



The Manitoba Pharmaceutical Association

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MPhA Standards of Practice Committee Report Review of the Draft Regulations to Bill 41

March 20, 2007

During the months of February and March 2007 the MPhA Standards of Practice Committee met six times to review the regulations and in doing so offer the following suggestions:

Definitions:

- The definition of LTC and hospital should be expanded to include Federal sites; both hospitals and nursing homes. This would enable MPhA specific LTC standards to be applied on reserves and penitentiaries etc. which may technically be forced to use community standards otherwise;
- Placing the definitions of LTC and hospital in section 1(1) was suggested;
- Removing the word "direct" from the definition of a health care setting was suggested as a method of enabling a wider range of pharmacist practices but still dealing with patient care;

Part 3: Licensing of Pharmacists:

General Discussion Summary:

- 100 % of the committee felt that the current measurement tool to distinguish between Part A and Part B is inappropriate, not effective or needs to be removed;
- 50% of the committee felt that although the current tool is inappropriate, if there is no other available, it should remain until we develop an alternative.
- 50% of the committee felt that there should be no distinction between pharmacists. A pharmacist is a pharmacist providing they maintain their PD requirements or the then current competency/performance testing.
- It was noted that PEBC is not far from defining an appropriate model that could be used in Manitoba
- It was noted that a Part B pharmacist has to resign their licence and become an intern to transfer from Part B to Part A. It was felt that this was inappropriate, notwithstanding that the internship process was a good process for transferring from Part A to Part B
- The concept of a measurement tool of performance/competency was supported;
- Under **14 (2)** it was felt that any direct patient care time should qualify towards a Part A licence;

Comments Included:

- The option for patient contact should be available for Part B licensees;
- Hours worked in a site do not determine competency;
- Most pharmacists have an understanding of their scope of practice and are able to self assess and ensure they practice in a safe manner;
- The current measure under the old Act and the new measure under the new Act are measures based on the site of practice which the committee feels is an inadequate measuring tool;

- Competency can not be measured based on performance at one site as the needs of practice in a different site is very different
- The current system and the system presented in these Regs are black & white but the issue is way more complicated;
- Knowledge requirements depend on the areas of practice. Patient care is different in each category;
- There is agreement that a pharmacist is a pharmacist but that does not imply competence in all practice sites;
- Self regulated or mandated mentorship may be a viable method of ensuring competence and/or transition from one category or practice site to another;

Part 5: Pharmacy Licences:

Section 29 (2):

- Support was expressed for addition of a long term care component as a separate entity;
- Concern was expressed that the current model in 29 (3) would appear to entail a pharmacy servicing more than one of the four areas of practice (community, hospital, LTC & clinical) requiring multiple licenses and multiple licensing fees. Recommended was a system where there was one licence with four categories (community, hospital, LTC, and clinical) with the appropriate subcategories (telepharmacy, lock and leave, central fill, distance care);

Section 29 (6):

- A method of one hospital pharmacy servicing more than one hospital under one licence is needed. A possible solution is a hospital sub category; "remote ward", "distance ward" or "satellite ward" be added;
- A possible solution might entail defining a distant ward under definitions and adding under 38 (1) another point that requires the "remote wards" to be listed on the application and the requirement for remote ward practice be compliant with MPhA Standards of Practice;
- Without this provision, pharmacy service to smaller rural hospitals from a larger referral centre remains hampered. There is a need for a defined practice model through licensing for service provision to these sites. The current model where a pharmacist is assumed to be practicing as a pharmacist and is not able to "practice pharmacy" at these sites is problematic. With the new definition, practice of pharmacy in the new Act, under **2(1)** and **2(2)**, does not include a form of licensing the remote wards would prevent a pharmacist from working with these sites. This might possibly eliminate pharmacy services to these sites as these sites are not licensable as a pharmacy (e.g. no pharmacist onsite etc.)

29 (9): Provision needs to be made for after hour service and emergency service. In LTC practice it is the norm for a traditional community pharmacy to undertake calls during the hours they are open and the LTC pharmacy is closed. In addition, a community, LTC, hospital, or a clinical pharmacist may need to unexpectedly fill in for or supplement services to another category.

29(8): Discussion involved the advantages of a mobile pharmacy serving multiple remote communities. At the close of the conversation it was noted that the telepharmacy component should/would provide a stable site better suited to pharmacy as it would be easier to regulate, and have suitable cleanliness, sterility and temperature control

Section 30:

- Staff levels are hard to predict and subjective; some concern was expressed by a minority of members (2/14) that the requirement might be too subjective;

32, 33, and 37: Hours of Operation (DC, LL, TP):

- Strong opinions expressed if there was a need for minimum hours of operation, the need was similar for Distance Care, Lock and Leave and Telepharmacy;
- The consensus was that there were 2 components to practice: cognitive and distributive. The general consensus of the group was that having access to a pharmacist in Distance Care, Lock and Leave and Telepharmacy was reasonable for regular business hours (e.g. Monday to Friday, 9-6) and that a reasonable number might be between; 30 to 40. The group was split on the requirement for a minimum number of hours open for distribution. The general consensus was if there was a requirement for minimum hours, about 20 is reasonable;
- For Distance Care the hours of operation should be posted on the website;
- Northern Distance Care is an example where the pharmacist needs to be available;
- An alternative might be to add the phrase "or as approved by Council" to allow Council to be flexible.

