College of Pharmacists of British Columbia

Professional Practice Policy

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PPP-17	RESCINDED Proposed Bylaws of the Council of the College of Pharmacists of BC (Draft 10) *(February 2000)*
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PPP-33	RESCINDED Pharmacist-Patient Dialogue Bylaw Interpretation Guidelines *(April 2009)*
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PPP-36	RESCINDED Exempted Codeine Product Sales *(April 2000)*
PPP-37	RESCINDED Mutual Recognition Agreement for the Profession of Pharmacy in Canada *(April 2009)*
PPP-38	RESCINDED Emergency Contraceptive Pills Collaborative Agreement Protocol *(February 2007)*
PPP-39	RESCINDED Responsibility of the Pharmacist When Asked to Provide a Drug That May Harm the Patient *(April 2009)*
PPP-40	RESCINDED Repackaging Bulk Nonprescription Drugs *(June 2019)*
PPP-41	RESCINDED PharmaNet Patient Record Access and Use *(April 2009)*
PPP-42	RESCINDED Return-to-Practice Requirements *(February 2002)*
PPP-44	RESCINDED Distribution of Medication Samples by Pharmacists *(April 2009)*
PPP-45	RESCINDED Shredding Confidential Material *(April 2009)*

PPP-47 RESCINDED Operational Procedures for Complying with *Benzodiazepines and Other Targeted Substances Regulations (June 2019)*
PPP-48 RESCINDED Internet Pharmacy Standards *(April 2009)*
PPP-49 RESCINDED Prescription Transmission from Prescriber's Computer to Pharmacy Fax Machine *(September 2002)*
PPP-51 RESCINDED Medical Marijuana *(April 2009)*
PPP-52 RESCINDED Medication Packaging for Facilities *(April 2009)*
PPP-53 RESCINDED Drug Interchangeability *(April 2009)*
PPP-55 RESCINDED Telepharmacy *(November 2017)*
PPP-62 RESCINDED Medication Management (Administration of Injections) *(August 2009)*
PPP-72 RESCINDED Inquiry and Discipline Publication Policy *(June 2019)*
PPP-61 RESCINDED Hospital Pharmacy Published Standards *(July 2022)*

PROFESSIONAL PRACTICE POLICY (Alphabetical By Title):

POLICY FOCUS AREAS:

RESCINDED PROFESSIONAL PRACTICE POLICY:

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-3**
POLICY FOCUS: **Pharmacy References**

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)(v).

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)

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-3**
POLICY FOCUS: **Pharmacy References**

CATEGORY	VERSION	REFERENCE (* items marked with an asterisk are available electronically only)
COMPENDIUM	Current year	• ***Compendium of Pharmaceuticals and Specialties*** (Canadian Pharmacists Association)
COMPLEMENTARY / ALTERNATIVE	Within the last 4 years	• ***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	• ***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) **Error! Hyperlink reference not valid.**
DRUG INTERACTIONS	In its entirety every 2 years, or continual updates	• ***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	• ***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)
		• ***MedicinesComplete*** at www.MedicinesComplete.com • ***The Free Dictionary by Farlex*** at http://medical-dictionary.thefreedictionary.com/
NONPRESCRIPTION MEDICATION ***BOTH* references required**	Most current version	• ***Compendium of Therapeutics for Minor Ailments*** [formerly called *Therapeutic Choices For Minor Ailments* or *Patient Self-Care*] (Canadian Pharmacists Association) • ***Compendium of Products for Minor Ailments*** [formerly called *Products for Minor Ailments* or *Compendium of Self-Care Products*] (Canadian Pharmacists Association)
PREGNANCY AND LACTATION	Within the last 3 years	• ***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	• ***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	• ***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	• ***Compendium of Therapeutic Choices*** [formerly called *Therapeutic Choices*] (Canadian Pharmacists Association)

First approved: 02 May 1997
Revised: 11 Oct 2000 / 2 Nov 2001 / 22 Nov 2002 / 20 Jun 2003 / 09 Feb 2007 / 27 Mar 2009 / 18 Jun 2010 / 15 Apr 2011 / 15 Feb 2013 / 21 Feb 2014 / 17 Nov 2017 / 20 Apr 2018 / 13 Sep 2019 / 16 Jan 2020
Reaffirmed: 18 Jun 2010

PPP-3

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.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY-24**
POLICY FOCUS: **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

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 CATEGORY: **PROFESSIONAL PRACTICE POLICY-31**
POLICY FOCUS: **Emergency Supply for Continuity of Care**

This policy provides guidance to pharmacists when providing patients with an emergency supply of prescription drugs for continuity of care in exceptional circumstances in accordance with the *Pharmacy Operations and Drug Scheduling Act* ("PODSA**"**) Bylaws section 19(7)(d).

