

PROFESSIONAL PRACTICE POLICY (Chronological):

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This policy provides guidance to pharmacies for complying with reference material requirements as required under the *Pharmacy Operations and Drug Scheduling Act* (“PODSA”) Bylaws section 18(2)(w).

POLICY STATEMENT – HOSPITAL AND HOSPITAL PHARMACY SATELLITES:

1. All hospital pharmacies and hospital pharmacy satellites must be equipped with, current references relevant to the services provided (examples including but not limited to: Pediatrics, Psychiatric, Geriatric, Oncology and Compounding)

POLICY STATEMENTS – COMMUNITY PHARMACY AND TELEPHARMACY:

1. All community pharmacies and telepharmacies are required to have access to current versions of the following:
 - (a) all legislation relevant to pharmacy practice and management;
 - (b) College of Pharmacists of British Columbia (CPBC) Professional Practice Policies and Guides; and
 - (c) CPBC ReadLinks published within the last three years.

Electronic formatted files and electronic database[†] references are acceptable for any of the authorized choices within any of the required categories, provided that they are as comprehensive and current as the printed version, as well as readily accessible within the dispensary.

[†] Subscription may be required

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).

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)

CATEGORY	VERSION	REFERENCE (* items marked with an asterisk are available electronically only)
COMPENDIUM	Current year	<ul style="list-style-type: none"> • Compendium of Pharmaceuticals and Specialties (Canadian Pharmacists Association)
COMPLEMENTARY / ALTERNATIVE	Within the last 4 years	<ul style="list-style-type: none"> • Stockley's Herbal Medicines Interactions • *Facts & Comparisons@ eAnswers at online.factsandcomparisons.com • *iPharmacist (mobile app by Apotex) • *Lexicomp Online at online.lexi.com OR Lexicomp (mobile app by Lexi-comp or Wolters Kluwer) • *MedicinesComplete at www.MedicinesComplete.com • *Micromedex Pharmaceutical Knowledge at www.Micromedex.com • *Natural Medicines Comprehensive Database at www.naturaldatabase.com OR mobile app by Therapeutic Research Center • *Natural Medicines at www.naturalmedicines.com
DISPENSATORY	Within the last 9 years	<ul style="list-style-type: none"> • Martindale - The Complete Drug Reference (Published every 3 years) • *iPharmacist (mobile app by Apotex) • *Lexicomp Online (Lexi-Drugs) at online.lexi.com OR Lexicomp (mobile app by Lexi-comp or Wolters Kluwer) • *MedicinesComplete at www.MedicinesComplete.com • *Micromedex Pharmaceutical Knowledge at www.Micromedex.com OR Micromedex Drug Info – Mobile (mobile app by Truven)
DRUG INTERACTIONS	In its entirety every 2 years, or continual updates	<ul style="list-style-type: none"> • Stockley's Drug Interactions • Drug Interactions Analysis and Management (Hansten & Horn) *Loose leaf version must have continual updates* • Drug Interaction Facts: The Authority on Drug Interactions (Tatro) • *Facts & Comparisons@ eAnswers at online.factsandcomparisons.com • *iPharmacist (mobile app by Apotex) • *Lexicomp Online (Lexi-Interact) at online.lexi.com OR Lexicomp (mobile app by Lexi-comp/Wolters Kluwer) • *MedicinesComplete at www.MedicinesComplete.com • *Micromedex Pharmaceutical Knowledge at www.Micromedex.com OR Micromedex Drug Interactions (mobile app by Truven) • *RxTx Option 2 OR RxTx Option 3 at www.pharmacists.ca
MEDICAL DICTIONARY * Those listed or any equivalent professional medical dictionary	Within the last 15 years	<ul style="list-style-type: none"> • Dorland's Illustrated Medical Dictionary • Dorland's Pocket Medical Dictionary • Stedman's Medical Dictionary • Stedman's Medical Dictionary-Health Professions and Nursing • Taber's Medical Dictionary • *iPharmacist (mobile app by Apotex) • *Lexicomp (mobile app by Lexi-comp/Wolters Kluwer)

CATEGORY	VERSION	REFERENCE (* items marked with an asterisk are available electronically only)
		<ul style="list-style-type: none"> • *MedicinesComplete at www.MedicinesComplete.com • *The Free Dictionary by Farlex at http://medical-dictionary.thefreedictionary.com/
NONPRESCRIPTION MEDICATION *BOTH* references required	Most current version	<ul style="list-style-type: none"> • Compendium of Therapeutics for Minor Ailments [formerly called <i>Therapeutic Choices For Minor Ailments</i> or <i>Patient Self-Care</i>] (Canadian Pharmacists Association) • Compendium of Products for Minor Ailments [formerly called <i>Products for Minor Ailments</i> or <i>Compendium of Self-Care Products</i>] (Canadian Pharmacists Association)
PREGNANCY AND LACTATION	Within the last 3 years	<ul style="list-style-type: none"> • Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk (Briggs) • Drugs during Pregnancy and Lactation: Treatment Options and Risk Assessment (Schaefer et al) • Medications and Mother's Milk (Hale) • *Facts & Comparisons® eAnswers at online.factsandcomparisons.com • *iPharmacist (mobile app by Apotex) • *Lexicomp Online (Lexi-Pregnancy and Lactation) at online.lexi.com OR Lexicomp (mobile app by Lexi-comp/Wolters Kluwer) • *Medications and Mother's Milk at www.medsmilk.com • *MedicinesComplete at www.Medicinescomplete.com
PEDIATRICS	Within the last 4 years	<ul style="list-style-type: none"> • Pediatric & Neonatal Dosage Handbook (Taketomo/Lexicomp) • Pediatric Drug Dosage Guidelines (British Columbia's Children's Hospital) • *BC Children's and Women's Hospital (C&W) Online Formulary at http://www.pedmed.org/DrugApp/index.html • *iPharmacist (mobile app by Apotex) • *Lexicomp Online (Pediatric & Neonatal Lexi-Drugs) at online.lexi.com OR Lexicomp (mobile app by Lexi-comp/Wolters Kluwer) • *Micromedex Pharmaceutical Knowledge at www.Micromedex.com OR Micromedex Pediatrics Essentials (mobile app by Truven)
PROFESSIONAL / LEGISLATION *BOTH* required	Legislation, Professional Practice Policies and Guides: Current version CPBC ReadLinks: Within the last 3 years	<ul style="list-style-type: none"> • Legislation relevant to pharmacy practice and management (www.bcpharmacists.org) • CPBC Professional Practice Policies and Guides (www.bcpharmacists.org) • CPBC ReadLinks (www.bcpharmacists.org)
THERAPEUTICS	Within the last 4 years	<ul style="list-style-type: none"> • Compendium of Therapeutic Choices [formerly called <i>Therapeutic Choices</i>] (Canadian Pharmacists Association)

POLICY CATEGORY:

PROFESSIONAL PRACTICE POLICY-15

POLICY FOCUS:

Controlled Drug Substances Signing Authorizations

POLICY STATEMENT(S):

Any pharmacist registered under the full pharmacist registration category will be permitted to sign controlled drug substances orders, provided that the order is invoiced and delivered to a licensed pharmacy. The delegation of controlled drug substances signing authority is not required.

BACKGROUND:

Manufacturers and wholesalers who sell controlled drugs have been urged to purchase the *Registered Pharmacists Directory* to ensure that the signing pharmacist is, in fact, registered in our province.

