College of Pharmacists of British Columbia

Board Meeting
November 20, 2020
Via Video Conference

MINUTES

Members Present:
Christine Antler, Outgoing Chair, District 2
Anca Cvaci, Outgoing Vice-Chair, District 6
Claire Ishoy, Incoming Chair, District 7
Steven Hopp, Incoming Vice-Chair, District 4
Alex Dar Santos, District 1
Andrea Silver, District 3
Michael Ortynsky, District 5
Bal Dhillon, District 8
Tracey Hagkull, Government Appointee
Anne Peterson, Government Appointee
Katie Skelton, Government Appointee
Justin Thind, Government Appointee

Staff:
Bob Nakagawa, Registrar
David Pavan, Deputy Registrar
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Doreen Leong, Director of Registration and Licensure
Mary O'Callaghan, Chief Operating Officer
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Jon Chen, Communications Project Officer
Kimberly Hilchie, Pharmacy Policy Consultant
Stephanie Kwok, Executive Assistant and Board Coordinator
Hilary Leung, Policy and Legislation Analyst
Anu Sharma, Senior Policy and Legislation Analyst

Guests:
Michael Coughtrie, Dean, UBC Faculty of Pharmaceutical Sciences
Parsa Shahbazi-Amin, UBC Pharmacy Undergraduate Society President

Guests Presenters:
Dr. Sana Shahram, Assistant Professor, School of Nursing, UBC Okanagan

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1. **WELCOME & CALL TO ORDER**
   Chair Antler called the meeting to order at 12:48pm on November 20, 2020.

College of Pharmacists of British Columbia

Chair Antler acknowledged the Coast Salish People on whose unceded traditional territories the meeting is being chaired from, the Coast Salish, Squamish and Tsleil-Waututh First Nations. She also recognized that attendees of the videoconference are joining the call from other First Nations territories across BC.

2. ELECTION OF CHAIR

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

Registrar Nakagawa called for nominations.

- Claire Ishoy was nominated.
- Alex Dar Santos was nominated

After 12 votes were electronically cast and tallied, Claire Ishoy was elected as the new Board Chair for a one-year term to conclude at the start of the November 2021 Board meeting.

Claire Ishoy assumed the Board Chair position.

3. ELECTION OF VICE-CHAIR

Chair Ishoy called for nominations

- Steven Hopp was nominated.
- Alex Dar Santos was nominated.

After 12 votes were electronically cast and tallied, Steven Hopp was elected as the new Board Vice-Chair for a one-year term to conclude at the start of the November 2021 Board meeting.

Steven Hopp assumed the Board Vice-Chair position.

4. CONSENT AGENDA

a) Items for further discussion

b) Approval of Consent Items (Appendix 1)

It was moved and seconded that the Board:
Approve the Consent Agenda as circulated.

CARRIED

5. CONFIRMATION OF AGENDA (Appendix 2)

It was moved and seconded that the Board:
Approve the November 20, 2020 Draft Board Meeting Agenda as circulated.

CARRIED

College of Pharmacists of British Columbia

6. LEGISLATION REVIEW COMMITTEE: PROFESSIONAL PRACTICE POLICY 66: AMENDMENT TO TRAINING DEADLINE (Appendix 3)

Justin Thind, Chair of the Legislation Review Committee presented on the proposed amendments to Professional Practice Policy 66: Opioid Agonist Treatment (PPP-66) to extend the deadline for transitioning to the Opioid Agonist Treatment Compliance and Management Program for Pharmacy (OAT-CAMPP) to recognize the impact of COVID-19 and the temporary suspension of the OAT-CAMPP.

It was moved and seconded that the Board:
Approve amendments to Professional Practice Policy 66 Opioid Agonist Treatment (PPP-66) to extend the deadline for transitioning to the Opioid Agonist Treatment Compliance and Management Program for Pharmacy, from March 31, 2021 to September 30, 2021.

CARRIED

7. DRUG ADMINISTRATION COMMITTEE: *AMENDMENTS TO THE HPA DRUG ADMINISTRATION BY INJECTION AND INTRANSAL ROUTE STANDARDS, LIMITS AND CONDITIONS* (Appendix 4)

Alex Dar Santos, Member of the Drug Administration Committee presented to the Board on the amendments to the Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions, to remove certain restrictions on pharmacist injection and intranasal administration of medications. The motion from the September 2020 Board meeting was tabled to the November 2020 Board meeting for further discussion.

Registrar Nakagawa reported to the Board on his meeting with Mark Armitage, Assistant Deputy Minister, Health Sector Workforce and Beneficiary Services Division, Mitch Moneo, Assistant Deputy Minister, Pharmaceutical, Laboratory & Blood Services Division and David Byres, Associate Deputy Minister, Clinical Leadership on November 16, 2020. He expressed the Board's desire to collaborate with the Ministry in this matter. The Board has asked Registrar Nakagawa to follow-up with another conversation with the Ministry and keep the Board appraised of the progress.

It was moved and seconded that the Board:
Accept the amendments, in principle to the Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions, as circulated.

CARRIED

8. GOT YOUR HEALTH EQUITY GLASSES ON? UNPACKING THE SYSTEMIC ROOTS OF INEQUITABLE HEALTH OUTCOMES.

Dr. Sana Shahram presented to the Board on the systemic roots of inequitable health outcomes. Dr. Shahram discussed social determinants of health, with particular focus on race, gender and culture.

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9. COLLEGE NAME CHANGE (Appendix 5)

Bal Dhillon, District 8 Board Member requested that the Board request that the Minister of Health change the College's name to the College of Pharmacy of British Columbia. The aim of the change would be to more accurately reflect the College's full scope of responsibilities and enhance public protection, as well as to align better with the name changes of similar regulatory bodies.

It was moved and seconded that the Board:
Request that the Minister of Health change the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia, as part of the anticipated amendments to the Health Professions Act.

WITHDRAWN

It was moved and seconded that the Board:
Request that the Minister of Health change the name of the College of Pharmacists of British Columbia as part of the anticipated amendments to the Health Professions Act.

CARRIED

10. GOVERNANCE COMMITTEE (Appendix 6)

Anne Peterson, Chair of the Governance Committee presented to the Board the final recommendation of committee appointments and the 2021 Board meeting schedule.

a) Appointment of Board Members to Committees

Audit and Finance Committee

- Appoint newly elected Board Chair, Claire Ishoy as Member
- Reappoint newly elected Board Vice-Chair, Steven Hopp as Member and Committee Chair
- Reappoint Alex Dar Santos as Member and Committee Vice-Chair
- Reappoint Tracey Hagkull as a Member
- Reappoint Anca Cvaci as Member
- Remove Christine Antler as Member

Governance Committee

- Appoint Christine Antler as a Member, for a 3-year term, ending April 30, 2024.

Past Chairs Advisory Committee

- Appoint Christine Antler as a Member, for a 3-year term, ending April 30, 2024.

College of Pharmacists of British Columbia

Registrar Evaluation & Succession Planning Committee

- Appoint newly elected Board Chair, Claire Ishoy as Member and Committee Chair
- Reappoint newly elected Board Vice-Chair, Steven Hopp as Member and Committee Vice-Chair
- Reappoint Alex Dar Santos as Member
- Reappoint Justin Thind as a Member
- Reappoint Christine Antler as Member
- Remove Christine Antler as Committee Chair
- Remove Anca Cvaci as Member and Committee Vice-Chair

It was moved and seconded that the Board:
Approve College committee member appointments for terms beginning on November 20, 2020, and the removal of committee members, as circulated.

CARRIED

b) Approval of 2021 Board Meeting Schedule

It was moved and seconded that the Board:
Approve the 2021 Board Meeting Schedule, as amended.

CARRIED

11. MEDICAL DELEGATION REQUEST – HEART@HOME (Appendix 7)

Registrar Nakagawa presented to the Board a delegation request from Dr. Steven Gordon to pharmacists involved in the Heart@Home program, allowing pharmacists to conduct home visits and administer injections beyond vaccinations such as methotrexate, B-12 and post surgical anticoagulation.

*District 3 Board Member, Andrea Silver recused herself from the discussion due to a perceived conflict of interest.

It was moved and seconded that the Board:
Approve the delegation request to authorize pharmacists involved in the Heart@Home Program to administer injections beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician, as delegated by Dr. Steven C. Gordon.

CARRIED

12. ITEMS BROUGHT FORWARD FROM CONSENT AGENDA

ADJOURNMENT

Chair Ishoy adjourned the meeting at 3:56pm on November 20, 2020.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4. Consent Agenda
b) Approval of Consent Items

DECISION REQUIRED

Recommended Board Motion:

Approve the Consent Agenda as circulated, or amended.

i. Chair's Report
ii. Registrar's Update
    a. Compliance Certificate
    b. Risk Register (November 2020)
    c. Action Items & Business Arising
    d. Strategic Plan 2020/21 to 2024/25 Update
iii. Approval of September 18, 2020 Draft Board Meeting Minutes **[DECISION]**
iv. Committee Updates
v. Audit and Finance Committee: Finance Report: November Financials
vi. Approval of September 17, 2020 Draft Committee of the Whole Meeting Minutes **[DECISION]**
vii. Approval of September 18, 2020 Draft Committee of the Whole Meeting Minutes **[DECISION]**
viii. Corporate Resolution for Obtaining Sun Life Financial Inc. Shares **[DECISION]**

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.i. Chair's Report

INFORMATION ONLY

It is my pleasure to provide this report for the November 2020 Board meeting. Since the previous Board Meeting report (September 2020), I have been involved in the following activities as Board Chair:

General:

- Liaised with Registrar, Vice Chair and Board to plan November 2020 Board meeting
- Reviewed draft September 2020 board meeting and Committee of the Whole meeting minutes
- Attended regular teleconferences with Registrar and Vice-Chair on Board items including those related to November board meeting
- Liaised with guest speaker for November Committee of the Whole meeting
- Communications regarding Registrar evaluation process
- Submitted letter to Mark Armitage, Assistant Deputy Minister regarding pharmacist drug administration
- Discussions with Board members regarding Board executive succession planning
- Liaised with College staff to prepare for November Annual General Meeting
- Answered general questions/queries of fellow Board members

Events:

- Attended Council for Licensure, Enforcement and Regulation (CLEAR) annual conference (virtual)
- Attended Canadian Network of Agencies of Regulation (CNAR) annual conference (virtual)
- Attended Tri-provincial meeting November 6, 2020 with Registrar, Vice-Chair and members of the Alberta College of Pharmacists and Saskatchewan College of Pharmacy Professionals
- WATSON Webinar – The Critical Board-CEO/Executive Dynamic: Experiences from the Front Line

Committees:

- Application Committee
- Audit and Finance Committee
- Governance Committee
- Registrar Evaluation and Succession Planning Committee

Compliance Certificate

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

Annual Report - Filed June 24, 2020

Non-profit Tax Return – Filed August 19, 2019

Non-profit Information Return – Filed August 19, 2019

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

Employee pension plan remittances – all remittances are current.

WorkSafeBC BC assessments – all remittances are current.

Employer Health Tax assessments – all remittances are current.

Sales Taxes – all remittances are current.

Investments – invested as per policy.

Bank signing authority documents – current as per policy.

Insurance – all insurance policies are up to date.

Business Licence – current.

Signed by:

Registrar

Chief Operating Officer

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.ii Registrar's Update
d) Strategic Plan 2020/21 to 2024/25 Update

INFORMATION ONLY

Purpose
To provide an update on the status of the College's Strategic Plan 2020/21 - 2024/25 ("Strategic Plan"), as of October 2020.

Background
The Board-approved Strategic Plan was recently reviewed by the Committee of the Whole on June 11, 2020. The College Management Team also reviewed the Strategic Plan on June 24 and 25th with the focus on operationalizing it, planning action items, and identifying resourcing. Additionally, meetings have been held with key personnel and the Strategic Plan is a regular item on the Management Team's meeting agendas.

At the September 17, 2020, Committee of the Whole meeting, the Board discussed reviewing the Strategic Plan. This discussion focused on reviewing the Strategic Plan to ensure that it reflects: lessons-learned; the impact of emerging issues such as the recent public health emergency related to COVID-19 and the continuing Opioid Overdose Crisis; and, the Steering Committee on Modernization of Health Professional Regulation's August 2018 recommendations.

College staff have met with an external consultant to develop a framework for the above-noted review. And, a facilitated Board discussion with the external consultant is currently being scheduled to conduct this review.

Discussion
Below is an update on the work completed to date:

Goal One

- Completed a jurisdiction scan of standards of practice of other BC health regulators as well as each Pharmacy Regulatory Authority ("PRA") across Canada to determine whether standards of practice are located in a stand-alone document or embedded in bylaw and to identify whether their standards of practice are principle-based.
- Mapped existing College standards of practice to the NAPRA Model Standards of Practice to determine gaps in current practice.
- Reviewed the existing standards of practice to identify misalignments with current practice.

Next Steps

Over the next couple of months staff will:

- Continue reviewing the standards of practice.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.iii Approval of September 18, 2020 Draft Board Meeting Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the September 18, 2020 draft Board meeting minutes as circulated.

Appendix	
1	http://library.bcpharmacists.org/2_About_Us/2-1_Board/Board_Videoconference_Minutes-20200918.pdf

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BOARD MEETING
November 20, 2020

4b.iv Committee Updates

INFORMATION ONLY

Purpose

To provide updates of committee activities since the last Board meeting.

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

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

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i. Application Committee

The Application Committee met four times since the September 2020 Board meeting. The committee reviewed ten pharmacy files. Six files were incomplete renewals, two had false/misleading information and two pharmacy files were eligibility-related cases. Please note, as this update was submitted on November 5, 2020, the number of pharmacy files reviewed may increase dependent on the number of cases reviewed in November. (E.g., late November renewal and any new eligibility cases.)

ii. Audit and Finance Committee

The Audit and Finance Committee has not met since the last Board meeting.

iii. Discipline Committee

The Discipline Committee did not have any files heard in court for the period of August 2020 to September 2020. There are two files in progress and three pending files. Two files have been resolved via consent order pursuant to section 37.1 of the HPA.

iv. Drug Administration Committee

The Drug Administration Committee met on October 30, 2020 via videoconference to discuss the amendments to the HPA Drug Administration Standards, Limits and Conditions being brought forward to the November Board meeting for approval.

v. Ethics Advisory Committee

The Ethics Advisory Committee has not met since the last Board meeting.

vi. Governance Committee

The Governance Committee met on October 29, 2020 via videoconferencing. The committee reviewed the September 18, 2020 Board meeting evaluation survey results and discussed about the following survey comments:

- Review of governance principles;
- Informal check-ins amongst Board members; and
- Board meeting format and frequency.

The committee also discussed about the following agenda items:

- Ways to reduce virtual meeting fatigue;
- Board competency matrix;
- Questions to pose to Chair and Vice-Chair candidates;
- Removing Board members as Chairs to Committees; and
- Committee Member Appointments at the November 2020 Board meeting.

The committee will aim to bring to the Board for approval a CPBC Board competency matrix at the February 2021 Board meeting. The committee will also recommend for approval the removal of Board members as Chairs to committees at the April 2021 Board meeting, pending review of the committee terms of references at its next meeting.

vii. Inquiry Committee

The Inquiry committee met three times via videoconference and eight times via teleconference for the period of August 2020 to September 2020. Fourty-seven files were reviewed or disposed of, of which twenty-three files were new files, twenty-one were reconsideration files, and three were PODSA s. 18 report files. 143calls/tips were received during this reporting period and nineteen formal complaints were received. The increase in number of files disposed by the Inquiry Committee for the months of August to September 2020 was attributed to registrants requesting for reconsideration of the terms in their consent agreements and registrants breaching terms of their consent agreements.

viii. Jurisprudence Examination Subcommittee

The Jurisprudence Examination Subcommittee has not met since the last Board meeting.

ix. Legislation Review Committee

The Legislation Review Committee met on October 21, 2020. They discussed one item being brought forward to the Board's November 2020 meeting: amending the training program requirement in Professional Practice Policy 66: Opioid Agonist Treatment. In addition, they received an update on the work being undertaken by the Drug Administration Committee, and on the upcoming legislation-related items.

x. Pharmacy Advisory Committee

The Pharmacy Advisory Committee has not met since the last Board meeting.

xi. Practice Review Committee

The Practice Review Committee met through Microsoft Teams on October 29th, 2020 and discussed the following agenda items:

- PRP operational updates including:
  - Statistics
  - Risk register
  - Insight Articles
- September Board Meeting update – PRP Annual Report
- Launch of Virtual Reviews

The committee will meet next in January 2021.

xii. Quality Assurance Committee

The Quality Assurance Committee has not met since the last Board meeting.

xiii. Registrar Evaluation and Succession Planning Committee

The Registrar Evaluation and Succession Planning Committee met on November 4 and November 9, 2020 via videoconference to discuss the Registrar and CEO Goals for 2021 and review the Registrar's annual report.

xiv. Registration Committee

The Registration Committee met five times since the September 2020 Board meeting. The committee reviewed three files, one for amendments to the Registration Committee Policy, one was a jurisprudence examination accommodation request, and one was a statutory declaration issue. Please note, as this update was submitted on November 5, 2020, the number of cases may increase if we receive more cases in November.

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

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.v. Audit and Finance Committee: Finance Report (September Financials)

INFORMATION ONLY

Purpose

To report on the highlights of the **September 2020** financial reports.

Background

The September 2020 financial reports reflect **seven month's** activity. Attached are the Statement of Financial Position, a summary Statement of Revenue and Expenditures and more detailed reports on Revenue and on Expenditures.

Statement of Financial Position

The College's cash position is well funded to meet payables with a balance of about $1,793,000. Investments totalled just under $4,768,000. Payables and accruals are just over $700,000.

The Working Capital Ratio (a test of liquidity) is 1.1.

Revenue

The total *Licensure revenues* are slightly under budget, by about $137,000 or 2%. This is primarily due to one-time fees as well as the 2020 UBC grads being unable to register as full pharmacists. A little over $57,000 in Jurisprudence Exam fees were received in September. *Other revenues* (administrative fees, etc.) are over budget by about $13,000, mainly due to fines received, while Grant revenue is under budget due to timing until the one remaining grant milestone payment has completed the next milestone. Investment income is under budget by about $14,000, while Joint Venture income is right on budget. The combined result is that actual revenues are under budget, approximately $143,000 or 2% under budget.

Expenses

Total Year to Date Actual expenditures are considerably under budget, by almost $906,000 or 13%. See the variance analysis which follows for details. Much of the under-budget variances are due to changes in operations due to COVID-19.

Variance analysis by department:

Department	Budget	Actual	%	Comment
Board & Registrar's Office	472,424	341,287	28	Reduced travel and accommodation and conferences.
Finance and Administration	1,179,806	1,125359	5	Reduced professional development, timing re: bank charges.
Information Technology	1,411,388	1,275,570	10	Timing as project priorities changed due to COVID-19
Registration & Licensure	598,680	515,251	14	Salary gapping and reduced committee travel and accommodation.
Quality Assurance	187,653	159,883	15	Timing.
Practice Review	989,484	822,116	17	Salary gapping and reduced travel and accommodation for committee meetings and staff as well as timing re: outside services.
Complaints Resolution	1,078,157	919,838	15	Salary gapping and timing re legal and outside services.
Policy and Legislation	327,748	268,258	18	Salary gapping.
Communications & Engagement	244,187	234,695	4	Timing re: engagement activities.
Projects (PODSA Modernization)	71,487	0	100	Timing re: outside services.
Amortization	173,182	166,258	4	
Total Expenses	6,734,196	5,828,514	13	13% under budget. ($905,681)

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

College of Pharmacists of BC

Statement of Financial Position

As at September 30, 2020

ASSETS	
Cash and Cash Equivalents	1,792,536
Investments	4,767,664
Receivables	76,925
Prepaid Expense and Deposits	391,208.55
Current Assets	7,028,333
Investments in College Place Joint Venture	1,481,167.33
Development Costs	127,331.29
Property & Equipment	667,812.03
Non-current Assets	2,276,311
Total Assets	**9,304,644**

LIABILITIES AND NET ASSETS	
Payables and Accruals	706,335
Capital Lease Obligations (Current)	5,107
Deferred Revenue	5,514,885
Deferred Contributions	60,237
Total Current Liabilities	6,286,565
Capital Lease Obligations (non-current)	32,719
Total Liabilities	6,319,283
Total Net Assets	2,985,360
Total Liabilites and Net Assets	**9,304,644**

College of Pharmacists of BC

Statement of Revenue and Expenses

For the 7 months ended September 30, 2020

	Budget YTD 2020/21	Actual YTD 2020/21	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Licensure revenue	5,599,311	5,462,712	(136,599)	(2%)
Non-licensure revenue	283,887	277,293	(6,594)	(2%)
Transfer from Balance Sheet	-	-	-	0%
Total Revenue	**5,883,197**	**5,740,005**	**(143,192)**	(2%)
Total Expenses Before Amortization	6,561,013	5,662,256	898,757	14%
Amortization	173,182	166,258	6,924	4%
Total Expenses Including Amortization	**6,734,196**	**5,828,514**	**905,681**	13%
Net Surplus/(Deficit) of revenue over expenses after amortization expense	**(850,998)**	**(88,509)**	**762,489**	

College of Pharmacists of BC

Statement of Revenue and Expenses

For the 7 months ended September 30, 2020

	Budget YTD 2020/21	Actual YTD 2020/21	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Revenue				
Pharmacy fees	2,131,341	2,094,456	(36,886)	(2%)
Pharmacists fees	2,927,285	2,864,906	(62,379)	(2%)
Technician fees	540,684	503,350	(37,334)	(7%)
Licensure revenue	5,599,311	5,462,712	(136,599)	(2%)
Other revenue (fines/assessments, late fees, certificate of letter of standing)	**55,982**	**69,252**	**13,269**	**24%**
Grant Revenue	**7,793**	**1,560**	**(6,233)**	**(80%)**
Investment income	**76,346**	**62,717**	**(13,630)**	**(18%)**
College Place joint venture income	**143,765**	**143,765**	**0**	**0%**
Non-licensure revenue	283,887	277,293	(6,594)	(2%)
Transfer from Balance Sheet	-	-	-	0%
Total Revenue	**5,883,197**	**5,740,005**	**(143,192)**	(2%)

College of Pharmacists of BC

Statement of Expenses

For the 7 months ended September 30, 2020

	Budget YTD 2020/21	Actual YTD 2020/21	Variance ($) (Budget vs. Actual)	Variance (%) (Budget vs. Actual)
Expenses				
Board and Registrar's Office	472,424	341,287	131,137	28%
Finance, Human Resources and Administration	1,179,806	1,125,359	54,447	5%
Information Technology	1,411,388	1,275,570	135,817	10%
Registration and Licensure	598,680	515,251	83,430	14%
Quality Assurance	187,653	159,883	27,769	15%
Practice Reviews	989,484	822,116	167,368	17%
Complaints and Investigations	1,078,157	919,838	158,319	15%
Policy and Legislation	327,748	268,258	59,490	18%
Communications and Engagement	244,187	234,695	9,492	4%
Projects	71,487	-	71,487	100%
Total Expenses Before Amortization	6,561,013	5,662,256	898,757	14%
Amortization	173,182	166,258	6,924	4%
Total Expenses Including Amortization	**6,734,196**	**5,828,514**	**905,681**	13%

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.vi Approval of September 17, 2020 Draft Committee of the Whole Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the September 17, 2020 draft Committee of the Whole minutes as circulated.

Appendix	
1	September 17, 2020 Draft Committee of the Whole Minutes (and appendices)

College of Pharmacists of British Columbia

Committee of the Whole Meeting
September 17, 2020
Via Video Conference

MINUTES

Members Present:
Christine Antler, Chair, District 2
Anca Cvaci, Vice-Chair, District 6
Alex Dar Santos, Board member, District 1
Andrea Silver, Board member, District 3
Steven Hopp, Board member, District 4
Michael Ortynsky, Board member, District 5
Claire Ishoy, Board member, District 7
Bal Dhillon, Board Member, District 8
Tracey Hagkull, Government Appointee
Anne Peterson, Government Appointee
Katie Skelton, Government Appointee
Justin Thind, Government Appointee

Staff:
Bob Nakagawa, Registrar
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Doreen Leong, Director of Registration and Licensure
Mary O'Callaghan, Chief Operating Officer
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Ed Diaz, Practice Reviews and Quality Assurance Coordinator / Compliance Officer
Patricia Fu, Complaints & Investigations Operations Manager
Bethany Gamache, Hospital Compliance Officer
Stephanie Kwok, Executive Assistant and Board Coordinator
Anu Sharma, Senior Policy and Legislation Analyst

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1. **WELCOME & CALL TO ORDER**
   Chair Antler called the meeting to order at 12:34pm on September 17, 2020.

   Chair Antler acknowledged the Coast Salish People on whose unceded traditional territories the meeting is being chaired from, the Coast Salish, Squamish and Tsleil-Waututh First Nations. She also recognized that attendees of the videoconference are joining the call from other First Nations territories across BC.

2. **NATIONAL ASSOCIATION OF PHARMACY REGULATORY AUTHORITIES' MODEL STANDARDS FOR PHARMACY COMPOUNDING**
   Registrar Nakagawa, Ed Diaz, Practice Reviews Coordinator/Compliance Officer and Bethany Gamache, Compliance Officer presented to the Board an overview of a pharmacy's role in patient safety through the implementation of sterile compounding standards.

College of Pharmacists of British Columbia

3. REVIEW OF CPBC STRATEGIC PLANNING SESSION REPORT AND OPERATIONAL CONSIDERATIONS

The Board engaged in a discussion on the potential impact of delaying the launch of CPBC's strategic plan. The Board agreed that in light of the existing launch delay due to the COVID-19 pandemic, this is an opportunity to revisit and fine-tune the strategic plan to ensure existing goals are reflective of the current environment in BC, including the existing dual public health emergencies and the modernization of the Health Professions Act. . The Board is in consensus of relooking at the strategic plan before launching to the public. College staff will assist in setting up a strategic planning session in November 2020.

4. BOARD MEMBER'S ROLE ON COMMITTEES

The Board discussed the pros and cons of having Board members as Chairs of non-statutory advisory committees. The Board has directed the Governance Committee to revise the terms of references of the non-statutory advisory committees, removing the requirement of Board members to chair such committees. The Governance Committee will bring back to the Board the revised terms of references for approval at the November Board meeting. The Board also directed the Governance Committee to create a Board competency matrix to aid in the recruitment of committee members.

5. OPERATIONAL IMPACT OF COVID-19 ON THE COLLEGE OF PHARMACISTS OF BC

Doreen Leong, Director of Registration and Licensure, Ashifa Keshavji, Director of Practice Reviews and Quality Assurance and Patricia Fu, Complaints and Investigations Operations Manager presented to the Board the operational impact of COVID-19 on their departments. The presentation outlined internal operational changes, changes affecting external stakeholders, ongoing projects and tasks. Upcoming changes were also highlighted, in particular online pre-registration, virtual practice reviews and restarting on-site investigations.

6. ADJOURNMENT

Chair Antler adjourned the meeting at 4:12pm on September 17, 2020.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.vii Approval of September 18, 2020 Draft Committee of the Whole Minutes

DECISION REQUIRED

Recommended Board Motion:

Approve the September 18, 2020 draft Committee of the Whole minutes as circulated.

Appendix	
1	September 18, 2020 Draft Committee of the Whole Minutes (and appendices)

College of Pharmacists of British Columbia

Committee of the Whole Meeting
September 18, 2020
Via Video Conference

MINUTES

Members Present:
Christine Antler, Chair, District 2
Anca Cvaci, Vice-Chair, District 6
Alex Dar Santos, Board member, District 1
Andrea Silver, Board member, District 3
Steven Hopp, Board member, District 4
Michael Ortynsky, Board member, District 5
Claire Ishoy, Board member, District 7
Bal Dhillon, Board Member, District 8
Tracey Hagkull, Government Appointee
Anne Peterson, Government Appointee
Katie Skelton, Government Appointee
Justin Thind, Government Appointee

Staff:
Bob Nakagawa, Registrar
Ashifa Keshavji, Director of Practice Reviews and Quality Assurance
Doreen Leong, Director of Registration and Licensure
Mary O'Callaghan, Chief Operating Officer
Christine Paramonczyk, Director of Policy and Legislation
Gillian Vrooman, Director of Communications and Engagement
Stephanie Kwok, Executive Assistant and Board Coordinator
Anu Sharma, Senior Policy and Legislation Analyst

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1. **WELCOME & CALL TO ORDER**
   Chair Antler called the meeting to order at 8:35am on September 18, 2020.

   Chair Antler acknowledged the Coast Salish People on whose unceded traditional territories the meeting is being chaired from, the Coast Salish, Squamish and Tsleil-Waututh First Nations. She also recognized that attendees of the videoconference are joining the call from other First Nations territories across BC.

2. **CONFLICT OF INTEREST**
   The Board discussed about a perceived conflict of interest to Board agenda item 4. Drug Administration: Amendments to HPA Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions due to Chair Antler's recent change in her role to a non-profit organization.

   The Board is in consensus that there is no conflict of interest as Chair Antler does not have a vested interest in the number of injections done.

College of Pharmacists of British Columbia

3. PUBLIC HEALTH ORDER

The Board discussed about the public health order issued on Wednesday, September 16, 2020 by Dr. Bonnie Henry, Provincial Health Officer, authorizing registered nurses and registered psychiatric nurses to prescribe pharmaceutical alternatives in response to the increasing overdoses and overdose deaths in BC. The Board discussed potential ways pharmacy professionals could contribute to the opioid epidemic response in BC.

The Board directed the College to draft two letters; one in response to Dr. Bonnie Henry's public health order and the other to Mark Armitage, Assistant Deputy Minister in efforts to move forward with the Ministry of Health in the discussion of pharmacist's administration of drugs by injection and intranasal route.

4. ADJOURNMENT

Chair Antler adjourned the meeting at 9:10am on September 18, 2020.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

4b.viii Corporate Resolution for Obtaining Sun Life Financial Inc. Shares

DECISION REQUIRED

Recommended Board Motion:

RESOLVED THAT, in respect of Sun Life Financial Inc. shares, the Registrar/Chief Executive Officer, Deputy Registrar and / or the Chief Operating Officer be and they are hereby authorized on behalf of the Corporation to accept and convey, assign, transfer or otherwise dispose of all or any shares, stocks, bonds, debentures, debenture stock and other securities of every description now or hereafter registered in the name of the Corporation or held or owned by the Corporation and to sign and execute on behalf of the Corporation all and any instruments of acceptance and transfer and other documents whenever necessary or proper to effectuate the same with full power to appoint any attorneys with full power of substitution therein, and that any and all instruments of acceptance and transfer and other documents in connection therewith heretofore signed and executed on behalf of the Corporation in accordance with the authority set out above are hereby ratified and confirmed.

Purpose

In order to obtain shareholder information confirming ownership of Sun Life Financial Inc. shares, we are required to submit this motion and a Certificate with the signatures of the named staff to AST Trust Company.

Background

The College has owned 475 shares in Sun Life for a number of years but does not have any proof of that ownership, other than periodically receiving a small dividend. It is believed to have been part of a transition of employee benefits from Sun Life to Great West Life. We've been attempting to obtain copies of these shares for a while now, using the current signing authority wording approved by the Board (in the Board Reference and Policy Manual). However, the trust company requires this motion.

Recommendation

Approve the above motion.

Appendix	
1	Sample Corporate Resolution and Certificate

Certified Corporate Resolution

RESOLVED THAT

_____

_____

be and they are hereby authorized on behalf of the Corporation to accept and convey, assign, transfer or otherwise dispose of all or any shares, stocks, bonds, debentures, debenture stock and other securities of every description now or hereafter registered in the name of the Corporation or held or owned by the Corporation and to sign and execute on behalf of the Corporation all and any instruments of acceptance and transfer and other documents whenever necessary or proper to effectuate the same with full power to appoint any attorneys with full power of substitution therein, and that any and all instruments of acceptance and transfer and other documents in connection therewith heretofore signed and executed on behalf of the Corporation in accordance with the authority set out above are hereby ratified and confirmed.

CERTIFICATE

I hereby certify that the foregoing is a true and correct copy of a Resolution duly passed at a meeting of the Directors of _____ regularly held on the_____ day of _____, _____, and that the said Resolution is still in full force and effect. I further certify that the following is a list of persons authorized by this Resolution to do any act or thing along with specimens of their signatures.

Names	**Title**	**Signature**

I hereby certify that I am the sole signing officer of the corporation [delete and initial if inapplicable]

I hereby certify that no corporate seal exists for this corporation [delete and initial if inapplicable]

WITNESS my hand and seal of the Corporation this _____day of _____,_____.

Affix Seal

Authorized Signature _____

Print name _____

Print title _____

[To be completed if applicable}
We hereby certify that _____ is the sole signing officer of _____

_____
(signature of acceptable guarantor)

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

5. Confirmation of Agenda

DECISION REQUIRED

Recommended Board Motion:

Approve the November 20, 2020 Draft Board Meeting Agenda as circulated, or amended.

Appendix	
1	November 20, 2020 Draft Board Meeting Agenda

College of Pharmacists of British Columbia

Board Meeting
Friday, November 20, 2020

AGENDA

12:45pm - 1:05pm	20	**1.** Call to Order *Land Acknowledgement*	Chair Antler
		2. Election of Chair **[DECISION]**	Registrar Nakagawa
		3. Election of Vice-Chair **[DECISION]**	Chair
		4. Consent Agenda a) Items for Further Discussion b) Approval of Consent Items **[DECISION]**	Chair
		5. Confirmation of Agenda **[DECISION]**	Chair
1:05pm - 1:15pm	10	**6.** Legislation Review Committee: Professional Practice Policy 66: Amendment to Training Deadline **[DECISION]**	Justin Thind
1:15pm - 2:15pm	60	**7.** Drug Administration Committee: Amendments to the HPA Drug Administration Standards, Limits and Conditions **[DECISION]**	Alex Dar Santos
2:15pm - 2:45pm	30	**8.** College Name Change **[DECISION]**	Bal Dhillon
2:45pm - 3:05pm	25	***BREAK***	
3:05pm - 3:35pm	30	**9.** Got your Health Equity Glasses On? Unpacking the Systemic Roots of Inequitable Health Outcomes	Dr. Sana Shahram
3:35pm - 3:40pm	5	**10.** Governance Committee: a) Appointment of Board Members to Committees **[DECISION]** b) 2021 Board Meeting Schedule **[DECISION]**	Anne Peterson
3:40pm - 3:55pm	15	**11.** Medical Delegation Request - Heart@Home **[DECISION]**	Registrar Nakagawa
3:55pm - 4:00pm	5	**12.** Items Brought Forward from Consent Agenda	Chair

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

6. Legislation Review Committee: Professional Practice Policy-66: Amendment to Training Deadline

DECISION REQUIRED

Recommended Board Motion:

Approve amendments to *Professional Practice Policy 66 Opioid Agonist Treatment* (PPP-66) to extend the deadline for transitioning to the *Opioid Agonist Treatment Compliance and Management Program for Pharmacy*, from March 31, 2021 to September 30, 2021.

