COMMUNITY PHARMACY REVIEW

External to the Dispensary

Reference	Requirement(s)
PODSA Bylaws s.27(2)(a)	The registrar is notified of the hours during which a full pharmacist is not present.
PODSA Bylaws s.27(2)(f)	The hours when a full pharmacist is on duty are posted.
PODSA s.4.1(2)	The manager must display the College license in a place within the pharmacy where it is conspicuous to the public.
PODSA Bylaws s.25(4)	In all new and renovated community pharmacies or telepharmacies, an appropriate area must be provided for patient consultation that (a) ensures privacy and is conducive to confidential communication, and (b) includes, but is not limited to, one of the following: (i) a private consultation room; (ii) a semiprivate area with suitable barriers.
PODSA Bylaws s.25(1)	In locations where a community pharmacy or telepharmacy does not comprise 100 per cent of the total area of the premises, the community pharmacy manager or the central pharmacy manager in the case of a telepharmacy, must ensure that (a) the professional products area extends not more than 25 feet from the perimeter of the dispensary and is visually distinctive from the remaining areas of the premises by signage, and (b) a sign reading “Medication Information” is clearly displayed to identify a consultation area or counter at which a member of the public can obtain a full pharmacist's advice.
PODSA Bylaws s.19(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
PODSA Drug Schedule Regulations s.2(3)	Schedule III drugs may be sold by a pharmacist to any person from the self-selection Professional Products Area of a licensed pharmacy.
PODSA Drug Schedule Regulations s.2(3)	Schedule II drugs may be sold by a pharmacist on a non-prescription basis and which must be retained within the Professional Service Area of the pharmacy where there is no public access and no opportunity for patient self-selection.
PPP-40 Policy Statement #1	Repackaged non-prescription drugs must not be sold from the Professional Products Area of licensed pharmacies.

PPP-40 Policy Statement #2	Repackaged non-prescription drugs may be sold from the Professional Service Area of licensed pharmacies under the following conditions: (a) the package labelling should include the name of the medication, appropriate expiry date, lot number, the classification of the drug (laxative, anti-allergenic, etc.), and at a minimum common directions; (b) the medication should be repackaged in a child-resistant container when possible.
PPP-40 Policy Statement #3	There must be pharmacist-patient consultation for all repackaged drugs, with particular emphasis on contraindications for use of the drug.

Dispensary

Reference	Requirement(s)
PODSA Bylaws s.25(2)	The dispensary area of a community pharmacy and telepharmacy must (a) be at least 160 square feet, (b) be inaccessible to the public by means of gates or doors across all entrances, (c) include a dispensing counter with at least 30 square feet of clear working space, in addition to service counters, (d) contain adequate shelf and storage space.
PODSA s.4.1(3)	A direct owner must give to the registrar 30 days' written notice of any changes respecting the name or layout of the pharmacy.
Food and Drugs Act s.8(a)	No person shall sell any drug that was manufactured, prepared, preserved, packaged or stored under unsanitary conditions.
HPA Bylaws Schedule F Part 1 s.5	A registrant may delegate technical functions relating to the operation of the community pharmacy to a pharmacy assistant if the registrant directly supervises the pharmacy assistant and implements procedures, checks and controls to ensure accurate and safe delivery of community pharmacy services.

Security

Reference	Requirement(s)
Narcotic Control Regulations s.43	A pharmacist shall take all reasonable steps that are necessary to protect narcotics on his premises or under his control against loss or theft.
PPP-47 Policy Statement #4	Targeted Substances received by the community pharmacy, hospital pharmacy department or nursing unit must be stored in a secure environment.
PODSA Bylaws s.19(4)	Every registrant practising in a pharmacy is responsible for the protection from loss, theft or unlawful sale or dispensing of all Schedule I, II, and III drugs and controlled drug substances in or from the pharmacy.
PODSA Bylaws s.26(1)	A community pharmacy or telepharmacy must: (a) Keep Schedule IA drugs in a locked metal safe that is secured in place and equipped with a time delay lock set at a minimum of five minutes; (b) Install and maintain a security camera system that: (i) has date/time stamp images that are archived and available for no less than 30 days, and (ii) is checked daily for proper operation; (c) Install and maintain motion sensors in the dispensary

PPP-74 Policy Statement #4	Under the Personal Information Protection Act (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras.
PODSA Bylaws s.26(2)	When no full pharmacist is present and the premise is accessible to non-registrants, (a) the dispensary area must be secured by a monitored alarm, and (b) Subject to section 2.1, Schedule I and II, controlled drug substances and personal health information, are secured by physical barriers
PODSA Bylaws s.26(3)	A community pharmacy and a telepharmacy must clearly display at all external entrances that identify the premises as a pharmacy, and at the dispensary counter signage provided by the College
PODSA Bylaws s.26(4)	The manager, direct owner or indirect owner(s) of a community pharmacy or telepharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises.
PODSA Bylaws s.27(1)	Except as provided in subsection (2), a community pharmacy must not be open to the public unless a full pharmacist is present.
PODSA Bylaws s.27(2)(b) to (e)	A community pharmacy may operate without a full pharmacist present if all the following requirements are met: (b) a security system prevents the public, support persons and other nonpharmacy staff from accessing the dispensary, the professional service area and the professional products area; (c) a pharmacy technician is present and ensures that the pharmacy is not open to the public; (d) Schedule I, II, and III drugs and controlled drug substances in a secure storage area are inaccessible to support persons, other non-pharmacy staff and the public; (e) dispensed prescriptions waiting for pickup may be kept outside the dispensary if they are inaccessible, secure and invisible to the public and the requirements of section 12 of the Community Pharmacy Standards of Practice have been met.
PODSA Bylaws s.27(3)	If the requirements of subsection (2) are met, the following activities may be performed at a community pharmacy by anyone who is not a registrant: (a) requests for prescriptions, orders for Schedule II and III drugs and telephone requests from patients to order a certain prescription may be placed in the dispensary area by dropping them through a slot in the barrier; (b) orders from drug wholesalers, containing Schedule I, II and III drugs, may be received but must be kept secure and remain unopened.

Equipment and References

Reference	Requirement(s)
PPP-59 Policy Statement #1; PPP-68 Policy Statement	The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw 3(2)(w): (a) telephone; (b) refrigerator; (c) prescription filing supplies; (d) prescription balance having a sensitivity rating of 0.01; (e) metric weights (10 mg to 50 g) for balances requiring weights or instruments with equivalent capability; (f) metric scale glass graduates (a selection, including 10 ml size); (g) mortar and pestle; (h) Spatulas (metal and nonmetallic); (i) funnels (glass or plastic); (j) stirring rods (glass or plastic); (k)