As long as a pharmacist is registered with the College under the full pharmacist registration category, he or she may sign controlled drug substances orders for any pharmacy in which he or she is practising, and may sign for orders in more than one pharmacy.

Pharmacy managers may exercise their business management authority to develop corporate or individual pharmacy policies and procedures to limit the employee pharmacists who may order controlled drug substances. It is not necessary to register this information with the College.

Although College staff will not be required to check that a signing pharmacist has been reported as being an employee of the pharmacy to which the drugs are to be shipped, pharmacists must still notify the College of their employment sites as they change, in compliance with the Health Professions Act Bylaw 54.

First approved: 15 Jul 1996
Revised: 20 Jun 2003 / 15 Apr 2011
Reaffirmed: 27 Mar 2009

PPP-15

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-24
Depot Shipments of Prescriptions

POLICY STATEMENT(S):

Registrants are not permitted to deliver prescriptions to depots for subsequent dispersal to or retrieval by individual patients.

First approved: Nov 1993
Revised: 20 Jun 2003 / 15 Apr 2011
Reaffirmed: 27 Mar 1998 / 27 Mar 2009

PPP-24

POLICY STATEMENT(S):

1. Notwithstanding the provisions of *The Health Professions Act, the Pharmacy Operations and Drugs Scheduling Act, the Regulation and the bylaws* of the College of Pharmacists of BC made pursuant to these Acts or any other provision of law, a pharmacist in good faith may furnish a drug without prescription in reasonable quantities during a declared state of emergency to further the health and safety of the public.
2. If a drug is provided in accordance with point 1 above, a record containing the date, name and address of the person to whom the drug is furnished, and the name, strength and quantity of the drug furnished must be maintained. The pharmacist shall communicate this information to the patient's prescriber as soon as possible.
3. The Registrar may waive pharmacy licensure requirements (pertaining to minimum equipment, minimum space, sanitary facilities or any other licensing requirements) and issue a temporary pharmacy licence to a licensed pharmacy required to relocate because of a declared state of emergency.
4. It is the responsibility of each pharmacy manager to approach regional emergency preparedness coordinators and be aware of and participate in local plans. Pharmacy managers should develop more detailed individual disaster plans for their own pharmacies (beyond the regional plans).

POLICY STATEMENT(S):

1. While acting in the capacity of a pharmacist, a person enrolled in the Pharm.D. Program in the Faculty of Graduate Studies at the University of British Columbia must either:
 - Be registered with the College of Pharmacists of BC under the full pharmacist registration category, or
 - Be under the full, direct supervision of a registered pharmacist preceptor.

BACKGROUND

In June 1998 Council reviewed correspondence from the BC Branch of the Canadian Society of Hospital Pharmacists, expressing concerns about nonpharmacists or nonpractising registrants performing pharmacist duties in hospital settings.

Subsequently, the Registrar corresponded with all hospital pharmacy managers to emphasize that they must ensure that activities listed in the definition of the “practice of pharmacy” are performed or directly supervised by individuals registered under the *Health Professions Act Bylaw Section 42*. All functions which involve direct individual patient care must be performed or directly supervised by a pharmacist registered under the full pharmacist registration category. Professional practice decisions which indirectly affect individual patient care must also be made by pharmacists registered under the full pharmacist registration category.

As a result of this communication, the Registrar received a query about the level of supervision required for Pharm.D. students on rotations through in-patient and out-patient pharmacy service areas. The October 1998 Council meeting discussion resulted in the interpretation policy noted above.

POLICY STATEMENT(S):

Pharmacists may exercise professional judgment in the provision of emergency prescription refill supplies of a medication. This practice is *the exception to the rule and not the normal practice*.

A pharmacist may dispense an emergency refill in the following situations;

- where a patient's medication supply has been exhausted, a refill may be dispensed to ensure continuity of care. OR
- where a patient attends the pharmacy for an authorized refill of a valid prescription but PharmaNet returns the message, '101 Prescriber not found' or 'D3 Prescriber is not authorized' and the pharmacist ensures that the patient is not on Pharmacare's *Restricted Claimants Program*, a refill may be dispensed to ensure continuity of care and to allow time for the patient to find a new prescriber.

The pharmacist must comply with each of the following practice fundamentals;

1. Individual competence

- a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

2. Appropriate information

- a. Pharmacist has sufficient information about the specific patient's health status to ensure that dispensing an emergency refill of the prescription will ensure continuity of care and will not put the patient at increased risk.

3. Appropriateness

- a. Pharmacist must use their professional judgment to determine whether provision of an emergency refill is appropriate in the circumstances, and must determine an appropriate days supply based on the drug involved and how long it will take the patient to see a prescriber.

4. Informed consent

- a. Pharmacist must obtain the informed consent of the patient or patient's representative before undertaking an emergency refill.

5. Documentation

- a. Pharmacists must use their CPBC pharmacist registration numbers in the PharmaNet practitioner ID field to identify the responsible decision-maker when providing an emergency supply of a drug to a patient.
- b. Pharmacists must document in the client's record any emergency refill of the prescription, the rationale for the decision, and any appropriate follow-up plan.

BACKGROUND:

Protocol for provision of an emergency prescription refill

This professional practice policy enables pharmacists to exercise their professional judgment and education by providing authorization to provide an emergency prescription refill to ensure continuity of patient care until the prescriber can be contacted for authorization. This policy is not mandatory and the decision of whether to provide an emergency prescription refill is at the discretion of the individual pharmacist.

POLICY STATEMENT(S):

1. An automatic counting device that is capable of recording data and producing printed reports may be replenished without completely emptying the container only under the following criteria:
 - The dispensing device records all lot numbers and expiry dates and is capable of printing a report of that information for a registrant's review.
 - The pharmacy manager ensures that all appropriate reports are printed and reviewed at least monthly to ensure that inventory is well within the "use-by" date.
 - The reports are filed and available for review for one year.
 - If a drug recall occurs, the entire contents of the affected drug's cassette are removed and returned or destroyed if the affected lot number has been used at any time since the last complete emptying and cleaning of the cassette.

2. An automated dispensing device that is not capable of recording data and printing reports must be operated and replenished under the following conditions:
 - The cell or cassette must be identified with the drug name, strength, Drug Identification Number (DIN), lot number and expiry date of the stock currently contained in the cell.
 - The replenishment of the cells and cassettes must occur only when they are completely empty of stock before having stock added to them (no "topping up").
 - The replenishment of cells and cassettes must be checked by a registrant. An accountability record must be maintained, including the replenishment date for each cell and the handwritten identification of the registrant who checked the stock.

POLICY STATEMENT(S):

1. It is permissible for a licensed pharmacy to be closed temporarily for up to 14 consecutive days without surrendering its operating license, provided that the following provisions are performed:
 - Contact all prepared prescription recipients to advise of the closure and given them the opportunity to obtain their prepared prescription prior to the temporary closure start date. Any prepared prescriptions remaining in the pharmacy at the time of the temporary closure must be returned to inventory and reversed on the patients' PharmaNet record.
 - Post notices to the public at least 30 days prior to the temporary closure start date.
 - Post signage at the store entrance and provide a telephone answering machine message advising the public about the closure, its duration, the location of the nearest licensed pharmacy, and other information to assist with obtaining necessary pharmacy services during the closure period.
 - Make alternate arrangements with local prescribers.