Purpose

To seek Board approval to amend PPP-66 to extend the deadline for transitioning to the *Opioid Agonist Treatment Compliance and Management Program for Pharmacy*, from March 31, 2021 to September 30, 2021.

Background

In November 2018, the Board approved amendments to PPP-66 to phase out the CPBC Methadone Maintenance Treatment (MMT) training program and transition to a new opioid agonist treatment training program called *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP), developed by the Ministry of Health (Ministry) and the British Columbia Pharmacy Association (BCPhA). OAT-CAMPP consists of a self-study component for both pharmacists and pharmacy technicians, as well as an in-person component for pharmacists only. PPP-66 requires that registrants complete the applicable component(s) of OAT-CAMPP by March 30, 2021. See Appendix 1 for more information on these previous PPP-66 amendments.

In addition to these CPBC training requirements, the Provider Regulation under the *Pharmaceutical Services Act* requires that one pharmacist from every B.C. pharmacy enrolled as an Opioid Agonist Treatment Provider complete the OAT-CAMPP by March 2021.

Discussion

On March 17, 2020, the Provincial Health Officer, Dr. Bonnie Henry, declared a public health emergency due to the spread of COVID-19. Due to COVID-19, OAT-CAMPP training was suspended in March 2020. Prior to the emergency, 2,444 pharmacists and 89 pharmacy technicians completed OAT-CAMPP training. However, the BCPhA has identified that another 956 pharmacists still need to complete it.

Additionally, on July 9, 2020, the Minister of Health issued Ministerial Order M213 to amend the Provider Regulation by waiving the March 31, 2021 deadline requirement for pharmacists completing OAT-CAMPP. We understand that this is related to the COVID-19 emergency.

The BCPhA has now developed an on-line version of OAT-CAMPP, which has been accredited by the Canadian Council on Continuing Education in Pharmacy (CCCEP). This training is expected to be launched in the beginning of November 2020, and the first virtual class is tentatively scheduled for November 15, 2020.

Due to the suspension of the OAT-CAMPP in March and its re-launch as a virtual program in November, the Ministry of Health, BCPhA and College staff met in October 2020 to discuss a potential training deadline extension. BCPhA noted that a 6-month extension from the original March 31, 2021 training deadline would allow enough time for the remaining 956 pharmacists to complete the training. As such, proposed amendments to PPP-66 to extend the March 31, 2021 deadline to September 30, 2021 are included in Appendix 2.

We understand that Ministry staff will prepare proposed amendments to the Provider Regulation to align with the extended training deadline. However, the timing of amendments to provincial regulations is unclear due to the Fall Provincial election.

Next Steps

If approved by the Board, the above-noted amendments would take effect immediately. Key next steps would include:

- Communicate the amendments to PPP-66 to the public and registrants; and
- Update the College website with the revised PPP-66 document.

Recommendation

The Legislation Review Committee recommends that the Board approve the proposed amendments the *PPP 66 - Opioid Agonist Treatment* to extend the deadline for transitioning to the *Opioid Agonist Treatment Compliance and Management Program* for Pharmacy from March 31, 2021 to September 30, 2021.

Guiding Questions:

When reviewing the proposed amendments to PPP-66, the Board is asked to consider:

1. Is the deadline extension to complete the OAT-CAMPP reasonable and in the best interest of the public?

Appendix	
1	November 2018 Board Briefing Package
2	Amendments to *PPP-66 Opioid Agonist Treatment* (track changes)

College of Pharmacists of British Columbia

BOARD MEETING
November 23, 2018

11. Legislation Review Committee
c) Professional Practice Policy-66: Amendment to Training Requirements

DECISION REQUIRED

Recommended Board Motions:

1) Approve amendments to *Professional Practice Policy 66 Opioid Agonist Treatment* (PPP-66) to align with a new opioid agonist treatment training program for pharmacy, as circulated, effective on January 1, 2019.

2) Amend the following policy guides to incorporate consequential and housekeeping amendments, as circulated, effective on January 1, 2019:

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

Purpose

To seek Board approval to amend *PPP-66* to align with a new opioid agonist treatment (OAT) training program for pharmacy, and consequential and housekeeping amendments for the corresponding policy guides.

Background

PPP-66 requires pharmacists and technicians to complete the CPBC Methadone Maintenance Treatment (MMT) training program prior to dispensing methadone; in addition, the pharmacy manager must educate non-pharmacist staff of their relevant roles. However, neither PPP-66 nor the CPBC have specific training program requirements related to the other OAT drugs (i.e., buprenorphine/naloxone and slow release oral morphine). To date, there has been no identified fulsome OAT training program specifically tailored to pharmacies.

In conjunction with the Ministry of Health ("Ministry"), the British Columbia Pharmacy Association (BCPhA) has developed an OAT training program for pharmacy that covers all three OAT medications outlined in PPP-66 (i.e., buprenorphine/naloxone, methadone and slow release oral morphine). The resulting *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program is comprised of a four-hour online component and a one-day in-person workshop. OAT-CAMPP officially launches in January 2019.

Discussion

It is proposed that PPP-66 be amended to align with the new BCPhA training program, as it is pharmacy-specific and more fulsome than the current CPBC MMT training program. This will better equip registrants with the tools needed to provide the best care for patients with opioid use disorder.

The Ministry and the BCPhA propose that within six months of the January 2019 launch date, all community pharmacies that deliver OAT will have one pharmacist on staff complete the training program. And, within about two and a half years (i.e., by March 31, 2021) all community pharmacists who dispense OAT in their practice will have completed the OAT-CAMPP course.

Pharmacy Technician Training Requirement
The proposed amendment to PPP-66 with respect to the training requirement for pharmacy technicians, only requires the online component of OAT-CAMPP. The content of the in-person workshop focuses primarily on clinical cases that are not as relevant for pharmacy technicians.

Transition Period
Over the January 1, 2019 to March 31, 2021 transition period, PPP-66 will require either the CPBC MMT training program or the OAT-CAMPP course as a requirement to dispense OAT. The MMT training program will sunset at the end of this transition period (i.e., March 2021), and will be replaced with only the OAT-CAMPP[1].

It is important to note that currently, pharmacists and pharmacy technicians who dispense buprenorphine/naloxone and slow release oral morphine are not required to take the CPBC MMT training program. However, given that patients taking MMT may eventually be prescribed other OAT drugs, it is seen a good practice for registrants dispensing any OAT drug to take either the College's MMT training program or OAT-CAMPP.

Consequential and House-keeping Amendments
The above-noted proposed changes to PPP-66 require limited consequential amendments to the MMT policy guide. In addition, College staff are proposing minor house-keeping amendments to the PPP-66 and the corresponding policy guides (e.g., style consistency, formatting, and abbreviation).

[1] Please also see the materials regarding item 10 on the Board meeting agenda for related information on the BCPhA OAT-CAMPP training program.

Next Steps

If approved by the Board, the above-noted amendments would take effect on January 1, 2019. Key next steps would include:

- Communicate the amendments to the policy documents to the public and registrants; and
- Update the College website with revised policy documents.

Recommendation

The Legislation Review Committee recommends that the Board approve the proposed amendments the *PPP 66 - Opioid Agonist Treatment* and its three corresponding policy guides (i.e., *PPP 66-Policy Guide – Methadone Maintenance Treatment (2013), PPP 66-Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)*, and *PPP 66-Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)).*

Appendix	
1	Amendments to *PPP-66 Opioid Agonist Treatment* (track changes and clean copy)
2	Amendments to *PPP-66 Policy Guide – Methadone Maintenance Treatment (2013)* (track changes)
3	Amendments to *PPP-66 Policy Guide – Buprenorphine/Naloxone Maintenance Treatment (2018)* (track changes)
4	Amendments to *PPP-66 Policy Guide – Slow Release Oral Morphine Maintenance Treatment (2018)* (track changes)

This policy provides guidance to registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment.

POLICY STATEMENTS:

Effective January 1, 2019:

1. All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or
    b. successfully complete the British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and
    c. record self-declaration of training completion in eServices.
2. All pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the CPBC MMT training program (2013), or
    b. successfully complete the online component of the BCPhA OAT-CAMPP training program, and
    c. record self-declaration of training completion in eServices.
3. Pharmacy managers must:
    a. educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to opioid agonist treatment, and
    b. document the completion of the education of individual non-pharmacist staff members on a form signed and dated by the pharmacy manager and the non-pharmacist staff member, and retain the completed forms in the pharmacy's files.

Effective March 31, 2021:

The CPBC MMT training program (2013) will not be available beyond March 31, 2021. Registrants will no longer be able to fulfill the College's training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by March 31, 2021. The above-noted Policy Statements 1a and 2a will be repealed and all other requirements will continue to be in effect.

During the period between January 1, 2019 and March 31, 2021, registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment are strongly encouraged to complete the OAT-CAMPP program as soon as practicable.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

~~***Effective January 1, 2018:***~~

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The ~~College of Pharmacists of British Columbia (~~CPBC~~)~~ *Buprenorphine/Naloxone Maintenance Treatment Policy Guide* (2018) is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU*) A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.
2. The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs.~~, and~~
    ~~d) successfully complete the mandatory CPBC MMT training program (2013), record self-declaration of training completion in eServices prior to dispensing the 10mg/ml preparation.~~
4. ~~Upon completion of the mandatory CPBC MMT training program pharmacy managers must educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to methadone maintenance treatment. (Note: documentation forms that confirm the education of individual non-pharmacist staff members must be signed and dated by the community pharmacy manager and the non-pharmacist staff member and retained in the pharmacy files).~~

The Methadone Maintenance Policy Statements must be read in conjunction with *PPP-71 Delivery of Methadone Maintenance Treatment*.

Required References

In addition to the currently required pharmacy reference materials (*PPP-3*), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and subsequent revisions.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most current version of the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders ~~(2015)~~*.
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

~~***Effective January 1, 2018:***~~

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths and formulations.
2. The CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

This policy provides guidance to registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment.

POLICY STATEMENTS:

Effective January 1, 2019:

1. All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or
    b. successfully complete the British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and
    c. record self-declaration of training completion in eServices.
2. All pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the CPBC MMT training program (2013), or
    b. successfully complete the online component of the BCPhA OAT-CAMPP training program, and
    c. record self-declaration of training completion in eServices.
3. Pharmacy managers must:
    a. educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to opioid agonist treatment, and
    b. document the completion of the education of individual non-pharmacist staff members on a form signed and dated by the pharmacy manager and the non-pharmacist staff member, and retain the completed forms in the pharmacy's files.

Effective March 31, 2021:

The CPBC MMT training program (2013) will not be available beyond March 31, 2021. Registrants will no longer be able to fulfill the College's training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by March 31, 2021. The above-noted Policy Statements 1a and 2a will be repealed and all other requirements will continue to be in effect.

During the period between January 1, 2019 and March 31, 2021, registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment are strongly encouraged to complete the OAT-CAMPP program as soon as practicable.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide* (2018) is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU*) A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.
2. The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs.

The Methadone Maintenance Policy Statements must be read in conjunction with *PPP-71 Delivery of Methadone Maintenance Treatment*.

Required References

In addition to the currently required pharmacy reference materials (*PPP-3*), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and subsequent revisions.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most current version of the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders.*
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths and formulations.
2. The CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 Sept 2013 / 17 Nov 2017 / 20 Apr 2018 / 14 Sept 2018 / 23 Nov 2018
Reaffirmed:

College of Pharmacists
of British Columbia

Professional Practice Policy #66

Policy Guide

Methadone Maintenance Treatment (2013)

Forward

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

Many studies, conducted over several decades in different countries, have clearly demonstrated that the effective delivery of methadone maintenance treatment reduces non-medical opioid use, other problematic substance use, criminal activity, mortality, injection-related risks and transmission of blood-borne disease. Additional positive results are improvement in physical and mental health, social functioning, quality of living and pregnancy outcomes.

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

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

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

How to Use This Guide

Note:

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

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

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

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

Declaration

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

Acknowledgement

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

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

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

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

Feedback

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

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Table of Contents

Methadone Maintenance Treatment Policy Guide

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

Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1

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

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

1.2 Privacy and Confidentiality – Premise

Principle 1.2.1

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

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

1.3 Security – Premise

Principle 1.3.1

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

2.0

Receiving Methadone Prescriptions

2.1 Methadone Maintenance Controlled Prescription Forms – Overview

Principle 2.1.1

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

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

Principle 2.1.2

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

Principle 2.1.3

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

Note:

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

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

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

Principle 2.1.4

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

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

Principle 2.1.5

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

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

2.2 Methadone Maintenance Controlled Prescription Forms – Alterations

Principle 2.2.1

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

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

Note:

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

Guideline:

Alterations completed at the prescriber's office:

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

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

Alterations completed at the pharmacy:

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

2.3 Out-of-Province Prescriptions

Principle 2.3.1

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

Note:

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

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

3.0

Processing (Dispensing) Methadone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Methadone for maintenance must be dispensed to patients in a concentration of 10 mg/ml.

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

Principle 3.1.2 Positive identification is required for all patients presenting a prescription for the first time, and reasonable steps to positively identify the patient must be taken prior to dispensing any subsequent prescriptions.

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

Principle 3.1.3 Pharmacists and pharmacy technicians must review the prescription to ensure that it is completed by the prescriber as outlined in the *Methadone Maintenance Controlled Prescription Form Guidelines* (Appendix 3) and that the directions for use appropriately meet the specific needs of the patient and can be accommodated by the pharmacy.

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

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a weekend when the patient will not be able to see a physician for a new prescription.
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, divided dose, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.
- Confirm that stamped or preprinted sticker directions do not conflict with written directions.

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

3.2 Assessment of a Prescription

Principle 3.2.1

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

Principle 3.2.2

As with all medications a pharmacist **must** review each individual PharmaNet patient record, as stated in HPA Bylaws (Schedule F Part 1), and resolve any drug-related problems prior to dispensing any methadone prescription.

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

Guideline: A PharmaNet patient record review must be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3

Mood altering drugs, including benzodiazepines and narcotics, are not generally prescribed to patients on the methadone maintenance program. Should a patient present a prescription for a mood altering drug or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of methadone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the methadone maintenance program.

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

Principle 3.2.4

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

Principle 3.2.5

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

3.3 Preparing Methadone Prescriptions

Principle 3.3.1

Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 ml.

Guideline: All devices used to measure the methadone 10 mg/ml solutions should be distinctive and recognizable and must be used only to measure methadone solutions. Devices must be labeled with a "methadone only" label and a "poison" auxiliary label with the international symbol of the skull and cross bones.

Principle 3.3.2

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

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

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

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

3.4 Loss or Theft and Disposal of Methadone

Principle 3.4.1

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

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

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

Principle 3.4.2

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

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

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

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

3.5 Methadone in Tablet Form for Air Travel

Principle 3.5.1

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

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

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

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

4.0

Releasing Methadone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1

A pharmacist must be present and witness the release of a methadone prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2

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

Guidelines: Pharmacists must assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's 'normal' behaviour in order to be able to detect significant deviations from normal.

If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and attach it to the original prescription.

Principle 4.1.3

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

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

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

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

Principle 4.1.4

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

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

Principle 4.1.5

With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

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

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

Principle 4.1.6

With respect to take-home doses the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion with all subsequent take-home doses dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient.

Note:

The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

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

Each container must be individually labeled.

If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses it must be documented on the patient record.

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

Principle 4.1.7

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

Note:

Patient representative is defined in HPA Bylaws.

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

Principle 4.1.8

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

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

Responding to Methadone Dosing Issues

5.1 Divided (Split) Doses

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

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

5.2 Missed Doses

Principle 5.2.1 Any methadone prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet before the end of the business day.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up methadone doses as other healthcare practitioners rely on this information in making treatment decisions.

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

Principle 5.2.3 The pharmacist must notify the prescriber of any missed doses (unless a specified number of missed doses has been indicated by the prescriber) before the next scheduled release of medication.

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

5.3 Partial Consumption of Doses

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

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

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

5.4 Vomited Doses

Principle 5.4.1

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

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

5.5 Lost or Stolen Doses

Principle 5.5.1

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

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

5.6 Tapering

Principle 5.6.1

If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication form* (Appendix 6) can be used for the purpose of notifying the prescriber.

5.7 Emergency Dosing

Principle 5.7.1

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

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

6.0

Continuity of Care

6.1 Transfer of Pharmacy

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

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

6.2 Hospitalization or Incarceration

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

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

6.3 Compounding in Exceptional Circumstances

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

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

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

Guideline: The compounding log must incorporate the following elements:

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

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

Principle 6.3.4

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

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

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

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

Principle 6.3.5

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

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

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

References

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

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

Stockley's Drug Interactions. Pharmaceutical Press (2010)

This Appendix will be updated to align with the amended PPP-66

CPBC Professional Practice Policy 66 – Opioid Agonist Treatment

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

Effective January 1, 2018:

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The College of Pharmacists of British Columbia (CPBC) *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to buprenorphine/naloxone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE POLICY STATEMENT:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.
2. The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to methadone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*,
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs
    d) successfully complete the mandatory CPBC MMT training program (2013), record self-declaration of training completion in eServices prior to dispensing the 10mg/ml preparation.

4. Upon completion of the mandatory CPBC MMT training program pharmacy managers must educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to methadone maintenance treatment. (Note: documentation forms that confirm the education of individual non-pharmacist staff members must be signed and dated by the community pharmacy manager and the non-pharmacist staff member and retained in the pharmacy files).

The Methadone Maintenance Policy Statements must be read in conjunction with PPP-71 Delivery of Methadone Maintenance Treatment.

Required References

In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions
- The most recent version of the BCCSU's "*A Guideline for the Clinical Management of Opioid Use Disorder*"
- Most current edition of Methadone Maintenance: A Pharmacist's Guide to Treatment, Centre for Addiction and Mental Health
- Product monographs for the commercially available 10mg/ml methadone oral preparations

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

Effective January 1, 2018:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths.
2. The College of Pharmacists of British Columbia (CPBC) *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provide pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*,
    c) be familiar with the information included in the product monographs of approved, commercially available strengths.

CPBC Professional Practice Policy 71 – Delivery of Methadone Maintenance Treatment

Policy Statement

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

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

Delivery Standards:

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

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

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

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

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

2. **Home Delivery Schedule and Location**

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

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

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

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

      ii. Time for delivery

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

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

3. **Secure Transportation and Storage**

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

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

4. **Release of Methadone for Maintenance**

   The pharmacist must be present to:

   a. Confirm the identity of the patient.

   b. Assess the competence of the patient.

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

   d. Provide appropriate patient counseling.

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

5. **Documentation**

   The pharmacist must:

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

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

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

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

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

Background:

Legislation

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

Controlled Drugs and Substances Act

"Section 2 - Interpretation, Definitions[1]

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

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

Narcotic Control Regulations

"Section 2 - Interpretation, Definitions [2]

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

Dealers' Licenses and Licensed Dealers [3]

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

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

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

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

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

Methadone for Maintenance Controlled Prescription Form Guidelines

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

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

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

Top Section of Form:

Note:

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

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

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

Middle Section of Form:

Note:

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

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

- State the daily dose:
    - the daily dose multiplied by the number of days must equal the total quantity indicated on the prescription, if there is a discrepancy the pharmacist should seek clarification from the prescriber
- Indicate the 'start day' and 'last day':
    - if no 'start day' is indicated, the 'prescribing date' becomes the 'start day'
    - should the 'start day' overlap with, or leave gaps from, an existing prescription the pharmacist should seek clarification from the prescribe
- Indicate any special instructions:
    - may be used to provide special instructions to the pharmacist for example split doses, or special situations for carries.

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

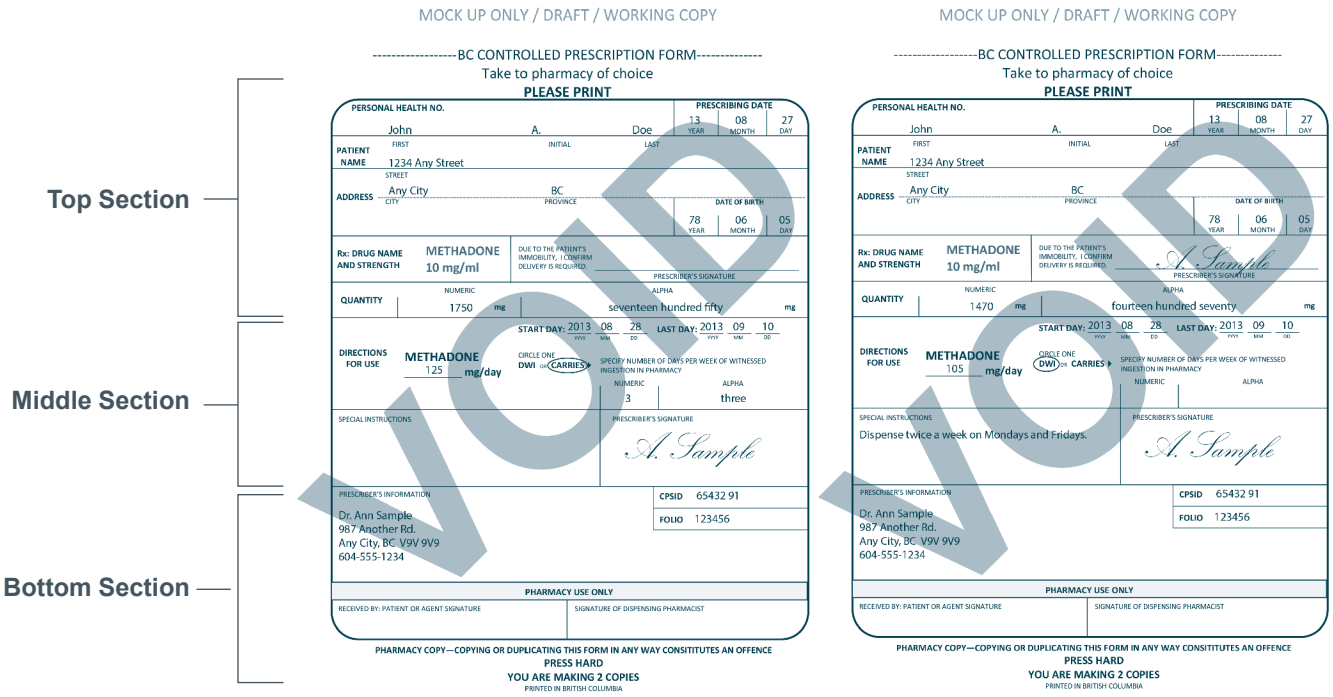
Bottom Section of Form:

Note:

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

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

Figure 1: Methadone Maintenance Controlled Prescription Form



Emergency Fax Methadone Maintenance Controlled Prescription Form Documentation

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

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

Prescriber: _____ Patient Name: _____

Pharmacy: _____ Fax Number: _____

Pharmacist: _____ Date: _____

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

Brief description of the emergency situation:

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Methadone Maintenance Treatment Expectation Form

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

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

As your pharmacists, you can expect that we will:

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

As our patient, we can expect that you will:

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

Pharmacist – Prescriber Communication

Date: _____ Patient Name: _____

To (Prescriber): _____ Patient PHN: _____

Fax: _____ Prescription Form Folio Number: _____

From (Pharmacy): _____ Pharmacy Fax: _____

Pharmacist: _____ Pharmacy Telephone: _____

For Prescriber's Information and Patient Records

☐ This patient missed their methadone dose _____ (dates).

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

For Prescriber's Signature and Return of Form to Pharmacy

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

Prescribing Date: _____

Dispensing Start Date or Range: _____

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

Description of authorized changes: _____

_____

_____

_____

_____

Prescriber's Name: _____

CPSID: _____

Prescriber's Signature: _____

Signature Date: _____

Affix Methadone Maintenance Controlled Prescription form here

Drug Interactions – General Information

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

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

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

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

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

Compounding Log

10 mg/ml Stock Solution

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

Appendix

9

Methadone Part-Fill Accountability Log

Patient Name: _____

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

Patient Name: _____

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

Methadone Information For Patients

What is methadone?

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

How is methadone taken?

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

How does methadone work?

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

How long do I have to stay on methadone?

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

Does methadone have side effects?

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

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

Can methadone interact with other drugs?

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

Is methadone dangerous?

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

What is my responsibility?

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

Will methadone cure me?

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

Recommended Reading

Methadone Maintenance Treatment

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

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

Literature Review – Methadone Maintenance Treatment

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

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

Best Practices – Methadone Maintenance Treatment

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

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

Methadone for Pain Guidelines

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

Contact Information

Alberta Health Services Opioid Dependency Program

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

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

Alcohol & Drug Information and Referral Service

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

British Columbia Pharmacy Association

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

British Columbia Centre on Substance Use (BCCSU)

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

Med Effect Canada (report adverse drug reactions)

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

College of Pharmacists of British Columbia

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

College of Physicians and Surgeons of British Columbia

W: www.cpsbc.ca
T: 604-733-7758 or 800-461-3008
F: 604-733-1267

Office of Controlled Substances

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

Health Protection Branch

Drug diversion of narcotics and controlled drugs

T: 604-666-3350

Non-Insured Health Benefits Program

ESI Canada

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

PharmaCare Help Desk (includes PharmaNet)

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

For Pharmacists

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

For the Public

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

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of British Columbia

Professional Practice Policy #66

Policy Guide

Buprenorphine/Naloxone Maintenance Treatment (2018)

Buprenorphine/Naloxone Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment (BMT) must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC (CPBC) *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

Guideline: When a pharmacy accepts a patient who requires daily dispense (i.e., 7 days per week) the pharmacy hours of service need to accommodate this dosing requirement. A pharmacist does not have the independent authority to adapt a prescription for buprenorphine/naloxone maintenance treatment from 'daily dispense' to a 'take-home' dose.

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take buprenorphine/naloxone tablets.

Guideline: For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. Avoid swallowing, talking, eating, drinking, and smoking.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, cravings, and/or non-medical opioid use. Educate on risks of precipitated withdrawal during buprenorphine/naloxone induction. Educate patients on the inclusion of naloxone in buprenorphine/naloxone formulations and its purpose to deter use in a manner not intended as prescribed.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the most recent version of the British Columbia Centre on Substance Use (BCCSU) ~~-~~*A Guideline for the Clinical Management of Opioid Use Disorder*. Recommend completion of online training through the University of British Columbia, Faculty of Medicine~~,~~ Continuing Professional Development's *Provincial Opioid Addiction Treatment Support Program*.

2.0 Receiving Buprenorphine/Naloxone Prescriptions

2.1 Controlled Prescription Program Forms - Overview

Principle 2.1.1 Buprenorphine/naloxone prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting buprenorphine/naloxone prescriptions, the pharmacist must ensure that the Controlled Prescription Program Form is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) Buprenorphine/Naloxone Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 Buprenorphine/naloxone for maintenance must be dispensed to patients as an approved, commercially available formulation.

Guideline: Buprenorphine/naloxone is currently available in multiple strengths of sublingual formulations. Tablets can be halved and/or combined to achieve target doses.

Principle 3.1.2 Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g., weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily dispense, take-home doses), including the specific days of the week for each dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of buprenorphine/naloxone and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the buprenorphine/naloxone maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the buprenorphine/naloxone maintenance program. Co-ingestion of buprenorphine/naloxone with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing Buprenorphine/Naloxone Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the buprenorphine/naloxone prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a buprenorphine/naloxone prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a buprenorphine/naloxone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *Buprenorphine/Naloxone Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

College of Pharmacists of British Columbia

Principle 4.1.4 If a prescriber orders the buprenorphine/naloxone for daily dispense, the pharmacist is not required to observe the patient ingesting the dose. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: If the prescription states daily dispense, the patient may ingest the dose without pharmacist observation.

Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves, this may take up to 10 minutes. The patient should avoid swallowing, talking, eating, drinking, and smoking.

Principle 4.1.5 If a prescriber orders the buprenorphine/naloxone to be dispensed as a 'Daily Witnessed Ingestion' or 'DWI', the pharmacist must directly observe the patient placing the medication under the tongue. If the prescriber's intentions regarding witnessing are unclear, the pharmacist must consult with the prescriber to clarify, and the outcome of this consultation must be documented and included with the original prescription.

Guideline: Patients should be given instructions on how to take the dose. For example you may instruct the patient to place and hold the tablet(s) under their tongue until it fully dissolves - this may take up to 10 minutes. The patient should avoid swallowing, talking, eating, drinking, and smoking.

The patient is not required to remain in the pharmacy once the pharmacist has directly observed the patient placing the medication under the tongue.

Principle 4.1.6 If take home doses (carries) are prescribed, the first dose does not need to be witnessed, unless ordered by the prescriber. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.

Compliance packaging (e.g., blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy must still ensure that the medications are provided in child-resistant packaging.

Patients should be reminded that buprenorphine/naloxone should be stored out of the reach of children, preferably in a locked cupboard or small lock box.

5.0 Responding to Buprenorphine/Naloxone Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any buprenorphine/naloxone prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up buprenorphine/naloxone doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses before the next scheduled release of medication. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

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

Principle 5.1.4 If a patient misses 6 or more consecutive days, the prescription must be cancelled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder* - Appendix 2: Induction and Dosing Guidelines for Buprenorphine/Naloxone.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the documentation and communication.

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

5.3 Lost or Stolen Doses

Principle 5.3.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Tapering

Principle 5.4.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

Buprenorphine/Naloxone Part-Fill Accountability Log

Patient Name: _____

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

Patient Name: _____

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

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their buprenorphine/naloxone dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

College of Pharmacists of British Columbia

College of Pharmacists
of British Columbia

Professional Practice Policy #66

Policy Guide

Slow Release Oral Morphine (SROM) Maintenance Treatment (2018)

Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide

All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to SROM maintenance treatment must know and apply the principles and guidelines outlined here in the College of Pharmacists of BC (CPBC) *Slow Release Oral Morphine (SROM) Maintenance Treatment Policy Guide (2018)* and all subsequent revisions.

1.0 Administration

1.1 Pharmacy Operating Hours

Principle 1.1.1 The pharmacy hours of service must be consistent with the dosing requirements of your patient.

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

1.2 General Guidance for Pharmacy Professionals

Principle 1.2.1 Provide patient education on how to properly take SROM.

Note: See Principle 4.1.4 for detailed administration requirements.

Principle 1.2.2 Advise patients to talk to their prescriber and pharmacist about any continuing withdrawal symptoms, craving, and/or non-medical opioid use.

Principle 1.2.3 Refer colleagues, prescribers, and clinical staff who are unfamiliar with the most recent version of the British Columbia Centre on Substance Use (BCCSU) *A Guideline for the Clinical Management of Opioid Use Disorder*. Recommend completion of online training through the University of British Columbia Faculty of Medicine~~,~~ Continuing Professional Development's Provincial Opioid Addiction Treatment Support Program.

2.0 Receiving SROM Prescriptions

2.1 Controlled Prescription Program Forms – Overview

Principle 2.1.1 SROM prescriptions can only be accepted when written using an original Controlled Prescription Program form. When accepting SROM prescriptions, the pharmacist must ensure that the Controlled Prescription Program Form is completed by the prescriber as outlined in the Controlled Prescription Program.

3.0 Processing (Dispensing) SROM Prescriptions

3.1 Accepting a Prescription

Principle 3.1.1 SROM for maintenance must be dispensed in approved, commercially available strengths and formulations. Capsule contents cannot be split.

Principle 3.1.2 **Guideline:** Only the once-daily, 24-hour formulation of SROM has been studied in clinical trials for the treatment of opioid use disorder. Other formulations of oral morphine, such as twice-daily, 12-hour sustained- or extended-release formulations, have not been empirically studied in this context and are not recommended. Pharmacists and pharmacy technicians (working within their scope) must review the prescription to ensure that the specific needs of the patient can be accommodated by the pharmacy.

Guideline: Each prescription should be reviewed in detail in consultation with the patient, to ensure that the patient's specific needs can be accommodated. For example:

- Evaluate the end date of the prescription to ensure that the authorization for dispensing does not end on a day when the patient will not be able to see a prescriber for a new prescription (e.g., weekends and holidays).
- Review the prescription directions to determine the dosing schedule (daily witnessed ingestion, take-home doses), including the specific days of the week for each witnessed dose or take-home doses, to confirm that the pharmacy operating hours match the dosing schedule.

3.2 Assessment of a Prescription

Principle 3.2.1 Pharmacists and pharmacy technicians must correctly identify the product as prescribed 'for pain' or 'Opioid Agonist Treatment (OAT)' by using the appropriate Drug Identification Number (DIN) or Product Identification Number (PIN) to ensure patient safety and accurate PharmaNet patient records.

Guideline: Effective June 5, 2017, PharmaCare established PINs for the use of Kadian® SROM as OAT. These PINs are to be used when submitting claims for the various dosing strengths through PharmaNet. Similar to methadone, DINs will be used by pharmacists exclusively for claims for analgesia, and the PINs will be used for claims for OAT.

Prescriptions for Kadian® should specify whether it is designated for analgesia or OAT (i.e., "for OAT" or "for opioid agonist treatment" is to be indicated on the prescription). If there is a question as to whether the prescription is for OAT (i.e., indicated by the dose strength, directions to

"open and sprinkle" capsules for daily witnessed ingestion, or other elements of the prescription), but the prescription lacks the explicit indication "for OAT", the pharmacist should contact the prescriber to confirm the intended use prior to dispensing the medication and properly document any alteration of the prescription.