Long Term Care & Hospital: Hours of Operation:

- The consensus was there is a continuing need for 24/7 access to the cognitive portion of practice and the current practice of requiring 24/7 pharmacist coverage should continue.

Section 33: Distance Care:

- It was noted that section 33(3) (b) (i) and the requirement for malpractice insurance would eliminate the Distance Care component of practice for clients outside Canada. Concern was expressed that these two Distance Care requirements would be perceived as MPhA attempting to eliminate this component of practice;
- It was noted that Distance Care in Canada would not be affected to the same extent as the use of NAPRA as a vehicle to facilitate the need in 33 (3) (b) (i) and obtaining malpractice insurance wouldn't limit distance care within Canada;
- Setting aside the effect on non Canadian Distance Care, the consensus was the requirement for malpractice insurance was reasonable in principle.

34 (1): Provision needs to be made for service to facilities not listed in *The Health Services Insurance Act*.

Examples include federal hospitals, personal care homes and incarceration facilities not covered under this Act.

Section 37: Telepharmacy:

- **37 (2) (d):** The need for an onsite attendance by a member every two months was confirmed.
- There was significant discussion on the requirement for onsite attendance by a member every two months. After explanation by several members who had served on the Sub Committee responsible for drafting the original suggestions for practice standards in this area, the consensus was there was a need for a "member" to attend onsite on a regular basis, although onsite reviews by a technician was acceptable in addition to the required visits by a member;

Section 38(1) (a) was discussed in detail:

- **LTC:** The consensus was for LTC there was a need for sponsorship of the clinical pharmacy by a distribution pharmacy and that it should be changed to allow both for LTC. It was felt that due to capitation reimbursement in LTC there was not an ethical dilemma for LTC.
- **Hospital:** The ethical dilemma and perception of a conflict of interest was not significant for hospital practice, although having the possibility of the Clinical Pharmacist practicing under the general pharmacy licence was "cleaner" and easier to implement and maintain;
- **Community:** The clause is problematic for rural and remote sites where one pharmacist undertaking both roles may be the only option for a clinical pharmacist;
- In general, 25% of the members present wanted the concept to be retained and 75% felt it should be removed;
- If it is to apply, in general, it was felt that it should apply or only apply where there is an opportunity for inappropriate monetary gain.

Section 39:

- Section 39 (b) needs to be supplemented with **...or as approved by Council** to ensure that the MPhA and members have the flexibility and authority to mould the model to accommodate unique circumstances;
- In addition a mentoring process would be helpful as would a jurisprudence process and perhaps development a list of skill requirements;
- The need for Council flexibility on 39 c) was confirmed;

40 & 41 General Comments:

- Reporting changes to the MPhA makes sense;
- Substantial change needs to be defined;
- 14 days notice is reasonable;

Section 43:

- Concern was expressed that this section could and may interfere with provision of emergency service or a temporary change when the 30 day notice is applied;

Part 7: Duties and Delegation:

- There needs to be clarification surrounding technicians of their accountability, and whom, the pharmacist, pharmacy manager, or the technician, is responsible for a significant error;
- **52(2):** Concern was expressed that the Competency is specific to one sector of the profession and it is put forward that the qualification be limited to the category or sub category of a pharmacy licence;
- **54(2):** Add "selecting an appropriate container";

Part 8: Prescriptions and Records

58 (1) (a): The value of documenting the date of request is unclear and it was felt it was unnecessary information

58 3 (e): It was felt that there should be provision for the PHIN to be stored on the patient profile and there was limited or no value in it being on the prescription

58 3 (j): It was felt that documentation of the declaration needed to be stored on the profile and not each and every prescription

59 (1) c) The value of having the owner on the label in addition to the pharmacy name was felt unnecessary; in addition if there is a numbered company or a partnership the space on the label is limited;

59 (1) Is there value in adding “readily retrievable” as a requirement?

59 (3): Please amend to “does not apply for a drug dispensed for an inpatient of a hospital and a **Personal Care Home Resident** under *The Health Services Insurance Act*.”

59 (4): Please amend to “No drug may be dispensed pursuant to a prescription for an in-patient of a hospital, or a **Personal Care Home Resident** under *The Health Services Insurance Act* unless the container in which a drug is dispensed is marked in accordance with any pertinent Standards of Practice or Practice Direction.”.