POLICY STATEMENTS:

1. A pharmacist may exercise professional judgment to provide a patient with an emergency supply of prescription drugs for continuity of care using the following principles:
   a) **Individual competence**: The pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed for emergency supply;
   b) **Sufficient information**: The pharmacist has sufficient information about the patient's health status to determine that dispensing an emergency supply is appropriate in the given circumstances;
   c) **Appropriate quantity**: The pharmacist should determine an appropriate quantity of the emergency supply based on what is reasonable in the given circumstances, and based on the drug involved;
   d) **Informed consent**: The pharmacist has obtained the patient's or the patient representative's informed consent before undertaking an emergency supply;
   e) **Documentation**: The pharmacist responsible for making the decision to provide an emergency supply should:
      i. document in the patient's record the rationale for the decision and any appropriate follow-up plan;
      ii. ensure the PharmaNet dispensing record includes the College of Pharmacists of British Columbia pharmacist registration number in the practitioner ID field to identify the pharmacist responsible for the decision; and
   f) **Notification of other health professionals:** Where possible and appropriate, the pharmacist should notify the practitioner in a timely fashion and should make a record of this in the patient's record.

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.

This policy sets out requirements for pharmacy managers on complying with their responsibility under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws sections 18(2)(cc)(i) and 18(2)(dd)(i) as related to notification of anticipated and unanticipated pharmacy closures.

POLICY STATEMENTS:

Anticipated Pharmacy Closure (no more than 14 consecutive days)

The need for an anticipated pharmacy closure may arise in situations where, for instance, pharmacy owners and managers are unable to employ locum pharmacist staff to enable regular pharmacist staff to take vacation leave or to replace pharmacist staff who are unable to work due to urgent medical problems.

1. **Notification Procedures**
   As outlined in PODSA Bylaws section 18(2)(cc)(i), pharmacy managers must notify patients and the public of the anticipated temporary closure at least 30 days prior to the start of the closure. In addition to the requirements in the PODSA Bylaws, the following notification procedures must also be followed when notifying the public:

   - Provide notification to the public at least 30 days prior to the temporary closure start date (for example post signage at the store entrance with information on upcoming closure); and,

   - At the time of closure, post signage at the store entrance and provide a telephone answering machine message advising the public about the closure including information on duration of closure, the location of the nearest pharmacy, and other information to assist with obtaining necessary pharmacy services during the closure period.

Unanticipated Pharmacy Closure (no more than 90 days)

The need for an unanticipated pharmacy closure may arise in unforeseeable situations where, for instance, a natural disaster such as flooding occurs and the pharmacy becomes temporarily inaccessible to the public.

2. **Notification Procedures**
   As outlined in PODSA Bylaws section 18(2)(dd)(i), pharmacy managers must notify the registrar of closures. The following notification procedures must be followed:

   - If the closure is over 14 days, notify the registrar by completing Form 4B and submitting it to the **CPBC Licensure Department** via email (**licensure@bcpharmacists.org**) as soon as possible at time of closure;

   - If the premises is safe and accessible, post signage at the store entrance and provide a telephone answering machine message advising the public about the closure including information on duration of closure, the location of the nearest pharmacy, and other information to assist with obtaining necessary pharmacy services during the closure period, as soon as possible; and,

- Notify the registrar by completing Form 4B, at least 5 days before the pharmacy re-opens.

First approved: 1 Feb 2002 **PPP-46**
Revised: 20 Jun 2003 / 15 Apr 2011 / 17 Nov 2017/ 16 Jan 2020
Reaffirmed: 27 Mar 2009

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 CATEGORY: **PROFESSIONAL PRACTICE POLICY-54**
POLICY FOCUS: **Identifying Patients and Patient Representatives in Community Pharmacy and Telepharmacy Settings**

This policy provides guidance for registrants on complying with the *Pharmacy Operations and Drug Scheduling Act ("*PODSA") Bylaws section 36 in taking reasonable steps to confirm the identity of a patient, patient's representative, registrant or practitioner before providing any pharmacy service that requires accessing, using or disclosing of patient personal health information.

POLICY STATEMENTS:

1. Registrants should 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 or patient's representative is personally known to the registrant, the registrant may positively identify the patient or patients' representative. In cases where the patient or patient's representative is not known to the registrant, positive identification is best achieved by viewing one piece of primary identification or two pieces of secondary identification. As a best practice, these steps should be documented. Below are some examples of primary and secondary identification.

PRIMARY IDENTIFICATION:

- Driver's License
- Passport
- B.C. Services Card
- Police Identity Card issued by RCMP or Municipality
- Secure Certificate of Indian Status or Certificate of Indian Status[1]
- Permanent Resident Card issued by the Government of Canada

SECONDARY IDENTIFICATION:

- CareCard issued by the Province of B.C.
- Birth Certificate
- Canadian Citizenship 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

3. Where a patient or patient's representative does not have a primary or secondary identification, the registrant should use their professional judgement in identifying the patient or patient's representative. These steps should be documented.

First approved: 2 May 2003 **PPP-54**
Revised: 25 Sep 2008 / 21 Nov 2008 / 15 Apr 2011 / 12 Apr 2012 / 8 Jan 2015 / 17 Nov 2017 / 16 Jan 2020 / 17 Apr 2020
Reaffirmed: 27 Mar 2009

[1] https://www.sac-isc.gc.ca/eng/1100100032424/1572461852643#s1

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.*

Standards for Pharmacy Technician Verification - July 2001 **Appendix A**

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.*

Description of Verification Process **Appendix A**

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.

This policy outlines a protocol for pharmacists to renew a prescription or dispense a drug contrary to the terms of a prescription (adapt a prescription) in accordance with section 25.92 of the *Health Professions Act*. This policy applies in all practice settings where another protocol approved by a governing body of a hospital or by the Board for the College of Pharmacists of British Columbia does not exist.