BACKGROUND:

These policy statements supplement PODSA Bylaw 18(2)(u).

POLICY STATEMENT(S):

1. The parties performing or contracting for centralized prescription processing services must maintain a policy and procedures manual, along with documentation that implementation is occurring in a manner that shall be made available for inspection and review upon request and that includes, but is not limited to, the following:
 - (a) A description of how the parties will comply with federal and provincial laws and regulations
 - (b) The maintenance of appropriate records to identify the responsible registrant(s) in the various stages of the pharmaceutical care and drug product preparation processes
 - (c) The maintenance of a mechanism for tracking the prescription drug order during each step in the pharmaceutical care and drug product preparation processes
 - (d) The maintenance of a mechanism to identify on the prescription label all pharmacies involved in dispensing the prescription drug order
 - (e) The provision of adequate security to protect the confidentiality and integrity of patient information
 - (f) The maintenance of a quality assurance program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.

POLICY STATEMENT(S):

1. Registrants must ensure that only one PharmaNet patient record is created and maintained for each person and that only one Personal Health Number (PHN) is assigned to each person. By viewing and confirming appropriate identification documents, duplicate PHNs and patient records can be avoided.
2. Where a patient is personally known to the registrant the registrant may positively identify the patient. In cases where the patient is not known to the registrant, positive identification is best achieved by viewing one piece of primary identification or two pieces of secondary identification.

PRIMARY IDENTIFICATION:

- Drivers License
- Passport
- Provincial Identity card issued by the Province of BC
- Police Identity Card issued by RCMP or Municipality
- Certificate of Indian Status Card
- Permanent Resident Card issued by the Government of Canada
- B.C. Services Card

SECONDARY IDENTIFICATION:

- Care card issued by the Province of B.C.
- Birth Certificate
- Canadian Citizenship Card
- Record of Landing of Permanent Residency
- Work/Visitor/Study Permit issued by the Government of Canada
- Naturalization Certificate
- Marriage certificate
- Change of Name Certificate
- Identification or Discharge Certificate from External Affairs Canada or Canadian Armed Forces
- Consular Identity Card

BACKGROUND:

The above policy statements supplement PODSA Bylaw 36 which requires that registrants must take reasonable steps to positively identify a patient, patient's representative, registrant or a practitioner before providing any pharmacy service, including but not limited to:

- (a) establishing a patient record,
- (b) updating a patient's clinical information,
- (c) providing a printout of an in-pharmacy or requesting a PharmaNet patient record,
- (d) establishing, deleting, or changing a patient keyword,
- (e) viewing a patient record,
- (f) answering questions regarding the existence and content of a patient record,

- (g) correcting information, and
- (h) disclosing relevant patient record information to another registrant for the purpose of dispensing a drug or device, and/or for the purpose of monitoring drug use.

POLICY STATEMENT(S):

1. Technical functions specified in the Hospital Pharmacy Standards of Practice, section 10 may be delegated to pharmacy assistants in accordance with the *Hospital Pharmacy Standards of Practice*.
 2. The pharmacist may delegate the function of verifying medication container contents to a pharmacy assistant under the following conditions:
 - the pharmacist is responsible for ensuring that the verification procedure has the sensitivity and accuracy to detect all possible errors.
 - the pharmacy must have established written policies and procedures for all aspects of medication container verification, including quality assurance procedures and checks, procedures if an error occurs, and documentation records.
 3. A pharmacy assistant may verify the medication contents of non-patient specific medication containers (e.g. prepackaging) or patient-specific medication containers (e.g. refill drawers, cards or vials). A pharmacy assistant may only verify medication containers prepared by another assistant.
 4. The pharmacist at the telepharmacy central site may delegate the function of verifying medication container contents to a pharmacy assistant certified to verify medication container contents. A hospital policy and procedure for all aspects of the medication verification process must be established. The policy must include quality assurance procedures and checks, procedures if an error occurs and copies of all documentation.
 5. The verification process may occur between central/remote sites or between remote/remote sites.
 6. A pharmacy assistant may not verify his or her own work.
- Qualifications:**
7. In order to verify medication container contents, a pharmacy assistant must:
 - be a graduate of a recognized pharmacy technician training course prior to January 2011* or have an equivalent of two years experience in a hospital pharmacy setting, and
 - work sufficient hours to maintain competence in the function, as determined by the hospital pharmacy manager, and
 - complete a standard departmental training program on verifying medication container contents, and
 - demonstrate, on an ongoing basis, a commitment to exemplary accuracy in verifying the contents of medication containers, as determined by the hospital pharmacy manager.
- Training**
8. A pharmacist or pharmacy technician with relevant expertise must ensure that the required knowledge and skills are appropriately taught. The required knowledge and skills must be acquired through a combination of educational modules, in-service programs and work experience with the opportunity for repeated practice of the skills under supervision. Work experience must be at the site where the verifying will be done.
- Initial Certification**
9. Pharmacy assistants must be trained and assessed prior to becoming certified to verify medication container contents. The supervising pharmacist or pharmacy technician may grant certification if the assistant achieves an accuracy rate of 100%***. (see Appendix A)
- Quality Control**
10. The certified assistant must maintain an accuracy rate of 100%.
 - (a) If an error occurs during day-to-day checking activities, the institutions must have written procedures to address this situation.

- (b) The accuracy of all pharmacy assistants who verify medication containers must be audited at least annually and if possible conducted without the assistant's knowledge. The results of the audit must be discussed with the audited assistant. An assistant who is certified to verify both non-sterile and sterile products may be audited on a balanced combination of the two types of products to achieve the audit quantity.

Decertification

11. If the accuracy rate of a checker falls below the established standard on one occasion, perform a re-audit shortly after the first failed audit. If the pharmacy assistant fails to meet the minimum standard on re-audit, s/he must be decertified and removed from the verifying function.
12. The pharmacy manager or supervisory pharmacist or pharmacy technician for the area may decertify an assistant at any time if there is any reason to believe that the assistant is not capable of safely carrying out the delegated function. The assistant may be recertified only if the problem is resolved to the satisfaction of the pharmacy manager.
13. A decertified checker must reenter and complete the training and initial certification process prior to being reassigned to verify medication containers.

Documentation

14. A log or record showing the training, certification and quality assurance audits for each pharmacy assistant who verifies medication container contents must be maintained. The identification of the pharmacy assistant who prepares or verifies medication container contents must be documented. This record must be retained for at least three years.

Continuous Quality Improvement

15. An ongoing process of continuous quality improvement must be implemented to prevent or eliminate system errors. Documentation of the continuous quality improvement process must be retained for at least three years.

BACKGROUND:

The expected outcome of every medication distribution system is that 100% of medication doses will be correct when administered to the patient. Recognizing that "human failure" may create errors in any segment of the system, the medication distribution system processes must be designed with numerous checks to identify and remove potential errors prior to dispensing. Errors and other potential problems must be constantly identified and eliminated through a process of continuous quality improvement (CQI).

Medication distribution system processes include both technical functions and cognitive or professional functions.

Examples of professional functions, which may **NOT** be delegated to a pharmacy assistant, are:

- checking the accuracy of a transcription of a written medication order into the computer,
- checking a new medication order against the patient medication profile for therapeutic appropriateness,
- approving the calculations for a new product or formula.

Examples of technical functions, which may be delegated to a pharmacy assistant, are:**

- verifying the label and content of a compounded or prepackaged product prepared in a batch
- verifying the medication container contents against a patient-specific label or fill list.