61: Add a section (g) that specifies compliant with federal legislation is required;

Disposal Records:

- The term “disposal” was felt not to be appropriate, but an alternate was not suggested;
- **63(2):** It was recommended that the lot number and expiry date should be documented;
- **63(3):** The assumption is that this does not include medication returned by a patient. It was felt that a proper disposal process should be noted and that this section should apply to only drugs covered under the CDSA as the workload will be onerous for many pharmacies especially the large tertiary centres;
- **65 (6):** Ensure federal hospitals and PCH's are included

Part 9: Dispensing of Drugs

68 (4) needs to be further defined as a clinically significant error;

69 (1): Provision needs to be made to ensure compounding is acceptable; e.g. add (d) compounded by a pharmacist

69 (3): Provision needs to be made for First Nations patients who are residents of Manitoba but do not have a PHIN or their PHIN is inactivated;

72 (4): Consideration should be given to changing “owner” to “pharmacy”

70(2): Provision needs to be made for a request for all prescriptions rather than each individual one and that exclusion can be documented in a central file (e.g. patient profile);

70: there needs to be exclusion for hospital in patients and residents of a LTC facility;

72 (4): be amended by adding after manual ...or **Exempted Codeine...**

Section 73 Inducements:

- 100 % of the Committee felt that Bonus Points were a safety and health care issue and that Bonus Points should not be an option;
- Approximately 1/3 felt there should be allowance for inducements as long as Bonus point were not allowed;
- Approximately 2/3's felt that that inducements should not be allowed without exception. It was expressed that section 73 should be made “ironclad” for prescriptions;
- The 1/3 in favour of inducements but without bonus points felt that points were a business issue and should remain acceptable.
- It was felt that delivery and parking were part of the dispensing process and were not inducements

Part 11: Clinical Pharmacists & Specialties

Section 82: Consideration needs to be given to eliminating the list. It's presence restricts the areas of specialty practice to the list, or as an alternative add **82 (g) or any other specialty as designated by Council**

Part 12: Prescribing by Members:

86(1): c) needs to be better defined as NAPRA unscheduled drugs or its meaning clarified. The phrase “for the purposes of allowing the patient to access benefits under a drug plan should be removed to enable pharmacist prescribing in non benefit circumstances (e.g. Income Tax);

86 (1.1): Add ...hospital or LTC licence....to in in patient of a hospital or a resident of a Personal Care Home...designated ..

Section 87:

- Section 87 (b) needs to be clarified to be consistent with the policy of the CPSM and the need for on call and remote prescribing for situations such as northern reserve medicine;
- Section 87 (d) is excellent as it allows each owner or pharmacy manager to add on further criteria for prescribing;

Section 88:

It's recommended this section be used to ensure that Exempted Codeine products may only be sold subsequent to a prescription by a pharmacist or practitioner with the appropriate documentation; including mandatory documentation on DPIN similar to any other prescription;

90 (1) c: Remove the phrase ..without any recent changes or dosage... as this is limiting for some circumstances and limits the ability to use professional judgement

91(4): (C) Add **established venous access route**

95 (1):

- Change may order to **may request** and diagnostic test to **test result**;
- Concern was expressed with the possibility of this section being non compatible with coming electronic health records

Appendix A: Standards of Practice

Comments:

SofP #1: Drug Acquisition and Handling: Nuances will need to be captured in the interpretive document;

SofP #2: Patient Counselling: Nuances will need to be captured in the interpretive document;

SofP #3: Incidents and Discrepancies: Needs to be changed from “Errors” to “Incidents and Discrepancies” consistent with the June 2006 changes to the SofP;

SofP #4: Pharmacy Facilities: Nuances will need to be captured in the interpretive document;

SofP #5: Records: Nuances will need to be captured in the interpretive document;

SofP #6: Dispensing and Sale: Can be combined with #13 “Scope of Practice or Operation” for ease of use;

SofP #7: Pharmacy Hours: Nuances will need to be captured in the interpretive document;

SofP #8: Prescribing: Nuances will need to be captured in the interpretive document;

SofP #9: Administration of Drugs: Nuances will need to be captured in the interpretive document;

SofP #10: Test Interpretation: As it is written, it seems to deny the ability of a pharmacist to interpret non patient administered tests and is restrictive rather than empowering. As written it may restrict current practice rather than enhancing;

SofP #11: Test Orders: Number 10 & 11 should be combined;

SofP #12: Policies for Staff; Nuances will need to be captured in the interpretive document;

SofP #13: Scope of Practice or Operation: Nuances will need to be captured in the interpretive document. There is a need to define competency and have a form of assessment. Competency should be defined by category of practice and licensure and Competency should be linked:

SofP #14: Delegation: Reasonable; Nuances will need to be captured in the interpretive document;

SofP #15: Pharmacist to Staff Ratio: Concern was expressed there is the potential for exploitation by larger employers. There is a need to develop greater depth in the interpretative document;

SofP #16: Please add old SofP on Drug Information;

SofP #17: Please add SofP requiring documentation;

SofP #18: Please add the old SofP #4 on formularies.

SofP#19: Please add old SofP #8 on Extemporaneous Compounding