	ointment slab or parchment paper; (l) counting tray; (m) disposable drinking cups; (n) double sink with running hot and cold water; (o) soap dispenser and paper towel dispenser; (p) plastic or metal garbage containers to be used with plastic liners; (q) fax machine.
HPA Bylaws Schedule F Part 1 s.7(1)(b)	Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if the facsimile equipment is located within a secure area to protect the confidentiality of the prescription information.
PPP-3 Policy Statement 1	All community pharmacies and telepharmacies are required to have access to the most current versions of the BC Pharmacy Practice Manual.
PPP-3 Policy Statement 1	The CPBC ReadLinks is an exception, as only the most recent three years must be readily accessible.
PPP-3 Policy Statement 2	All community pharmacies and telepharmacies at a minimum must have one of the following authorized library references in each of the categories listed in the table (unless otherwise noted). [which are: Compendium (current year); Complementary/Alternative (within the last 4 years); Dispensatory (within last 9 years); Drug Interactions (in its entirety every 2 years, or continual updates); Medical Dictionary (within the last 15 years); Nonprescription Medication (most current issue of BOTH references required); Pregnancy and Lactation (within the last 3 years); Pediatrics (within the last 4 years); Therapeutics (within last 4 years)]
PPP-3 Policy Statement 2	In addition to the list in the table, pharmacies must be equipped with current references relevant to the services provided (examples including but not limited to: Opioid Agonist Treatment, Veterinary, Psychiatric, Geriatric and Compounding)
PODSA Bylaws s.23.3(1)	A pharmacy may maintain electronic records containing personal health information if the pharmacy has the equipment, software and systems necessary for the input, storage, use, protection and retrieval of records that are required to be kept under bylaws of the college or other legislation that regulates the practice of pharmacy.
PODSA Bylaws s.23.3(2)	For purposes of subsection (1), the equipment, software and systems must: (a) be capable of storing the electronic records for the periods required by applicable law; b)keep the records secure from unauthorized access, use, disclosure, modification and destruction (c) for audit purposes, be capable of uniquely identifying each time an electronic record is accessed and modified; (d) be capable of restricting the functions that may be used by an authorized person;(e) be capable of tracing alterations to records by identifying the original entry, the identity of the individual who made the alteration and the date of the alteration; (f) be capable of searching and sorting electronic prescription records chronologically, and by drug name, drug strength, patient, prescriber, prescription number and transaction number; (g) ensure that electronic records can be stored, backed up and recovered in accordance with subsection (3); and, (h) provide for a deliberate and auditable procedure to be carried out by the pharmacy manager or by an authorized person prior to the destruction of any electronic record that includes information identifying the pharmacy manager or

	authorized person who destroyed the record and the date, time and reason for its destruction

Prescriptions

Reference	Requirement(s)
HPA Bylaws Schedule F Part 1 s.6(1)	A registrant must ensure that a prescription is authentic.
HPA Bylaws Schedule F Part 1 s.6(2)	Upon receipt from the practitioner, a prescription must include the following information: (a) the date the prescription was written; (b) the name of the patient; (c) the name of the drug or ingredients and strength if applicable; (d) the quantity of the drug; (e) the dosage instructions including the frequency, interval or maximum daily dose; (f) refill authorization if applicable, including number of refills and interval between refills; (g) the name and signature of the practitioner for written prescriptions.
HPA Bylaws Schedule F Part 1 s.10(5)	A registrant must not dispense a prescription more than one year from the prescribing date, except for oral contraceptives which may be dispensed for up to two years.
HPA Bylaws Schedule F Part 1 s.6(8)	A registrant must not dispense a prescription issued for more than one patient.
ReadLinks Vol 38 No 4 - Jan 10 2014 On Call - Accepting an Electronic Prescription	Electronic prescriptions are only permitted if the electronic prescriber's signature is unique. Health Canada considers a unique electronic signature to be equivalent to a paper and pen signature. Therefore the signature must be a fresh new signature written on the prescription with an electronic pen pad, similar to signing a pen and paper prescription. Cutting and pasting a signature into an electronic prescription is not permitted.
HPA Bylaws Schedule F Part 1 s.6(4)	At the time of dispensing, a prescription must include the following additional information: (a) the address of the patient; (b) the identification number from the practitioner's regulatory college; (c) the prescription number; (d) the date on which the prescription was dispensed; (e) the manufacturer's drug identification number or the brand name of the product dispensed; (f) the quantity dispensed; (g) written confirmation of the registrant who (i) verified the patient identification, (ii) verified the patient allergy information, (iii) reviewed the personal health information stored in the PharmaNet database in accordance with section 11(4), (iv) performed the consultation, (v) performed the final check including when dispensing a balance owing, and (vi) identified and addressed a drug therapy problem, if any.
HPA Bylaws Schedule F Part 1 s.9.1(1)(d)	A registrant who prepares a prescription product must ensure that his or her identity is documented in writing.
Narcotic Control Regulations s.37;	A pharmacist shall not use an order or prescription, written or verbal, to dispense a narcotic after the quantity of the narcotic specified in the order or prescription

Reference	Requirement(s)
CPBC Prescription Regulation Chart	has been dispensed. The narcotic prescription must specify the total quantity to be dispensed, the part fill quantities and the interval between the part fills.
PODSA Bylaws s.19(6)	Drugs included in the controlled prescription program (CPP) must not be sold or dispensed unless (a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of British Columbia, and (b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug.
HPA Bylaws Schedule F Part 1 s.7(3)	A registrant must not dispense a prescription authorization received by facsimile transmission for a drug referred to on the controlled prescription drug list.
HPA Bylaws Schedule F Part 1 s.7(1)(c)	Prescription authorizations may be received by facsimile from a practitioner to a pharmacy, if (c) in addition to the requirements of section 6(2), the prescription includes (i) the practitioner's telephone number, facsimile number and unique identifier if applicable, (ii) the time and date of transmission, and (iii) the name and fax number of the pharmacy intended to receive the transmission.
HPA Bylaws Schedule F Part 1 s.6(7)	A registrant must make a written record of a verbal authorization, and include his or her signature or initial.
HPA Bylaws Schedule F Part 1 s.6(9)	For refill authorizations, a registrant (a) may accept a refill authorization for Schedule I drugs from a practitioner's agent if confident the agent consulted the practitioner and accurately conveyed the practitioner's direction, and (b) must (i) cancel any unused refill authorizations remaining on any previous prescription if a patient presents a new prescription for a previously dispensed drug, (ii) advise the other pharmacy of the new prescription if unused refills are at another pharmacy, and (iii) create a new prescription number.
PPP-31 Policy Statement #4(a)	Pharmacist must obtain the informed consent of the patient or patient's representative before undertaking an emergency refill.
PPP-31 Policy Statement #5(b)	Pharmacists must document in the client's record any emergency refill of the prescription, the rationale for the decision, and any appropriate follow-up plan.
PPP-31 Policy Statement #5(a)	Pharmacists must use their CPBC pharmacist registration numbers in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.
HPA Bylaws Schedule F Part 1 s.8(3)	Upon request, a registrant must transfer to a pharmacy licenced in Canada a prescription for a drug if (a) the drug does not contain a controlled drug substance, and (b) the transfer occurs between a registrant and another registrant or an equivalent of a registrant in another Canadian jurisdiction.
Benzodiazepines and Other Targeted Substances Regulations s.54	A pharmacist may transfer a prescription for a targeted substance to another pharmacist, except a prescription that has already been transferred.

