College of Pharmacists of British Columbia

Board Teleconference
June 3, 2016
4:30 pm

MINUTES

Members Present:
Blake Reynolds, Chair & District 4 Board Member
Anar Dossa, Vice-Chair & District 6 Board Member
Mona Kwong, District 1 Board Member
Ming Chang, District 2 Board Member
Tara Oxford, District 3 Board Member
Frank Lucarelli, District 5 Board Member
Arden Barry, District 7 Board Member
Sorell Wellon, District 8 Board Member
Kris Gustavson, Public Board Member
Jeremy Walden, Public Board Member *(absent for item 4)*

Regrets:
Norman Embree, Public Board Member
George Walton, Public Board Member

Staff:
Suzanne Solven, Deputy Registrar
Kellie Kilpatrick, A/Director of Policy & Legislation
Lori Tanaka, Board & Legislation Coordinator

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1. **WELCOME & CALL TO ORDER**

   Chair Reynolds called the meeting to order at 4:32pm.

   Deputy Registrar Solven conducted a roll call to confirm attendance on the call and confirm quorum.

College of Pharmacists of British Columbia

2. CONFIRMATION OF AGENDA (APPENDIX 1)

It was moved and seconded that the Board:

Approve the June 3, 2016 Draft Board Teleconference Meeting Agenda as circulated.

CARRIED

3. MEDICAL ASSISTANCE IN DYING (MAID) (APPENDIX 2)

It was moved and seconded that the Board:

Approve the following resolution:

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

The Board requests that the bylaw amendments come into force on June 6, 2016.

CARRIED

4. DRUG SCHEDULE REGULATION AMENDMENTS (APPENDIX 3)

It was moved and seconded that the Board:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 22(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minster as required by section 22(2) of the Pharmacy Operations and Drug Scheduling Act, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, as set out in the schedule attached to this resolution.

CARRIED

ADJOURNMENT

Chair Reynolds adjourned the meeting at 5:32pm.

College of Pharmacists of British Columbia

Board Meeting
June 3, 2016 at 4:30 pm

By Teleconference
Dial-in Number: 1.855.281.8596
Participant Code: 8565484

AGENDA

1) Welcome and Call to Order	Chair Reynolds
2) Confirmation of Agenda	Chair Reynolds
3) Medical Assistance in Dying (MAID) **[DECISION]**	Deputy Registrar Solven
4) Drug Schedule Regulation Amendments	Jeremy Walden
5) Adjournment	Chair Reynolds

College of Pharmacists of British Columbia

EXTRAORDINARY BOARD MEETING
June 3, 2016

3. Medical Assistance in Dying (MAID)

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution:

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

The Board requests that the bylaw amendments come into force on June 6, 2016.

Purpose

The purpose of this Decision Note is to seek Board approval for proposed amendments to the *Health Professions Act* (HPA) - Bylaws listed below by approving filing of these amendments with the Minister of Health.

- Health Professions Act (HPA) – Bylaws, Schedule A - Code of Ethics
- HPA – Bylaws, Schedule F – Standards of Practice, Parts 1 – 3
- New: HPA – Bylaws, Schedule F – Part 5 – Standards, Limits and Conditions outlining additional standards for the provision of MAID in addition to outlining exceptions for registrants from the Standards of Practice, Parts 1-3

These amendments support the ruling made by the Supreme Court of Canada (SCC) on the decriminalization of Medical Assistance in Dying (MAID) – formerly known as physician-assisted dying. The SCC ruling will take effect on June 6, 2016. Due to the impending timeline the Ministry of Health has committed to a shortened filing period.

Background

Last year, on February 6, 2015, the SCC unanimously ruled in *Carter v. Canada* that the federal *Criminal Code* prohibitions on MAID infringe the *Charter of Rights and Freedoms*, particularly the rights to life, liberty, and security. The SCC's ruling states the decriminalization of MAID will be in effect one year later on February 6, 2016. The intention of a 12 month period was to provide time for both the Federal and Provincial governments to develop a legislative framework along with regulatory authorities and associations to develop corresponding policies and guidelines. The Federal government requested an

extension and the SCC subsequently ruled that MAID will be decriminalized June 6, 2016 rather than the original date of February 6, 2016.

A Senate Committee was appointed to review the proposed federal legislation (Bill C-14). The Committee heard evidence and reviewed submissions from a range of stakeholders including regulatory authorities from BC. On May 17, 2016, they tabled their report along with 10 recommendations. The recommendations include provisions for conscientious objections; permission to use advanced directives; and the addition of terminal illness to the definition of grievous and irremediable medical condition. At this time, it is unknown if these recommendations will be included in any future federal legislation.

As of June 3, 2016, it is uncertain if federal legislation will be in force by June 6, 2016. In either context, the College as well as the College of Physicians and Surgeons of BC (CPSBC) and the College of Registered Nurses of BC (CRNBC) are working together with the Ministry of Health, Health Authorities and other stakeholders to ensure registrants are provided with guidance on how to proceed with providing MAID services.

The proposed amendments were sent to all the College committees, the BC Pharmacy Association, and the Ministry of Health Working group (includes representatives from both the health and regulatory authorities) for feedback. The College received approximately 25 responses, all of which were considered in the final revisions.

Discussion

The overall approach for establishing standards of practice for MAID was to create a new set of standards, limits, and conditions specifically for the purpose of MAID. These are outlined in a new section titled Part 5 under Schedule F of the HPA-Bylaws. The intention is to have any new additional requirements for MAID outlined along with any exceptions from the usual set of standards of practice (Parts 1-3 of Schedule F).

A detailed summary of the changes are outlined below.

Code of Ethics (Standard 1)

The *HPA* Bylaws, Schedule A outlines the Code of Ethics for registrants. Standard 1(g) (iii) outlines the framework regarding conscientious objection. Conscientious objection is defined as “a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral or religious value system.”

As the Code of Ethics reads now, a registrant may object to the provision of a product or service, however they must follow a set of conditions, the most significant one is the requirement to “refer.“

The SCC *Carter* decision stated that that physicians should not be compelled to participate in a physician assisted death. That view is being generalized beyond physicians to include all healthcare

providers. Fundamentally, freedom of conscience and religion is a right as per Section 2 (a) of the *Charter of Rights and Freedoms*.