The claim entered into PharmaNet should match the prescription written by the prescriber. If a claim marked "for OAT" has been entered under the DIN rather than under the PIN for Kadian® for OAT, it must be reversed, following the full standard procedure for reversing a claim entered under the wrong DIN or PIN. Only after a claim has been reversed can it then be re-entered with the correct PIN.

Principle 3.2.2 As with all medications a pharmacist must review each individual PharmaNet patient record, as stated in *HPA Bylaws* (Schedule F Part 1), and resolve any drug-related problems prior to dispensing any SROM prescription. This step is particularly critical for SROM for OAT prescriptions as the automated drug usage evaluation (DUE) built into the PharmaNet system **does not include SROM for OAT**.

Pharmacists providing SROM for OAT maintenance treatment must therefore ensure they maintain their knowledge with respect to potential drug interactions related to SROM.

Guideline: A PharmaNet patient record review should be completed for all prescriptions, including those patients obtaining their prescription on a daily basis or those long-term patients whom the pharmacist may know well.

Principle 3.2.3 Should a patient present a prescription for a mood altering drug, including benzodiazepines and opioids, or if the pharmacist discovers that a mood altering drug is also being prescribed to the patient in their review of the PharmaNet patient record, they must contact both the prescriber of SROM and, if different, the prescriber of the mood altering drug, prior to dispensing the medication. The pharmacist must document the outcome of the consultation(s) with the prescriber(s) and include it with the original prescription. The purpose of the consultation is to ensure the prescriber(s) are aware that the patient is currently on the SROM maintenance program.

Guideline: Mood altering drugs, including benzodiazepines and opioids, should not be prescribed to patients on the SROM maintenance program.

Co-ingestion of SROM with alcohol or benzodiazepines is contraindicated, as combined effects can potentially result in fatal respiratory depression.

4.0 Releasing SROM for OAT Prescriptions

4.1 Releasing a Prescription

Principle 4.1.1 A pharmacist must be present to release the SROM prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff.

Principle 4.1.2 Prior to releasing a SROM prescription the pharmacist must assess the patient to ensure that the patient is not intoxicated, including by centrally-acting sedatives and/or stimulants or in any other acute clinical condition that would increase the risk of an adverse event. If the pharmacist believes that it is not safe for the patient to receive their prescription they must consult with the prescriber and document the outcome of the dialogue and include it with the original prescription.

Guideline: Assess patients for symptoms such as slurred speech, ataxia, drowsiness, alcohol smell or unusual behaviour. It is important for the pharmacist to be familiar with each patient's usual behaviour in order to be able to detect significant deviations.

Principle 4.1.3 Prior to releasing a SROM prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log. Every part-fill dispensed must be accounted for. The patient/prescription specific log must be included with the original Controlled Prescription Program form. Once complete, it must be filed sequentially by the first prescription or transaction number assigned to the prescription. The pharmacist must be able to review every part-fill dispensed as a complete history on one document.

Guideline: The sample *SROM Part-Fill Accountability Log* (Appendix 1) can be used for this purpose.

Neither the pharmacist nor the patient is permitted to pre-sign for future doses or backdate signing.

Principle 4.1.4 With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication and be assured that the entire dose has been swallowed.

Guideline: SROM has a high risk of diversion, even when administered as witnessed doses (e.g., intact capsules can be 'cheeked' or 'palmed').

To reduce the risk of diversion, daily witnessed ingestion doses should be prepared by opening the capsule(s) and sprinkling the enclosed pellets for immediate ingestion. The patient should be instructed that pellets must not be chewed or crushed.

Pellets may be sprinkled into a 30 mL medicine cup or small cup followed by at least 30 mL of water to ensure that all pellets have been swallowed.

Immediately following observing the patient's ingestion of the medication, the pharmacist should ensure that the entire dose has been swallowed. This may include: engaging the patient in short conversation, asking the patient if there are pellets remaining in their teeth or gums, offering additional water for rinsing, or inspecting the inside of the patient's mouth.

Important Safety Notice: SROM pellets must be swallowed whole. Crushing, chewing, or dissolving slow-release oral morphine capsules or pellets can cause rapid release and absorption of a potentially fatal dose of morphine sulphate.

Principle 4.1.5 If take home doses (carries) are prescribed, the first dose must be a witnessed ingestion. The subsequent take-home doses must be dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient. If a pharmacist determines that due to a specific patient circumstance a non-child-resistant container will be used for take-home doses, it must be documented on the patient record.

Guideline: The decision to authorize take-home doses can only be made by the prescriber. However, should a pharmacist believe that a patient is or is

not ready to manage take-home doses they should discuss their recommendations or concerns with the prescriber.
Note that the majority of prescriptions for SROM will be for daily witnessed ingestion (DWI). In exceptional cases, patients may be transitioned to take-home dosing schedules. If a patient's prescription indicates transition to a take-home dosing schedule for SROM, it is best practice to call and confirm with the prescriber.

Compliance packaging (e.g., blister packaging, pouch packs) may be ordered by the prescriber to discourage diversion and allow for better monitoring during medication call-backs. In these cases, the pharmacy still needs to ensure that the medications are provided in child-resistant packaging.

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

5.0 Responding to SROM Dosing Issues

5.1 Missed Doses

Principle 5.1.1 Any SROM prescription that has been processed and prepared but is not consumed or picked up by the patient on the prescribed day is considered cancelled and must be reversed on PharmaNet **before the end of the business day**.

Guideline: It is imperative that the PharmaNet patient record reflects accurate and current information in terms of consumed and picked-up SROM doses as other healthcare practitioners rely on this information in making treatment decisions.

Principle 5.1.2 If a patient misses a dose, they cannot receive the missed dose at a later date.

Principle 5.1.3 The pharmacist must notify the prescriber of any missed doses before the next scheduled release of medication. The notification document must be retained and filed with the prescription consistent with filing retention requirements.

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

Principle 5.1.4 If a patient misses 2 or more consecutive doses, the prescription must be cancelled.

Guideline: The pharmacist should advise the patient to see the prescriber for a new prescription, as dose adjustment and re-stabilization may be required.

For more information, refer to the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder* - Appendix 3: Induction and Dosing Guidelines for Slow Release Oral Morphine.

5.2 Partial Consumption of Doses

Principle 5.2.1 If a patient declines or is unable to consume their full dose, the pharmacist must respect the patient's choice. The unconsumed portion cannot be given as a take-home dose. The patient's partial consumption of a dose and their reason(s) for it must be documented and reported to the prescriber. All patient documentation including the patient-prescription specific log and PharmaNet record must accurately reflect the actual dose consumed by the patient.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the documentation and communication.

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

5.3 Vomited Doses

Principle 5.3.1 If a patient reports that they vomited their dose, a replacement dose cannot be provided. The pharmacist must notify the prescriber and provide them with information about the incident (time the dose was taken, time of vomiting, and other relevant points). If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.4 Lost or Stolen Doses

Principle 5.4.1 If a patient reports that their take-home dose(s) have been lost, stolen or misplaced, a replacement dose(s) cannot be provided. The pharmacist must notify and consult with the prescriber. If the prescriber chooses to authorize a replacement dose, a new original Controlled Prescription Program form must be received by the pharmacy.

5.5 Tapering

Principle 5.5.1 If a patient has decided to initiate a self-tapering regimen by decreasing their daily dose consumption, the pharmacist must record the dose consumed on the patient/prescription specific log (refer to Principle 4.1.3), record the actual dose consumed on the patient's PharmaNet record and notify the prescriber.

Guideline: The *Pharmacist-Prescriber Communication* form (Appendix 2) can be used for the purpose of notifying the prescriber.

Appendix 1

SROM Part-Fill Accountability Log

Patient Name: _____

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

Patient Name: _____

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

Appendix 2

Pharmacist – Prescriber Communication

Date:_____ Patient Name:_____

To (Prescriber):_____ Patient PHN:_____

Fax: _____ Prescription Form Folio Number:_____

From (Pharmacy):_____ Pharmacy Fax:_____

Pharmacist:_____ Pharmacy Telephone:_____

For Prescriber's Information and Patient Records

- ❑ This patient missed their slow release oral morphine dose on _____(date).
- ❑ This patient did not take their full daily dose today _____ (date) and consumed only ____ mg of the ____ mg prescribed dose.
- ❑ This patient's dose has been held due to _____ (reason and date).
- ❑ This patient lost or had their dose(s) stolen _____(dates).
- ❑ This patient's prescription has been cancelled due to _____(number of missed doses).

Additional Information

You May Attach Controlled Prescription Program Form.

This policy provides guidance to registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment. This policy must be read in conjunction with *PPP-71 Delivery of Opioid Agonist Treatment.*

POLICY STATEMENTS:

Effective January 1, 2019:

1. All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or
    b. successfully complete the British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and
    c. record self-declaration of training completion in eServices.
2. All pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:
    a. successfully complete the CPBC MMT training program (2013), or
    b. successfully complete the online component of the BCPhA OAT-CAMPP training program, and
    c. record self-declaration of training completion in eServices.
3. Pharmacy managers must:
    a. educate all non-pharmacist staff regarding their role in the provision of community pharmacy services related to opioid agonist treatment, and
    b. document the completion of the education of individual non-pharmacist staff members on a form signed and dated by the pharmacy manager and the non-pharmacist staff member, and retain the completed forms in the pharmacy's files.

Effective ~~March 31~~September 30, 2021:

The CPBC MMT training program (2013) will not be available beyond ~~March 31~~September 30, 2021. Registrants will no longer be able to fulfill the College's training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by ~~March 31~~September 30, 2021. The above-noted Policy Statements 1a and 2a will be repealed and all other requirements will continue to be in effect.

During the period between January 1, 2019 and ~~March 31~~September 30, 2021, registrants employed in a community pharmacy that provides pharmacy services related to opioid agonist treatment are strongly encouraged to complete the OAT-CAMPP program as soon as practicable.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.
2. The CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide* (2018) is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Buprenorphine/Naloxone Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the British Columbia Centre on Substance Use (BCCSU*) A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available formulations.

2. METHADONE MAINTENANCE POLICY STATEMENTS:

1. Methadone maintenance treatment (MMT) must only be dispensed as the commercially available 10mg/ml methadone oral preparation.
2. The CPBC *Methadone Maintenance Treatment Policy Guide (2013)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to methadone maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the commercially available 10mg/ml methadone oral preparation product monographs.

Required References
In addition to the currently required pharmacy reference materials (*PPP-3*), pharmacies providing methadone maintenance treatment services must also maintain as required references the following:

- CPBC *Methadone Maintenance Treatment Policy Guide (2013)* and subsequent revisions.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most current version of the Centre for Addiction and Mental Health *Opioid Agonist Maintenance Treatment: A Pharmacist's Guide to Methadone and Buprenorphine for Opioid Use Disorders.*
- Product monographs for the commercially available 10mg/ml methadone oral preparations.

3. SLOW RELEASE ORAL MORPHINE POLICY STATEMENTS:

1. Slow release oral morphine maintenance treatment must only be dispensed in approved, commercially available strengths and formulations.
2. The CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* is in force.
3. All pharmacy managers, staff pharmacists, relief pharmacists and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to slow release oral morphine maintenance treatment must:
    a) know and apply the principles and guidelines outlined in the CPBC *Slow Release Oral Morphine Maintenance Treatment Policy Guide (2018)* and all subsequent revisions,
    b) be familiar with the information included in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*, and
    c) be familiar with the information included in the product monographs of approved, commercially available strengths and formulations.

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 Sep 2013 / 17 Nov 2017 / 20 Apr 2018 / 14 Sep 2018 / 23 Nov 2018 17 Mar 2020
Reaffirmed:

College of Pharmacists of British Columbia

6. Legislation Review Committee: Professional Practice Policy 66: Amendment to Training Deadline

Justin Thind

Chair, Legislation Review Committee

College of Pharmacists of British Columbia

Background

- In November 2018, the Board approved amendments to PPP-66 to phase out the MMT training program and transition to the OAT-CAMPP.
- The OAT-CAMPP was developed by the Ministry of Health and BCPhA:
  - It encompasses training requirements for three opioid agonist treatment drugs (buprenorphine/naloxone, methadone and slow-release oral morphine) included in the College's professional practice policies.
  - It consists of a self-study component for both pharmacists and pharmacy technicians, as well as an in-person component for pharmacists only.
- PPP-66 requires that registrants complete the applicable component(s) of OAT-CAMPP by March 30, 2021.

College of Pharmacists of British Columbia

Additional Provincial Requirements

- The Provider Regulation under the *Pharmaceutical Services Act*, requires that one pharmacist from every B.C. pharmacy enrolled as an Opioid Agonist Treatment Provider complete the OAT-CAMPP by March 2021.

College of Pharmacists of British Columbia

Impact of COVID-19 on the Training Deadline

- On March 17, 2020, a public health emergency was declared due to the spread of COVID-19.
- OAT-CAMPP training was suspended in March 2020.
- Almost 1,000 pharmacists still need to complete OAT-CAMPP training.
- On July 9, 2020, the Minister of Health issued Ministerial Order M213 to amend the Provider Regulation by waiving the March 31, 2021 deadline requirement for pharmacists completing OAT-CAMPP.

College of Pharmacists of British Columbia

New On-line Version of OAT-CAMPP Training

- An online version of the OAT-CAMPP training has been developed by the BCPhA.
- It is accredited by the Canadian Council on Continuing Education in Pharmacy.
- This training launched in the beginning of November 2020, with the first virtual class tentatively scheduled for November 20th.

College of Pharmacists of British Columbia

Amendments to Deadlines Related to OAT-CAMPP Training

- The Ministry of Health, BCPhA and College staff recently discussed a potential training deadline extension.
- BCPhA forecast that extending the deadline by six months, to September 30, 2021, would allow enough time for the remaining 956 pharmacists to complete it.
- Amendments to the Provider Regulation to align with the extended training deadline are also expected.

College of Pharmacists of British Columbia

Next Steps

- If the recommended amendments to PPP-66 are approved by the Board:
  - The training extension will be communicated to registrants and the public.
  - The College's website will be updated with the revised PPP-66 document.

College of Pharmacists of British Columbia

6. Professional Practice Policy 66: Amendment to Training Deadline

MOTION:

Approve amendments to Professional Practice Policy 66 Opioid Agonist Treatment (PPP-66) to extend the deadline for transitioning to the Opioid Agonist Treatment Compliance and Management Program for Pharmacy, from March 31, 2021 to September 30, 2021.

College of Pharmacists of British Columbia

Questions

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

7. Drug Administration Committee – Amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*

DECISION REQUIRED

Recommended Board Motion:

Accept the amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions,* as circulated.

Background

The Board was presented with the proposed amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions (Standards, Limits and Conditions)* at the September 2020 Board meeting (see Appendix A)[1]. The Board decided to table the in-principle acceptance of the proposed amendments until the November 2020 Board meeting; however, the Board did direct the Registrar to engage with the Ministry of Health on moving the proposed amendments forward.

Discussion

Since the September Board meeting, the National Advisory Committee on Immunization (NACI) released updated recommendations for post-vaccination observation periods for influenza vaccinations during the COVID-19 pandemic.[2] Their recommendations were also incorporated into the BC Centre for Disease Control "Guidance for Influenza Vaccine Delivery in the Presence of COVID-19 (October, 2020)" document.[3]

[1] Note: An updated version of the proposed *Standards, Limits and Conditions* has been included with the September 2020 briefing materials in Appendix A, which includes minor referencing changes within the application section as recommended by legal counsel, and minor updates recommended by the Drug Administration Committee.

[2] An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): Recommendations on the Duration of the Post-vaccination Observation Period for Influenza Vaccination during the COVID-19 Pandemic (Accessed October 15, 2020)

[3] See page 6 of the BCCDC's "Guidance for Influenza Vaccine Delivery in the Presence of COVID-19 (October, 2020)" (Accessed November 5, 2020)

The College considered moving forward with the proposed amendments to the *Standards, Limits and Conditions* (not including the removal of the restriction that limits pharmacists to administering immunizations only) in response to the updated recommendations from NACI, as they already include a more principle-based post-vaccination wait-period requirement. The Drug Administration Committee (DAC) met on October 30, 2020 to discuss the proposed amendments to the *Standards, Limits and Conditions* in the context of the NACI recommendation. At that time, the DAC suggested and approved additional minor changes to the *Standards, Limits and Conditions* which include a clarified requirement for ensuring the frequency of drug administration is appropriate, and taking appropriate steps to ensure the right drug is administered to the right patient. These changes are included in the draft amendments in Appendix A.

The College discussed moving the proposed amendments forward (not including the removal of the restriction that limits pharmacists to administering immunizations only) with the Ministry of Health, however the Ministry was not supportive of any changes to the *Standards, Limits and Conditions* in response to the NACI recommendation at this time.

The Registrar continues to engage with the Ministry of Health, as directed by the Board at the September meeting, on the removal of restrictions. A letter was sent to Mark Armitage, the Assistant Deputy Minister, Ministry of Health, on October 16, 2020 in response to the letter dated August 20, 2020 (see Appendix B). As outlined in the letter, the Registrar met with executives from the Ministry of Health on November 16, 2020. The College committed to providing a written response to questions raised at the meeting.

Recommendation

It is recommended that the Board approves, in-principle, the proposed amendments to the *Standards, Limits and Conditions*, as circulated.

Next Steps

The Registrar will continue to engage with the Ministry of Health on moving the proposed amendments to the *Standards, Limits and Conditions* forward.

Appendix	
A	Drug Administration Committee September 2020 Board Briefing Materials (note: contains an updated version of the proposed amendments to the *Standards, Limits and Conditions* as described in footnote 1)
B	Letter from Christine Antler to Mark Armitage, October 16, 2020

Appendix A

College of Pharmacists of British Columbia

BOARD MEETING
September 18, 2020

3. Drug Administration Committee - Amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*

DECISION REQUIRED

Recommended Board Motions:

1. Accept the amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*, as circulated.

2. Direct the Registrar to engage with the Ministry of Health to move the amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions* forward.

Purpose

- To propose amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions.*
- To provide the Board with a recommendation for moving forward with the removal of certain restrictions on pharmacist drug administration authority.

Background

The *Pharmacists Regulation* enables pharmacists to administer any drug specified in Schedule I, IA or II of the *Drug Schedules Regulation* or a substance through intradermal, intramuscular or subcutaneous injection or the intranasal route. It also requires a committee (i.e., the Drug Administration Committee ("DAC")) to be established to develop, review and recommend the standards, limits and conditions under which a registrant may administer a drug or substance to patients and the successful completion of a certification program.

Currently, the College of Pharmacists of British Columbia ("the College") *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions* ("*Standards, Limits and Conditions*") only permits a pharmacist to administer a drug for the purpose of immunization. At its February 2019 meeting, based on the recommendations of the DAC, the Board directed the Registrar to remove certain restrictions on pharmacist injection and intranasal administration of medications.

In April 2019, the College received a letter from the Assistant Deputy Minister, Ministry of Health, inviting the College to work with the Professional Regulation and Oversight Branch to establish a working group to determine the impacts of removing the restrictions on pharmacist drug administration. The first meeting of the Safe Drug Administration by Pharmacists Working Group ("Working Group") was held on October 28, 2019. A second meeting of the Working Group was scheduled to take place on February 12, 2020, but was cancelled after staff from the Ministry of Health indicated they were unable to participate. Additionally, in December 2019 the Ministry of Health announced a temporary moratorium on bylaws submitted by health professional regulatory Colleges.

The DAC next met on May 25, 2020. At that meeting, an overview of the events following February 2019 was presented. Additionally, the DAC was presented with two options to move forward with their February 2019 recommendation to remove certain restrictions on pharmacist drug administration. In considering the two options, the DAC was informed of a meeting between the Ministry of Health and the College held on May 22, 2020. The DAC was made aware that the Ministry of Health advised that a response would be provided to the College on a collaborative path forward within one week. As a result, the DAC decided to postpone their decision and wait for the response from the Ministry of Health.

Following the College's meeting with the Ministry of Health in May 2020, the College provided briefing materials to the Assistant Deputy Minister, which contained the findings gathered for the second Working Group Meeting. The briefing note and findings are available in Appendix 1.

At their June 2020 meeting, the Board was given an update on these events (see Appendix 2). The DAC was also to reconvene in June to discuss the response from the Ministry of Health once it was received.

Discussion

The College did not receive a response from the Ministry of Health on a timeline or collaborative path forward in June, as anticipated. In light of this, the College continued working on the *Standards, Limits and Conditions,* and the DAC reconvened on August 14, 2020 to review the proposed amendments and options.

Proposed Amendments to the *Standards, Limits and Conditions*

On August 14, 2020 the DAC was presented with proposed amendments to the *Standards, Limits and Conditions*, to align with the DAC's previous recommendation to the Board. Amendments were made to the limits to allow administration of Schedule I and II drugs by injection and the intranasal route with the exception of Schedule IA, and to prohibit the injection of cosmetic drugs and substances. As recommended, the existing age limits were maintained.

In addition to the amendments directed by the Board, the College reviewed the *Standards, Limits and Conditions* and compared them to drug administration standards for pharmacists in Canadian jurisdictions where pharmacists are not limited to administering vaccines only. Overall, the *Standards, Limits and Conditions* align well with the drug administration standards of pharmacy regulatory authorities in other Canadian jurisdictions (see Appendix 3). Despite this, some areas were identified where the *Standards, Limits and Conditions* may benefit from additional provisions or clarification. These additional amendments are summarized in Appendix 4.

The proposed amendments are presented in Appendix 5. The DAC recommends that the Board move forward with the proposed amendments to the *Standards, Limits and Conditions*, as circulated.

Options Presented to the DAC for Moving Forward

The first option presented to the DAC was to proceed with the original DAC recommendations as approved by the Board in February 2019. The Working Group would be provided a summary of the information gathered for the second Working Group meeting, and would be informed of the decision to proceed with the original DAC recommendations.

The second option was to reschedule the second Working Group meeting when the Ministry of Health staff are available and the moratorium has been lifted. The Working Group would then present findings to the DAC, and the DAC would review and present the findings to the Board, if changes to the original recommendation result from the findings.

The new, third option presented to the DAC was to recommend that the Board direct the Registrar to post the proposed amendments to the *Standards, Limits and Conditions* for public comment. It is important to note that the *Health Professions Act* ("HPA") does *not* require the public posting of amendments to standards, limits and conditions. However, this option was recommended to the DAC to better ensure transparency and provide an opportunity for all stakeholders, including the public, to provide meaningful feedback, and to allow more time to engage with the Ministry of Health.

The DAC discussed the three options for moving forward. However, since posting the amendments for public comment is not required under the HPA and may be considered a strategic decision, the DAC determined that the Board should decide how to proceed.

Engagement with the Ministry of Health

A letter was received from Mark Armitage, Assistant Deputy Minister, Ministry of Health, two weeks after the DAC meeting on August 28, 2020 (see Appendix 6). In the letter, the Ministry requested that the College not proceed forward with the *Standards, Limits and Conditions* to allow more time for the Working Group to complete its work. Specifically, the letter requested that the *Standards, Limits and Conditions* not be posted for public comment. A timeline on a path forward was not presented.

The Ministry of Health also advised that the temporary bylaw moratorium is still in effect, and that they would inform of the Colleges when they are in a position to return to regular operations. At this time, the Ministry of Health is only advancing bylaw changes that align with their current priorities: the COVID-19 response, the opioid overdose emergency response, restarting health services to address the needs of the broader population, and modernization of the regulation of health professionals.

Recommendation

It is recommended that the Board accept the amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions* as recommended by the DAC, and direct the Registrar to engage with the Ministry of Health to move the amendments forward.

Guiding Questions:

When reviewing the proposed amendments to the *Standards, Limits and Conditions*, the Board is asked to consider:

- Do the proposed amendments to the *Standards, Limits and Conditions* align with the Board's previous direction to the Registrar to remove certain restrictions on pharmacist drug administration authority?

Appendix	
1	Briefing materials provided to the Ministry of Health, May 26, 2020 (with selected appendices)
2	June 2020 Board Briefing Note (without appendices)
3	Drug Administration by Pharmacists – Jurisdictional Scan Summary
4	Summary of Additional Amendments to the *Standards, Limits and Conditions*
5	Proposed amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions* (clean and track changes)
6	August 28, 2020 Letter to CPBC from Mark Armitage, Assistant Deputy Minister

Appendix 1 Appendix A

College of Pharmacists of British Columbia

Pharmacist Drug Administration
May 26, 2020

Pharmacist Drug Administration

FOR INFORMATION

Purpose
To provide the Ministry of Health, Professional Regulation and Oversight Branch, with an overview of the status of the College of Pharmacists of BC's (CPBC's) removal of restrictions on pharmacist drug administration.

Background
The *Pharmacists Regulation*[1] enables pharmacists to administer any drug specified in Schedule I, IA or II of the *Drug Schedules Regulation* or a substance through intradermal, intramuscular or subcutaneous injection or the intranasal route. It also requires a committee, the Drug Administration Committee (DAC), to be established to develop, review and recommend the standards, limits and conditions under which a registrant may administer a drug or substance to patients and the successful completion of a certification program.

The Standards, Limits and Conditions governing pharmacists' administration of drugs by injection or intranasal route are established in Schedule "F", Part 4 under the *Health Professions Act* Bylaws.[2] The existing limits placed on drug administration are such that a practising pharmacist must not administer a drug by injection or intranasal route unless it is for the purpose of immunization.

In 2018, the DAC met to review CPBC's restrictions on pharmacist drug administration in relation to patient safety and public protection. The DAC discussed options for removing restrictions, as conferred by the *Pharmacists Regulation*. The DAC also considered the experience of other pharmacy regulatory authorities in order to formulate evidence-based recommendations for the CPBC Board. In recent years, the CPBC Board has approved several Delegation of a Medical Act requests to allow medical practitioners to delegate drug administration by injection to pharmacists. This was also considered in the DAC's recommendation.

At its February 2019 meeting, based on the recommendations of the DAC, the CPBC Board directed the Registrar to remove current restrictions on pharmacist injection and intranasal administration of medications as follows:

[1] http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/417_2008
[2] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5099-HPA_Bylaws_Drug_Administration_Injection_Intranasal.pdf

- Amend the "Limits" to allow for injection and intranasal administration of any Schedule I and II medication with the exception of Schedule IA[3];
- Amend the "Limits" to restrict pharmacists from administering injections for cosmetic purposes; and
- Maintain the existing "Limits" on the age restrictions for injection and intranasal drug administration.

On April 10, 2019, CPBC received a letter addressed to the Board Chair from Mark Armitage, Assistant Deputy Minister, Ministry of Health (MoH) inviting CPBC to work with the Professional Regulation and Oversight Branch to establish a working group, comprised of representatives of regulatory colleges of health professions with prescribing authority, to determine the impacts of removing the restrictions on pharmacist injection and intranasal administration of medications. The College worked collaboratively with the MoH to draft the Terms of Reference and Timeline and Activities for the Safe Drug Administration by Pharmacists Working Group ("Working Group") (see Appendix 1).

First Meeting of the Working Group
The first meeting of the Working Group occurred on October 28, 2019, and an update was provided to the Board at the November 2019 Board meeting. Key items were discussed, and included the following:

- Reframing the removal of the restrictions using the principles of Right-touch regulation;
- Outlining the impacts of removing the restrictions, including defining the specific drugs or drug classes which would be included or excluded from the authority;
- Determining the potential impacts on the broader healthcare system; and
- In the future, consider existing drug administration issues that could be potentially addressed by pharmacists, including expanding pharmacist administration to include intravenous infusions.

Additional issues were raised concerning pharmacist communication with the prescriber, management of adverse reactions including anaphylaxis, and maintenance of a patient record. The current Standards, Limits and Conditions do address each of these concerns, as pharmacists are required to notify and provide relevant information to other health care professionals, pharmacists must implement appropriate emergency measures including CPR and first aid, and pharmacists are required to document the administration of a drug in the patient record.

The Working Group raised specific questions regarding the accreditation of training programs for pharmacist drug administration and the range of drugs that pharmacists would be permitted to inject after the removal of restrictions. Despite these questions, there was general

[3] Note: no changes were proposed to the routes of administration currently permitted under the *Pharmacists Regulation.*

support from the other regulatory colleges for removing restrictions on pharmacist drug administration.

Second Meeting of the Working Group (Cancelled)
A second meeting of the Working Group was scheduled to take place on February 12, 2020, but cancelled after staff from the Professional Regulation and Oversight Branch indicated they were unable to participate.

A presentation for the second meeting of the Working Group was prepared by CPBC staff to address the key issues raised at the first meeting (see Appendix 2). This included reframing the removal of the CPBC's restrictions on pharmacist drug administration using the elements of Right-touch regulation and presentation of data from the MoH on injectable drugs dispensed from community pharmacies over a one-year period. A joint presentation by the BC Pharmacy Association (BCPhA) and the UBC Faculty of Pharmaceutical Sciences on their drug administration training programs for pharmacists was also planned, along with discussion on NAPRA's competency 15 *Essential Competencies for Injection of other Substances* (see Appendix 3).

1. Right-Touch Regulation

There are eight elements of Right-touch regulation, including identifying the problem before the solution, quantifying and qualifying the risks, using regulation only when necessary, and checking for unintended consequences. Right-touch regulation requires that regulation aims to be proportionate to the risk posed, and is able to adapt and anticipate change.[4] The draft presentation for the second meeting of the Working Group includes a synopsis of how CPBC's removal of restrictions aligns with the elements of Right-touch regulation (see Appendix 2).

2. Injectable Drugs Dispensed from Community Pharmacies

The Working Group expressed an interest in the range of drugs that pharmacists would be permitted to inject once the current restrictions are removed. To objectively quantify this, data on Schedule I and II injectable drugs dispensed from community pharmacies over a one-year period (August 1, 2018 – July 31, 2019) was obtained. The data was limited to those products that could be injected by the intramuscular (IM) or subcutaneous (SC) route, and represents dispenses of drugs, and not the quantity of drug dispensed. Schedule IA and cosmetic drugs were excluded from the data, as they are restricted under the current recommendation of the DAC.

[4] https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=eaf77f20_20

The data indicates that there were approximately 2,859 different drugs dispensed in BC during the one-year period. Of the different drugs dispensed, 93% were not IM or SC injectable drugs, and 9.6% were IM or SC injectable drugs (see Appendix 2, slide 15).[5]

CPBC was also provided with the number of dispenses of each injectable drug. To summarize the dispensing information, drugs were grouped into categories based on clinical experience, and visualized on slide 17 of Appendix 2. Vaccines, which pharmacists are permitted to inject, make up 42% of IM and SC injectable drug dispenses. Insulins, which are typically self-injected by patients, make up 22% of IM and SC injectable drug dispenses.

Schedule IA Drugs – Emerging Issue
Buprenorphine extended-release injection is a new Schedule IA drug available in Canada for the management of moderate-to-severe opioid use disorder. It was recently listed by PharmaCare as a limited coverage benefit.[6] This injectable drug is unique in that it must not be dispensed directly to a patient, and must be administered by health care provider, due to significant risks if incorrectly administered.

The current recommendation of the DAC excludes injection of Schedule IA drugs; however, buprenorphine extended-release injection was not available and therefore not considered in the DAC's recommendation to remove restrictions on pharmacist drug administration made to the CPBC Board in February 2019.

3. Pharmacist Drug Administration Training Programs

The Canadian Council on Continuing Education in Pharmacy (CCCEP) provides accreditation of drug administration training programs for pharmacists through a competency-mapped accreditation process.[7] CCCEP accreditation ensures programs meet established Standards and Guidelines, and is recognized by all provinces and territories. The required competencies to obtain authorization to administer immunizations and injections are outlined in the *Supplemental Competencies on Injection for Canadian Pharmacists by the National Association of Pharmacy Regulatory Authorities* (Appendix 3), and programs must meet these competencies in order to be accredited by CCCEP. The competencies set forth by the National Association of Pharmacy Regulatory Authorities include competencies for both immunization, and also essential competencies for injection of other substances in addition to vaccines.

In order to obtain certification to provide drug administration, pharmacists must complete an CPBC approved drug administration training program.
In order to obtain certification to provide drug administration in BC, pharmacists must complete a drug administration training program approved by CPBC. Drug administration

[5] The total percentage is slightly more than 100%, as drugs could be counted in both categories if they had a route of administration that was non-injectable and injectable, for example furosemide which is available in injectable and oral formulations.
[6] https://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/newsletters/news20-008.pdf
[7] https://www.cccep.ca/pages/immunization_and_injections.html

training programs approved by CPBC are accredited by CCCEP and therefore should already meet the required competencies set out by the National Association of Pharmacy Regulatory Authorities for injection of both vaccines and other substances by the intramuscular and subcutaneous routes.[8]

Discussion

To determine the steps forward in removing restrictions on pharmacist drug administration, the DAC reconvened on May 25, 2020. The meeting was originally planned for March 19, 2020, but was postponed due to competing priorities related to COVID-19.

At the meeting of the DAC, the DAC was presented with an update of events since the last DAC meeting in December 2018. Issues raised at the first Working Group meeting were presented to the DAC for consideration and discussion. The DAC was presented with two options for moving forward.

The first option is to proceed with the original DAC recommendations as approved by the CPBC Board in February 2019. The Working Group would be provided a summary of the information gathered for the second Working Group meeting, and would be informed of the decision to proceed with the original DAC recommendations.

The second option is to reschedule the second Working Group meeting when the Professional Regulation and Oversight Branch staff are available and bylaw moratorium has been lifted (date unknown). The Working Group would then present findings to the DAC, and the DAC would review and present the findings to the CPBC Board, if changes to the original recommendation result from the findings.

In considering these options, the DAC was informed of the meeting between the MoH and CPBC held on May 22, 2020. The DAC was made aware that the MoH advised they would be providing a response to CPBC on a timeline within one week.

Additionally, the DAC expressed interest in re-examining their previous recommendation to exclude schedule IA drugs from pharmacist drug administration authority in light of the newly available buprenorphine extended-release injection.

