consultation with a patient or patient's representative respecting the selection and use of a Schedule III drug.

Sole Pharmacy Services Provider

14 The manager of a pharmacy may enter into an agreement with another person to be the sole provider of pharmacy services in a premise or part of a premise, if

(a) pharmacy services are provided in a manner that is consistent with the *Residential Care Facilities and Homes Standards of Practice,*

(b) patient therapeutic outcomes are monitored to enhance patient safety, and

(c) appropriate provision has been made for safe and effective distribution, administration and control of drugs.

Prohibition on the Provision of Incentives

15 (1) A registrant must not provide or distribute, or be a party to the provision or distribution of, an incentive 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.

(2) Subsection (1) does not prevent a registrant 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) Subsection (1) does not apply in respect of a Schedule III drug or an unscheduled drug, unless the drug has been prescribed by a practitioner.

Health Professions Act – BYLAWS

SCHEDULE F

PART 2 – Hospital Pharmacy Standards of Practice

Table of Contents

Application

1. This Part applies to all registrants providing pharmacy services in a hospital pharmacy or a hospital pharmacy satellite.

Definitions

2. In this Part:

"bulk/batch drug repacking" means the repackaging in a single process of multiple units, not for immediate use;

"bulk compounding" means the preparation of products which are not commercially available in anticipation of a practitioner's order;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established in Part 1 of this Schedule;

"final check" means ensuring that:

(a) the prescription product and the prescription product label match the product information with respect to:

(i) drug,

(ii) dosage form,

(iii) strength, and

(iv) quantity;

(b) the drug is not expired and will not expire within the duration of use; and

(c) a pharmacist has completed a clinical assessment of the prescription after reviewing the patient profile.

"hazardous drugs" means pharmaceutical preparations in which the concentration, toxicity, environmental persistence, degradation characteristics, flammability, corrosiveness, or reactivity represents a risk to the health of humans or other living organisms;

"hospital pharmacy" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"hospital pharmacy satellite" has the same meaning as in section 1 of the bylaws of the college under the *Pharmacy Operations and Drug Scheduling Act*;

"individual patient prescription system" means a form of drug distribution in which drugs are dispensed in patient-specific labelled drug containers;

"master formula" means a set of instructions outlining in detail the materials, equipment, and procedures required to produce a specific quantity of a product;

"multiple pouch packaging" means a pouch containing drugs to be administered at a particular time;

"unit dose distribution" means a form of drug distribution in which orders for each patient are dispensed individually and packaged in unit-of-use packages containing one dose;

"ward stock" means drugs that are stocked in a patient care area and are not labelled for a particular patient.

Drug Distribution

3. (1) The pharmacy's manager must establish a drug distribution system that

(a) provides drugs in identified dosage units ready for administration whenever possible and practical,

(b) protects drugs from contamination,

(c) provides a method of recording drugs at the time of administration, and

(d) eliminates or reduces the need to maintain ward stock.

(2) A unit dose, monitored dose, multiple pouch packaging or individual patient prescription drug distribution system must be used for dispensing drugs.

(3) Sterile products must be prepared and distributed in an environment that is in accordance with

(a) the Canadian Society of Hospital Pharmacists' Guidelines for Preparation of Sterile Products in Pharmacies,

(b) the USP Pharmaceutical Compounding – Sterile Products Guidelines, and

(c) such other published standards approved by the board from time to time.

(4) Hazardous drugs must be handled and prepared in accordance with the Requirements for the Safe Handling of Antineoplastic Agents in Health Care Facilities published by the Workers Compensation Board of British Columbia and such other published standards approved by the board from time to time.

Preparation of Prescription Product

3.1 (1) A registrant who prepares a prescription product must ensure that:

(a) the prescription product label matches the product information with respect to:

(i) drug,
(ii) dosage form,
(iii) strength,
(iv) quantity; and

(b) the drug is not expired and will not expire within the duration of use.

Patient Identification

3.2 Unless dispensing to staff, outpatients or the general public under section 4(5), all registrants must use at least two person-specific identifiers to confirm the identity of a patient before providing any pharmacy service to the patient.

Drug Label

4. (1) Drug container labels must include

(a) the generic name of the drug, strength and dosage form, and

(b) hospital approved abbreviations and symbols.

(2) Only hospital pharmacy staff may alter a drug container label.

(3) Inpatient prescription labels must include

(a) a unique patient name and identifier,

(b) the generic name of the drug, strength and dosage form,

(c) parenteral vehicle if applicable, and

(d) hospital approved abbreviations and symbols.

(4) The following information must be included on the inpatient prescription label if not available on the medication administration record:

(a) the frequency of administration;

(b) the route of administration or dosage form;

(c) auxiliary or cautionary statements if applicable;

(d) the date dispensed.

(5) All drugs dispensed to staff, outpatients or the general public from a hospital pharmacy or hospital pharmacy satellite must be labeled and dispensed according to the *Community Pharmacy Standards of Practice.*

(6) Prior to releasing a prescription product, a registrant must perform a final check of the prescription product and record his or her identity in writing as required by section 17.

Returned Drugs

5. (1) Unused dispensed drugs must be returned to the hospital pharmacy.

(2) Previously dispensed drugs must not be re-dispensed unless

(a) they are returned to the hospital pharmacy in a sealed dosage unit or container as originally dispensed,

(b) the labeling is intact and includes a legible drug lot number and expiry date, and

(c) the integrity of the drug can be verified.

Drug Transfer

6. A registrant who supplies a Schedule I drug to another registrant or practitioner must comply with section 8(3) and (4) of the *Community Pharmacy Standards of Practice.*

Inpatient Leave of Absence and Emergency Take-Home Drugs

7. (1) A system must be established to provide drugs to an emergency department short stay patient requiring take-home drugs, who is unable to obtain them from a community pharmacy within a reasonable time frame.

(2) All take-home drugs issued from the emergency department must be documented in the patient's health record.

(3) All inpatient leave of absence drugs must be documented in the patient's health record.

(4) Labels for inpatient pass and emergency department take-home drugs must include

(a) the hospital's name,

(b) the patient's name,

(c) the practitioner's name,

(d) the drug name, strength and directions for use,

(e) identification of the person preparing the drug, and

(f) the date the drug is issued.

(5) Drugs must be dispensed in a container that is certified as child-resistant unless

(a) the practitioner, the patient or the patient's representative directs otherwise,

(b) in the registrant's judgment it is not advisable to use a child-resistant container,

(c) a child-resistant package is not suitable because of the physical form of the drug or the manufacturer's packaging is designed to improve patient compliance, or

(d) child-resistant packaging is unavailable.

Investigational and Special Access Program Drugs

8. Registrants must comply with the policies and directives of Health Canada with respect to storage and dispensing of Special Access Program or investigational drugs.

Drug Repackaging and Compounding

9. (1) A registrant must supervise all bulk/batch drug repackaging and bulk drug compounding.

(2) Bulk/batch drug repackaging records must be kept for three years after the repackaging date.

(3) A master formula record must be kept for each bulk compounded drug product.

(4) A separate production record must be kept for each compounded bulk product and must include

(a) the date of compounding,

(b) the lot or batch number assigned to the compounded product,

(c) the manufacturer's name and lot number for each raw material used,

(d) ~~handwritten~~the identification of each registrant and pharmacy assistant involved in each step of the compounding process,

(e) the process including weights and measures performed,

(f) the results of all quality control testing,

(g) a statement of the final yield,

(h) signatures for final verification and authorization for release,

(i) a sample label, and

(j) the expiry date of the product.

(5) A production record must be kept for a period of three years after the expiry date of the compounded batch.

(6) A label must be affixed to the finished bulk/batch repackaged or bulk compounded drug and must contain

(a) generic name(s) of the drug,

(b) strength and quantity of active ingredients,

(c) dosage form,

(d) total amount of final product,

(e) expiry date of the compound,

(f) manufacturer identification and lot number or hospital pharmacy control number,

(g) storage conditions, if applicable,

(h) auxiliary labels, if applicable, and

(i) the name of the hospital.

Hospital Pharmacy Technicians

10. (1) Pharmacy technicians in a hospital pharmacy or hospital pharmacy satellite may prepare, process and compound prescriptions, including

(a) receiving and transcribing verbal prescriptions from practitioners,

(b) ensuring that a prescription is complete and authentic,

(c) transferring prescriptions to and receiving prescriptions from other pharmacies,

(d) ensuring the accuracy of a dispensed prescription,

(e) performing the final check of a dispensed prescription, and

(f) ensuring the accuracy of drug and personal health information in the PharmaNet patient record.

(2) Despite subsection (1), a pharmacy technician in a hospital pharmacy or hospital pharmacy satellite may dispense a drug but must not

(a) perform the task of ensuring the pharmaceutical and therapeutic suitability of a drug for its intended use,

(b) do anything described in

(i) sections 13, 15 or 16 of this Part

(ii) Part 4 of this Schedule, or

(c) dispense a drug pursuant to HPA Bylaws Schedule F, Part 5.

(3) A pharmacy technician must identify his or her registrant class in any interaction with a patient or a practitioner.

Hospital Pharmacy Assistants

11. Specific technical functions may be performed by a pharmacy assistant in a hospital pharmacy or hospital pharmacy satellite after the pharmacy's manager has established written procedures for performing the functions.

Patient Record

12. (1) The registrant must ensure the preparation and maintenance of patient records for each patient for whom drugs are prepared are complete, accurate and current, except patients admitted for less than 24 hours to

(a) surgical day care,

(b) ambulatory care,

(c) emergency short-stay, or

(d) other short-stay diagnostic or treatment units.

(2) The patient record must include

(a) the patient's full name and admission date,

(b) the hospital number and location,

(c) the patient's date of birth and gender,

(d) the attending practitioner's name,

(e) the patient's weight and height if applicable to therapy,

(f) the patient's allergies, adverse drug reactions, intolerances, and diagnoses,

(g) a chronological list of drugs which have been prescribed for the patient since admission to hospital, or, if admission is prolonged, for a minimum period of two years, and

(h) a list of all current drug orders including

(i) the drug name,

(ii) the drug strength,

(iii) the dosage,

(iv) the route,

(v) the dosage form,

(vi) intravenous diluent if applicable,

(vii) the directions for use,

(viii) administration time or frequency,

(ix) the attending practitioner,

(x) the quantity,

(xi) the start and stop date, or length of therapy, and

(xii) the date drug was dispensed, refilled or discontinued.

Patient Oriented Pharmacy Practice

13. (1) During pharmacy hours the full pharmacist must review the drug order before the drug is dispensed.

(2) The full pharmacist must check the drug order for

(a) the patient's name, hospital number and location,

(b) the signature of the practitioner,

(c) the name of the drug,

(d) the dosage form and strength,

(e) the route and frequency of administration,

(f) the duration of treatment if limited,

(g) directions for use,

(h) the date and time the order was written, and,

(i) in the case of verbal and/or telephone orders, the name and signature of the person who received the order.

(3) The full pharmacist must review the pharmacy patient record before dispensing the patient's drug and at appropriate intervals thereafter to assess

(a) appropriateness of therapy,

(b) drug interactions,

(c) allergies, adverse drug reactions and intolerances,

(d) therapeutic duplication,

(e) correct dosage, route, frequency and duration of administration and dosage form,

(f) contraindicated drugs,

(g) intravenous administration problems including potential incompatibilities, drug stability, dilution volume and rate of administration, and

(h) any other drug related problems.

(4) The full pharmacist must notify the patient's nursing staff immediately if a problem with a prescription for a ward stock item is discovered.

(5) The full pharmacist must monitor drug therapy to detect, resolve and prevent drug-related problems at a frequency appropriate for the medical condition being treated.

(6) Monitoring includes but is not limited to

(a) a review of the patient record and/or health record,

(b) discussion with the patient's practitioner and/or other appropriate individual, and

(c) use of physical assessment skills when trained to do so.

(7) The full pharmacist must provide drug information, including patient-specific information to patients and health care personnel.

(8) A full pharmacist, or a limited or student pharmacist under the direct supervision of a full pharmacist, must provide drug consultation to an outpatient or the outpatient's representative, or to an inpatient on request, and must

(a) confirm the identity of the patient,

(b) identify the name and strength of drug,

(c) identify the purpose of the drug,

(d) provide directions for use of the drug including the frequency, duration and route of therapy,

(e) discuss common adverse effects, drug and food interactions and therapeutic contraindications that may be encountered, including their avoidance, and the actions required if they occur,

(f) discuss storage requirements,

(g) provide prescription refill information,

(h) provide information regarding

(i) how to monitor the response to therapy,

(ii) expected therapeutic outcomes,

(iii) action to be taken in the event of a missed dose, and

(iv) when to seek medical attention, and

(i) provide other information unique to the specific drug or patient.

(9) If a full pharmacist requests a history from a patient or a patient's representative, the following information must be obtained:

(a) medical conditions and physical limitations;

(b) allergies, adverse drug reactions, and idiosyncratic responses;

(c) past and current prescribed drug therapy including the drug name, strength, dosage, frequency and duration and effectiveness of therapy;

(d) compliance with the prescribed drug regimen;

(e) Schedule II and III and unscheduled drug use.

(10) A full pharmacist must provide information about the assessment, management and prevention of drug poisoning within the hospital.

Medication Administration

14. (1) The registrant must collaborate with nursing and medical staff to develop written policies and procedures for the safe administration of drugs.

(2) A medication administration record of all prescribed drugs for each patient must be produced from the pharmacy-maintained patient record.

(3) The medication administration record must include

(a) the patient's full name and identification number,

(b) the patient's location in the hospital,

(c) the presence or absence of known allergies, adverse drug reactions, and intolerances,

(d) the date or period for which the drug administration record is to be used,

(e) the name, dosage and form of all drugs currently ordered,

(f) complete directions for use for all drugs,

(g) stop or expiry dates for drug orders for which there is an automatic stop policy (if not reported by another means),

(h) predetermined, standard medication administration times for regularly scheduled drugs, and

(i) changes to drug orders.

Residential Care

15. A full pharmacist providing pharmacy care to residential care patients residing in a facility that is not licensed under the *Community Care and Assisted Living Act* must

(a) use a monitored dosage, multiple pouch packaging or unit dosage system except where the form of the drug does not permit such packaging,

(b) restrict ward stock to drugs that do not have a high potential for toxicity or require a complex dosage titration, and are commonly prescribed on a "when needed" basis,

(c) maintain a current patient record for each patient,

(d) provide administration records of all current drugs for each patient from the pharmacy maintained patient record within seventy-two hours of admission and at least monthly thereafter,

(e) review each patient's drug regimen at least every six months preferably in the setting of multidisciplinary rounds, and

(f) maintain a written record of drug reviews in the patient's permanent health record, including the date of each review, identified concerns and recommendations.

Documentation

16. (1) The full pharmacist must document directly in the patient record all activities and information pertaining to the drug therapy of the patient.

(2) ~~The~~For the purposes of subsection (1), the documentation must include but is not limited to

(a) actual or potential drug-related problems that warrant monitoring,

(b) recommendations for changes in drug selection, dosage, duration of therapy, and route of administration,

(c) recommendations for monitoring the response to drug therapy,

(d) notations of consultations provided to other health care professionals about the patient's drug therapy selection and management,

(e) notations of drug-related patient education and/or consultation provided,

(f) clarification of drug orders and practitioner's telephone orders received directly by the registrant,~~ and~~

(g) allergies, adverse drug reactions and intolerances~~.~~, and

~~(g)~~(h) the full pharmacist's signature.

17. Documentation of the identity of any registrant who prepared a prescription product or performed a final check must be in writing, readily available and retained for at least three years after the date on which the prescription product was last dispensed.

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 23(1).

REPEAL

First approved: 18 Jan 1996 **PPP-12**
Revised: 11 Oct 2000 / 22 Jun 2001 / 1 Feb 2002 / 22 Nov 2002 / 20 Jun 2003 / 15 Apr 2011 / 17 Nov 2017
Reaffirmed: 27 Mar 2009

POLICY STATEMENT(S):

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

1. A computerized transaction log is maintained, or

2. A new prescription number is assigned and a new hard copy prescription is prepared.

Also see PPP-31

REPEAL

POLICY STATEMENT(S):

Pharmacists may exercise professional judgment in the provision of emergency prescription refill supplies of a medication. This practice is *the exception to the rule and not the normal practice*.

A pharmacist may dispense an emergency refill in the following situations;

- where a patient's medication supply has been exhausted, a refill may be dispensed to ensure continuity of care. OR
- where a patient attends the pharmacy for an authorized refill of a valid prescription but PharmaNet returns the message, '101 Prescriber not found' or 'D3 Prescriber is not authorized' and the pharmacist ensures that the patient is not on Pharmacare's *Restricted Claimants Program*, a refill may be dispensed to ensure continuity of care and to allow time for the patient to find a new prescriber.

The pharmacist must comply with each of the following practice fundamentals;

1. **Individual competence**
   a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.
2. **Appropriate information**
   a. Pharmacist has sufficient information about the specific patient's health status to ensure that dispensing an emergency refill of the prescription will ensure continuity of care and will not put the patient at increased risk.
3. **Appropriateness**
   a. Pharmacist must use their professional judgment to determine whether provision of an emergency refill is appropriate in the circumstances, and must determine an appropriate days supply based on the drug involved and how long it will take the patient to see a prescriber.
4. **Informed consent**
   a. Pharmacist must obtain the informed consent of the patient or patient's representative before undertaking an emergency refill.
5. **Documentation**
   a. Pharmacists must use their CPBC pharmacist registration numbers in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.
   b. Pharmacists must document in the client's record any emergency refill of the prescription, the rationale for the decision, and any appropriate follow-up plan.

BACKGROUND:

Protocol for provision of an emergency prescription refill

This professional practice policy enables pharmacists to exercise their professional judgment and education by providing authorization to provide an emergency prescription refill to ensure continuity of patient care until the prescriber can be contacted for authorization. This policy is not mandatory and the decision of whether to provide an emergency prescription refill is at the discretion of the individual pharmacist.

~~*Also see PPP-20*~~

POLICY STATEMENT(S):

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

1. **Individual competence**
   a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

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

3. **Prescription**
   a. Pharmacist has a prescription that is current, authentic, and appropriate.

4. **Appropriateness**
   a. Pharmacist determines whether adapting the prescription is appropriate in the circumstances.

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

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

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

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

BACKGROUND:

Protocol for medication management (adapting a prescription)

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

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

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

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

Benefits of professional practice policy

The benefits to clients are to:

a) Optimize drug therapy leading to improved client health outcomes
   1) Better therapeutic responses.
   2) Reduced drug errors.
   3) Fewer adverse drug reactions/interactions.

b) Have an effective and efficient health care system
   1) Minimize delays in initiating and changing drug therapy.
   2) Make the best use of human resources in the health care system.

c) Expand the opportunities to identify people with significant risk factors.

d) Encourage collaboration among health care providers.

Supporting documents

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

First approved: 21 Sep 2007
Revised: 14 Sep 2018
Reaffirmed: 27 Mar 2009

SCHEDULE OF AMENDMENTS

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended to clarify responsibilities relating to record keeping, and in particular electronic record keeping, as follows:

1. The following new definition has been added after the definition of **"drug"**:

   "electronic signature" means

   (a) information in electronic form that a person has created or adopted in order to sign a record, other than with respect to a prescription signed by a full pharmacist for the purpose of prescribing, that is in, attached to or associated with a record, is secure and is only reproducible and used by that person; and,
   (b) with respect to a prescription signed by a full pharmacist for the purpose of prescribing, the electronic signature must meet the requirements of paragraph (a) and must be a unique mark personally applied by that pharmacist;

2. The following new definition has been added after the definition of **"professional service area"**:

   "record" has the same meaning as the definition of record in Schedule 1 of the *Freedom of Information and Protection of Privacy Act*.

3. The following new definition has been added after the definition of **"Schedule I, Schedule IA, Schedule II, or Schedule III"**:

   "signature" on a record means either a handwritten signature in ink or an electronic signature;

4. The following section has been added after section 18.(2)(j):

   (j.1) ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction;

5. Section 23.(3) has been added under section 23.(1) and "(2)" is substituted for "(3)":

   (2) Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices and documentation as described in subsection (1) until the completion of any audit or investigation for which the registrant has received notice.

6. Section 23.(2) is amended by striking out "(2)" and substituting "(3)".

7. The following new sections have been added after section 23.:

   23.1.(1) All records required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval.

(2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately.

(3) For purposes of subsection (2):

(a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and

(b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.

(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.

(5) Prescriptions stored electronically must accurately reflect the original prescription, including the original colour composition of that prescription.

23.2.(1) A pharmacy manager must ensure that a policy is in place that:

(a) describes the pharmacy's records filing system, the records format and the method and system for storing records,

(b) is compliant with the sections 23.1, 23.2 and 23.3 requirements; and

(c) is readily accessible to and understood by pharmacy staff.

(2) With respect to electronic records, the policy must include a description of the process for the preservation, storage and backing up of records that is compliant with section 23.3 requirements.

23.3.(1) A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of records that are required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy.

(2) For purposes of subsection (1), the equipment, software and systems must:

(a) be capable of storing the electronic records for the periods required by applicable law;

(b) keep the records secure from unauthorized access, use, disclosure, modification and destruction;

(c) for audit purposes, be capable of uniquely identifying each time an electronic record is accessed and modified;

(d) be capable of restricting the functions that may be used by an authorized person;

(e) be capable of tracing alterations to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration;

(f) be capable of searching and sorting electronic prescription records chronologically, and by drug name, drug strength, patient, prescriber, prescription number and transaction number;

(g) ensure that electronic records can be stored, backed up and recovered in accordance with subsection (3); and,

(g) provide for a deliberate and auditable procedure to be carried out by the pharmacy manager or by an authorized person prior to the destruction of any electronic record that includes information identifying the pharmacy manager or authorized person who destroyed the record and the date, time and reason for its destruction.

(3) A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily and that such electronically preserved and backed up records are stored:

(a) in a location resistant to environment perils including but not limited to fires and floods;

(b) so that they are secure from unauthorized access, use, modification, destruction and disclosure; and,

(c) in a manner that would enable the backed up records, once restored, to be compliant with section 23.1(1) requirements.

(4) Notwithstanding subsections (1), (2) and (3), a pharmacy that presently stores electronic records has six months from the date this section comes into effect to bring itself into full compliance with the requirements of subsections (1), (2) and (3).

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 clarify responsibilities relating to record keeping, and in particular electronic record keeping, as follows:

1. The following new definition has been added after the definition of **"controlled drug substance"**:

   "controlled prescription program" has the same meaning as in section 1 of the *Pharmacy Operations and Drug Scheduling Act* Bylaws;

2. The following new definition has been added after the definition of **"elected board member"**:

   "electronic initial" means

   (a) information in electronic form that a person has created or adopted in order to initial a record, other than with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, that is in, attached to or associated with a record, is secure and is only reproducible and used by that person; and
   (b) with respect to a prescription initialed by a full pharmacist for the purpose of prescribing, the electronic initial must meet the requirements of paragraph (a) and must be a unique mark personally applied by that pharmacist;

3. The following new definition has been added after the definition of **"in good standing"**:

   "initial" on a record means either an original handwritten initial or an electronic initial;

4. The definition of **"record"** has been amended by striking out "means a record", "defined", "Schedule" and "*Freedom of Information*" and "*Protection of Privacy*" and substituting "has the same meaning", "section", "*Pharmacy Operations*", "*Drug Scheduling"* and "Bylaws" to read as follows:

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

5. The following new definition has been added after the definition of **"Regulation"**:

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

6. The following new section has been added after section 65:

   Record Keeping

   65.1(1) All records required to be kept under the bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete and filed systematically by a registrant in a

manner that is secure, auditable and allows for easy retrieval.

(2) Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately.

(3) For purposes of subsection (2):

(a) prescriptions for oral contraceptives are valid for a period of up to two years from the prescribing date; and

(b) prescriptions other than for oral contraceptives are valid for a period of up to one year from the prescribing date.

(4) With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.

(5) Prescriptions stored electronically must accurately reflect the original prescription, including the colour composition of that prescription.

(6) A registrant who creates and stores electronic records must do so using the equipment, software and systems prescribed by subsections 23.3(1) and 23.3(2) of the *Pharmacy Operations and Drug Scheduling Act* Bylaws.

7. Section 69 has been amended by adding "(1)" before "The registrant must".

8. The following new section has been added after section 69.(1):

(2) In addition to correcting personal information in a record in accordance with section 70, a registrant who discovers an error or omission in such a record must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record, the date of the amendment and the reasons for the amendment.

9. Section 70.(2) has been repealed and replaced with the following sections:

(2) If, after receiving a request for correction under subsection (1):

(a) 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; or,

(b) the registrant agrees that there is an error or omission in the record, the registrant must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending

the record, the date of the amendment, and the reasons for the amendment.

10. Section 75 is amended by striking out “referred to in section 74” and adding “or destroyed” after “disposed of”.

11. Sections 75.(b) and (c) are repealed and replaced with the following section:

(b) destroying the records in a manner that ensures that they cannot be reconstructed.

SCHEDULE OF AMENDMENTS

Schedule F – Part 1 – Community Pharmacy Standards of Practice of bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended for minor corrections and to clarify registrant responsibilities surrounding certain records, as follows:

1. Section 6.(9)(a) is amended by striking out "(a)" and the word "may".

2. Section 6.(9)(a)(i) is amended by striking out "(i)" and substituting "(a)" and adding the word "may" before "accept" as well as the word "and" after "direction".