The requirement for a pharmacist to "refer" a patient to another pharmacist is generally being considered and viewed as the pharmacist acting as an "agent." As such, regulatory authorities are using language that ensures a service delivery system that is timely, non-judgemental, continuous and non-discriminatory. Consistent with the CPSBC and the CRNBC, the College proposes using the term "transfer" of care and guides registrants to fulfill the duty of care to the patient and cooperate in the effective transfer of care of the patient to another pharmacy or pharmacist.

"Pharmacists will cooperate in effective transfers of care initiated by the patient and are not required to make a referral"

Community/Hospital/Residential Standards of Practice (Schedule F, Part 1, 2, 3)

Parts 1-3 have proposed amendments that include reference to the new Part 5 Standards, Limits, and Conditions for the purpose of delivering pharmacy services for MAID.

Any exceptions to Parts 1-3 for services regarding MAID have been outlined in Part 5. For example, the requirement for registrants to counsel patients on drug therapy is exempted for MAID as the physician leading the service will be interacting with the patient rather than the pharmacist/registrant.

Dispensing for the Purposes of Medical Assistance in Dying –Standards, Limits and Conditions (Schedule F, Part 5)

Currently, pharmacy professionals operate within a collection of legislative and policy requirements – bylaws; standards; standards, limits and conditions, policies and other guidance documents. Pharmacy professionals are required to dispense in a manner that is aligned with all of the requirements.

For the purposes of dispensing for MAID, there are additional factors that must be considered in the balancing of access to a service with patient safety. To that end, these Standards, Limits and Conditions are developed specifically to add those safeguards while at the same time, not significantly impacting access. This is consistent with the work underway by the CPSBC and the CRNBC.

The Standards, Limits and Conditions specify what a pharmacist must do when dispensing for MAID. Requirements include:

- **Discussing** a full range of related issues with the prescribing physician (the patient's drug therapy; confirmation of eligibility; the protocol selected; completion of the medical record; and procedures for returning unused drugs to the pharmacy)

- **Dispensing** the drugs in a sealed tamper proof kit; directly to the physician
- **Documenting** the date the drugs were dispensed; the name and signature of the physician the drugs were dispensed to
- **Limits** to a pharmacist participating in medical assistance in dying for themselves or a family member; to only dispensing to the prescribing physician
- **Limits** to a pharmacy professional performing any activity that may imply they are leading the medical assistance in dying process including but not limited to assessing the individual against the criteria in *Carter v Canada (Attorney General)* or Bill C-14
- **Conditions** that the pharmacy professionals have the requisite competency, knowledge and skills to prepare and/or dispense the prescription for medical assistance in dying

Recommendation

The College recommends that the Board accept changes to the following HPA-Bylaws by approving filing of the amendments with the Minister of Health:

- HPA – Bylaws, Schedule A - Code of Ethics
- HPA – Bylaws, Schedule F – Standards of Practice, Parts 1 – 3
- New: HPA – Bylaws, Schedule F – Part 5 – Standards, Limits and Conditions outlining additional standards for the provision of MAID in addition to outlining exceptions for registrants from the Standards of Practice, Parts 1-3

Appendix	
1	Schedule to the Resolution
2	Bylaw Amendments (tracked changes version)

Code of Ethics - Detailed
College of Pharmacists of British Columbia

Responsibility to Patients

Standard 1: Registrants Protect and Promote the Health and Well-Being of Patients

Guidelines for Application

a) Registrants are committed first and foremost to protecting and promoting the health and well-being* of their patients.

b) Registrants practice only within the scope of their education, training and competence.

c) Registrants are aware of the limitations of their knowledge and expertise and refer as necessary and appropriate.

d) Registrants are knowledgeable of, and adhere to, national and provincial legislation, standards of practice and policies relevant to the practice of pharmacy.

e) Registrants maintain appropriate resources to facilitate their efforts to deliver services according to the standards of practice.

f) Registrants dispense, distribute, recommend and advertise drugs and health-related products that are approved by Health Canada.

g) Registrants must provide pharmacy services requested by patients and may only refuse to provide these services for any of the following reasons:

i. the drug or product requested is not available

ii. the registrant does not possess the knowledge, skills and abilities to provide the service or product

iii. ~~the registrant objects to~~ the provision of the product or service is contrary to the sincerely held conscientious or religious belief of a registrant, in which case the ~~on the basis of conscientious objection (a sincerely held belief that the provision of a particular product or service will cause the registrant to contravene their personal moral and/or religious convictions value system. In the event of a conscientious objection to the provision of a product or service, a~~ registrant must ensure th~~at~~e~~:~~ ~~following:~~

- ~~that~~ they have informed and explained to the~~ir~~ pharmacy manager and employer of their conscientious or religious belief~~objection~~ before they accept employment;~~.~~
- ~~i~~~~that i~~f the belief is formed after employment is accepted, they inform the pharmacy manager and employer at the earliest opportunity;

*In the context of medical assistance in dying (MAID), death may be considered by the patient as the choice of well-being.

- ~~that they do not, at any time, express their conscientious objection directly to the prescriber or the patient~~
- ~~that~~ they do not discuss their personal beliefs ~~, nor~~ ask patients to disclose or justify their own beliefs~~;~~
- ~~that~~ they~~, in goodwill,~~ participate in ~~the development and delivery of a system~~ a process designed to ~~respect the patient's right to receive products and services in a timely and convenient manner which minimizes suffering and hardship to the patient~~ exercise their~~accommodate~~ freedom of conscience and religion in a manner that respects ~~while respecting~~ the patient's right to receive products and services in a timely manner and in a way that minimizes suffering and hardship to the patient;

- ~~that~~ they fulfill their duty of care to the patient in a manner that is non-judgmental, continuous and non-discriminatory~~;~~
- in the event of failure of
- ~~that should~~ the system developed to ensure the timely delivery of the product or service~~,~~ ~~fail,~~ ~~the registrant~~and ~~,~~ notwithstanding the registrant's ~~ir~~ conscientious or religious beliefs, they ~~objection, has a duty to the patient to provide the product or service requested to~~ provide patients with enough information and assistance to allow them to make informed choices for themselves;