Decision

- Due to the advisement from the Ministry of Health, Professional Regulation and Oversight Branch, that a timeline for moving forward on this file would be presented to CPBC by the end of the week, the DAC decided to postpone their decision and wait for the response from the MoH on a collaborative path forward.

[8] https://www.cccep.ca/ckfinder/userfiles/files/Immunization-Injection%20Programs%202020-05-12.pdf

Next Steps

- The DAC will reconvene in early June to review the timeline presented by the MoH, to consider removing the restriction on schedule IA drugs, and to discuss the next steps moving forward.
- The DAC will provide an update to the Board at the June 12, 2020 meeting of the Board.

Appendix	
1	Safe Drug Administration by Pharmacists Working Group Terms of Reference and Timeline *(Appendix not included, previously provided to the Board)*
2	Draft Presentation for the second Working Group meeting *(Appendix included)*
3	Supplemental Competencies on Injection for Canadian Pharmacists by the National Association of Pharmacy Regulatory Authorities *(Appendix not included, available online: https://napra.ca/sites/default/files/2017-09/Supplemental_Competencies_on_Injection_for_Canadian_Pharmacists2012.pdf)*

Appendix 1

Appendix A

College of Pharmacists of British Columbia

We acknowledge that the land on which we gather today is the unceded and traditional territories of the Coast Salish peoples – sḵwx̱wú7mesh (Squamish), seĺílwitulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) nations.

College of Pharmacists of British Columbia

Drug Administration by Pharmacists

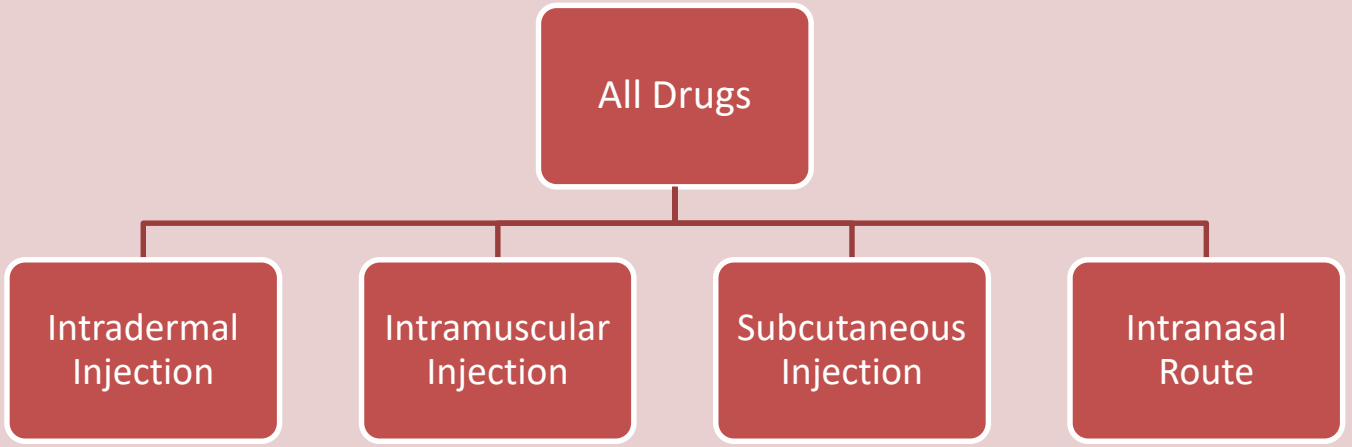
College of Pharmacists of British Columbia

February 12, 2020

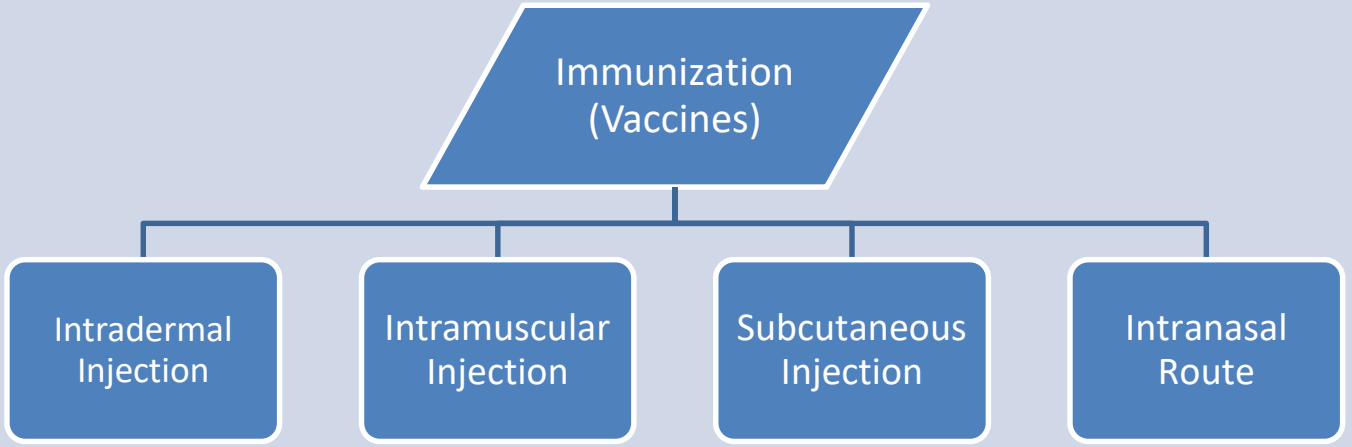
College of Pharmacists of British Columbia

Appendix A

Provincial *Pharmacist Regulation*



CPBC *Standards, Limits and Conditions*



College of Pharmacists of British Columbia

Safe Drug Administration by Pharmacists Working Group

- Purpose is to consider the patient safety risks and potential benefits of changing the authority of pharmacists to administer drugs or substances via intradermal, intramuscular or subcutaneous injection or intranasal routes
- Activities will culminate in documented findings regarding patient safety risks, mitigation strategies and benefits of changing pharmacists' drug administration authority
- Findings will be provided to the Drug Administration Committee, Ministry of Health and other health professional regulatory colleges for consideration

College of Pharmacists of British Columbia

Working Group Timeline and Activities

- First meeting – October 28, 2019
- Second meeting – February 12, 2020
- Findings to be finalized March 2020
  - Working group to prepare summary of findings for consideration for the Ministry of Health, CPBC and the Drug Administration Committee, and other regulatory colleges

College of Pharmacists of British Columbia

Safe Drug Administration by Pharmacists Working Group

- Key items discussed at October 28, 2019 Meeting:
  - ❑ Defining the need for removal of the restrictions using the principles of Right-touch regulation;
  - ❑ Outlining the impacts of removing the restrictions, including defining the specific drugs or drug classes which would be included or excluded from the authority;
  - ❑ Determining the potential impacts on the broader healthcare system; and
  - ❑ In the future, consider existing drug administration issues that could be potentially addressed by pharmacists, including expanding pharmacist administration to include intravenous infusions.

College of Pharmacists of British Columbia

Purpose of Presentation

- To provide the Safe Drug Administration by Pharmacists Working Group with an overview of the College of Pharmacist of BC's (CPBC) proposed removal of restrictions on drug administration authority, in the context of Right-touch regulation.

College of Pharmacists of British Columbia

CURRENT STATE: DRUG ADMINISTRATION BY PHARMACISTS IN BC

College of Pharmacists of British Columbia

Presentation: Administration of Injections Training in Pharmacy

College of Pharmacists of British Columbia

Drug Administration Certification Requirements

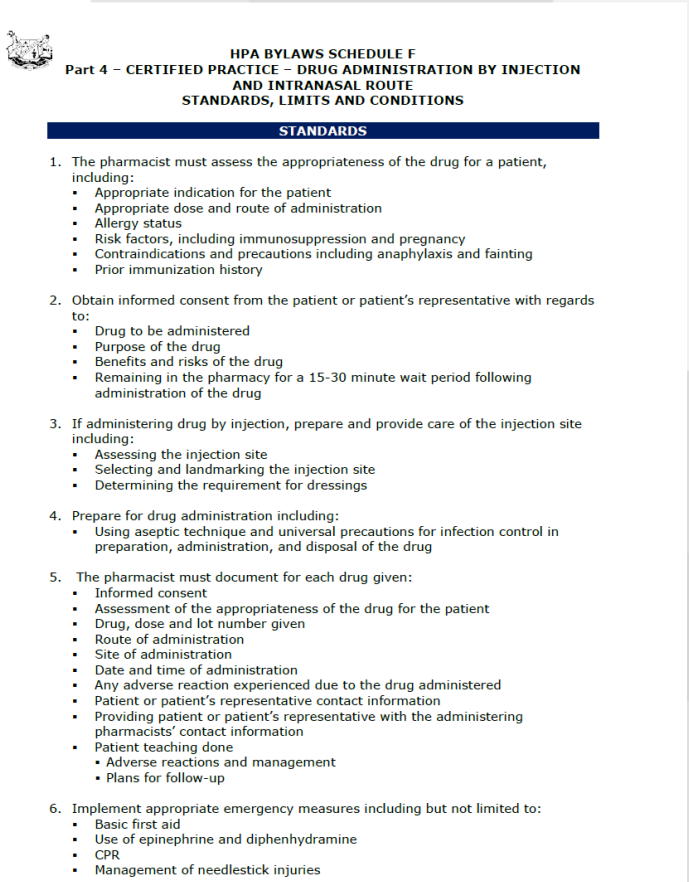
- CPBC *Health Professions Act Bylaws*
  - Be a practising pharmacist registered with CPBC
  - Complete a CPBC approved accredited program in drug administration
  - Hold a current certificate in CPR and first aid from a program approved by the Board, declared annually
  - Submit application to CPBC
- Registered pharmacists (full and limited) with injection authority as of February 2020: 4,399 (69.3%)

Appendix 1

College of Pharmacists of British Columbia

Appendix A

Current Drug Administration Standards



HPA BYLAWS SCHEDULE F
Part 4 – CERTIFIED PRACTICE – DRUG ADMINISTRATION BY INJECTION AND INTRANASAL ROUTE
STANDARDS, LIMITS AND CONDITIONS

STANDARDS

1. The pharmacist must assess the appropriateness of the drug for a patient, including:
   - Appropriate indication for the patient
   - Appropriate dose and route of administration
   - Allergy status
   - Risk factors, including immunosuppression and pregnancy
   - Contraindications and precautions including anaphylaxis and fainting
   - Prior immunization history
2. Obtain informed consent from the patient or patient's representative with regards to:
   - Drug to be administered
   - Purpose of the drug
   - Benefits and risks of the drug
   - Remaining in the pharmacy for a 15-30 minute wait period following administration of the drug
3. If administering drug by injection, prepare and provide care of the injection site including:
   - Assessing the injection site
   - Selecting and landmarking the injection site
   - Determining the requirement for dressings
4. Prepare for drug administration including:
   - Using aseptic technique and universal precautions for infection control in preparation, administration, and disposal of the drug
5. The pharmacist must document for each drug given:
   - Informed consent
   - Assessment of the appropriateness of the drug for the patient
   - Drug, dose and lot number given
   - Route of administration
   - Site of administration
   - Date and time of administration
   - Any adverse reaction experienced due to the drug administered
   - Patient or patient's representative contact information
   - Providing patient or patient's representative with the administering pharmacists' contact information
   - Patient teaching done
     - Adverse reactions and management
     - Plans for follow-up
6. Implement appropriate emergency measures including but not limited to:
   - Basic first aid
   - Use of epinephrine and diphenhydramine
   - CPR
   - Management of needlestick injuries

1. The pharmacist must assess the appropriateness of the drug for a patient
2. Obtain informed consent from the patient or patient's representative
3. If administering drug by injection, prepare and provide care of the injection site
4. Prepare for drug administration including
5. The pharmacist must document for each drug given
6. Implement appropriate emergency measures including but not limited to:
   - Basic first aid
   - Use of epinephrine and diphenhydramine
   - CPR
   - Management of needle stick injuries

College of Pharmacists of British Columbia

Current Drug Administration Standards

7. Develop, maintain and review, at least annually, a policy and procedure manual including:
   - Emergency procedure and treatment protocol
   - Precautions required for patients with latex allergies
8. Maintain a setting within which the drug is to be administered that is clean, safe, comfortable and appropriately private and furnished for the patient
9. Notify and provide relevant information to other health professionals, as appropriate

College of Pharmacists of British Columbia

Current Drug Administration Limits

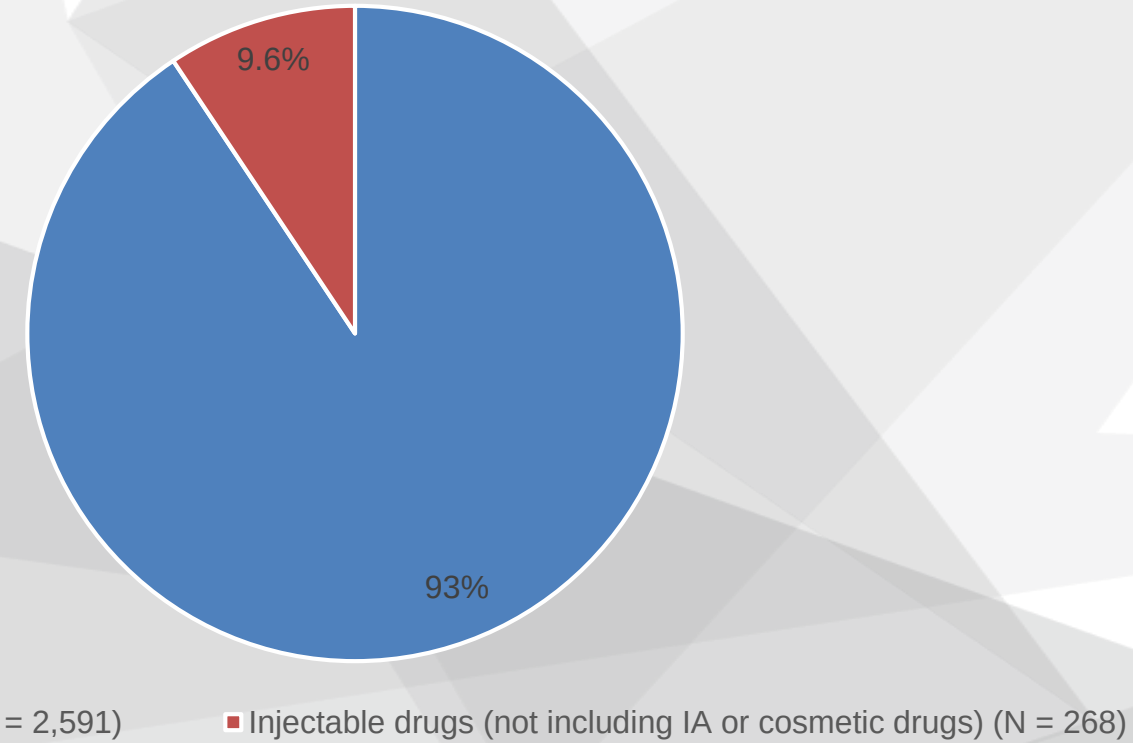
LIMITS

1. A practising pharmacist must not administer a drug by injection or intranasal route unless it is for the purpose of immunization.
2. A practising pharmacist must not administer an injection to a child under 5 years old.
3. A practising pharmacist must not administer a drug by intranasal route to a child under 2 years old.

College of Pharmacists of British Columbia

Current Status: Injectable Drugs in BC

Drugs dispensed at least once from a community pharmacy in BC, August 1, 2018 to July 31, 2019 (PharmaNet data provided by Ministry of Health).



College of Pharmacists of British Columbia

Injectable Drugs Dispensed from Community Pharmacies

Summary and Limitations:

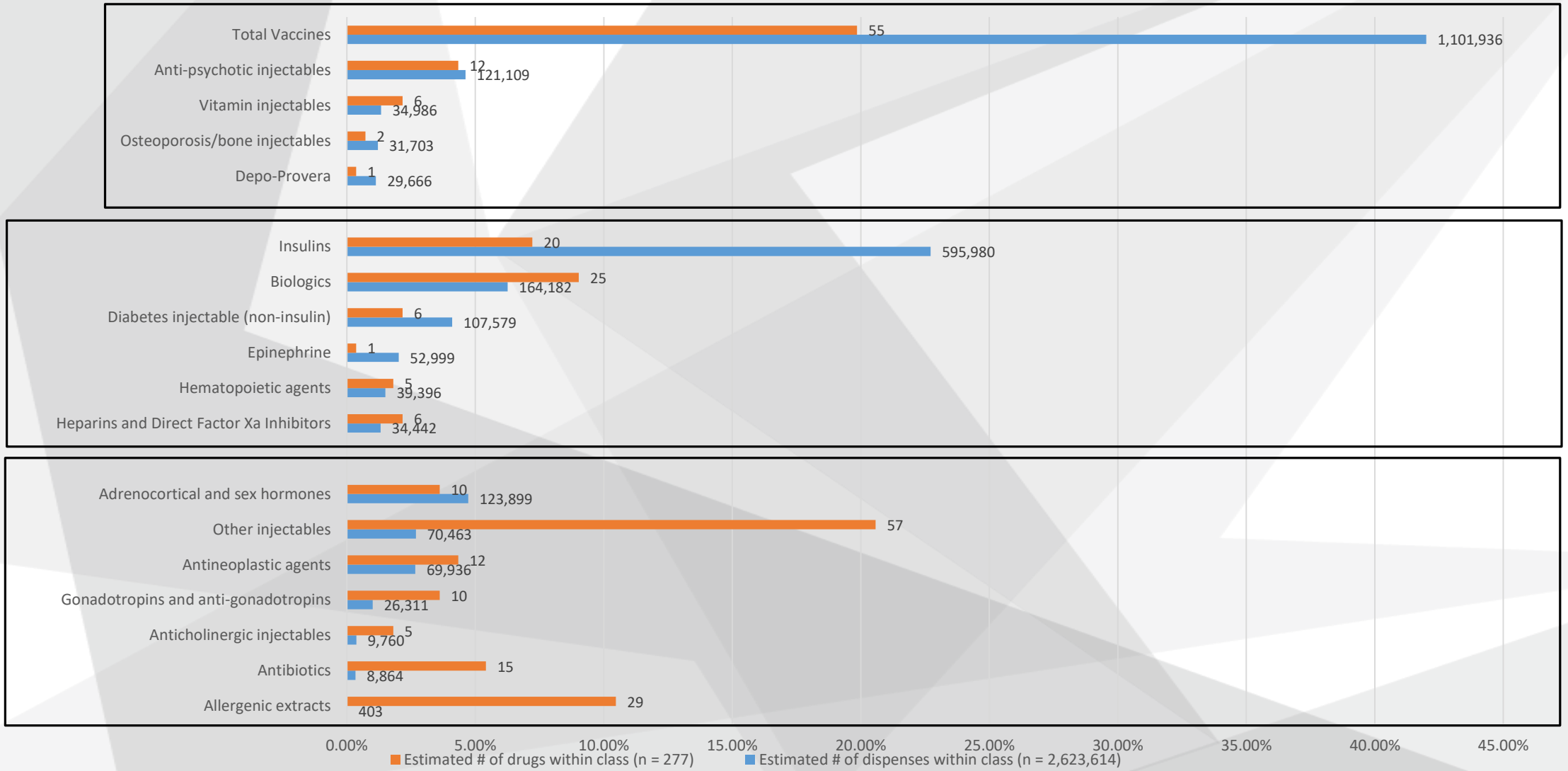
- List of DINS/PINS provided to MoH based on all marketed Schedule I and II IM & SC drugs listed in Health Canada's Drug Database and publicly funded vaccines
  - Does not include Schedule IA drugs or cosmetic drugs/substances
  - Does not include compounded products
- Captures *dispensing* events, and does not reflect *quantity* dispensed
  - E.g. a single influenza vaccine dispense and 30 day supply of dalteparin dispensed (i.e. 30 syringes) are both counted as 1 dispense
- Date range: August 1, 2018 – July 31, 2019
- Likely an overestimation of drugs that pharmacists would administer, as some drugs
  - Can also be administered by intravenous (IV), intra-articular, or oral routes
  - May have been dispensed for veterinary use
  - Are dispensed directly to hospice or residential care, or through home IV programs

Appendix 1

College of Pharmacists of British Columbia

Injectable drugs dispensed from community pharmacies in BC, August 1, 2018 to July 31, 2019 (not including schedule IA and cosmetic drugs). Raw data provided by the Ministry of Health, analysis by CPBC.

Appendix A



College of Pharmacists of British Columbia

RIGHT-TOUCH REGULATION AND THE PROPOSED REMOVAL OF RESTRICTIONS ON DRUG ADMINISTRATION

College of Pharmacists of British Columbia

Right-Touch Regulation Elements

1. Identify the problem before the solution
2. Quantify and qualify the risks
3. Get as close to the problem as possible
4. Focus on the outcome
5. Use regulation only when necessary
6. Keep it simple
7. Check for unintended consequences
8. Review and respond to change

College of Pharmacists of British Columbia

1. Identify the problem before the solution

What we are hearing:

- Patients have difficulty receiving injections due to systemic barriers (e.g., clinic location, clinic opening time, availability of practitioner)
- Patients ask why pharmacists can administer vaccines, but not other injectable medications when technique is the same
- Pharmacists are expected to teach patients to self-inject medications, but cannot administer that same injection to a patient
- Some patients have vision or dexterity difficulties, making self-injection challenging

College of Pharmacists of British Columbia

2. Quantify and qualify the risks

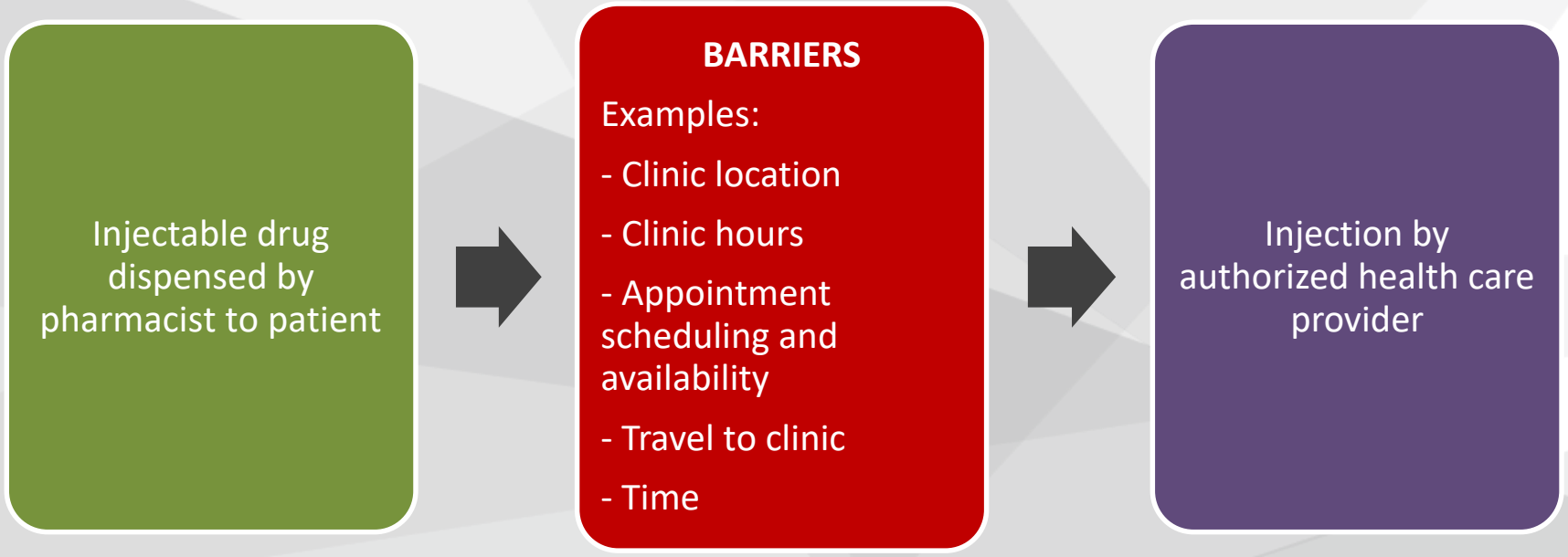
If patients do not receive adequate or timely treatment…

- Medical conditions are not adequately treated
- Risk varies, depending on disease state
- Worse outcomes for patients and increased health service utilization

College of Pharmacists of British Columbia

2. Quantify and qualify the risks

- Risks are caused by steps required between dispensing at the pharmacy and administration by authorized provider



College of Pharmacists of British Columbia

3. Get as close to the problem as possible

"Look for a solution as close to the problem as possible"

- Pharmacists are at the point of dispensing, and could conveniently provide injection
- Pharmacists are accessible
- Pharmacists are trained to give IM & SC injections
- Physicians are requesting pharmacists do this through Delegation of a Medical Act

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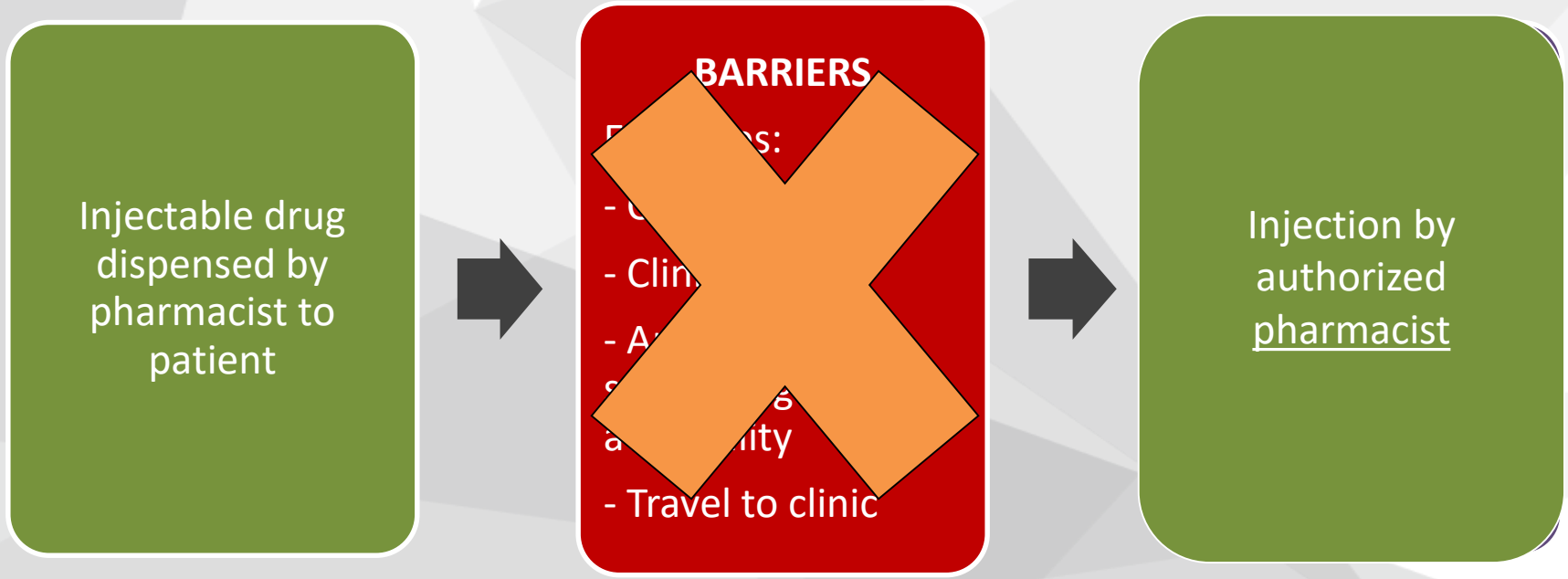
3. Get as close to the problem as possible



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4. Focus on the outcome

- What we expect
  - Patient receives drug when and where they need it
  - Improved medication adherence
  - Improved efficacy and safety of treatment (i.e. reduced harms for the public)
  - Improved patient outcomes and patient care

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5. Use regulation only when necessary

- *Standards, Limits and Conditions* are used to ensure patient safety
- This change can only be implemented through regulatory change to CPBC's *Standards, Limits and Conditions*
- Six other pharmacy regulatory authorities in Canada have enabled broad injection authority for pharmacists for any drug or vaccine (AB, SK, MB, NB, PEI, NL)

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6. Keep it simple

Removal of restrictions on pharmacist drug administration authority will be simple, and will include

- Minor amendments to the *Standards, Limits and Conditions*
- Minor adaptations to current training programs

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7. Check for unintended consequences

Concerns raised at last Working Group meeting:

- Communication with prescriber
  - Mitigated by current standard that requires pharmacist to notify and provide relevant information to other health care professionals
- Management of adverse reactions, including anaphylaxis
  - Mitigated by current standard that requires certified pharmacist to implement appropriate emergency measures including CPR, first aid and use of epinephrine and diphenhydramine
- Maintenance of patient record
  - Mitigated by current standard that requires certified pharmacist to document drug, dose, and lot number given, route and site of administration, date and time of administration, any adverse reaction experienced, etc.
  - Dispensed drug is documented on PharmaNet

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7. Check for unintended consequences

- CPBC developed a questionnaire to learn from the experiences of other jurisdictions
- Questionnaire was sent to the six PRAs with broad injection authority
- Questions included:
  - What has been your experience to-date, since implementing broad injection authority, of the following:
    - Has it been beneficial to public safety? Why or Why not?
    - Have you had any discipline or public/patient safety issues?
  - If you could start over, would you do anything differently?

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7. Check for unintended consequences

Questionnaire Results:

- None used a step-wise approach in removing restrictions on injection authority
- All concluded it was safe and in the public interest
- Very few complaints shared specific to pharmacist administered injections
  - Of these, the results suggest none were directly due to broad injection authority (e.g., relate to cold chain, documentation, adverse events)
- None indicated they would make an substantive changes to this broad authority, if they could start over

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7. Check for unintended consequences

Drug Administration Committee:

- Multidisciplinary committee discussed potential patient safety risks
- Identified potential patient safety implications of restriction removal
  - Injection of cosmetic drugs and substances
    - Pharmacists lack of experience with craniofacial muscles
    - General lack of knowledge of these substances
    - Potential conflict of interest & deviation from expertise
    - Recommended excluding these drugs and substances

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8. Review and respond to change

- Practice Review Program
  - In-person review of a pharmacy professional's practice
  - Program aims to protect public safety by improving compliance with CPBC Bylaws and Professional Practice Policies
- Complaints
  - Patients and members of the public who feel they've received unsafe or otherwise poor-quality care can submit complaints to CPBC
  - CPBC investigates complaints related to practices conducted by pharmacy professionals that present a risk to public safety
- Opportunity for post-implementation external evaluation

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Questions

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9. Drug Administration Committee – Pharmacists' Injection Authority Update

FOR INFORMATION

Purpose

To provide the Board with an update on the Drug Administration Committee, and the status of the recommendation made by the Drug Administration Committee to the Board on February 15, 2019.

Background

The *Pharmacists Regulation*[1] enables pharmacists to administer any drug specified in Schedule I, IA or II of the *Drug Schedules Regulation* or a substance through intradermal, intramuscular or subcutaneous injection or the intranasal route. It also requires a committee, the Drug Administration Committee (DAC), to be established to develop, review and recommend the standards, limits and conditions under which a registrant may administer a drug or substance to patients and the successful completion of a certification program.

The Standards, Limits and Conditions governing pharmacists' administration of drugs by injection or intranasal route are established in Schedule "F", Part 4 under the *Health Professions Act* Bylaws.[2] The existing limits placed on pharmacist drug administration are such that a practising pharmacist must not administer a drug by injection or intranasal route unless it is for the purpose of immunization.

In 2018, the DAC met to review the College of Pharmacists of BC (the College) restrictions on pharmacist drug administration in relation to patient safety and public protection. The DAC discussed options for removing restrictions, as conferred by the *Pharmacists Regulation*. The DAC also considered the experience of other pharmacy regulatory authorities in order to formulate evidence-based recommendations for the Board.

[1] http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/417_2008
[2] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5099-HPA_Bylaws_Drug_Administration_Injection_Intranasal.pdf

At its February 2019 meeting, based on the recommendations of the DAC, the Board directed the Registrar to remove current restrictions on pharmacist injection and intranasal administration of medications as follows (see Appendix 1):

- Amend the "Limits" to allow for injection and intranasal administration of any Schedule I and II medication with the exception of Schedule IA;
- Amend the "Limits" to restrict pharmacists from administering injections for cosmetic purposes; and
- Maintain the existing "Limits" on the age restrictions for injection and intranasal drug administration.

On April 10, 2019, the College received a letter addressed to the Board Chair from Mark Armitage, Assistant Deputy Minister, Ministry of Health (MoH) inviting the College to work with the Professional Regulation and Oversight Branch of the MoH to establish a working group, comprised of representatives of regulatory colleges of health professions with prescribing authority, to determine the impacts of removing the restrictions on pharmacist injection and intranasal administration of medications. College staff worked collaboratively with the MoH to draft the Terms of Reference and Timeline and Activities for the Safe Drug Administration by Pharmacists Working Group (see Appendix 2).

First Meeting of the Working Group
The first meeting of the Working Group occurred on October 28, 2019, and an update was provided to the Board at the November 2019 Board meeting (see Appendix 3). Key items were discussed, and included the following:

- Reframing the removal of the restrictions using the principles of "Right-touch regulation"[3];
- Outlining the impacts of removing the restrictions, including defining the specific drugs or drug classes which would be included or excluded from the authority;
- Determining the potential impacts on the broader healthcare system; and
- In the future, consider existing drug administration issues that could be potentially addressed by pharmacists, including expanding pharmacist administration to include intravenous infusions.

The Working Group raised specific questions regarding the accreditation of training programs for pharmacist drug administration and the range of drugs that pharmacists would be permitted to inject after the removal of restrictions. Despite these questions, there was general support from the other regulatory colleges for the removal of restrictions on pharmacist drug administration.

[3] https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=eaf77f20_20

Second Meeting of the Working Group (Cancelled)
A second meeting of the Working Group was scheduled to take place on February 12, 2020, but was cancelled after staff from the Professional Regulation and Oversight Branch indicated they were unable to participate. An update was provided to the Board in April 2020 (see Appendix 4).