Reference	Requirement(s)
HPA Bylaws Schedule F Part 1 s.8(4)(b)	A registrant who transfers a prescription to another registrant under subsection (3) must (b) transfer all prescription information listed in subsection (2) (a) to (f) [which are: (a) the name and address of the patient, (b) the name of the practitioner, (c) the name, strength, quantity and directions for use of the drug, (d) the dates of the first and last dispensing of the prescription, (e) the name and address of the community pharmacy, (f) the number of authorized refills remaining.]
HPA Bylaws Schedule F Part 1 s.7(4)	Prescription transfers may be completed by facsimile transmission if (a) the transferring registrant includes his or her name and the address of the pharmacy with the information required in section 8(4), and (b) the name of the registrant receiving the transfer is known and recorded on the document to be faxed.
PharmaNet Professional and Software Compliance Standards Volume 2 – Business Rules (2010) s.3.17.2	All sales of medications for use by the practitioner must be transmitted to PharmaNet using the pharmacy's O-Med PHN and corresponding keyword.
PODSA Bylaws s.20(2)	A registrant must record a transfer of drugs that occurs for any reason other than for the purpose of dispensing in accordance with a practitioner's prescription.
PharmaNet Professional and Software Compliance Standards Volume 3 – Technical Rules (2010) s.3.2.22	The local software must record the sale of emergency quantities of all drug inventories. This must be handled by functionality separate from 'filling of a prescription'. These transactions must not be transmitted to PharmaNet. These sales must be auditable through inventory facilities.
PharmaNet Professional and Software Compliance Standards Volume 2 – Business Rules (2010) s.3.13.2(4) and (5)	Prescriptions dispensed for animals (written by veterinarians) must be transmitted to PharmaNet and recorded on the local system. Prescriptions for animals are processed under the owner's PHN.
Narcotic Control Regulations s.40(1)	A pharmacist shall maintain a special narcotic prescription file in which shall be filed in sequence as to date and number all written orders or prescriptions for narcotics dispensed and the written record of all verbal prescription narcotics dispensed pursuant to a verbal order or prescription.
Food and Drug Regulations s.G.03.009	A pharmacist shall maintain a special prescription file in which shall be filed in sequence as to date and number all written orders or prescriptions in writing for controlled drugs dispensed and the written record of all controlled drugs dispensed pursuant to a prescription or order verbally given.

Confidentiality

Reference	Requirement(s)
PODSA Bylaws s.34(b)	A pharmacy must connect to PharmaNet and be equipped with the following: (b) a terminal that is capable of accessing and displaying patient records, located in an area of the pharmacy which (i) is only accessible to registrants and support persons, (ii) is under the direct supervision of a registrant, and (iii) does not allow information to be visible to the public, unless intended to display information to a specific patient.
PharmaNet Professional and Software Compliance Standards Volume 5 – Security (2010) s.2.3.1(1) to (4)	Unique User IDs must be assigned to each individual who requires access. Individual providers must assign a unique password to their User ID. User IDs must be authorized to access an authorized set of system functions (e.g., filling prescriptions, stock control, etc.). User IDs must not be shared. To ensure individual accountability, each User ID is to be assigned to a single person who is accountable for all activities of that User ID.
HPA Bylaws s.74	A registrant must ensure that all records pertaining to his or her practice, and containing personal information about patients are safely and securely stored (a) at the pharmacy or (b) off site.
HPA Bylaws s.75	A registrant must ensure that records are disposed of or destroyed only by (a) transferring the record to another registrant, or (b) destroying the records in a manner that ensures that they cannot be reconstructed.
HPA Bylaws s.77(1)	A registrant must protect personal information about patients by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal.
HPA Bylaws s.77(2)	A registrant must take reasonable measures to ensure that a third party, including a volunteer, employee or contractor of the registrant, or a limited pharmacist does not access, collect, use, disclose, store or dispose of personal information about patients except in accordance with this Part.
HPA Bylaws s.78	A registrant must ensure that, if personal information about patients is transferred to any person or service organization for processing, storage or disposal, a contract is made with that person which includes an undertaking by the recipient that confidentiality and physical security will be maintained.
HPA Bylaws s.79	A registrant must take appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal information about patients under this Part as soon as possible after the breach is discovered, including (a) taking steps to recover the personal information or to ensure its disposal if it cannot be recovered, (b) taking steps to ensure that any remaining personal information is secured, (c) notifying (i) anyone affected by the unauthorized access including patients and other health care providers, (ii) the college, and (iii) law enforcement officials, if criminal action may have contributed to the unauthorized action, and (d) modifying existing security arrangements to prevent a reoccurrence of the unauthorized access.

HPA Bylaws s.80(2)	If a patient or a patient's representative makes a request for access to personal information about the patient, the registrant must comply as soon as practical but not more than 45 days following the request.

Inventory Management

Reference	Requirement(s)
PODSA Bylaws s.20(3)	All drug shipments must be delivered unopened to the pharmacy or a secure storage area.
PODSA Bylaws s.25(2)(f)	The dispensary area of a community pharmacy or telepharmacy must contain an adequate stock of drugs to provide full dispensing services.
Policy on Manufacturing and Compounding Drug Products in Canada s5.1(a)	Healthcare professionals who provide compounding related services and products to patients/clients must be able to demonstrate that a patient-healthcare professional relationship exists.
PODSA Bylaws s.19(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
PODSA Bylaws s.22	No registrant may accept for return to stock or reuse any drug previously dispensed except in accordance with section 11(3) of the Residential Care Facilities and Homes Standards of Practice.
PODSA Bylaws s.20(4)	Non-usable and expired drugs must be stored in a separate area of the pharmacy or a secure storage area until final disposal.
ReadLinks Vol 32 No 6 Nov/Dec 2007 Take Sharps Back	Regardless of where a pharmacy is located in BC, it should accept and safely dispose of sharps from patients who purchased them at that pharmacy.
PODSA Bylaws s.35(5)	A registrant must reverse information in the PharmaNet database, for any drug that is not released to the patient or patient's representative, and record the reason for the reversal no later than 30 days from the date of the original entry of the prescription information in PharmaNet.
PODSA Bylaws s.35(4)	A registrant must revise information in the PharmaNet database pertaining to corrected billing for prescriptions billed to the patient or a payment agency other than PharmaCare and record the reason for the revision within 90 days of the original entry on PharmaNet
PPP-65 Policy Statement	The pharmacy manager must ensure that narcotic counts and reconciliations are completed for the pharmacy, pharmacy satellites and all areas of a facility where narcotics are stored: at a minimum of every 3 months; after a change of pharmacy manager; after a break and enter or robbery; after an identified drug diversion; when a pharmacy closes and ceases to operate its business, and after any event where the security of the narcotic drugs may have been compromised.

PPP-65 Required Procedures #1(a) and (d)	Pharmacies must maintain a separate perpetual inventory for each narcotic drug. If the pharmacy does not have a computerized perpetual inventory, then a manual perpetual inventory must be maintained.
PPP-65 Required Procedures #1(b)	The perpetual inventory must include entries for: i. purchases, ii. transfers, iii. losses, iv. purchases returned, expired or destroyed, v. quantities dispensed, and vi. a running balance.
PPP-65 Required Procedures #1(c)	Any manual adjustments to the perpetual inventory must be documented, including: i. the reason for the adjustment, ii. the date adjusted, and iii. the identity of the person who made the adjustment.
PPP-65 Required Procedures #2(b)	All narcotics must be counted, including: i. active inventory, ii. compounded mixtures, and iii. expired inventory.
PPP-65 Required Procedures #2(c)	When completing the narcotic count, the following information must be documented: i. the name, strength, quantity and DIN/brand of the drug counted, ii. the date and signature of the person(s) who completed the count, and iii. the date and signature of the responsible pharmacist.
PPP-65 Required Procedures #2(d)	The count must not be conducted by the same person who enters narcotic purchases into the records.
PPP-65 Required Procedures #3(a)	Perpetual inventory, physical inventory counts, and purchase invoices must be reconciled and documented.
PPP-65 Required Procedures #3(b)	Discrepancies must be investigated, addressed, and documented on a narcotic incident report and maintained at the pharmacy for a period of not less than 3 years.
PPP-65 Required Procedures #4(a)	The inventory counts and reconciliation documentation must be kept in chronological order in a separate and dedicated record that is retained for 3 years.
PPP-65 Required Procedures #4(b)	Within ten days of the discovery of a loss or theft of a narcotic, the pharmacy manager must: (i) report the loss or theft to the local police and to the appropriate office at Health Canada (Note: shortages which cannot be accounted for must also be reported to the appropriate office at Health Canada), (ii) forward to the College a copy of any report sent to the appropriate office at Health Canada.
PPP-47 Policy Statement #2	Any loss or theft of Targeted Substances must be reported to the federal Minister of Health within 10 days of discovery with a copy of the report to the College.