- they~~. Pharmacists will~~ cooperate in effective transfers of care initiated by the patient and are not required to make a referral~~-~~; and

- ~~that~~ they do not rely on conscientious or religious beliefs ~~utilize an appeal to conscientious objection~~ in order to discriminate against any patient on morally irrelevant grounds including those outlined in *Standard 3, Guideline g* of this Code.

iv. the patient is unable or unwilling to provide payment for the requested pharmacy service or product

v. the patient is abusive physically or mentally to the registrant

~~*Note: In the case of the above (g) the registrant must refer the patient as appropriate.*~~

h) Registrants must provide essential pharmacy care throughout the duration of any job action or pharmacy closure.

i) In the event of either a patient emergency or a public emergency, registrants take appropriate action to provide care within their professional competence and experience.

Commented [RS1]: Bill C-14 Section 241.2(8) requires the prescriber (MP or NP) to inform the dispensing pharmacist that the prescribed substance is intended for MAID. Since, the prescriber will work in collaboration with the dispensing pharmacist, a prescriber may encounter a pharmacist with a conscientious objection, at which time there should be no prohibition on the objecting pharmacist to disclose his or her objection to the prescriber.

Commented [RS2]: This does not align with Bill C-14 or the Canadian Charter of Rights and Freedoms as there are no obligations to compel health care professional to complete MAID services.

Standard 2: Registrants ~~Protect~~ Act in the Best Interests of their Patients In Achieving their Chosen Health Outcome

Guidelines for Application

a) Registrants utilize their professional judgment to ~~protect~~ act in the best interests of their patients in achieving their chosen health outcome.

b) Pharmacists support patients in making informed choices about their ~~medical~~ care by ~~providing them with~~ explaining the benefits and risks associated with medication therapy. ~~Risks are defined as the most frequent and serious adverse effects.~~

c) Pharmacists provide information that is evidence based, relevant, up-to-date and consistent with the standard of care.

d) Registrants provide information in an understandable and sensitive manner and respond to patients' questions.

e) Registrants respect their patient's right to accept or refuse any drug or health product related recommendation.

f) Registrants ensure that they obtain the patient's informed, implied or expressed and voluntary consent prior to the provision of pharmacy services.

g) Registrants recognize and respect the autonomy of a competent minor to provide informed consent and make decisions about their healthcare.

h) Registrants recognize and respect persons authorized either through personal directives or proxy designations to act as surrogate decision-makers in the case of incompetent patients.

Commented [RS3]: Remove the definition of risks.

Risks associated with drug therapy outcomes for MAID may not align with the existing definition. Removing the definition and deferring to the professional judgment of registrants to interpret the definition in an evolving health care sector.

Standard 3: Registrants Practice Respect for Patients

Guidelines for Application

a) Registrants respect the value and dignity of patients.

b) Registrants respect the patient's autonomy and freedom to make an informed decision. ~~of choice~~.

c) Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

d) 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.

e) Registrants treat patients with sensitivity, caring, courtesy and respect.

f) Registrants provide pharmacy care that is respectful of the values, customs and beliefs of patients.

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.

Standard 4: Registrants Protect the Right to Confidentiality of their Patients

Guidelines for Application

a) Registrants respect their patient's right to privacy and confidentiality.

b) Registrants do their utmost to protect patient confidentiality when they share patient information with colleagues or other healthcare professionals.

c) Registrants do not disclose confidential information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

d) Registrants maintain confidentiality in creating, storing, accessing, transferring and disposing of records they control.

Standard 5: Registrants Participate in Ethically Valid Research

Guidelines for Application

a) Registrants ensure that any research they participate in is evaluated both ethically and scientifically and is approved by a research ethics board that meets applicable standards recognized by National Council on Ethics and Human Research (NCEHR) requirements for research involving human participants. (http://www.pre.ethics.gc.ca/policy-politique/tcps-eptc/docs/TCPS%20October%202005_E.pdf)

b) Registrants ensure that before proceeding with their research study they have obtained the informed consent of the patient or proxy and advised the patient that they have the right to withdraw from the study at any time without penalty.

c) Registrants inform the patient of the purpose of the study, its source of funding, the risks of harm and benefits, and the nature of their participation including any applicable compensation.

d) Registrants ensure that they inform research participants that all participant information will be kept confidential and not disclosed without the participants approval and consent.

Responsibility to Society

Standard 6: Registrants are Committed to Benefiting Society

Guidelines for Application

a) Registrants have an ethical duty to uphold public trust and confidence in the profession by acting with honesty and integrity.

b) Registrants have a responsibility to report incompetent or unethical behavior by colleagues or other healthcare professionals to the appropriate regulatory authority.

c) Registrants recognize the professions' responsibility to society to participate in*:
   i. advocacy
   ii. research
   iii. public education programs

d) Registrants endeavor to advance the quality of pharmacy services and care provided to the public.

e) Registrants contribute to the future of the profession by participating in student, intern and resident education including multidisciplinary and collaborative experiences as appropriate.

f) Registrants ensure that they maintain appropriate professional boundaries in pharmacy student/instructor and supervisor/subordinate relationships.

g) Registrants recognize the responsibility of the profession to provide access to pharmacy services and resources.

h) Registrants have a responsibility for ensuring the provision of cost-effective pharmacy services in overall healthcare delivery.

i) Registrants provide safe disposal of drugs and health related products and support environmentally friendly practices.

*It is understood that this is not an obligation of all individual registrants but rather a responsibility of the profession as a whole.

Responsibility to the Profession

Standard 7: Registrants are Committed to Personal and Professional Integrity

Guidelines for Application

a) Registrants have an ethical duty to act conscientiously and avoid unethical behavior.

b) Registrants act with honesty and integrity in all professional relationships and fulfill their responsibilities as described in the Code of Ethics and companion documents: Conflict of Interest Standards and Patient Relations Program.

c) Registrants uphold the spirit of the Code of Ethics and its intent as well as its written articulation.

d) Registrants comply with legislation, standards of practice and accepted best practice guidelines.