**Prior to 2011 some training programs graduated "pharmacy technicians" whereas they are now graduating "pharmacy assistants" until the programs have been accredited by the Canadian Council for Accreditation of Pharmacy Programs.*

***These functions relate to Framework of Professional Practice (March 2006), Role 2: Produce and Distribute Drug Preparations and Products, and Role 3: Contribute to the Effective Operation of the Pharmacy.*

**** This document is meant as a guide to institutions to enable them to establish a tech-check program to meet their specific needs. Each institution should set certification and audit numbers that will reflect a measurement that is logistically feasible to ensure a level of acceptable performance and is reflective of all order types.*

Patient-Specific Medication Containers

Patient-specific medication containers generally consist of individually labelled medication containers or exchange drawers containing a one to 35 day supply of medication. Patient-specific medication containers are filled according to a refill or pick list or from labels generated from the patients' computerized medication profile.

Verification of the patient-specific medication containers against a list or label will include a check to ensure:

- correct patient name
- correct patient location, if applicable
- correct medication
- correct strength
- correct dosage form
- correct number of doses or units in container
- medication is within expiry date
- correct auxiliary label(s) applied, if applicable

Non-Patient Specific Medication Containers

Non-patient specific medication containers are usually prepared in batches in anticipation of individual medication orders. Non-patient specific medication containers may include compounded medications, wardstock medications, prepackaging or crash cart trays. Each medication container batch must be documented with a compounding / prepackaging worksheet or record.

Verification of medication container batches against the compounding / prepackaging record must include a check to ensure correct:

- medication
- number of doses or units in container
- ingredient or medication expiry date(s) and lot number(s) documented
- expiry date and lot number for the batch or prepackaging
- labelling
- integrity of final product

POLICY STATEMENT(S):

1. Technical functions as specified in the Hospital Pharmacy Standards of Practice, section 10 may be delegated to pharmacy assistants in accordance with the *Hospital Pharmacy Standards of Practice*.
2. The pharmacist may delegate the function of verifying sterile products to a pharmacy assistant under the following conditions:
 - the pharmacist is responsible for ensuring that the verification procedure has the sensitivity and accuracy to detect all possible errors.
 - the pharmacy must have established written policies and procedures for all aspects of the verification of sterile products, including quality assurance procedures and checks, procedures if an error occurs, and documentation records.
3. A pharmacy assistant may verify either the medication contents of patient specific compounded sterile products against a label or pick-list (e.g. refills) or the medication contents of a compounded sterile batch products against an approved written procedure or compounding record. A pharmacy assistant may only verify another assistant's preparation of compounded sterile products.
4. The pharmacist at the telepharmacy central site may delegate the function of verifying patient specific compound sterile products against a label or pick-list (eg. refills) or the medication contents of a compounded sterile batch products against an approved written procedure or compounding record to a pharmacy assistant certified to verify compounded sterile products. A hospital policy and procedure for all aspects of the sterile product verification process must be established. The policy must include quality assurance procedures and checks, procedures if an error occurs and copies of all documentation.
5. The verification process may occur between central/remote sites or between remote/remote sites.
6. A pharmacy assistant may not verify his or her own work.

Prior to verifying sterile products, the pharmacy assistant must be trained and certified in the delegated function.

Qualifications

7. In order to verify compounded sterile products, a pharmacy assistant must:
 - be a graduate of a recognized pharmacy technician training course prior to January 2011* or have an equivalent of two years experience in a hospital pharmacy setting, and
 - work sufficient hours to maintain competence in the function, as determined by the hospital pharmacy manager, and
 - be trained in aseptic technique and qualified to prepare sterile products, and
 - complete a standard departmental training program on verifying compounded sterile products, and
 - demonstrate, on an ongoing basis, a commitment to exemplary accuracy in verifying compounded sterile products, as determined by the hospital pharmacy manager.

Training

8. A pharmacist or pharmacy technician with relevant expertise must ensure that the required knowledge and skills are appropriately taught. The required knowledge and skills may be acquired through a combination of educational modules, inservice programs and work experience with the opportunity for repeated practice of the skills under supervision. Work experience must be at the site where the verifying will be done but didactic educational programs or inservices may be conducted either in-house or at another hospital pharmacy.

Initial Certification

9. Pharmacy assistants must be trained and assessed prior to becoming certified to verify compounded sterile products. The supervising pharmacist or pharmacy technician may grant certification if the assistant achieves an accuracy rate of 100%***. (See Appendix A).

Quality Control

10. The certified assistant must maintain an accuracy rate of 100%.
 - (a) If an error occurs during the day-to-day checking activities, the institution must have written procedures to address this situation.
 - (b) The accuracy of all pharmacy assistants who verify medication containers must be audited at least annually and if possible conducted without the assistant's knowledge. The results of the audit must be discussed with the audited assistant. An assistant who is certified to verify both non-sterile and sterile products may be audited on a balanced combination of the two types of products to achieve the audit quantity.

Decertification

11. If the accuracy rate of a verifying assistant falls below the established standard, a minimum of 2 re-audits will be performed shortly after the first failed audit. If the pharmacy assistant fails to meet the minimum standard on any re-audit, s/he must be decertified and removed from the verifying function.
12. The pharmacy manager or supervisory pharmacist or pharmacy technician for the area may decertify an assistant at any time if there is any reason to believe that the assistant is not capable of safely carrying out the delegated function. The assistant may be recertified only if the problem is resolved to the satisfaction of the pharmacy manager.
13. A decertified checker must reenter and complete the training and certification process prior to being reassigned to verify compounded sterile products.

Documentation

14. A log or record showing the training, certification and quality assurance for each pharmacy assistant who verifies compounded sterile products must be maintained. The identification of the pharmacy assistant or any other person who prepares or compounded sterile products must be documented. This record must be retained for at least three years.

Continuous Quality Improvement

15. An ongoing process of continuous quality improvement must be implemented to prevent or eliminate system errors. Documentation of the continuous quality improvement process must be retained for at least three years.

BACKGROUND:

The expected outcome of every sterile preparation and distribution system is that 100% of the parenteral medication doses will be correct when administered to the patient. Recognizing that "human failure" may create errors in any segment of the process, the processes of compounding and labelling sterile products must be designed with numerous checks to identify and remove potential errors prior to dispensing. Errors and other potential problems must be constantly identified and eliminated through a process of continuous quality improvement (CQI).

Compounding and labelling sterile products involves both technical functions and cognitive or professional functions.

Examples of professional functions, which may **not** be delegated to a pharmacy assistant, are:

- checking the accuracy of a transcription of a written medication order into the computer,
- checking a new medication order against the patient medication profile for therapeutic appropriateness,
- approving the stability or compatibility information or calculations for a new product or formula.

Examples of technical functions, which may be delegated to a pharmacy assistant, are**:

- verifying diluents and volumes of reconstituted sterile medications according to an approved procedure,
- verifying the label and content of a compounded sterile product prepared in a batch,
- verifying the medication container contents against a patient-specific label or fill list.