3. Sections 6.(9)(a)(ii) and 6.(9)(a)(iii) are repealed.

4. Section 6.(9)(b)(iii) is amended by striking out "if a renewal authorization involves a different drug identification number, practitioner or directions for use".

5. Section 11.(2) is amended by striking out "the" and substituting "For the purposes of section (1), the" before "patient record".

SCHEDULE OF AMENDMENTS

Schedule F – Part 2 – Hospital Pharmacy Standards of Practice of bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended for minor corrections and to clarify registrant responsibilities surrounding certain records, as follows:

1. Section 9.(4)(d) is amended by striking out “handwritten” and substituting “the” before “identification”.

2. Section 16.(2) is amended by striking out “the” and substituting “For the purposes of section (1), the” before “documentation”.

3. Section 16.(2)(f) is amended by striking out “and” after “registrant,”.

4. Section 16.(2)(g) is amended by striking out the period and substituting a comma and the word “and”.

5. The following new section is added after section 16.(2)(g):

    (h) the full pharmacist’s signature.

College of Pharmacists of British Columbia

5. Legislation Review Committee

Jeremy Walden

Chair, Legislation Review Committee

College of Pharmacists of British Columbia

5 a) Committee Update

College of Pharmacists of British Columbia

Committee Update

August 15, 2018 Meeting

Consent Agenda Items:

- PODSA Phase 2 Update
- PODSA Fee Changes
- PPP Housekeeping Amendments

Regular Agenda Items:

- Electronic Recordkeeping

College of Pharmacists of British Columbia

Committee Update, continued

Key Upcoming Committee Work

- Amendments to the Drug Schedules Regulation

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

College of Pharmacists of British Columbia

Background

- In February 2018, the Board approved publicly posting electronic record keeping bylaw amendments for a period of 90 days.
- The bylaws would create a new records management framework, which would allow retention of electronic and/or hard copy records.

College of Pharmacists of British Columbia

Background, continued

Proposed Electronic Record Keeping Requirements:

- Electronic record keeping: ***Optional***
- Minimum technology requirements: ***Mandatory***
- New general record keeping requirements: ***Mandatory***
  - Written record keeping policy
  - Records must be readable complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval

College of Pharmacists of British Columbia

Bylaws and Policies Affected

Amendments to the Following Bylaws and Policies are Proposed:

- PODSA Bylaws
- HPA Bylaws
  - Community Pharmacy Standards of Practice
  - Hospital Pharmacy Standards of Practice
- PPP-12 Prescription Hard Copy File Coding System *(to be rescinded)*
- PPP-20 Prescription Refills *(to be rescinded)*

College of Pharmacists of British Columbia

Bylaws and Policies Affected, continued

Consequential Amendments to the Following Policies are Proposed:

- PPP-31 Emergency Prescription Refills
- PPP-58 Medication Management (Adapting a Prescription)

College of Pharmacists of British Columbia

Public Posting Comments

- 8 responses were received during the public posting period.
- Based on the responses received, staff recommend minor clarification amendments to the bylaws, but no substantive amendments.

College of Pharmacists of British Columbia

Public Posting Comments, continued

Highlights from the public posting comments include the following:

Feedback	Response/Recommendation
• The definitions of “electronic signature” and “electronic initials” are unclear. • Questioned the requirement for pharmacists to apply signatures by hand when prescribing.	• Revised definitions for clarification. • Pharmacists should have same signature requirements as other practitioners when prescribing.
• The requirement that records must be “readable, complete, filed systematically and maintained in a manner that is secure, auditable and allows for easy retrieval” is not sufficiently prescriptive.	• No change recommended. • College is taking principle-based approach to these bylaws. • College believes that terms are sufficiently clear. • Clarification can be provided in guidance document.

College of Pharmacists of British Columbia

Public Posting Comments, continued

Feedback	Response/Recommendation
• Requiring colour scanning of prescriptions stored electronically will result in increased costs, and disrupt work flow. • Commenters questioned the need for colour scanning.	• Revised for clarification. • Colour scanning helps to verify the authenticity of a prescription and identify prescription forgery and tampering. • Pharmacies will not be required to scan if they continue to retain prescription hard copies. • Additional costs are expected to be minimal.
• The computer systems requirements are not sufficiently prescriptive.	• No change recommended. • Technology is constantly changing and the Bylaws would quickly become outdated if specific technical requirements were prescribed.

College of Pharmacists of British Columbia

Public Posting Comments, continued

Feedback	Response/Recommendation
• The College should adopt NAPRA's Pharmacy Practice Management Systems (PPMS) guidelines.	• No change recommended. • The Bylaws are fairly consistent with NAPRA's PPMS, but PPMS goes beyond what College requires, and some those requirements are out of scope.
• Retention of hard copies of Controlled Prescription Program prescriptions is unnecessary. The scanned copy should be sufficient.	• No change recommended. • Maintaining hard copies of CPP prescriptions is needed to verify the authenticity of a prescription and identify prescription forgery and tampering. • The College will engage the CPP Advisory Committee on this issue.

College of Pharmacists of British Columbia

Filing – September 2018

- Comments and recommendations shared with Ministry of Health and PharmaCare Audit.
- It is recommended that:
  - Minor clarification amendments be made to the bylaws.
  - The bylaws be filed with the Minister of Health for a period of 60 days, after which they would come into force.
  - PPP-12 and PPP-20 be rescinded, effective on the day that the bylaws come into force.
  - Consequential amendments be made to PPP-31 and PPP-50, effective on the day that the bylaws come into force.

College of Pharmacists of British Columbia

Proposed Timeline (subject to Board approval)

Date	Action
September 2018 to November 2018	60 day filing period with Minister of Health
November 2018	Amendments to PODSA and HPA Bylaws come into force; Amendments to PPPs become effective
May 2019	End of transition period for meeting new technology requirements

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

MOTION #1:

Approve the following resolution to amend the bylaws made under the Pharmacy Operations and Drug Scheduling Act and the Health Professions Act regarding electronic record keeping:

"RESOLVED THAT, in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act ("PODSA") and section 19(1) of the Health Professions Act ("HPA"), and subject to filing with the Minister as required by section 21(4) of PODSA and section 19(3) of HPA, the Board of the College of Pharmacists of BC approves the proposed bylaws made under PODSA and HPA relating to electronic record keeping for filing with the Minister of Health, as set out in the schedules attached to this resolution."

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

MOTION #2:

Approve rescinding Professional Practice Policy-12 Prescription Hard Copy File Coding System, effective on the date that the amended bylaws come into force.

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

MOTION #3:

Approve rescinding Professional Practice Policy-20 Prescription Refills, effective on the date that the amended bylaws come into force.

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

MOTION #4:

Approve consequential amendments to Professional Practice Policy-31 Emergency Prescription Refills, as circulated, effective on the date that the amended bylaws come into force.

College of Pharmacists of British Columbia

5 b) Electronic Record Keeping

MOTION #5:

Approve consequential amendments to Professional Practice Policy-58 Medication Management (Adapting a Prescription), as circulated, effective on the date that the amended bylaws come into force.

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

6. British Columbia's Approach to Cannabis Legalization and Regulation

INFORMATION ONLY

Presenter's Biography

Mary Shaw, Executive Director, Cannabis Legalization and Regulation Secretariat

Mary Shaw is the Executive Director of British Columbia's Cannabis Legalization and Regulation Secretariat (the Secretariat), within the Policing and Security Branch of the Ministry of Public Safety and Solicitor General. The Secretariat is responsible for coordinating the provincial government's planning for the safe implementation of legalized non-medical cannabis. Mary and her team led the development of the Cannabis Control and Licensing Act and Cannabis Distribution Act, both recently passed by the B.C. legislature.

Presentation Synopsis

In anticipation of federal legalization of non-medical cannabis on October 17, 2018, the B.C. Legislature has enacted the Cannabis Control and Licensing Act and the Cannabis Distribution Act. These statutes establish a provincial regulatory framework that reflects the Province's priorities of protecting children and youth, promoting health and safety, keeping the criminal element out of cannabis, keeping B.C. roads safe, and supporting economic development. This presentation provides an overview of the regulatory framework, and addresses the BC retail system, rules for possession, use and home cultivation, enforcement, and the existing federal scheme for medical cannabis that will remain in place after non-medical cannabis legalization.

BRITISH COLUMBIA'S APPROACH TO CANNABIS LEGALIZATION AND REGULATION

College of Pharmacists of BC – September 14, 2018

Ministry of Public Safety & Solicitor General

BRITISH COLUMBIA
BC Public Service

Federal Cannabis Regime

Cannabis Act

- In force October 17, 2018
- Regulates cannabis production and producers
- Carves out a space for legal regulated non-medical cannabis, but many activities related to cannabis will continue to be criminal
- Maintains existing system for medical cannabis
- Authorizes sale of dried cannabis and oil; edibles will be legal within a year

BC Cannabis Regime

3 pieces of legislation:

- *Cannabis Control and Licensing Act*, SBC 2018 c. 29
  - Private retail regime; provincial age limit; restrictions on possession, public use and personal cultivation; enforcement; and provincial offences
- *Cannabis Distribution Act*, SBC 2018 c. 28
  - Authorizes exclusive provincial distribution and public retail sales
- Amendments to the *Motor Vehicle Act* (the *MVA*), SBC 2018, c. 18
  - Extends GLP zero tolerance to cannabis; new 90 day ADP for drug-affected driving

BC Cannabis Regime

Minimum age

- Minimum age is 19. Legislation prohibits:
  - Possession by a person under 19
  - Selling or giving cannabis to a person under 19
  - Allowing a person under 19 to enter a cannabis store
  - Allowing a person under 19 to work in a cannabis business
  - Allowing a person under 19 to consume cannabis
  - Using fake ID to buy cannabis
- Contraventions are provincial regulatory offences, not criminal offences

BC Cannabis Regime

Personal possession

- Public possession limit – 30 grams dried cannabis or equivalent
- Private possession limit – to be prescribed in regulation (based on reasonable yield from four plants)
- Cannabis transported in a motor vehicle must be in a sealed package, or inaccessible to vehicle occupants

BC Cannabis Regime

Places of use

- Cannabis smoking and vaping will be permitted in most public spaces where tobacco smoking and vaping are allowed
- No cannabis smoking and vaping in places that children commonly gather – playgrounds, parks, sports fields, outdoor pools
- No restriction on public use of non-inhaled forms, except in vehicles and on school property
- Local governments can set additional restrictions, as they do with tobacco
- Some details to be set out in regulations – e.g., restrictions in provincial parks

BC Cannabis Regime

Personal cultivation

- Adults can grow up to four plants per household
- Plants must not be visible from a public place off the property
- No home cultivation in licensed home daycares
- Additional restrictions can be imposed by regulation
- Local governments can also set additional restrictions

BC Cannabis Regime

Medical Cannabis

- Federal government will continue to oversee a separate medical cannabis system under which authorized medical users can buy or grow cannabis or have it grown for them by a designated producer
- Medical users will have to comply with BC rules on cannabis possession, public use, and cultivation, with some exceptions as required by the Charter or human rights legislation
- Medical users will need to carry evidence of their authorization to be eligible for those exemptions

BC Cannabis Regime

Distribution and retail

- Provincially-run wholesale distribution system
- Public and private retail – local governments can choose public, private, a mix, or no retail stores
- Standalone stores that do not sell other retail goods
- Retail licensing regime similar to liquor
- Liquor and Cannabis Regulation Branch currently considering private retail applications
- Public retail – online sales; first public store in Kamloops
- Licence applicants must pass a background check and obtain local or Indigenous government support
- Cannabis workers will also have to register and pass a background check

BC Cannabis Regime

Enforcement

- Licensed and unlicensed cannabis retailers will be subject to compliance and enforcement provisions similar to liquor

  These could include:

  - inspection, search, seizure of illegal product
  - imposition of terms and conditions on licences
  - licence suspension or cancellation
  - administrative monetary penalties
  - prosecution of an offence

BC Cannabis Regime

Enforcement (continued)

- Liquor and Cannabis Licensing Branch will be responsible for compliance and enforcement for licensed retailers
- Community Safety Unit will be responsible for enforcement for illegal sellers (dispensaries, illegal online sales, pop-up stores)
- Illegal sale of cannabis is and will continue to be a criminal offence, but the hope is that the provincial regulatory scheme will provide efficient and effective tools to deal with illegal sales

BC Cannabis Regime

Questions?

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

7. Transformative Leadership to achieve First Nations Health and Wellness

INFORMATION ONLY

Presenter's Biography

Joe Gallagher, Chief Executive Officer, First Nations Health Authority

Joe Gallagher, Kwunuhmen, is Coast Salish of Tla'Amin First Nation ancestry and serves as the Chief Executive Officer for the First Nations Health Authority. Over the past decade, Mr. Gallagher was a lead in the formation of a new health governance partnership between BC First Nations, the province of BC, and the government of Canada which included the negotiation of the successful transfer of federal health services to BC First Nations control. This work, a first for Canada, led to the formation of the First Nations Health Authority, a wellness organization driven by the First Nations holistic and traditional perspective of health and wellness. A senior leader in health for the past 10 years, Joe brings over 25 years' experience in community development, intergovernmental affairs and negotiations. Throughout his career, Joe has worked with all levels of government, First Nations communities and organizations in both rural and urban settings.

First Nations Health Authority
Health through wellness

The FNHA/CPBC and Cultural Safety & Humility

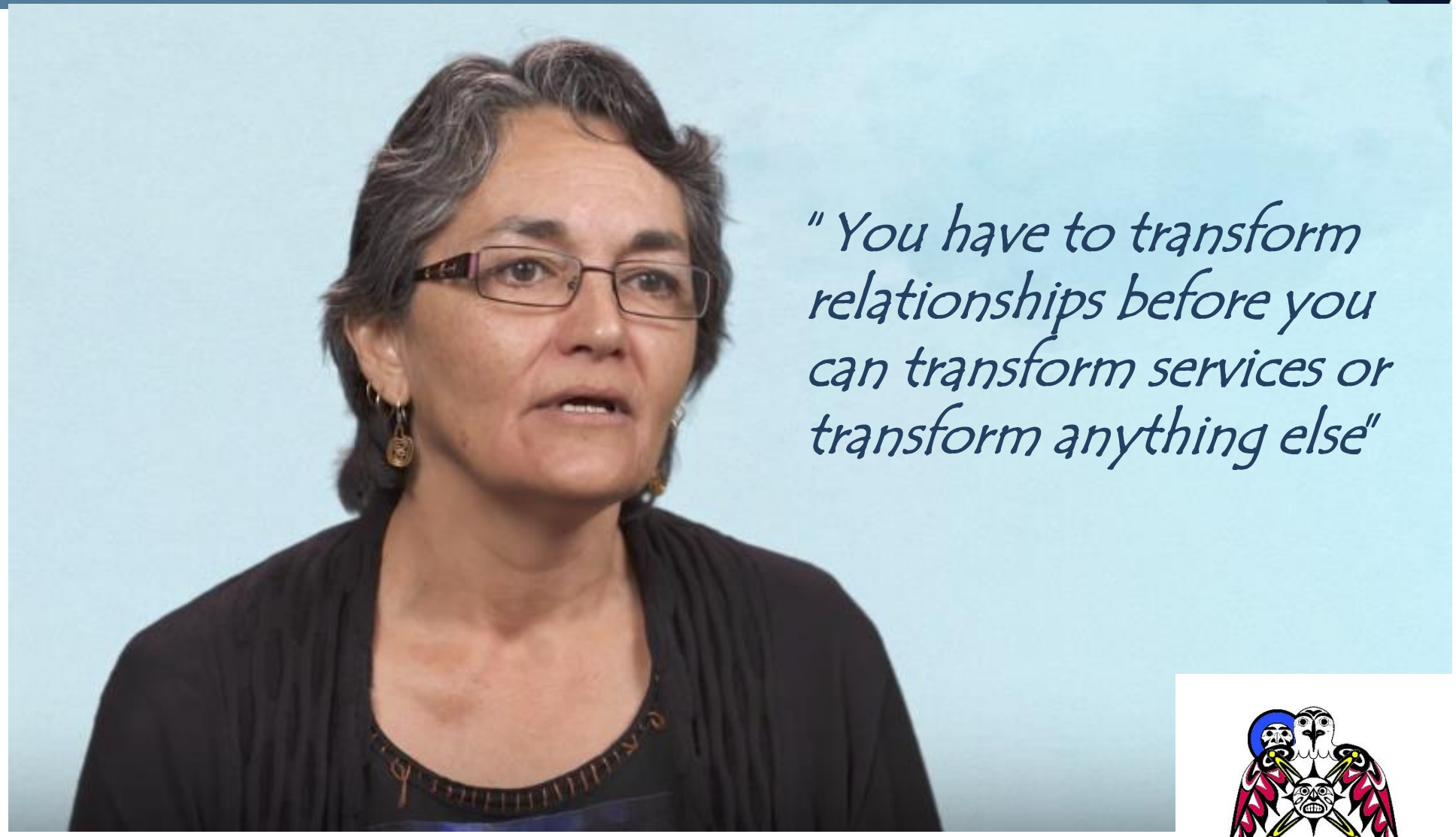
Transformative Leadership to achieve First Nations Health & Wellness

September 14, 2018

Kwunuhmen, **Joe Gallagher**
Tla'amin Nation
CEO, First Nations Health Authority


VICTORIA
RACISM IN HEALTH CARE
The National
00:27 / 02:41

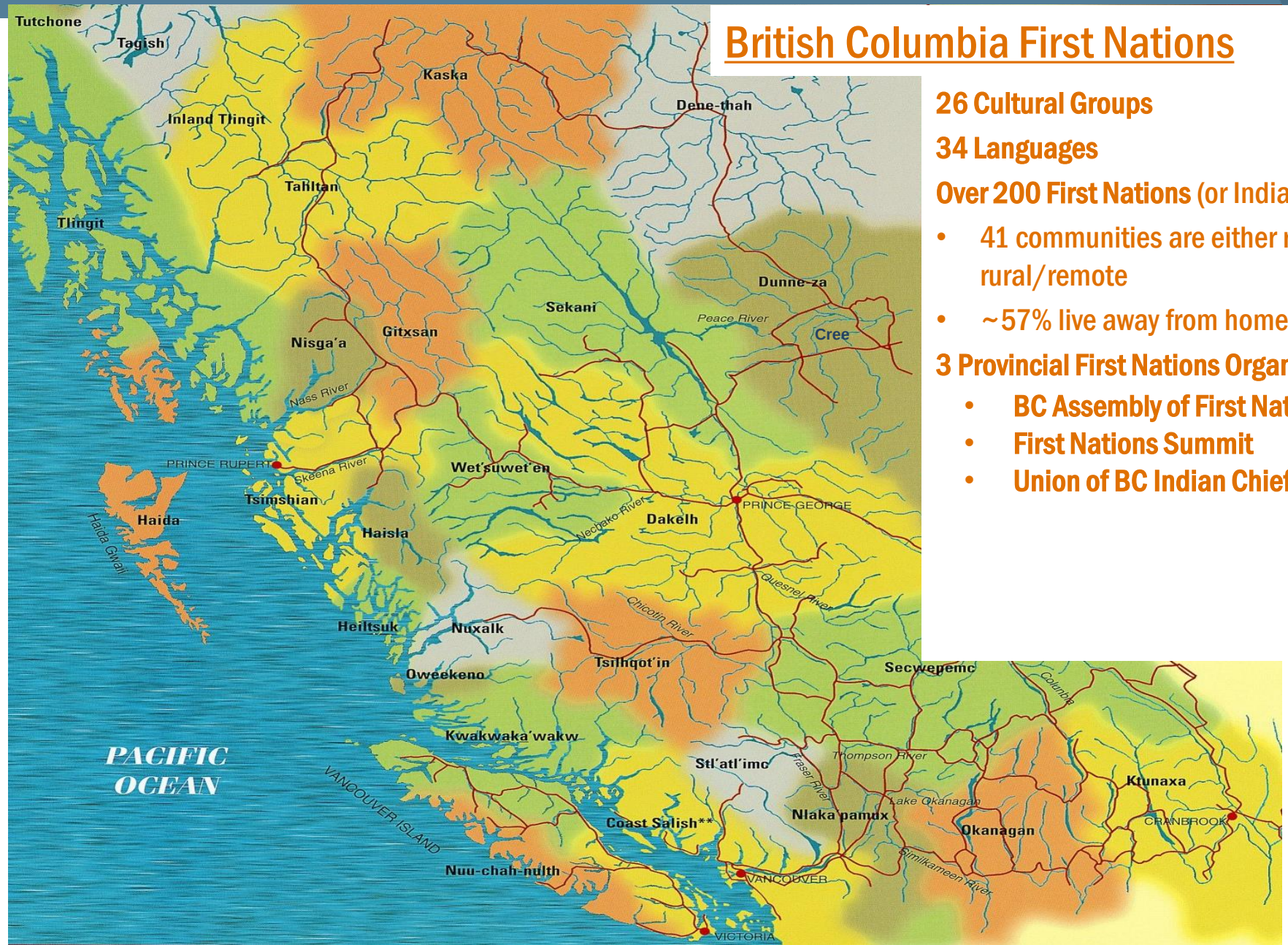
Systemic Racism



Gwen Phillips, *Ktunaxa Nations,*
First Nations Health Council – Interior Region

First Nations Health Council

British Columbia First Nations



26 Cultural Groups

34 Languages

Over 200 First Nations (or Indian Bands)

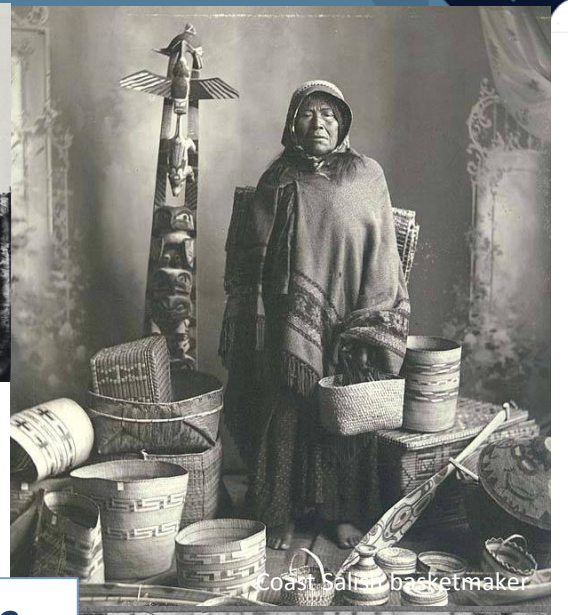
- 41 communities are either rural or rural/remote
- ~57% live away from home

3 Provincial First Nations Organizations

- **BC Assembly of First Nations**
- **First Nations Summit**
- **Union of BC Indian Chiefs**


Kwakwaka'wakw women & children


K'uuna village, Haida Gwaii


Coast Salish basketmaker

Terra Nullius *- Latin term "empty & uninhabited land"*

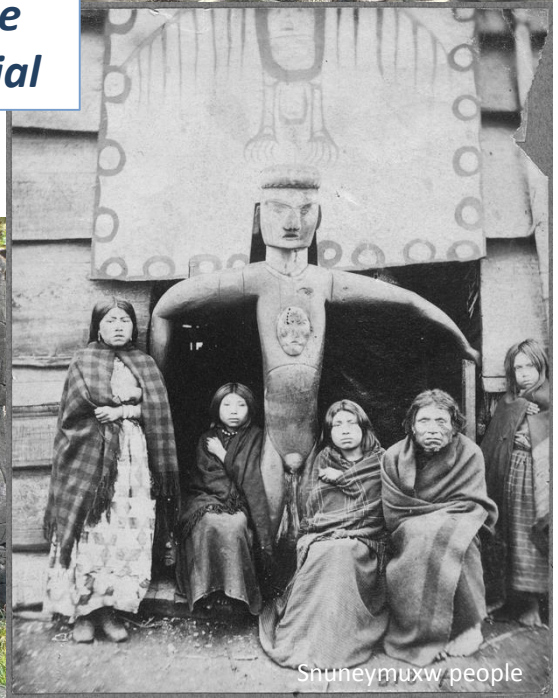
- *Policy and legislation to remove First Nations people from the land*
- *Policy and legislation designed to "Kill the Indian in the child"*