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.

f) Registrants shall resist any influence or interference that could undermine their professional integrity.

g) Registrants have a responsibility to protect and maintain their physical and mental health and well-being and seek care and support as appropriate.

h) Registrants must discontinue the provision of professional services if their physical or mental health poses a risk of harm.

i) Registrants take appropriate steps to prevent and report the misuse or abuse of substances by patients, colleagues, other healthcare professionals or other pharmacy employees.

j) Registrants recognize that professional obligations override management policies, and take all reasonable steps to resolve situations where management policies and professional obligations are in conflict.

k) Registrants report any policies, systems or working conditions to the College that pose a risk of harm to the public.

l) Registrants cooperate with investigations into their own or another healthcare professionals' fitness to practice and abide by undertakings or limitations and conditions placed on their practice.

m) Registrants enter only into relationships, contracts and agreements in which they can maintain their professional integrity and safeguard the interests of their patients.

Standard 8: Registrants are Sensitive to and Avoid Conflict of Interest

Guidelines for Application

a) Registrants must consider first the health and well-being of the patient and avoid situations that are, or may reasonably be perceived to be, a conflict of interest.

b) Registrants abide by and conscientiously follow the Code of Ethics companion document, Conflict of Interest Standards.

c) Registrants inform relevant parties, if they are involved in a real, perceived, or potential, conflict of interest scenario and resolve the situation as outlined in the Conflict of Interest Standards.

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.

Standard 9: Registrants Participate in Ethical Business Practices

Guidelines for Application

a) Registrants do not participate in, condone, or are associated with dishonesty, fraud, misrepresentation or any other kind of unethical or illegal behavior.

b) Registrants do not make false, deceptive or fraudulent statements concerning their training, experience, competence, academic degrees or credentials, affiliations, services, research, fees, etc.

c) Registrants conform to legal and professional norms that support the integrity and dignity of the profession.

d) Registrants use only truthful, accurate, fully informative and non-deceptive information in their marketing and public education programs.

e) Registrants do not make false claims for any purpose.

f) Registrants are transparent in the fees they charge, consider the ability of the patient to pay and discuss options with the patient.

g) Registrants ensure that any comparison to the business services of competitors is fair and accurate.

h) Registrants only enter relationships with industry which are appropriate and in compliance with the Code of Ethics and Conflict of Interest Standards and maintain the integrity of the fiduciary relationship between the registrant and the patient.

i) Registrants refrain from participating in activities that could undermine patient trust in registrants and society's trust in the pharmacy profession.

Standard 10: Registrants are Committed to Professional Development

Guidelines for Application

a) Registrants keep up to date with new pharmacy knowledge and practices by participating in continuous lifelong learning.

b) Registrants participate in continuous evaluations of their practice and are responsive to the outcomes of evaluations and reviews by undertaking constructive change or further training if necessary.

c) Registrants endeavour to advance the knowledge and skills of the profession and make relevant information available to patients, colleagues and the public.

d) Registrants participate in professional development opportunities that support learning in professional ethics and the development of sound professional judgment in ethical decision making.

e) Registrants develop, promote and participate in quality assurance and accountability processes.

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*;

"**incentive**" means money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods or rewards;

"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) or 13(3) 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) the handwritten identification of each registrant and pharmacy assistant involved in each step of the dispensing process;

(h) written confirmation and identification of the registrant who

(i) reviewed the personal health information stored in the PharmaNet database,

(ii) reviewed the drug usage evaluation messages (DUE) from the PharmaNet database,

(iii) performed the consultation in accordance with section 12 of this Part, and

(iv) performed the final check including when dispensing a balance owing.

(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 potential drug interactions, allergies, 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) follow-up on suspected adverse drug reactions.

(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) 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,

(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

(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 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 10 digit 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.

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,

(d) child-resistant packaging is unavailable, or~~,~~

~~(d)~~(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.

Patient Record

11. (1) A patient record must be prepared and kept current for each patient for whom a Schedule I drug is dispensed.

(2) 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 10 digit 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) compliance with the prescribed drug regimen, and

(t) 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) allergies, adverse drug reactions and intolerances;

(c) past and current prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy;

(d) compliance with the prescribed drug regimen;

(e) 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

(a) appropriateness of drug 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) degree of compliance, and

(h) any other potential drug related problems.

Pharmacist/Patient Consultation

12. (1) Full pharmacist/patient consultation for Schedule I, II and III drugs should occur in person if practical, or by telephone and must respect the patient's right to privacy.

(2) Full pharmacist/patient consultation is required for all prescriptions.

(3) Subject to subsection (6), a full, limited or student pharmacist must engage in direct consultation with a patient or the patient's representative regarding a Schedule I drug, and must

(a) confirm the identity of the patient,

(b) identify the name and strength of drug being dispensed,

(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.

(4) If a drug-related problem is identified during full pharmacist/patient consultation, the full pharmacist must take appropriate action to resolve the problem.

(5) If an adverse drug reaction as defined by Health Canada is identified, a full pharmacist must notify the patient's practitioner, make an appropriate entry on the PharmaNet record and report the reaction to the Canada Vigilance Program Regional Office.

(6) A full, limited or student pharmacist must use reasonable means to comply with subsections (1), (2) and (3) for patients or the patient's representatives who have language or communication difficulties.

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) If a patient purchases a Schedule II drug, a full, limited or student pharmacist must counsel the patient or the patient's representative regarding the selection and use of the drug.

(3) A full pharmacist must be available for consultation with a patient or patient's representative who wishes to select 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;

"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.

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.*

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 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, ~~or~~

(b) do anything described in

(i) sections 13, 15 or 16 of this Part~~, or~~

(ii) Part 4 of this Schedule, or~~.~~

(c) Dispense a drug pursuant to HPA Bylaws Schedule F, Part 5.

(3) A pharmacist 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 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.