** Prior to 2011 some training programs graduated "pharmacy technicians" whereas they are now graduating "pharmacy assistants" until the programs have been accredited by the Canadian Council for Accreditation of Pharmacy Programs.*

***These functions relate to Role 2: Produce and Distribute Drug Preparations and Products, and Role 3: Contribute to the Effective Operation of the Pharmacy from the Framework of Professional Practice (April 2003).*

**** This document is meant as a guide to institutions to enable them to establish a tech-check program to meet their specific needs. Each institution should set certification and audit numbers that will reflect a measurement that is logistically feasible to ensure a level of acceptable performance and is reflective of all order types.*

Patient-Specific Sterile Products

Patient-specific sterile products generally consist of a 24-hour supply of individually labelled compounded or purchased sterile product. These sterile products are labelled according to a refill or pick list or from labels generated from the patients' computerized medication profiles.

Verification of the individual sterile product units against a label or list will include a check to ensure correct:

- patient name,
- patient location,
- medication,
- amount added,
- solution and volume,
- dosage form,
- number of doses or units,
- ingredients are within expiry dates,
- compounded sterile product expiry date,
- auxiliary label(s), if applicable,
- integrity of the final product.

Compounded Sterile Product Batches

Compounded sterile products are usually prepared in non-patient specific batches, in anticipation of individual patient medication orders. Each batch must be documented with a compounding worksheet or record.

Verification of compounded sterile product batches against the compounding record will include a check to ensure correct:

- medication,
- amount added,
- solution and volume,
- admixture devices,
- number of units,
- ingredient expiry dates and lot numbers documented,
- compounding expiry date and lot number for the batch,
- labelling,
- integrity of the final product.

POLICY STATEMENT(S):

A pharmacist may dispense a drug contrary to the terms of a prescription (adapt a prescription) if the action is intended to optimize the therapeutic outcome of treatment with the prescribed drug and meets **all** of the following elements of a protocol to adapt a prescription:

1. Individual competence

- a. Pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

2. Appropriate information

- a. Pharmacist has sufficient information about the specific client's health status to ensure that adapting the prescription will maintain or enhance the effectiveness of the drug therapy and will not put the client at increased risk.

3. Prescription

- a. Pharmacist has a prescription that is current, authentic, and appropriate.

4. Appropriateness

- a. Pharmacist determines whether adapting the prescription is appropriate in the circumstances.

5. Informed consent

- a. Pharmacist must obtain the informed consent of the client or client's representative before undertaking any adapting activity.

6. Documentation

- a. Pharmacist must document in the client's record any adaptation of the prescription, the rationale for the decision, and any appropriate follow-up plan.

7. Notification of other health professionals

- a. Pharmacist must notify the original prescriber (and the general practitioner if appropriate) as soon as reasonably possible (preferably within 24 hours of dispensing) and this must be recorded in the client's record or directly on the prescription.

Note: PPP-58 is not a stand-alone document and must be read with the Orientation Manual and the Amendment to the Orientation Manual. For a pharmacist to use PPP-58 they will be required to sign the PPP-58 Declaration Form.

BACKGROUND:

Protocol for medication management (adapting a prescription)

This professional practice policy enables pharmacists to maximize their full educational and professional competencies by providing authorization to adapt existing prescriptions. This policy is not mandatory and the decision whether to adapt a prescription is at the discretion of the individual pharmacist.

To guide decisions with respect to adapting a prescription, where a specific hospital board - or College of Pharmacists of BC - Board approved protocol does not exist, the pharmacist must refer to all applicable legislation and standards. This includes, but is not limited to, the Health Professions Act, Pharmacy Operations and Drug Scheduling Act, the Regulation and Bylaws of the College of Pharmacists of BC made pursuant to these Acts, the Health Care (Consent) and Care Facility (Admission) Act, the Framework of Professional Practice, the Code of Ethics and Professional Practice Policies. This specific policy (PPP-58) does not apply to controlled drug substances and cancer chemotherapy agents.

The Framework of Professional Practice (FPP) is the standards of pharmacy practice in British Columbia. In adapting a prescription the pharmacist must follow the FPP Role 1 *Provide pharmaceutical care*. Role 1 elements include:

- Function A – Assess the client’s health status and needs
- Function B – Develop a care plan with the client
- Function C – Support the client to implement the care plan
- Function D – Support and monitor the client’s progress with the care plan
- Function E – Document findings, follow-ups recommendations, information provided and client’s outcomes

Benefits of professional practice policy

The benefits to clients are to:

- a) Optimize drug therapy leading to improved client health outcomes
 - 1) Better therapeutic responses.
 - 2) Reduced drug errors.
 - 3) Fewer adverse drug reactions/interactions.
- b) Have an effective and efficient health care system
 - 1) Minimize delays in initiating and changing drug therapy.
 - 2) Make the best use of human resources in the health care system.
- c) Expand the opportunities to identify people with significant risk factors.
- d) Encourage collaboration among health care providers.

Supporting documents

- [Amendment to PPP-58](#)
- [Orientation Guide – Declaration Form PPP-58 Orientation Guide](#)
- [Pharmacist Prescription Adaptation Documentation and Notification Form](#)
- [Sample letter/fax introducing PPP-58](#)
- [Quick Reference Guide](#)

First approved: 21 Sep 2007
Revised: 14 Sep 2018
Reaffirmed: 27 Mar 2009

POLICY STATEMENT(S):

1. The dispensary of all community pharmacies at a minimum must have the following equipment as per PODSA Bylaw 18(2)(w).
 - (a) Telephone
 - (b) Refrigerator
 - (c) Prescription filing supplies
 - (d) Prescription balance having a sensitivity rating of 0.01
 - (e) Metric weights (10 mg to 50 g) for balances requiring weights or instruments with equivalent capability
 - (f) Metric scale glass graduates (a selection, including 10 ml size)
 - (g) Mortar and pestle
 - (h) Spatulas (metal and nonmetallic)
 - (i) Funnels (glass or plastic)
 - (j) Stirring rods (glass or plastic)
 - (k) Ointment slab or parchment paper
 - (l) Counting tray
 - (m) Disposable drinking cups
 - (n) Double sink with running hot and cold water
 - (o) Soap dispenser and paper towel dispenser, and
 - (p) Plastic or metal garbage containers to be used with plastic liners
 - (q) Fax machine
2. All community pharmacies must have a dedicated high-speed internet connection.
3. All hospital pharmacies and hospital pharmacy satellites must be adequately equipped to provide safe and proper medication compounding, dispensing and/or preparation of medication orders, and for the provision of patient-oriented and administrative pharmacy services.

POLICY CATEGORY:
POLICY FOCUS:

PROFESSIONAL PRACTICE POLICY-60
Professional Liability Insurance

POLICY STATEMENT(S):

1. The professional liability insurance coverage must meet the following criteria:
 - a) The policy provides occurrence-based coverage or claims made coverage with an extended reporting period of at least three years, and
 - b) If not issued in the registrant's name, the group policy covers the registrant as an individual.
2. Each registrant is responsible to ensure their individual or group plan meets the minimum criteria.

BACKGROUND:

The above policy statements are supplemental to HPA Bylaw 81.