Dispensed Products

Reference	Requirement(s)
HPA Bylaws Schedule F Part 1 s.9(1)	All drugs dispensed pursuant to a prescription or a full pharmacist-initiated adaptation, must be labeled.

HPA Bylaws Schedule F Part 1 s.9(2)	The label for all prescription drugs must include (a) the name, address and telephone number of the pharmacy, (b) the prescription number and dispensing date, (c) the full name of the patient, (d) the name of the practitioner, (e) the quantity and strength of the drug, (f) the practitioner's directions for use, and (g) any other information required by good pharmacy practice.
HPA Bylaws Schedule F Part 1 s.9(3)	For a single-entity product, the label must include (a) the generic name, and (b) at least one of (i) the brand name, (ii) the manufacturer's name, or (iii) the drug identification number (DIN).
HPA Bylaws Schedule F Part 1 s.9(4)	For a multiple-entity product, the label must include (a) the brand name, or (b) all active ingredients and at least one of (i) the manufacturer's name or (ii) the drug identification number (DIN).
HPA Bylaws Schedule F Part 1 s.9(5)	For a compounded preparation, the label must include all active ingredients.
HPA Bylaws Schedule F Part 1 s.9(6)	If a drug container is too small to accommodate a full label in accordance with subsection (2), (a) a trimmed prescription label must be attached to the small container, (b) the label must include (i) the prescription number, (ii) the dispensing date, (iii) the full name of the patient, and (iv) the name of the drug, and (c) the complete prescription label must be attached to a larger container and the patient must be advised to keep the small container inside the large container.
HPA Bylaws Schedule F Part 1 s.9(7)	All required label information must be in English, but may contain directions for use in the patient's language following the English directions.
HPA Bylaws Schedule F Part 1 s.10(4)	All drugs must be dispensed in a container that is certified as child-resistant unless (a) the practitioner, the patient or the patient's representative directs otherwise, (b) in the registrant's judgment, it is not advisable to use a child-resistant container, (c) a child-resistant package is not suitable because of the physical form of the drug or the manufacturer's packaging is designed to improve patient compliance, or (d) child-resistant packaging is unavailable, or (e) the drugs are prescribed for medical assistance in dying.

Documentation

Reference	Requirement(s)
HPA Bylaws Schedule F Part 1 s.11(1)	A patient record must be established and maintained for each patient for whom a Schedule I drug is dispensed.
HPA Bylaws Schedule F Part 1 s.11(2)	The patient record must include (a) the patient's full name, (b) the patient's personal health number, (c) the patient's address, (d) the patient's telephone number if available, (e) the patient's date of birth, (f) the patient's gender, (g) the patient's clinical condition, allergies, adverse drug reactions and intolerances if available including the source and date the information was collected, (h) the date the drug is dispensed, (i) the prescription number, (j) the generic name,

	strength and dosage form of the drug, (k) the drug identification number, (l) the quantity of drug dispensed, (m) the intended duration of therapy, specified in days, (n) the date and reason for discontinuation of therapy, (o) the directions to the patient, (p) the identification of the prescribing practitioner, (q) special instructions from the practitioner to the registrant, if appropriate, (r) past and present prescribed drug therapy including the drug name, strength, dosage, frequency, duration and effectiveness of therapy, (s) the identification of any drug therapy problem and the description of any action taken, (t) the description of compliance with the prescribed drug regimen, and (u) Schedule II and III drug use if appropriate.
HPA Bylaws Schedule F Part 1 s.8(4)(a)	A registrant who transfers a prescription to another registrant under subsection (3) must (a) enter on the patient record (i) the date of the transfer, (ii) the registrant's identification, (iii) identification of the community pharmacy to which the prescription was transferred, and (iv) identification of the person to whom the prescription was transferred.
HPA Bylaws Schedule F Part 1 s.8(1)	If requested to do so, a registrant must provide a copy of the prescription to the patient or the patient's representative, or to another registrant.
HPA Bylaws Schedule F Part 1 s.8(2)	A prescription copy must contain (a) the name and address of the patient, (b) the name of the practitioner, (c) the name, strength, quantity and directions for use of the drug, (d) the dates of the first and last dispensing of the prescription, (e) the name and address of the community pharmacy, (f) the number of authorized refills remaining, (g) the signature of the registrant supplying it, and (h) an indication that it is a copy.
PharmaNet Professional and Software Compliance Standards Volume 2 – Business Rules s.2.1.2(3) and (5)	Messages sent by CPBC relating to written forgeries, verbal forgeries, stolen prescription pads and other important announcements approved by the CPBC. Printed messages must be filed for future reference.
PODSA Bylaws s.23(1)	All prescriptions, patient records, invoices and documentation in respect of the purchase, receipt or transfer of Schedule I, II and III drugs and controlled drug substances must be retained for a period of not less than three years from the date (a) a drug referred to in a prescription was last dispensed, or (b) an invoice was received for pharmacy stock.
PODSA Bylaws s.23(2)	Despite subsection (1), a registrant must not destroy prescriptions, patient records, invoices and documentation as described in subsection (1) until the completion of any audit or investigation for which the registrant has received notice
PODSA Bylaws 23.1 (1)	All records required to be kept under the bylaws of the college or other legislation that regulates the practice of pharmacy shall be readable, complete and filed systematically by a registrant in a manner that is secure, auditable and allows for easy retrieval.

PODSA Bylaws 23.1 (2)	Notwithstanding subsection (1), a prescription record that is valid must be retrievable immediately.
PODSA Bylaws 23.1 (4)	With respect to prescriptions for drugs included in the controlled prescription program, the original prescription form must be retained, regardless of whether or not such prescription form has also been stored electronically.
PODSA Bylaws 23.1 (5)	Prescriptions stored electronically must accurately reflect the original prescription, including the colour composition of that prescription.
HPA Bylaws s.69(2)	In addition to correcting personal information in a record in accordance with section 70, a registrant who discovers an error or omission in such a record must amend the record to correct the error or omission and that amendment must reflect the original record entry, the identity of the registrant amending the record, the date of the amendment and the reasons for the amendment.