Health Professions Act – BYLAWS

SCHEDULE F

PART 3 – Residential Care Facilities and Homes Standards of Practice

Table of Contents

Application

1. This Part applies to registrants providing pharmacy services in or to facilities and homes.

Definitions

2. In this Part:

"administration" means the provision of a drug to a resident as prescribed, or for drugs listed in Schedule II or III of the Drug Schedules Regulation, B.C. Reg. 9/98, or unscheduled drugs initiated by a registered nurse;

"audit" means a periodic review of the pharmacy services provided in accordance with this Part;

"*Community Pharmacy Standards of Practice*" means the standards, limits and conditions for practice established in Part 1 of this Schedule;

"facility" means a community care facility licensed under the *Community Care and Assisted Living Act* to provide care to 7 or more persons;

"home" means a community care facility licensed under the *Community Care and Assisted Living Act* to provide care to 3 to 6 persons;

"licensed practical nurse" means a registrant of the College of Licensed Practical Nurses of British Columbia;

"medication safety and advisory committee" means a committee appointed under section 8.2 of the Adult Care Regulations, B.C. Reg. 536/80;

"monitored dose system" means a system of drug distribution in which drugs are dispensed for an individual resident at scheduled times from packaging which protects a dose or doses from contamination until a designated medication time;

"natural product" has the same meaning as in the *Natural Health Products Regulations* under the *Food and Drug Act* (Canada) as amended from time to time;

"registered nurse" means a registrant of the College of Registered Nurses of British Columbia;

"registered psychiatric nurse" means a registrant of the College of Registered Psychiatric Nurses of British Columbia;

"resident" means a person who lives in and receives care in a facility or home;

"Schedule II and III drugs" mean drugs listed in Schedule II or III of the *Drug Schedules Regulation*.

Supervision of Pharmacy Services in a Facility or Home

3. (1) A registrant must not provide pharmacy services in or to a facility or home unless appointed to do so by the licensee of that facility or home.

(2) A registrant must not allow any person to interfere with the provision of pharmacy services in accordance with the *Act* or the *Pharmacy Operations and Drug Scheduling Act*.

(3) The full pharmacist appointed to provide services to the facility or home must do the following:

(a) visit and audit the medication room at the facility at least every 3 months,

(b) visit and audit the medication room or storage area at the home at least once annually,

(c) make a record of all audits and meetings of the medication safety and advisory committee held in accordance with this bylaw, which must be retained in the pharmacy for at least 3 years, and

(d) arrange a meeting of the medication safety and advisory committee at least once in every 6 month period for a facility and once a year for a home.

(4) The full pharmacist appointed to provide services to a facility or home must be a member of and advise the medication safety and advisory committee about the policies and procedures in place for the

(a) safe and effective distribution, administration and control of drugs,

(b) monitoring of therapeutic outcomes and reporting of adverse drug reactions in respect of residents,

(c) reporting of drug incidents and discrepancies, and

(d) training and orientation programs for staff members who store, handle, or administer drugs to residents.

(5) The policies and procedures referred to in subsection (4) must be included in a manual kept in the facility, home and pharmacy.

(6) Except where a person in care self-administers drugs in accordance with regulations under the *Community Care and Assisted Living Act* , the registrant must ensure that all drugs are stored in a separate and locked area that is not used for any other purpose.

(7) The registrant must ensure that a copy of this Part is available in the facility or home.

Quality Management

4. A pharmacy providing services to a facility or home must have a documented ongoing quality management program that

   (a) monitors the pharmacy services provided, and

   (b) includes a process for reporting and documenting drug incidents and discrepancies and their follow-up.

Pharmacy Technicians

5. (1) Pharmacy technicians providing pharmacy services to a facility or home 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 providing pharmacy services to a facility or home 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 3(3), 3(4), 13(4), 15 or 16 of this Part, ~~or~~

   (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.

Prescription Authorizations

6. (1) A registrant may only dispense a drug to a resident upon receipt of a prescription.

   (2) When a resident is readmitted following hospitalization, new prescriptions must be received for that resident before drugs may be dispensed.

   (3) A prescription may be transmitted to the pharmacy servicing the facility or

home verbally, electronically or in writing.

(4) If a prescription is transmitted to the pharmacy by facsimile, the registrant must comply with section 7 of the *Community Pharmacy Standards of Practice.*

(5) If a prescription is transmitted verbally, the registrant must make a written record of the verbal authorization, and include his or her signature or initial.

(6) If a prescription is transmitted electronically, the registrant must use the facsimile or make a written copy as the permanent record for dispensing, numbering, initialling and filing.

(7) A prescription, written and signed by a practitioner on a resident's record, may be electronically transmitted to the pharmacy and the registrant may dispense the drug.

(8) Upon receipt from the practitioner, a prescription must include the following information:

(a) the date the prescription was written;

(b) the name of the resident;

(c) the name of the drug or ingredients and strength where 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.

(9) A registrant may accept a new drug order that is transmitted verbally from a practitioner to a facility's registered nurse, registered psychiatric nurse or licensed practical nurse, if

(a) the drug does not contain a controlled drug substance,

(b) the registered nurse, registered psychiatric nurse or licensed practical nurse writes the verbal order on a practitioner's order form or electronic equivalent, and

(c) transfers the written order to the pharmacy.

Dispensing

7. (1) All prescriptions dispensed to residents must be dispensed in a monitored dose system except where the form of the drug does not permit such packaging, and each package must contain not more than a 35 day supply of

medication.

(2) Where directions for the use of a drug are changed by the practitioner, the registrant must, following receipt of the required confirmation, initiate and dispense a new prescription.

Contingency Drugs

8. (1) A registrant may establish a supply of contingency drugs to permit the commencement of therapy upon receipt of a prescription, until the drug supply arrives from the pharmacy.

(2) Contingency drugs must be prepared by the pharmacy and dispensed in a monitored dose system in accordance with section 7(1).

(3) A list of the contingency drugs must be available in the facility, home and pharmacy.

(4) Records of use of contingency drugs must be kept in the facility or home and must include

(a) the date and time the drug was administered,

(b) the name, strength and quantity of the drug administered,

(c) the name of the resident for whom the drug was prescribed,

(d) the name or initials of the person who administered the drug, and

(e) the name of the practitioner who prescribed the drug.