This policy must be read in conjunction with the *Health Professions Act* Bylaws Schedule A, Conflict of Interest Standards section 1(a)(ii-iii) and Schedule F, Part 1 - Community Pharmacy Standards of Practice section 6(10).

POLICY STATEMENTS:

1. 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 it is in the best interest of the client to do so.

2. A pharmacist may adapt a prescription, including a transferred prescription, by doing one or more of the following:
    a. changing the dose, formulation, or regimen of the prescription;
    b. renewing the prescription for continuity of care;
    c. making a therapeutic drug substitution within the same therapeutic class for the prescription.

3. A pharmacist must meet each of the following principles when adapting a prescription:

    a. **Individual competence:** The pharmacist has appropriate knowledge and understanding of the condition and the drug being dispensed in order to adapt the prescription.

    b. **Sufficient information about health status:** The 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.

    c. **Prescription:** The pharmacist has a prescription that is current, authentic, and valid.

    d. **Sufficient information about any previous adaptations:** The pharmacist has access to the documentation listed in paragraph g. below for any previous adaptations.

    e. **Appropriateness:** The pharmacist determines whether adapting the prescription is appropriate in the circumstances.

    f. **Informed consent:** The pharmacist obtains the informed consent of the client or client's representative[1].

1 "client's representative" means "patient's representative" as defined in section 64 of the *Health Professions Act* Bylaws.

g. **Documentation:** The pharmacist documents the adaptation in the client record[2], and the documentation includes all of the following:
    i. client information, including PHN;
    ii. pharmacist information, including their signature and the name of the pharmacy;
    iii. prescription information, including the prescriber's name and contact information;
    iv. a description of the adaptation, including all relevant prescription details;
    v. the rationale for the decision to adapt the prescription;
    vi. details of the assessment and client history along with any instructions to the client and relevant follow-up plan;
    vii. acknowledgement of informed consent;
    viii. the name of the practitioner(s) notified and the date of the notification.

h. **Notification of other health professionals:** The pharmacist notifies the prescriber, if available, (and the client's primary health care provider, if different) as soon as reasonably possible after dispensing. When adapting a prescription that has been adapted previously by another pharmacist, the pharmacist doing the new adaptation also notifies the pharmacist who did the most recent previous adaptation, if available, unless both adaptations are done in the same pharmacy. Notification includes the information listed in paragraph g. i., ii., iv., v., vi. and vii above.

4. When adapting a prescription, a pharmacist takes full responsibility and assumes liability for the adaptation.

5. A pharmacist may adapt a prescription at the time of the first or subsequent refills of that prescription.

6. A pharmacist may adapt a prescription from a former practitioner or a practitioner whose prescribing authority is suspended or subject to limits or conditions, if the prescription, at the time of adapting, is otherwise current, authentic, and valid.

7. A pharmacist may adapt a prescription that has been adapted by a pharmacist previously. There is no limit on the number of times a prescription may be adapted in accordance with this Policy as long as the prescription, at the time of each adaptation, is current, authentic, and valid.

8. Adaptation is an exercise of dispensing authority, not prescribing authority. Every adaptation is a new adaptation. The adaptation of a prescription:
    a. does not cancel, replace, or modify the prescription as issued by the practitioner;
    b. does not create a new prescription;
    c. cannot be adapted further; and
    d. cannot be transferred.

9. A prescription that has been adapted, and that is still current, authentic, and valid, may be transferred in accordance with the *Health Professions Act* Bylaws Schedule F, Part 1 - Community Pharmacy Standards of Practice, except that a pharmacist must not transfer a prescription for a narcotic, controlled drug or targeted substance that has been adapted unless such transfer is also permitted under:
    a. the Controlled Prescription Program, if applicable to the narcotic, controlled drug or targeted substance; and
    b. a section 56 exemption to the *Controlled Drugs and Substances Act*.

2 "client record" means, as applicable, the patient record referred to in section 11 of the *Health Professions Act* Bylaws Schedule F Part 1 - Community Pharmacy Standards of Practice or section 12 of the *Health Professions Act* Bylaws Schedule F Part 2 - Hospital Pharmacy Standards of Practice, or the resident record referred to in section 13 of the *Health Professions Act* Bylaws Schedule F Part 3 - Residential Care Facilities and Homes Standards of Practice.

10. The College of Pharmacists of British Columbia pharmacist registration number must be entered in the practitioner ID field of the PharmaNet dispensing record to identify the pharmacist responsible for the adaptation, where applicable.

11. All documentation, including the prescription information and the documentation required for adaptations, must be retained for the period specified in the bylaws of the College of Pharmacists of British Columbia.

Change of Dose, Formulation or Regimen:

12. A pharmacist may change the dose, quantity, formulation and/or regimen of a prescription, other than a prescription for a narcotic, controlled drug or targeted substance, if:
    a. the strength of the drug is not commercially available;
    b. in the case of a change in dose and/or regimen,
        i. the client's age, weight or kidney or liver function requires the change, or
        ii. the change would otherwise benefit the client; or
    c. in the case of a change in formulation and/or regimen, the change would improve the ability of the client to effectively take the drug.