Since time immemorial


Kwakwaka'wakw & Tla-o-qui-aht men in regalia

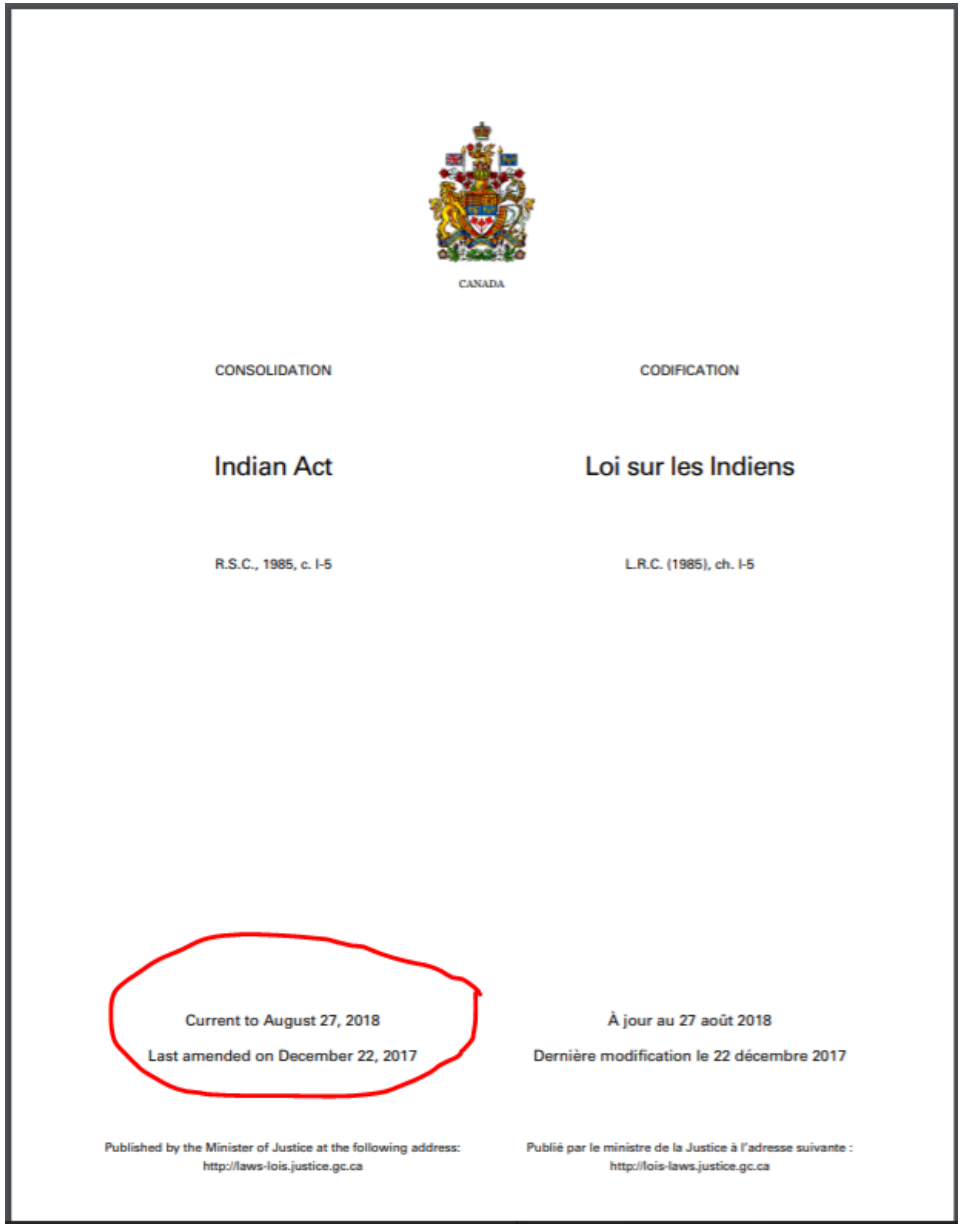

Kwakwaka'wakw wedding party


K'ak'awin petroglyphs (Hupacasath)


Snuneymuxw people

The Indian Act, 1876

- **Current** (a living legislation that continues to control Indigenous peoples' lives)
- **Segregation** (created reserves, Indian hospitals, Residential Schools, pass systems)
- **Imposition of foreign governance** (eg. Band councils, denied women status until 1985)
- **Denied access to Justice** (denied voting rights, prohibited legal action until 1951)
- **Cultural genocide** (removal of children, ceremonies and potlatches outlawed until 1951)



CANADA

CONSOLIDATION

CODIFICATION

Indian Act

Loi sur les Indiens

R.S.C., 1985, c. I-5

L.R.C. (1985), ch. I-5

Current to August 27, 2018

Last amended on December 22, 2017

À jour au 27 août 2018

Dernière modification le 22 décembre 2017

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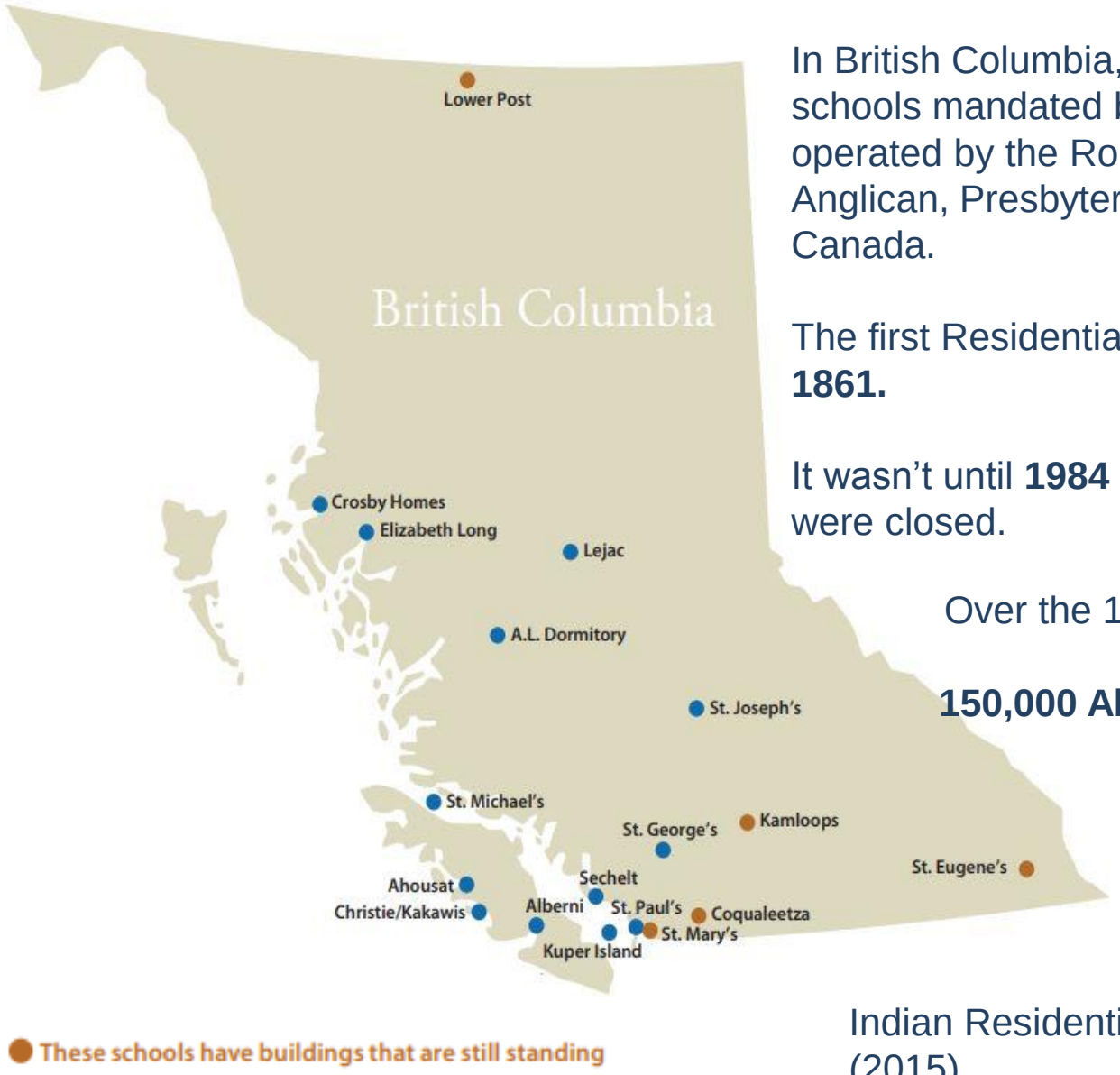


In British Columbia, there were 21 residential schools mandated by the federal government and operated by the Roman Catholic, Methodist, Anglican, Presbyterian, and United Churches of Canada.

The first Residential School in BC was introduced **1861.**

It wasn't until **1984** that all residential schools in BC were closed.

Over the 135 years of residential schools across Canada:
150,000 Aboriginal children were taken

Estimated reported number of residential schools student deaths: **Over 6,000**

Indian Residential School Survivors: **80,000** (2015)

The Nanaimo Indian Hospital, 1946 - 1967

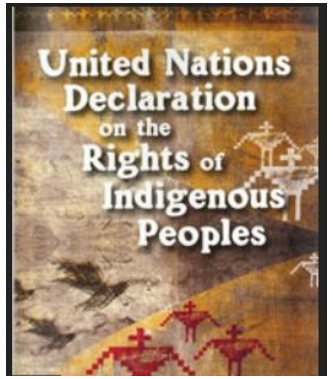
The Coqualeetza Indian Hospital, 1941-1969

Miller Bay Indian Hospital, 1946 - 1971

Since 1941, **29 Indian Hospitals** were federally run across Canada. (**3 in BC).**

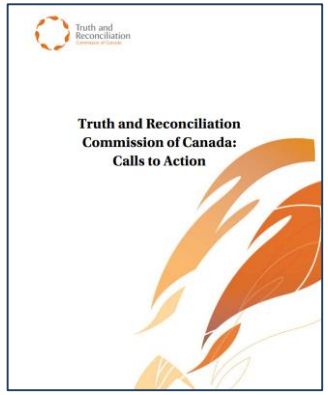
- **Segregated** (admission of patients based on Indian status, rather than disease).
- **Medical experiments w/o consent** (vaccine trials on infants).
- **Western Medicine only** (did not provide or allow for Indigenous medicines, midwives or holistic notions of illness and its treatment). Medical training programs for Indigenous people in the Indian hospitals were not created.
- **Indian Act amended in 1953 to include Indian Health Regulations**
  - Illegal for Indigenous people to refuse to see a doctor, to refuse to go to hospital, and to leave the hospital before discharge.
  - RCMP would arrest patients and return them to hospital or take them to jail
- If a patient died at a hospital, the government would not pay to return those who died to their communities unless the family paid. Many were buried in nearby cemeteries in unmarked graves.

Federal and Provincial Governments committed to implement the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Truth and Reconciliation Commission Report (TRC).



UNDRIP adopted as a framework for reconciliation and its articles provides for:

- **Right to self-determination and self-government**
- **Right to participate in decision-making through representatives of their own choosing and through their own processes, and maintain indigenous decision-making institutions**
- **Right to be actively involved in developing and determining health and as far as possible to administer such programs through their own institutions**



In BC, First Nations have established and agreed to work through a collective First Nations health governance structure which provides for the FNHA and has begun to address many of the TRC calls to action.

“We are at a pivotal moment in our collective history, one where we have a unique opportunity to mature as a society. We are now entering a post-colonial era. This country is founded and built on a very solid foundation of Indigenous people. We will no longer be invisible in our own land.”

-Chief Ian Campbell, Squamish Nation

Relationships - Amongst Ourselves & with our Partners

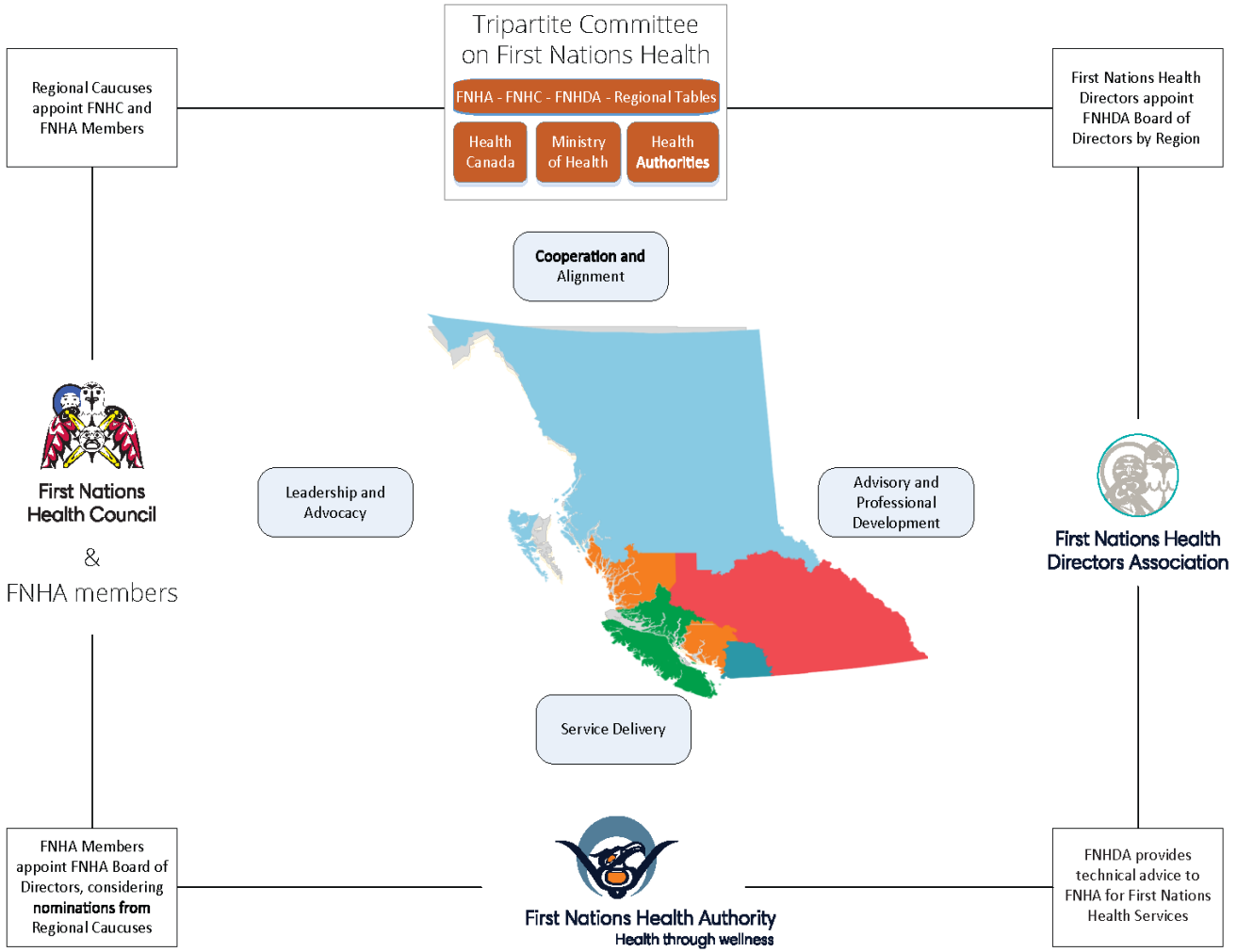
A series of progressive political, legal and operational agreements incrementally building a true health partnership

First Nations **consensus-based, collective decision-making.**
Process of Nation-rebuilding through **collective governance.**

"The health & wellbeing of my people depends on how well I work with each & every one of you in this room."

-Chief Douglas White III
Kwulasuitun

First Nations Health Governance Structure



Reciprocal accountability: Work at all levels to achieve our shared goals, living up to our individual and collective commitments.

Each Partner is accountable to the others for its actions, and for the effective implementation and operation of their responsibilities and systems, recognizing that our work as Partners is interdependent and interconnected.

We strive not only to live up to one another's expectations, but to exceed them.

Our Common Foundation

Our Shared Vision

Healthy, self-determining and vibrant, BC First Nations children, families and communities

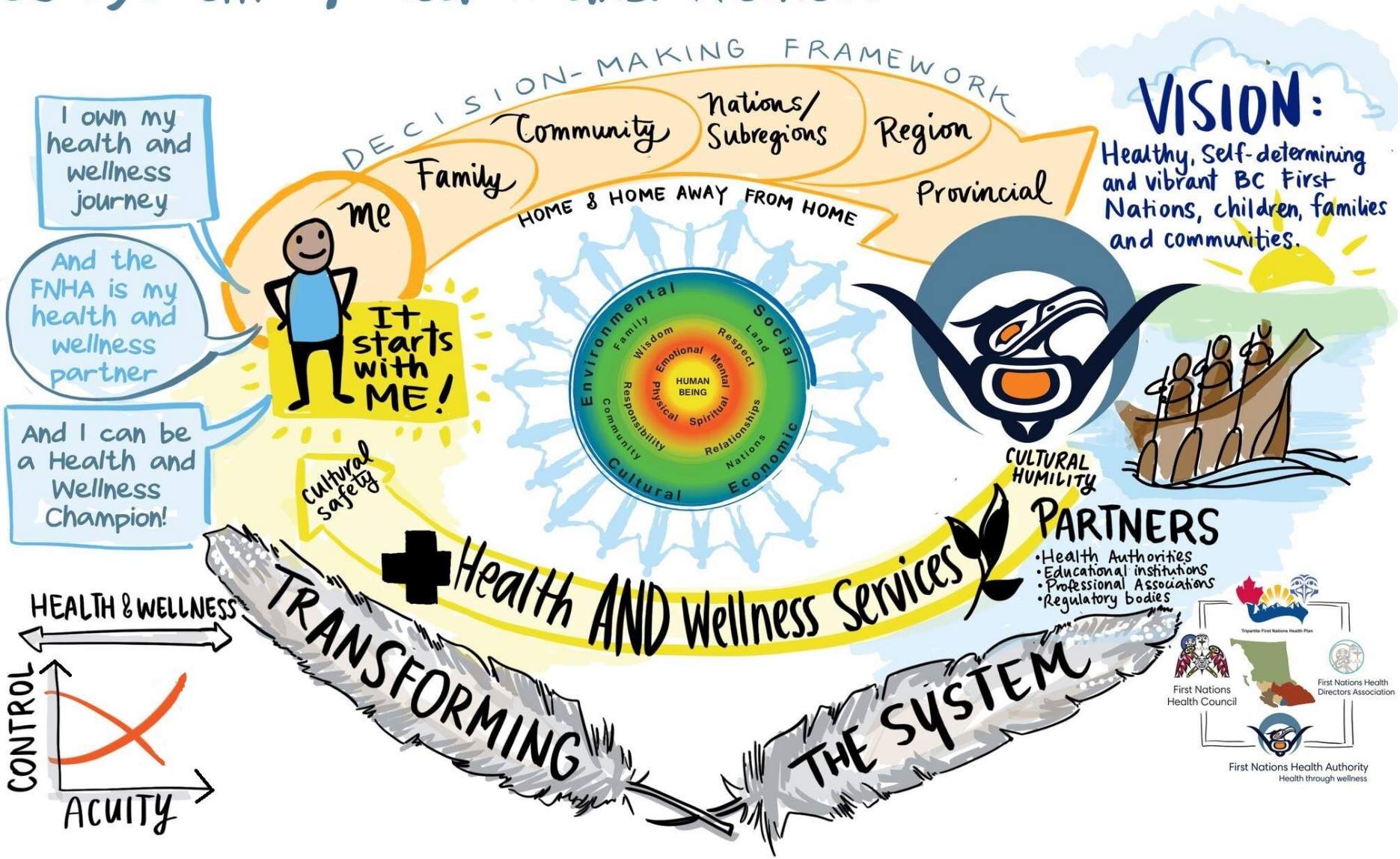
Our Shared Values

Respect, Discipline, Relationships, Culture, Excellence & Fairness

Our 7 Directives

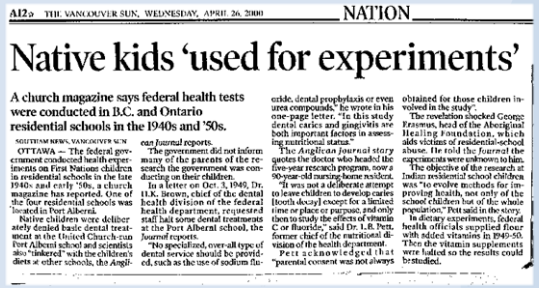
1. Community Driven, Nation Based
2. Increase First Nations Decision-Making
3. Improve Services
4. Foster Meaningful Collaboration and Partnerships
5. Develop Human and Economic Capacity
6. Be without Prejudice to First Nations Interests
7. Function at a High Operational Standard

Ecosystem of Health and Wellness



Harmful Encounters in Health Care

We Remember



A12 ▸ THE VANCOUVER SUN, WEDNESDAY, APRIL 26, 2000 NATION

Native kids 'used for experiments'

A church magazine says federal health tests were conducted in B.C. and Ontario residential schools in the 1940s and '50s.

SOUTHAM NEWS, VANCOUVER SUN

OTTAWA — The federal government conducted health experiments on First Nations children in residential schools in the late 1940s and early '50s, a church magazine has reported. One of the four residential schools was located in Port Alberni.

Native children were deliberately denied basic dental treatment at the United Church-run Port Alberni school and scientists also "tinkered" with the children's diets at other schools, the Anglican Journal reports.

The government did not inform many of the parents of the research the government was conducting on their children.

In a letter on Oct. 3, 1949, Dr. H.K. Brown, chief of the dental health division of the federal health department, requested staff halt some dental treatments at the Port Alberni school, the Journal reports.

"No specialized, over-all type of dental service should be provided, such as the use of sodium fluoride, dental prophylaxis or even urea compounds," he wrote in his one-page letter. "In this study dental caries and gingivitis are both important factors in assessing nutritional status."

The Anglican Journal story quotes the doctor who headed the five-year research program, now a 90-year-old nursing-home resident.

"It was not a deliberate attempt to leave children to develop caries [tooth decay] except for a limited time or place or purpose, and only then to study the effects of vitamin C or fluoride," said Dr. L.B. Pett, former chief of the nutritional division of the health department.

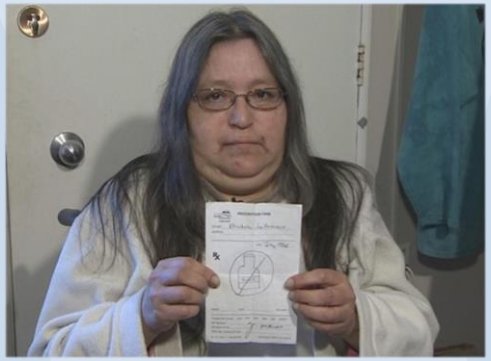
Pett acknowledged that "parental consent was not always obtained for those children involved in the study".

The revelation shocked George Erasmus, head of the Aboriginal Healing Foundation, which aids victims of residential-school abuse. He told the Journal the experiments were unknown to him.

The objective of the research at Indian residential school children was "to evolve methods for improving health, not only of the school children but of the whole population," Pett said in the story.

In dietary experiments, federal health officials supplied flour with added vitamins in 1949-50. Then the vitamin supplements were halted so the results could be studied.

We Witness



We Experience

Many of us have examples from our own lives when:

- Our concerns are discounted
- Assumptions are made about our behaviour
- We are blamed or belittled
- Our cultural health practices are sidelined
- Our rights are undermined

Examples of Culturally Unsafe Practices in Pharmacy

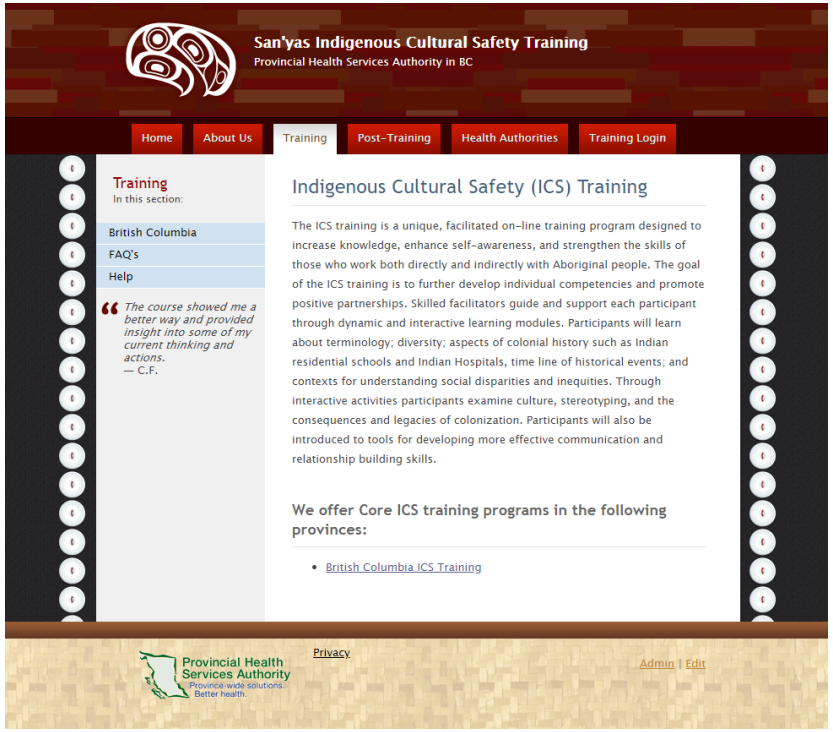
"Here's another PLAN W!"

- Instructing Indigenous patients to pay for a non-benefit medication instead of trying to find a covered medication as a solution and explaining/reassuring that the alternative is a good option.

- Being disrespectful of Indigenous patients' privacy, e.g., calling out for everyone to hear, "Here's another Plan W!"