Nurse Initiated Drugs

9. (1) A registrant may provide Schedule II or III drugs and unscheduled drugs for a resident upon the request of a registered nurse if the medication safety and advisory committee has approved protocols for doing so.

(2) A record of use of all medications must be on the resident's medication administration record.

Standing Orders

10. (1) Standing orders for Schedule II and III drugs and unscheduled drugs that are administered for common self-limiting conditions may be established by the medication safety and advisory committee.

(2) Standing order drugs must be authorized and signed for by a practitioner annually and a record of the signed authorization must be kept in the facility or home.

(3) A record of use of all medications must be on the resident's medication administration record.

Returned Drugs

11. (1) A registrant must provide for the return of all discontinued drugs at the time of the next scheduled delivery.

(2) Policies and procedures must be in place to ensure that upon the hospitalization of a resident, the resident's drugs are returned to the pharmacy.

(3) Previously dispensed drugs must not be re-dispensed unless

(a) they have been returned to the pharmacy in a single-drug, sealed dosage unit or container as originally dispensed,

(b) the labelling is intact and includes a legible drug lot number and expiry date, and

(c) the integrity of the product can be verified.

Drug Containers and Prescription Labels

12. (1) All drugs dispensed pursuant to a prescription must be labeled.

(2) The label for all prescriptions must include

(a) the name, address and 10-digit telephone number of the pharmacy,

(b) the prescription number and dispensing date,

(c) the full name of the resident,

(d) the name of the practitioner or registered nurse,

(e) the strength of the drug,

(f) the dosage instructions including the frequency, interval or maximum daily dose,

(g) the route of administration,

(h) medical indication for use for all "as required" prescription authorizations, and

(i) any other information required by good pharmacy practice.

(3) For single-entity products the label must include

(a) the generic name and at least one of

(i) the brand name,

(ii) the manufacturer's name, or

(iii) the drug identification number.

(4) For multiple-entity products 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 compounded preparations the label must include all active ingredients.

(6) If the pharmacy is unable to supply prescribed Schedule II or III drugs or unscheduled drugs to a resident and the resident has obtained a supply from another source, the drug must be in the original sealed packaging and be sent to the pharmacy for

(a) identification,

(b) repackaging in a monitored dose system if appropriate,

(c) labeling, and

(d) notation on the resident's record and the medication administration record.

(7) If labels are produced to be attached to a resident's medication administration record, the label must state "for MAR".

(8) All drugs must be labelled with the drug expiry date and manufacturer's lot number, except multi-drug sealed dosage units.

(9) A registrant must not delegate the labelling of drugs in a monitored dose system to an employee of a facility or home.

Resident Records

13. (1) A registrant must maintain a record for each resident.

(2) The record must include

(a) the resident's full name, personal health number, birth date, gender, practitioner name, name of the facility or home, and if possible, the resident's location within the facility or home,

(b) diagnoses,

(c) the presence or absence of known allergies, adverse drug reactions or intolerances relevant to drugs,

(d) the prescription number, names and drug identification numbers or natural product numbers for all drugs dispensed,

(e) the medical indication for use for all "as required" prescription

authorizations and drugs dispensed,

(f) directions for use, dosage form, strength, quantity, route of administration, dosage times, dates dispensed, and

(g) the dates and reasons for early discontinuation of drug therapy if applicable.

(3) When a drug is to be administered on a "when necessary" basis, the record and prescription label must clearly indicate

(a) the specific indication for which the drug is to be given,

(b) the minimum interval of time between doses, and

(c) the maximum number of daily doses to be administered.

(4) A full pharmacist must review the resident record before dispensing a drug and take appropriate action when necessary with respect to

(a) the appropriateness of drug therapy,

(b) drug interactions,

(c) allergies, adverse drug reactions, and intolerances,

(d) therapeutic duplication,

(e) contraindicated drugs,

(f) the degree of compliance,

(g) the correct dosage, route, frequency and duration of administration and dosage form, and

(h) any other potential drug-related problems.

Resident Medication Administration Records

14. (1) The registrant must provide a medication administration record for each resident.

(2) The medication administration record must be current for each resident based on the information on the resident's record and must be sent to the facility or home each month.

(3) A resident's medication administration record must include

(a) the resident's full name,

(b) the resident's location within the facility or home, where possible,

(c) the name of the practitioner,

(d) allergies,

(e) diagnoses,

(f) the month for which the record is to be used,

(g) the name and strength of all drugs currently being administered, including those to be administered on a “when necessary” basis, and

(h) full directions for use.

Resident Medication Review

15. (1) The full pharmacist responsible for a facility must

(a) review each resident’s drug regimen on site or by videoconference at least once every 6 months with a practitioner if available, or a registered nurse and a facility staff member approved by the medication safety and advisory committee, and

(b) review the resident’s personal health information stored on the PharmaNet database before releasing any drug to the facility.

(2) A full pharmacist must maintain a record of the reviews referred to in subsection (1) in the resident’s record and in the record at the pharmacy, and the record of review must include information about

(a) the people in attendance,

(b) the date of the review, and

(c) recommendations, if any.

(3) At a facility or home, if a resident’s practitioner does not attend the review, the full pharmacist must advise the practitioner of any recommendations arising from the review.

(4) The full pharmacist responsible for a home must

(a) review each resident’s drug regimen and document the result of the review at least once every 6 months, and

(b) conduct the review on site at least once in every 12 month period.

(5) To continue dispensing drugs for a resident in a facility or home, prescriptions must be received from the resident’s practitioner every six 6 months, either by written, verbal or electronic communication.

Resident Oriented Pharmacy Practice

16. (1) When a resident is first admitted to a facility or home, the full pharmacist must obtain a history for the resident, and the following information must be obtained if available:

(a) allergies, adverse drug reactions, and intolerances,

(b) past and present prescribed drug therapy including the drug name,

strength, dosage, frequency and duration of therapy,

(c) compliance with prescribed drug regimen,

(d) Schedule II, III and unscheduled drug use, and

(e) laboratory results.

(2) The full pharmacist must routinely provide written or verbal drug information relevant to a resident's drugs to the medical, nursing or other appropriate facility or home staff.