First approved: 21 Nov 2008
Revised: 15 Apr 2011
Reaffirmed: 27 Mar 2009

PPP-60

POLICY STATEMENT(S):

Sterile products must be prepared in accordance with the published standards noted below:

1. CSHP Official publications – Guidelines for Preparation of Sterile Products in Pharmacies
2. CSHP Official Publications – Handling and Disposal of Hazardous Pharmaceuticals (including cytotoxic drugs)

Hazardous drugs must be handled and prepared in accordance with the requirements for the Safe Handling of Antineoplastic Agents in Health Care Facilities published by WorkSafe BC and the published standards noted below:

3. CSHP Official Publications – Handling and Disposal of Hazardous Pharmaceuticals (including cytotoxic drugs)

POLICY STATEMENT(S):

A hospital pharmacy manager must have in place:

1. Organization-specific policies and procedures to ensure patient safety and effectiveness of drug delivery systems, drug administration devices, products and services.
2. Organization-specific policies, procedures, training and certification as appropriate, to ensure safety and effectiveness of persons assuming responsibilities for the provision of drug delivery systems, drug administration devices, products and services.
3. A system to monitor and evaluate the safety and effectiveness of drug delivery systems, drug administration devices, products, personnel and services. Quality assurance checks should be conducted and documented.
4. A system to investigate unsafe practices in accordance with professional requirements. Practices resulting in actual or potential risks are to be stopped immediately.

BACKGROUND:

The intent of this policy is to provide direction for hospital pharmacy managers to minimize practice errors, omissions and unsafe practices in hospital pharmacy as it relates to drug delivery systems, drug administration devices, products and services.

Pharmacists bear a substantial responsibility for ensuring optimal clinical outcomes from drug therapy and should participate in organizational and clinical decisions with regard to drug distribution systems, drug administration systems, products and services.

POLICY STATEMENT(S):

1. The Board of the College of Pharmacists of BC adopts the NAPRA Guidelines to Pharmacy Compounding as the Standard of Practice for registrants:
http://www.napra.org/Content_Files/Files/Guidelines_to_Pharmacy_Compounding_Oct2006.pdf

BACKGROUND:

In 2005, the National Association of Pharmacy Regulatory Authorities (NAPRA) formed the Compounding Guidelines Task Force (CGTF). The task force was comprised of pharmacists from across Canada experienced in the area of compounding preparations. The task force members recognized that compounding is an essential part of pharmacy practice, and the guidelines reflect the knowledge they felt was required to prepare a safe and appropriate product.

Once the draft guidelines were completed, they were reviewed by NAPRA's National Advisory Committee on Pharmacy Practice, the Council of Pharmacy Registrars of Canada, and NAPRA's Executive Committee. The guidelines also underwent an extensive external review.

These guidelines, referred to as the Guidelines to Pharmacy Compounding http://napra.ca/Content_Files/Files/Guidelines_to_Pharmacy_Compounding_Oct2006.pdf are intended to enhance the standards of practice area addressing compounding (in BC, Role 2 of the Framework of Professional Practice).

The guidelines apply to registrants or their delegates in the preparation of all extemporaneous products. The guidelines are based on the following performance indicators for registrants fulfilling this role:

- Have accurate knowledge and expertise to compound preparations
- Confirm the need for a compounded product
- Maintain access to contemporary equipment
- Use of quality ingredients and procedures
- Appropriate labeling
- Suitable containers for each unique product
- Safe and acceptable storage
- Documentation to ensure accurate checking, duplicating, and tracing

The key elements of good compounding include qualified and trained personnel, adequate premises and space, approved compounding procedures and instructions, suitable equipment, labels and containers, and accurate documentation.

For reference, the following definitions differentiate between the activities of “compounding” and “manufacturing”:

Compounding - Pharmaceutical preparation of components into drug products that:

- Are considered to be within the professional practice of pharmacy, regulated by provincial regulatory authorities in accordance with guidelines and standards that ensure the quality and safety of pharmaceuticals.
- Involve a relationship that can be demonstrated to exist between a patient and / or a regulated health care professional or a practitioner.
- Do not circumvent regulatory requirements including the Food and Drugs Act and the Food and Drug Act Regulations, the National Drug Schedules, or intellectual property legislation.
- Provide a customized therapeutic solution to improve patient care without duplicating a commercially available, approved product.

Manufacturing - Preparation of products:

- Are subject to all the appropriate divisions and sections of the Food and Drugs Act and Regulations, including all applicable standards and guidelines.
- Require a Drug Identification Number (DIN) and / or Notice of Compliance (NOC) to be sold in Canada.
- Are produced independently of the demonstrated regulated health care professional-patient relationship or valid pharmacist-veterinarian-client-patient relationship.
- Are required to obtain an Establishment License (EL) (Division 1A of the Food and Drugs Act and Regulations) and meet the appropriate sections of Division 2 Good Manufacturing Practices (GMP).

The NAPRA Guidelines to Pharmacy Compounding have been adopted by five other provincial pharmacy regulatory authorities (NB, NL, NS, ON and SK).

The pharmacy manager must ensure that narcotic counts and reconciliations are completed for the pharmacy, pharmacy satellites and all areas of a facility where narcotics are stored:

- at a minimum of every 3 months,
- after a change of pharmacy manager,
- after a break and enter or robbery,
- after an identified drug diversion,
- when a pharmacy closes and ceases to operate its business, and
- after any event where the security of the narcotic drugs may have been compromised.

REQUIRED PROCEDURES:

The narcotic counts and reconciliations must consist of the following four components, and must be verified and signed off by the pharmacy manager after each completion:

1. Perpetual Inventory¹

- a) Pharmacies must maintain a separate perpetual inventory for each narcotic drug.
- b) The perpetual inventory must include entries for:
 - i. purchases,
 - ii. transfers,
 - iii. losses,
 - iv. purchases returned, expired, or destroyed,
 - v. quantities dispensed, and
 - vi. a running balance.
- c) Any manual adjustments to the perpetual inventory must be documented, including:
 - i. the reason for the adjustment,
 - ii. the date adjusted, and
 - iii. the identity of the person who made the adjustment.
- d) If a pharmacy does not have a computerized perpetual inventory, then a manual perpetual inventory must be maintained. (Note: A sample Perpetual Inventory Record can be found on the CPBC website).

2. Physical Inventory Counts

- a) A physical inventory count must be done at a minimum of every 3 months.
- b) All narcotics must be counted, including:
 - i. active inventory,
 - ii. compounded mixtures, and
 - iii. expired inventory.
- c) When completing the narcotic count, the following information must be documented:
 - i. the name, strength, quantity, and DIN/brand of the drug counted,
 - ii. the date and signature of the person(s) who completed the count, and
 - iii. the date and signature of the responsible pharmacist

¹**Perpetual Inventory:** A book record of every inventory kept continuously up to date by detailed entries for all incoming and outgoing items. (Merriam-Webster Dictionary)

- d) The count must not be conducted by the same person who enters narcotic purchases into the records.

3. Reconciliation²

- a) Perpetual inventory, physical inventory counts, and purchase invoices must be reconciled and documented.
- b) Discrepancies must be investigated, addressed, and documented on a narcotic incident report and maintained at the pharmacy for a period of not less than 3 years.

4. Documentation Requirements

- a) The inventory counts and reconciliation documentation must be kept in chronological order in a separate and dedicated record that is retained for 3 years.
- b) Within 10 days of the discovery of a loss or theft of a narcotic, the pharmacy manager must:
 - i. report the loss or theft to the local police and to the appropriate office at Health Canada. (Note: Shortages which cannot be accounted for must also be reported to the appropriate office at Health Canada.)
 - ii. forward to the College a copy of any report sent to the appropriate office at Health Canada. (Note: Please refer to PPP-74 Community Pharmacy Security)

BACKGROUND:

The above policy statement is supplemental to PODSA Bylaw 18 and 19, PPP-74 Community Pharmacy Security, and the *Narcotic Control Regulations*.