Pharmacy Manager's Responsibilities

Reference	Requirement(s)
PODSA s.11	Subject to this Act and the bylaws, a pharmacist named in a pharmacy license as manager must personally manage and be responsible for the operation of the pharmacy.
PODSA Bylaws s.18(1)	A full pharmacist may not act as manager of more than one pharmacy location, unless the pharmacy of which the full pharmacist is manager includes (a) a telepharmacy, (b) a hospital pharmacy, (c) a hospital pharmacy satellite, or (d) a pharmacy education site.
PODSA Bylaws s.18(2)	A manager must do all of the following: **(a)** actively participate in the day-to-day management of the pharmacy; **(b)** confirm that the staff members who represent themselves as registrants are registrants; **(c)** notify the registrar in writing of the appointments and resignations of registrants as they occur; **(d)** cooperate with inspectors acting under section 17 of the Act or sections 28 or 29 of the Health Professions Act; **(e)** ensure that (i) registrant and support persons staff levels are sufficient to ensure that workload volumes and patient care requirements are met at all times in accordance with the bylaws, Code of Ethics and standards of practice, and (ii) meeting quotas, targets or similar measures do not compromise patient safety or compliance with the bylaws, Code of Ethics or standards of practice; **(f)** ensure that new information directed to the pharmacy pertaining to drugs, devices and drug diversion is immediately accessible to registrants and support persons; **(g)** establish policies and procedures to specify the duties to be performed by

Reference	Requirement(s)
	registrants and support persons; **(h)** establish procedures for (i) inventory management, (ii) product selection, and (iii) proper destruction of unusable drugs and devices; **(i)** ensure that all records related to the purchase and receipt of controlled drug substances are signed by a full pharmacist; **(j)** ensure appropriate security and storage of all Schedule I, II, and III drugs and controlled drug substances for all aspects of pharmacy practice including operation of the pharmacy without a registrant present; (j.1) ensure that pharmacy records containing personal information about patients are secure from unauthorized access, use, disclosure, modification and destruction; **(k)** ensure there is a written drug recall procedure in place for pharmacy inventory; **(l)** ensure that all steps in the drug recall procedure are documented, if the procedure is initiated; **(m)** ensure that each individual working in the pharmacy wears a badge that clearly identifies the individual's registrant class or other status; **(n)** notify the registrar as soon as possible in the event that he or she will be absent from the pharmacy for more than eight weeks; **(o)** notify the registrar in writing within 48 hours of ceasing to be the pharmacy's manager; **(p)** ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising and stationery; **(q)** establish and maintain policies and procedures respecting pharmacy security; **(r)** ensure that pharmacy staff are trained in policies and procedures regarding pharmacy security; **(s)** notify the registrar of any incident of loss of narcotic and controlled drug substances within 24 hours; **(t)** in the event of a pharmacy closure or relocation, (i) provide for the safe transfer and appropriate storage of all Schedule I, II, and III drugs and controlled drug substances, (ii) advise the registrar in writing of the disposition of all drugs and prescription records at the time of a closure, (iii) provide the registrar with a copy of the return invoice and any other documentation sent to Health Canada in respect of the destruction of all controlled drug substances, (iv) arrange for the safe transfer and continuing availability of the prescription records at another

Reference	Requirement(s)
	pharmacy, or an off-site storage facility that is bonded and secure, and (v) remove all signs and advertisements from the closed pharmacy premises; **(u)** in the event that a pharmacy will be closed temporarily for up to 14 consecutive days, (i) notify patients and the public of the temporary closure at least 30 days prior to the start of the temporary closure, and (ii) make arrangements for emergency access to the pharmacy's hard copy patient records. **(v)** advise the registrar if the pharmacy is providing pharmacy services over the internet, and provide to the registrar the internet address of every website operated or used by the pharmacy; **(w)** ensure the pharmacy contains the reference material and equipment approved by the board from time to time; **(x)** require anyone who will access the in-pharmacy computer system to sign an undertaking in a form approved by the registrar to maintain the confidentiality of patient personal health information; **(y)** retain the undertakings referred to in paragraph (x) in the pharmacy for 3 years after employment or any contract for services has ended; **(z)** provide the registrar with access to the pharmacy premises in cases where a pharmacy licence has been cancelled or suspended due to loss of eligibility under section 3 of the Act; **(aa)** ensure that no incentive is provided to a patient or patient's representative for the purpose of inducing the patient or patient's representative to (a) deliver a prescription to a particular registrant or pharmacy for dispensing of a drug or device specified in the prescription, or (b) obtain any other pharmacy service from a particular registrant or pharmacy, and **(bb)** notify the registrar of persistent non-compliance by a direct owner and indirect owner(s) with their obligations under the bylaws to the Act; and **(cc)** notify the registrar of any change of telephone number, fax number, electronic mail address or any other information previously provided to the registrar.
PODSA Bylaws s.23.2(1)	A pharmacy manager must ensure that a policy is in place that: (a) describes the pharmacy's records filing system, the records format and the method and system for storing records, (b) is compliant with the sections 23.1, 23.2 and 23.3 requirements; and (c) is readily accessible to and understood by pharmacy staff.
PODSA Bylaws s.23.2(2)	With respect to electronic records, the policy must include a description of the process for the preservation, storage and backing up of records that is compliant with section 23.3 requirements.

Reference	Requirement(s)
PODSA Bylaws s.23.3(3)	A pharmacy manager must ensure that electronic records are preserved and backed up at least once daily and that such electronically preserved and backed up records are stored: (a) in a location resistant to environment perils including but not limited to fires and floods; (b)so that they are secure from unauthorized access, use, modification, destruction and disclosure; and, (c) in a manner that complies with section 23.1(1) requirements.
PODSA Bylaws s.24	A community pharmacy's manager must develop, document and implement an ongoing quality management program that (a) maintains and enforces policies and procedures to comply with all legislation applicable to the operation of a community pharmacy, (b) monitors staff performance, equipment, facilities and adherence to the Community Pharmacy Standards of Practice, and (c) includes a process for reporting, documenting and following up on known, alleged and suspected errors, incidents and discrepancies.
CPBC Four-Year Implementation Plan for New NAPRA MSOP for Compounding	Four-year implementation plan of the new Model Standards for Pharmacy Compounding of Non-hazardous and Hazardous Sterile Preparations as approved by the Board.

Owner/Director Responsibilities

Reference	Requirement(s)
PODSA s.18(8)	A direct owner, directors and officers must do all of the following: (a) ensure compliance with subsections 2(d), (e), (g), (j), (k), (p), (p.1), (q), (z) and (aa); (b) ensure that the requirements to hold a pharmacy licence under the Act are met at all times; (c) notify the registrar of any change of name, address, telephone number, electronic mail address or any other information previously provided to the registrar; and (d) in the event of a pharmacy closure under subsection 2(t), notify the registrar in writing at least thirty days before the effective date of proposed closure in Form 4.
PODSA Bylaws 17(5C)	If there is a change in layout of the pharmacy, the direct owner must submit the following (c) a diagram, photographs or video to demonstrate the changes in layout in accordance with section 3(2)(c),(d) and (e) for a community pharmacy
PODSA Bylaws 23(3)	Registrants, support persons, managers, direct owners, and indirect owners must not, for commercial purposes, disclose or permit the disclosure of information or an abstract of information obtained from a prescription or patient record which would permit the identity of the patient or practitioner to be determined.
PODSA Bylaws 26(4)	The manager, direct owner or indirect owner(s) of a community pharmacy or telepharmacy that does not stock IA drugs must complete a declaration attesting that Schedule IA drugs are never stocked on the premises.