(3) If an adverse drug reaction as defined by Health Canada is identified, a full pharmacist must

(a) notify the resident's practitioner,

(b) make an appropriate entry on the resident's record, and

(c) report the reaction to the Canada Vigilance Program Regional Office.

(4) Where a self-medication program is deemed suitable for a resident, the full pharmacist must comply with all applicable regulations under the *Community Care and Assisted Living Act* and must

(a) participate in the development of policies and procedures for the program, including appropriate storage and security requirements,

(b) ensure a drug consultation with the resident occurs,

(c) ensure authorization from the resident's practitioner and the medication safety and advisory committee is obtained,

(d) include any drugs in the self-medication program in the drug regimen review referred to in section 13(4), and

(e) document the consultation referred to in paragraph (b) in the resident's record.

(5) The drug consultation referred to in subsection (4)(b), should occur in person with the resident or resident's representative and must

(a) confirm the identity of the resident,

(b) identify the name and strength of drug being dispensed,

(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 information regarding

(i) how to monitor 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

(h) provide other information unique to the specific drug or resident.

Respite Care

17. (1) When a resident is admitted for short-stay respite care, the registrant must confirm all prescription authorizations with the resident's practitioner.

(2) The registrant must dispense drugs using a monitored dose system and provide medication administration records.

(3) Emergency stay respite care residents who arrive without notice may be administered drugs from their own supply if it is reasonable and safe to do so only until a supply is obtained from the pharmacy.

Leave of Absence Drugs

18. (1) The registrant must establish a system to ensure that leave-of-absence drugs are prepared correctly.

(2) The label on a leave of absence medication must include

(a) the facility or home name,

(b) the resident's name,

(c) the practitioner's name,

(d) the drug name, strength, quantity and complete directions for use,

(e) the initials of the person preparing the drug, and

(f) the date of issue.

(3) All leave of absence drugs must be documented on the resident's medication administration record.

SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended as follows:

1. Standards 1, 2, and 3 of Schedule A Code of Ethics – Detailed are repealed and the following is substituted:

Standard 1: Registrants Protect and Promote the Health and Well-Being of Patients

Guidelines for Application

(a) Registrants are committed first and foremost to protecting and promoting the health and well-being* of their patients.

(b) Registrants practice only within the scope of their education, training and competence.

(c) Registrants are aware of the limitations of their knowledge and expertise and refer as necessary and appropriate.

(d) Registrants are knowledgeable of, and adhere to, national and provincial legislation, standards of practice and policies relevant to the practice of pharmacy.

(e) Registrants maintain appropriate resources to facilitate their efforts to deliver services according to the standards of practice.

(f) Registrants dispense, distribute, recommend and advertise drugs and health-related products that are approved by Health Canada.

(g) Registrants must provide pharmacy services requested by patients and may only refuse to provide these services for any of the following reasons:

i. the drug or product requested is not available

ii. the registrant does not possess the knowledge, skills and abilities to provide the service or product

iii. the provision of the product or service is contrary to the sincerely held conscientious or religious belief of a registrant, in which case the registrant must ensure that:
   - they have informed and explained to the pharmacy manager and employer of their conscientious or religious belief before they accept employment;
   - if the belief is formed after employment is accepted, they inform the pharmacy manager and employer at the earliest opportunity;

- they do not discuss their personal beliefs or ask patients to disclose or justify their own beliefs**;**
- they participate in a process designed to exercise their freedom of conscience and religion in a manner that respects the patient's right to receive products and services in a timely manner and in a way that minimizes suffering and hardship to the patient;
- they fulfill their duty of care to the patient in a manner that is non-judgmental, continuous and non-discriminatory;
- in the event of failure of the system developed to ensure the timely delivery of the product or service, and notwithstanding the registrant's conscientious or religious beliefs, they provide patients with enough information and assistance to allow them to make informed choices for themselves;
- they cooperate in effective transfers of care initiated by the patient and are not required to make a referral; and
- they do not rely on conscientious or religious beliefs in order to discriminate against any patient on morally irrelevant grounds including those outlined in *Standard 3, Guideline g* of this Code.

iv. the patient is unable or unwilling to provide payment for the requested pharmacy service or product

v. the patient is abusive physically or mentally to the registrant

(h) Registrants must provide essential pharmacy care throughout the duration of any job action or pharmacy closure.

(i) In the event of either a patient emergency or a public emergency, registrants take appropriate action to provide care within their professional competence and experience.

Standard 2: Registrants Act in the Best Interests of their Patients In Achieving their Chosen Health Outcome

Guidelines for Application

a) Registrants utilize their professional judgment to act in the best interests of their patients in achieving their chosen health outcome.

b) Pharmacists support patients in making informed choices about their care by explaining the benefits and risks associated with medication therapy.

c) Pharmacists provide information that is evidence based, relevant, up-to-date and consistent with the standard of care.

d) Registrants provide information in an understandable and sensitive manner and respond to patients' questions.

e) Registrants respect their patient's right to accept or refuse any drug or health product related recommendation.

f) Registrants ensure that they obtain the patient's informed, implied or expressed and voluntary consent prior to the provision of pharmacy services.

g) Registrants recognize and respect the autonomy of a competent minor to provide informed consent and make decisions about their healthcare.

h) Registrants recognize and respect persons authorized either through personal directives or proxy designations to act as surrogate decision-makers in the case of incompetent patients.

Standard 3: Registrants Practice Respect for Patients

Guidelines for Application

a) Registrants respect the value and dignity of patients.

b) Registrants respect the patient's autonomy and freedom to make an informed decision.

c) Registrants recognize the power imbalance inherent in professional relationships (registrant-patient relationship) and maintain appropriate professional boundaries.

d) 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.

e) Registrants treat patients with sensitivity, caring, courtesy and respect.

f) Registrants provide pharmacy care that is respectful of the values, customs and beliefs of patients.

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.

2. Section 4(2) of Part 1 of Schedule F is amended by adding the following:

    (c) Dispense a drug pursuant to HPA Bylaws Schedule F, Part 5

3. Section 10(4)(d) of Part 1 of Schedule F is repealed and the following is substituted:

    (d) child-resistant packaging is unavailable, or

4. Section 10(4) of Part 1 of Schedule F is amended by adding the following:

    (e) the drugs are prescribed for medical assistance in dying.