San’yas Indigenous Cultural Safety Training Since 2010

- Educational intervention
- Accredited training
- Trained 31,000+ people in BC
  - Approx. 25% of Provincial HA employees
  - FNHA @ 90%+



Source: San’yas Cultural Safety Training

Top Stereotypes

1. Alcohol
2. Drug addicted – drug seeking
3. Abuse the system
4. Stupid/illiterate
5. Incompetent/neglectful parents

Source: San’yas Cultural Safety Training Data

Stereotyping/Biases leads to harmful Health Care Provider Behaviours

1. Less effort
2. Misdiagnosis
3. Improper procedure
4. No medication/no treatment
5. Condition minimized
6. Delay/denial of service
7. Withholding pain medication

Source: San'yas Cultural Safety Training, Laurie Harding & Yvette Ringham-Cowan

Harding, L. (2017) Unpublished Doctoral Dissertation, SFU

Not Fully Human/Dehumanized

- Undeserving of care
- Inferior to White people
- Drug addicted
- Alcoholic
- Unintelligent
- Violent
- Need to be Saved

"I clearly remember what my preceptors (two family physicians sharing a practice in the town) told me repeatedly during the weeks of that elective: "You can't kill an Indian."

I feel shame for typing those words, but they were said to me."

"For example, when dealing with trauma patients I have heard surgeons and residents comment about Indigenous patients having a "toughness" that allows them to recover from injuries such as skull fractures, traumatic brain injuries, cerebral hemorrhages far better then Caucasian patients would.

If you or me had that injury we'd be dead."

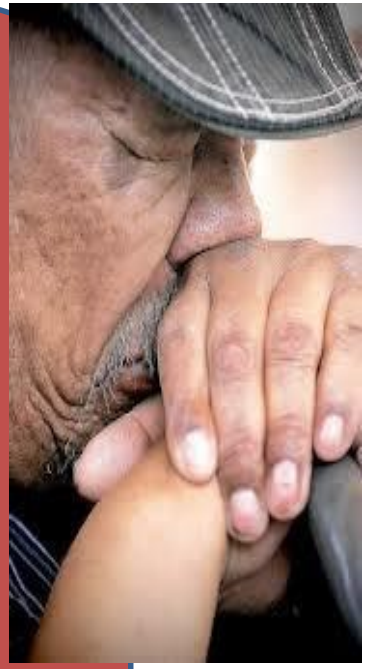
Source: San'yas Cultural Safety Training Data

"We had a man come into the ER with abdominal pain. He was Aboriginal, in his 50's, and when the physician wanted to perform a rectal exam, he flatly refused.

The physician then told him that if he didn't allow the rectal exam, he should just leave because if he couldn't examine him completely , there was no way he could help him.

Of course the patient left.

When I asked the physician why he insisted on the rectal exam when it was likely that this man had suffered abuse in a residential school, the physician stated that he had to set the ground rules for assessment and treatment or *'they will just try to get away with drug seeking*' and that '*the abuse in residential schools was over reported.'"*



Source: San'yas Cultural Safety Training Data

Makara's Story, 2012

Loss of a loved one Makara

importance of cultural protocols

Two worldviews in conflict:

- Advocacy for Makara's Family
- An "exemption" granted

must fix this

Leadership:

- Difficult meetings
- BC Coroner's Service reflects on & revises their policy

listen, learn, act

Developing a partnership with BCCS:

- Cultural safety & humility

signing of declaration

A new relationship:

- Listen to our people
- Respect our decision-making
- Honour our governance

self determination

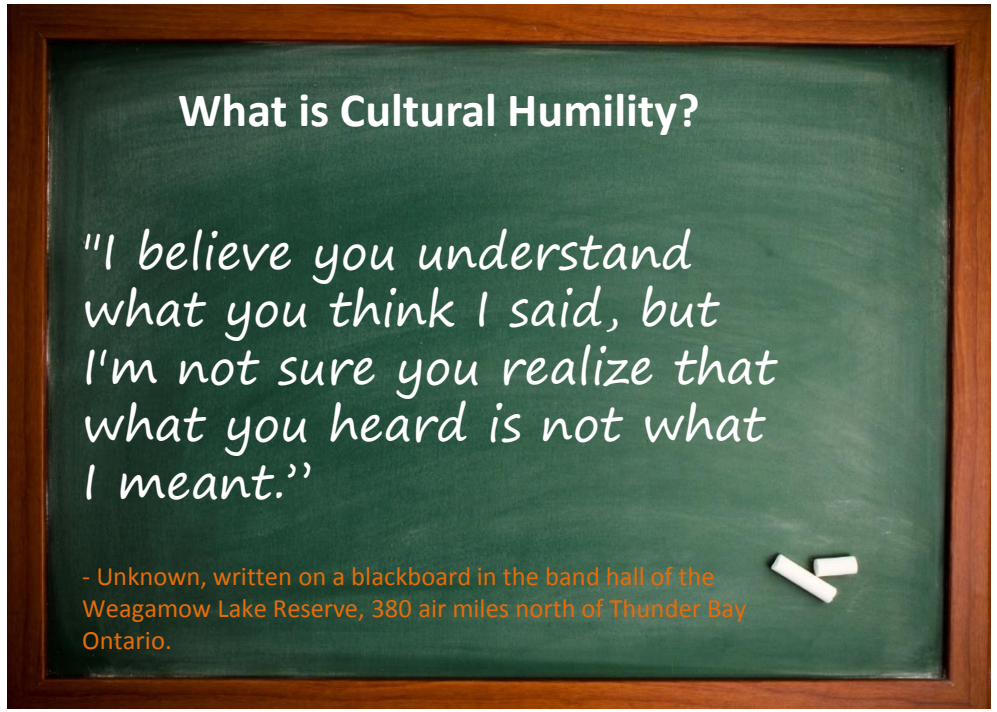
Makara's Story: Impact

- BC Corners Service Signs Declaration, May 17, 2017
- 91/99 infant autopsies completed with no retention [Oct 2014 – Oct 2017]
- BCCS/FNHA partnered work on death review panels, data information sharing
- Two First Nations coroners

"The legacy of Makara's story is that it makes me pause and think about the decisions we're making for all families regardless of their background or culture and asking myself, whose need is being met by doing something or ordering something. "
– Matt Brown, Regional Coroner, Vancouver Island

Declaration of Commitment: Cultural Safety and Humility in Health Services for First Nations and Aboriginal People in BC

- **Cultural Competency:** something that we strive for.
- **Cultural Safety:** space created by an open heart and open mind.
- **Cultural Humility:** the only way we get there.



DECLARATION OF COMMITMENT - JULY 16 2015

CULTURAL SAFETY AND HUMILITY IN HEALTH SERVICES DELIVERY FOR FIRST NATIONS AND ABORIGINAL PEOPLE IN BRITISH COLUMBIA

Our Declaration of Commitment is an important step toward embedding cultural safety and humility within health services for First Nations and Aboriginal people in British Columbia. This commitment reflects the high priority we, as the designated BC First Nations and Aboriginal health system leaders, place on cultural safety and humility as essential dimensions of quality and safety within the First Nations and Aboriginal health services for which we are responsible.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility:

- Cultural humility builds mutual trust and respect and enables cultural safety.
- Cultural safety is defined by each individual client's health service experience. As such, approaches to cultural safety must be client-centred.
- Cultural safety must be understood, embraced and practiced at all levels of the health system including governance, health organizations and within individual professional practice.
- All stakeholders, including First Nations and Aboriginal individuals, elders, families, communities, and nations must be involved in co-development of action strategies and in the decision making process with a commitment to reciprocal accountability.

Strong leadership on concrete actions is essential to achieving our vision of a culturally safe health system for First Nations and Aboriginal people in our province. We, the members of the Leadership Council, will:

CREATE A CLIMATE FOR CHANGE BY:

- Articulating the pressing need to ensure cultural safety within First Nations and Aboriginal health services in BC.
- Opening an honest and convincing dialogue with all stakeholders to show that change is necessary.
- Forming a coalition of influential leaders and role models who are committed to the priority of embedding cultural humility and safety in BC health services.
- Leading the creation of the vision for a culturally safe health system and developing a strategy to achieve the vision.
- Supporting the development of workplans and implement through available resources.

ENGAGE AND ENABLE STAKEHOLDERS BY:

- Communicating the vision of culturally safe health system for First Nations and Aboriginal people in BC and the absolute need for commitment and understanding on behalf of all stakeholders, partners and clients.
- Openly and honestly addressing concerns and leading by example.
- Identifying and removing barriers to progress.
- Tracking, evaluating and visibly celebrating accomplishments.

IMPLEMENT AND SUSTAIN CHANGE BY:

- Empowering health organizations and individuals to innovate, develop cultural humility and foster a culture of cultural safety.
- Allowing organizations and individuals to raise and address problems without fear of reprisal.
- Leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of the health system.

Our signatures demonstrate our long term commitment to providing culturally safe health services for First Nations and Aboriginal people in British Columbia and to championing the process required to achieve this vision.

This Declaration of Commitment is endorsed by the BC Tripartite Committee on First Nations Health and signed by the members of the Leadership Council.

SIGNED on this date: July 16, 2015

MR. STEPHEN BROWN, DEPUTY MINISTER, MINISTRY OF HEALTH

MR. JOE GALLAGHER, CHIEF EXECUTIVE OFFICER, FIRST NATIONS HEALTH AUTHORITY

MR. CARL RYCK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PROVINCIAL HEALTH SERVICES AUTHORITY

MR. MICHAEL MARCHBANK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FRASER HEALTH

DR. ROBERT HALPENNY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, INTERIOR HEALTH

DR. BRENDAN CARR, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ISLAND HEALTH

MS. [illegible], PRESIDENT AND CHIEF EXECUTIVE OFFICER, NORTHERN HEALTH

MS. MARY ACKENHUSEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VANCOUVER COASTAL HEALTH

All 23 BC Health Regulators sign Declaration - March 1/17

"First Nations people deserve respectful and culturally safe care each and every time they receive pharmacy services. I signed the declaration as a commitment from all of us in pharmacy practice."

- Bob Nakagawa, Registrar- College of Pharmacists of BC

May 11, 2017: BCHR Blanketing Ceremony

October 13, 2017: BC Health Regulators Fall Symposium

A full day dedicated to Cultural Safety & Humility

Learnings from:

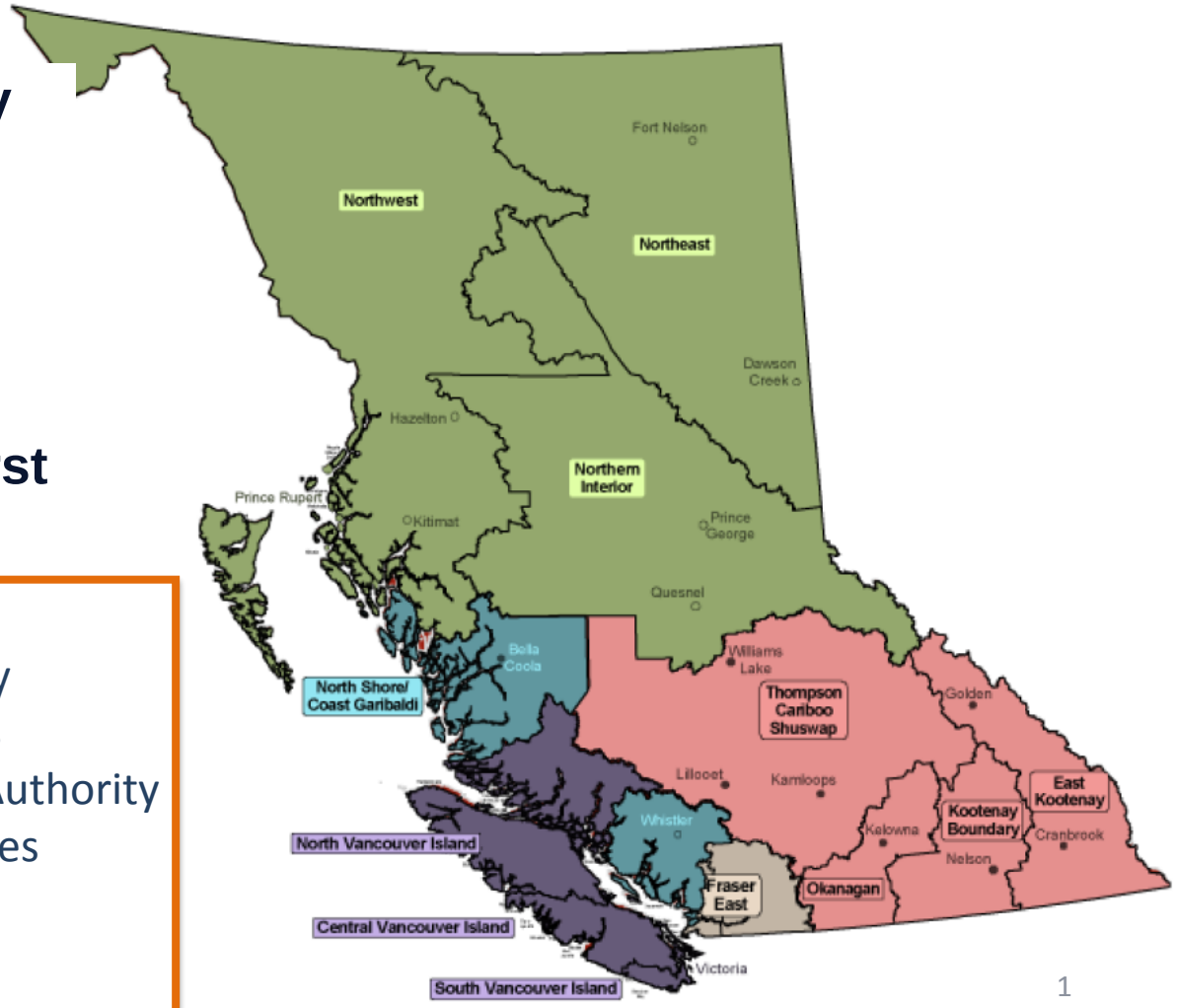
- Indigenous people of the territory we gathered on
- Academics on structural racism
- System Change Leaders

Hardwiring into the Health System

'Hardwire' Cultural Safety & Humility into health services in BC as part of the FNHA's Quality & Safety Agenda

With accountability to First Nations

- ✓ Ministry of Health
- ✓ First Nations Health Authority
- ✓ 5 Regional Health Authorities
- ✓ 1 Provincial Health Services Authority
- ✓ Regulatory Bodies and Colleges
- ✓ Health system partners
- ❑ Health System Associations
- ❑ Academic Institutions



FNHA's vision *for* Cultural Safety & Humility

The FNHA envisions a future where First Nations people have a new relationship with their care providers.

- One which is based on mutual respect, understanding and reciprocal accountability.
- One that provides an understanding of what Health & Wellness means to the First Nations people that are seeking care that we are responsible to provide.
- One that resets the balance of power between a care provider and the client we are here to serve, clients who deserve respect and have a right to access the best service we are able to deliver.
- One that provides for a health system that has mechanisms that proactively and effectively addresses appropriate actions and behaviours within the operations of the various health institutions.

And we will know that we've achieved cultural safety when the voice of the people receiving our services tells us we have.

Cultural Safety and Humility Resource Booklet:
www.fnha.ca/culturalhumlity

#ItStartsWithMe

- Group shot
- Take a selfie (with your pledge) and upload to FNHA website
- Take your pledge and post in your office
- Share your experience with your teams
- Team pics are encouraged ☺

Questions & Discussion

Thank you

Gayaxsixa (Hailhzaqvla)

Huy tseep q'u (Stz'uminus)

Haawa (Haida)

Gila'kasla (Kwakwaka'wakw)

Kleco Kleco (Nuu-Chah-Nulth)

kʷukʷstéyp (Nlaka'pamux)

Snachailya (Carrier)

Kukwstum'clhkal'ap (St'atimc)

Tooyksim niin (Nisga'a)

Kukwstsétsemc (Secwepemc)

čɛčɛhaθɛč (Ayajuthem)

Sechanalyagh (Tsilhqot'in)

kw'as ho:y (Halq̓eméylem)

T'oyaxsim nisim (Gitxsan)

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

8. Acting on our Commitment to Improve Cultural Safety and Humility for First Nations and Aboriginal Peoples

INFORMATION ONLY

Purpose

To inform the Board of ongoing work surrounding the College's commitment to improve cultural safety and humility for First Nations and Aboriginal Peoples.

Background

On March 1, 2017, the College's Registrar, Bob Nakagawa, pledged the College's commitment to improving BC pharmacy professionals' work with First Nations and Aboriginal Peoples by signing the "*Declaration of Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in BC*"

The College believes that cultural safety and humility are vital for the provision of fair and equal health services, as well as the creation of a healthcare environment free of racism and discrimination, where individuals feel safe and respected.

First Nations and Aboriginal people have a right to access a health care system that is free of racism and discrimination and to feel safe when accessing health care. This means individuals, families and communities are able to voice their perspectives, ask questions, and be respected by health care professionals on their beliefs, behaviours and values.

By signing the Declaration of Commitment, the College has committed to actions and processes which will ultimately embed culturally safe practices within all levels of health professional regulation.

The declaration compels the College to report on its progress in its annual report and outlines strategic activities that demonstrate how it is meeting its commitment.

Understanding Cultural Safety, Cultural Humility and Systemic Racism

Cultural Safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

Cultural Humility is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience.

Systemic Racism, also known as structural or institutional racism, is enacted through societal systems, structures and institutions in the form of "requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups" (Paradies et al., 2008). Systemic racism is not only enacted proactively in efforts that create racialized inequality, but also in the failure by those in power (e.g. policymakers, funders) to redress such inequalities (Reading, 2013). It is commonly manifested in social exclusion and isolation that limits or prevents political and economic participation, or access to and participation in other social systems such as education and health (Reading, 2013).

Developing a Strategy for Acting on the Commitment to First Nations and Aboriginal Peoples in BC

The College developed a strategy to fulfill its pledge to improve BC pharmacy professionals' work with First Nations and Aboriginal Peoples and presented the strategy to the College Board in September 2017.

The College recognizes that making impactful change requires working together with the First Nations Health Authority, other health regulators, pharmacy associations, First Nations groups, and others to act on its plan and create a healthcare environment free of racism and discrimination, where individuals feel safe and respected.

It is also a journey of learning about the culture and experiences of First Nations and Aboriginal Peoples of BC. Relationship building and engagement with First Nations and Aboriginal Peoples communities and organizations are essential in enabling the College to meet its goals in improving care.

The strategy includes actions under three themes which are based on the First Nations Health Authority's Cultural Safety and Humility Key Drivers and Ideas for Change.

CULTURAL SAFETY CONCEPTS

The first key objective in fulfilling the College's commitment to cultural humility and safety is to change and influence the values and attitudes of both its registrants and staff. This involves embedding the concepts and principles of cultural humility and safety into the College's current internal processes. The College will also build on the First Nations Health Authority's #ItStartsWithMe campaign to build awareness of cultural humility and safety, while encouraging pharmacy professionals and staff to reflect on cultural humility and safety and make a pledge as part of the campaign. Leadership from the College Board and executive will help set an example for pharmacy professionals and staff by demonstrating their commitment through participation in cultural safety activities.

PARTNERSHIP AND ENGAGEMENT

In order to inform the College's transition to a more culturally inclusive healthcare environment for BC's First Nations and Aboriginal People, it will focus efforts toward building and strengthening relationships with local communities to involve them in the decisions that affect them.

LEARNING, KNOWLEDGE EXCHANGE & QUALITY HEALTH
In order to address the healthcare service gaps and unmet needs of BC's First Nations population, the College will work to build the principles of cultural humility and safety into its communications messaging and training requirements. This process will involve conducting culturally safe research respecting ceremony and tradition and encouraging pharmacy professionals to learn about and reflect on the best practices for cultural safety and humility in service delivery.

Discussion

The College began to operationalize its strategy in 2018. Each of the three themes include activities and deliverables intended to improve cultural humility and safety.

The approach to meeting deliverables must be thoughtful and respectful and avoid tokenism. The College's actions need to effect change in the care First Nations and Aboriginal Peoples receive across BC.

To ensure that the College is accountable and transparent, it has begun to reflect on its progress towards meeting its commitment each year in its annual report.

While there is still work to do, much progress has been made since the strategy was developed in late 2017.

New College Board Cultural Safety and Humility Resource

The College is launching a Cultural Safety and Humility Resource for its Board Members to ensure they have the information, tools and training available to understand the College's commitment and learn about cultural safety and humility, reconciliation and the health inequalities of First Nations and Aboriginal Peoples.

The resource will also include information on how to join into the #ItStartsWithMe Campaign.

Resources included

- BC Health Regulators Declaration of Commitment to Cultural Safety and Humility in the Regulation of Health Professionals
- First Nations Health Authority's Policy Statement on Cultural Safety and Humility
- Our Commitment to Cultural Humility (College Strategy)
- Cultural Safety and Humility Definitions
- Relevant webinars including the cultural safety and humility webinar series from FNHA and the National Indigenous Cultural Safety Learning Series webinars
- Recommended reading materials including the Truth and Reconciliation report and the Health Inequalities and Social Determinants of Aboriginal Peoples' Health report
- Information on the San'yas Indigenous Cultural Safety Training including that the College can cover the cost of the course if requested.
- First Nations Health Authority's Creating a Climate for Change Resource Booklet
- Information on how to make a cultural safety and humility pledge and join into the #itstartswith me campaign

Public Acknowledgements of the Commitment to Cultural Safety and Humility

The College has updated its processes to recognize the indigenous lands on which it is situated through a land acknowledgement and has incorporated a statement on its commitment to cultural safety and humility into all public reports and presentations.

Integrate Cultural Safety and Humility into Organizational Policies

The College has developed an organizational Workplace Diversity Policy which sets out expectations relating to workplace diversity at the College.

As part of this policy, in accordance with the *Employment Equity Act*, the College will make reasonable efforts to ensure that it is a representative employer of women and men, members of visible minority groups, people with disabilities and First Nations and Aboriginal Peoples. The College will endeavor, where feasible, to make every effort to equalize the under-utilization of designated groups.

In order to establish a working environment that respects and values differences, the College is also committed to fostering open communication by sharing information and resources on diversity (including information on cultural safety and humility) with all its employees and stakeholders; and providing applicable educational programs relating to diversity management. Moving forward, the College will continue to review and assess where organizational policies may need to be revised or developed to support cultural humility and safety for First Nations and Aboriginal Peoples.

FNHA Mental Health and Wellness Summit

In February 2018, the College was fortunate to be a part of the first Mental Health and Wellness Summit hosted by the First Nations Health Authority.

In addition to the College's Communications and Engagement Team, six additional College staff volunteered to spend time at the College's booth where they had the opportunity to both answer questions and learn from participants.

The College connected with local public health directors and administrators, mental health professionals, and community leaders. The conversations were focused on what the College, as one of BC's largest health professions, can do to advance cultural safety and humility for First Nations and Aboriginal Peoples within BC's public health system.

Over 50 participants shared their responses:

On Access
"Pharmacies should show cultural sensitivity and be aware that many of our people fall below the economic poverty line and are not able to pay for their medicine and they should also be aware of all social programs that assist in paying for medicines to better facilitate our people in getting their medicines."

"Make sure there are places people can gather to talk, to belong & to access culturally appropriate services."

"Transparency to all."

On Welcoming Environments
"Always see the human, not the stats, not the stigma."

"Kind, compassionate approach to people who have addictions."

"Reaching out to your open indigenous community to open dialog and sharing."

On Tradition
"It's time to incorporate First Nations medicine and all its healing properties, into the health system so it's not lost."

"Respect and understanding of Indigenous needs; Recognition of Indigenous medicines; Respectful communication with Indigenous people."

"The integration of both traditional and Western knowledge regarding healing."

On Attitude
"Seeing people equally – as human beings regardless of what they look like or where they come from."

"Honesty and Respect and Open mindedness."

"Being open, respectful, positive and non-judgmental."

See the reflections we shared with registrants and watch the event highlights.

Gathering Wisdom for a Shared Journey IX

Over 700 Chiefs, Leaders, Health Directors, Youth Leaders, Elders, and federal and provincial partners attended the 3-day Gathering Wisdom forum in May, 2018 to engage in discussions surrounding the health and wellness of BC First Nations.

The Gathering Wisdom IX forum featured discussions on health, mental health and the social determinants of health. It was also an opportunity for First Nations to engage in direct dialogue

with each other and federal, provincial and health system partners on factors that influence the health and wellness of their children, families and communities.

The College was honored to join into the BC Health Regulators Information Booth at the Gathering Wisdom IX forum. This provided a valuable opportunity to speak with First Nations representatives from across BC about the role of health regulators in protecting patient safety.

The College also engaged in conversations on what health professionals can do in their practice to improve cultural safety and humility for First Nations and Aboriginal Peoples within BC's public health system.

Over 80 participants shared their thoughts and ideas:

> *"Have knowledge of history of Indigenous people and how this impacts health outcomes, social issues etc. and incorporate this into practice."*
>
> *"Be open minded to doing things differently."*
>
> *"Visible First Nations Art Work so people can see and recognize our culture (Totems, paddles, speaking sticks)"*
>
> *"Respect that our elders are IRS Survivors… and hospitals are much like Residential Schools. When told patient is a survivor, deal with respect and know the situation is linked to PTSD. Notify all staff involved."*
>
> *"Be mindful of personal bias/ lived experience and how that influences tour interactions with others."*

Read all the comments in Appendix: BCHR/FNHA First Nations Community Feedback Gathering Wisdom IX and watch the highlights.

The College is in the process of reflecting on this feedback and considering how to take action on the ideas raised.