13. As long as the quantity dispensed does not exceed the stated amount authorized in the prescription, a pharmacist may change the dose, formulation and/or regimen of a prescription for a narcotic, controlled drug or targeted substance if:
    a. the strength of the drug is not commercially available;
    b. in the case of a change in dose and/or regimen,
        i. the client's age, weight or kidney or liver function requires the change, or
        ii. the change would otherwise benefit the client; or
    c. in the case of a change in formulation and/or regimen, the change would improve the ability of the client to effectively take the drug.

14. A pharmacist may change the dose, quantity, formulation or regimen of a prescription, other than a prescription for a narcotic, controlled drug or targeted substance, if the information provided is incomplete or ambiguous but the intended treatment can be determined through consultation with the client and a review of client records.

15. As long as the quantity dispensed does not exceed the stated amount authorized in the prescription, a pharmacist may change the dose, formulation or regimen of a prescription for a narcotic, controlled drug or targeted substance if the information provided is incomplete or ambiguous but the intended treatment can be determined through consultation with the client and a review of client records.

16. A pharmacist must not change the dose, quantity, formulation, or regimen of a prescription except in accordance with this Policy.

Renewal for Continuity of Care:

17. A pharmacist may renew a prescription for the purpose of continuity of care. In general, this requires that the pharmacist be reasonably satisfied that:
    a. there has been no clinically significant change to the prescription for a minimum of three to six months, to be assessed at the time of each renewal by reference to accepted clinical practice applicable to the condition being treated; and
    b. the condition being treated is stable.

18. For the purpose of continuity of care, a pharmacist may renew a prescription for an appropriate time period as long as that time period does not exceed the expiry date of the prescription. In addition, if the prescription is for a narcotic, controlled drug or targeted substance, it may only be renewed:
    a. for a time period that does not exceed the same duration as prescribed or 30 days, whichever is greater; and
    b. if permitted under a section 56 exemption to the *Controlled Drugs and Substances Act*.

Therapeutic Drug Substitution:

19. A pharmacist may make a therapeutic drug substitution for a prescription within the same therapeutic class.

20. When making a therapeutic substitution, the pharmacist must be satisfied that the dose and dosing regimen of the new drug will have an equivalent therapeutic effect as the prescribed drug.

21. When making a therapeutic substitution, the pharmacist must ensure the new drug is approved for the intended indication by Health Canada or evidence supports using the drug for the intended indication (e.g., it is considered a best practice or is accepted clinical practice in peer-reviewed clinical literature or clinical practice guidelines).

22. A pharmacist must not make a therapeutic drug substitution of a prescription for a narcotic, controlled drug or targeted substance.

Limits:

23. A pharmacist must not adapt a prescription for a cancer chemotherapy agent.

24. A pharmacist must not adapt an expired prescription.

25. A pharmacist must not adapt a prescription if the prescriber indicates it should not be adapted using a hand-written “do not renew/adapt” notation (not pre-stamped). If a prescriber electronically produces their prescriptions, they must sign or initial beside the notation.

26. A pharmacist must not adapt:
    a. a prescription from a veterinarian; or
    b. an emergency supply for continuity of care.

This policy sets out requirements for pharmacy managers on complying with their pharmacy equipment obligations under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws section 18(2)(v). Additional equipment requirements for drugs that require cold chain management are set out in *PPP-68 Cold Chain Management*. Note that PODSA Bylaws section 25(2) has additional requirements for community pharmacies and telepharmacies.

POLICY STATEMENTS:

1. The dispensary of all community pharmacies or telepharmacies at a minimum must have the following equipment
   (a) telephone,
   (b) fax machine or other equipment with fax capability,
   (c) digital prescription balance with a readability of 0.01g or smaller, and associated calibration tools,
   (d) at least one 10mL graduated cylinder,
   (e) mortar and pestle,
   (f) spatula,
   (g) funnel,
   (h) stirring rod,
   (i) ointment slab or parchment paper,
   (j) counting tray,
   (k) soap in a dispenser,
   (l) paper towels in a dispenser, and
   (m) plastic or metal garbage containers to be used with plastic liners.

2. 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.

3. Pharmacy equipment must be clean and sanitary, well-maintained, and properly functioning.

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.

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.

This policy sets out the National Association of Pharmacy Regulatory Authorities (NAPRA) standards adopted by the Board of the College of Pharmacists of BC, as referenced in the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws section 18(9), the *Community Pharmacy Standards of Practice* section 9.2, the *Hospital Pharmacy Standards of Practice* section 3(3), and the *Residential Care Standards of Practice* section 6.3.

POLICY STATEMENT:

1. The Board of the College of Pharmacists of BC adopts the following NAPRA standards for compounding of sterile preparations for registrants:
    - Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations; and,
    - Model Standards for Pharmacy Compounding of Hazardous Sterile Preparations.

First approved: 29 Jan 2010
Revised: 04 Jul 2022
Reaffirmed:

PPP-64

This policy sets out requirements for pharmacy managers on complying with their obligations for narcotic counts and reconciliation under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws sections 18(2)(s), 18(2)(t), 23.1(1), and if applicable, section 31(6).