Opioid Agonist Treatment♦

Reference	Requirement(s)
PPP-66 Policy Guide MMT (2013) 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.
PPP-66 Policy Guide Principle 1.1.1	The pharmacy hours of service must be consistent with the dosing requirements of your patient.
PPP-66 Policy Guide BMT Principle 2.1.1	BMT prescriptions can only be accepted when written using an original Controlled Prescription Program form.
PPP-66 Policy Guide MMT (2013) Principle 2.1.1	Methadone maintenance prescriptions can ONLY be accepted when written using an original Methadone Maintenance Controlled Prescription form.
PPP-66 Policy Guide SROM Principle 2.1.1	SROM prescriptions can only be accepted when written using an original Controlled Prescription Program form.
PPP-66 Policy Guide MMT (2013) 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.
PPP-66 Policy Guide MMT (2013) 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. GUIDELINE: *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. *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.
PPP-66 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.

PPP-66 Policy Guide MMT (2013) Principle 3.2.4	The 'sig field' on the prescription label must include the start and end dates of the original current prescription.
PPP-66 Policy Guide BMT Principle 3.1.1	Buprenorphine/Naloxone for maintenance must be dispensed to patients as an approved, commercially available formulation.
PPP-66 Policy Guide MMT (2013) Principle 3.1.1	Methadone for maintenance must be dispensed to patients in a concentration of 10 mg/ml (cherry flavoured).
PPP-66 Policy Guide SROM Principle 3.1.1	SROM for maintenance must be dispensed in approved, commercially available strengths. Capsule contents cannot be split.
PPP-66 Policy Guide MMT (2013) Principle 3.1.1	Methadone doses must be accurately measured in a calibrated device that minimizes the error rate to no greater than 0.1 mL.
PPP-66 Principle 4.1.1	A pharmacist must be present and witness the release of an OAT prescription to a patient. This function cannot be delegated to a pharmacy technician or any other pharmacy support staff. 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.
PPP-66 Principle 4.1.2	Prior to releasing an OAT 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. 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.
PPP-66 Policy Guide BMT 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.
PPP-66 Policy Guide MMT (2013) Principle 4.1.3	Prior to releasing a methadone prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log.
PPP-66 Policy Guide SROM Principle 4.1.3	Prior to releasing a SROM prescription, the patient and pharmacist must acknowledge receipt by signing a patient/prescription-specific log.
PPP-66 Policy Guide BMT 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.
PPP-66 Policy Guide MMT (2013) Principle 4.1.5	With respect to witnessed ingestion doses, the pharmacist must directly observe the patient ingesting the medication, and be assured the entire dose has been swallowed.

PPP-66 Policy Guide SROM 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.
PPP-66 Policy Guide BMT 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.
PPP-66 Policy Guide MMT (2013) Principle 4.1.6	With respect to take-home doses, the first dose (whether it is stated on the prescription or not) must be a witnessed ingestion with all subsequent take-home doses dispensed in child-resistant containers with an explicit warning label indicating that the amount of drug in the container could cause serious harm or toxicity if taken by someone other than the patient.
PPP-66 Policy Guide SROM 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.
PPP-66 Policy Guide MMT (2013) Principle 5.2.1 & BMT/SROM Principle 5.1.1	Any OAT 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.
PPP-66 Policy Guide MMT (2013) Principle 5.2.2 & BMT/SROM Principle 5.1.2	If a patient misses a dose, they cannot receive the missed dose at a later date.
PPP-66 Policy Guide BMT Principle 5.1.4	If a patient misses 6 or more consecutive days, the prescription must be cancelled.
BCCSU Appendix 1, section 4 (MMT)	Pharmacists are required to notify prescibers of missed doses and clinicians must document review of PharmaNet profiles. Prescribers and patients should be aware that if three consecutive doses are missed, the dispensing pharmacy will cancel the prescription and notify the prescribing clinician.
PPP-66 Policy Guide SROM Principle 5.1.4	SROM: If a patient misses 2 or more consecutive doses, the prescription must be cancelled.

PPP-66 Required References	In addition to the currently required pharmacy reference materials (PPP-3), pharmacies providing methadone maintenance treatment services must also maintain as required references the following: (1) CPBC Methadone Maintenance Treatment Policy Guide (2013) and subsequent revisions. (2) The most recent version of the BCCSU A Guideline for the Clinical Management of Opioid Use Disorder. (3) 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. (4) Product monographs for the commercially available 10mg/ml methadone oral preparations.
PPP-66 Policy Statement #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 (OATCAMPP) training program, and c. record self-declaration of training completion in eServices.

Non-sterile Compounding Preparations♦

Reference	Requirement(s)
PPP-3 Page 2	Pharmacies must be equipped with references relevant to their practices (compounding).
PODSA Bylaws s.19(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada (2009) s.5.1(n)	The expiration date of the compounded product is based on known stability data. If stability data is not available, the expiration date should be short, usually limited to the duration of the prescription or use.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(c)	It is expected that healthcare professionals who compound products will have appropriate risk management processes in place to manage risks associated with the compounded product and the workplace (facilities, safety etc.), in line with the standards set by their provincial/territorial regulatory bodies (for example but not limited to the toxicology, pharmacology, therapeutic value, stability, adverse reactions, labelling requirements etc. of the compounded product).
Health Canada Policy on	A pharmacy may prepare drugs in very limited quantities, in anticipation of a prescription. For the purpose of this Policy, preparation involves compounding or

Manufacturing and Compounding Drug Products in Canada s5.1(d)	repackaging of multiple units, not for immediate use, in a single process, by the same operator in accordance with a standardized batch preparation procedure
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(e)	Compounding should only be done if there is a therapeutic need or lack of product availability and should not be done solely for economic reasons for the healthcare professionals.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(h)	Drugs should not be compounded in order to be sold to third parties who will in turn sell/deliver to patients outside of their defined patient-healthcare professional relationship (see definition of "sell"). Pharmacists that do not provide specific compounding services may contract this activity to another pharmacist who provides this type of specific compounding service.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(j)	Product should be produced from an authorized drug or Active Pharmaceutical Ingredient (API) used in an authorized drug for use in Canada or listed in a recognized Pharmacopoeia (USP, PhEur, PhF, PhI, BP, CF, NF, Codex - Schedule B Food and Drugs Act.)

Non-hazardous Sterile Compounding Preparations & Hazardous Sterile Compounding Preparations♦

Reference	Requirement(s)
PPP-3 Page 2	Pharmacies must be equipped with references relevant to their practices (compounding).
PODSA Bylaws s.19(2)	A registrant must not sell or dispense a quantity of drug that will not be used completely prior to the manufacturer's expiry date, if used according to the directions on the label.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada (2009) s.5.1(n)	The expiration date of the compounded product is based on known stability data. If stability data is not available, the expiration date should be short, usually limited to the duration of the prescription or use.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada (2009) s.5.1(k)	Compounding of sterile products is only permitted in hospitals or other practice settings where carefully established standards for operation of clean rooms and the preparation of sterile products are in place and documented, in accordance with a recognized source.

Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(c)	It is expected that healthcare professionals who compound products will have appropriate risk management processes in place to manage risks associated with the compounded product and the workplace (facilities, safety etc.), in line with the standards set by their provincial/territorial regulatory bodies (for example but not limited to the toxicology, pharmacology, therapeutic value, stability, adverse reactions, labelling requirements etc. of the compounded product).
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(d)	A pharmacy may prepare drugs in very limited quantities, in anticipation of a prescription. For the purpose of this Policy, preparation involves compounding or repackaging of multiple units, not for immediate use, in a single process, by the same operator in accordance with a standardized batch preparation procedure
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(e)	Compounding should only be done if there is a therapeutic need or lack of product availability and should not be done solely for economic reasons for the healthcare professionals.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(h)	Drugs should not be compounded in order to be sold to third parties who will in turn sell/deliver to patients outside of their defined patient-healthcare professional relationship (see definition of "sell"). Pharmacists that do not provide specific compounding services may contract this activity to another pharmacist who provides this type of specific compounding service.
Health Canada Policy on Manufacturing and Compounding Drug Products in Canada s5.1(j)	Product should be produced from an authorized drug or Active Pharmaceutical Ingredient (API) used in an authorized drug for use in Canada or listed in a recognized Pharmacopoeia (USP, PhEur, PhF, PhI, BP, CF, NF, Codex - Schedule B Food and Drugs Act.)
CPBC Four-Year Implementation Plan for New NAPRA MSOP for Compounding	Four-year implementation plan of the new Model Standards for Pharmacy Compounding of Non-hazardous and Hazardous Sterile Preparations as approved by the Board.

Residential Care♦

Reference	Requirement(s)
HPA Bylaws Schedule F Part 3 - 3(1)	A registrant must not provide pharmacy services in or to a facility or home unless appointed to do so by the licensee of that facility or home

HPA Bylaws Schedule F Part 3 - 3(2)	A registrant must not allow any person to interfere with the provision of pharmacy services in accordance with the Act or the Pharmacy Operations and Drug Scheduling Act
HPA Bylaws Schedule F Part 3 - 3(3)(a to d)	The full pharmacist appointed to provide services to the facility or home must do the following: (a) visit and audit the medication room at the facility at least every 3 months, (b) visit and audit the medication room or storage area at the home at least once annually, (c) make a record of all audits and meetings of the medication safety and advisory committee held in accordance with this bylaw, which must be retained in the pharmacy for at least 3 years, and (d) arrange a meeting of the medication safety and advisory committee at least once in every 6 month period for a facility and once a year for a home.
HPA Bylaws Schedule F Part 3 - 3(4)(a to d)	The full pharmacist appointed to provide services to the facility or home must be a member of and advise the medication safety and advisory committee about the policies and procedures in place for the (a) safe and effective distribution, administration and control of drugs, (b) monitoring of therapeutic outcomes and reporting of adverse drug reactions in respect of residents, (c) reporting of drug incidents and discrepancies, and (d) training and orientation programs for staff members who store, handle, or administer drugs to residents.
HPA Bylaws Schedule F Part 3 - 3(5)	The policies and procedures referred to in subsection (4) must be included in a manual kept in the facility, home and pharmacy.
HPA Bylaws Schedule F Part 3 - 4(a to b)	A pharmacy providing services to a facility or home must have a documented ongoing quality management program that (a) monitors the pharmacy services provided, and (b) includes a process for reporting and documenting drug incidents and discrepancies for their follow-up.
HPA Bylaws Schedule F Part 3 - 6(1)	A registrant may only dispense a drug to a resident upon receipt of a prescription.
HPA Bylaws Schedule F Part 3 - 6(2)	When a resident is readmitted following hospitalization, new prescriptions must be received for that resident before drugs may be dispensed.
HPA Bylaws Schedule F Part 3 - 6(3)	A prescription may be transmitted to the pharmacy servicing the facility or home verbally, electronically or in writing.
HPA Bylaws Schedule F Part 3 - 6(6)	If a prescription is transmitted electronically, the registrant must use the facsimile or make a written copy as the permanent record for dispensing, numbering, initialing and filing.
HPA Bylaws Schedule F Part 3 - 6(7)	A prescription, written and signed by a practitioner on a resident's record, may be electronically transmitted to the pharmacy and the registrant may dispense the drug.

HPA Bylaws Schedule F Part 3 - 6(9)(a to c)	A registrant may accept a new drug order that is transmitted verbally from a practitioner to a facility's registered nurse, registered psychiatric nurse or licensed practical nurse, if (a) the drug does not contain a controlled drug substance, (b) the registered nurse, registered psychiatric nurse or licensed practical nurse writes the verbal order on a practitioner's order form or electronic equivalent, and (c) transfers the written order to the pharmacy.
HPA Bylaws Schedule F Part 3 - 6.1(1)(a to d)	A registrant who prepares a prescription product must ensure that" (a) the prescription product label matches the prescription information and the information on the manufacturer's label with respect to (i) drug, (ii) dosage form, (iii) strength, (iv) quantity; and (v) drug identification number; (b) the prescription product label matches the prescription information with respect to the matters set out in Section 6(8)(a) to (g); (c) the drug is not expires and will not expire within the duration of use; and (d) his or identity is documented in writing
HPA Bylaws Schedule F Part 3 - 6.1(2)	A pharmacy manager must ensure the record in paragraph (1)(d) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed
HPA Bylaws Schedule F Part 3 - 6.2	All registrants must use at least two person-specific identifiers to confirm the identity of a resident before providing any pharmacy service to the resident
HPA Bylaws Schedule F Part 3 - 7(1)	All prescriptions dispensed to residents must be dispensed in a monitored dose system except where the form of the drug does not permit such packaging, and each package must contain not more than a 35 day supply of medication.
HPA Bylaws Schedule F Part 3 - 7(2)	Where directions for the use of a drug are changed by the practitioner, the registrant must, following receipt of the required confirmation, initiate and dispense a new prescription.
HPA Bylaws Schedule F Part 3 - 7(3)	Before dispensing a prescription product, a registrant must perform a final check and must record his or her identify in writing
HPA Bylaws Schedule F Part 3 - 7(4)	A pharmacy manager must ensure the record in paragraph (3) is readily available and is retained for at least three years from the date on which the prescription product was last dispensed
HPA Bylaws Schedule F Part 3 - 8(1)	A registrant may establish a supply of contingency drugs to permit the commencement of therapy upon receipt of a prescription, until the drug supply arrives from the pharmacy.
HPA Bylaws Schedule F Part 3 - 8(2)	Contingency drugs must be prepared by the pharmacy and dispensed in a monitored dose system in accordance with section 7(1).

HPA Bylaws Schedule F Part 3 - 8(3)	A list of the contingency drugs must be available in the facility, home and pharmacy.
HPA Bylaws Schedule F Part 3 - 8(4)(a to e)	Records of use of contingency drugs must be kept in the facility or home and must include (a) the date and time the drug was administered, (b) the name, strength and quantity of the drug administered, (c) the name of the resident for whom the drug was prescribed, (d) the name or initials of the person who administered the drug, and (e) the name of the practitioner who prescribed the drug.
HPA Bylaws Schedule F Part 3 - 9(1)	A registrant may provide Schedule II or III drugs and unscheduled drugs for a resident upon the request of a registered nurse if the medication safety and advisory committee has approved protocols for doing so.
HPA Bylaws Schedule F Part 3 - 10(1)	Standing orders for Schedule II and III drugs and unscheduled drugs that are administered for common self-limiting conditions may be established by the medication safety and advisory committee.
HPA Bylaws Schedule F Part 3 - 10(2)	Standing order drugs must be authorized and signed for by a practitioner annually and a record of the signed authorization must be kept in the facility or home.
HPA Bylaws Schedule F Part 3 - 11(1)	A registrant must provide for the return of all discontinued drugs at the time of the next scheduled delivery.
HPA Bylaws Schedule F Part 3 - 11(2)	Policies and procedures must be in place to ensure that upon the hospitalization of a resident, the resident's drugs are returned to the pharmacy.
HPA Bylaws Schedule F Part 3 - 11(3)(a to c)	Previously dispensed drugs must not be re-dispensed unless (a) they have been returned to the pharmacy in a single-drug, sealed dosage unit or container as originally dispensed, (b) the labelling is intact and includes a legible drug lot number and expiry date, and (c) the integrity of the product can be verified.
HPA Bylaws Schedule F Part 3 - 12(6)(a to d)	If the pharmacy is unable to supply prescribed Schedule II or III drugs or unscheduled drugs to a resident and the resident has obtained a supply from another source, the drug must be in the original sealed packaging and be sent to the pharmacy for (a) identification,(b) repackaging in a monitored dose system if appropriate,(c) labeling, and(d) notation on the resident's record and the medication administration record.
HPA Bylaws Schedule F Part 3 - 12(7)	If labels are produced to be attached to a resident's medication administration record, the label must state "for MAR".
HPA Bylaws Schedule F Part 3 - 12(8)	All drugs must be labelled with the drug expiry date and manufacturer's lot number, except multi-drug sealed dosage units.