Day of Wellness 2018

June 21 is National Indigenous Peoples Day. This is a day for all Canadians to recognize and celebrate the unique heritage, diverse cultures and outstanding contributions of First Nations, Inuit and Métis peoples.

In BC, First Nations and Aboriginal peoples and partners came together at 145 Day of Wellness events to mark health and wellness across the province. Celebrations reflected the cultural pride of communities and brought together the wisdom of Elders and the energy of youth.

As part of celebrating National Indigenous Peoples Day, the College participated in the BC Women's Indigenous Day of Wellness event in Vancouver, BC.

The College also encouraged pharmacists and pharmacy technicians to join Day of Wellness celebrations by attending an event in their area.

The College used its booth at BC Women's Indigenous Day of Wellness event to share information on its role in protecting patient safety and its plan to improve cultural safety and humility. Handouts were available with information about the College's role in regulating pharmacy practice, its cultural humility plan, as well as its naloxone resources.

The College also engaged in conversations on what pharmacy professionals can do in their practice to improve cultural safety and humility for First Nations and Aboriginal Peoples.

The College is in the process of transcribing the feedback received and will be reflecting on how to take action on the ideas raised. See the event highlights.

Reflection in the College's 2017/18 Annual Report

As a BC Health Regulator, the College recognizes that its annual report plays an important role in demonstrating transparency and accountability. It is also a great opportunity for the College to reflect on its own performance and the many ways it is involved in protecting public safety.

Together with launching a new annual report website in June 2018, the College introduced a new Cultural Safety and Humility section into the annual report that is dedicated to reflecting on its progress towards improving cultural safety and humility for First Nations and Aboriginal Peoples. The section also includes tracking its progress against each of the deliverables in its strategy.

The annual report also includes a land acknowledgement on its homepage and as part of the information about the College.

Dedicated Cultural Humility and Safety Resource for Registrants

The College established a dedicated landing page at bcpharmacists.org/humility to share cultural safety and humility information with pharmacy professionals and patients.

Moving forward, the College will be continuing to develop and recruit more articles on cultural humility and safety and adding additional resources to the landing page.

In addition to being accessible on its website, the College also features the resource page through conference presentations and through social media (including ads focused towards pharmacy professionals).

Huy chexw and Hay ce:p q̓a' (Thank You)

The College would like to extend a great **Huy chexw and Hay ce:p q̓a'** (thank you in Sḵwx̱wú7mesh Sníchim of the skwxwú7mesh úxwumixw and in hən̓q̓əmin̓əm̓ of xʷməθkʷəy̓əm and sel̓íl̓witulh nations)* to the First Nations Health Authority for working with the College in the development and implementation of its strategy to improve cultural humility and safety for First Nations in BC.

The College appreciates their leadership and wisdom in caring for First Nations and Aboriginal Peoples in BC.

**Respectfully practicing the language of the sḵwx̱wú7mesh úxwumixw (Squamish), sel̓íl̓witulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) nations, whose unceded and traditional territory the College of Pharmacists of BC is located.*

Appendix	
1	Strategy for Acting on Our Commitment to First Nations and Aboriginal Peoples in BC
2	BCHR/FNHA First Nations Community Feedback Gathering Wisdom IX
3	Commitment to Cultural Safety and Humility Resource Page
4	2017/18 Annual Report - Commitment to Cultural Humility 2017/18 Progress

How can BC's Health Professionals incorporate Cultural Safety and Humility into their individual practices?

- More medical information/ access to information from doctors & specialists to semi-remote communities
- A more user-friendly system that encourages collaboration
- Understand the system of NIHB. It is there to help not something to be withheld.
- Learn about impacts of Residential School "Indian Horse"
- Cultural is Healing *Showed up multiple times*
- Incorporate Indigenous voices and perspectives into planning and collaborative work
- Promote Language- learn the language of the 1st Nations in the area
- Trauma informed training to understand effects of Residential schools through all generations
- By questioning regular common practices and keeping an open mind/ continually learning
- Remove Stereotyping
- Include traditional medicines in practices and be more connected with patients
- Hold training/ conferences on/in First Nations communities with First Nations Health Reps
- Accessible services
- Ask, don't assume!
- For doctors and services to learn about the local First Nations culture and the effects of IRS- we cannot "just get over it."
- Professionals should learn about First Nations culture
- Community information workshop for health benefits
- Go to the source for solutions- the patients with mental health issues in particular.
- Better Business Bureau oversight for quality assurance, quality control, alternative medicine and practitioners.
- Start naloxone learning with a prayer or brushing
- Bring information to the community
- Native liaison workers in hospitals should "Go see" the patient and let the patient know what supports they offer. Most times I've visited family, they were not aware that these support existed in the hospital; or will not go look for the native liaison.
- Talking circles
- Cultural intervention- i.e. Elder RCMP (multi-level intervention)
- Let clients know that it is "ok" for a friend or perhaps a community assist in making a complaint to a regulator!
- Workshops- cultural workshops for health professionals
- Teach bed side manners and better communication
- Develop and incorporate lens of reconciliation into their practices
- Understanding that residential school trauma effects multiple generations
    - Sexual
    - Physical
    - Mental
    - More awareness
    - Education

- Advocate for ongoing funding for MH NOT time limited funding.
- Host informational/ educational workshops that are focused on awareness/ initiatives and create a safe environment for people to share their traditional remedies/ treatments and encourage to find a balance between traditional and western medicine (i.e. diabetes awareness with traditional diets etc.)
- Be kind always!
- Always be unconditional and remember we have two ears and only one mouth and a big fat open heart.
- Be mindful of personal bias/ lived experience and how that influences tour interactions with others.
- Listen, learn and apply
- Educate yourself on First Nations; learn to notice your biases and assumptions and put them aside.
- Learn each Nations protocol's and implement them info how you deliver your services; create table tops; be respectful- be courteous- I slow down!
- Host the community for a meal first there's magic that happens and speech is free flowing after a meal.
- Be compassionate to our people! A strange setting is traumatizing already!
- Acknowledge, Respect and Honor the unseeded Traditional Territory of the Ucwalmicw where you live and work. Not just the reserves!! Nor just at conference meetings.
- By being educated in cultural ways of First Nations they work with, knowing is power!
- Respect that our elders are IRS Survivors… and hospitals are much like Residential Schools. When told patient is a survivor, deal with respect and know the situation is linked to PTSD. Notify all staff involved.
- Inclusive of all family members. Respectful settings incorporate longhouse (self-place?)
- Learn/ Listen and be open minded!
- Cultural Competency
- Understanding multiple traumas
- They should visit communities and speak to the elders
- Train and hire more indigenous service providers. Women = Woman provider
- Work with hospitals on cultural awareness and cultural safety
- Provide training in conjunction with medical teachings
- First Nations 101
    - Orientation to Non- First Nations (i.e. Sixties scoop, residential schools)
    - Ongoing education
    - What does FN governance look like?
    - Learn about traditional healing (i.e. soopalilie for cancer)
- Include elders in how to incorporate cultural teachings
- Youth Council
- Professionals need to work with elders to learn and understand how cultural healing is medicine.
- Provide training in conjunction with medical teachings
- Know the cultural practices of bands in their area. Ask input from the band on what traditions/ culture are utilized in the band. Follow the lead of the band members.
- Work with hospitals on cultural awareness and cultural safety
- Offer training on health and culture

- Listen to community knowledge
- Getting into culture/ ceremony
- Understanding knowledge and culture to aid in healing
- Relationship between local nation and health to be developed so that the nation and health organization can be open to each other events, practices, ceremony
- Understand our cultural history
- Elder teachings!
- Inclusive of First Nations- Community health workers
- Show that you care about how the people feel when they are in need
- Get the youth educated and involved 100%
- Consistent, relationship building!
- Have knowledge of history of Indigenous people and how this impacts health outcomes, social issues etc. and incorporate this into practice.
- Be patient and listen
- Work with physicians on Culture Humility. Don't judge or assume.
- Be open minded to doing things differently
- People need people- share your time, coffee, a meal, your wisdom. Support through talking!
- Learn about the history of pre-contact First Nations in BC
    - Contact
    - Colonization
    - Residential Schools
    - Current State
    - The road forward- Reconciliation!
- Cultural competency as part/ requirement of BC Registry with Health Regulators
- Speak with Knowledge Keepers and Elders within communities to create a connection and build relationships.
- Provide advocacy to remote community understanding.
- Treat all as you would your own loved ones. Be sure our Elders and Youth are heard!
- Afterhours support for our members
- Don't look at the color of the skin when caring for patients
- Incorporate as part of Nations HR Policy
- Understand how to practice humility and being humble- understanding the person and not always the condition/ health
- Visible First Nations Art Work so people can see and recognize our culture (Totems, paddles, speaking sticks)
- Accepting their past so they heal collectively
- Be humble and open minded- respect everyone!

College of Pharmacists of British Columbia

8. Acting on our Commitment to Improve Cultural Safety and Humility for First Nations and Aboriginal Peoples

Gillian Vrooman

Director of Communications & Engagement

College of Pharmacists
of British Columbia

Acting on our commitment to improve cultural safety and humility for First Nations and Aboriginal Peoples in BC

September 14, 2018

College of Pharmacists of British Columbia

The College acknowledges with respect that the College of Pharmacists of BC is located on the unceded and traditional territories of the Coast Salish peoples – sḵwx̱wú7mesh úxwumixw (Squamish), sel̓íl̓witulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) nations whose historical relationships with the land continue to this day.

Health Regulators pledged to make our health system more culturally safe


College signs
Declaration

CULTURAL SAFETY

An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system.

It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

CULTURAL HUMILITY

A process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust.

Cultural humility involves humbly acknowledging oneself as a life-long learner when it comes to understanding another's experience.

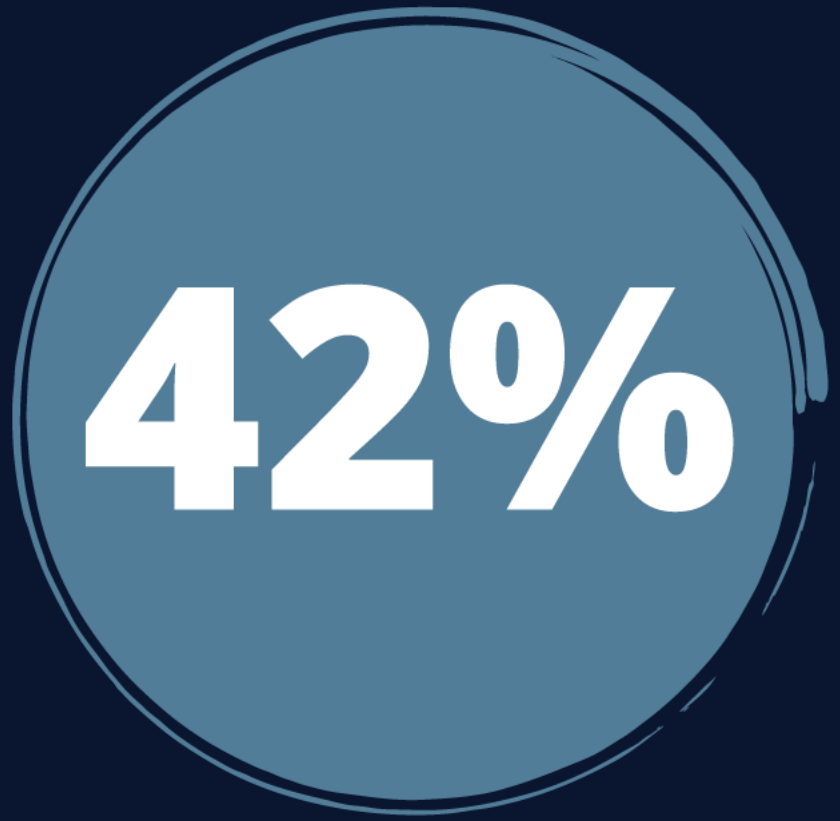
SYSTEMIC RACISM

Systemic racism is enacted through societal systems, structures and institutions in the form of "requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups".

It is commonly manifested in social exclusion and isolation that limits access to and participation in social systems.

A Status First Nations person in BC is expected to live 7.5 fewer years than a non-Aboriginal BC resident born in the same period.

Creating a Climate For Change Cultural Humility Resource Booklet, First Nations Health Authority, fnha.ca/wellness/cultural-humility



42 percent of Aboriginal people in Canada reported experiencing racism in the past two years, 74 percent of which was enacted by non-Indigenous people.

Creating a Climate For Change Cultural Humility Resource Booklet, First Nations Health Authority, fnha.ca/wellness/cultural-humility

This Act is current to May 16, 2018

See the Tables of Legislative Changes for this Act's legislative history, including any changes not in force.

HEALTH PROFESSIONS ACT

[RSBC 1996] CHAPTER 183

Duty and objects of a college

16 (1) It is the duty of a college at all times

(a) to serve and protect the public, and

(b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.

(2) A college has the following objects:

(a) to su[illegible]

It's part of our duty to serve and protect First Nations and Aboriginal Peoples in BC

[illegible]e college;

[illegible]registration of a person as a member of the college;

[illegible]establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;

(e) to establish and maintain a continuing competency program to promote high practice standards amongst registrants;

(f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;

(g) to establish, monitor and enforce standards of professional ethics amongst registrants;

(h) to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances;

(i) to inform individuals of their rights under this Act and the *Freedom of Information and Protection of Privacy Act*;

(i.1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair;

(j) to administer the affairs of the college and perform its duties and exercise its powers under this Act or other enactments;

(k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance

How have we been taking action?

Developed strategy to take action on our commitment

College of Pharmacists of British Columbia

Our Commitment to Cultural Humility

Acting on our commitment to improve cultural safety and humility for First Nations and Aboriginal People in BC

August 18, 2017

Cultural Safety Concepts

Changing and influencing the values and attitudes of both our registrants and staff

Partnership and Engagement

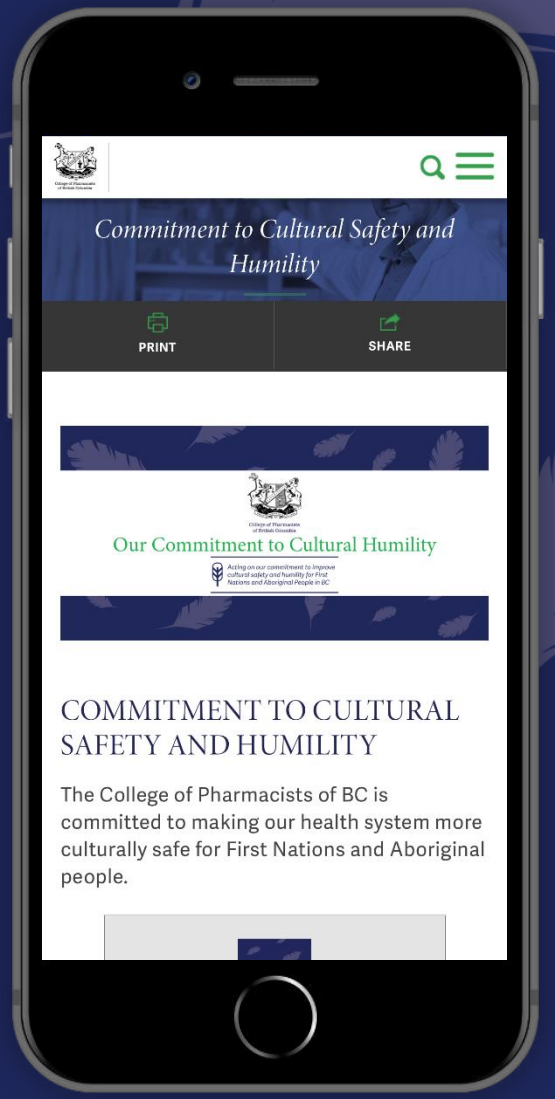
Building and strengthening relationships with local communities to involve them in decisions that affect them

Learning, Knowledge Exchange and Quality Health

Building the principles of cultural humility and safety into our communications messaging and organizational training

Open Transparent Online

bcpharmacists.org/humility



Cultural humility and safety resource page

CULTURAL SAFETY TRAINING

The College encourages BC's pharmacy professionals to complete cultural safety training. As one of the most accessible health care professions, having BC's pharmacy professionals acknowledge racism in healthcare and pledge to work towards improving the quality of health services for First Nations and Aboriginal People is important in leading our provincial health system toward a more inclusive future.

SAN'YAS INDIGENOUS CULTURAL SAFETY COURSE

The College encourages all pharmacy professionals to consider completing the online San'yas Indigenous Cultural Safety course as part of their professional development. Currently less than 2% of all licensed pharmacists in BC have taken the course which is provided by the Provincial Health Services Authority, making this a significant commitment for you and other pharmacists to make.

- See San'yas Indigenous Cultural Safety Course

CULTURAL SAFETY AND CULTURAL HUMILITY WEBINARS

Watch the 12 part Cultural Safety and Cultural Humility Action Series hosted by the First Nations Health Authority and BC Patient Safety & Quality Council. The series will support the development of tools and skills on how to be effective allies for advancing cultural safety and humility and what health service staff and allies can do to understand and integrate this work into their practice or interaction with First Nations and Aboriginal People. Hear from thought leaders such as Joe Gallagher, Dr. Evan Adams, Dr. Nadine Caron, Margo Greenwood, and representatives from each regional health authority in the province.

bcpharmacists.org/humility

CULTURAL HUMILITY PORTAL HEALTH AUTHORITY

Learn more about cultural safety and humility and how to improve your practice with the resources available in the First Nations Health Authority Cultural Humility Portal, and pledge your commitment to cultural safety and humility.

- See First Nations Health Authority Cultural Humility Portal

College of Pharmacists of British Columbia

Land acknowledgements and our commitment to cultural safety and humility incorporated into all public reports and presentations

The College of Pharmacists of BC acknowledges and thanks the Coast Salish People on whose traditional territories we are gathered on.

We are grateful to carry out our work on the ancestral lands of the Musqueam, Squamish and Tsleil-Waututh First Nations.

Integrating cultural safety and humility into organizational policies

College of Pharmacists of British Columbia

3.2 Workplace Diversity *(New 03/18)*

Objective

The College is dedicated in being a leader by supporting and valuing the diversity of the people, our organization and the stakeholders we serve. The College has an inclusive working environment which values and respects all employees and stakeholders. Managing and valuing diversity improves the creativity and productivity of all employees. It also gives a clear competitive advantage to our organization and ensures representation in our organization of the communities that we live and work in. This policy provides a definition and the expectations relating to workplace diversity.

Definitions

Workplace diversity is recognizing and respecting human differences and similarities within the organization.

Target groups are designated groups of concern that include women, disabled, visible minorities and Aboriginal peoples. These groups are selected as the focus of Employment Equity because their labour market experience reveals long-standing patterns of high unemployment, lower than above pay rates, concentration in low status jobs and limited opportunities for advancement.

Expectations

The College is committed to the establishment of a working environment that respects and values diversity in all aspects of employment. All decisions regarding recruitment, hiring, promotion, compensation, employee development decisions such as training and all other terms and conditions of employment, are made without regard to race, religious beliefs, colour, gender, sexual orientation, marital status, physical and mental disability, age, ancestry or place of origin.

In accordance with the *Employment Equity Act*, the College will make reasonable efforts to ensure that it is a representative employer of women and men, members of visible minority groups, people with disabilities and First Nations at all the organization's operations. The College will endeavor, where feasible, to make every effort to equalize the under-utilization of designated target groups.

In order to establish a working environment that respects and values differences, the College fosters open communication by sharing information and resources on diversity with all its employees and stakeholders; and provides applicable educational programs relating to diversity management.

(Internal organizational policy)

Participated in FNHA's Mental Health and Wellness Summit

bcpharmacists
The Westin Bayshore

bcpharmacists We're at the @fnha Mental Health & Wellness Summit Feb 7 & 8!
Come say hi, learn about Naloxone & our plans to improve cultural humility, share your thoughts, & grab some cool swag! 🤗
#fnhawellness

drhennigar Love this. So important ❤️‍🩹

59 likes

FEBRUARY 7

Add a comment...

WHAT WE HEARD: FNHA MENTAL HEALTH AND WELLNESS SUMMIT

This past February, The College was fortunate to be a part of the first Mental Health and Wellness Summit hosted by the First Nations Health Authority!

...we took the opportunity to try and spread awareness of emergency use ...lose deaths and what we've ...eply encouraging to see not ...ne and how to use it, but how many people ...

Sharing our learnings through ReadLinks

PHARMACIES LOOK LIKE TO YOU?

ON ACCESS

"Pharmacies should show cultural sensitivity and be aware that many of our people fall below the economic poverty line and are not able to pay for their medicine and they should also be aware of all social programs that assist in paying for medicines to better facilitate our people in getting their medicines."

"Make sure there are places people can gather to talk, to belong & to access culturally appropriate services"

"Transparency to all"

ON WELCOMING ENVIRONMENTS

"Always see the human, not the stats, not the stigma"

"Kind, compassionate approach to people who have addictions"

"Reaching out to your open indigenous community to open dialog and sharing"

ON TRADITION

"It's time to incorporate First Nations medicine and all its healing properties, into the health system so it's not lost."

"Respect and understanding of Indigenous needs; Recognition of Indigenous medicines; Respectful communication with Indigenous people."

"The integration of both traditional and Western knowledge regarding healing"

ON ATTITUDE

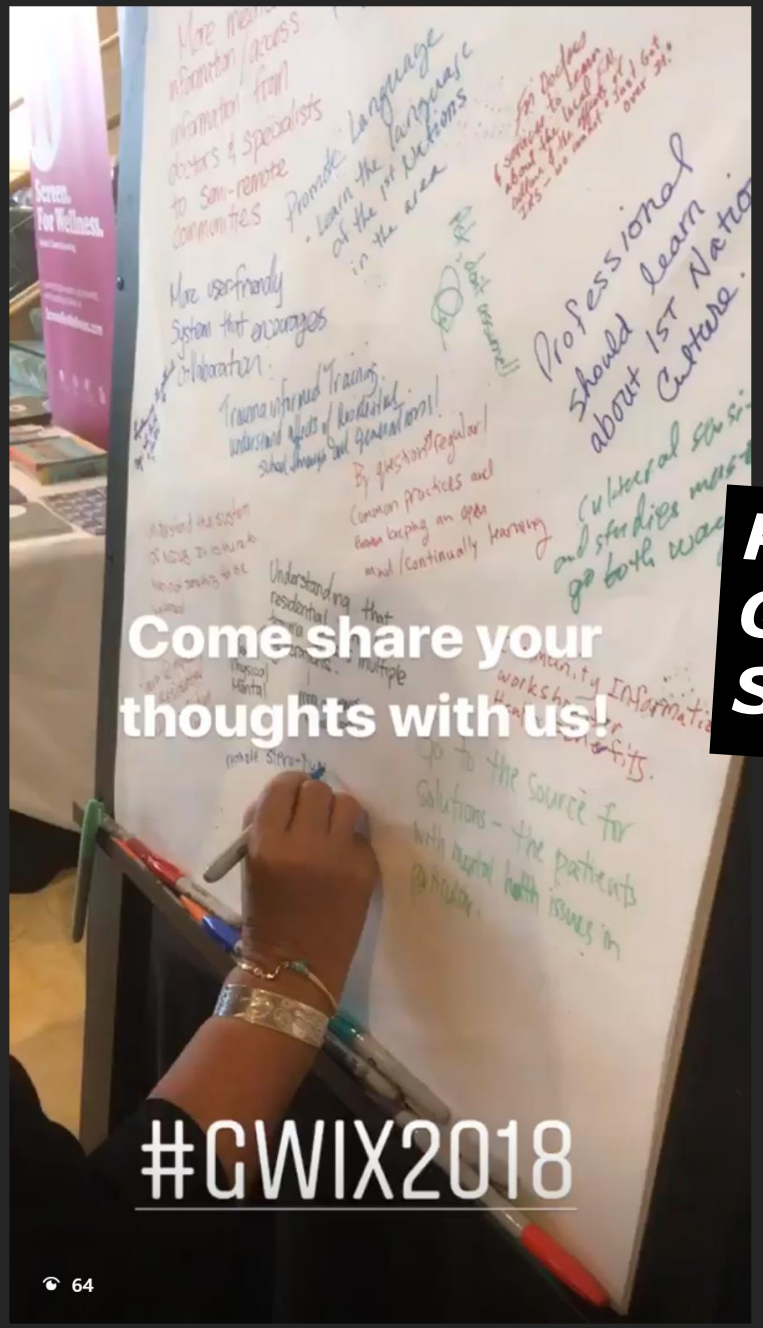
"Seeing people equally – as human beings regardless of what they look like or where they come from"

"Honesty and Respect and Open mindedness"

"Being open, respectful, positive and non-judgmental"

GWIX 2018 16w

GWIX 2018 16w



GWIX 2018 16w

"Have knowledge of history of Indigenous people and how this impacts health outcomes, social issues etc. and incorporate this into practice."

"Be open minded to doing things differently."