5. Section 10(2) of Part 2 of Schedule F is repealed and the following is substituted:

    (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.

6. Section 5(2) of Part 3 of Schedule F is repealed and the following is substituted:

    (2) Despite subsection (1), a pharmacy technician providing pharmacy services to a facility or home 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 3(3), 3(4), 13(4), 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.

7. The attached new Part 5 is added to Schedule F.

HPA BYLAWS SCHEDULE F
Part 5 - DISPENSING DRUGS FOR THE PURPOSES OF MEDICAL ASSISTANCE in DYING
STANDARDS, LIMITS AND CONDITIONS

STANDARDS

1. The physician and the full pharmacist must work in a collaborative team based approach throughout the process.

2. The full pharmacist must discuss and confirm with the physician:
   (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 per 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 physician the drugs were dispensed to; and
   (c) If the physician is not known to the pharmacist, that the pharmacist confirmed the physician’s identity by means of photo identification.

6. The full pharmacist must follow up with the physician within 48 hours of the scheduled date and time for administration of the drugs to ensure appropriate return of unused medications for disposal.

7. The following Standards of Practice do not apply to medical assistance in dying:
   (a) Sections 6(5) (c) and (e), 6(6), 11(4)(f) and (g), and 12 of the Health Professions Act Bylaws, Schedule F, Part 1; and
   (b) Section 13(5) of the Health Professions Bylaws, Schedule F, Part 2.

8. Where there is an inconsistency between this Part and any other Part of Schedule F, the provisions of this Part prevail.

LIMITS

1. Only a full pharmacist can dispense drugs for the purposes of medical assistance in dying.
2. A full pharmacist cannot delegate any aspect of the dispensing of drugs for the purposes of medical assistance in dying.
3. A full pharmacist must only dispense the drugs for medical assistance in dying directly to the physician.
4. A full pharmacist must not dispense a drug to a physician 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 who 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) Prior to the proclamation of Bill C-14 assess whether an individual is a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstance of his or her condition;
    (b) Following the proclamation of Bill C-14, assess whether an individual meets the legislated criteria for medical assistance in dying; or
    (c) 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.

College of Pharmacists of British Columbia

EXTRAORDINARY BOARD MEETING
June, 3, 2016

4. Drug Schedule Regulation Amendments to enable Nurse Practitioner prescribing

DECISION REQUIRED

Recommended Board Motion:

Approve the following resolution:

RESOLVED THAT, in accordance with the authority established in section 22(1) of the *Pharmacy Operations and Drug Scheduling Act*, and subject to filing with the Minister as required by section 22(2) of the *Pharmacy Operations and Drug Scheduling Act*, the board amend the Drug Schedules Regulation, B.C. Reg. 9/98, as set out in the schedule attached to this resolution.

Purpose

To amend the provincial Drug Schedule Regulation in order to authorize and support the Nurse Practitioner (NP) prescribing standards of practice.

Background

NP Prescribing

The College of Registered Nurses of BC (CRNBC) is preparing for the implementation of NP prescribing; they will be authorized to prescribe a limited subset of controlled drugs and substances. Controlled drugs and substances are federally regulated and are prescription only; it is outside of BC's jurisdiction to change the scheduling status of these types of drugs. Federal legislation has been amended to permit NP's to prescribe controlled drugs and substances under the laws of the province in which they are registered and entitled to practise. The BC's Nurses (Registered) and Nurse Practitioners Regulation authorizes NPs to prescribe (and administer, compound and dispense) from Schedules I, IA and II of the BC's Drug Schedule Regulation.

Currently, BC's Drug Schedule Regulation does not include controlled drugs and substances, except for controlled drugs and substances that are included in Schedule IA (i.e. the Controlled Prescription Program). As they are already prescription only, adding these drugs to Schedule 1 of BC's Regulation will not change the status of these drugs. Rather, it will provide clarity and ensure legal authority for NP's to prescribe.

Legislative Authority for the College of Pharmacists of British Columbia (CPBC)
The legislative authority to amend the Drug Schedules Regulation is outlined in section 22 of the *Pharmacy Operations and Drug Scheduling Act*. The *Act* states:

Regulations of the board
22 (1) Subject to the *Food and Drugs Act* (Canada), the board, by regulation, may make drug schedules specifying the terms and conditions of sale for drugs and devices.
(2) A regulation under subsection (1) must be filed with the minister.

The proposed amendments include drugs that may be used for Medical Assistance in Dying (MAID) protocols. As NP's are authorized to prescribe drugs for MAID as per the anticipated federal legislative framework, there is an agreed upon sense of urgency between the College, CRNBC and the Ministry of Health to have these drugs included before the June 6, 2016 decriminalization of MAID.

Discussion

The current state of BC's Drug Schedules Regulation, in which most controlled drugs and substances are not included has raised an issue for CRNBC as it develops its standards of practice for NP prescribing. Most of these drugs were not included as it was unnecessary to duplicate federal legislative requirements in a provincial regulation. However, due to the structure of the NP's Regulation outlining their scope of practice, the College will need to make these benign amendments.

The list of prioritized drugs that are missing from the Drug Schedule Regulations are as follows:

- Dextroamphetamine
- Diphenoxylate (Lomotil)
- Methylphenidate
- Phenobarbital
- Secobarbital
- Tramadol[1]

Recommendation

The College recommends that the Board approve the proposed Drug Schedules Regulation amendments as presented.

Appendix	
1	Tagged schedule of Drug Schedule Regulation amendments

[1] Tramadol has been added for administrative purposes. It is not a controlled drug substance, rather it is on Health Canada's Prescription Drug List and accordingly should be added as a Schedule 1 on BC's Drug Schedule Regulation.

APPENDIX

The Drug Schedules Regulation, B.C. Reg. 9/98, is amended in the Schedules by adding the following:

I Dextroamphetamine or its salts
Diphenoxylate or its salts
Methylphenidate or its salts
Phenobarbital or its salts
Secobarbital or its salts
Tramadol or its salts.