HPA Bylaws Schedule F Part 3 - 12(9)	A registrant must not delegate the labelling of drugs in a monitored dose system to an employee of a facility or home.
HPA Bylaws Schedule F Part 3 - 13(1)	A registrant must maintain a record for each resident.
HPA Bylaws Schedule F Part 3 - 13(3)(a to c)	When a drug is to be administered on a "when necessary" basis, the record and prescription label must clearly indicate (a) the specific indication for which the drug is to be given, (b) the minimum interval of time between doses, and (c) the maximum number of daily doses to be administered.
HPA Bylaws Schedule F Part 3 - 14(1)	The registrant must provide a medication administration record for each resident.
HPA Bylaws Schedule F Part 3 - 14(2)	The medication administration record must be current for each resident based on the information on the resident's record and must be sent to the facility or home each month.
HPA Bylaws Schedule F Part 3 - 14(3)(a to h)	A resident's medication administration record must include (a) the resident's full name, (b) the resident's location within the facility or home, where possible, (c) the name of the practitioner, (d) allergies, (e) diagnoses, (f) the month for which the record is to be used, (g) the name and strength of all drugs currently being administered, including those to be administered on a "when necessary" basis, and (h) full directions for use.
HPA Bylaws Schedule F Part 3 - 15(1)(a to b)	The full pharmacist responsible for a facility must (a) review each resident's drug regimen on site or by videoconference at least once every 6 months with a practitioner if available, or a registered nurse and a facility staff member approved by the medication safety and advisory committee, and (b) review the resident's personal health information stored on the PharmaNet database before releasing any drug to the facility.
HPA Bylaws Schedule F Part 3 - 15(2)(a to c)	A full pharmacist must maintain a record of the reviews referred to in subsection (1) in the resident's record and in the record at the pharmacy, and the record of review must include information about (a) the people in attendance, (b) the date of the review, and (c) recommendations, if any.
HPA Bylaws Schedule F Part 3 - 15(3)	At a facility or home, if a resident's practitioner does not attend the review, the full pharmacist must advise the practitioner of any recommendations arising from the review.

HPA Bylaws Schedule F Part 3 - 15(4)(a to b)	The full pharmacist responsible for a home must (a) review each resident's drug regimen and document the result of the review at least once every 6 months, and (b) conduct the review on site at least once in every 12 month period.
HPA Bylaws Schedule F Part 3 - 15(5)	To continue dispensing drugs for a resident in a facility or home, prescriptions must be received from the resident's practitioner every six 6 months, either by written, verbal or electronic communication.
HPA Bylaws Schedule F Part 3 - 16(1)(a to e)	When a resident is first admitted to a facility or home, the full pharmacist must obtain a history for the resident, and the following information must be obtained if available: (a) allergies, adverse drug reactions, and intolerances, (b) past and present prescribed drug therapy including the drug name, strength, dosage, frequency and duration of therapy, (c) compliance with prescribed drug regimen, (d) Schedule II, III and unscheduled drug use, and (e) laboratory results.
HPA Bylaws Schedule F Part 3 - 16(2)	The full pharmacist must routinely provide written or verbal drug information relevant to a resident's drugs to the medical, nursing or other appropriate facility or home staff.
HPA Bylaws Schedule F Part 3 - 16(4)(a to e)	Where a self-medication program is deemed suitable for a resident, the full pharmacist must comply with all applicable regulations under the Community Care and Assisted Living Act and must (a) participate in the development of policies and procedures for the program, including appropriate storage and security requirements, (b) ensure a drug consultation with the resident occurs, (c) ensure authorization from the resident's practitioner and the medication safety and advisory committee is obtained, (d) include any drugs in the self-medication program in the drug regimen review referred to in section 13(4), and (e) document the consultation referred to in paragraph (b) in the resident's record.
HPA Bylaws Schedule F Part 3 - 16(5)(a to h)	The drug consultation referred to in subsection (4)(b), should occur in person with the resident or resident's representative and must(a) confirm the identity of the resident,(b) identify the name and strength of drug being dispensed,(c) identify the purpose of the drug,(d) provide directions for use of the drug including the frequency, duration and route of therapy,(e) discuss common adverse effects, drug and food interactions, and therapeutic contraindications that may be encountered, including their avoidance, and the actions required if they occur,(f) discuss storage requirements,(g) provide information regarding(i) how to monitor response to therapy, (ii) expected therapeutic outcomes,(iii) action to be taken in the event of a missed dose, and(iv) when to seek medical attention, and(h) provide other information unique to the specific drug or resident.
HPA Bylaws Schedule F Part 3 - 17(1)	When a resident is admitted for short-stay respite care, the registrant must confirm all prescription authorizations with the resident's practitioner.

HPA Bylaws Schedule F Part 3 - 17(2)	The registrant must dispense drugs using a monitored dose system and provide medication administration records.
HPA Bylaws Schedule F Part 3 - 17(3)	Emergency stay respite care residents who arrive without notice may be administered drugs from their own supply if it is reasonable and safe to do so only until a supply is obtained from the pharmacy.
HPA Bylaws Schedule F Part 3 - 18(1)	The registrant must establish a system to ensure that leave-of-absence drugs are prepared correctly.
HPA Bylaws Schedule F Part 3 - 18(2)(a to f)	The label on a leave of absence medication must include(a) the facility or home name,(b) the resident's name,(c) the practitioner's name,(d) the drug name, strength, quantity and complete directions for use,(e) the initials of the person preparing the drug, and(f) the date of issue.
HPA Bylaws Schedule F Part 3 - 18(3)	All leave of absence drugs must be documented on the resident's medication administration record.
PODSA Bylaws Part I - 4(6)(a to b)	Drugs included in the controlled prescription program must not be sold or dispensed unless (a) the registrant has received the prescription on the prescription form approved by both the board and the College of Physicians and Surgeons of BC and (b) the prescription form is signed by the patient or the patient's representative upon receipt of the dispensed drug
PODSA Bylaws Part I - 4(8)(a to b)	Subsection (6) does not apply to prescriptions written for (a) residents of a facility or home subject to the requirements of the Residential Care Facilities and Homes Standards of Practice
PPP 3	Pharmacies providing services to licensed residential care facilities and homes must obtain a minimum of one reference applicable to geriatric residents or to psychiatric care residents, as appropriate to the pharmacy's service area.
PPP 43	Automated pharmacy dispensing systems are maintained and operated according to PPP-43

♦ if service is provided