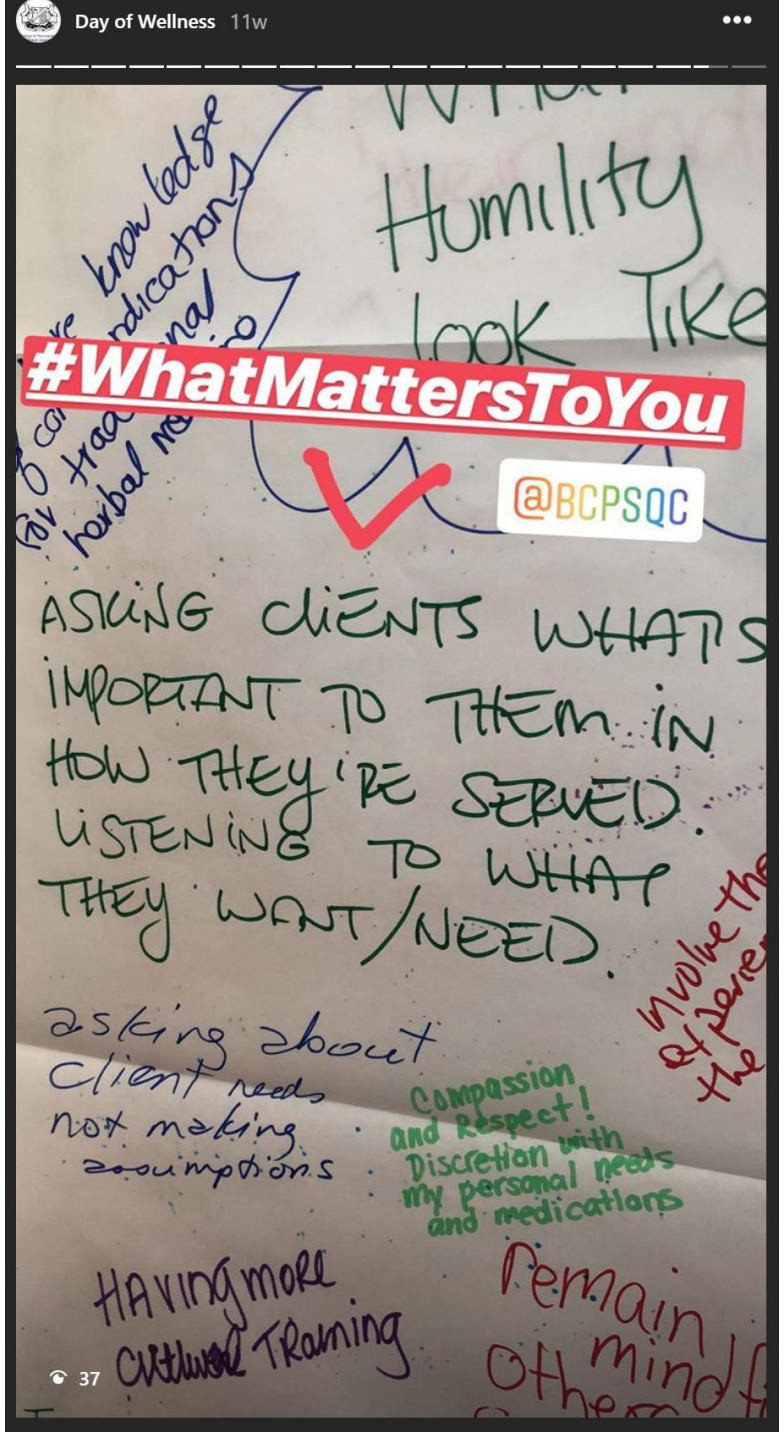
"Visible First Nations Art Work so people can see and recognize our culture (Totems, paddles, speaking sticks)"

"Respect that our elders are IRS Survivors… and hospitals are much like Residential Schools. When told patient is a survivor, deal with respect and know the situation is linked to PTSD. Notify all staff involved."

"Be mindful of personal bias/ lived experience and how that influences tour interactions with others."


Day of Wellness 11w
#INDIGENOUSPEOPLESDAY
Indigenous Health
Participated in 2018 Day of Wellness
BC WOMEN'S HOSPITAL + HEALTH C...
56


Day of Wellness 11w
Come and share your thoughts!
#ThoughtsForSocks
58


Day of Wellness 11w
#WhatMattersToYou
@BCPSQC
ASKING CLIENTS WHAT'S IMPORTANT TO THEM IN HOW THEY'RE SERVED.
LISTENING TO WHAT THEY WANT/NEED.
asking about client needs not making assumptions
Compassion and Respect! Discretion with my personal needs and medications
HAVING MORE CULTURE TRAINING
37

College of Pharmacists of British Columbia

Annual Report 2017/2018

Regulating pharmacy practice in the public interest

01

College Vision, Mission and Values

VISION

Better Health through excellence in pharmacy.

MISSION

The College regulates the pharmacy profession in the public interest. We set and enforce standards and promote best practices for the delivery of pharmacy care in British Columbia.

VALUES

The College of Pharmacy of British Columbia's activities and decisions are based on the following values:

- Being professional and ethical
- Providing quality service
- Building quality relationships
- A culture of excellence

The College acknowledges with respect that the College of Pharmacists of BC is located on the unceded and traditional territories of the Coast Salish peoples – skwxwú7mesh úxwumixw (Squamish), selílwitulh (Tsleil-Waututh), and xWməkʷəyəm (Musqueam) nations whose historical relationships with the land continue to this day

Land acknowledgment included in Annual Report

College of Pharmacists of British Columbia

ANNUAL REPORT 2017/18

Commitment to Cultural Safety and Humility

On March 1, 2017, the College's Registrar, Bob Nakagawa, pledged the College's commitment to improving BC pharmacy professionals' work with First Nations and Aboriginal People by signing the "*Declaration of Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in BC*"

The College believes that cultural safety and humility are vital for the provision of fair and equal health services, as well as the creation of a healthcare environment free of racism and discrimination, where individuals feel safe and respected.

Signing the Declaration of Commitment reflects the high priority placed on advancing cultural safety and humility for First Nations people among regulated health professionals by committing to actions and processes which will ultimately embed culturally safe practices within all levels of health professional regulation.

The declaration commits the College to report on its progress within our annual report and outline strategic activities that demonstrate how we are meeting our commitment to cultural safety.

This Declaration of Commitment is based on the following guiding principles of cultural safety and humility.

> *Cultural Humility is a life-long process of reflection to understand individual and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust.*
>
> *Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. Cultural safety is the outcome of people feeling safe when receiving health care services.*


College of Pharmacists of British Columbia

Our Commitment to Cultural Humility

Acting on our commitment to improve cultural safety and humility for First Nations and Aboriginal People in BC

August 18, 2017

College of Pharmacists of British Columbia

ANNUAL REPORT 2017/18

Commitment to Cultural Humility 2017/18 Progress

Cultural Safety Concepts

The first key objective in fulfilling the College's commitment to cultural humility and safety is to change and influence the values and attitudes of both its registrants and staff. This involves embedding the concepts and principles of cultural humility and safety into the College's current internal processes. The College will also build on the First Nations Health Authority's ***#ItStartsWithMe*** campaign to build awareness of cultural humility and safety, while encouraging pharmacy professionals and staff to reflect on cultural humility and safety and make a pledge as part of the campaign. Leadership from the College Board and executive will help set an example for pharmacy professionals and staff by demonstrating their commitment through participation in cultural safety activities.

Activity	Deliverables	Progress
Board member education on the concepts and principles of cultural humility and safety	• Integrate the First Nations Health Authority's cultural safety and humility webinars and the National Indigenous Cultural Safety Learning Series webinars into the Board's annual orientation. • Recommend Board members to complete the provincial San'yas Indigenous Cultural Safety Training. • Encourage Board members to read the Truth and Reconciliation report and the Health Inequalities and Social Determinants of Aboriginal Peoples' Health report.	**In Progress** – A College Board Cultural Safety and Humility content package is under development. The package will include: • BC Health Regulators Declaration of Commitment to Cultural Safety and Humility in the Regulation of Health Professionals • First Nations Health Authority's Policy Statement on Cultural Safety and Humility • Our Commitment to Cultural Humility (College Strategy) • Cultural Safety and Humility

Reflecting on our progress

New College Board Cultural Safety and Humility Resource

- *BC Health Regulators Declaration of Commitment to Cultural Safety and Humility*
- *First Nations Health Authority's Policy Statement on Cultural Safety and Humility*
- *Our Commitment to Cultural Humility (College Strategy)*
- *Cultural Safety and Humility Definitions*
- *Relevant educational webinars*
- *Truth and Reconciliation report*
- *Health Inequalities and Social Determinants of Aboriginal Peoples' Health report*
- *Information on the San'yas Indigenous Cultural Safety Training*
- *FNHA's Creating a Climate for Change Resource Booklet*
- *How to join into the FNHA's #itstartswith me campaign*

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Huy chexw and Hay ce:p q̓a̓ (Thank You)

First Nations Health Authority
Health through wellness

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Questions?

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BOARD MEETING
September 14, 2018

9. Practice Review Committee: Committee Update

INFORMATION ONLY

Purpose

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

Background

The Practice Review Program is an in-person review of a pharmacy professional's practice and the pharmacy where they work. The program aims to protect public safety by improving compliance with College Bylaws and Professional Practice Policies and ensuring consistent delivery of pharmacy services across British Columbia.

Every pharmacy and pharmacy professional will be reviewed to ensure they meet College standards. The Program's multi-year time frame allows for all pharmacies and pharmacy professionals currently practicing in British Columbia to be reviewed on a cyclical basis. In some cases reviews may occur more frequently in order to address areas of concern.

Transparency is an important element of the Practice Review Program. The results of the Pharmacy Review are shared with the pharmacy manager, and results of all Pharmacy Professionals Reviews are shared confidentially with each individual pharmacist and pharmacy technician.

The Practice Review Program first began in February 2015 and started with reviews in community pharmacy practice settings. The program expanded to include hospital pharmacy practice settings with reviews beginning in April 2017.

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BOARD MEETING
September 14, 2018

Practice Review Program Update

OPERATIONS	
Update	**Next Steps**

General
• Preparing 2017-18 fiscal year reports to present to the Board(update on progress to be presented):
  ○ Data Report
  ○ Registrant Feedback Survey Report
• Initial stages of determining impact of the new Pharmacy Operations and Drug Scheduling Act (PODSA) on PRP
• Monitoring the Risk Register and updating as needed
	General
	• Finalize 2017-18 fiscal year reports to present to the Board
	  ○ Data Report
	  ○ Registrant Feedback Survey Report
	• PODSA impact on PRP
	  ○ Scope requirements, resources, and timelines
	  ○ Develop business case for IT
	• Continue to monitor the Risk Register and make updates as needed

Community Practice • Conducted June, July and August reviews • Scheduled September and October reviews • Integrate for implementation, review form for Residential Care services ○ IT fixing Question Bank module to enable addition of review services	Community Practice • Schedule pharmacies for November reviews • Implement review form for Residential Care services once IT fix of Question Bank module is complete • Develop review forms for other services: telepharmacy, central fill, packaging, compounding and other services based on Board direction and resources

Hospital Practice
• Conducted June, July and August reviews
• Scheduled September reviews
• Selected pharmacies for October to December reviews
• Pharmacist Compliance Officer Resignation
  ○ Posted position
  ○ Cancelled Pharmacist Reviews scheduled in hospital pharmacies from August - September
	Hospital Practice
	• Schedule pharmacies for October to December reviews
	• Interview applicants and hire Pharmacist Compliance Officer
	• Continue to monitor and adjust policies and processes as needed

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BOARD MEETING
September 14, 2018

COMMUNICATIONS & ENGAGEMENT	
Update	**Next Steps**
Community Practice • Released new PRP Insights article ○ Documentation Requirements for Emergency Prescription Refills	Community Practice • Continue to draft and release PRP Insights articles based on findings from reviews
Hospital Practice • Drafted new PRP Insights article ○ Scheduling FAQ for Pharmacy Managers	Hospital Practice • Continue to draft and release PRP Insights articles based on findings from reviews

POLICY & LEGISLATION	
Update	**Next Steps**

General
• Provided feedback on legislation based on findings from reviews
• Provided subject matter expertise (SME) for
  ○ National working group on the National Association of Pharmacy Regulatory Authorities' (NAPRA) Model Standards for Pharmacy Compounding of Non-Sterile Preparations
  ○ Internal working group for Pharmacy Operations and Drug Scheduling Act (PODSA) Modernization
	General
	• Continue to provide feedback on legislation based on findings from review
	• Continue to provide SME:
	  ○ Meet with other Provincial Regulatory Authorities (PRA) on the NAPRA Model Standards for Pharmacy Compounding of Non-Sterile Preparations
	  ○ Regular internal working group meetings for PODSA Modernization

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

COMPLAINTS & INVESTIGATIONS	
Update	**Next Steps**
General • Prioritizing pharmacies/registrants for reviews as per requests from the Complaints and Investigations department • Working with the Complaints and Investigations department to review selected pharmacies (to prevent overlap) • Sharing PRP Information as needed	General • Continue to prioritize pharmacies/ registrants for reviews as per requests from the Complaints and Investigations department • Continue to work with Complaints and Investigations Department to review selected pharmacies (to prevent overlap) • Continue to share PRP information as needed

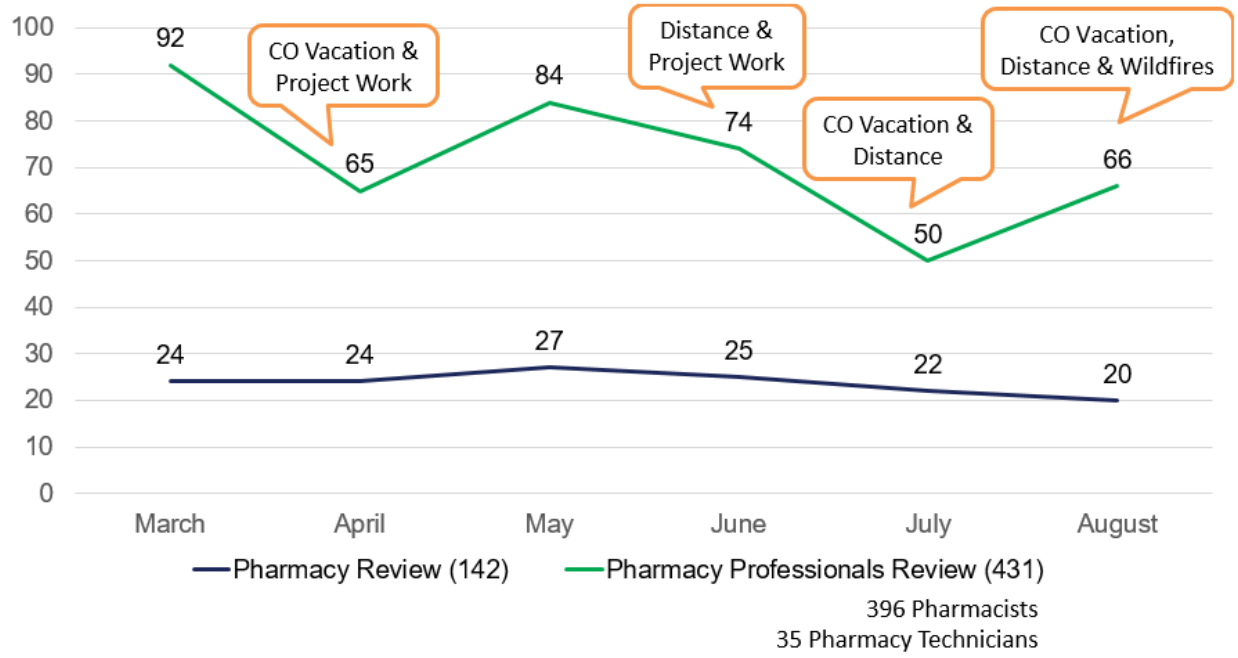
INFORMATION TECHNOLOGY	
Update	**Next Steps**
Community Practice • Fixing Question Bank module in PRP Application ○ Enable addition of review services	Community Practice • User acceptance testing of Question Bank module
Hospital Practice • Provide support as needed	Hospital Practice • Provide support as needed

Appendix	
1	Community Practice Operational Statistics
2	Hospital Practice Operational Statistics
3	PRP Insights Articles for ReadLinks

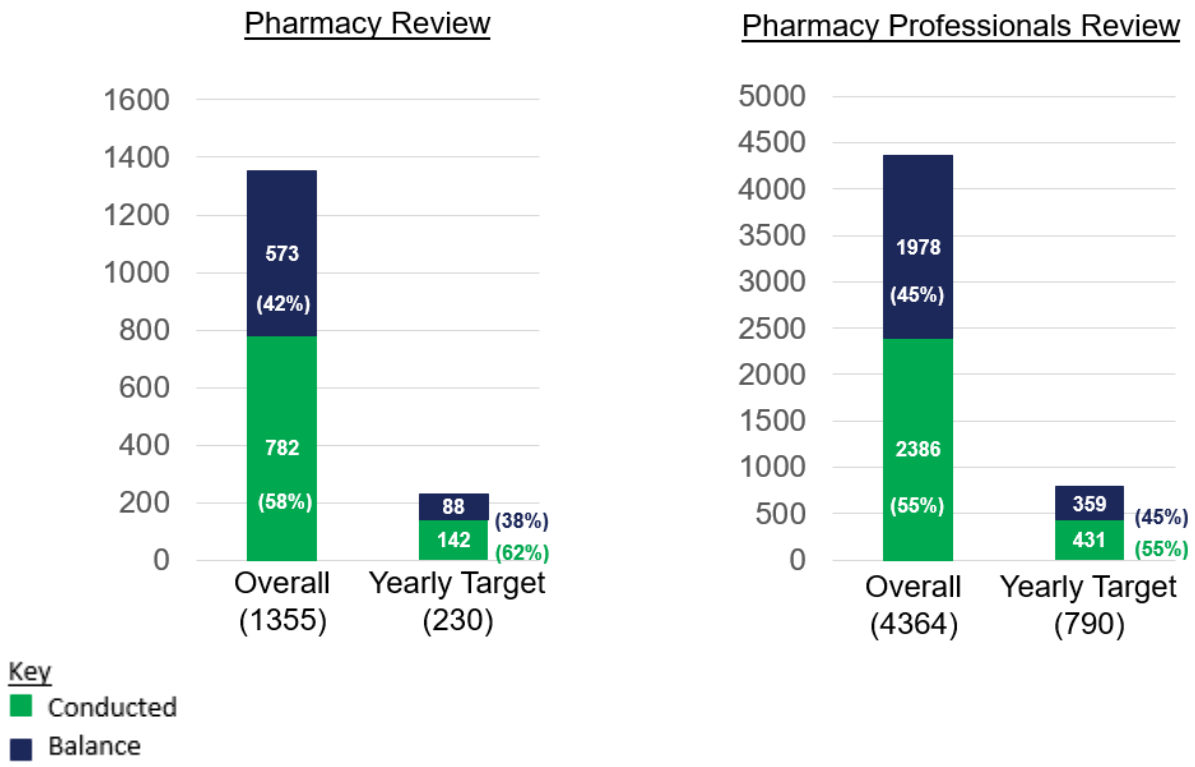
Appendix 1

PRP: Community Practice Operational Statistics
2018-19 Fiscal Year Progress: March 1st, 2018 – August 31st, 2018

Fiscal Year:

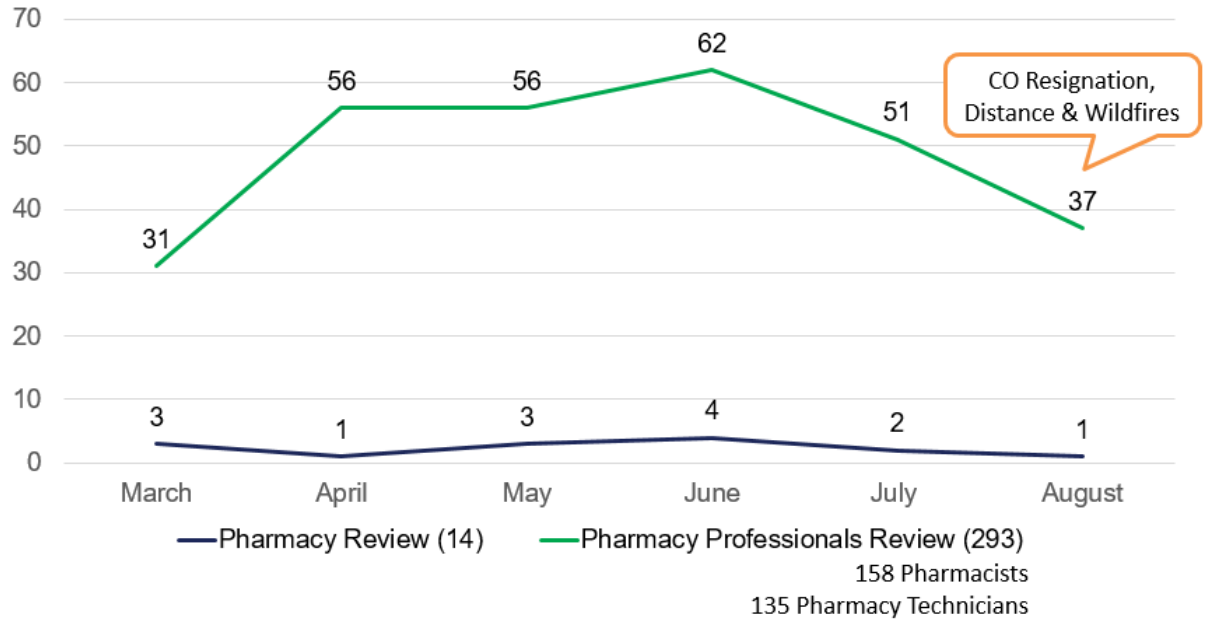


Overall and Fiscal Year:

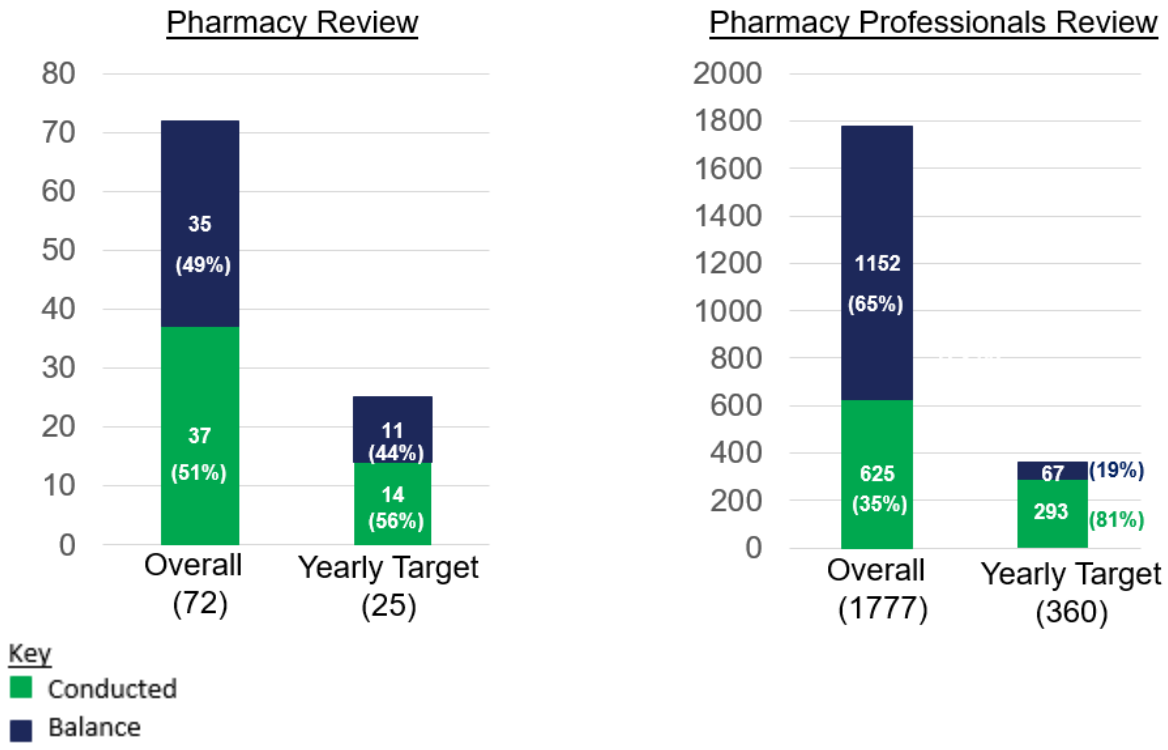


PRP: Hospital Practice Operational Statistics
2018-19 Fiscal Year Progress: March 1st, 2018 – August 31st, 2018

Fiscal Year:



Overall and Fiscal Year:



PRP: Insights Articles

July 2018 Article: Documentation Requirements for Emergency Prescription Refills

PRP INSIGHTS

Helping Patients Receive Safe and Effective Drug Therapy through Therapeutic Substitutions

PRP INSIGHTS: DOCUMENTATION REQUIREMENTS FOR EMERGENCY PRESCRIPTION REFILLS

In our Practice Review Program, Compliance Officers have come across questions from pharmacists regarding documentation requirements for emergency prescription refills ("emergency supplies"). As per Professional Practice Policy 31: Emergency Prescription Refills:

- *Pharmacists must use their CPBC pharmacist registration numbers in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient*
- *Pharmacists must document in the client's record any emergency refill of the prescription, the rationale for the decision, and any appropriate follow-up plan*

Confusion has occurred around what is sufficient documentation for a **rationale** and **follow-up plan**:

Rationale: This refers to the reasoning behind your decision. Simply stating "continuity of care" alone is insufficient because that is already an assumed requirement of an emergency prescription refill and does not give any additional information about the scenario or why you made the decision. Every scenario is different and the details affect whether it's appropriate to provide an emergency supply at all, and if so how much to give. For example, the patient may have run out of medication, or the patient goes to the pharmacy for an authorized refill of a valid prescription but PharmaNet returns the message "101 Prescriber not found".