A presentation for the second meeting of the Working Group was prepared by College staff to address the key issues raised at the first meeting. This included reframing the removal of the College's restrictions on pharmacist injection authority using the elements of "Right-touch regulation" and presentation of data from the MoH on injectable drugs dispensed from community pharmacies over a one-year period. The purpose of obtaining data on injectable drugs dispensed was to determine in an objective way what drugs pharmacists would be permitted to inject once the restrictions on pharmacist drug administration are removed.

A joint presentation by the BC Pharmacy Association and the University of British Columbia's Faculty of Pharmaceutical Sciences on their drug administration training programs for pharmacists was also planned, along with discussion on the National Association of Pharmacy Regulatory Authorities' (NAPRA's) *Supplemental Competencies on Injection for Canadian Pharmacists* competency 15: *Essential Competencies for Injection of other Substances*.[4] Drug administration training programs for pharmacists approved by the College are accredited by the Canadian Council on Continuing Education in Pharmacy, and therefore should already meet the required competencies set out by NAPRA for injection of both vaccines and other substances by the intramuscular and subcutaneous routes.[5]

Discussion

To determine the steps forward in removing restrictions on pharmacist drug administration, the DAC reconvened on May 25, 2020. The meeting was originally planned for March 19, 2020, but was postponed due to competing priorities related to the COVID-19 public health emergency.

At the meeting of the DAC, the DAC was presented with an update of events since the last DAC meeting in December 2018. Issues raised at the first Working Group meeting were presented to the DAC for consideration and discussion, and the DAC was presented with two options for moving forward.

The first option was to proceed with the original DAC recommendations as approved by the Board in February 2019. The Working Group would be provided a summary of the information gathered for the second Working Group meeting, and would be informed of the decision to proceed with the original DAC recommendations.

[4] https://napra.ca/sites/default/files/2017-09/Supplemental_Competencies_on_Injection_for_Canadian_Pharmacists2012.pdf
[5] https://www.cccep.ca/ckfinder/userfiles/files/Immunization-Injection%20Programs%202020-05-12.pdf

The second option was to reschedule the second Working Group meeting when the Professional Regulation and Oversight Branch staff are available. The Working Group would then present findings to the DAC, and the DAC would review and present the findings to the Board, if changes to the original recommendation result from the findings.

In considering these options, the DAC was informed of a meeting between the Registrar, Bob Nakagawa, and the Assistant Deputy Minister of the Ministry of Health, Mark Armitage, held on May 22, 2020 to discuss the status of the removal of restrictions on pharmacist drug administration. At the meeting, the Ministry of Health advised the College that they would provide the College with information on a plan to move forward in a collaborative manner as soon as possible. The meeting of the DAC on May 25, 2020 was arranged prior to the meeting between the Registrar and the Assistant Deputy Minister.

Due to the advisement from the Ministry of Health that a timeline for moving forward on this file would be presented to the College in a timely manner, the DAC decided to postpone their decision and wait for the response from the Ministry of Health on a collaborative path forward.

Additionally, the DAC expressed interest in re-examining their previous recommendation to exclude Schedule IA drugs from pharmacist drug administration authority in light of buprenorphine extended-release injection, a limited coverage drug now available in BC for the management of moderate-to-severe opioid use disorder. This drug must be administered by a health care professional.

Next steps

The DAC will reconvene in early June to review the timeline presented by the Ministry of Health, and to discuss the options and next steps moving forward.

Appendix	
1	February 2019 Board Briefing Note (without appendices)
2	September 2019 Board Briefing Note (with appendices – ToR & Timeline)
3	November 2019 Board Briefing Note (without appendices)
4	April 2020 Board Briefing Note (without appendices)

Appendix 3

Drug Administration by Pharmacists – Jurisdictional Scan Summary

Jurisdictions with broad drug administration authority and links to relevant standards:

- Alberta College of Pharmacy (AB)
- Saskatchewan College of Pharmacy Professionals (SK)
- College of Pharmacists of Manitoba (MB)
- New Brunswick College of Pharmacists (NB)
- Newfoundland and Labrador Pharmacy Board (NL)
- Nova Scotia College of Pharmacists (NS)
- Prince Edward Island College of Pharmacists (PEI)
- Yukon (YT)

Table 1. Summary of Drug Administration Provisions – Overarching Themes

	BC	AB	SK	MB	NB	NL	NS	PEI	YT
Assess patient and/or appropriateness of administration	✓	✓	✓	✓	✓	✓	✓	✓	✓
Have proper regard for the interest of the patient	Code of ethics	✓	X	X	✓	X	✓	✓	✓
Obtain informed consent	✓	✓	✓	✓	✓	✓	✓	✓	✓
Take all appropriate/necessary steps to ensure that the injection is administered safely[1]	Code of ethics	✓	✓	X	✓	X	✓	X	✓
Prepare the drug for administration	✓	✓	✓	✓	✓	✓	✓	✓	✓
Use universal precautions for infection control	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prepare and provide care of the injection site	✓	X	X	✓	✓	✓	✓	X	X
Following the administration of a drug, ensure the patient is appropriately monitored	X	✓	X	✓	✓	✓	✓	✓	✓
Implement appropriate emergency measures	✓	✓	X	✓	✓	✓	✓	✓	✓
Safe and appropriate disposal of devices, equipment, and remaining drug	Code of Ethics	✓	✓	✓	✓	✓	✓	✓	✓
The pharmacist must document for each drug given	✓	✓	✓	✓	✓	✓	✓	✓	✓
Develop and maintain a policy and procedure manual[2]	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maintain a setting within which the drug is to be administered that is appropriate[3]	✓	✓	✓	✓	✓	✓	✓	✓	✓
Notify and provide relevant health information	✓	✓	✓	✓	✓	✓	✓	✓	✓

[1] NAPRA Model Standard: Administer medications by injection only: the pharmacist can take all appropriate steps to ensure that the injection is administered safely

[2] NAPRA Model Standard: Administer medications by injection only when there are policies and procedures established for handling emergencies

[3] NAPRA Model Standard: Administer medications by injection only: the environment in which the injection is to be administered is appropriate

Appendix 4

Summary of Additional Proposed Amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*

Eight other pharmacy regulatory authorities (PRAs) allow pharmacists to administer drugs by injection, and do not restrict administration to vaccines only (see Appendix 3). A cross-jurisdictional scan of their drug administration regulations, standards, and practice directions was completed, and an analysis was undertaken to understand where the College's *Standards, Limits and Conditions* may have gaps. Overall, the *Standards, Limits and Conditions* align well with the drug administration standards of other PRAs (see Appendix 3). Despite this, some areas were identified where the *Standards, Limits and Conditions* may benefit from additional provisions or clarification. Based on this analysis, as well as an internal consultation with College staff with drug administration experience, additional amendments to the *Standards Limits and Conditions* are proposed and are summarized below.

1. *New standard requiring pharmacist to act in the best interest of the patient and take all appropriate steps to ensure the drug is administered safely*
    - Similar provisions exist within the Code of Ethics, but it may be beneficial to have a provision outlining this expectation within the *Standards, Limits and Conditions* as well.

2. *New standard requiring pharmacists to administer a drug within the scope of their education training and experience*
    - A provision requiring pharmacists to practice within the scope of their education, training and competence exists within the Code of Ethics. However, having a similar provision in the *Standards, Limits and Conditions* clarifies requirements for pharmacists with respect to drug administration. As intradermal administration and intramuscular injection sites other than the deltoid are not routinely taught in drug administration training programs, it may be beneficial to have a standard that requires pharmacists to only administer a drug if they are competent to do so.

3. *Amendments to assessment of appropriateness requirements*
    - A new standard was added that requires a pharmacist to assess the appropriateness of the time for administration, as all of the other "seven rights" of administration[1] are already embedded within the *Standards, Limits and Conditions*, but this was not explicitly included.
    - Assessing prior immunization status may not always be necessary with the new range of administered drugs. So, it was clarified that this requirement is only necessary "as applicable."

[1] The "seven rights" of drug administration: right product, right client, right dose, right time, right route, right reason, and right documentation (https://napra.ca/sites/default/files/2017-09/Supplemental_Competencies_on_Injection_for_Canadian_Pharmacists2012.pdf)

Appendix 4

4. *Amendments to informed consent requirements*
    - Many PRAs require pharmacists to discuss the expected reaction with the patient or patient's representative as part of the informed consent process. This was not deemed to be embedded within existing requirements, and its addition may ensure patients receive this information to aid in making an informed decision.
    - To align with a principle-based approach and to accommodate for a wider range of drugs, the requirement to obtain informed consent with respect to a "15-30 minute wait period" was amended to "an appropriate wait period." Additionally, the reference to waiting in the pharmacy was removed, as pharmacists are not prohibited from administering drugs in other settings (e.g. multidisciplinary clinics).

5. *Amendments to drug preparation requirements*
    - A new standard was added requiring that pharmacists ensure the drug to be administered is stable and has been stored and labelled appropriately prior to administration. This may be important for scenarios where a pharmacist administers a drug that was previously dispensed and/or brought in by a patient. This requirement is also common among other PRAs.

6. *New standard on requirements following administration*
    - A new standard outlining requirements following drug administration was added. In this section, new provisions were added requiring a pharmacist to appropriately monitor a patient following drug administration, and to dispose of drugs, devices and supplies in a safe and appropriate manner. Currently, the *Standards, Limits and Conditions* only speak to safe disposal from an infection control standpoint; however, proper disposal of sharps and remaining drug should also be considered. This is also required by many other PRAs.

7. *Amendments to notification and providing relevant information requirements*
    - To align with workflow, this standard was rearranged to fall within the "following administration" standard.
    - A new standard was added outlining existing requirements to report adverse events and reactions to the applicable government agency. Adverse events following immunization must be reported as per section 5(3) in the *Reporting Information Affecting Public Health Regulation.*[2] Community pharmacists are also required to report adverse drug reactions as per s.12(7) of the *HPA Bylaws Schedule F Part 1 – Community Pharmacy Standards of Practice.*[3] To make the *Standards, Limits and Conditions* more principle-based, the reference to the Adverse Event Following Immunization (AEFI) form was removed.

[2] https://www.bclaws.ca/civix/document/id/lc/statreg/167_2018#section5
[3] http://library.bcpharmacists.org/6_Resources/6-1_Provincial_Legislation/5078-HPA_Bylaws_Community.pdf

Appendix 4

8. Amendments to documentation requirements

- A new requirement to document the identification of the pharmacist who administered the drug was added, as this is important for accountability and traceability.
- New requirements to document the patient response to drug administration, and to document the management provided if an adverse event occurs were added. These are important for a complete record of the administration of the drug, as the absence of documentation may not be sufficient to demonstrate that the patient tolerated the drug administration well. Documentation of the patient response and management provided are required by most other PRAs.
- A new requirement to document the expiry date of the drug was added. This is required by many other PRAs and documenting the expiry date ensures that the pharmacist has checked it prior to administration. This may be of importance when administering a drug that was previously dispensed and/or brought in by a patient.

9. Amendments to requirement to implement emergency measures

- To align with a principle-based format, the examples of emergency measures were removed. In their place, a new standard was added requiring pharmacists to ensure there is access to the drugs, devices, and other necessary equipment and supplies used to treat reactions to administered drugs. Another new standard was added requiring pharmacists to respond appropriately to complications and emergencies if they arise.

10. Additional minor amendments

- "Application" section added to link to other relevant legislation.
- Bulleted lists under each standard changed to lettered lists to allow for easier referencing.
- Minor housekeeping and typographical corrections.

HPA BYLAWS SCHEDULE F
Part 4 – CERTIFIED PRACTICE – DRUG ADMINISTRATION BY INJECTION AND INTRANASAL ROUTE
STANDARDS, LIMITS AND CONDITIONS

APPLICATION

This Part applies to all practising pharmacists, and should be read in conjunction with sections 4 (c.1) and 4.1(1) of the *Pharmacists Regulation,* B.C. Reg. 417/2008 under the *Health Professions Act,* R.S.B.C. 1996 c. 183, and in conjunction with sections 43, 43.1 and 46(5.1) of the College bylaws made under the *Health Professions Act.*

STANDARDS

1. A pharmacist who administers a drug acts in the best interest of the patient and takes all appropriate steps to ensure that the drug is administered safely.

2. A pharmacist who administers a drug does so within the scope of their education, training and competence.

3. A pharmacist must assess the appropriateness of the drug for a patient, including:
    (a) Appropriate indication for the patient
    (b) Appropriate dose and route of administration
    (c) Appropriate time and frequency for administration
    (d) Allergy status
    (e) Risk factors, including immunosuppression and pregnancy
    (f) Contraindications and precautions including anaphylaxis and fainting
    (g) Prior immunization history, if applicable

4. Obtain informed consent from the patient or patient's representative with regards to:
    (a) Drug to be administered
    (b) Purpose of the drug
    (c) Benefits and risks of the drug
    (d) Expected reaction
    (e) Remaining for an appropriate wait period following administration of the drug

5. If administering a drug by injection, prepare and provide care of the injection site including:
    (a) Assessing the injection site
    (b) Selecting and landmarking the injection site
    (c) Determining the requirement for dressings

6. Prepare for drug administration including:
    (a) Taking appropriate steps to ensure the right drug is administered to the right patient
    (b) Ensuring the drug is stable, and has been stored and labelled appropriately prior to administration
    (c) Using aseptic technique and universal precautions for infection control in preparation, administration, and disposal of the drug

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7. Following drug administration, a pharmacist must
   (a) Ensure devices, supplies and any remaining drug are disposed of safely and appropriately
   (b) Ensure the patient is appropriately monitored
   (c) Notify and provide relevant information to other health professionals, as appropriate
   (d) Report adverse events or reactions to the applicable government agency, as required

8. A pharmacist must document for each drug given:
   (a) Informed consent
   (b) Assessment of the appropriateness of the drug for the patient
   (c) Drug and dose administered
   (d) Lot number and expiry date of the drug
   (e) Route of administration
   (f) Site of administration
   (g) Date and time of administration
   (h) The identification of the pharmacist who administered the drug
   (i) Patient response
   (j) Any adverse reaction experienced due to the drug administered and management provided
   (k) Patient or patient's representative contact information
   (l) Providing patient or patient's representative with the administering pharmacist's contact information
   (m) Patient teaching done, including adverse reactions and management and plans for follow-up

9. Ensure there is ready access to drugs, devices and other necessary equipment and supplies used to treat reactions to administered drugs.

10. Respond appropriately to complications and emergencies if they arise.

11. Develop, maintain and review, at least annually, a policy and procedure manual including:
   (a) Emergency procedure and treatment protocol
   (b) Precautions required for patients with latex allergies

12. Maintain a setting within which the drug is to be administered that is clean, safe, comfortable and appropriately private and furnished for the patient.

LIMITS

1. A practising pharmacist must not administer any Schedule IA drug by injection or intranasal route.
2. A practising pharmacist must not administer drugs and substances for cosmetic purposes by injection.
3. A practising pharmacist must not administer an injection to a child under 5 years old.
4. A practising pharmacist must not administer a drug by intranasal route to a child under 2 years old.

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CONDITIONS

1. A practising pharmacist must apply to the College of Pharmacists of B.C. for certification to administer Schedule I and II drugs by injection or intranasal route within 1 year of successful completion of the required certification program.

2. A practising pharmacist must not administer a drug or substance by injection or intranasal route in B.C. prior to receiving notification from the College of Pharmacists of B.C. of their certification to administer drugs and substances by injection or intranasal route.

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HPA BYLAWS SCHEDULE F
Part 4 – CERTIFIED PRACTICE – DRUG ADMINISTRATION BY INJECTION AND INTRANASAL ROUTE
STANDARDS, LIMITS AND CONDITIONS

APPLICATION

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STANDARDS

1. A pharmacist who administers a drug acts in the best interest of the patient and takes all appropriate steps to ensure that the drug is administered safely.

2. A pharmacist who administers a drug does so within the scope of their education, training and competence.

~~1.~~3. ~~The~~ A pharmacist must assess the appropriateness of the drug for a patient, including:
   (a) Appropriate indication for the patient
   (b) Appropriate dose and route of administration
   ~~(b)~~(c) Appropriate time and frequency for administration
   ~~(c)~~(d) Allergy status
   ~~(d)~~(e) Risk factors, including immunosuppression and pregnancy
   ~~(e)~~(f) Contraindications and precautions including anaphylaxis and fainting
   ~~(f)~~(g) Prior immunization history, if applicable

~~2.~~4. Obtain informed consent from the patient or patient's representative with regards to:
   (a) Drug to be administered
   (b) Purpose of the drug
   (c) Benefits and risks of the drug
   ~~(c)~~(d) Expected reaction
   ~~(d)~~(e) Remaining ~~in the pharmacy~~ for an appropriate ~~15-30 minute~~ wait period following administration of the drug

~~3.~~5. If administering a drug by injection, prepare and provide care of the injection site including:
   (a) Assessing the injection site
   (b) Selecting and landmarking the injection site
   (c) Determining the requirement for dressings

~~4.~~6. Prepare for drug administration including:
   (a) Taking appropriate steps to ensure the right drug is administered to the right patient
   (b) Ensuring the drug is stable, and has been stored and labelled appropriately prior to administration
   ~~(a)~~(c) Using aseptic technique and universal precautions for infection control in preparation, administration, and disposal of the drug

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7. Following drug administration, a pharmacist must
   (a) Ensure devices, supplies and any remaining drug are disposed of safely and appropriately
   (b) Ensure the patient is appropriately monitored
   (c) Notify and provide relevant information to other health professionals, ~~,~~ as appropriate
   ~~(a) , including:~~
      ~~(i) The Adverse Event Following Immunization (AEFI) form~~
   (d) Report adverse events or reactions to the applicable government agency, as required

~~5.~~8. ~~The~~ A pharmacist must document for each drug given:
   ~~—~~Informed consent
   (a)
   (b) Assessment of the appropriateness of the drug for the patient
   (c) Drug and ~~,~~ dose ~~and lot number given~~administered
   ~~(c)~~(d) Lot number and expiry date of the drug
   ~~(d)~~(e) Route of administration
   ~~(e)~~(f) Site of administration
   (g) Date and time of administration
   (h) The identification of the pharmacist who administered the drug
   ~~(f)~~(i) Patient response
   ~~(g)~~(j) Any adverse reaction experienced due to the drug administered and management provided
   ~~(h)~~(k) Patient or patient's representative contact information
   ~~(i)~~(l) Providing patient or patient's representative with the administering pharmacist's~~'~~ contact information
   ~~(j)~~(m) Patient teaching done, including adverse reactions and management and plans for follow-up
   ~~• Adverse reactions and management~~
   ~~• Plans for follow-up~~

9. Ensure there is ready access to drugs, devices and other necessary equipment and supplies used to treat reactions to administered drugs.

10. Respond appropriately to complications and emergencies if they arise.

~~6. Implement appropriate emergency measures including but not limited to:~~
   ~~• Basic first aid~~
   ~~• Use of epinephrine and diphenhydramine~~
   ~~• CPR~~
   ~~• Management of needlestick injuries~~

~~7.~~11. Develop, maintain and review, at least annually, a policy and procedure manual including:
   (a) Emergency procedure and treatment protocol
   (b) Precautions required for patients with latex allergies

~~8.~~12. Maintain a setting within which the drug is to be administered that is clean,

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~~HPA_Bylaws_Drug_Administration_Injection_Intranasal 2020_v.9 (Track Changes)~~~~HPA_Bylaws_Drug_Administration_Injection_Intranasal v2019.1 (Track Changes)~~~~5099-HPA_Bylaws_Drug_Administration_Injection_Intranasal v2016.1~~ Posted 2016-06-06

safe, comfortable and appropriately private and furnished for the patient.

~~9.~~1. ~~Notify and provide relevant information to other health professionals, as appropriate, including:~~
- ~~The Adverse Event Following Immunization (AEFI) form~~

LIMITS

~~1. A practising pharmacist must not administer a drug by injection or intranasal route unless it is for the purpose of immunization.~~
1. A practising pharmacist must not administer any Schedule IA drug by injection or intranasal route.
2. A practising pharmacist must not administer drugs and substances for cosmetic purposes by injection.
~~2.~~3. A practising pharmacist must not administer an injection to a child under 5 years old.
~~3.~~4. A practising pharmacist must not administer a drug by intranasal route to a child under 2 years old.

CONDITIONS

1. A practising pharmacist must apply to the College of Pharmacists of B.C. for certification to administer ~~immunizations~~Schedule I and II drugs by injection or intranasal route within 1 year of successful completion of the required certification program.

~~1.~~2. A practising pharmacist must not administer a drug or substance by injection or intranasal route ~~provide immunization services~~ in B.C. prior to receiving notification from the College of Pharmacists of B.C. of their certification to administer drugs and substances by injection or intranasal route ~~immunizations~~.

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~~HPA_Bylaws_Drug_Administration_Injection_Intranasal 2020_v.9 (Track Changes)~~~~HPA_Bylaws_Drug_Administration_Injection_Intranasal v2019.1 (Track Changes)~~~~5099-HPA_Bylaws_Drug_Administration_Injection_Intranasal v2016.1~~ Posted 2016-06-06

Appendix A

1173509

August 20, 2020

Christine Antler, RPh
Chair,
College of Pharmacists of British Columbia
200 – 1765 W 8th Ave
Vancouver BC V6J 5C6

Dear Ms. Antler:

I hope that you are staying well during this unprecedented time.

I write to you regarding the email and information package on Pharmacist Drug Administration that I received from Registrar Bob Nakagawa on May 26, 2020, his subsequent email received on July 28, 2020 (see attachments), and the unfinished work of the Safe Drug Administration by Pharmacists Working Group (the Working Group).

While I know the subject of pharmacist injecting has been a topic of discussion for a number of years, the Ministry is concerned with the direction the College of Pharmacists of British Columbia (CPBC) is presently considering. Mr. Nakagawa's July 28 email indicated that he will be seeking approval at the September 18, 2020 Board meeting to move forward with public consultation on bylaw amendments that would expand pharmacist drug administration authority. In our view this would be premature prior to completion of the work we previously agreed to undertake collaboratively. To that end, we agreed to work together with other regulators to review the impacts (benefits and risks) and policy considerations of an expanded drug administration authority. The findings of this work were to be shared with the Drug Administration Committee, the Ministry and relevant regulators.

At the Working Group's first and only meeting on October 28, 2019, key questions were raised regarding:

- the identified need for pharmacists to provide additional injections;
- the types of drugs contemplated;
- the conditions under which expanded injection authority would be appropriate;
- how that authority would fit with team-based and/or other models for health services delivery; and
- how the service would be reimbursed.

Following this initial meeting and to help facilitate further discussions, the CPBC committed to provide to the Ministry a list of contemplated drugs with accompanying rationale for

…2

Ministry of Health
Office of the Assistant Deputy Minister
Health Sector Workforce and Beneficiary Services Division
PO Box 9649 STN PROV GOVT
Victoria BC V8W 9P4
Tel: 250.952-3519
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consideration prior to the second meeting originally planned for February 2020. The Ministry was therefore pleased to receive a drug categories list as part of the May 26, 2020 information package.

This drug categories list provides a starting point to help identify what the CPBC considers appropriate for pharmacists to inject. It is based on raw data for community pharmacy dispensing in BC from 2018-2019.

It is the Ministry's view that considerable work remains before being able to consider moving forward with an expanded injecting authority. This includes:

- defining the underlying problem which expanded pharmacist injecting authority may solve; and
- considering the respective merits of a pharmacist-based model, models involving other injecting professionals, and/or a hybrid model.

On December 12, 2019 the Ministry communicated to regulators the difficult decision to put a temporary moratorium on bylaw changes, largely due to the volume, complexity and urgency of the modernization work. Since then, the COVID-19 pandemic has resulted in considerable work for the Ministry to support the provincial emergency response. This work continues, as does work to restart many of the health services which were impacted by the acute COVID-19 response. Also, of concern, the province has seen an increase in the number of deaths from opioid overdose.

These factors have resulted in the following areas being identified by the Ministry and executive as our top priorities:

- COVID-19 response;
- opioid overdose emergency response;
- restarting health services to address the needs of the broader population; and
- modernization of the regulation of health professionals.

Despite this prioritization, the Ministry remains committed to a collaborative approach with the CPBC and our continued participation on the Working Group. As time allows over the coming months, the Ministry intends to take more of a lead role on key pieces of the work, including internal consultation (e.g. with primary care and public health divisions, the Ministry of Mental Health and Addictions, and other areas as appropriate), to determine whether there is an identified need to:

- adjust the way in which patients receive regular and/or intermittent injections; and
- identify barriers and/or potential solutions.

Please confirm with Mark MacKinnon, Executive Director, Professional Regulation and Oversight, the Board's continued support for the CPBC to collaborate on the remaining

…3

necessary work, as well as support for postponing the posting of draft bylaw amendments for public consultation. To reiterate, in our view posting would be premature until the work has been completed and findings are available for consideration by the Drug Administration Committee, Ministry and regulatory colleges. You can reach Mark MacKinnon by email at Mark.MacKinnon@gov.bc.ca.

Sincerely,

Mark Armitage
Assistant Deputy Minister
Health Sector Workforce and Beneficiary Services

Attachments

Pc: Bob Nakagawa, Registrar, College of Pharmacists of British Columbia
Honourable Adrian Dix, Minister of Health
Stephen Brown, Deputy Minister, Ministry of Health
David Byres, Associate Deputy Minister, Ministry of Health
Mitch Moneo, Assistant Deputy Minister, Pharmaceutical Services
Mark MacKinnon, Executive Director, Professional Regulation and Oversight

Appendix B

College of Pharmacists
of British Columbia

Mark Armitage
Assistant Deputy Minister
Health Sector Workforce and Beneficiary Services
Ministry of Health
PO Box 9649
STN PROV GOVT
Victoria, BC V8W 9P4

October 16, 2020

Thank you for your letter of August 20, 2020 regarding pharmacist drug administration.

As Chair of the Board of the College of Pharmacists of British Columbia ("the College"), I take your comments and concerns very seriously.

The College strongly believes in the importance of collaboration. Working together helps both of our organizations achieve our mutual public safety and public health goals. While it appears that our perspectives differ on how our collaborative relationship has progressed on the topic of pharmacist drug administration, we are pleased to note your commitment and are eager to continue working with you on this important initiative.

I understand from your letter that the Ministry is focused on its current top priorities, which include responding to COVID-19 and the opioid overdose emergency. It is critically important that there be effective and timely responses to these crises. That is why the College has continued to prioritize collaborating with the Pharmaceutical, Laboratory and Blood Services Division of the Ministry of Health and the Ministry of Mental Health and Addictions on opioid overdose emergency issues. While not the original intent of the amendments, we strongly believe that removing restrictions on pharmacist drug administration could help alleviate the burden on the healthcare system and play an important role in addressing these dual public health emergencies.

I also understand from your letter that *"…the Ministry intends to take more of a lead role on key pieces of the work…"* involved in the pharmacist drug administration initiative. It is important to highlight that this project does not involve expanding the scope of practice of pharmacists related to injection authority, which would be under the Ministry's purview. Rather, it involves removing certain College restrictions within the standards of practice of pharmacists. Setting pharmacist practice standards is a key College responsibility.

Under the *Health Professions Act,* one of the objects of the College is to establish standards for the practice of pharmacists. The role of the colleges in establishing professional standards is reinforced by Harry Cayton's, *An Inquiry into the Performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (2018) and the Steering Committee on Modernization of

College of Pharmacists
of British Columbia

Health Professional Regulation's, *Recommendations to Modernize the Provincial Health Profession Regulatory Framework* (2020). Both of those reports recommend that the health professional regulatory colleges in British Columbia remain responsible for this important work. As Board Chair, I would be greatly concerned if the College stepped away from its responsibility to fulfill its mandate and objects.

As you may know, the Ministry of Health recently highlighted the importance of pharmacists administering influenza vaccinations during this flu season – as more physicians are working remotely, pharmacists are expected to administer more flu vaccines than normal and a higher proportion of the provincial total[1]. While access to health care is not under the College's jurisdiction, we do recognize that pharmacists could also improve patient care and patient safety for the broader population of British Columbians during these challenging times, by administering other injectable medications to patients.

Your letter also highlighted a preference that the College not engage publicly on the draft amendments at this time. Notably, we are not obligated to post standards made under the *Health Professions Act* for public comment; however, public consultation is a valuable component of practice standard development, bringing forward stakeholders' views and experiences. Healthcare professionals involved in the Safe Drug Administration by Pharmacists Working Group and the College's Drug Administration Committee, which include nursing and physicians, have already stated their support for the removal of restrictions from the pharmacist drug administration standards. Even so, posting for public comment would allow the College to move forward in a gradual, step-wise manner consistent with the Standards of Good Regulation[2].

Given the concerns raised in your letter, and our interest in continuing to collaborate with the Ministry of Health, the College has not moved forward with public engagement on the standards at this time. Instead, at our September 2020 meeting, the College Board directed our Registrar to engage with the Ministry of Health to move the amendments to the *Drug Administration by Pharmacists Standards, Limits and Conditions* forward. The Board also decided to table approval of the amendments until our November 2020 Board meeting.

[1] https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacare-publications/pharmacare-newsletters

[2] For further information, see the Standards of Good Regulation, as outlined in the Harry Cayton report, *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (2018). https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/cayton-report-college-of-dental-surgeons-2018.pdf

Appendix B

College of Pharmacists
of British Columbia

Due to our strong belief that the proposed changes are important for public safety during the dual public health emergencies, fall within our legislated mandate, and the College Board's decision to table approval of the amendments until its November Board meeting, I request that a meeting with Ministry of Health executives be arranged as soon as possible to discuss these important issues. Bob Nakagawa, Registrar and Chief Executive Officer, will be contacting you to discuss next steps.

Best Regards,

Christine Antler, B.Sc., B.Sc. (Pharm).
Chair and Board Member

cc: Bob Nakagawa, Registrar, College of Pharmacists of BC
Honourable Adrian Dix, Minister of Health
Stephen Brown, Deputy Minister, Ministry of Health
David Byres, Associate Deputy Minister, Ministry of Health
Mitch Moneo, Assistant Deputy Minister, Pharmaceutical Services
Mark MacKinnon, Executive Director, Professional Regulation and Oversight

College of Pharmacists of British Columbia

7. Drug Administration Committee: Amendments to the HPA *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*

Alex Dar Santos

Member, Drug Administration Committee

College of Pharmacists of British Columbia

Purpose of Presentation

- To put forth the motion tabled at the September 18, 2020 Board meeting to accept the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions (Standards, Limits and Conditions)*.
- To update the Board on the status of the proposed amendments to the *Standards, Limits and Conditions*.

College of Pharmacists of British Columbia

Board Meeting – September 18, 2020

- The Board was presented with two motions at the September meeting
  1. To accept the proposed amendments, as recommended by the DAC, in principle; and,
  2. To direct the Registrar to engage with the Ministry of Health on moving the amendments forward.
- The Board tabled the motion to accept the proposed amendments in principle until the November 2020 Board meeting.
- The Board directed the Registrar to engage with the Ministry of Health on moving the amendments forward.

College of Pharmacists of British Columbia

Updates Since the September Board Meeting

- A letter was sent from Chair Antler to Mark Armitage, Assistant Deputy Minister, Ministry of Health on October 16, 2020 in response to his letter dated August 20, 2020.
- The Registrar met with executives from the Ministry of Health on November 16, 2020.
- The College committed to providing a written response to the questions raised at the meeting.

College of Pharmacists of British Columbia

Updates Since the September Board Meeting, continued

- The National Advisory Committee on Immunization (NACI) released an updated recommendation for post-vaccination observation periods for influenza vaccination during the COVID-19 pandemic.
- The updated NACI recommendation and potential need for amendments to the *Standards, Limits and Conditions* was discussed with the Drug Administration Committee (DAC) on October 30, 2020, and was also discussed with the Ministry of Health.

College of Pharmacists of British Columbia

Meeting of the Drug Administration Committee

- At the October 30, 2020 meeting, the DAC also recommended and approved additional minor amendments:
  - A clarified requirement for ensuring the frequency of drug administration is appropriate; and,
  - A new provision was added that requires a pharmacist to "[take] appropriate steps to ensure the right drug is administered to the right patient."

College of Pharmacists of British Columbia

Recommendation

- It is recommended that the Board accepts, in-principle, the proposed amendments to the *Standards, Limits and Conditions*, as circulated.

College of Pharmacists of British Columbia

Next Steps

- The Registrar will continue to engage with the Ministry of Health on moving the proposed amendments to the *Standards, Limits and Conditions* forward.

College of Pharmacists of British Columbia

7. Amendments to the HPA *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*

MOTION:

Accept the amendments to the *Drug Administration by Injection and Intranasal Route Standards, Limits and Conditions*, as circulated.

College of Pharmacists of British Columbia

Questions

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

9. College Name Change

DECISION REQUIRED

Recommended Board Motion:

Request that the Minister of Health change the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia, as part of the anticipated amendments to the Health Professions Act.

Purpose

To provide background on requests to change the name of the College of Pharmacists of British Columbia (the College). And, to recommend that the Board Chair request that the Minister of Health change the College's name as part of the Ministry's anticipated amendments to the *Health Professions Act* (HPA).

Background

The College's name has not been static over its 125-year existence. The original name of the College was the Pharmaceutical Association of British Columbia. It was not until the late 1960s that the College began using its current name.

Section 12(2)(a) of the HPA states that the Minister may prescribe the name of a college for a health profession by regulation. As such, implementing changes to the College's name is a matter under the jurisdiction of the Minister of Health. And, the College must make a request to the Minister of Health, if wishing to initiate a name change.

2016 Engagement on a College Name Change

In 2016, the College held an engagement to solicit feedback on a potential name change. In general, the results highlighted support for a change (see Appendix 1 for further information).