POLICY STATEMENTS:

1. Perpetual Inventory

a) A pharmacy manager must ensure that a separate perpetual inventory log for each narcotic drug is maintained for the pharmacy, telepharmacy, pharmacy satellites and all areas of a facility where narcotics are stored.

b) A perpetual inventory log may be manual[4] or automated, and 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) Each entry in the perpetual inventory log must have an associated record, including but not limited to the following
   i. purchase record,
   ii. prescription,
   iii. loss and theft reports, and
   iv. record for purchase returned, expired, transferred, or destroyed.

d) Any adjustment to an entry in a perpetual inventory log must be documented, including
   i. the reason for the adjustment,
   ii. the date adjusted,
   iii. the identity of the person who made the adjustment, and
   iv. the identity of a full pharmacist authorizing the adjustment.

2. Counts and Reconciliations

a) A pharmacy manager must ensure that physical inventory counts and reconciliations for each narcotic drug are completed for the pharmacy, telepharmacy[5], pharmacy satellites and all areas of a facility where narcotics are stored:
   i. at a minimum of every 3 months,
   ii. after a change of pharmacy manager,
   iii. after a break and enter or robbery,
   iv. after an identified drug diversion,
   v. when a pharmacy closes and ceases to operate its business, and
   vi. after any event where the security of the narcotic drugs may have been compromised.

4 See sample Perpetual Inventory Form: http://library.bcpharmacists.org/7_Forms/7-7_Others/9060-Narcotics_Inventory_Form_Sample.pdf

5 Please note that as per section 31(6) of the PODSA Bylaws, a telepharmacy located at an address listed in Schedule "G" to those bylaws must perform a monthly count of narcotics at the telepharmacy and retain a record of each monthly count signed by the supervising pharmacist for three years at both the central pharmacy and the telepharmacy location, and provide the signed record to the registrar immediately upon request.

b) A physical inventory count for each narcotic drug must be conducted prior to each inventory reconciliation in accordance to the following requirements:
   i. all inventory must be counted, including
      - active inventory,
      - compounded mixtures, and
      - non-usable and expired inventory;
   ii. when completing a physical inventory count, the following information must be documented
      - the name, strength, quantity, and DIN/brand of the drug counted,
      - the date and signature of the person(s) who completed the count, and
      - the date and signature of the responsible pharmacist, and
   iii. the count must not be conducted by the same person who enters narcotic purchases into the records.

c) An inventory reconciliation must include the following components:
   i. the physical inventory count is compared with the perpetual inventory count for accuracy and discrepancies;
   ii. associated records of the perpetual inventory log are audited for completeness, accuracy and discrepancies; and
   iii. discrepancies must be investigated, addressed, and documented on a narcotic incident report together with relevant supporting information.

d) The completion of each physical inventory count and reconciliation must be verified and signed by the pharmacy manager.

3. Documentation Requirements

a) The perpetual inventory record must be retained for a period of not less than 3 years.

b) The physical inventory count and reconciliation documentation must be maintained and retained in chronological order in a separate and dedicated record for a period of not less than 3 years.

c) If a loss or theft of a narcotic is discovered, the pharmacy manager must:
   i. notify the College within 24 hours of the incident in accordance with *PPP-74 Community Pharmacy Security*;
   ii. report the loss or theft within 10 days in accordance with Health Canada's requirements; and
   iii. forward to the College a copy of any report sent to Health Canada in accordance with *PPP-74 Community Pharmacy Security*.

First approved: 18 Jun 2010
Revised: 20 Feb 2015 / 17 Nov 2017 / 16 Jan 2020
Reaffirmed:

PPP-65

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

POLICY STATEMENTS:

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 British Columbia Pharmacy Association (BCPhA) *Opioid Agonist Treatment Compliance and Management Program for Pharmacy* (OAT-CAMPP) training program, and
    b. record self-declaration of training completion in eServices.

    Notice: November 26, 2021
    Effective immediately and for the duration of the COVID-19 public health emergency in British Columbia, policy statement 1 above does not apply to pharmacists who are only providing the COVID-19 and/or flu immunizations, including boosters.

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 online component of the BCPhA OAT-CAMPP training program, and
    b. 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 or non-pharmacy technician staff member, and retain the completed forms in the pharmacy's files.

1. BUPRENORPHINE/NALOXONE POLICY STATEMENTS:

1. Buprenorphine/naloxone maintenance treatment must only be dispensed as an approved, commercially available formulation.

2. 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 using the commercially available 10 mg/mL methadone oral preparation, except
    a. as a last resort for a patient who has a diagnosis of opioid use disorder and has not benefited from documented, reasonable trials of at least two commercially available methadone formulations, and for whom methadone remains the optimal OAT option, or
    b. during a period of shortage or no supply of a commercially available methadone oral preparation**.**

2. Pharmacies may only compound methadone for MMT, or dispense compounded methadone for MMT,
    a) in one or more of the circumstances described in MMT Policy Statement 1 a) or b) above, and
    b) in accordance with the most recent version of the Health Canada *Policy on Manufacturing and Compounding Drug Products (POL-0051*).