> *Example of rationale documentation: *"Patient ran out of medication, her doctor is away this weekend. The dose is stable and the drug is currently effective with no issues"*

Follow-up plan: This refers to the need of documenting what happens after the emergency supply is used up. Lacking a documented follow-up plan leaves the situation open-ended, where there's no resolution or plan of action for patient care and continuity of therapy. For example, is the patient going to see the doctor for a new prescription? Does the patient have an appointment with the doctor or knows to make one before the emergency supply is used up? Or is the patient expecting the pharmacy to contact the doctor for a refill? Documentation of a follow-up plan removes ambiguity and serves to reinforce the rationale and appropriate course of action.

> *Example of follow-up plan documentation: *"Patient will make an appointment to see her doctor next week for a new prescription"*

*The above documentation examples are for illustrative purposes only. The level of detail expected varies with each scenario and is based on professional judgement.

Previous Articles:

May 2018 Article: Scheduling and Preparing for your Practice Review in Community Pharmacies

December 2017 Articles: Patient ID in Community Pharmacy , Profile Check in Community Pharmacy , Counseling in Community Pharmacy, Documentation in Community Pharmacy

November 2017: New PRP Focus Areas

July 2017: New PRP Focus Areas for Pharmacy Technicians in Community Practice Coming Soon

May 2017: Prepare for Your Next Practice Review with the New PRP Support Tools!

April 2017: Advice from our Compliance Officers on your next review

March 2017: Compliance Officers offer individual perspectives on practice reviews

February 2017: Meet our Compliance Officers

January 2017: Managing Return-to-Stock Medications

October 2016: When Are CPP Forms Required for Residential Care Facilities, Hospices and Hospitals

June 2016: Privacy, Confidentiality and Security of Patient Health Information

March 2016: Expiry Dates of Compounding Materials and Products

November 2015: Signing Narcotic Records

August 2015: Policy and Procedure Manual

June 2015: Retaining Prescriptions

March 2015: Drug Product Distribution Requirements

College of Pharmacists of British Columbia

9. Practice Review Committee Update

Tracey Hagkull

Chair, Practice Review Committee

James Van

Community Pharmacy Compliance Officer

College of Pharmacists of British Columbia

Outline

- Practice Review Program
  - Background
  - Overview
- Practice Review Team
- 2017-2018
  - Review Data
  - Registrant Feedback Survey
- Key Messages & Next Steps

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Background

2012-2014

- Changes to quality assurance program initiated
- Consultations
- Program development
- Knowledge Assessment Exam discontinued

2015

- Community pharmacy practice reviews launched

2017

- Hospital pharmacy practice reviews launched

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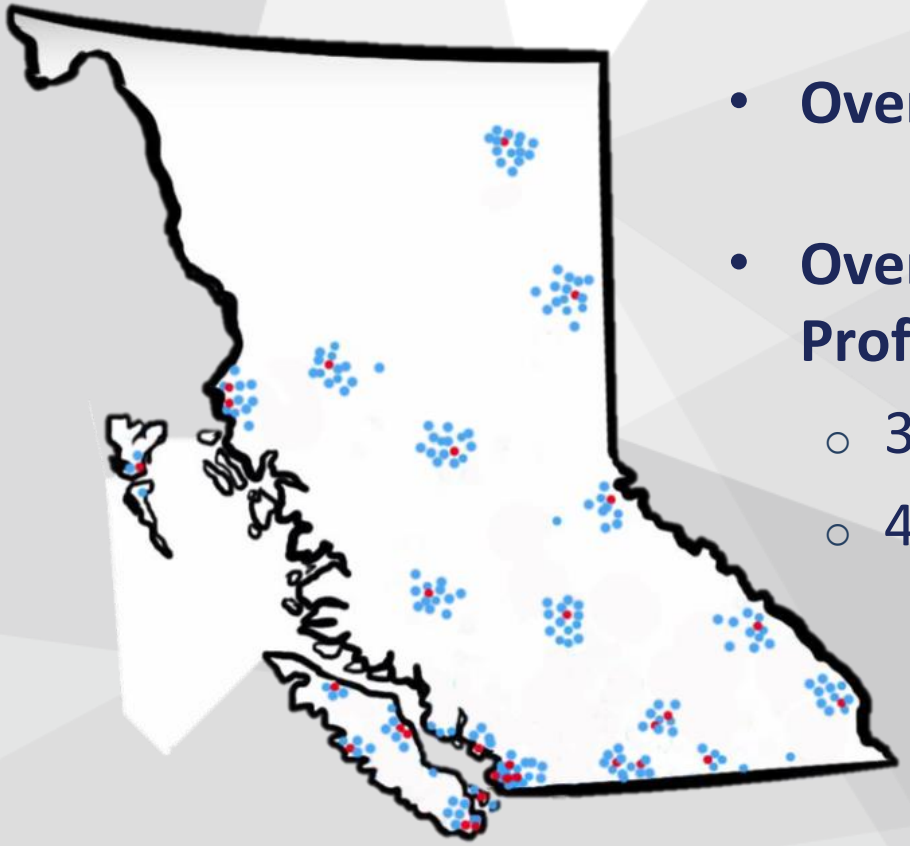
Community Pharmacy Demographics



- **Over 1350 Community Pharmacies**
- **Over 4300 Community Pharmacy Professionals**
  - 3900~ Pharmacists
  - 450~ Pharmacy Technicians

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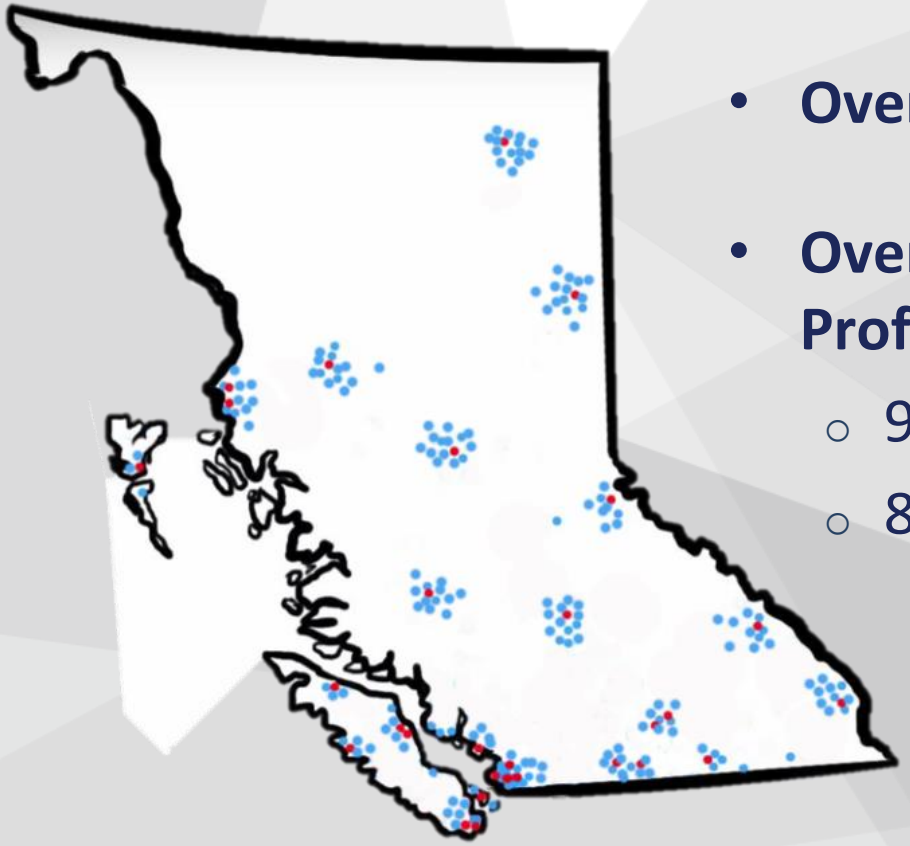
Hospital Pharmacy Demographics



- **Over 70 Hospital Pharmacies**
- **Over 1700 Hospital Pharmacy Professionals**
  - 900~ Pharmacists
  - 850~ Pharmacy Technicians

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Overview

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Pharmacy Inspections Prior to Practice Review Program

Fiscal Year	Community Pharmacy	Hospital Pharmacy
2012-13	90	34
2013-14	138	20
2014-15	122	20
Total	**350**	**74**

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Reviews Since Launch of Practice Review Program

Fiscal Year	Community Pharmacy	Hospital Pharmacy
2015-16	211	N/A
2016-17	181	N/A
2017-18	240	23
Total	**632**	**23**

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Reviews Since Launch of Practice Review Program

Fiscal Year	Community Pharmacists	Hospital Pharmacists	Community Technicians	Hospital Technicians
2015-16	487	N/A	40	N/A
2016-17	527	N/A	51	N/A
2017-18	713	160	95	172
Total	**1727**	**160**	**186**	**172**

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Meet the Practice Review Team

Ashifa Keshavji

Director of Practice Reviews & Quality Assurance

Ashley Le

Practice Reviews & QA Coordinator

Ed Diaz

Practice Reviews & QA Coordinator / Hospital Compliance Officer

Megi Koroveshi

Practice Reviews & QA Administrative Assistant

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Community Compliance Officers

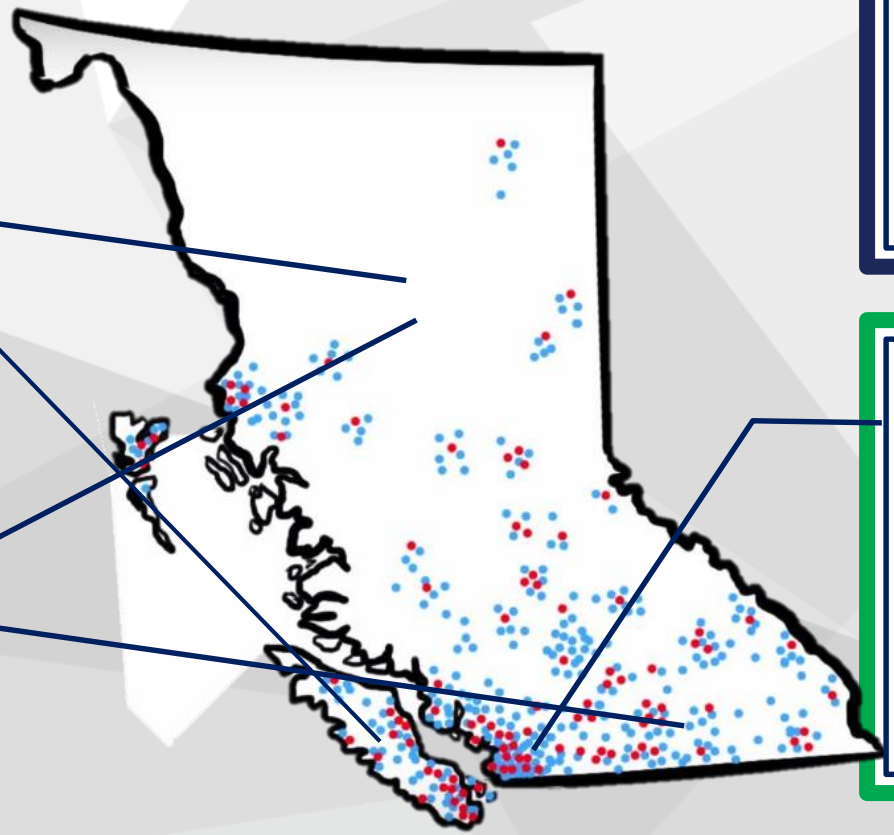
Hospital Compliance Officers

District 3 & 5 *(Vancouver Island / Coastal & Northern BC)*

Dwain

District 4 & 5 *(Kootenay / Okanagan & Northern BC)*

David



Districts 6 & 7
(Urban/Community Hospitals)

Bethany

Ed

Districts 1 & 2 *(Metro Vancouver / Fraser Valley)*

James

Mark

Monica

John

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Practice Review Program Data

Reviews Conducted 2017-2018

	Pharmacies	Pharmacists	Pharmacy Technicians
Community	240	713	95
Hospital	23	160	172
Total	263	873	267

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Practice Review Program Data

Methodology

- Community pharmacy
  - Data collected via computer application
  - More detailed results
- Hospital pharmacy
  - Data collected manually via excel forms
  - Data extraction and analysis limited to broader scope

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Community Pharmacy Review Categories

- External to Dispensary
- Dispensary
- Security
- Equipment & References
- Prescriptions
- Confidentiality
- Inventory Management
- Dispensed Products
- Documentation
- Pharmacy Manager Responsibilities
- *Methadone**
- *Compounding**

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Hospital Pharmacy Review Categories

- Pharmacy Security
- Equipment & References
- Drug Orders
- Confidentiality
- Inventory Management - Pharmacy
- Inventory Management – Nursing Unit
- Narcotics and Controlled Drug Substances
- Dispensed Products
- Patient Records / Documentation
- After Hours Services
- Pharmacy Manager's Responsibilities
- Non-Sterile Compounding*
- Bulk Packaging*
- Residential Care*
- Sterile Compounding*
- Ambulatory / Outpatient Services*

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Pharmacist Review Categories

Community	Hospital
Patient Identification Verification	Patient Identification Verification
Profile Check	Profile Check
Counselling	Counselling
Documentation	Documentation

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Pharmacy Technician Review Categories

Community
Patient Identification Verification
Product Distribution
Collaboration
Documentation

Hospital
Patient Identification Verification
Product Distribution
Collaboration
Documentation

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Impact of Data

- All action items identified during review in 2016-2018 fiscal years were resolved by end of process
  - No referrals to Inquiry Committee
- Registrant support tools developed based on review outcomes
- Computerized application allows for collection of data
  - PRP evaluation, improvement, and development
  - To inform other College areas for consistency

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Registrant Feedback Survey

Methodology

- Online Surveys emailed to registrants after reviews conducted and action items are complete
  - Voluntary and anonymous
  - 7 point Likert Scale
    - Strongly Agree – Strongly Disagree
  - Written comments

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Registrant Feedback Survey

Response Rate:

- 29% of community pharmacy registrants
- 33% of hospital pharmacy registrants

Data Analysis:

- Quantitative data using agreement rating
- Qualitative data in process

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Calculation of Overall Rating Score (7 point Likert Scale)

$$Agreement\ Rating\ \% = \frac{\#\ Agree + \#\ Strongly\ Agree}{Total\ \#\ of\ Responses}\ x\ 100$$

$$Neutral\ Rating\ \% = \frac{\#\ Somewhat\ Agree + \#\ Neutral + \#\ Somewhat\ Disagree}{Total\ \#\ of\ Responses}\ \text{x}\ 100$$

$$Disagreement\ Rating\ \% = \frac{\#\ Disagree + \#\ Strongly\ Disagree}{Total\ \#\ of\ Responses}\ x\ 100$$

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What are Pharmacy Professionals saying about the Practice Review Program?

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Feedback Survey Initial Findings – Community

Registrants <u>MOST</u> Satisfied with:

1. Compliance Officers (98.37% - Agreement Rating)
2. Pharmacy Review (97.78% - Agreement Rating)
3. Pharmacy Review Results (97.22% - Agreement Rating)

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Feedback Survey Initial Findings – Community

Registrants <u>LEAST</u> Satisfied with:

1. Action Item Portal (84.62% - Agreement Rating)
2. Pre-Review (88.52% - Agreement Rating)
3. Pharmacy Review Scheduling (88.89% - Agreement Rating)

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Feedback Survey Initial Findings – Community

Most Impactful Areas of Pharmacy Review to Practice:

1. Documentation
2. Prescriptions
3. Pharmacy Manager Responsibilities
4. Security

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Feedback Survey Initial Findings – Hospital

Registrants <u>MOST</u> Satisfied with:

1. Hospital Pharmacy Review Scheduling (100.00% - Agreement Rating)
2. Hospital Pharmacy Review Results (100.00% - Agreement Rating)
3. Compliance Officers (98.60% - Agreement Rating)

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Feedback Survey Initial Findings – Hospital

Registrants <u>LEAST</u> Satisfied with:

1. Pre-Review (66.67% - Agreement Rating)
2. Hospital Pharmacist Review Results (81.43% - Agreement Rating)
3. Hospital Pharmacy Technicians – PRP Tools (84.38% - Agreement Rating)

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Feedback Survey Initial Findings – Hospital

Most Impactful Areas of Pharmacy Review to Practice:

1. Patient Records and Documentation
2. Narcotics and Controlled Drug Substances
3. Inventory Management – Pharmacy
4. Pharmacy Manager's Responsibilities

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Key Messages

- Overall identified as beneficial by registrants
- All pharmacies and pharmacy professionals reviewed in 2016-2018 in compliance after completion of review process
- Registrants most satisfied with PRP team
- Information Technology identified as area most needing enhancement
- Ongoing program evaluation and development

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Next Steps

- Investigate further data analysis
- Continue to enhance IT services with possible platform expansion
- Ongoing collaboration and communication with Registrants and other College program areas

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Questions

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BOARD MEETING
September 14, 2018

10. Application Committee - Committee Update

INFORMATION ONLY

Purpose

For the Committee Chair to provide an update on the Application Committee.

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10. Application Committee Update

Sorell Wellon

Chair, Application Committee

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Pharmacy Files Referred to Application Committee

AC Meeting Date	Incomplete (also includes late renewals)	Eligibility-Related	Total
June 21, 2018	1 (from June cohort)	3 (2 x change of Indirect Owner, 1 x change of Pharmacy Manager)	**4**
July 11, 2018	11 (from July cohort)	1 (1 x Indirect Owner)	**12**
August 8, 2018	14 (from Aug cohort)	2 (1x change Pharmacy Manager and 1x change Direct Owner)	**16**
September 7, 2018	13 (from Sept cohort)	1 (1x Indirect Owner)	**14**

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Pharmacy Licence Renewal

Licence Expiry	# Pharmacies Due	# Direct Owners	# Pharmacies completed before deadline	# Pharmacies Late	# Pharmacies Renewed by Expiry Date
June	77	69	68	9 (11.7%)	• 74 renewed x 12 months • 1 renewed x 1 month (AC) • 2 Δ Direct Owner from renewal
July	78	66	61	17 (21.8%)	• 74 renewed x 12 months • 1 renewed x 1 month (AC) • 1 renewed x 11 months (from June cohort) • 2 Δ Direct Owner from renewal
Aug	82	69	68	14 (17.1%)	• 80 renewed x 12/12 • 1 Δ DO from renewal • 1 Closure
Sept	98	73	82	16 (16.3%)	

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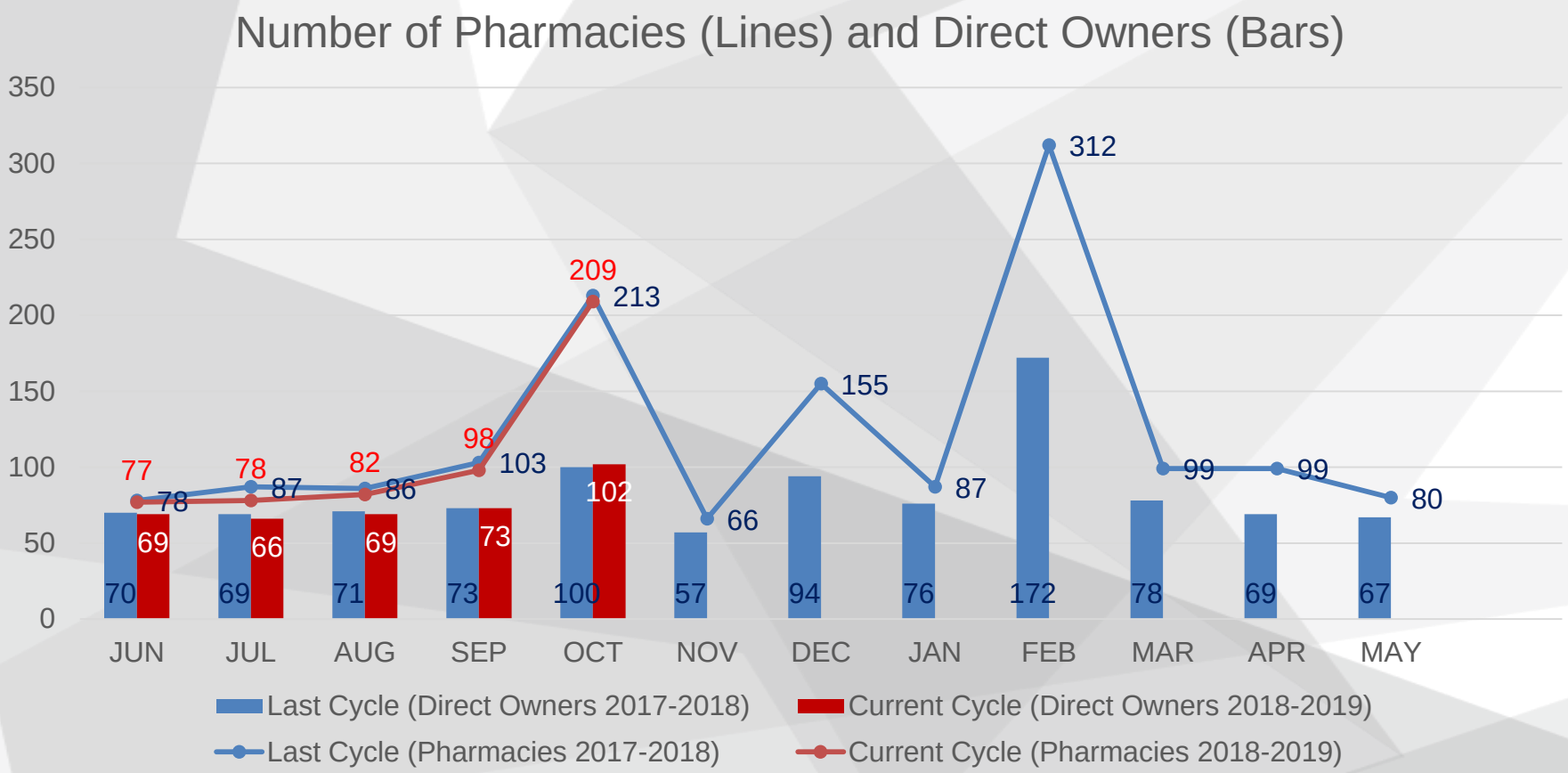
Pharmacy Licence Renewal



College of Pharmacists of British Columbia

of Pharmacies Completed New Ownership Requirements*

Licence Expiry/ Licence Type	Community	Tele-pharmacy	Education Site	Hospital	Grand Total
June 30, 2018	78			2	80
July 31, 2018	83	2	1	2	88
August 31, 2018	74		2	2	78
Grand Total	235	2	3	6	246

- Includes applications for 1) New Pharmacy Licence, 2) Pharmacy Renewal, and 3) Change of Direct Owner
- *Excludes Change of Pharmacy Manager

College of Pharmacists of British Columbia

of Direct Owners Completed New Ownership Requirements*

License Expiry	# Direct Owners	Min # Pharmacies Owned by Direct Owner	Max # Pharmacies Owned by Direct Owner	# of Direct Owners who own 1 Pharmacy
June 30, 2018	75	1	3	72
July 31, 2018	74	1	4	65
Aug 31, 2018	63	1	6	58
Grand Total	**212**			**195**
# Unique Direct Owners	**210**			

- Includes applications for 1) New Pharmacy Licence, 2) Pharmacy Renewal, and 3) Change of Direct Owner
- *Excludes Change of Pharmacy Manager

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Proof of Eligibility (Attestation & Criminal Record History)

Proof of Eligibility is required from the following individuals:

Type of Application	Pharmacy Manager	Indirect Owners
New Pharmacy Licence	Yes	Yes if owned by corporation
Pharmacy Licence Renewal	Yes	Yes if owned by corporation
Change of Direct Owner	Yes	Yes all Indirect Owner from NEW *direct owner* if it is a corporation
Change of Indirect Owner	Yes	Yes from NEW *indirect owner* if the direct owner is a corporation
Change of Manager	Yes from NEW pharmacy manager	N/A

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Number of Proof of Eligibility (POE) Completed Each Month

License Expiry	# of POE	Min # POE per Pharmacy	Max # POE per Direct Owner	AVG # POE per Direct Owner
June 30, 2018	281	1	21	3.75
July 31, 2018	319	1	24	4.25
Aug 31, 2018	314	1	42	4.91
Grand Total	**914**			

- Includes all types of applications that require Proof of Eligibility to be submitted
- Note: a person may have to attest to multiple pharmacies at the same time

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Number of People Completed Proof of Eligibility Each Month

License Expiry	Non-Registrants	Pharmacists	Pharmacy Technicians	Grand Total
June 30, 2018	94	128	1	223
July 31, 2018	70	147	-	217
Aug 31, 2018	72	129	-	201
Grand Total	**236**	**404**	**1**	**641**
# Unique Persons	**183**	**363**	**1**	**547**

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Criminal Record History Statistics from Sterling

Statistics between April 1, 2018 to June 15, 2018

Clear	Not Clear	Total Completed
399	2	401

Turnaround time

	Within 1 Day	2-3 days	4-5 days	> 5 days
# of Files (Total 405)	400	4	0	1

- *Variance between 405 vs 401 as some cannot be completed -> required the individual to obtain a Criminal Record History through their local police station

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Emails, Phone Calls & Walk-ins/Appointments Statistics

Statistics between June 1, 2018 – August 31, 2018

Month	# of Calls (incoming & outgoing)	# of Emails (Received)	# of Walk-ins/Appointments
June 2018	136	1040	2
July 2018	161	1067	4
August 2018	220	1010	7
Grand Total	**517**	**3117**	**13**

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Common Questions / Comments

Ownership Requirements

- What requirements/documents do I still need to submit
- How do I submit the documents
- Can I send the Annual Report instead of the corporate documents

Proof of Eligibility

- Where do I complete my Proof of Eligibility/Is my Proof of Eligibility already completed
- When will you get my Criminal Record History results
- Why does it say “pending” when I completed them already

Technology

- I can’t find the correct section to complete my ownership information
- Why do I have to submit the same corporate documents for the same direct owner
- I’ve uploaded the business licence but it shows it is not uploaded
- I shouldn’t need a Computer Science degree to be able to navigate your website

College of Pharmacists of British Columbia

Common Reasons for Rejecting an Application

Ownership documents incorrect

- Central securities register not certified
- BC Company Summary not current
- Parent company documents not submitted

Proof of Eligibility

- Attestation not completed for all indirect owners
- Criminal Record History not completed for all direct owners
- Criminal Record History started but not completed

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Enhancements

- On-going revisions to the Pharmacy Licensure Guide
- Revisions to the College Website
- Template letters/emails drafted to respond to missing requirements
- ReadLinks articles drafted on commonly encountered issues / deficiencies
- Continual direct communication with registrants / non-registrants / authorized representatives

Coming in November…

- PODSA Ownership Experience Survey - Online

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Resource Materials

- **Pharmacy Licensure Guide**
  http://library.bcpharmacists.org/3_Registration_Licensure/5237-Pharmacy-Licensure-Guide.pdf
- **College Website Ownership Page**
  http://www.bcpharmacists.org/ownership
- **Youtube videos**
  http://www.bcpharmacists.org/pharmacy-licence-renewals
- **ReadLinks Articles**
  http://www.bcpharmacists.org/readlinks/
- **Licensure Web Pages**
  http://www.bcpharmacists.org/community-pharmacy

College of Pharmacists of British Columbia

Questions

College of Pharmacists of British Columbia

BOARD MEETING
September 14, 2018

11. Patient Relations Program Standard

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution:

"RESOLVED THAT, in accordance with the authority established in section 19(1)(l) of the Health Professions Act, the board approve the proposed bylaws of the College of Pharmacists of British Columbia regarding a patient relations program standard, for public posting as circulated."