2018 Formal Request for a College Name Change

In June 2018, the Board Chair wrote to the Minister of Health requesting a change to the College's name to the *College of Pharmacy of British Columbia* (see Appendix 2 for a copy of the June 2018 letter). Key reasons cited were:

- To more accurately reflect its full scope of responsibilities and enhance public protection. Currently, the College's name identifies only one of the two types of professionals that it regulates (i.e., pharmacists and not pharmacy technicians). In

addition, it is silent on the College's responsibilities regarding pharmacy licensure, the inspection of pharmacy sites and its oversight over non-registrant pharmacy owners.
- To align better with the name changes of similar regulatory bodies (e.g., the Saskatchewan College of Pharmacy Professionals and Alberta College of Pharmacy, etc.)
- To reflect stakeholder feedback (e.g., overall, 63% of respondents in the 2016 engagement, noted above, indicated support for a College name change).

In August 2018, the College received a response from the Minister of Health (See Appendix 3 for a copy of the August 2018 letter). In his response, the Minister declined to move forward with a College name change. The following main reasons provided were as follows:

- Changing the College's name would involve regulatory amendments to the *Pharmacists Regulation*, and consequential regulatory and legislative changes. This would require significant resources, and the Ministry already has a number of initiatives underway.
- Within the College's online engagement initiative on this issue, there was support for retaining the College's current name and there was limited public feedback.
- There was an article on the College's website noting that a name change could serve to more fully integrate pharmacy technicians within the College. A motivation to enhance the profile of a professional group is outside of the jurisdiction of the College.

In September 2018, the Board Chair replied to Minister of the Health (see Appendix 4 for a copy of the September 2018 letter). The response clarified that the College was not motivated by a desire to enhance the profile of the pharmacy technician profession, but rather to enhance public protection.

Current Status

Currently, the Ministry of Health is working on amendments to the HPA, to implement wide-scale changes to health professional regulation. The College has engaged in consultations to help inform this work and provided a general recommendation on name changes for the health professional colleges. More specifically, in January 2020, the College's feedback (see Appendix 5) included a recommendation to:

> *"….consider taking a principle-based approach to naming each regulatory body that increases transparency and provides clarity to the public on who to turn to. We recommend that a college name reflect the profession(s) they regulate in order to enhance transparency and support easy patient navigation."*

A Steering Committee on Modernization of Health Professional Regulation (the Steering Committee) was initiated to consider how best to modernize health professional regulation in the province. In its August 2020 report, it highlights that the naming convention of the colleges may contribute to role confusion for the public, as the term 'college' is often associated with education and training institutions. Further, the report states, "*To reduce confusion and make the regulatory role of colleges more apparent, it is recommended that other terms or descriptors be considered."*

The August 2020 report also highlights that the Steering Committee remains committed to reducing the number of regulators in a manner that addresses current resources challenges, improves regulatory effectiveness and creates new economies of scale. The report included a recommended arrangement of regulatory colleges into the following groupings:

1. Regulatory College of Complementary and Alternative Health and Care Professionals;
2. Regulatory College of Allied Health and Care Professionals;
3. Pharmacists;
4. Nursing Professionals;
5. Physicians and Surgeon;
6. Oral Health Professionals.

College staff understand that the modernization of health profession regulation is a key Ministry of Health priority. While it is anticipated that HPA amendments will take place in the near future, the exact timing has not yet been communicated.

Options

Option One: Via correspondence from the Board Chair, the College request that the Minister of Health change the College's name to the *College of Pharmacy of British Columbia,* as part the anticipated amendments to the HPA.

Pros:

- The Minister of Health previously noted as a barrier the resources involved with the regulatory and legislative changes required to change the College's name. As the Ministry of Health is currently working on amendments to the HPA, it may be timely to incorporate the recommended name change at this time.
- This is aligned with the Steering Committee's August 2020 recommendation that college names be changed to reduce confusion for the public.
- The proposed name better aligns with other pharmacy regulatory authorities across Canada as well as the recently re-named British Columbia College of Nurses and Midwives[1].
- The proposed name maintains the same acronym as the current College name, which may reduce the impact of the change on communications materials and tools.

Cons:

- The College has already requested a name change about two years ago.
- In its August 2020 report, the Steering Committee noted that as the term 'college' is often associated with education and training institutions and may cause confusion for the public. As such, it is unclear if the term 'college' will be maintained in the anticipated amended version of the HPA.

Option Two: Do Not Request a Name Change at this Time

Pros:

- The College has already requested a name change within the last two years.

[1] Formerly known as the British Columbia College of Nursing Professionals, https://www.bccnp.ca/Pages/Default.aspx

- The Steering Committee's recommendations are aligned somewhat with the College's name change request. As such, it is likely that the anticipated amendments to the HPA will include name changes to the health professional regulatory colleges.

Cons:

- Timing of the anticipated amendments to the HPA is not yet known.
- The previous College name change request may not be top of mind for the Ministry of Health. An opportunity to re-emphasize the request during a time when amendments to the HPA are anticipated, would be lost.

Recommendation

Option 1 (Via correspondence from the Board Chair, the College request that the Minister of Health change the College's name to the *College of Pharmacy of British Columbia,* as part the anticipated amendments to the HPA) is recommended. This option re-emphasizes that value of the proposed name change of the *College of Pharmacists of British Columbia* to the *College of Pharmacy of British Columbia* as it reduces confusion of who the College regulates, enhances transparency, and is aligned with the Steering Committee's August 2020 report.

Considerations

There was a recent provincial election, and as of October 29, 2020, the government has yet to determine its Cabinet membership. The College should wait to send any correspondence on this issue, until the Minister of Health for this government's term is confirmed.

Guiding Question:

A key question for the Board to consider is:

- Is the recommendation to request a name change of the *College of Pharmacists of British Columbia* to the *College of Pharmacy of British Columbia* as part of the planned amendments to the HPA to re-emphasize previous such requests, in the interest of public safety and public protection?

Appendix	
1	College Name Change – Results of Online Engagement
2	June 2018 Letter (From CPBC to the Minister of Health)
3	August 2018 Letter (From the Minister of Health to CPBC)
4	September 2018 Letter (From CPBC to the Minister of Health)
5	January 2020 Letter (From CPBC to the Members of the Steering Committee on Modernization of Health Professional Regulation)

College of Pharmacists of British Columbia

College Name Change

Results of Online Engagement

September 9, 2016

Introduction

In 2010, the responsibilities of the College of Pharmacists of BC were expanded to include regulating pharmacy technicians in BC. Since then, the College's name has not reflected its role in regulating both pharmacists and pharmacy technicians. Several Canadian pharmacy regulators who register pharmacy technicians are facing the same challenge and are considering name changes. Recently, the Saskatchewan regulator changed its official name from the Saskatchewan College of Pharmacists to the Saskatchewan College of Pharmacy Professionals.

The College Board has acknowledged the issue with the College's name. At the same time, the Board also recognizes that the provincial government is ultimately responsible for the decision to change the College's name as it would require a regulatory amendment. It is also clear that there would be a significant amount of work required to complete the name change, which would not take priority over the College's important work in regulating pharmacy and protecting public safety.

The College Board felt that it was important to hear from others on this issue. In September 2015, the College of Pharmacists of BC Board passed a motion for the Registrar to engage with stakeholders on changing the College name and report back at the September 2016 meeting.

The College launched an engagement on a proposed College name change to learn how pharmacy professionals, other health stakeholders and the public feel about a College name change. The online survey was open from August 12 open until September 5, 2016 – providing a three week period for feedback to be submitted.

The survey asks whether the College should pursue changing its name to reflect our role in regulating both pharmacists and pharmacy technicians in BC. It also asks for input on suggested new names for the College.

Over 1500 contributed to the survey during the three week period. We'd like to thank everyone who took the time to share their thoughts on a College name change.

Who We Heard From

The College heard from pharmacy professionals, other health stakeholders and the public through an online survey and through social media.

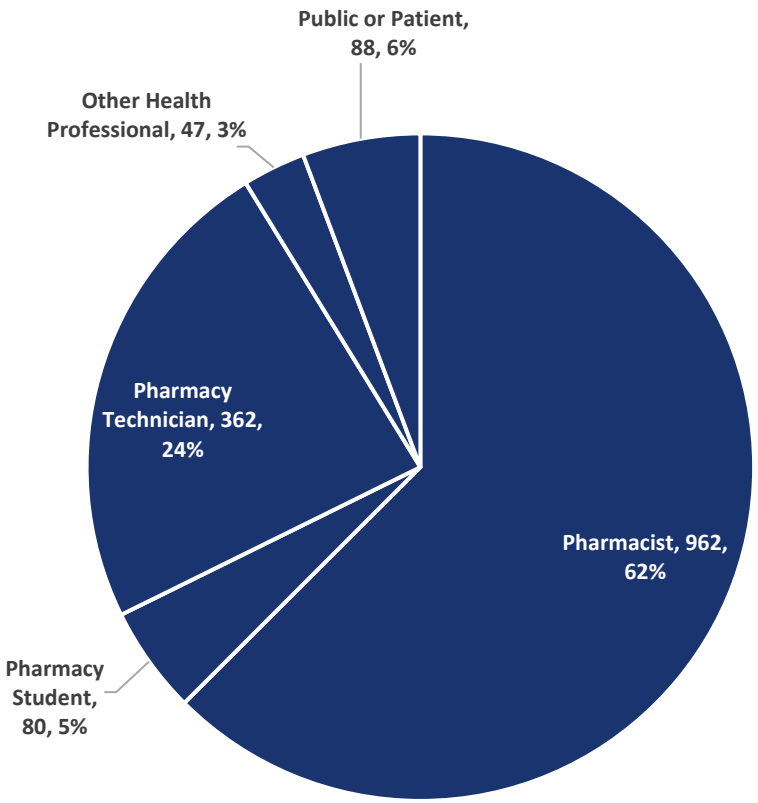
Online Survey

The College's name change survey was shared with all registrants by email. It was also shared with other health regulators, organizations and patient stakeholder groups. The College received 1539 responses to its name change survey.

Survey participants indicated whether they were a pharmacist, pharmacy student, pharmacy technician, other health professional or member of the public. These make up the five respondent groups identified in this report.

Pharmacists (with 962 responses), followed by pharmacy technicians (with 362 responses) had the highest response rate. Those who identified as a patient or member of the public had the third highest response rate.

Online Survey Participation



Social Media

The College used social media to build awareness of the College name change online engagement and encourage those interested to participate in the survey. College name change posts on Twitter and Facebook were viewed over 130,000 times (impressions). Only a small number of comments were shared through social media (less than 5), however this was expected as the primary focus of the social media posts were intended encourage participation in the survey.

ReadLinks Blog

The College published two different ReadLinks articles on the College's website that provided context for the College Name Change Engagement and encouraged participation in the survey.

The first article, *What's in a Name? College Explores Official Name Change*, was published on August 12, 2016 and introduced the College Name Change Engagement. The article received over 770 unique views.

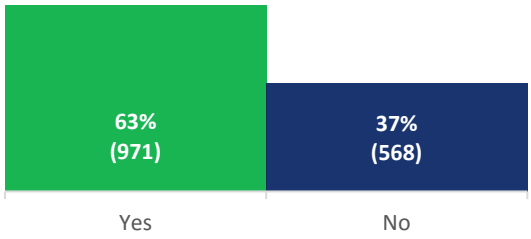
The second article published was a guest post by Pharmacy Technician Society of BC Director Bal Dhillon. In this article, *Guest Post: Thoughts on the College name change*, Bal shared her thoughts on the name change and encouraged others to participate in the survey. The article was published on August 24, 2016 and was viewed by over 370 unique visitors.

Should the College Change its Name?

We asked survey respondents to tell us if the College should pursue changing its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC. Participants were asked to indicate yes or no to the question and were given the opportunity to provide additional comments.

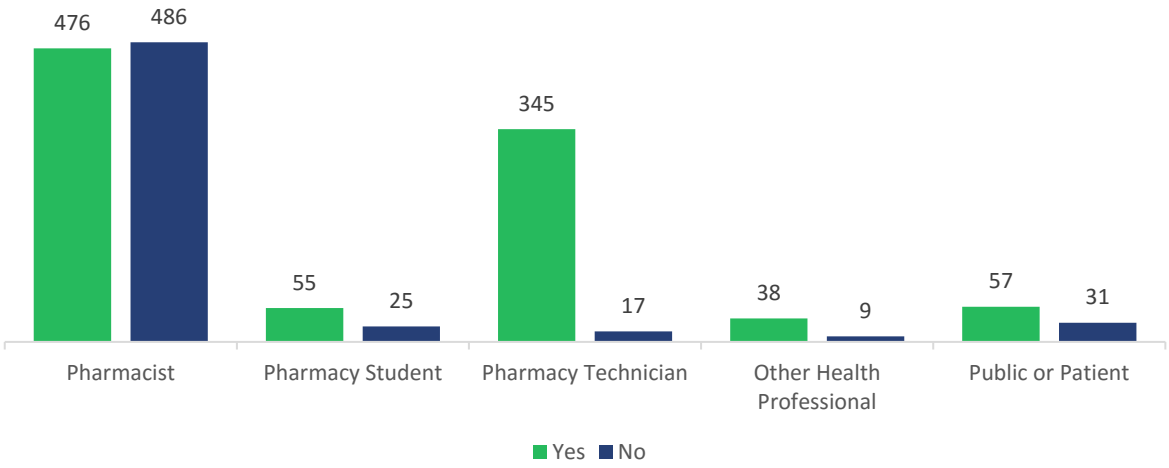
Overall, 63% indicated that the College should change its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC. The remaining 37% did not think that the College should change its name.

Overall Response - Should the College Change its Name?



While the overall response indicated support for a College name change, not every respondent group felt the same way.

Response by Respondent Group - Should the College Change its Name?



Pharmacists

Pharmacist responses on changing the College's name change were split. Out of the 962 responses received from pharmacists, 50.5% indicated the College should not pursue a name change, while 49.5% indicated the College should pursue a name change.

Pharmacy Students

Pharmacy student responses were mostly in favour of a College name change. Of the 80 pharmacy students who responded to survey, 68.8% indicated the College should pursue a name change. The remaining (31.3%) of respondents were not in favor of a name change.

Pharmacy Technicians

Pharmacy technician responses were largely in favour of a College name change. Out of the 362 responses received from pharmacy technicians, 95.3% indicated the College should pursue a name change. Only 4.7% of Pharmacy Technicians who responded to the survey indicated they did not support the College pursuing a name change.

Patients and Members of the Public

Responses from those who identified as a patient or member of the public were mostly in favour of a College name change. Of the 88 responses in this respondent group, 64.8% were in favour of the College pursuing a name change. The remaining (35.2%) of respondents were not in favor of a name change.

Other Health Professionals

Responses from other health professionals were also largely in favour of a College name change. Of the 88 responses received, 80.9% indicated the College should pursue a name change. 19.1% indicated that the College should not pursue a name change.

As a pharmacy tech the current name does not at all represent me. It should be changed.
– Pharmacy Technician

If pharmacy technicians are also regulated, the current name is misleading - not adequately descriptive/inclusive.
– Member of the Public

The name should be changed to BC College of Pharmacy because you also regulate pharmacies as well as the people working in them. – Pharmacist

It's just a name and it's not worth all the overhead costs just to change it. I think the general public assumed, even before technicians were regulated by the College, that technicians fell under this category.
– Member of the Public

I didn't know the College regulated pharmacy technicians. The name is not clear currently.
– Other Health Professional

Time for a fresh and more modern relevant name.
– Member of the Public

Names for Consideration

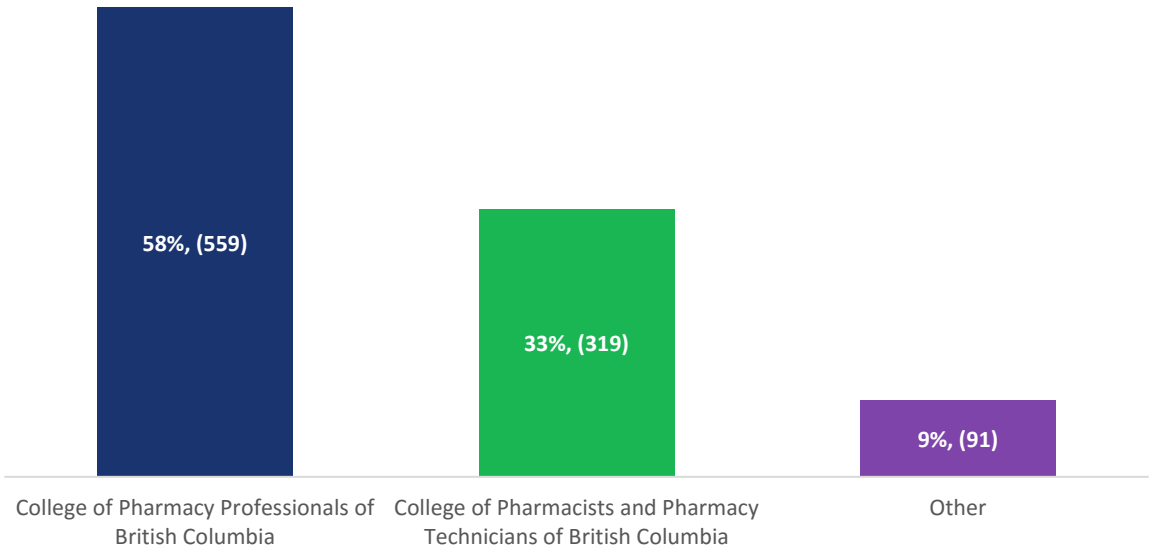
The 971 survey respondents who indicated the College should pursue changing its name were asked which name they would encourage the College to consider.

The options provided were:

- College of Pharmacy Professionals of BC,
- College of Pharmacists and Pharmacy Technicians, and
- Other (with an invite to suggest an alternative name).

Overall the majority of respondents (58%) recommended the name "College of Pharmacy Professionals of British Columbia" for a possible College name change. The name suggestion of "College of Pharmacists and Pharmacy Technicians" was selected by 33% of respondents. The remaining 9% provided alternative suggestions.

Overall Results – Names for Consideration



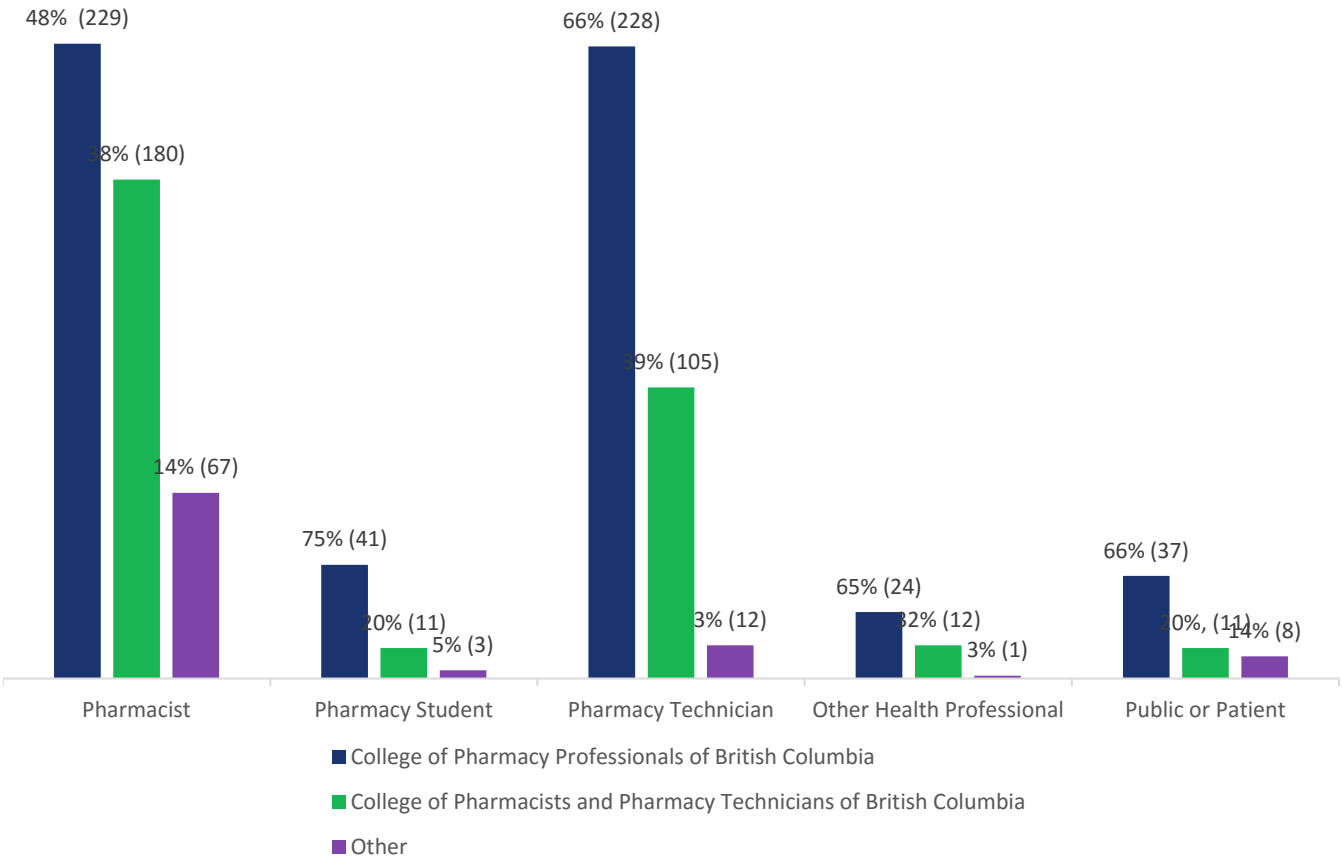
The preference for "College of Pharmacy Professionals of British Columbia" continued across all the respondent groups as the majority consensus. However, the amount of support for names varied.

Pharmacy students had the highest level of support for the name “College of Pharmacy Professionals of British Columbia” with 75% of the respondent group suggesting it for a possible College name change. Both pharmacy technicians and members of the public showed the second most support for this name with 66% of each group recommending it. Other health professionals also indicated 65% support for “College of Pharmacy Professionals of British Columbia”.

Pharmacists were more closely split between the two suggested names for a College name change. Only 48% of pharmacists chose “College of Pharmacy Professionals of British Columbia”.

While the suggested name of “College of Pharmacists and Pharmacy Technicians” did not receive the majority of support from any of the respondent groups, it received just under 40% support from both pharmacy technicians (39%) and pharmacists (38%).

Response by Respondent Group – Names for Consideration

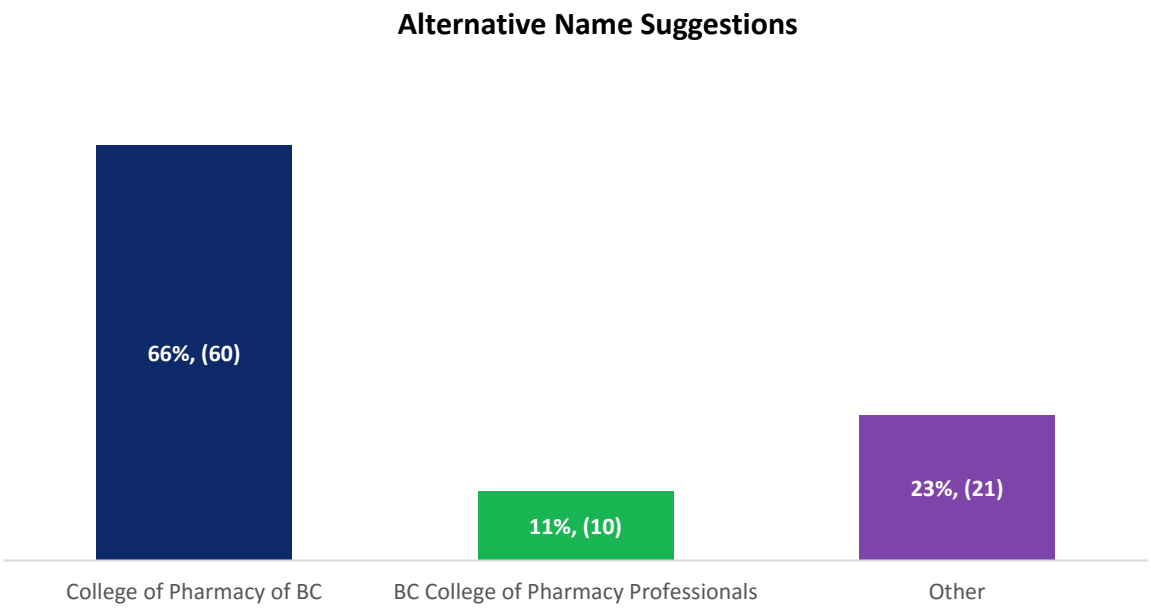


Alternative Name Suggestions

In seeking input on a possible College name change, we also invited respondents to provide us with additional name suggestions. Of the 971 survey respondents who indicated the College should pursue changing its name, 91 chose to provide an alternative name.

Within the alternative names suggestions received there was a clear trend towards "College of Pharmacy BC". Over 65% of the "Other" responses included versions of "College of Pharmacy of BC" or "BC College of Pharmacy".

A smaller trend of 11% (10 out of the 91 responses) suggested changing the order of "BC" to become "BC College of Pharmacy Professionals".



Other name suggestions provided by respondents included:

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- College of Pharmacy Registrants of British Columbia, and
- College of Pharmacy and Pharmacy Affairs.

Comments on Pursuing a College Name Change

The College received over 460 comments through the survey that expressed thoughts on whether the College should pursue changing its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC.

Pursuing a College Name Change

We heard that a name change was important to clarify the College's role in regulating pharmacy technicians to ensure the public recognizes that pharmacy technicians are a regulated health professional that must adhere to the College's *Code of Ethics* and follow legislated requirements. Others felt that accuracy in both name and practice were important. We also heard that the current name could be misleading to the public by only referencing pharmacists. Pharmacy technicians also felt that a name change would build greater awareness of this newly regulated health profession in BC and help address issues that arise when other health professionals and the public are not aware of the scope of practice provided to the profession.

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I didn't know the college regulated technicians. Not clear currently. – Other Health Professional

As a regulated technician, I am strongly in favor of this! College of Pharmacy Professionals has a lovely ring to it! – Pharmacy Technician

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I think College of Pharmacists, pharmacy professionals, doesn't adequately communicate to the public the primary role of the regulating body which is to protect the public. – Pharmacist

I think it is clearer for the public and others to know who what professionals you are regulating. – Other Health Professional

Clarity matters here. The proposed name change would capture the broadened scope and mandate of the College. This particularly important for public perception of the profession and its changing scope of practice. – Other Health Professional

Retaining the College's Current Name

We also heard that some think it is unnecessary to change the College's name – that our name is already well known for its role in regulating all pharmacy professionals in BC. Others felt that the benefit of providing more clarity through a name change would not outweigh the time and cost that would likely be required to change the College's name. Some also felt that a name that reflected both professions could mislead the public into thinking that pharmacists and pharmacy technicians have the same scope of practice.

I do not feel that it is necessary to change the name to include technicians. We are all under the same umbrella of pharmacy. – Pharmacy Technician

I believe the name is already quite clear and aligned with all the other regulatory colleges. – Member of the Public

Technicians are still working under the guidance of, or in co-operation with pharmacists. Leaving the name the same does somewhat reflect that for the general public. As such, I am comfortable with leaving the name the same. I do not, and will not, feel excluded from having the college keep its name unchanged. – Pharmacy Technician

The College should not spend money on a name change, better to spend it elsewhere. – Pharmacy Technician

If there is no chance that implementing this change would lead to an increase in yearly dues then I would say yes to a name change, but if there is a cost associated with the change that could not be covered by the current budget and requires an increase then I do not support a name change. – Pharmacy Technician

It's just a name and it's not worth all the overhead costs just to change it. I think the general public assumed, even before technicians were regulated by the College, that technicians fell under this category. – Member of the Public

I believe the focus should be on the patient - as opposed to the different types of professionals within it. The College of Pharmacists is an established name that is clear to understand. Any name change should be driven by public/patient need/benefit. Unless people are contacting the College with issues about the name, I don't think time and money should be spent changing it. – Member of the Public

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Although it is a great idea to have an inclusive name which will better reflect the role of the College, I personally think the College of pharmacists BC should keep its current name. Instead of going though complex name changing process, the College could work to inform the public and related health professionals about the changed role of the College. – Pharmacy Student

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The name has little bearing on the role of the College to regulate its members. It is also a change that costs significant financial amounts that could be diverted to another effort. – Pharmacy Student

So long as the public is aware of the role of pharmacy technicians and their regulation, the name does not need to be changed. – Pharmacy Student

I don't think it is necessary. I don't think the public is confused by the role the College plays in regulating those working in pharmacies. It would have to be a really good new name! – Other Health Professional

College of Pharmacists
of British Columbia

Honourable Adrian Dix
Minister of Health
Parliament Buildings
Victoria, British Columbia V8V 1X4

June 14, 2018

Re: Request to Amend the Name of the College of Pharmacists of British Columbia

Dear Minister Dix:

As Chair of the Board of the College of Pharmacists of British Columbia, I am writing to you for your consideration of an amendment to our College's official name to the *College of Pharmacy of British Columbia.*

Over the course of the last ten years, the scope of responsibilities of the College has expanded significantly. Regulation of pharmacists is still a core function of the College, but it comprises only one piece of our mandate. Another critically important part of our role has always been to license and regulate pharmacies throughout the province. And, in 2010, the College began to regulate a brand new group of registrants – pharmacy technicians. In addition, this year we began providing more oversight over pharmacy ownership, including non-registrant owners of pharmacies. We now collect and assess information such as criminal record histories of pharmacy owners, and determine if they meet strict eligibility criteria to own a pharmacy.

To fulfill the College's public protection role, it is essential that members of the public know who to turn to, if they have concerns about the delivery of pharmacy care in the province. The current name of the College, with its sole focus on pharmacists, does not provide clarity on the variety of roles of the College in licensing pharmacies, regulating pharmacy technicians, and providing oversight over pharmacy ownership, including the oversight of non-pharmacist owners of pharmacies.

Several Canadian pharmacy regulators have implemented, or are considering, official name changes to better reflect their multiple roles. Recently, the Saskatchewan regulator changed its name from the Saskatchewan College of Pharmacists to the Saskatchewan College of Pharmacy Professionals. In July 2018, the Alberta College of Pharmacists will change its name to the Alberta College of Pharmacy. Similarly, we understand that the new provincial nursing regulator, which will also have a wide range of responsibilities by amalgamating several nursing colleges into one, will be called the British Columbia College of Nursing Professionals.

In 2016, the College reached out to its registrants and members of the public to ascertain their views on a potential College name change. Over 1500 individuals contributed to an online survey on the issue (enclosed is a summary of our findings). Overall, 63% of respondents indicated that the College should change its name to better reflect its role. One of the concerns raised in the survey was that the College's current name could be misleading to the public by only referencing pharmacists.

The College's Board of Directors has acknowledged this issue with the College's name. The Board also recognizes that the Minister of Health is ultimately responsible for the decision to amend the College's name. This authority is included under section 12(2)(a) of the *Health Professions Act*, which states that the Minister of Health may prescribe the name of a college for a health profession, by regulation.

We believe that providing clarity on the multiple responsibilities of the College is essential to our public protection role. If the public does not understand our full scope of responsibilities, it reduces the likelihood that they will reach out to us when they have concerns about pharmacy practice or operations. The College's Board feels strongly that changing our name to the *College of Pharmacy of British Columbia* would better enable the public to understand the multiple ways in which we serve the public interest. Such a change would also be aligned with similar regulatory authorities and what we have heard from registrants and the public on this issue.

We thank you for your time and consideration of this matter. We will be happy to participate in future discussions.

Best Regards,

Mona Kwong, BSc(Pharm), PharmD, MSc
Chair and Board Member

Enclosure

cc: Stephen Brown, Deputy Minister of Health
Bob Nakagawa, Registrar of the College of Pharmacists of British Columbia

College of Pharmacists
of British Columbia

College Name Change

Results of Online Engagement

September 9, 2016

Introduction

In 2010, the responsibilities of the College of Pharmacists of BC were expanded to include regulating pharmacy technicians in BC. Since then, the College's name has not reflected its role in regulating both pharmacists and pharmacy technicians. Several Canadian pharmacy regulators who register pharmacy technicians are facing the same challenge and are considering name changes. Recently, the Saskatchewan regulator changed its official name from the Saskatchewan College of Pharmacists to the Saskatchewan College of Pharmacy Professionals.

The College Board has acknowledged the issue with the College's name. At the same time, the Board also recognizes that the provincial government is ultimately responsible for the decision to change the College's name as it would require a regulatory amendment. It is also clear that there would be a significant amount of work required to complete the name change, which would not take priority over the College's important work in regulating pharmacy and protecting public safety.

The College Board felt that it was important to hear from others on this issue. In September 2015, the College of Pharmacists of BC Board passed a motion for the Registrar to engage with stakeholders on changing the College name and report back at the September 2016 meeting.

The College launched an engagement on a proposed College name change to learn how pharmacy professionals, other health stakeholders and the public feel about a College name change. The online survey was open from August 12 open until September 5, 2016 – providing a three week period for feedback to be submitted.

The survey asks whether the College should pursue changing its name to reflect our role in regulating both pharmacists and pharmacy technicians in BC. It also asks for input on suggested new names for the College.

Over 1500 contributed to the survey during the three week period. We'd like to thank everyone who took the time to share their thoughts on a College name change.

Who We Heard From

The College heard from pharmacy professionals, other health stakeholders and the public through an online survey and through social media.