3. All pharmacy managers, staff pharmacists, relief pharmacists, and pharmacy technicians employed in a community pharmacy that provides pharmacy services related to MMT must:
    a) know and apply the principles and guidelines in the most recent version of the CPBC *PPP-66 Policy Guide: Methadone Maintenance Treatment (2013)*,
    b) be familiar with the information in the most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder*,
    c) be familiar with the information in the most recent version of the Health Canada *Policy on Manufacturing and Compounding Drug Products (POL-0051*), and
    d) be familiar with the information in the commercially available 10 mg/mL methadone oral preparation product monographs.

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

- The most recent version of the CPBC *PPP-66 Policy Guide: Methadone Maintenance Treatment (2013)*.
- The most recent version of the BCCSU *A Guideline for the Clinical Management of Opioid Use Disorder.*
- The most recent 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.*
- The most recent version of the Health Canada *Policy on Manufacturing and Compounding Drug Products (POL-0051*).
- Product monographs for the commercially available 10 mg/mL methadone oral preparations.

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. 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 most recent version of 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.

3. COMMUNITY HEALTH FACILITY POLICY STATEMENTS:

1. A pharmacist may provide individually-labelled, patient-specific doses of methadone, buprenorphine/naloxone and/or slow release oral morphine to a community health facility[6] when directed by the prescriber, and in accordance with a section 56 exemption to the *Controlled Drugs and Substances Act*.
2. A pharmacist may provide clinic stock of methadone, buprenorphine/naloxone and/or slow release oral morphine to a community health facility in accordance with a section 56 exemption to the *Controlled Drugs and Substances Act*.
3. All pharmacy managers, staff pharmacists, relief pharmacists, and pharmacy technicians employed in a community pharmacy that provides opioid agonist treatment (OAT) drugs to a community health facility should be familiar with the information included in the most recent version of the Ministry of Health and BCCSU's 'Integrated interdisciplinary Model of OAT' guidance document.
4. When a pharmacist provides an OAT drug to a community health facility for administration by another regulated health professional in accordance with the Ministry of Health and BCCSU's 'Integrated Interdisciplinary Model of OAT', sections 1(2)(a), 2(2)(a), and 3(2)(a) of this policy do not apply.
5. The pharmacist should document in the patient record that a patient's dose of OAT has been provided to a community health facility.
6. The pharmacist should use a secure and confidential method of transporting the OAT drugs to a community health facility and should consider the use of tamper-proof boxes or seals.
7. The pharmacy manager must ensure written policies and procedures are in place to ensure the requirements of the section 56 exemption to the *Controlled Drugs and Substances Act* are met when providing OAT drugs to a community health facility.

First approved: 19 Nov 2010 **PPP-66**
Revised: 15 Apr 2011 / 20 Sep 2013 / 17 Nov 2017 / 20 Apr 2018 / 14 Sep 2018 / 23 Nov 2018
17 Mar 2020 / 20 Nov 2020 / 24 Sep 2021 / 26 Nov 2021 / 17 Nov 2022 / 17 Nov 2023
Reaffirmed:

6 Community Health Facility is defined in Health Canada's S.56 exemption as "a facility where health care services are delivered and managed by a nurse as part of the nurse's professional practice."

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.

First approved: 15 Jun 2018 **PPP-67**
Revised: 14 Sep 2018
Reaffirmed:

This policy sets out requirements for pharmacy managers on cold chain management and their responsibilities under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws sections 18(2)(c)(ii), 18(2)(e), 18(2)(l), 18(2)(v), 18(2)(ee)(i), 23.1(1), 24(1), 25(2)(g), and 29(1)(a-c).

DEFINITIONS:

In this policy,

"**drug**" means a drug that requires cold chain management according to the required storage temperature range;

"**cold chain management**" means the processes used to maintain a drug within the required storage temperature range, starting at the manufacturer and ending with release of the drug to the patient, which includes transporting, handling and storage of the drug;

"**temperature excursion**" means an event in which a drug is exposed to a temperature outside of the required storage temperature range; and

"**cold storage equipment**" means the equipment (i.e., refrigerator or freezer) used to maintain a drug within the required storage temperature range. The recommended temperature range for a refrigerator is between +2°C to +8°C and for a freezer is between -25 °C to -10 °C.

POLICY STATEMENTS:

For a drug that requires cold chain management, the pharmacy manager must ensure the following:

1. the drug is maintained in accordance with the manufacturer's requirements and any other applicable requirements;
2. the pharmacy is equipped with cold storage equipment that
    a. must be purposed for drugs only,
    b. must maintain only one temperature range enclosed by a door with an air-tight seal (a standard "bar" fridge (combination fridge/freezer with one exterior door) is not acceptable as it does not maintain even temperatures), and
    c. is equipped with a digital thermometer or temperature monitoring system;
3. temperatures of the cold storage equipment are monitored and recorded
    a. manually at least twice each working day, preferably at opening and closing of the pharmacy, documenting the current temperature, and the minimum and maximum temperatures reached since the last temperature recording, or
    b. automatically with a temperature monitoring system that
        i. records temperatures at a frequency that can determine current temperatures, and minimum and maximum temperatures reached at least twice a day, and
        ii. monitors and notifies pharmacy staff when a temperature excursion occurs;

4. establish written policies and procedures that include processes
    a. to ensure proper cold chain management,
    b. to record temperatures of the cold storage equipment in accordance with section 3,
    c. to determine and document actions taken when a temperature excursion occurs, and
    d. for regular maintenance that ensures functionality of cold storage equipment and documenting those processes;
5. all pharmacy staff are trained on the policies and procedures necessary to maintain cold chain management; and
6. the following documentation must be retained and easily retrievable for at least three years
    a. the temperature records of the cold storage equipment required by section 3, and
    b. the documentation resulting from
        i. actions taken when a temperature excursion occurs, and
        ii. regular maintenance that ensures functionality of the cold chain equipment.