APPENDIX:

Sample – Perpetual Inventory Form

²**Reconciliation:** To check (example a financial account) against another for accuracy (Merriam Webster Dictionary)

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.

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

1. INJECTABLE HYDROMORPHONE POLICY STATEMENTS:

Effective September 1, 2018:

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

POLICY STATEMENT(S):

The Board of the College of Pharmacists of BC adopts the BCCDC guidelines on the Cold Chain Management of Biologicals. Refer to BCCDC's Communicable Disease Control Immunization Program: Section VI – Management of Biologicals.

[http://www.bccdc.ca/resource-gallery/Documents/Guidelines and Forms/Guidelines and Manuals/Epid/CD Manual/Chapter 2 - Imms/Appendix E ManagementBiologicals.pdf](http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%20-%20Imms/Appendix%20E%20Management%20Biologicals.pdf)

BACKGROUND:

“Cold chain” refers to the process used to maintain optimal temperature conditions during the transport, storage and handling of vaccines and other refrigerated pharmaceuticals, starting at the manufacturer and ending with the administration of the product to the client.

Vaccines are sensitive biological products; protection of vaccine potency and stability is important.

The recommended temperature for vaccine storage is, at all times, +2°C to +8°C.

Biologicals may be inactivated by exposure to excess light or heat or freezing, depending on the nature of the product, the temperature reached and the duration of exposure. Freezing will reduce the potency of inactivated vaccines and exposure to heat and light can compromise the stability of live-virus vaccines. **Any loss of vaccine potency is permanent and irreversible. Damage from successive exposures to adverse conditions is cumulative.** It is important to know the correct storage conditions for each biological product and to ensure that each is kept under the recommended conditions.

When the temperature is in the 0°C to 2°C range, adjust the refrigerator temperature and restore the temperature to within the +2°C to +8°C range **immediately**.

All biological products freeze at temperatures below 0°C; products that have been exposed to temperatures below 0°C should not be used. Consult with BCCDC Vaccine and Pharmacy Services, as there may be specific exceptions to this (e.g., lyophilized products.)

Committee endorsement:

The B.C. Centre for Disease Control guidelines were endorsed by the following College committees: Community Pharmacy Practice Committee, Residential Care Committee and the Hospital Pharmacy Committee.

This policy provides guidance to community pharmacy managers on complying with their obligations under the *Pharmacy Operations and Drug Scheduling Act* (“PODSA”) and the PODSA Bylaws, including section 18(2) of the PODSA Bylaws.

POLICY STATEMENT:

Effective September 1, 2018:

Community pharmacy managers must complete the following educational program to ensure that they are aware of, understand, and comply with all of their obligations under PODSA and the PODSA Bylaws:

Course Name: BC Community Pharmacy Manager Training Program
Course Provider: British Columbia Pharmacy Association

The program must be completed in accordance with the following schedule:

- (a) for community pharmacy managers appointed as such before September 1, 2018, on or before September 1, 2019;
- (b) for community pharmacy managers appointed as such on or after September 1, 2018, as soon as practicable and no later than one year after appointment; and
- (c) for all community pharmacy managers, every three years after compliance with (a) or (b), as applicable.

For further clarity, pharmacy managers are considered to have complied with (b) on the date that they completed the program, whether that date is before or after their appointment as pharmacy manager.

Registrants who are interested in becoming community pharmacy managers are encouraged to complete the program at their discretion in preparation for their future positions.

BACKGROUND:

Pharmacy managers have distinct and extensive responsibilities that are beyond those of general registrants. All pharmacy managers have a responsibility to educate themselves with respect to their obligations under PODSA and the PODSA Bylaws.

POLICY STATEMENT(S):

Under extraordinary circumstances, if the patient has 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 for maintenance. 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 methadone 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 Methadone Maintenance Program, Controlled Prescription Program 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 restrictions in mobility have been identified.
 - iii. Distance between patient home and pharmacy does not qualify as a restriction in mobility.

2. Home Delivery Schedule and Location

If delivery is authorized as noted in section 1 above, the pharmacist must meet the following delivery 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 - methadone 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 methadone 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, Definitions¹

"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, Definitions²

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

Dealers' Licenses and Licensed Dealers³

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 restrictions in mobility patients would require delivery of their methadone for maintenance to ensure best patient health outcomes and continuity of care.

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

POLICY STATEMENT(S):

Pharmacy owners, directors and managers must establish and implement a written policy and procedure to verify the identity and registration status of individuals applying for pharmacist or pharmacy technician positions prior to employment.

The Policy and Procedure Must Include the Following Steps that the Pharmacy Manager Must Take:**1. Confirm Applicant Identification**

The pharmacy manager must confirm identification of the applicant by viewing a valid and current source of picture identification, such as a Canadian driver's licence, passport or Canadian citizenship card.

2. Confirm Registration Status with the College of Pharmacists of BC

The pharmacy manager must access the online registry on the College website to:

- Confirm the applicant's registration status as pharmacist or pharmacy technician.
- Review any limits and/or conditions on practice published for the pharmacist or pharmacy technician.
- Confirm whether the pharmacist is authorized to administer injections.

3. Confirm that the College Registration Number Provided by the Pharmacist Matches the Registration Number on PharmaNet

The pharmacy manager must use the practitioner ID look up function 'P1' on their local pharmacy system to verify that the pharmacist registration number provided by the applicant matches the College registration number and pharmacist name returned by PharmaNet.

Note: Once a pharmacist has been hired and has created a profile on the local pharmacy software, the pharmacy manager must verify the information created by the pharmacist by confirming the registration number and name matches the information returned by the practitioner ID look up function 'P1' on PharmaNet.

BACKGROUND:

This policy supplements Pharmacy Operations and Drug Scheduling Act (PODSA) Bylaws Part 1 - All Pharmacies, Section 18(2)(b) a manager must confirm that staff members who represent themselves as registrants are registrants.

This policy provides guidance to community pharmacies for complying with community pharmacy and telepharmacy security requirements. *Pharmacy Operations and Drug Scheduling Act ("PODSA")* Bylaws section 1, section 18(2)(q), section 18(2)(r), section 18(2)(s), section 18(2)(bb), section 18(8) and section 26 address community pharmacy and telepharmacy security.

POLICY STATEMENT(S):

1. Written Policies and Procedures Regarding Pharmacy Security

Pharmacy security policies and procedures should be included in the pharmacy's policy and procedure document. The policies and procedures should contain information on the following:

- Training,
- Pharmacy security equipment,
- Emergency responses,
- Incident review, and
- Pharmacy security evaluation,

Additionally, direct and indirect owner(s) of the pharmacy should ensure that critical stress debriefing and stress counseling is offered as soon as possible following an incident.

2. Staff Training on Pharmacy Security Policies and Procedures

Pharmacy managers should ensure that staff members are retrained at least annually to maintain knowledge of pharmacy security policies and procedures.

Staff training is critical both to prevent and respond effectively to security breaches. Training includes initial training and periodic review/refresher of skills. Training should include instruction on:

- Operation of security-related equipment, such as security camera, alarms, safes, etc.,
- What to do in the event of a pharmacy security breach, and
- How to handle potential precursors to robbery (e.g., the presence of suspicious customers and phishing style phone calls, etc.).