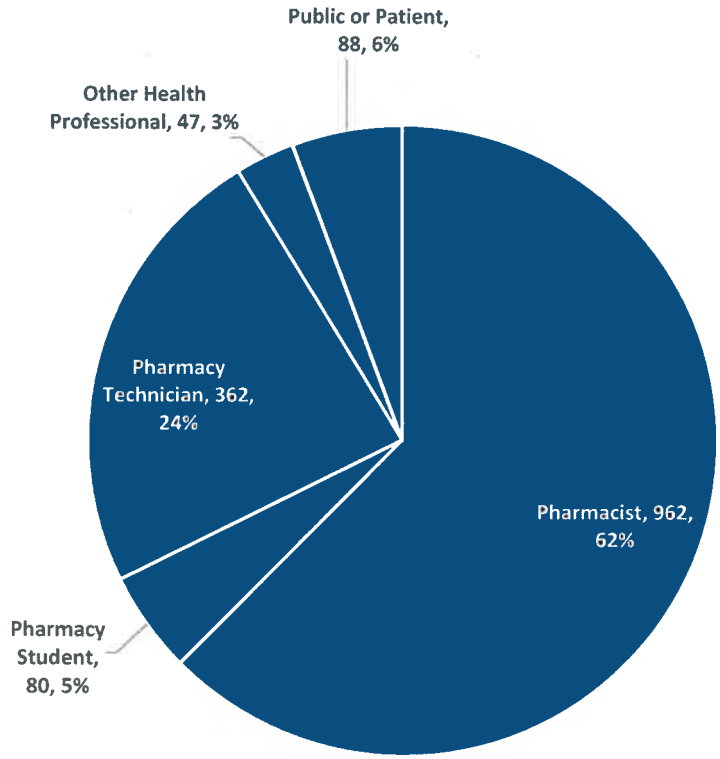
Online Survey

The College's name change survey was shared with all registrants by email. It was also shared with other health regulators, organizations and patient stakeholder groups. The College received 1539 responses to its name change survey.

Survey participants indicated whether they were a pharmacist, pharmacy student, pharmacy technician, other health professional or member of the public. These make up the five respondent groups identified in this report.

Pharmacists (with 962 responses), followed by pharmacy technicians (with 362 responses) had the highest response rate. Those who identified as a patient or member of the public had the third highest response rate.

Online Survey Participation



Social Media

The College used social media to build awareness of the College name change online engagement and encourage those interested to participate in the survey. College name change posts on Twitter and Facebook were viewed over 130,000 times (impressions). Only a small number of comments were shared through social media (less than 5), however this was expected as the primary focus of the social media posts were intended encourage participation in the survey.

ReadLinks Blog

The College published two different ReadLinks articles on the College's website that provided context for the College Name Change Engagement and encouraged participation in the survey.

The first article, *What's in a Name? College Explores Official Name Change*, was published on August 12, 2016 and introduced the College Name Change Engagement. The article received over 770 unique views.

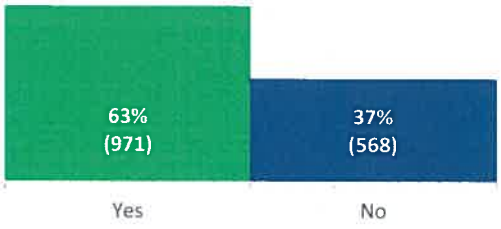
The second article published was a guest post by Pharmacy Technician Society of BC Director Bal Dhillon. In this article, *Guest Post: Thoughts on the College name change*, Bal shared her thoughts on the name change and encouraged others to participate in the survey. The article was published on August 24, 2016 and was viewed by over 370 unique visitors.

Should the College Change its Name?

We asked survey respondents to tell us if the College should pursue changing its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC. Participants were asked to indicate yes or no to the question and were given the opportunity to provide additional comments.

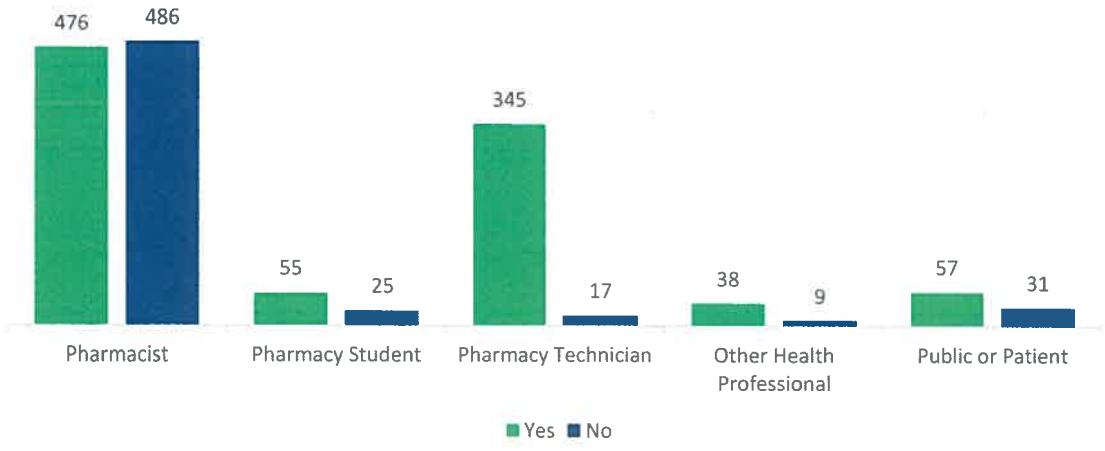
Overall, 63% indicated that the College should change its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC. The remaining 37% did not think that the College should change its name.

Overall Response - Should the College Change its Name?



While the overall response indicated support for a College name change, not every respondent group felt the same way.

Response by Respondent Group - Should the College Change its Name?



Pharmacists

Pharmacist responses on changing the College's name change were split. Out of the 962 responses received from pharmacists, 50.5% indicated the College should not pursue a name change, while 49.5% indicated the College should pursue a name change.

Pharmacy Students

Pharmacy student responses were mostly in favour of a College name change. Of the 80 pharmacy students who responded to survey, 68.8% indicated the College should pursue a name change. The remaining (31.3%) of respondents were not in favor of a name change.

Pharmacy Technicians

Pharmacy technician responses were largely in favour of a College name change. Out of the 362 responses received from pharmacy technicians, 95.3% indicated the College should pursue a name change. Only 4.7% of Pharmacy Technicians who responded to the survey indicated they did not support the College pursuing a name change.

Patients and Members of the Public

Responses from those who identified as a patient or member of the public were mostly in favour of a College name change. Of the 88 responses in this respondent group, 64.8% were in favour of the College pursuing a name change. The remaining (35.2%) of respondents were not in favor of a name change.

Other Health Professionals

Responses from other health professionals were also largely in favour of a College name change. Of the 88 responses received, 80.9% indicated the College should pursue a name change. 19.1% indicated that the College should not pursue a name change.

As a pharmacy tech the current name does not at all represent me. It should be changed.
– Pharmacy Technician

If pharmacy technicians are also regulated, the current name is misleading - not adequately descriptive/inclusive.
– Member of the Public

The name should be changed to BC College of Pharmacy because you also regulate pharmacies as well as the people working in them. – Pharmacist

It's just a name and it's not worth all the overhead costs just to change it. I think the general public assumed, even before technicians were regulated by the College, that technicians fell under this category.
– Member of the Public

I didn't know the College regulated pharmacy technicians. The name is not clear currently.
– Other Health Professional

Time for a fresh and more modern relevant name.
– Member of the Public

Names for Consideration

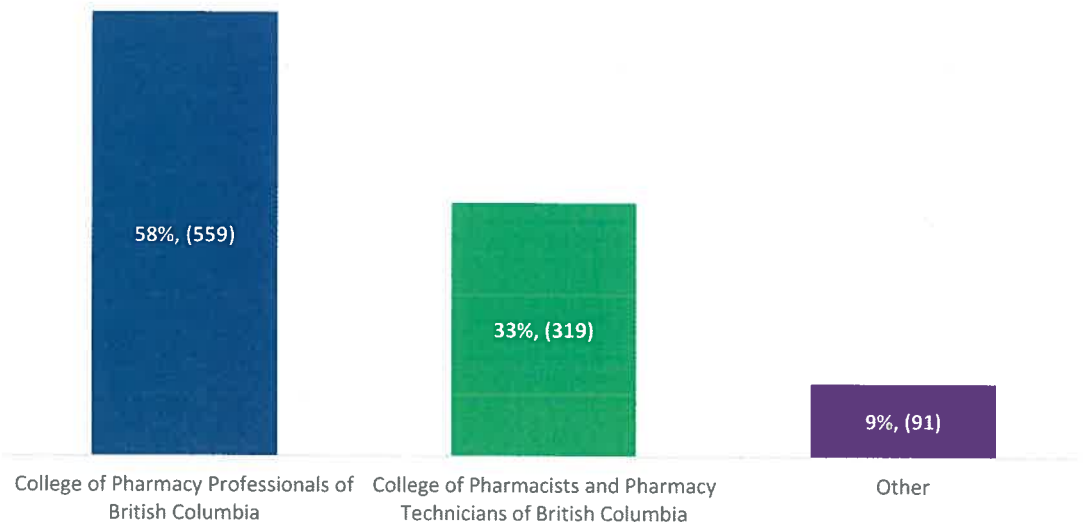
The 971 survey respondents who indicated the College should pursue changing its name were asked which name they would encourage the College to consider.

The options provided were:

- College of Pharmacy Professionals of BC,
- College of Pharmacists and Pharmacy Technicians, and
- Other (with an invite to suggest an alternative name).

Overall the majority of respondents (58%) recommended the name "College of Pharmacy Professionals of British Columbia" for a possible College name change. The name suggestion of "College of Pharmacists and Pharmacy Technicians" was selected by 33% of respondents. The remaining 9% provided alternative suggestions.

Overall Results – Names for Consideration



The preference for "College of Pharmacy Professionals of British Columbia" continued across all the respondent groups as the majority consensus. However, the amount of support for names varied.

Pharmacy students had the highest level of support for the name "College of Pharmacy Professionals of British Columbia" with 75% of the respondent group suggesting it for a possible College name change. Both pharmacy technicians and members of the public showed the second most support for this name with 66% of each group recommending it. Other health professionals also indicated 65% support for "College of Pharmacy Professionals of British Columbia".

Pharmacists were more closely split between the two suggested names for a College name change. Only 48% of pharmacists chose "College of Pharmacy Professionals of British Columbia".

While the suggested name of "College of Pharmacists and Pharmacy Technicians" did not receive the majority of support from any of the respondent groups, it received just under 40% support from both pharmacy technicians (39%) and pharmacists (38%).

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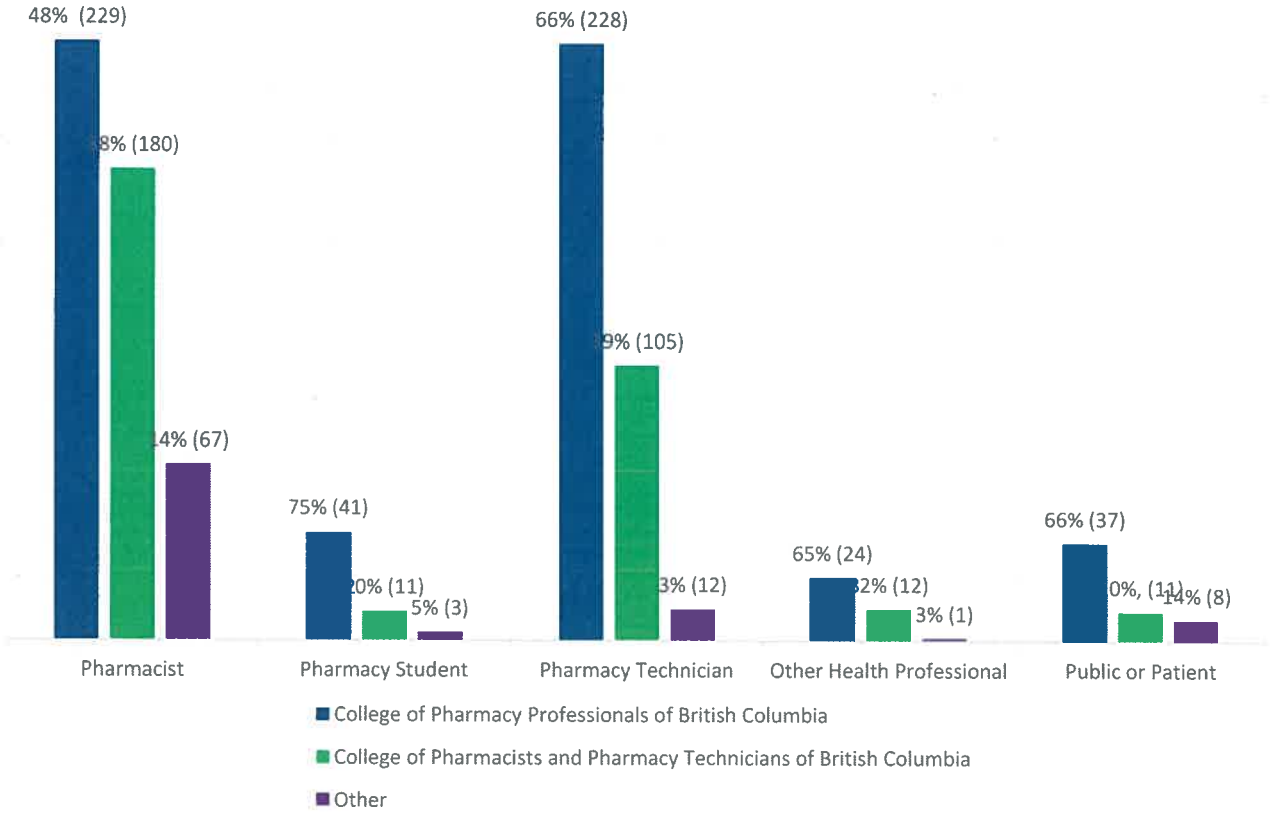

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In seeking input on a possible College name change, we also invited respondents to provide us with additional name suggestions. Of the 971 survey respondents who indicated the College should pursue changing its name, 91 chose to provide an alternative name.

Within the alternative names suggestions received there was a clear trend towards "College of Pharmacy BC". Over 65% of the "Other" responses included versions of "College of Pharmacy of BC" or "BC College of Pharmacy".

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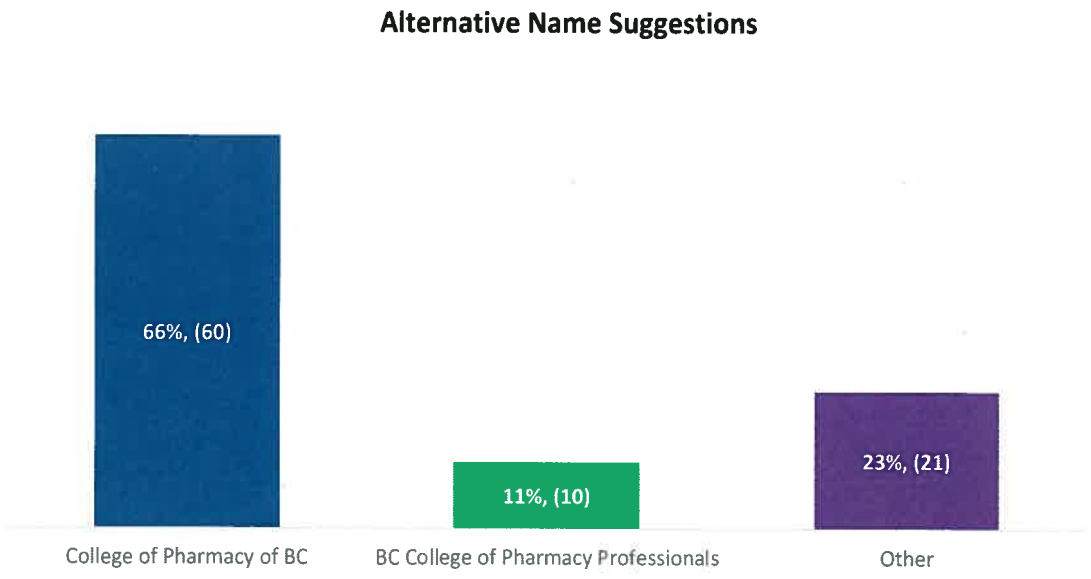

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Other Comments

Some respondents suggested that separate Colleges for the different regulated health professional roles in pharmacy would help provide clarity. This suggestion is outside of the scope of the College Name Change Engagement and is not an option the College is considering pursing.

Each profession should have its distinct and independent regulator. – Member of the Public

I feel that such a name change will confuse the public as to what the technicians do and what the pharmacists do. I would prefer a separate lineage for technicians. – Pharmacy Student

The College of Pharmacists has proudly served the public for many years and it should remain a prestigious College as it so named. A separate College of Pharmacy Technicians should be created to govern a profession that so often be confused as "pharmacists". The service I received from a technician at a drugstore has been quite different than from a pharmacist. Grouping it together create an expectation that would be too high for the public and oversight will follow if you are talking to a technician. – Member of the Public

Conclusion

The majority of feedback to the College's Name Change Engagement suggested that the College should consider changing its name to better reflect the College's role in regulating both pharmacy technicians and pharmacists in BC. However, feedback also emphasized that the College should take into consideration the time and cost that may be involved in completing an official name change.

"College of Pharmacy Professionals of British Columbia" received the most support from survey respondents as a new name for consideration. Consideration should also be given to the alternative name suggestion of "College of Pharmacy of BC" which was the clear consensus among those who suggested other names and reflects the College's regulation of both pharmacy professionals and pharmacies.

The results of the this Name Change Engagement will provide the College Board with valuable feedback from pharmacy professionals, other health stakeholders and the public that can aid in Board discussions and decision making. Ultimately, the Provincial Government is responsible for the decision to change the College's name. This report is intended to assist the Board in forming a decision on whether to begin discussions with the Provincial Government's Ministry of Health on a College name change.

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BRITISH COLUMBIA

AUG 29 2018

1116358

Ms. Mona Kwong, BSc(Pharm), PharmD, MSc
Board Chair
College of Pharmacists of British Columbia
200 - 1765 W 8th Ave
Vancouver BC V6J 5C6

Dear Ms. Kwong: Mona

Thank you for your letter of June 14, 2018, requesting to amend the name of the College of Pharmacists of British Columbia. I apologize for the delayed response.

I understand that in 2016 the College facilitated a stakeholder engagement process to obtain input on a potential College name change. From the comments provided in the *Results of Online Engagement* document (the Document), it appears that the majority of respondents believe that the current name of the College is not representative of all registrants, that it is not sufficiently descriptive, and may be misleading. However I also acknowledge the support for retaining the College's current name, particularly the point that the College is a well-established entity in pharmacy regulation.

I note from the Document that:

- 91% of all respondents to the survey were pharmacists, pharmacy technicians or pharmacy students;
- 6% of respondents to the survey were members of the public; and.
- the greatest level of support for a change of name for the College came from pharmacy technicians.

I also note that the College's website includes a reference to the College being "committed to regulating – *and accurately representing* – the pharmacy profession." The website further states that a name change would serve to "fully [integrate] pharmacy technicians into the College… and [reinforce their] key role in the profession". This information can be found at the following link: http://www.bcpharmacists.org/readlinks/guest-post-thoughts-college-name-change

Under Section 16 of the *Health Professions Act*, it is the duty of a college at all times to serve and protect the public, and to exercise its powers and discharge its responsibilities under all enactments in the public interest. A college's actions and motivations must be consistent with this in substance. A college has no authority to advocate for a profession, or promote professional identity. It is not clear how a name change which appears to be motivated by a desire to enhance the professional profile of a profession (in this case pharmacy technicians) is consistent with the College's legal duty.

…2

Ministry of Health
Office of the Minister
Mailing Address:
PO Box 9050 Stn Prov Govt
Victoria V8W 9E2
Location:
Parliament Buildings
Victoria

With respect to the time and cost of a name change noted in the Document—that is a significant consideration for government. As you know, a change to the College name would require amendments to the Pharmacists Regulation by government. Such changes would require a three month public posting period, and would need to be made available on the Ministry website, found here: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/professional-regulation

Additionally, amending the name of the College would require consequential legislative and regulatory amendments including (but not necessarily limited to) amendments to the *Health Professions Act, Pharmacy Operations and Drug Scheduling Act*, *Pharmaceutical Services Act*, *Freedom of Information and Privacy Protection Act,* the Pharmacists Regulation, Provider Regulation, and Information Regulation. Such amendments require significant Ministry resources to process and coordinate, and some would require review and approval by Cabinet.

Given the the volume of important and transformative initiatives in the Ministry that serve to protect the public interest and ensure appropriate care for citizens, I am not inclined to initiate a name change for the College of Pharmacists of British Columbia at this time.

I appreciate the opportunity to respond.

Sincerely,

Adrian Dix
Minister

pc: Mr. Stephen Brown, Deputy Minister, Ministry of Health
Mr. Bob Nakagawa, Registrar, College of Pharmacists of British Columbia

College of Pharmacists
of British Columbia

Honourable Adrian Dix
Minister of Health
Parliament Buildings
Victoria, British Columbia V8V 1X4

September 28, 2018

Dear Minister Dix,

Thank you for your letter in response to our request for a College name change.

We appreciate that the Ministry of Health has many priorities and a high volume of initiatives in its work to protect and care for the health of the public in British Columbia.

We'd like to assure you that the College is focused on ensuring the public is aware of our role in protecting public safety through the regulation of pharmacists and pharmacy technicians and the pharmacies where they practice, including the owners of those pharmacies.

While it's clear pharmacy technicians would prefer not be excluded in the College's name, the College's request for a name change is not based on the needs of the profession. We continue to believe that providing clarity on the multiple ways the College is involved in regulating pharmacy practice is essential to our public protection role. If the public does not understand our full scope of responsibilities, it reduces the likelihood that they will reach out to us when they have concerns about pharmacy practice. This is why pharmacy regulators across Canada – most recently Alberta – are moving towards more accurate names to reflect the practices they regulate.

While the College Board is disappointed to hear the Ministry is not interested in exploring a name change at this time, we hope the Ministry will continue to consider a name change at a more opportune time.

Sincerely,

Mona Kwong, BSc(Pharm), PharmD, MSc
Board Chair and Member | College of Pharmacists of BC
www.bcpharmacists.org

College of Pharmacists
of British Columbia

January 10, 2020

Members of the Steering Committee
The Honourable Adrian Dix, M.L.A.
Minister of Health
Ms. Sonia Furstenau, M.L.A.
Health Critic and House Leader for the BC Green Party
Mr. Norm Letnick, M.L.A.
Official Opposition Health Critic

Mark MacKinnon
Executive Director, Professional Regulation and Oversight, Ministry of Health
3rd Floor, 1515 Blanshard Street
PO BOX 9649 STN Prov Govt
Victoria, BC V8V 9P4
PROREGADMIN@gov.bc.ca

Re: Feedback on *"Modernizing the provincial health profession regulatory framework: A paper for consultation"*

Dear Members of the Steering Committee:

As Board Chair and Registrar of the College of Pharmacists of British Columbia ("CPBC"), we are writing to you in response to your request for feedback on *"Modernizing the provincial health profession regulatory framework consultation paper"* ("the consultation paper").

CPBC has a duty to serve the public by regulating pharmacists and pharmacy technicians as well as licensing the pharmacies where they practice, which is aligned with the government's goal of increasing transparency, patient safety, accountability and public confidence in the health profession regulatory framework.

Our Board met on November 29 and December 20, 2019 to discuss the consultation paper and a CPBC response. We have outlined our feedback and recommendations to each consultation question in the attached enclosure to assist with your deliberations.

Similar to the recommendations made by Harry Cayton in his report, *An Inquiry into the College of Dental Surgeons and the Health Professions Act*, many of the proposals in the consultation paper resonated with us, as they reinforced current practices underway at CPBC. Where possible within our response, we have provided recommendations from our perspective as a high-performing college within existing legislation. For example, the consultation paper proposes that regulatory college boards move to a more consistent and smaller size. CPBC's current board is comprised of only twelve members and our feedback is provided with this experience in mind.

Similarly, one of the major themes of the consultation paper is simplifying the complaints and discipline process in order to provide a clear focus on patient safety, public protection and strengthening public trust in regulation. CPBC's current disciplinary process has been developed to be as independent as possible to ensure procedures are objective, impartial and fair and we offer our feedback for best-practices from this experience.

We support amending the *Health Professions Act* or replacing it, to better enable efficient and effective health profession regulation in the public interest. Also, we support moving toward greater public accountability and transparency in line with privacy and human rights legislation. Further, we support increasing public protection and improving the efficiency and effectiveness of regulation. As health care delivery shifts from individual professions to team-based care, the regulatory framework must also evolve. Where there is alignment between professions, amalgamation makes sense for efficiencies. We are supportive of reducing the number of regulatory colleges, but we are concerned that five regulatory colleges may be too few and may result in public confusion due to a lack of alignment amongst amalgamated colleges as currently proposed. Any amalgamation should be conducted to better enable public navigation of health care regulation. We recommend that the Steering Committee consider the contemplated changes through the public lens to guide the rational alignment of colleges. We would suggest that any mergers between existing regulatory colleges should be conducted to increase ease of access and public understanding.

In light of the health care regulation reform work being conducted at this time, the Steering Committee may wish to consider taking a principle-based approach to naming each regulatory body that increases transparency and provides clarity to the public on who to turn to. We recommend that a college name reflect the profession(s) they regulate in order to enhance transparency and support easy patient navigation. In addition, we suggest that the Steering Committee consider replacing the word "College" in each regulatory body's title to avoid confusion with any educational or academic organizations.

We commend the Steering Committee for their foresight and leadership, and for their work to reform health profession regulation in the public interest. We look forward to participating in this consultation process, and we are committed to assisting you in any way that we can.

Please do not hesitate to contact us if you have any questions or if we can be of any further assistance to you in your deliberations.

Best Regards,

Christine Antler, B.Sc., B.Sc.(Pharm.)
Chair and Board Member

Bob Nakagawa, B.Sc.(Pharm.), RPEBC, FCSHP, ACPR
Registrar

Enclosures

cc: David Byres, Associate Deputy Minister, Clinical Leadership

Response to *Modernizing the Provincial Health Profession Regulatory Framework Consultation Paper*

We have organized our response to the consultation paper to align with its five themes: improved governance, improved efficiency and effectiveness through a reduction in the number of regulatory colleges, strengthening the oversight of regulatory colleges, complaints and adjudication, and information sharing to improve patient safety and public trust. Each theme has been broken down into subjects, including the specific proposals and stakeholder consultation questions from the consultation paper. The College of Pharmacists of BC's response is provided for each of these.

Proposal included in *Modernizing the provincial health profession regulatory framework*	**Stakeholder Consultation Questions**	**CPBC Response/Recommendations**
1. Improved Governance		
Competency-based board appointments and balanced board membership		
It is proposed that regulatory college boards have equal numbers of registrant and public members.	**Q1a.** Do you support an equal number (50/50) of public and professional board members?	The College of Pharmacists of BC (CPBC) supports an equal number (50/50) of public and professional board members. The CPBC recognizes the important role of public members on the board in carrying out the College's duty to protect the public. It is also important for the board to have professional expertise to succeed. The proposed equal number (50/50) of public and professional board members provides that balance and reflects the board's commitment to the public.
It is proposed that all board members (registrant and public) be recommended for appointment through a competency-based process, which considers diversity, is independently overseen, and is based on clearly specified criteria and competencies. The Minister of Health would appoint all board members based on the recommendations of the competency-based process.	**Q1b.** Are there any possible challenges to the proposed approach, and if so, how can they be addressed?	The CPBC supports a competency-based process to select all board members. The CPBC recognizes that elections create the potential for misunderstanding, because registrants elected to the board do not serve those who elected them – they serve to protect the public. The CPBC recognizes that a competency-based process would ensure the board is comprised of a diverse group of people with the necessary expertise, skills and knowledge. When establishing criteria for a competency-based appointment process, the CPBC recommends considering geographical, demographic, cultural background, practice area and practice experience (for professional members) as well as governance literacy or board experience. The CPBC also recommends that the competency-based process be a transparent and non-partisan process. We recommend that the Steering

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		Committee utilize any existing best-practices within colleges to develop the competency-based process. As identified in our June 2019 submission to the Steering Committee, we also believe that there are opportunities to help build the capacity of potential board members. The CPBC currently expends considerable resources educating and training board members on their roles. In considering changes to the appointment process, the Steering Committee should consider the use of education and training for appointees before they join a board to help ready them to serve on boards. Providing an appropriate level of education and training to these individuals on the role of boards and board members may assist with developing the capacity to serve more effectively and more quickly on the boards they are appointed to. It will also be important to ensure knowledge transfer by the staggering appointments of all board members in an effort to minimize significant turnover and maintain historical background.
Size of boards		
To improve functioning and effectiveness, it is proposed that regulatory college boards move to a more consistent and smaller size.	**Q1c.** Do you support reducing the size of boards?	The CPBC supports an optimal board size of 12 members. The CPBC's current board is comprised of twelve members and in our experience, this number has produced an effective board with appropriate representation and perspectives. We note that any fewer board members may reduce the board diversity (e.g. varied cultural, regional and practice experience) that supports effective board decision making.
	Q1d. Are there any possible challenges to reducing board size, and if so, how can they be addressed?	The CPBC's current board is comprised of public members, pharmacists and a pharmacy technician, each bringing specific expertise and knowledge to the board. In addition, the CPBC's current election process for professional members ensures different practice areas and regional perspectives are represented on the board. One challenge the CPBC has identified in reducing board size is ensuring a small board has appropriate representation of different professions, practice areas and regions. We would suggest that the Steering

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		Committee consider practice areas and location of practice in the competency-based appointment process in order to ensure a good mix of skills, backgrounds and competencies are represented at the board to better protect the public. Another challenge the CPBC has identified in reducing board size is ensuring efficiency and effectiveness is not reduced by reducing the number of professional members on the board. The CPBC notes that sufficient professional representation is needed on a board to ensure appropriate subject matter expertise at the board table. Sufficient professional representation allows questions to be asked and answered in real time at the board table, rather than having to refer to professional subcommittees and incurring delays and potential loss of insight.
Board member compensation		
It is proposed that board and committee members be fairly and consistently compensated (within and between colleges) and move away from volunteerism.	**Q1e.** Do you support fair and consistent compensation for board and committee members?	The CPBC is generally supportive of fair and consistent compensation for board and committee members. Please see our below comments regarding Q1g outlining our concerns for further explanation.
	Q1f. What are the benefits of this approach?	Fair and consistent compensation for board and committee members, regardless of appointment type, establishes equity among board members and promotes equal contribution and work. Compensation also acknowledges the important work completed by board and committee members and appropriately reimburses them for their time.
	Q1g. What are challenges and how can they be addressed?	When determining a consistent compensation rate between colleges, it will be important to ensure that compensation attracts experienced and competent individuals from all professions. We understand that currently there is a range of compensation rates set across colleges (ranging from no compensation to high compensation). If one compensation rate is determined for all colleges, it will be important to consider a fair level of compensation that allows members from all professions to see the time they invest in board and college activities

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		are valued and worthwhile. Otherwise, individuals from higher-paid professions may not agree to board appointment and individuals from lower-paid professions may apply in higher numbers, motivated by finances rather than contribution. In our view, compensation should reflect what is paid in the profession being regulated and should encourage altruism.
2. Improved efficiency and effectiveness through a reduction in the number of regulatory colleges		
Reduction in the number of regulatory colleges – from 20 to five		
To increase public protection, and improve efficiency and effectiveness of regulation, a reduction in the number of regulatory colleges from 20 to five is proposed. Maintain: • College of Physicians and Surgeons of B.C. • College of Pharmacists of B.C. • B.C. College of Nursing Professionals. Create: • oral health regulatory college • College of Health and Care Professions of B.C.	**Q2a.** Are you supportive of the proposed approach to reduce the number of regulatory colleges from 20 to five?	The CPBC supports increasing public protection and improving the efficiency and effectiveness of regulation. The province is moving toward interdisciplinary teams of health care professionals to better meet the health care needs of patients and families. As health care delivery shifts from individual professionals to team-based care, the regulatory framework must also evolve. Where there is alignment between professions, amalgamation makes sense for efficiencies. Five regulatory colleges may be too few. We believe that a single College of Health and Care Professions may result in public confusion due to lack of alignment amongst amalgamated colleges as currently proposed. Any amalgamation should be conducted to better enable public navigation of health care regulation. Amalgamation of aligned colleges may present opportunities to educate the public and registrants on the public protection role of colleges rather than the existing focus on complaints and discipline. The CPBC recommends developing a framework using the public lens to guide the rational alignment of colleges. We suggest that the Steering Committee give some consideration to developing a framework that considers the impact on the public, alignment in models of care or other commonalities and the likelihood of enhanced efficiencies.
	Q2b. Please share your concerns with this approach,	The CPBC is supportive of increasing public protection and improving the efficiency and effectiveness of regulation. However, removing self-regulation

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
	as well as your suggestions to address challenges.	entirely (or restricting it), may hamper the board to use its professional experience to ask the right questions, particularly in cases of multi-disciplinary Colleges. A proposed suggestion could be to reduce the number of colleges by grouping professions or realm of practice. In addition, in order to ensure ease of navigation of the system by members of the public, the Steering Committee may wish to consider the importance of college titles or communication strategies to assist the public in identifying which college to refer to regarding different professionals. For instance, the proposed 'College of Health and Care Professionals', will likely have over 22,000 registrants from eleven different professions, none of which are identifiable within the proposed name. In fact, 'Health and Care Professionals' could arguably encompass *all* health professions in the province.
Given the current commitment to a reduction in the number of regulatory colleges, it is proposed that any new health professions be regulated by an existing regulatory college or the new College of Health and Care Professions.	**Q2c.** Are you supportive of a moratorium on the creation of new regulatory colleges?	The CPBC is supportive of a moratorium on the creation of new regulatory colleges given the proposed commitment to a reduction in the number of regulatory colleges. However, the Steering Committee may wish to consider ensuring flexibility, when necessary, to allow new professions to enter regulation in the future by developing a process and framework to assess for their "fit" within existing regulatory bodies.
Legislative change to support amalgamations		
The creation of broader legislated merger provisions to minimize disruption resulting from future amalgamations is proposed.	**Q2d.** Do you have suggestions for ways to minimise the disruption caused by a merger of regulatory colleges that can be addressed through broader legislative provisions?	The CPBC acknowledges that merging regulatory colleges will likely cause a level of disruption. The Steering Committee may wish to consider clear communication to existing staff and the public, and establishing clear transition timelines. This is a lengthy project that requires existing regulation to continue during the transition period, so there should also be clear communication to registrants on the matter.
Subcommittees to ensure clinical expertise		

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
It is proposed that sub-committees will be created within multi-profession regulatory colleges to address matters requiring profession-specific clinical expertise.	**Q2e.** The importance of and continued reliance on profession-specific clinical expertise is acknowledged as an important element of effective regulation; for example, in the development of professional standards. Where is profession-specific experience required to ensure effective regulation?	The CPBC agrees with the importance of and continued reliance on profession-specific clinical expertise. In our experience, profession-specific expertise aids in all areas of effective regulation, providing context and essential information to decision-making on committees and college program areas such as: complaints and investigation, practice review, registration, policy and legislation. The CPBC notes that the consultation paper states that board members will be unable to serve on subcommittees. The CPBC recommends that board members be allowed to serve on subcommittees to ensure alignment of subcommittee activities with college mandates.
3. Strengthening the oversight of regulatory colleges		
Creation of a new oversight body with the following responsibilities is proposed: 1. Routine audits of regulatory colleges based on clear performance standards. 2. Public reporting on common performance standards. 3. Conducting systemic reviews and investigations. 4. Review of registration and complaint investigation decisions. 5. Publishing guidance on regulatory policy and practice. 6. Identify core elements of shared standards of ethics	**Q3a.** Do you support the creation of an oversight body?	The CPBC supports enhanced accountability of the Ministry of Health to the Legislative Assembly. However, the CPBC is concerned that the oversight body may increase bureaucratic overhead by adding an extra layer of accountability. Steps should be taken to prevent duplication/redundancy in the accountability structure, and the Steering Committee should consider the burdens and the costs of added bureaucracy. The CPBC recommends considering establishing the oversight body as a standard-setting body rather than a governing body over all colleges. The steering committee may also wish to consider making some of the functions of the oversight body a temporary measure only through the transition to a reduction in the number of regulatory colleges. The Steering Committee may wish to reconsider after amalgamations have occurred whether all functions of the oversight body are necessary on an ongoing basis.
	Q3b. Do you agree with the functions listed above?	The CPBC generally agrees with the functions listed as responsibilities of the new oversight body. Please see our comments directly below regarding Q3c outlining our concerns for further explanation.