Purpose

To seek Board approval on the proposed Patient Relations Program Standard for a 90-day public posting.

Background

The proposed Patient Relations Program Standard ("the Standard") outlines the responsibilities of registrants in relation to:

- Professional boundaries and dual relationships;
- Relationships with former patients; and,
- The duty to report sexual misconduct.

In addition, it also raises awareness of registrants' responsibility to educate themselves on professional ethics. See Appendix 1 for the proposed Standard.

Legislative Requirements for a Patient Relations Program Standard

The establishment of a patient relations program standard is a requirement for the College under s.16(2)(f) of the *Health Professions Act* ("HPA")[1]. Under the HPA, the purpose of a patient relations program standard is to seek to prevent professional misconduct of a sexual nature.

[1] http://www.bclaws.ca/civix/document/id/lc/statreg/96183_01

Furthermore, the Board is required to establish a patient relations program standard under s. 84 of the HPA Bylaws[2]. Lastly, the Standard corresponds with College's Code of Ethics, which references the "Patient Relations Program Standard" as a companion document in Standard 7(b).[3]

The proposed Standard primarily addresses s. 84(2)(c) of the HPA Bylaw requirement (i.e. to "develop guidelines for the conduct of registrants with their patients"). The other two requirements for a Patient Relations Program Standard under the HPA Bylaws (as noted under s. 84(2)(a) and (b)) are regarding the setting of procedures, monitoring and evaluation of the program. It is proposed that those other requirements be addressed via a corresponding program information document to be adapted for the College's website (see Appendix 2). This information document is operational in nature would not require filing; therefore, it is not the primary focus of this briefing note.

Development of the College's Patient Relations Program Standard

In 2013, the BC Health Regulators (BCHR) established a working group (the Working Group) to review programs dealing with patient-practitioner relationships and to make recommendations on a framework for a model patient-practitioner relationship program. The Working Group was comprised of registrars and compliance staff from ten different colleges. A key outcome was the development of a framework, to ensure that consistent principles and program elements are used in the development of each respective college's patient relations program standard (see the BCHR Framework in Appendix 3).

The Board approved the BCHR Framework at its September 2016 meeting. The College's Ethics Advisory Committee drafted a patient relations policy statement and program document, which has since been incorporated into the Standard and program information document (two separate documents). The Standard incorporates findings from cross jurisdictional research, and has been reviewed by legal counsel and College staff.

Discussion

The Standard provides guidance to registrants on maintaining proper professional boundaries with patients and former patients, and preventing professional misconduct of a sexual nature. These guidelines are based on international benchmarking of professional standards on sexual misconduct, and are informed by legal counsel review. The Standard also outlines the statutory requirement of all registrants to report sexual misconduct under s. 32.4 of the HPA.

[2] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5076-HPA_Bylaws.pdf

[3] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5087-HPA_Bylaws_Code_of_Ethics.pdf

The Standard is intended to be read and understood in relation to its companion documents – the Code of Ethics and Conflict of Interest Standards. Collectively, these three documents address all key aspects of professional misconduct (see Appendix 4) and form a comprehensive suite of regulatory tools to enforce the College's patient relations program. Standard.

Alignment with the BCHR Framework

Careful consideration has been made to ensure the College's patient relations program standard aligns with the BCHR Framework. The Standard addresses three program elements related to sexual misconduct and dual relationships, whereas the Code of Ethics and Conflict of Interest Standards address other aspects of professional misconduct (see Appendix 4). BCHR Framework elements which are not explicitly addressed via regulatory means – e.g. social media – could be addressed through communications tools on the College's website.

Spousal Relationships and Sexual Misconduct

The Standard does directly discuss the issue of providing pharmacy services to family members, including spouses. However, dispensing prescriptions to family members is generally prohibited under Standard 2(e) of the Conflict of Interest Standards[4]. This is consistent with the BCHR Framework, which requires all colleges to address "treatment of partners, spouses, or other family members" and "care of family members in emergency situations". Where further information is required on this matter, it is suggested that communications tools such as FAQs or Readlinks be employed.

Next Steps

Upon Board approval, the Standard would undergo public posting for a period of 90 days. All feedback received will be reviewed and is expected to be brought forward to the February 2019 Board meeting. At that time, the Board is expected to consider whether to file the draft Standard with the Ministry of Health for inclusion under Schedule A of the *Health Professions Act* Bylaws.

[4] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5111-Code_of_Ethics_Conflict_of_Interest_Standards.pdf

Recommendation

The Legislation Review Committee recommends that the Board approve the proposed Standard for a 90-day public posting period.

Appendix	
1	Patient Relations Program Standard
2	Patient Relations Program Information
3	BCHR Framework
4	CPBC Regulatory Tools for Non-Sexual Professional Misconduct

Patient Relations Program Standard

Application

This standard applies to all registrants in all practice settings, and should be read in conjunction with Standard 7(b) of the Code of Ethics in Schedule "A" of the *Health Professions Act* Bylaws. It should also be read in connection with sections 32.2 and 32.4 of the *Health Professions Act*.

Definitions

In this standard:

"professional misconduct" has the same meaning as in s.26 of the Act*;*

"sexual misconduct" includes:

i. sexual intercourse or other forms of sexual relations between the registrant and the patient,

ii. touching of a sexual nature, of the patient by the registrant, or

iii. behaviour or remarks of a sexual nature, by the registrant towards the patient,

but does not include touching, behaviour or remarks by the registrant towards the patient that are of a clinical nature appropriate to the service being provided.

Purpose

This standard is to inform registrants and the public of the college's expectations for registrants to ensure that proper professional boundaries are observed and to prevent professional misconduct of a sexual nature.

Standards

(i) *Maintaining Professional Boundaries and Avoiding Dual Relationships*

It is important to ensure that there are clear professional boundaries between registrants and their patients. Professional boundaries are based on trust, respect and the appropriate use of power as there is a power imbalance between patients and registrants. Patients are entitled to rely on registrants to act in a professional and ethical manner and to never put their personal interests above those of their patients. Registrants have the responsibility to maintain appropriate professional boundaries at all times and should refrain from having dual relationships with patients.

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The ways in which registrants must maintain appropriate professional boundaries include: (a) showing respect for the patient's privacy at all times; (b) avoiding physical contact outside of clinical necessity; (c) avoiding behaviour or remarks that may be interpreted as sexual or inappropriate by a patient; (d) refraining from asking personal information that is irrelevant to the professional services being provided; (e) refraining from sharing inappropriate personal information with the patient; and (f) showing sensitivity to the patient's cultural or religious background;

Forming a relationship with a patient outside the professional setting may place a registrant in an ethically compromising situation, and may result in the violation of a professional boundary which is a serious regulatory matter.

As a consequence, registrants should generally avoid dual relationships, even when the patient attempts to initiate the relationship or consents to enter into a personal relationship. The existence of a dual relationship may compromise the registrant's ability to provide objective and unbiased care which places the patient (and broader public) at risk.

(ii) *Relationships with Former Patients*

It is unethical for a registrant to terminate a professional relationship in order to initiate a personal or sexual relationship with a patient. Depending on the circumstances, it may be considered unethical and unprofessional conduct to form a relationship with a former patient. Registrants should have regard to the following considerations before considering a relationship with a former patient:

- The nature of the previous professional relationship and whether it involved a significant imbalance of power;
- Whether the former patient was, or is, vulnerable;
- Whether the registrant is using the knowledge or influence that the registrant gained through the professional relationship to develop or continue the personal relationship;
- Whether the registrant is already treating, or are likely to treat, any other members of the former patient's family;
- Whether the patient understands that the registrant-patient relationship has ended;
- Whether the patient is capable of consenting;

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- Whether or not a reasonable interval of time has passed since the professional relationship ended with the patient.*

* Registrants should consider the following guidelines to self-assess whether a reasonable interval of time has passed:

- The nature, intensity and frequency of the former registrant-patient relationship, as well as the level of patient vulnerability and power imbalance should be taken into consideration.

- The relationship must not be a result of or appear to be a result of the use or exploitation of the trust, knowledge, influence, or emotions derived from the previous professional relationship.

- Registrants—not their clients—assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(iii) *Duty to Report Sexual Misconduct*

Registrants have a statutory duty to report sexual misconduct under s. 32.4 of the *Health Professions Act*.

The college requires registrants who have reason to believe that a registrant of a health profession is engaging in sexual misconduct to promptly report that information to the college, and in any event no later than 30 days of reasonably concluding that such conduct is or has taken place. Any delay in filing a report may jeopardize public safety.

Guidelines

<u>Education on Professional Ethics</u>

Registrants have a responsibility to educate themselves on professional ethics and should be aware that the college has an online ethics program.

Patient Relations Program Information

In order to maintain professional boundaries between registrants and patients, and to prevent professional misconduct of a sexual nature, the College has established a patient relations program.

The College's patient relations program includes:

1. Procedures for dealing with complaints involving professional misconduct of a sexual nature;
2. Training to key College staff on how to appropriately handle complaints involving professional misconduct;
3. Requirements and guidelines for the conduct of registrants with their patients, outlined in the Patient Relations Program Standard, Conflict of Interest Standards, and Code of Ethics;
4. Education to registrants on professional boundaries and misconduct prevention;
5. Monitoring and evaluation of the patient relations program.

Establishing a Patient Relations Program is a requirement of all BC health regulators as stated in HPA s.16(2)(f):

> *(2) A college has the following objects:*
>
> > *(f)to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;*

<u>Role of the Ethics Advisory Committee</u>

To provide advice and guidance to the Board and the registrar on matters relating to the Patient Relations Program, and educational program proposals relating to ethics issues. The Ethics Advisory Committee also oversees the implementation of the Patient Relations Program.

1. Procedures for dealing with complaints involving professional misconduct

When a complaint involving professional misconduct is received by the College, it will follow the College's usual complaints process. The complaint is taken to the Inquiry Committee for "direction to investigate" the matter.

If the complainant wishes to meet with a College Investigator prior to formalizing their complaint, a meeting shall be arranged. The complainant will be advised, prior to the meeting that they may bring other persons of their choosing (e.g., a patient advocate, relative, friend or another support person) to the meeting if desired. They will also be advised that although all matters coming before the College are required to be kept in

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confidence, all persons who could provide information concerning the complaint must be included in the formal complaint in the interest of fairness to both parties.

At the time of the meeting, the role of the College and its mandate, and the inquiry and disciplinary procedures will be explained prior to hearing the complaint. At the conclusion of the meeting, authorization will be sought from the complainant to proceed with an investigation, including providing the College with a formal complaint form and authorization for any other required information. The College Investigator shall assist the complainant to draft any submission required by the College's Inquiry Committee.

During the investigation phase, the Complaints Investigator gathers all relevant information from all parties involved. This step may, but is not limited to include telephone conversations, in-person interviews, and gathering of pharmacy records, PharmaNet patient profiles.

After the investigation is complete, the Inquiry Committee reviews the complaint and determines the appropriate actions needed to resolve the complaint. The Registrar may issue a citation for a Discipline Committee hearing in instances where the Inquiry Committee has determined an issue to be serious, a consensual agreement cannot be reached with the registrant, or the registrant has not responded to the complaint.

2. The College's guidelines on handling complaints regarding sexual abuse includes the following:

- Registrants and College staff must be educated about the nature of sexual abuse, the seriousness and magnitude of the problem and the range of problems suffered by victims of sexual abuse.
- Staff dealing with complaints regarding sexual abuse must be educated about barriers to disclosure and how to facilitate disclosure.
- Ensure reports taken by staff are received and processed in a competent, caring and sensitive manner.
- Ensure staff are appropriately trained on the proper procedures for the intake of complaints or reports of sexual abuse.
- Be aware of and able to refer complainants to treatment options for sexual abuse.
- Participate in and contribute to strategies for recognizing, confronting and treating abuse by colleagues and other healthcare professionals, and for reporting knowledge or suspicion of such abuse.

3. Guidelines for the conduct of registrants with their patients

Registrants demonstrate respect for patients by faithfully adhering to their professional Code of Ethics and behaving in the following ways:

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- Respect the value, dignity and autonomy of patients,
- Respect patient vulnerability and maintain professional boundaries with patients,
- Do not exploit patients for personal advantage,
- Treat patients with sensitivity, caring, courtesy and respect,
- Utilize their professional judgment to serve the best interests of their patients.

4. Education to registrants on professional boundaries and sexual abuse prevention

The College's on-line ethics training program provides registrants with education and guidance regarding professional boundaries and sexual abuse prevention.

5. The Patient Relations Program will include a monitoring and evaluation strategy to measure the success of the program.

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Framework for a Model Patient-Practitioner Relationship Program for BC Health Regulators

1. Legislative Framework

All Colleges regulated under the *Health Professions Act (HPA)* are required to establish a program to deal with patient-practitioner relationships:

> Section 16 (2) (f)
> … to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature.

2. Program Position Statement

Health care practitioners regulated by Colleges of the BC Health Regulators provide health care that is built on a foundation of trust and respect. Patients trust their professional practitioner because they believe the practitioner has special knowledge, skills and abilities and uses these to provide safe, effective and ethical care. Practitioners demonstrate respect for patients by acknowledging their position of power and maintaining professional boundaries.

A Patient-Practitioner Relationship Program helps both patients and practitioners understand the need for boundaries in establishing the context and limits of care. The professional relationship between the professional and the patient exists for the patient's benefit. Setting boundaries requires the practitioner be a professional and to ensure that the autonomy and dignity of patients is maintained.

3. Key Concepts and Definitions

"*Professional misconduct*" is defined in the HPA (Part 3) to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession".

"Dual relationships" in the health service context pertains to relationships in which the registered professional has more than one relationship with the service recipient. An example of a dual relationship is providing clinical services to a family member or friend.

"Conflict of Interest" arises where a reasonable person could form the view that a professional's ability and obligation to act in the patient's best interests may be affected or influenced by other competing interests. Such conflicts of interest can be real, potential or perceived. Conflicts of interest occur in a variety of circumstances including financial, non-financial, direct, and indirect transactions with patients and others.

"Informed consent" is defined in S. 7 of this Framework.

4. Principles for the Patient-Practitioner Relationship Program

a) Each program is developed in the context of the type of health care and the health care environment in which it is provided.
b) Each program must establish appropriate professional boundaries between the registrant and the patient, ensuring that:
   (i) the patient is able to provide full, free and informed consent;
   (ii) patient autonomy is maintained at all times; and
   (iii) the practitioner provides objective care to every patient.
c) Each program must have clear, concise and accessible information and materials for both registrants and the public.
d) Each program must provide training for College staff to support their understanding of the program and how it applies in practice.
e) The program is designed to enhance the registrant's capacity to understand and set boundaries and communicate those effectively to every patient.

5. Patient-Practitioner Relationship Program Elements

Each College's patient-practitioner relationship program must address the following areas:

a) romantic or sexual relationship with patients;
b) treatment of partners, spouses, or other family members;
c) relationships with former patients;
d) "bartering" or exchanging health care services for other services with a patient;
e) monetary gain from patients outside of the cost of the service/care provided;
f) use of social media;
g) non-trivial gifts from patients;
h) care of family members in emergency situations; and
i) guidance for practitioners working in small, rural or remote communities.

6. Shared Underlying Principles in the Patient-Practitioner Relationship

1. Avoidance, as much as possible, of any professional relationship with a patient when the professional's objectivity or competence could reasonably be expected to be impaired because of the professional's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the patient or with another relevant person associated with or related to the patient.

2. If a dual relationship or conflict of interest is unavoidable, the professional should document the specific circumstance, an account of why the duality or conflict is unavoidable and document the informed consent of the patient(s) for all services.

3. Obtaining informed consent at the beginning of professional relationships and understanding that informed consent is an ongoing process, rather than a onetime event.

7. What Constitutes Informed Consent

The BC *Health Care (Consent) and Care Facility (Admission) Act* defines "*Informed Consent"* as follows:

4 Every adult who is capable of giving or refusing consent to health care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,

(b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,

(c) the right to revoke consent,

(d) the right to expect that a decision to give, refuse or revoke consent will be respected, and

(e) the right to be involved to the greatest degree possible in all case planning and decision making.

5 (1) A health care provider must not provide any health care to an adult without the adult's consent except under sections 11 to 15.

(2) A health care provider must not seek a decision about whether to give or refuse substitute consent to health care under section 11, 14 or 15 unless he or she has made every reasonable effort to obtain a decision from the adult.

6 An adult consents to health care if

(a) the consent relates to the proposed health care,

(b) the consent is given voluntarily,

(c) the consent is not obtained by fraud or misrepresentation,

(d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,

(e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about

(i) the condition for which the health care is proposed,

(ii) the nature of the proposed health care,

(iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and

(iv) alternative courses of health care, and

(f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

Appendix

CPBC Provisions for Professional Misconduct of a Non-Sexual Nature

Regulatory tool	Type of professional misconduct	Provision
Conflict of Interest Standards	Financial gain	Standard 1(a)(ii): Pharmacists must only adapt a prescription to optimize the patient's therapeutic outcome of treatment. In no instance should a pharmacist adapt a prescription in order to benefit financially or in kind.
Conflict of Interest Standards	Financial gain	Standard 1(a)(iii): Registrants must always provide/promote the drug or drug substitution that will best serve the patients needs. They must not provide/promote a particular drug or drug substitution simply in order to take advantage of a manufacturer's discount or other incentives.
Conflict of Interest Standards	Financial gain	Standard 1(a)(iv): Registrants must not dispense a smaller quantity than that required to serve the patient's best interests simply to accrue additional dispensing fees.
Conflict of Interest Standards	Financial gain	Standard 1(b): Registrants must not offer loyalty or incentive programs that are contrary to the patient's best interests.
Conflict of Interest Standards	Financial gain	Standard 2(b): Registrants must not ask for or accept any incentive, or gift which may affect or be seen to affect their commitment to their patient's best interests.

Appendix

CPBC Provisions for Professional Misconduct of a Non-Sexual Nature

Regulatory tool	Type of professional misconduct	Provision
Conflict of Interest Standards	Financial gain	Standard 2(c): Registrants must not accept cash payments or other incentives (excluding generally accepted ethical business practices) over and above remuneration for services provided to patients.
Conflict of Interest Standards	Financial gain	Standard 2(d): Registrants must not provide to or receive cash payments or other incentives from other registrants, other healthcare professionals or any other person or organization solely for the referral of patients.
Conflict of Interest Standards	Dual relationships with family members	Standard 2(e)(i,ii): e) Registrants must not dispense prescriptions for themselves or to their family members except; i. in an emergency situation, or ii. when another registrant is not readily available.
Conflict of Interest Standards	Financial gain	Standard 2(f): Registrants who have a financial interest in an organization, such as a pharmacy, pharmaceutical company, recovery home or clinic must not allow these interests to adversely affect the quality of patient care.
Code of Ethics	Professional boundaries	Standard 3(a): Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

Appendix

CPBC Provisions for Professional Misconduct of a Non-Sexual Nature

Regulatory tool	Type of professional misconduct	Provision
Code of Ethics	Professional boundaries	Standard 3(b): Registrants act in the best interests of their patients and do not exploit the professional relationship for any personal, physical, emotional, financial, social or sexual gain.
Code of Ethics	Discrimination	Standard 3(g): Registrants ensure that their personal beliefs and values do not prejudice patient care and do not engage in discrimination based on age, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, lifestyle, disability, socio-economic status or any basis proscribed by law.
Code of Ethics	Professional boundaries	Standard 6(f): Registrants ensure that they maintain appropriate professional boundaries in pharmacy student/instructor and supervisor/subordinate relationships.
Code of Ethics	Unethical conduct	Standard 7(e): Registrants do not justify unethical behavior by rationalizing that such behavior is not explicitly captured in a standard or guideline and therefore ethically permissible.
Code of Ethics	Professional integrity	Standard 7(f): Registrants shall resist any influence or interference that could undermine their professional integrity.
Code of Ethics	Professional integrity	Standard 7(m): Registrants enter only into relationships, contracts and agreements in which they can maintain their professional integrity and safeguard the interests of their patients.

Appendix

CPBC Provisions for Professional Misconduct of a Non-Sexual Nature

Regulatory tool	Type of professional misconduct	Provision
Code of Ethics	Dual relationships	Standard 8(d): Registrants avoid dual or multiple relationships and other situations which may present a conflict of interest and potentially reduce their ability to be objective and unbiased in their professional judgment.

College of Pharmacists of British Columbia

11. Patient Relations Program Standard

Sorell Wellon

Chair, Ethics Advisory Committee

College of Pharmacists of British Columbia

Background

Legislative Requirements for a Patient Relations Program Standard:

HPA:

- Section 16 (2)(f) states that the board must: " …*establish…a patient relations program to seek to prevent professional misconduct of a sexual nature*."

College of Pharmacists of British Columbia

Background, continued

HPA Bylaws

- Section 84 requires that the patient relations program standard seek to prevent professional misconduct, including professional misconduct of a sexual nature.
- 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 (a), and
  c) develop guidelines for the conduct of registrants with their patients.

Code of Ethics

- The Patient Relations Program Standard is noted as a companion document.

College of Pharmacists of British Columbia

CPBC Patient Relations Program Standard

Development Timeline:

- **2013**: BCHR established a working group to review patient relations program standards and develop a model framework.
- **2016**: CPBC Board approved the BCHR framework at their September Board meeting.
- **2018**: Ethics Advisory Committee and College staff developed a proposed Patient Relations Program Standard.

College of Pharmacists of British Columbia

CPBC Patient Relations Program Standard, continued

Proposed Patient Relations Program Standard

- Key Topics Include:
  - Maintaining Professional Boundaries and Avoiding Dual Relationships;
  - Relationships with Former Patients;
  - Registrants' Statutory Requirement to Report Sexual Misconduct; and
  - Education on Professional Ethics (i.e., CPBC's online ethics program).

College of Pharmacists of British Columbia

Spousal Relationships and Sexual Misconduct

- The proposed Standard does not directly discuss the issue of providing pharmacy services to family members, including spouses.

- Dispensing prescriptions to family members is generally prohibited under Standard 2(e) of the Conflict of Interest Standards:

> *"Registrants must not dispense prescriptions for themselves or to their family members except;*
>
> *i. in an emergency situation, or*
>
> *ii. when another registrant is not readily available."*

College of Pharmacists of British Columbia

Next Steps

- Upon Board approval, the Standard would undergo public posting for a period of 90 days.
- Any comments received will be reviewed for possible amendments to the Standard.
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- After the 60-day filing period, the Standard would take effect.

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Sorell Wellon

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CPBC Patient Relations Program Standard, continued

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