3. Notification Procedures

As outlined in PODSA bylaws section 18(2)(s), pharmacy managers notify the registrar of any incident of loss of narcotic and controlled drug substances within 24 hours. This notification should occur through the Robbery Prevention Portal located in e-Services under the "report an incident" tab. Incidents to be reported include but are not limited to any of the following:

- Robbery (armed/unarmed) or attempted robbery
- Break and enter
- Forgery
- Theft
- Drug loss (unexplained or adulterated)

Additionally, pharmacy managers should provide the College Registrar, within 10 days of an occurrence, with a copy of the mandatory Health Canada report (**Form HC 4010 or HC 4004**) via the Robbery Prevention Portal located in e-Services containing the complete inventory of drugs (including the drug count) that were taken or diverted.

Pharmacy managers should notify the direct and indirect owners(s) of the pharmacy immediately as soon as the manager becomes aware that they are unable to meet the minimum pharmacy security requirements (as defined in PODSA bylaws section 26). If compliance is not achieved within a reasonable amount of time, then the pharmacy manager must notify the registrar of any persistent non-compliance by the direct and indirect owner(s) of the pharmacy with community pharmacy security bylaws and/or this policy as required in PODSA bylaws section 18(2)(bb). This notification should be provided to the CPBC Complaints and Investigations Department via the complaints line or email (**1-877-330-0967 or complaints@bcpharmacists.org**).

4. Pharmacy Security Equipment

Safe

The safe must be an actual metal safe, a “narcotics cabinet” is not sufficient. The safe must be securely anchored in place, preferably to the floor. The safe should only be open when items are being placed into or removed from the safe. ***It is never appropriate for the safe to be left open; this would defeat the purpose of the time-delay lock security measure.***

Security Camera System

It is important to ensure that images captured by the security camera system are sufficient to enable law enforcement to identify the criminals. In order to identify a person, specific individual features must be distinguishable.

Experts advise that camera systems are rated on frame rates per second and resolution. The higher the frame rate and resolution the better for detection and identification.

Under the *Personal Information Protection Act* (PIPA) pharmacies are required to post visible and clear signage informing customers that the premise is monitored by cameras. Guidance on the use of cameras, including security arrangements and policies can be found on the Office of Information Privacy Commissioner’s site.

Motion Sensors

Security experts recommend that 360 degree motion detectors be installed on the ceiling as wall mounted motion detectors are vulnerable to blind spots.

Monitored Alarms Systems

Independent alarms for the dispensary **are optional**, when a full pharmacist is present **at all times and the premise is accessible by non-registrants**.

Physical Barriers

Physical barriers provide an additional layer of security and deter:

1. Unauthorized access to drugs, including but not limited to:
 - All Schedule I, and II and, controlled drug substances and personal health information.

2. Unauthorized access to personal health information, including but not limited to:
- Hard copies of prescriptions,
 - Filled prescriptions waiting to be picked up, and/or
 - Labels, patient profiles, and any other personal health information documents waiting for disposal.

Physical barriers can be tailored to the needs and structure of the particular community pharmacy or telepharmacy. Examples of physical barriers include: locked gates, grillwork, locked cabinets, locked doors, and locked shelving units. The physical barriers should prevent access.

As per section 26(2.1), existing community pharmacies and telepharmacies have until April 21, 2020 to implement physical barriers. All new pharmacies must have physical barriers. Pharmacies that are renovated within this 3 year period must include physical barriers in the renovations.

When a full pharmacist is present at all times, physical barriers **are optional**. For telepharmacies, a full pharmacist is deemed to be present at a telepharmacy when he or she is engaged in direct supervision of the telepharmacy.

Signage

The College will send signs to all new pharmacies at the time of licensure approval. In addition, signs can also be ordered via the e-Services portal. Signage provides a consistent province-wide deterrent message that additional layers of security are in place. It is critical that all pharmacies comply with this requirement to ensure that their pharmacy does not become a “soft target”.

For pharmacies that do not stock Schedule 1A drugs, the declaration attesting this can be provided using the self-declaration template in Appendix 1 of this policy.

5. Emergency Response Kit

An emergency response kit should include a step-by-step guide on what to do in the event of a robbery or break and enter and be available to all pharmacy staff.

Pharmacy robberies and break and enters can be very stressful and traumatic events for pharmacy staff. Having an accessible and plain language step-by-step guide on what do if such an event occurs can help pharmacy staff take the steps necessary to appropriately respond to the situation.

6. Incident Review

Incident reviews should be conducted annually to determine concerns about pharmacy security and/or activity trends.

Policies and procedures should be in place regarding a privacy breach response plan consistent with s. 79 of the *Health Professions Act* Bylaws. The plan should provide for notification of affected individuals and other health care providers in appropriate cases. It should also include notification to the College and the Office of the Information and Privacy Commissioner of British Columbia.

7. Pharmacy Security Evaluation

Pharmacy security evaluations should be conducted on an annual basis to identify areas of risk and needed improvements.

Appendix 1: Safe Declaration Template

NO SCHEDULE 1A DRUGS ON-SITE DECLARATION

I, _____, the _____ (position title) of
_____ (legal pharmacy name), declare that,

1. Schedule 1A drugs are **never** stocked or dispensed at the above identified pharmacy, and I understand that non-compliance with this declaration may result in referral to the Inquiry Committee of the College of Pharmacists of BC.
2. In the event that the terms of the declaration above are no longer valid, I will notify the Registrar immediately and take action in advance to ensure that pursuant to sections 26 (1)(a) and 26 (3) of the *Pharmacy Operations and Drug Scheduling Act* Bylaws, a safe will be installed and signage will be displayed.

Date (MM/DD/YYYY)

Signature

Section 3.2 of Part 2 and section 6.2 of Part 3 of Schedule F to the HPA Bylaws require registrants to identify patients using at least two person-specific identifiers because registrants and patients may not be in the same location at the point of care. This Policy specifies acceptable way of identifying particular individuals based on Accreditation Canada's Required Organizational Practices Handbook 2016.

POLICY:

1. Acceptable person-specific identifiers are:
 - patient/resident's full name,
 - home address, if confirmed by the patient/resident or family,
 - date of birth,
 - personal identification number (e.g. hospital account number, medical record number), or
 - an accurate photograph.
2. In long-term or continuing care settings where the registrant is already familiar with the patient or resident, facial recognition is also an acceptable person-specific identifier.
3. The following are examples of person-specific identifiers that are not acceptable:
 - a. a patient/resident's room or bed number,
 - b. a home address that has not been confirmed with the patient or resident or his/her family, or
 - c. facial recognition in acute-care settings.

This policy provides guidance to direct owners, indirect owners and managers of pharmacies in British Columbia on submitting a criminal record history for the purpose of pharmacy licensure to the College as required in the *Pharmacy Operations and Drug Scheduling Act* sections 3(f), 5.1 and 21(1)(d.1) and *Pharmacy Operations and Drug Scheduling Act – Bylaws* sections 1 and 14.

POLICY STATEMENT:

The Board of the College of Pharmacists of BC adopts the vendor Sterling Backcheck for all criminal record history (CRH) checks.

BACKGROUND:

The *Pharmacy Operations and Drug Scheduling Amendment Act, 2016* considerably changed pharmacy ownership legislation. Some of the key changes included authorizing the College to:

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

The Act and Bylaws set out requirements for pharmacy licensure, including a CRH. The approved vendor will administer the criminal record check and will provide the results to the College for review in accordance with the legislation.