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 STATEMENTS:

1. 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 all community pharmacy managers, no later than one year after appointment;

(b) for all community pharmacy managers, every three years after compliance with (a); and,

(c) record self-declaration of training completion in e-Services for both (a) and (b).

For further clarity, pharmacy managers are considered to have complied with (a) 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.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 70**
POLICY FOCUS: **Making a Diagnosis and Prescribing – Regulatory Education Module**

This policy sets out the regulatory educational requirements approved by the Board for the purpose of section 18 of the *Health Professions Act* Bylaws Schedule F Part 8 – Making a Diagnosis and Prescribing Standards, Limits and Conditions.

POLICY STATEMENT:

1. Prior to making a diagnosis or prescribing a Schedule I drug, pharmacists must complete the following regulatory educational module and must record self-declaration of training completion in e-Services:

Module Name: Pharmacist Prescribing for Minor Ailments and Contraception (PPMAC): Regulatory Education Module

Module Provider: College of Pharmacists of British Columbia, hosted on the University of British Columbia's Learning Management System

First approved: 01 Jun 2023 **PPP-70**
Revised:
Reaffirmed:

This policy provides guidance to pharmacists and pharmacy managers working in community pharmacy settings on the delivery of opioid agonist treatment (OAT) drugs by pharmacists directly to patients.[1] This policy does not apply to injectable opioid agonist treatment.

The *Pharmacy Operations and Drug Scheduling Act* Bylaws sections 18(2)(b-e), (l), (m) and (t), 19(4), 19(6)(a-b), 23(1)(a-b), 23.1(1), and 36, and the *Health Professions Act* Bylaws Schedule F, Part 1 - *Community Pharmacy Standards of Practice* supplement this policy. This policy must be read in conjunction with *Professional Practice Policy – 66 Opioid Agonist Treatment* and its associated Policy Guides.

COVID-19 UPDATE

Effective immediately and while permitted by a section 56 exemption to the *Controlled Drugs and Substances Act*, a pharmacist, using their professional judgement, may authorize:

1. A regulated health professional to deliver OAT to a patient, ensuring that they have the appropriate scope and competence to assess a patient and witness the ingestion of OAT; or
2. A pharmacy employee to deliver OAT to a patient on the pharmacist's behalf. Note: The authorization of a pharmacy employee should be reserved for exceptional circumstances where it is not possible for a pharmacist or regulated health professional to deliver the OAT drug.

The pharmacist must ensure that the pharmacy employee authorized to deliver the OAT drug has the appropriate knowledge and competence to provide witnessed ingestion (where applicable), and to recognize when it may be unsafe to provide the dose to the patient (e.g. the patient is intoxicated) and how they should proceed in these situations. Where possible, the pharmacist should assess the patient by phone or other virtual means before the pharmacy employee releases the dose.

The pharmacist must ensure the required documentation for each OAT delivery is completed and retained in the patient record, including the signature and name of the person authorized to deliver the OAT drug for each delivery. Unconsumed or partially consumed doses must be documented and returned to the pharmacy as soon as possible.

All other requirements outlined within this policy, and the section 56 exemption to the *Controlled Drugs and Substances Act* must be met.

For the health and safety of the public and those delivering OAT, a pharmacist should confirm if their patient is experiencing symptoms of COVID-19 or are self-isolating prior to delivering OAT. In addition, consideration should be given on how to maintain social distancing while delivering medications to a patient.

POLICY STATEMENTS:

1. Determination to Deliver OAT

a. A pharmacist may deliver OAT to a patient from whom they have received a valid OAT prescription, if using their professional judgement, the pharmacist determines that providing delivery is safe, appropriate and in the best interest of the patient.
b. The pharmacist must document in the patient's record the decision to deliver or to not deliver, including the rationale for the decision. This documentation must be easily retrievable.

[1] Transportation of Controlled Substances in Canada: https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/policy-regulations/policy-documents/transportation-of-controlled-substances-in-canada.html

c. The pharmacist must notify the prescriber of the decision to initiate or stop delivery as soon as reasonably possible, and this must be recorded in the patient's record.
d. A pharmacist may refuse to deliver OAT if there is concern for the safety of the patient, pharmacist or public. Where appropriate, the pharmacist should discuss any concerns with the prescriber to resolve issues in the best interest of the patient.
e. A pharmacist must not deliver OAT to a patient if the prescriber indicates that delivery is not permitted.
f. If delivery is not feasible within the services and resources the pharmacy provides, the patient should be referred to a pharmacy that can provide the delivery.