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
and conduct across professions. 7. Establishing a range of standards of professional practice. 8. Development of model bylaws and oversight of the process for the bylaw amendments. 9. Overseeing a board member appointment process. 10. Recommending health occupations that should be regulated under the *Health Professions Act*. 11. Holding a list (single register) of all regulated health professionals. 12. Oversight of systemic progress on timeliness of the complaint process. 13. Collection of fees.	**Q3c.** Do you have any concerns and if so, what are they?	In regard to function 7 of the oversight body, the CPBC recommends clarifying which standards of professional practice will be established by the oversight body. In regard to function 9 of the oversight body, please see our previous comments regarding establishing a competency-based board member appointment process outlined in our response to improved governance (theme one). In regard to function 11 of the oversight body, that proposes the creation of a single register of all regulated health professionals, the CPBC recognizes the importance of an online list of all regulated health professionals that is publicly-accessible and easy to search. The register of the colleges is foundational to their work. At our college, we use register information within our key functions (e.g., registration, licensure, competency assurance and investigative processes, etc.). In addition to the information required of a register as set out in the *Health Professions Act*, the CPBC's register also contains information gathered under the *Pharmacy Operations and Drug Scheduling Act* such as the names of pharmacy managers. As identified in our June 2019 submission to the Steering Committee, the creation of a single register, while having many benefits, will affect all areas of the colleges. The Steering Committee may wish to consider involving all colleges on the development of a single register to ensure all technical and functional aspects are considered. In regard to function 13 of the oversight body, the CPBC is concerned that the collection of fees to support the oversight body may mean increasing registrant fees. The CPBC recommends that funding of the oversight body be independent of registrants to minimize expectations or pressures from health professionals or health service corporations and influence from different government political mandates. The Steering Committee may wish to consider a model

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		similar to the Office of the Ombudsperson which is funded through the Legislative Assembly.
Increased accountability to the Legislative Assembly		
It is proposed that annual reports of regulatory colleges and the oversight body be provided to the Legislative Assembly by the Minister of Health.	**Q3d.** Do you support increased accountability by requiring regulatory colleges' annual reports to be filed with the Legislative Assembly?	The CPBC supports increased accountability of the regulatory colleges through the filing of annual reports to the Legislative Assembly. As indicated in our June 2019 submission to the Steering Committee, we also believe colleges would benefit from clear expectations from the government with respect to the type of information that must be included in annual reports. This would be especially important once annual reports are filed with the Legislative Assembly, allowing for comparison across the colleges.
	Q3e. Should annual reports of the oversight body also be filed with the Legislative Assembly?	The CPBC supports requiring the oversight body to file annual reports to the Legislative Assembly.
4. Complaints and adjudication Simplifying the complaints and discipline process is proposed in order to provide a clear focus on patient safety, public protection and strengthening public trust in regulation.		
New independent discipline process		
A new disciplinary process is proposed in which independent discipline panels would make decisions regarding regulated health professionals.	**Q4a.** Do you support the creation of a new disciplinary process which would be independent from regulatory colleges?	The CPBC supports the creation of a disciplinary process independent from regulatory colleges. The CPBC's current disciplinary process is informed by current legislation and has been developed to be as independent as possible to ensure procedures are objective, impartial and fair. For example, the CPBC's discipline committee is comprised of entirely different members than the inquiry committee. In addition, the discipline committee is supported by external legal counsel, so the only communication the discipline committee has with the CPBC is regarding meeting or hearing logistics (scheduling, date and time, etc.) and reimbursement.

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		The CPBC appreciates that the proposed disciplinary process would ensure professional expertise on discipline panels. The CPBC supports including at least one health professional with clinical competence in the same health profession as the registrant facing the hearing. In the CPBC's experience, professional members are essential to discipline panel deliberation, providing context and explanation to the issues in question. A similar practice is currently used by the CPBC as the discipline committee must be comprised of at least one public member and at least one pharmacist for a pharmacist hearing and one pharmacy technician for a pharmacy technician hearing.
	Q4b. What are the benefits of such an approach?	A disciplinary process in which independent discipline panels make decisions regarding regulated health professionals eliminates any bias or appearance of bias with the creation of a neutral hearing process separate from the regulatory body. It would also increase public trust and provide consistency across all regulated health professions.
	Q4c. What are possible challenges and ways to address these?	The Steering Committee may wish to consider how costs are processed and distributed. The Steering Committee may also wish to consider the need for procedural fairness with respect to other non-health disciplines serving the public.
Regulatory college roles in the complaints process		
Regulatory colleges and their inquiry committees would continue to be responsible for the investigation of complaints. This will assure professional expertise in the investigation of complaints.	**Q4d.** Do you support regulatory colleges continuing to investigate complaints regarding health professionals?	The CPBC supports regulatory colleges continuing to investigate complaints. We believe it is essential to the investigation that the investigator have professional expertise and knowledge. Investigators are responsible for conducting a fair investigation and for drafting a recommendation for the inquiry committee's disposition with reasons in each case. To do this, investigators must have a thorough understanding of college requirements (relevant legislation, bylaws, standards of practice, etc.) as well as professional experience in order to identify any practice deficiencies and assess the severity of public safety risk.

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
	Q4e. Do you support improvements to the composition of inquiry committees? Note: "improvements" include – membership considers competence, merit and diversity, members undertake regular training/appraisal	The CPBC supports the proposed improvements to the composition of the inquiry committee. The CPBC's current process of appointing members to the inquiry committee is already competency-based, requiring an application and the use of a criteria matrix to determine a candidate's suitability for the position. In addition, current legislation mandates that one third of the inquiry committee be public members. When determining improvements to the composition of inquiry committees, the CPBC recommends that the appointment process for any professional members also include consultation with the appropriate college in order to ensure that the appointee is in good standing.
Transparency		
It is proposed that actions taken to resolve accepted* complaints about health professionals be made public. *Accepted complaints are those that are not dismissed, and where some action is being taken as a result of the complaint.	**Q4f.** Do you support publishing actions taken to resolve accepted complaints about health professionals?	The CPBC generally supports publishing actions taken to resolve accepted complaints about health professionals. The Steering Committee may wish to consider developing criteria to establish a threshold for evidence and/or severity of the complaint prior to publication. In addition to complete information, there should be a consistent, standardized and plain language summary of the outcome including the issue, actions taken, etc. which focuses on making this information meaningfully accessible to the public. There should also be standardized tracking of complaints issues and increased metadata on types of complaints (sexual assault, assault, racism, etc.). The CPBC notes that the proposed transparent process is similar to the current court system.
	Q4g. Do you support all actions resulting from agreements between	The CPBC supports being as transparent as possible. When discussing whether to support all actions resulting from agreements between registrants and regulatory colleges to become public, two sides to this issue emerged and were discussed extensively. The board was unable to reach consensus on this topic.

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
	registrants and regulatory colleges being public?	Key points on either side of the discussion are included below for the Steering Committee's consideration. ***Complete Transparency*** Complete transparency is necessary to gain public trust, and all actions resulting from agreements between registrants and the regulatory college should be made public because: • The decreasing societal acceptance of non-transparency; • Patients can only make informed choices about care providers with full information; • Public interest – not all colleges handle complaints and adjudication well; and • Impetus for the Cayton inquiry was lack of public trust in self-regulation and the perception of "closed-door" decision making. ***Transparency Commensurate with Seriousness of Incident*** The current process, which provides transparency proportional to the seriousness of the incident, should be maintained because: • This allows public disclosure of case information and registrant name when necessary; • There is already full transparency between complainant and registrant throughout the complaints process where the complainant could disclose case information to the media if they so choose; • It considers rehabilitation and restitution; • Consent agreements, which may preserve the anonymity of the registrant involved, are valuable for expediency which creates increased public confidence in health care; and • Privacy laws must be upheld.
Enable regulatory colleges to make public comments about known complaints		

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
It is proposed that regulatory colleges be able to make limited public comments if a complaint under investigation becomes known to the public.	**Q4h.** Do you support allowing regulatory colleges to make limited public comments about a complaint under investigation if the complaint becomes known to the public?	The CPBC is generally supportive of allowing regulatory colleges to make limited public comments about a complaint under investigation. We recognize that commenting on a complaint under investigation will increase transparency and public confidence. The CPBC agrees with the structured model of the Law Society of British Columbia (as identified in the consultation paper) which permits that the Law Society *may* disclose the existence of a complaint, subject matter, status and any interim undertakings when necessary.
	Q4i. What are the benefits of such an approach?	The CPBC recognizes that acknowledging a complaint under investigation may provide transparency to the public on the investigation process. If following the Law Society model, acknowledgement would not be an obligation and college discretion would be permitted.
	Q4j. What are the challenges, and how can these be addressed?	Acknowledging a complaint under investigation can impose professional consequences for the registrant involved prior to the completion of a fair investigation. At the investigation phase, nothing has been proven. The Steering Committee may wish to establish criteria such as subject matter, level of risk and level of public interest, for determining whether to release information regarding any issues if there is compelling public interest to disclose.
Ensuring past conduct is considered		
In order to better protect patients from harm, it is proposed that complaint and discipline decisions must take into consideration the professional's past history.	**Q4k.** Do you support requiring that regulatory colleges and disciplinary panels consider a registrant's past history of complaints and discipline when making decisions on a current complaint?	The CPBC supports requiring regulatory colleges and disciplinary panels to consider a registrant's relevant past history of complaints and discipline when making decisions on a current complaint. We recognize that considering a professional's past history ensures that repeat offenders are identified and appropriately handled.

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
	Q4l. What are the benefits of such an approach?	The CPBC believes that considering a professional's relevant past history assists the inquiry committee in making informed decisions based on all available information. Considering a professional's relevant past history addresses chronic behaviour and making the best decision to protect the public from future harm.
	Q4m. What are the challenges and how can they be addressed?	The CPBC recognizes that considering a professional's relevant past history could create bias or the appearance of bias among panel members. However, we believe any real or perceived bias could be addressed through thorough reasoning within the committee's decision.
Responses to sexual abuse and sexual misconduct		
The steering committee is seeking feedback to help establish consistency across regulatory colleges in relation to how they address sexual abuse and sexual misconduct.	**Q4n.** What measures should be considered in relation to establishing consistency across regulatory colleges regarding how they address sexual abuse and sexual misconduct?	The CPBC supports adopting specific measures to address sexual abuse by health professionals to create consistency across all regulatory colleges. In general, this should include trauma-informed care and cultural humility and safety training. It would also be important for measures to be transparent in order to build public confidence. In regard to requiring mandatory cancellation of practice for sexual abuse, the CPBC recommends recognizing that there is a spectrum of severity, and decisions should be "right-touch" based on the seriousness of each individual case. The CPBC notes that requiring a mandatory cancellation for sexual abuse identifies sexual abuse as different from other serious matters that may also be at the same spectrum of severity related to public safety such as racism or other forms of violence. In regards to requiring regulatory colleges to fund counselling for victims, the CPBC agrees overall that there should be support for counselling and support for victims. However, we recommend that it may be more appropriate for funding to come from British Columbia's existing resources for victims (such as the Crime Victim Assistance Program).

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
5. Information sharing to improve patient safety and public trust		
It is proposed that health profession regulatory colleges be enabled to share information (between each other and with other agencies) where necessary for public safety and protection.	**Q5a.** What are the benefits of enabling regulatory colleges to more easily share information?	The CPBC supports enabling regulatory colleges to more easily share information where necessary for public safety and protection. Increased communication among colleges likely produces more efficient regulation and also reflects the current and increasing team-based care approach to health care. Increased collaboration between colleges and looking at incidents and opportunities for improvements across the continuum of health care can be beneficial. In addition, by having the opportunity to share best practices, colleges can help each other better protect the public. The CPBC also believes that this will help remove barriers and challenges the public faces in making complaints where multiple different health professionals are involved. As outlined in our June 2019 submission to the Steering Committee, currently, the *Health Professions Act* limits colleges regarding what investigation information they can share with other colleges on the same issue. For instance, if a patient makes a complaint about one matter that involved a physician, nurse and pharmacist, the complaint would proceed to three different colleges who would each investigate their registrant only. Each college would carry out their own investigation, and could not share investigative approaches, findings or recommendations. This not only creates inefficiencies, but also reduces the ability of the colleges to learn from each other, and often causes frustration to the patient who made the complaint. As such, the CPBC believes investigations would be more efficient and effective if the colleges were permitted to share information amongst each other on related matters. With the commonality of team-based care and a collaborative approach to health care, this issue is only likely to increase in the future and it is therefore timely to implement amendments to the *Health Professions Act* on this issue now. Sharing complaint information would make it easier for the public to participate in the complaints process and only require the public to make one

Proposal included in *Modernizing the provincial health profession regulatory framework*	Stakeholder Consultation Questions	CPBC Response/Recommendations
		complaint (rather than having to repeatedly tell their story) aiding in reducing duplicative trauma and any stress associated with making multiple complaints.
	Q5b. What are the challenges of this approach and how can they be addressed?	While the CPBC is supportive of enabling regulatory colleges to more easily share information, a process should be developed in line with applicable privacy legislation for sharing and ensuring the confidentiality and security of information to avoid any privacy breaches.
	Q5c. What organizations should regulatory colleges be able to share information with in order to protect the public from future harm, or address past harms?	Other organizations that the CPBC thinks regulatory colleges should share information with in order to protect the public from future harm, or address past harms include: • Other regulators within BC; • Health Canada; • Law enforcement (e.g. police) both provincially and nationally; • Media, where appropriate; and • Other provincial regulators (especially when considering a registration application from another province).

College of Pharmacists of British Columbia

9. College Name Change

Bal Dhillon

Board Member, District 8

College of Pharmacists of British Columbia

Background

College's Name:

- The College's original name was the Pharmaceutical Association of British Columbia.
- In the late 1960s this name was changed to the current name, the College of Pharmacists of British Columbia.

Who Can Change the College's Name?

- Under the *Health Professions Act* (HPA), the Minister may prescribe the name of a college for a health profession by regulation.
- This means that a request to change the College's name requires approval from the Minister of Health.

College of Pharmacists of British Columbia

2018 Request for a College Name Change

June 2018

- The College officially requested that the Minister of Health change the College's name to the ***College of Pharmacy of British Columbia.***

August 2018

- The College received a response from the Minister of Health.
- The Minister declined the request for a name change.

September 2018

- The College replied to the Minister of Health.
- The response clarified that the College's motivation to change its name was driven by enhancing public protection.

College of Pharmacists of British Columbia

Anticipated HPA Amendments

- A Steering Committee on Modernization of Health Professional Regulation (the Steering Committee) was established by the Minister of Health to consider how best to modernize health professional regulation in the province.
- The Steering Committee released two key reports:
  - November 2019: *Modernizing the provincial health profession regulatory framework: A paper for consultation*. Feedback was submitted by the College Board.
  - August 2020: *Recommendations to modernize the provincial health profession regulatory framework.*
- The August 2020 report highlights that the naming convention of the colleges may be confusing for the public, as the term 'college' is often associated with education and training institutions.
- The Ministry of Health is currently working on amendments to the HPA, to implement wide-scale changes to health professional regulation in light of the Steering Committee's recommendations.

College of Pharmacists of British Columbia

Options for the Board's Consideration

- Considering the anticipated amendments to the HPA, there are two options for the Board to consider:

  - **Option 1:** Via correspondence from the Board Chair, the College request that the Minister of Health change the College's name to the *College of Pharmacy of British Columbia,* as part the anticipated amendments to the HPA.

  - **Option 2:** Not request a name change at this time.

College of Pharmacists of British Columbia

Recommendation

- Recommend that the Board proceed with Option 1:
  - The College request that the Minister of Health change the College's name to the *College of Pharmacy of British Columbia,* as part the anticipated amendments to the HPA. This could be done via correspondence from the Board Chair.

- This option re-emphasizes that value of the proposed name change to the *College of Pharmacy of British Columbia* as it reduces confusion of who the College regulates, enhances transparency, and is aligned with the Steering Committee's August 2020 report.

College of Pharmacists of British Columbia

9. College Name Change

MOTION:

Request that the Minister of Health change the name of the College of Pharmacists of British Columbia to the College of Pharmacy of British Columbia, as part of the anticipated amendments to the Health Professions Act.

College of Pharmacists of British Columbia

Questions

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

10. Governance Committee
a) Appointment of Board Members to Committees

DECISION REQUIRED

Recommended Board Motion:

Approve College committee member appointments for terms beginning on November 20, 2020, and the removal of committee members, as circulated.

Purpose

To propose the appointment and removal of Board members to certain College committees and the appointment of the Chair and Vice Chair to certain committees.

Background

The College committees are a vital resource to the Board that provide essential advice, expertise, and recommendations that ultimately help inform Board decisions.

Every year, two main processes are undertaken to fill anticipated vacancies on College committees:

- Current eligible Committee members are asked if they would like to be considered for re-appointment; and,
- The College issues a call for applications from pharmacists, pharmacy technicians and the public.

This process was most recently completed in April 2020.

Discussion

The Governance Committee met on October 29, 2020. It reviewed the current roster of committee members and is proposing certain changes to committee membership. The proposed changes are due in part to the Board Chair and Vice Chair election which takes place at every November Board meeting.

The following changes to committee membership and positions are proposed[1]:

Audit and Finance Committee

- Appoint newly elected Board Chair, Claire Ishoy as Member
- Reappoint newly elected Board Vice-Chair, Steven Hopp as Member and Committee Chair
- Reappoint Alex Dar Santos as Member and Committee Vice-Chair
- Reappoint Tracey Hagkull as a Member
- Reappoint Anca Cvaci as Member
- Remove Christine Antler as Member

Governance Committee

- Appoint Christine Antler as a Member, for a 3-year term, ending April 30, 2024.

Past Chairs Advisory Committee

- Appoint Christine Antler as a Member, for a 3-year term, ending April 30, 2024.

Registrar Evaluation & Succession Planning Committee

- Appoint newly elected Board Chair, Claire Ishoy as Member and Committee Chair
- Reappoint newly elected Board Vice-Chair, Steven Hopp as Member and Committee Vice-Chair
- Reappoint Alex Dar Santos as Member
- Reappoint Justin Thind as a Member
- Reappoint Christine Antler as Member
- Remove Christine Antler as Committee Chair
- Remove Anca Cvaci as Member and Committee Vice-Chair

Recommendation

The Governance Committee recommends that the Board approve the appointments of new members to certain College committees, the appointment of the Chair and Vice Chair of certain committees, and the removal of certain committee members, as outlined above.

All recommended appointments are for terms beginning on November 20, 2020 for one year term, unless stated otherwise.

[1] Please note: all terms are 1-year terms, ending at the November 2021 Board meeting, unless stated otherwise.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

10. Governance Committee
b) Approval of 2021 Board Meeting Schedule

DECISION REQUIRED

Recommended Board Motion:

Approve the 2021 Board Meeting Schedule, as circulated.

The Board Meeting Schedule for 2021 is:

Friday, February 19, 2021
Friday, February 26, 2021

Friday, April 23, 2021
Friday, April 30, 2021

Friday, June 18, 2021
Friday, June 25, 2021

Friday, September 17, 2021
Friday, September 24, 2021

Friday, November 19, 2021
Friday, November 26, 2021

CPBC Annual General Meeting
Friday, November 19, 2021

Please note: The Board will meet as the Committee of the Whole during the first Fridays as outlined above. Board meetings will take place on the following Fridays.

College of Pharmacists of British Columbia

10. Governance Committee

Anne Peterson

Chair, Governance Committee

College of Pharmacists of British Columbia

10 a) Appointment of Board Members to Committees

MOTION:

Approve College committee member appointments for terms beginning on November 20, 2020, and the removal of committee members, as circulated.

College of Pharmacists of British Columbia

10 b) Approval of 2021 Board Meeting Schedule

MOTION:

Approve the 2021 Board meeting schedule, as circulated.

College of Pharmacists of British Columbia

BOARD MEETING
November 20, 2020

11. Medical Delegation Request – Heart@Home

DECISION REQUIRED

Recommended Board Motion:

Approve the delegation request to authorize pharmacists involved in the Heart@Home program to administer injections beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician, as delegated by Dr. Steven C. Gordon.

Purpose

To seek Board approval of a Delegation of a Medical Act from Dr. Steven Gordon to pharmacists involved in the Heart@Home program, for the administration of injections beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants.

Background

Delegation of a Medical Act
The College of Physicians and Surgeons of BC ("CPSBC") allows persons other than physicians to be entrusted with performing a medical act via a Delegation of a Medical Act. According to CPSBC guidelines, when a medical act that is outside the scope of practice of another discipline is delegated, the responsibility for that act is shared. The physician who delegates the act still has a responsibility to the patient, and the person who carries out the act must do so with care and diligence and is legally liable if negligent.

Approval Process for Delegating the Authority for Administering Injections of Drugs and Substances Other than for Immunization Purposes
Currently, the administration of injections, except for immunization, is beyond the scope of practice of B.C. pharmacists. Section 4(1)(c.1) of the *Pharmacists Regulation* under the *Health Professions Act* permits pharmacists to administer Schedule I, IA, or II drugs or substances by intradermal, intramuscular or subcutaneous injection. However, section 4.1 of *Pharmacists Regulation* also states that a pharmacist may perform injections only if the College of Pharmacists of BC ("CPBC") establishes the associated standards, limits, and conditions. At this time, the CPBC has only developed standards, limits and conditions for providing immunizations by injection and intranasal route. Therefore, for B.C. pharmacists to provide injections of drugs or substances other than for the purposes of immunizations, the existing Delegation of a Medical Act process between the CPSBC and CPBC must be followed at this time.

Discussion

Heart@Home Delegation Request
The Heart@Home program is a pharmacist-led medication adherence and monitoring program. It involves registered care aids or nurses who visit patients' homes daily for wellness checks and medication adherence monitoring. Patients may require insulin or other injections (i.e., methotrexate, testosterone, B12, post-surgical anticoagulants).

Since the COVID-19 public health emergency, the Heart@Home program has experienced difficulty in securing nursing staff to administer injections due to nursing needs in other sectors of the community and/or having to be put on leave out of precaution due to respiratory symptoms or travel. Program staff are concerned that securing nursing staff will be even more challenging in the fall/winter, when respiratory viruses other than COVID-19 are circulating. In cases when a nurse is unavailable, the Heart@Home program would like to have a pharmacist conduct the home visit and administer injections. Dr. Steven Gordon, a family doctor, has agreed to work in partnership to delegate injection authority to such pharmacists.

More information on the request is included in Appendix 1.

CPSBC Approved Delegation of a Medical Act from Dr. Gordon to Heart@Home pharmacists
On September 30, 2020, the CPSBC Board approved Dr. Gordon's request to delegate to pharmacists involved in the team based Heart@Home program the ability to provide injections to patients beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician (see Appendix 2).

For this delegation request to be effective, the CPBC Board would need to also approve it.

Key Considerations

Key questions for the Board to consider are:

1. Does the request meet the requirements of the approval process of the Delegation of a Medical Act?
2. Does the delegation arrangement (e.g., pharmacists training, etc.) appropriately protect patient safety?

Recommendation

The Board approves the Delegation of a Medical Act from Dr. Steven C. Gordon to pharmacists involved in the team based Heart@Home program for the administration of injections to patients beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician.

Appendix	
1	Delegation Request Letter for Heart@Home
2	CPSBC Approval of Delegation Request

Heart@Home by the Heart Pharmacy Group

Dr Heidi Oetter, Registrar and CEO
College of Physicians and Surgeons of BC
669 Howe St #300, Vancouver BC, V6C 0B4

Bob Nakagawa, Registrar and CEO
College of Pharmacists of BC
1765 W 8th Ave #200, Vancouver BC, V6J 5C6

Dear Dr Oetter,

13 September 2020

As the Clinical Lead for the Heart@Home program, an interprofessional service aimed at managing medication issues on a daily basis to allow people to age at home for as long as possible, I write you to obtain authorization for delegation under the *Health Professions Act* for a select group of pharmacists to administer non-vaccine injections by subcutaneous and intramuscular route.

As you are aware, the current College of Pharmacists of BC *Health Professions Act* Bylaws Schedule F Part 4 restricts the scope of pharmacist-administered medications to immunizations. The College of Pharmacists of BC has applied to rescind the bylaw that limits the scope of pharmacist registrants to administer injections, and allow them to practice to the scope permitted by *Section 4(1)(c.1) of the Pharmacists Regulation* under the *Health Professions Act.* This application is currently under review. Across Canada, BC is among only 4 provinces/territories which restrict pharmacist injection.

Background:

The Heart@Home program is a pharmacist-led medication adherence and monitoring program that has registered care aids or nurses visit patients' homes daily for wellness checks and medication adherence monitoring. The program is introduced to the patient by the Clinical Lead (pharmacist), who provides a holistic assessment of the client to determine their understanding of conditions and medicines, barriers to adherence, and the current success and safety of that person's independent living. Our referrals come from family or community caregivers, physicians, nurses, and hospitalists out of concern that a patients' ability to be adherent to their medications is a primary threat to their capacity to safely live independently. Clinicians, patients, and caregivers provide informed consent prior to initiating services. Monitoring parameters are set by the Clinical Lead following the intake assessment, daily medication administration and monitoring is provided by the registered care aid or nurse, and information is fed back to the Clinical Lead, who effectively communicates arising issues and recommendations to prescribers and family on a regular basis.

Our nurses serve routes where patients require insulin or other injections (ie. methotrexate, testosterone, B12, post-surgical anticoagulants). We have had great success working with prescribers and patients to achieve blood glucose targets for clients living with Type I and Type II diabetes, identify and address adverse reactions to medications or other drug therapy problems, and have postponed the need to move to higher levels of care.

Issue:

Since the COVID-19 pandemic, we have had a number of pinch points in providing this service. Notably, nurses for injection routes have been difficult to hire or maintain because they are needed in other sectors for the community, restricted from working in multiple locations, or had to be put on leave out of precaution due to respiratory symptoms or travel. Our concern grows for the fall/winter of this year when respiratory viruses other than COVID-19 are circulating and will lead to further precautionary leave.

In these instances when a nurse was unavailable, it would otherwise have been reasonable to send a pharmacist familiar with the patient's case (ie. Clinical Lead or other team member if unavailable) to do the home visits to ensure the patients receive medications at the time needed. The prohibitive issue is that many of our patients are unable to self-administer their insulin, even with guidance, due to cognitive or physical limitations threatening their capacity to maintain independence. In Victoria, the jurisdiction in which Heart@Home operates, there are no publicly-funded services to assist patients with daily injections in their homes, and without services like Heart@Home, patients dependent on insulin and unable to self-administer would be kept in hospital or moved directly to assisted living facilities when available.

Proposed Solution:

Our Clinical Lead is a Certified Diabetes Educator, and all pharmacists involved with Heart@Home (4 in Victoria, and 4 in Langford/Colwood area) are required to be certified to administer injections (including First Aid and CPR training). These pharmacists are provided additional education to ensure they possess the clinical competence (knowledge, judgment, and expertise) to guide nurses in making the decisions on when it is necessary and safe to provide injection medications (primarily insulin), how to respond to hyper- and hypoglycemic events, and educate patients and caregivers on appropriate technique for administering and adjusting medication doses. Current regulations only prohibit pharmacists from the act of piercing the skin of the client for the purpose of injecting a non-vaccine medication.

Although having pharmacists administer injections other than immunizations is not the intention of the daily operation of Heart@Home, being able to have a pharmacist team member conduct the occasional visit would allow us to maintain a closer eye on the patients wellness, maintain continuity, and act as backups when nurses are on leave due to unforeseen circumstance including pandemic.

Dr Steven Gordon has kindly agreed to work in partnership to delegate injection authority to pharmacists involved in the Heart@Home program after collaborating with several clients served by this program.

We ask that you consider this application, endorsed by Dr Gordon, to provide us with the delegation of authority that will enable us to continue providing the same level of service to our clients in the event that further difficulty arises due to the pandemic or other unforeseen circumstances.

Thank you for your consideration of our request. Please do not hesitate to contact me for further information.

Andrea Silver, HBSc(Biol&Psych), BSc(Pharm), RPh, CDE
Clinical Lead | Heart@Home
Ph: 250.477.1881 | Fx: 250.477.7672
andreas@heartpharmacy.com

Dr Steven Gordon
Family Doctor | Ross Bay Health Center
Ph: 250.477.5433 | Fx: (250) 477-5431
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College of Physicians and Surgeons of British Columbia
300-669 Howe Street
Vancouver BC V6C 0B4
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Telephone: 604-733-7758
Toll Free: 1-800-461-3008 (in BC)
Fax: 604-733-3503

September 30, 2020

CPSID: 19778

VIA EMAIL (stevencsvhc@gmail.com)

Dr. Steven Gordon
16-1594 Fairfield Rd.
Victoria, BC
V8S 1G1

Dear Dr. Gordon,

We acknowledge receipt and thank you for your letter dated September 13, 2020, requesting authority to delegate to a select group of pharmacists involved in your team-based, pharmacist-led program Heart@Home to administer non-vaccine injections by subcutaneious and intramuscular route.

At its most recent meeting, the Board reviewed your request. We are pleased to inform you that the Board passed the following Resolution:

RESOLVED that the Board approve the request of Dr. Steven C. Gordon (CPSID #19778) to delegate to pharmacists involved in the team based Heart@Home program the ability to provide injections to patients beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician.

We thank you for your inquiry and if you have any questions regarding this correspondence, please do not hesitate to contact the undersigned.

Yours truly,

Heidi M. Oetter, MD
Registrar and CEO

HMO/js
cc: Mr. Bob Nakagawa, Registrar, College of Pharmacists of BC
Mr. Andrea Silver, Clinical Lead, Heart@Home

College of Pharmacists of British Columbia

11. Medical Delegation Request: Heart@Home

Bob Nakagawa

Registrar

College of Pharmacists of British Columbia

Background

- The *"Pharmacists Regulation"* under the HPA allows pharmacists to administer a Schedule 1, 1A or 2 drugs or substances by intradermal, intramuscular or subcutaneous injection or intranasally.
- That regulation also states that a pharmacist *may only* perform those activities if associated standards, limits, and conditions have been established for them.
- At this time, the CPBC has only established standards, limits and conditions about providing *immunizations* by injection or intranasal route.

College of Pharmacists of British Columbia

Background, continued

- Pharmacists may be permitted to administer other drugs and substances by injection via a Delegation of a Medical Act by the CPSBC.
- Key aspects of a Delegation of a Medical Act are:
  - Requires approval by the Boards of both Colleges involved.
  - The responsibility for the act is shared.
  - The physician who delegates the act still has a responsibility to the patient, and the person who carries out the act must do so with care and diligence and is legally liable if negligent.

College of Pharmacists of British Columbia

Delegation Request: Heart@Home

- The College recently received a delegation request.
- Authority would be delegated from a medical practitioner to pharmacists involved in the Heart@Home program to administer injections beyond vaccinations, such as methotrexate, B-12, and post-surgical anticoagulants.

Heart@Home

- A pharmacist-led medication adherence and monitoring program located on Vancouver Island.
- Involves registered care aids or nurses who visit patients' homes daily for wellness checks and medication adherence monitoring.
- Patients may require insulin or other injections (e.g., methotrexate, testosterone, B12, post-surgical anticoagulants).

College of Pharmacists of British Columbia

Delegation Request: Heart@Home, continued

- Since the onset of the COVID-19 pandemic, the Heart@Home program has experienced challenges in hiring/maintaining nursing staff.
- Having pharmacists conduct the occasional visit would allow them to maintain continuity and for pharmacists to act as “back-ups” when nursing staff are not available.
- All pharmacists involved with Heart@Home are:
  - Required to be certified to administer injections; and,
  - Provided with additional education to ensure clinical competence.

College of Pharmacists of British Columbia

Approval Process

Approval:

- The CPSBC approved this delegation on September 30, 2020.
- The final step of the approval process is for the CPBC Board to consider approval of the request.

College of Pharmacists of British Columbia

11. Medical Delegation Request: Heart@Home

MOTION:

Approve the delegation request to authorize pharmacists involved in the Heart@Home Program to administer injections beyond vaccinations such as methotrexate, B-12, and post-surgical anticoagulants based on a patient specific order provided by the attending physician, as delegated by Dr. Steven C. Gordon.