2. Delivery of OAT

If a pharmacist has made the determination to deliver OAT to a patient as noted in section 1, the pharmacist must meet the following delivery requirements:

a. The pharmacist must work with the patient to make arrangements for delivery that are in the best interest of the patient. Arrangements must include:
    i. A delivery location that is private, maintains the confidentiality of the patient, is safe for both the patient and the pharmacist, and has a verifiable address.
    ii. Time(s) and date(s) for delivery.
    iii. Procedure if the patient is not available at the location to receive the OAT delivery including communication of appropriate alternate arrangements for the patient to obtain their OAT drug.
b. The OAT drug must be packaged in the pharmacy and dispensed with the appropriate labelling.
c. A pharmacist must release an OAT drug to a patient in accordance with *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides.
d. Due to the requirement for a pharmacist to assess a patient prior to releasing an OAT drug,
    i. only a pharmacist may deliver OAT to a patient,
    ii. the OAT drug must only be delivered directly to the patient, and
    iii. the OAT drug must not be left with any other person.
e. In addition to meeting the requirements for documentation set out in *Professional Practice Policy-66 Opioid Agonist Treatment* and its associated Policy Guides, pharmacists must record the delivery date, time and address for each delivery on the patient record, which includes the patient specific accountability log.

3. Safety and Security

a. The pharmacy manager must ensure that written policies and procedures are in place to ensure the safety of the patient and the pharmacist and the security of the drug during the delivery.
b. The dispensing pharmacist is responsible for securely transporting and appropriately storing the OAT drug.
c. OAT drugs may not be stored outside of the pharmacy under any circumstances, nor be left unattended if the delivery is unsuccessful.

This policy sets out requirements for pharmacy managers on complying with their responsibility under the *Pharmacy Operations and Drug Scheduling Act* ("PODSA Bylaws") section 18(2)(g) to ensure that all individuals working in the pharmacy who present themselves as registrants have been granted and maintain registration with the College.

POLICY STATEMENTS:

New Registrant Staff at Time of Hiring:

1. **Confirm Registrant Identification**

   The pharmacy manager must confirm identification of the registrant upon hiring by viewing a valid and current government-issued photo identification, such as a Canadian driver's licence, passport or Canadian citizenship card.

2. **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 registrant matches the College registration number and pharmacist name returned by PharmaNet.

3. **Confirm Registration Status with the College of Pharmacists of BC**

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

   - Confirm the registrant's registration status as a 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 a drug or substance by injection or intranasal route.

All Registrant Staff from Time to Time:

4. **Confirm Registration Status with the College of Pharmacists of BC**

   The pharmacy manager must, at least annually, access the online register on the College website to:

   - Confirm the registrant's registration status as a 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 a drug or substance by injection or intranasal route.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 74**
POLICY FOCUS: **Community Pharmacy and Telepharmacy Security**

This policy provides guidance to community pharmacies for complying with community pharmacy and telepharmacy security requirements. *Pharmacy Operations and Drug Scheduling Act ("PODSA")* Bylaws sections 1, 18(2)(c)(iii), 18(2)(e), 18(2)(l), 18(2)(t), 18(2)(aa), 18(7), 26, and 31(3) 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)(t), 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)(aa). 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

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 75**
POLICY FOCUS: **Patient Identification**

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.

POLICY CATEGORY: **PROFESSIONAL PRACTICE POLICY- 76**
POLICY FOCUS: **Criminal Record History Vendor**

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, 3(5), 6(3), 9(3), 14, 16(3) and 16(4)(c).

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.

First approved: 17 Nov 2017 **PPP-76**
Revised: 13 Sep 2019 / 16 Jan 2020
Reaffirmed:

POLICY STATEMENT:

This policy provides guidance to pharmacies for the display of the Expectations of Care poster (the "sign") required to comply with the *Pharmacy Operations and Drug Scheduling Act* ("PODSA") Bylaws section 23.4.

1) The sign set out in Appendix A is provided by the College for the purpose of PODSA Bylaws section 23.4.

2) The sign can be downloaded or printed from the College's public website.

3) The sign is to be displayed:

    a) in colour, with the same colours as appear in Appendix A; and

    b) in a minimum size of 8.5 by 11 inches, and with an aspect ratio of 4:3 if displayed in a larger size.

First approved: 25 Apr 2024 **PPP-77**
Revised:
Reaffirmed:

APPENDIX A

What You can Expect from Your Pharmacy Visit

Pharmacists and Pharmacy Technicians in BC are licensed health professionals with a duty to provide safe pharmacy care in an ethical, equitable, and culturally safe manner to help people reach their desired health outcomes.

You Will Receive Culturally Safe and Inclusive Care

Your pharmacy team will provide unbiased care, free from prejudice and discrimination on any basis, respecting the needs of Indigenous, Black, people of colour, 2S/LGBTQINA+ and other communities.

Your Medication is Right for You

Your pharmacy team will take the time to check your health records and make sure your medications are safe, appropriate, and clearly labelled.

Your Pharmacist Will Speak With You About Your Medication

Your pharmacist will take the time to help you understand your medication, how to take it properly, and address any questions you may have.

Your Privacy is Respected

You will receive care in a space where you feel comfortable.

Your Health Records Are Correct And Protected

Your pharmacy team will protect your health records and medication history, ensuring they are accurate, up-to-date, and protected from loss, theft, or misuse.

College of Pharmacists of British Columbia

Regulating pharmacies and pharmacy professionals in the public interest.

Questions or concerns? Let us know.
Complaints@bcpharmacists.org
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